

108TH CONGRESS  
1ST SESSION

# H. R. 33

To amend title XVIII of the Social Security Act to establish a minimum geographic cost-of-practice index value for physicians' services furnished under the Medicare Program.

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## IN THE HOUSE OF REPRESENTATIVES

JANUARY 7, 2003

Mr. BEREUTER (for himself, Mr. BERRY, Mr. FOLEY, Mr. MURTHA, Mr. KILDEE, Mr. COSTELLO, Mr. GREEN of Wisconsin, Mr. NETHERCUTT, Mr. MCINTYRE, Mr. TOWNS, Mr. LUCAS of Oklahoma, Mrs. WILSON of New Mexico, Mr. BOUCHER, Mr. TERRY, Mr. BAIRD, Mrs. CUBIN, Mr. BASS, Mr. FROST, and Mr. OSBORNE) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committee on Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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## A BILL

To amend title XVIII of the Social Security Act to establish a minimum geographic cost-of-practice index value for physicians' services furnished under the Medicare Program.

1 *Be it enacted by the Senate and House of Representa-*  
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE; FINDINGS.**

4 (a) SHORT TITLE.—This Act may be cited as the  
5 “Rural Equity Payment Index Reform Act of 2003”.

1 (b) FINDINGS.—Congress makes the following find-  
2 ings:

3 (1) Variations in the physician work adjustment  
4 factors under section 1848(e) of the Social Security  
5 Act (42 U.S.C. 1395w–4w(e)) result in a physician  
6 work payment inequity between urban and rural lo-  
7 calities under the medicare physician fee schedule.

8 (2) The amount the medicare program spends  
9 on its beneficiaries varies substantially across the  
10 country, far more than can be accounted for by dif-  
11 ferences in the cost of living or differences in health  
12 status.

13 (3) Since beneficiaries and others pay into the  
14 program on the basis of income and wages and bene-  
15 ficiaries pay the same premium for Part B services,  
16 these payments result in substantial crosssubsidies  
17 from people living in low payment States with con-  
18 servative practice styles or beneficiary preferences to  
19 people living in higher payment States with aggres-  
20 sive practice styles or beneficiary preferences.

21 (4) Congress has been mindful of these vari-  
22 ations when it comes to capitation payments made  
23 to managed care plans under the Medicare+Choice  
24 program and has put in place floors that increase  
25 monthly payments by more than one-third in some

1 of the lowest payment counties over what would oth-  
2 erwise occur. But this change addresses only a very  
3 small fraction of medicare beneficiaries who are  
4 presently enrolled in Medicare+Choice plans oper-  
5 ating in low payment counties.

6 (5) Unfortunately, Congress has only begun to  
7 address the underlying problem of substantial geo-  
8 graphic variations in fee-for-service spending under  
9 traditional medicare.

10 (6) Improvements in rural hospital payment  
11 systems under the medicare program help to reduce  
12 aggregate per capita payment variation as rural hos-  
13 pitals are in large part located in low payment coun-  
14 ties.

15 (7) Many rural communities have great dif-  
16 ficulty attracting and retaining physicians and other  
17 skilled health professionals.

18 (8) Targeted efforts to provide relief to rural  
19 doctors in low payment localities would further re-  
20 duce variation by improving access to primary and  
21 tertiary services along with more equitable payment.

22 (9) Geographic adjustment factors in the medi-  
23 care program's resource-based relative value scale  
24 unfairly suppress fee-for-service payments to rural  
25 providers.

1           (10) Actual costs are not presently being meas-  
 2           ured accurately and payments do not reflect the  
 3           costs of providing care.

4           (11) Unless something is done about medicare  
 5           payment in rural areas, as the baby boom cohort  
 6           ages into medicare, the financial demands on rural  
 7           communities to subsidize care for their aged and dis-  
 8           abled medicare beneficiaries will progress from dif-  
 9           ficult to impossible in another 10 years.

10           (12) The impact on rural health care infra-  
 11           structure will be first felt in economically depressed  
 12           rural areas where the ability to shift costs is already  
 13           limited.

14 **SEC. 2. PHYSICIAN FEE SCHEDULE WAGE INDEX REVISION.**

15           Section 1848(e)(1) of the Social Security Act (42  
 16 U.S.C. 1395w-4(e)(1)) is amended—

17           (1) in subparagraph (A), by striking “subpara-  
 18           graphs (B) and (C)” and inserting “subparagraphs  
 19           (B), (C), and (E)”; and

20           (2) by adding at the end the following new sub-  
 21           paragraph:

22                           “(E) FLOOR FOR WORK GEOGRAPHIC INDI-  
 23           CES.—

24                                   “(i) IN GENERAL.—Notwithstanding  
 25           the work geographic index otherwise cal-

1           culated under subparagraph (A)(iii), in no  
2           case may the work geographic index ap-  
3           plied for payment under this section be  
4           less than—

5                   “(I) 0.976 for services furnished  
6                   during 2004;

7                   “(II) 0.987 for services furnished  
8                   during 2005;

9                   “(III) 0.995 for services fur-  
10                  nished during 2006; and

11                  “(IV) 1.000 for services fur-  
12                  nished during 2007 and subsequent  
13                  years.

14                  “(ii) EXEMPTION FROM LIMITATION  
15                  ON ANNUAL ADJUSTMENTS.—The increase  
16                  in expenditures attributable to clause (i)  
17                  shall not be taken into account in applying  
18                  subsection (c)(2)(B)(ii)(II).”.

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