Overview

Joseph R. Antos, Ph.D.

As part of the Omnibus Budget Reconciliation Act of 1989 (Public Law 101-289), Congress established a set of reforms related to payment for physicians' services under the Medicare program. Section 1848 of this law specified three major components of a new payment system for physicians' services: a fee schedule for Medicare based on a resource-based relative value scale; restrictions on the ability of physicians to balance-bill Medicare beneficiaries for amounts exceeding the fee schedule; and processes to set target annual growth rates for expenditures for physicians' services.

The Medicare fee schedule (MFS) went into effect on January 1, 1992. This system replaced the customary, prevailing, and reasonable charge methodology that had been in effect under the Medicare program since its inception. The MFS was intended to address problems seen in the existing system, including overcompensation of physicians for performing procedures and undercompensation for evaluation and management services; variations across localities without justifiable reasons. At the same time, volume performance standards were enacted to control growth of total program costs, and firm limits were set on actual physicians' charges to protect beneficiaries from increases in balance billing. The MFS includes a transition period that extends until 1996, with the largest proportion of the fee schedule changes having been implemented in 1992.

Now, less than 2 years after the implementation of the MFS, the United States is considering a major restructuring of the health care system to expand access for all Americans, including those having no insurance coverage, and possible short-term initiatives to slow the rise in health care expenditures until these major reforms are implemented. These initiatives are driven by the continuing increases in health care expenditures as a percentage of gross national product. U.S. health care expenditures increased by 11.4 percent in 1991. Expenditures for physicians' services grew by 10.2 percent and now constitute more than 21 percent of all expenditures for health services. Physicians are also the principal "gatekeepers" for hospital care, prescription drugs, and other important health care services. Clearly, physicians' services will be an important element of efforts to control the growth in health care expenditures.

It is likely that the enactment of the MFS will have a widespread impact, beyond Medicare. The establishment of the Medicare prospective payment system for hospitals, based on diagnosis-related groups (DRGs), led to the adoption of similar DRG-based systems by States. Already a number of private payers and State Medicaid programs are giving consideration to adopting a method similar to the MFS for paying physicians.

The theme of this issue of the *Review* focuses on the future of the MFS, as well as broader payment issues, specifically, "Physician Payment and Cost Contain-

ment: Perspectives from the U.S. and Abroad." The articles address several basic issues:

Should there be refinements to the MFS? Two articles consider possible modifications or refinements to the MFS. Pope and Burge present a specialty resource-based method of setting MFS relative value units (RVUs) for physicians' practice expenses. Currently these RVUs are determined by using historical physicians' charges. These authors consider a methodology that sets RVUs for practice expenses based on each specialty's expense proportion of total practice revenues.

Dayhoff, Cromwell, and Rosenbach analyze 1988 data from the physicians' practice costs and income survey to update the Health Care Financing Administration (HCFA) cost shares that are used in calculating two components of the MFS payment methodology—the Medicare Economic Index (MEI) and the geographic practice cost index (GPCI)—and to consider whether distinct MEIs or GPCIs are warranted for any subgroup of physicians if their practice cost shares vary systematically in comparison to other physicians. The authors find that substantial differences exist among key practices cost shares, particularly across specialties, but the implications of such differences for public policy are minor. They conclude that changes to the current methodology are not required.

Should the MFS be applied to other payers? Three articles consider the possible application of the MFS to other payers. Langwell presents the arguments for and against a nationwide system of price controls for health care services, such as the application of the Medicare hospital and physician payment systems, for all payers. A Medicare-based all-payer system could reduce the level of health spending and offer great potential for controlling future price increases. At the same time, establishing the correct level and rate of increase in prices for all patients would be difficult, and such a system could reduce research and development, access to care and to new technology, and could restrict consumers' choices. Langwell suggests that the acceptability of these tradeoffs depends on the priorities set for our health care system.

Miller, Zuckerman, and Gates examine how MFS payments compare with private insurance physicians' fees and how physicians' revenues would be affected if Medicare payment levels were adopted by these insurers. The authors find that payments to Medicare physicians are on average about 76 percent of private fees, but that the geographic variations in private fees are greater than under Medicare. Overall, they report that physicians' revenues would decline about 11 percent if Medicare fees were adopted.

The level of fees paid by State Medicaid programs to physicians has been a policy issue for many years. Many States' Medicaid physician fees are well below Medicare and private levels, resulting in reduced physician participation and access to services for Medicaid recipients (although outpatient departments and clinics may substitute for this care). Proposals have been made in the past to raise the fees for physicians under Medicaid to those paid by Medicare, in the belief that Medicaid recipients have reduced access to physician care as a result of these lower payments. "The Impact of Medicaid Adoption of the Medicare Fee Schedule" by Holahan, Wade, Gates, and Tsoflias,

estimates the cost of increasing Medicaid fees to the levels under the MFS by several alternative methods. The authors' analyses suggest that cost impacts would be greater than previous studies have estimated.

Is access to care affected by the MFS? Given that the success of the new Medicare payment system must be judged in part in the context of its impact on the beneficiaries, it is evident that there is a compelling need to develop reliable and valid methods for monitoring access and utilization under the new payment system. Two articles examine possible effects of changes in payments to physicians on access to care, and neither article finds evidence of reduced access at this time. McCall analyzes practice characteristics of individual physicians who provided services to Medicare beneficiaries in 1988, following a reduction in the Medicare prevailing charge for 12 "overpriced" procedures. Her analysis of changes in Medicare caseloads suggests that regardless of practice size or level of price change, most physicians experienced growth in their Medicare caseload. She concludes that physicians did not respond quickly to these 1988 price changes, nor did they respond in a way that would create access problems for Medicare beneficiaries.

Gornick describes the complexities involved in monitoring access to care under the MFS, summarizes the methods being used in HCFA for monitoring changes in access to and utilization of physician services, and highlights major findings included in HCFA's Third Annual Report to Congress (1993) on changes in utilization and access under physician payment reform. The basic approach used involves analyses of trends before and after the implementation of the MFS. The monitoring process focuses on the development of rates of utilization for specific vulnerable subgroups of the population. Based on the analyses, the author suggests that implementation of the MFS does not appear to have had a detrimental effect on access to care, nor has it exacerbated any of the differentials in access that may have existed before the MFS went into effect.

What can be learned from the experiences of other countries? The large number of uninsured persons and the increase in health expenditures in the United States have led many policymakers and consumers to examine the health care financing and delivery systems of other countries that provide care to nearly all of their citizens at a lower cost than does the United States. Many of these countries use global budgets or expenditure caps to constrain the growth in hospital and/or other expenditures—methods that have been suggested for consideration in U.S. health care reform. Included in this issue are two articles examining available information from other countries and possible lessons for the United States in future policy development.

Welch, Katz, and Zuckerman compare physician fee schedules under Medicare with the Canadian provinces and report that, on average, Canadian fees are 59 percent of Medicare fees. Canadians have limited their spending growth, in part by restraining fees rather than using policies such as utilization review (compared with the United States). Because the U.S. multiple-payer system makes it difficult for any individual payer to limit fees without running the risk of adversely affecting its subscribers' access, many U.S. payers have, instead, sought controls over the

volume of covered services in order to control outlays. Although Medicare physician fees are lower than those of U.S. private insurers, Medicare's payment levels are higher than fees in Canada. In the context of the current U.S. health care system, lowering Medicare physician fees to those of Canadian levels could jeopardize access to care for Medicare beneficiaries. However, if the United States adopted a system under which all payers faced the same fee schedule, Canadian fees could prove to be instructive. Despite the much lower fees in Canada, the aggregate supply of physicians is not measurably lower than that in the United States. The authors suggest that lowering physician fees in return for greater physician discretion over treatment decisions may be another alternative to the use of volume controls to constrain expenditures.

In their article, "Global Budgeting in the OECD Countries," Wolfe and Moran present highlights of a review of the literature on the structure and performance of global budgeting systems in the Organization for Economic Cooperation and Development countries. They report that the literature is largely descriptive and presents little evidence of rigorous empirical assessment of the effects of global budgeting schemes compared with other alternatives. Consequently, the value of this literature to guide policy deliberations on health care budgeting techniques in the United States will depend on how policymakers decide to proceed with health financing reform efforts. To the extent that reforms involve creation or expansion of new public programs, these other countries offer a broad range of examples of how global budgets might be applied. However, the authors suggest that the literature provides few ideas and no hard evidence of how to apply global budgeting techniques to control private sector health care spending.

Two other articles in this issue also present findings that are relevant to health care cost-containment programs. Gold, Chu, Felt, Harrington, and Lake review the effects of five previous U.S. health care cost-containment efforts on cost, quality, and access to care. Their findings suggest that the most effective cost-containment approaches tend to be comprehensive systems because they limit the ability of health care providers to offset cost constraints by raising prices to other payers or increasing the services. The article also presents an extensive bibliography of references on these five cost-containment initiatives. The article by Chulis, Eppig, Hogan, Waldo, and Arnett, "Health Insurance and the Elderly: Data from MCBS," reports that individuals without insurance coverage supplemental to Medicare have a lower level of health spending per person than individuals with supplemental coverage. Because the individuals with greater health expenditures tend to be protected from increases in copayments, the authors raise questions about the effectiveness of any cost-containment strategies that would involve increased copayments for Medicare services.

Finally, Cowan and McDonnell present data on health care spending by businesses, households, and governments in the United States in 1991. They report that out-of-pocket health expenditures by households have remained constant as a percentage of income, while health care costs for businesses and, in particular, governments have experienced rapid increases in these expenditures.