

PHYSICIAN PAYMENT REVIEW COMMISSION RECOMMENDATIONS ON PHYSICIAN PAYMENTS

HEARING
BEFORE THE
SUBCOMMITTEE ON HEALTH
OF THE
COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES
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**PHYSICIAN PAYMENT REVIEW COMMISSION
RECOMMENDATIONS ON PHYSICIAN PAY-
MENTS**

THURSDAY, MARCH 30, 1995

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, D.C.

The subcommittee met, pursuant to notice, at 10:35 a.m., in room 1100, Longworth House Office Building, Hon. Bill Thomas (chairman of the subcommittee) presiding.

The press release announcing the hearing follows:

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
 March 22, 1995
 No. HL-7

CONTACT: (202) 225-3943

THOMAS ANNOUNCES HEARING ON THE PHYSICIAN PAYMENT REVIEW COMMISSION RECOMMENDATIONS ON PHYSICIAN PAYMENTS

Congressman Bill Thomas (R-CA), Chairman, Subcommittee on Health of the Committee on Ways and Means, today announced that the subcommittee will hold a hearing on the physician payment recommendations included in Physician Payment Review Commission (PPRC) 1995 Annual Report to Congress. **The hearing will take place on Thursday, March 30, 1995, in the main Committee hearing room, 1100 Longworth House Office Building, beginning at 10:30 a.m.**

In view of the limited time available to hear witnesses, oral testimony at this hearing will be heard from invited witnesses only. Witnesses will include John M. Eisenberg, M.D., Chairman of the PPRC and physician groups. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

BACKGROUND:

In 1986, the Congress established the Physician Payment Review Commission to advise the Congress on issues regarding physician payment under Medicare. Each year, the PPRC has provided Congress with specific recommendations on ways to improve the program.

In announcing the hearing, Chairman Thomas said: "The 1995 recommendations of the PPRC are extremely important, especially in light of the Administration's refusal to deal seriously with the problems facing the Medicare program. The recommendations included in their annual report will help us to lay the foundation for reform to preserve the Medicare program."

FOCUS OF THE HEARING:

This hearing will review the formal recommendations of the PPRC regarding physician payment under the Medicare program.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Any person or organization wishing to submit a written statement for the printed record of the hearing should submit at least six (6) copies of their statement, with their address and date of hearing noted, by the close of business, Thursday, April 13, 1995, to Phillip D. Moseley, Chief of Staff, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. If those filing written statements wish to have their statements distributed to the press and interested public at the hearing, they may deliver 200 additional copies for this purpose to the Subcommittee on Health office, room 1136 Longworth House Office Building, at least one hour before the hearing begins.

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages including attachments.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. A witness appearing at a public hearing, or submitting a statement for the record of a public hearing, or submitting written comments in response to a published request for comments by the Committee, must include on his statement or submission a list of all clients, persons, or organizations on whose behalf the witness appears.

4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations to the full statement. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and the public during the course of a public hearing may be submitted in other forms.

Note: All Committee advisories and news releases are now available over the Internet at GOPHER.HOUSE.GOV, under 'House Committee Information'.

Chairman THOMAS. The subcommittee will come to order. This morning the subcommittee will review the 1995 annual recommendations of the Physician Payment Review Commission regarding physician payment. The Commission's 1995 recommendations will provide direction for the subcommittee as we consider further perfections of the Medicare fee schedule. These recommendations and the comments of groups from the physician community will help the subcommittee meet its responsibilities to set policy for physician payment.

The fee schedule has clearly had a positive influence on distribution of physician payment between primary and specialty services. It has also served as a vehicle for regulating payment increases for physicians. However, it does not provide real incentives for cost conscious purchasing of medical services for beneficiaries and, as we will learn today, has the flaws inherent with any government price regulatory scheme.

We should continue to examine and refine payment policy in the old-fashioned Medicare program, but we should also spend most of our energy over the next few months looking for the best means to transform Medicare coverage and bring to it the advantages of the experience in the private market. Cost conscious purchasing of quality care is the theme in the private market, and it is the goal of this subcommittee to look at the private sector to discover the structural reforms we need to bring both Medicare costs in line as well as ensure Medicare beneficiaries the same choices most employed Americans and their dependents now enjoy.

We particularly look forward to hearing from the PPRC, and I personally want to thank the outgoing Commission Chairman John Eisenberg for the contribution he has made in trying to improve the physician payment policies which have been developed by the Commission over time.

I yield to my colleague from California.

Mr. STARK. Thank you, Mr. Chairman. I am pleased to join with you in welcoming Dr. Eisenberg to the subcommittee. His work as Chairman of the Physician Payment Review Commission has been exemplary. As this year's report again demonstrates, the PPRC continues to be the best source of objective analysis about physician payment and related issues. I believe it is no accident that this standard of objective excellence has continued under Dr. Eisenberg's leadership.

Given this record of achievement, I am mystified, Mr. Chairman, by reports that my Republican colleagues intend to replace Dr. Eisenberg as Chairman of the PPRC. Perhaps someone from your side will be able to clear up this mystery today, given that, as far as I know, there is nothing in the work of the PPRC or Dr. Eisenberg which would suggest that he should be replaced.

There is no evidence, for example, that he has indulged in partisan activities or favored one point of view over another in the great debate on health reform. Previous chairs of PPRC and the Prospective Payment Assessment Commission have been allowed to continue essentially indefinitely, and I am just curious as to why a different standard has been imposed in Dr. Eisenberg's case. Since he is here and since I am sure that he too is wondering about why he is not even being given the opportunity to serve a complete

term as Chairman, might it not be appropriate for us to clear up for him the mystery of why the majority members of this committee believe he should not be reappointed?

Mr. Chairman, I would very much appreciate it, and for the courtesy of Dr. Eisenberg, who has long and faithfully served the Commission, if you could shed some light on this enigma.

Chairman THOMAS. The gentleman is asking me to respond to his comment. I do not know whether it is about the fact that Dr. Eisenberg replaced Dr. Lee, and has filled out the portion of that term, and that term has expired, or whether the gentleman from California is concerned about potential new appointees to the position or both? Which is it he is concerned about?

Mr. STARK. The tradition of the Physician Payment Review Commission and ProPAC has been since its inception that the chair has stayed as long as the chair has chosen to serve and not been forced out. And I just wonder what it is about Dr. Eisenberg's service which would cause a change?

Chairman THOMAS. The term has expired, and I guess the gentleman from California is concerned the Clinton administration has now offered Dr. Eisenberg the job as the previous chairman was offered.

Mr. STARK. I just repeat that it has been the policy to allow the chair to stay as long as he chooses, both ProPAC and PPRC.

Chairman THOMAS. And as a presidential appointment.

Mr. STARK. Until they decide for whatever reason to retire or resign.

Chairman THOMAS. Well, I guess maybe there ought to be traditions that are followed and some traditions that are not necessarily followed. And then patterns develop over time that do not lock us into an absolute requirement that a chairman stay in a position until the chairman decides whether or not they want to leave. I believe we have the ability to appoint people to the position and that it ought to be the elected officials who make the determination at the end of the term. Dr. Eisenberg is not being removed in the middle of the term. The term has expired. And if the gentleman wishes to have the chairmen of these commissions determine how long they are going to remain, perhaps he really fully does not understand the structure and relationship between the Members of Congress and the commissions themselves.

Mr. STARK. Well, Mr. Chairman, I bow to your superior knowledge and intelligence and perspicuity in these matters and that you have exhibited over a number of years. I thank the Chair for his comments.

Chairman THOMAS. I appreciate the gentleman from California's comments including the really earnest and honest way in which they were delivered. I am sure there was no hidden agenda in the way in which he described the Chairman, and I appreciate the kind words.

With that, Dr. Eisenberg, your written statement will be made a part of the record, and you may proceed in any way that you wish.

**STATEMENT OF JOHN M. EISENBERG, M.D., CHAIRMAN,
PHYSICIAN PAYMENT REVIEW COMMISSION, ACCOMPANIED
BY DAVID COLBY, STAFF, PHYSICIAN PAYMENT REVIEW
COMMISSION**

Dr. EISENBERG. You do have the written record. The Commission's report, the March report, will be released tomorrow, and will be made available to the subcommittee, to the full committee, to both Houses of the Congress. What I would like to do today is to try to briefly summarize what this report recommends, particularly the part of the report that deals with the Medicare system.

As you mentioned, Mr. Chairman, many of the goals that were set out by the Congress in the Omnibus Budget Reconciliation Act of 1989 in reforming the Medicare system are being achieved, and most would consider those reforms to be successful. There are problems, we believe, and we would like to help the Congress address those problems. I do want to emphasize that this system, which was designed by the Congress and implemented by HCFA, is being adopted by a large number of managed care organizations and States in their own Medicaid plans so that many of the issues that we will address today go far beyond Medicare and whether Medicare pays fee-for-service or not, whether Medicare moves to managed care or not. The system which Medicare uses, the resource-based relative value scale (RBRVS), has profound implications in the private sector, and decisions that the Congress makes in changing the RBRVS system will have major impacts on managed care programs who pay fee-for-service to the physicians as well as Medicaid plans.

Let me talk for a moment then about the Medicare RBRVS and the impact that has taken place because of the way the volume performance standard was established. In the Omnibus Budget Reconciliation Act of 1989, Congress decided to have two separate performance standards, one for surgery and one for nonsurgery. In the Omnibus Budget Reconciliation Act of 1993, we added a third, a separate category for primary care. The PPRC has suggested that there ought to be one standard.

The result of having three standards is we believe a distortion in the pattern of relative payments. And we have data in the report that give you specific numbers about how that distortion has taken place, but, in general, there has been a 9-percent relative increase for surgical fees compared with other fees beyond what would have happened had there been a single standard.

Now one of the problems here is that there was very high growth in Medicare in the eighties on the physician expenditure side. But that annual growth in physician expenditures has slowed, maybe as a result of Congress' actions, maybe because of things happening in the marketplace. We suspect because of both. But the fact is that from 1991 to 1993, the average annual growth in physician expenditures has decreased to 3.8 percent, average annual increase. Now, that has resulted in a larger update than would have otherwise been the case, a larger update in physician fees than inflation because of the fact that the volume increases were kept to a level below that which had existed before.

There was embedded in the formula for calculating how the update would be determined a 4-percent point reduction from the

standard, from the performance standard, which has caused there to be a potential for a reduction in physician fees that we believe was unintended, dramatic, and we think risky for the Medicare program. We provide you in our report in chapter 3 an analysis of what would happen if we do not change the current mechanism for calculating the Medicare volume performance standard, and what it boils down to basically is that within 10 years, Medicare would be paying less, not corrected for inflation, less than Medicare paid at the beginning of the resource based relative value scale system, and we do not think that the Congress intended that, but it is embedded now in the law, this 4-percentage point reduction, and we suggest that Congress reconsider this.

So we have five recommendations on the Medicare volume performance standards. The first is that we replace the historical trends that are used in the volume and intensity calculations and this 4-percentage point deduction with real gross domestic product growth plus 1 to 2 percentage points that would allow for expansion of the Medicare program's payment for increased access to technical services and other advances in medical care.

Second, we recommend that there be a single conversion factor and a single performance standard, and if there must be a separate standard for the three areas that currently exist, we would suggest that they be based on their own trends rather than on a common baseline trend in volume growth, and that if there is going to be a differential, that differential is in effect for only 1 year.

Third, we would like to suggest that the conversion factor reflect the difference between the actual expenditures and targeted expenditures that are accumulated since a base year rather than on a year-to-year basis. We would also like to suggest that we develop a mechanism for shortening the delay between the calculation of what the increase in volume has been and the determination of what the update will be. Right now it is like being in a shower where the lag time between your twisting the dial and the water being hot or cold is long, and you know what happens when you're in a shower like that. You twist it a little to the left and you get scalded. You twist it a little to the right and you are frozen, and you cannot quite get the dial fixed.

What we are suggesting is that we shorten that lag time so that the lag time between our understanding of what the rate of increase has been and our twisting this dial is shorter so that we do not have these wild fluctuations that we think we will have if we do not shorten that lag time.

And third, we would like to suggest that we recognize the fact that these fee increases that physicians have had during the past 2 years are because of the fact that the performance standard was met and performance was better than expected, and, therefore, that the increases that are greater than the Medicare economic index be recognized as a part of what has been described as a deal with physicians. If physicians kept the volume and intensity growth lower, the fee increases would be increased, and physicians should not be penalized for that as we look at rates of increase and expenditures in the future.

And I want to make one more comment about the Medicare fee-for-service system, and I also want to let you know that David

Colby has joined me. David is one of the senior members of the PPRC staff and will be available to help me respond to your questions. On the Medicare fee-for-service system, we have always been worried that if the gap between Medicare's payment levels and payment levels in the private sector widened too much or for any other reason physicians decided not to participate or to provide care to Medicare beneficiaries that there would be a problem in access.

It does not seem that this has happened. Now, the first piece of information that we want to let you know is this: That the Medicare payment rate compared to the payment rate for private insurers seems to have increased. It has increased for two reasons. One is that Medicare has been paying more because of this recent increase in the performance standard-based conversion factor. Second, the private sector has increased its payment levels less than it did in the past. In addition, there is a technical adjustment that we did to last year's estimate. So now Medicare is paying 68 percent of what the private insurers are paying. That is the first fact.

The second fact that we think is important is that overall access to Medicare is pretty good. Only 0.3 percent of Medicare beneficiaries said they could not get care because they could not find a doctor who would accept Medicare. Ninety-three percent of charges are on assignment. Eighty-six percent of charges are from participating physicians, and 65 percent of physicians participate. But it is still of concern to the Commission that Medicare beneficiaries who are African-American, who live in areas that are medically underserved, and people who live in areas of poverty, urban poverty, seem to have a lower use of primary care and a higher use of emergency rooms, and, in fact, higher mortality rates, not all of which can be attributed to the Medicare payment scheme. But we are worried that there is a signal that a problem could be brewing if payment rates do not allow those individuals to find physicians able to provide care to them.

Now let me turn to managed care. The PPRC, like the Congress, is interested in seeing Medicare take advantage of what has been happening in the private sector, including in the managed care component of the private sector. We believe, though, that the current way of paying Medicare, the way in which Medicare pays HMOs, needs to be fixed. The current so-called AAPCC system provides payments which in many areas discourage HMOs from taking care of Medicare beneficiaries, and in other areas probably provide profits that are higher than they need to be.

We would suggest that the Congress think about a system of competitive pricing whereby HMOs would offer a bid to the government and based upon those bids, which would be their minimal acceptable rates for which they would care for Medicare beneficiaries, a rate would be determined, not necessarily the lowest rate, but in order to encourage HMOs who want to provide risk contracts for Medicare beneficiaries to offer competitive bids. We believe that those who do not come in at or below the accepted bid need to be penalized in some fashion by, for example, having to offer the price that they put in as their bid rather than the bid that was agreed upon by Medicare.

Second, we suggest that we blend national and local per capita costs if the AAPCC is going to be used rather than having simply local per capita costs. We also would like to suggest that there are some innovative ways of paying for Medicare beneficiaries and HMOs that we ought to consider. One of those is something called partial capitation whereby the Medicare program pays the HMO not on a fully fee-for-service basis and not on a fully capitated basis but some amalgam of the two. It could work in one of two ways.

For example, it might work as a blended payment. A certain percentage of the payment would be capitated, but then a certain percentage of it would be on a fee-for-service basis so that the incentives for underservice and overservice could be offset. Another way to deal with this proposal is to have a risk corridor so that HMOs would be protected against having too much risk that they would assume for the Medicare beneficiaries.

We believe that these models of partial capitation would help to make Medicare's access to the managed care advances more positive than they would have otherwise been. Now there is a problem with moving toward managed care with Medicare, having to do with the way in which the Congress through HCFA pays for graduate medical education. We have suggested that, because of the fact that graduate education payments are embedded in the AAPCC because the direct and indirect medical education costs are a part of the way of calculating the AAPCC, they have got to be unlinked.

We would suggest, therefore, that the capitation methodology be altered so that we remove the Medicare payment to providers for medical education from the HMO payment, and a different way of paying for medical education be determined. We would suggest that the method chosen should encourage HMOs to participate in the education of young physicians because we believe that that would improve the educational opportunities for young physicians. We also are very concerned, as this commission always has been concerned, about the way in which the DME payments and IME payments have fostered an oversupply of physicians in this country. We believe that the oversupply of physicians is an inflationary factor, and needs to be addressed. We are not convinced as a commission that the mechanisms that have been proposed to date will deal with this oversupply of physicians in the long term, and we have suggested to the Congress in the past and would be pleased to work with the Congress in the future to develop ways of dealing with this problem.

Now let me in brief mention a couple of other issues. The first is coverage. We believe that Medicare's methodology for paying for new procedures needs to be altered. First, we believe that there needs to be a better information system so that Medicare can understand better the inconsistencies among its intermediaries and its carriers in their decisions about what gets covered by Medicare in different areas of the country.

Second, we believe that Medicare ought to pay up to the standard cost of care when a new service is introduced and it is substituting for an old service while it is being evaluated rather than simply not paying for a new service. We believe that that is injuri-

ous to the dissemination of potentially advantageous new advances in medical care.

Third, if the safety and efficacy of a new technology is questionable, we believe that Medicare ought to pay only those programs, those providers, physicians, hospitals and others, who are participating in a serious evaluation of that new technology.

Finally, if two covered services provide the same level of efficacy and the same level of safety, the PPRC believes that Medicare should pay the less expensive price of the two services.

We also have some recommendations with regard to Medicaid. We would like to encourage the Congress to continue its encouragement of the demonstration projects for Medicaid by modifying the so-called 1115 waivers to mandate more explicit research in those programs but on the other hand consider offering a new waiver authority to allow State Medicaid programs to use managed care programs and to expand coverage to the poor.

Now I want to emphasize one last issue which is the use of medical practice guidelines. We do not know, nobody knows, why the volume and intensity of medical services has fallen, but many physicians believe that at least a part of it, a part of this decrease, is because of an increased sensitivity of the medical community to practice a more cost effective medicine. We believe that the contributions of both the physician community, the research community, and the Agency for Health Care Policy and Research are very important in moving us toward a better understanding of what works and what does not work in medical care. We believe that the AHCPR, the Agency for Health Care Policy and Research, should be encouraged to continue its work on guidelines, to consider ways in which it might disseminate guidelines that it develops and others develop to help to build the infrastructure for the continued evaluation of safety and efficacy and efficiency of medical care. And that the AHCPR continue to work closely with the Congress and the administration to improve the quality, the effectiveness and the efficiency of medical care.

Let me just say, Mr. Chairman, that it has been a pleasure for me to serve on the PPRC. I am one of the inaugural members of the commission, and it was an honor to be able to fulfill the last 2 years of Phil Lee's term, and as Mr. Stark said, I have been flattered by the Congress, by the Democratic majority in the past, by the Republican majority now, at the attention and the care with which the Congress has communicated with the commission. I think that this commission stands for the best in health policy, health policy that is based on data, that is based on listening to the community, the physician community and the beneficiary community, and on relying on an outstanding staff of commission analysts, an outstanding group of commissioners, in bringing to the Congress what has been, I think, bipartisan, data-based, fact-based recommendations, and I am sure that the Commission will continue to do that in the future. Thank you.

[The prepared statement follows:]

TESTIMONY OF JOHN M. EISENBERG, M.D.
PHYSICIAN PAYMENT REVIEW COMMISSION

Mr. Chairman, I am pleased to be here today to discuss aspects of the Physician Payment Review Commission's 1995 *Annual Report to Congress* that are of interest to this committee. Two major developments set the context for the analyses and recommendations in the report: implementation of Medicare physician payment reforms passed in the Omnibus Budget Reconciliation Act of 1989 (OBRA89), and the rapid evolution of the health care market from indemnity insurance to managed-care products and from solo practitioners to integrated systems of care. These developments will challenge the Congress as it seeks to improve performance of the Medicare program and to further policy goals, such as containing costs, expanding access, and ensuring quality of care, that affect all Americans.

The report speaks to these two different but linked agendas. Analyses of Medicare are intended to help the Congress understand how federal policy changes are affecting physicians and beneficiaries, to investigate how to make changes in Medicare and Medicaid consistent with innovations in the private sector, and to pinpoint areas where action is needed. Chapters on payment rates of Medicare and private payers, the Medicare risk-contracting program, coverage decisions, and telemedicine specifically consider how the program can respond to the changing health care marketplace.

Several chapters reflect the Commission's ongoing responsibilities to monitor the implementation of physician payment reform. These assess the effect of the Medicare Fee Schedule on access to care for beneficiaries, consider the impact of the fee schedule on physician practice and payments, and analyze the changes needed to make the Volume Performance Standards (VPS) system more effective in slowing growth in Medicare expenditures to a sustainable level. Policies to enhance states' flexibility in meeting the health care needs of the poor through their Medicaid programs are also considered.

In response to growing congressional interest in the potential of competitive markets, the report also considers the changing nature of health services delivery and its implications for purchasers, providers, health plans, and consumers, as well as for the Medicare and Medicaid programs. Chapters on relationships between plans and providers, provider-driven integration, network development in rural areas, monitoring quality and plan performance, and the changing physician labor market provide systematic information about the dynamic forces at work in the marketplace. The relationship between delivery system changes and public policy is addressed through chapters on antitrust policies, insurance market reform, medical liability reform, and development and use of practice guidelines.

Because of this subcommittee's interest in reforming the Medicare program and its concerns about the size of the federal deficit, my comments today will focus on the Medicare issues considered in the first part of the Commission's report. In particular, my testimony will touch on three critical issues: addressing limitations of the Volume Performance Standard system, improving Medicare's payment policies for managed-care plans, and monitoring access for program beneficiaries, including the implications of the differential between the rates paid to physicians by private payers and those paid by Medicare. I will also briefly touch on two other important issues: making Medicare coverage decisions for new services, and development and use of practice guidelines. To set the context for these issues, I will begin by outlining the elements of the 1989 reforms, the progress that has been made in meeting the policy goals set out by that legislation, and the new challenges facing this Congress.

Given this subcommittee's recent hearing on the financing of graduate medical education (GME) and its interest in exploring changes in Medicare support for physician training, I would like to take this opportunity to remind you of the Commission's work in this area. In our past three annual reports, the Commission has provided analysis and recommendations on how Medicare could leverage its GME dollars to help achieve broader policy goals. We are now developing a series of options for changes in direct medical education payment policy and will assess their effects on numbers of residents, distribution by specialty, as well as their impact on different types of hospitals. We have also recommended that the capitation payment methodology for Medicare HMOs be revised to remove Medicare payments to providers for medical education costs from HMO payments. Instead, separate mechanisms should be explored for paying HMOs directly for medical education expenses they may incur in training residents or using teaching facilities. We have begun to consult with committee staff to identify options for GME reform and will keep them and you apprised as this work progresses.

Overview of Issues Related to Medicare Physician Payment

With the passage of OBRA89, the Congress created a new system of Medicare physician payment consisting of a fee schedule based on resource costs, limits on the amount physicians may charge beneficiaries above the fee schedule amount, and Volume Performance Standards (coupled with expanded federal support for effectiveness research and development of practice guidelines) to control expenditure growth. This package of reforms built on a series of policy changes enacted since the early 1980s. Subsequent legislation in 1990, 1993, and 1994 reaffirmed the direction of these reforms.

The effects of these changes have been substantial, and many of the policy goals set out in OBRA89 have been achieved. The pattern of relative payments has been significantly realigned. Moreover, other payers, including private insurers and state Medicaid programs, are adopting Medicare's relative value scale in realigning their own payments. A mechanism was put in place to link fee updates to performance in slowing volume growth, giving Medicare a tool to rein in expenditures. Balance billing, the practice of charging patients more than Medicare's allowed charge, decreased dramatically, reversing the trend of beneficiaries paying an ever larger proportion of income on out-of-pocket costs. In addition, there has been considerable progress in producing and synthesizing information on clinical effectiveness and creating tools to improve decisions about appropriate medical care, both by the federal Agency for Health Care Policy and Research and by the private sector.

In hindsight, however, payment reform has not been an unqualified success for several reasons. In part this reflects inconsistencies within the policy that resulted from compromises made in crafting the reform. For example, distortions in relative values have been reintroduced due to the existence of separate Volume Performance Standards for different categories of services: surgical, primary care, and other nonsurgical. As a result, the shifts in relative payments accomplished over the past several years will likely be reversed unless further legislative changes are made.

Second, despite progress in slowing the rate of growth in expenditures for Medicare physicians' services, there are questions about whether this signals a change in trend or if expenditures will start rising again at a rate that is unaffordable. At issue is whether price constraints can hold down expenditures sufficiently within the context of a fee-for-service payment structure or whether a more fundamental restructuring of the program, consistent with movement in the private sector toward capitated payment to organized systems of care, is necessary.

Third, although changes in physician payment have not diminished access to care, neither have they led to improvements for the most vulnerable beneficiaries, including the poor, the disabled, and minorities. These populations use fewer physicians' services, are more likely to receive care in the emergency room, and have poorer health outcomes. Finally, although there is great enthusiasm about progress in developing practice guidelines, new directions are needed to ensure that these can be effective tools for reducing inappropriate care and encouraging more cost efficient practice styles.

In addition to these concerns, Congress is also facing new challenges. Although fee for service is still the predominant form of payment under Medicare and the option chosen by over 90 percent of beneficiaries, dynamic changes in the private sector are creating pressures to shift Medicare's focus from its roots in traditional indemnity insurance to more innovative methods of service delivery and payment. At issue is how to maintain Medicare's commitment to its beneficiaries while taking advantage of the benefits that a competitive marketplace may offer.

In its 1995 report, the Commission presents its ideas about how Congress might address these important issues, offering both descriptive analyses and specific recommendations for legislative changes. We suggest different strategies for the fee-for-service and managed care sectors, recognizing that, at least in the short term, Medicare beneficiaries will continue to be served in both of these settings. In addition, where we have made recommendations for immediate changes, we have developed approaches that are consistent with the anticipated direction of more comprehensive reforms.

Addressing Limitations of the Volume Performance Standards System

Medicare's primary mechanism for addressing expenditure growth is the system of Volume Performance Standards. The VPS system serves two purposes. First, it curbs the rise in Medicare spending by linking payment levels to the growth in volume and intensity of physicians' services. Second, it is intended to serve as a collective incentive to the medical profession to find ways to reduce inappropriate care, such as developing and disseminating practice guidelines that promote cost-efficient practice styles. Methodological limitations within the VPS system may, however, prevent it from working as intended. The Commission has some specific suggestions on how to fix these problems.

Given pressure to find additional Medicare savings, the Congress may be inclined to achieve the savings by making adjustments to the VPS default formula. It is the Commission's view, however, that the technical problems should be corrected first in a budget-neutral manner. Then an across-the-board cut in the Medicare Fee Schedule conversion factor could be considered as a means of budget savings. Before explaining these issues, it may be helpful to describe the experience with the VPS.

Experience with Volume Performance Standards. The VPS system is used to determine updates in the conversion factors for the Medicare Fee Schedule. Under OBRA89, performance standards

(essentially target rates of expenditure growth) are to be set annually either by the Congress after consulting with the Commission and the Secretary of Health and Human Services or by a default formula specified in law. In fact, the default formula has been used in most years. Payment rates are then either reduced or increased two years later as actual expenditure growth exceeds or falls below these standards. Performance standards were first applied to physicians' services in 1990; conversion factor updates based on how well physicians met these standards were first applied in 1992.

Although the Commission had recommended a single performance standard, OBRA89 created a system with two: one for surgical services and one for nonsurgical services. A third standard (primary care) was added under OBRA93 in response to concerns that growth in volume for technical procedures in the nonsurgical service category was depressing fee levels for primary care. Even though this has resulted in larger conversion factor updates for primary care than under the two standard system, the existence of more than one standard has resulted in distortions in the patterns of relative payment, the very problem the Medicare Fee Schedule was intended to correct.

After extremely high growth during the early 1980s, annual growth in expenditures for physicians' services has slowed considerably relative to the historical trend. Between 1991 and 1993, estimated expenditure growth slowed to an average annual rate of 3.8 percent, primarily as a result of sharp decreases in growth in volume and intensity. As a result, Medicare conversion factor updates for 1994 and 1995 were much larger than had previously been anticipated.

The reasons for this slowdown in growth are unclear as are the prospects for its continuation. The slowdown may reflect secular changes in the practice of medicine. For example, growth in technologies introduced during the mid to late 1980s (such as cataract surgery and magnetic resonance imaging) has slowed. In addition, practice styles may be becoming more efficient as a result of the increased penetration of managed care. Others suggest that low volume growth in recent years merely reflects its inherent volatility. In fact, the trend probably reflects a combination of these factors.

Recommendations for Change. The current VPS system has several flaws. First under OBRA89, performance standards are determined in part by the historical trend in volume growth. At the time the law was written, historical trends were viewed as including some amount of inefficiencies and inappropriate care and therefore a decision was made to reduce the performance standard accordingly. Initially, deductions of one half of a percentage point were taken from the standard, phasing in over time to 2 percentage points. Under OBRA93, the deduction was increased to 4 percentage points.

The problem is that this deduction is now permanently embedded within the default formula and applies even as the 1991 to 1993 growth rate is the lowest two-year growth rate since 1985. In effect, the formula demands that however well physicians did in meeting the previous standard, they must reduce volume by an additional 4 percentage points each year or pay a penalty in reduced fees. Clearly, it is impractical to expect that physicians will continue to achieve such reductions year after year.

The combination of the 4 percentage point deduction enacted in OBRA93 and a lower than anticipated volume growth rate may make it extremely difficult to get additional savings by reducing physician payment. Since it is unlikely that volume growth will fall 4 points below current levels, reductions in fees are already anticipated to begin in 1997 and continue through 2005. In fact, projections suggest that within the next ten years, the conversion factor could fall below \$31, its level when the Medicare Fee Schedule was implemented in 1992.

The bottom line is that changes in the VPS default formula are urgently needed. To address this problem, the Commission recommends replacing the current formula (historical trend in volume and intensity and a 4 percentage point deduction) with a formula linked to the projected growth of real gross domestic product (GDP) per capita plus 1 or 2 percentage points to allow for advancements in medical capabilities. This would permit a reasonable rate of growth that is affordable over the long term and reflects changes in medical practice or in the economy as a whole.

The Commission also recommends two additional changes to limit further distortions in relative payments and to improve accuracy and accountability within the system. First, because the existence of three performance standards is introducing serious distortions in payment rates, separate performance standards and updates for categories of services should be replaced with a single standard and conversion factor update. If separate standards are retained, they should be based on the trend in volume growth for each category as required by OBRA90, and differential updates should be in effect for one year only. As long as you have differential updates and allow the differences to be built into the baseline, you will distort relative payments.

Second, conversion factor updates should reflect comparisons of total actual expenditures with total targeted spending accumulated since a base year. This method can be likened to a banking mechanism that maintains a running balance across all of the years since the account began. Under current policy, a performance standard is set in one year, and then two years later, adjustments to the conversion factor are made to bring spending back to target levels. Any shortfalls and surpluses in spending that accrue over the intervening two years, however, are not captured. A revised policy, establishing a cumulative VPS, would address this shortcoming, recouping the excesses or shortfalls and making adjustments to the conversion factor that keep total Medicare spending for physicians' services within its budget targets. This policy should only be considered, however, if the Congress also adopts the single performance standard and update, and the performance standard is linked to growth in GDP.

If Congress adopts this recommendation for a cumulative VPS, it should also adopt two companion policies to ensure that there is full accountability for total Medicare expenditures for physicians' services and that annual conversion factor updates are relatively stable and reasonable. First, it should develop a new default formula for the conversion factor update that would reduce volatility, either by shortening the delay before the update is set, or by incorporating a "smoothing adjustment." Limits on the size of both reductions and increases should be established to lessen the volatility of fee increases and reductions. Currently, updates are limited to a 5 percentage point penalty if actual expenditure growth exceeds the performance standard by more than 5 percentage points. No comparable limit constrains the size of increases. Symmetric limits of 5 percentage points should be used to prevent extraordinarily high increases as well as reductions. Second, the performance standard for the first year under the new method should also allow for previous fee increases in excess of the Medicare Economic Index. Otherwise, the revised policy would count the fee increase as excess spending (rather than the result of previous expenditures falling below the standard) and recapture it through a reduction to the conversion factor. For example, if this revised policy were implemented in 1996 without this allowance, physicians would face four years of a 3 percent fee reduction just to repay the 1995 fee increase.

Managed Care

As the health care system has moved toward managed care and integrated delivery systems, both the willingness of health maintenance organizations (HMOs) to participate in the Medicare program and beneficiary enrollment in these plans have increased. Currently about 9 percent of Medicare beneficiaries are enrolled in HMOs, up from 7 percent in 1993. Enrollment rates vary considerably across the country, with higher rates tending to occur where commercial HMO penetration is high. About 75 percent of enrollees are in HMOs with risk contracts which are paid on a per capita basis; the rest are in plans with cost contracts that are paid based on reasonable costs.

Further expansion of managed care within the Medicare program will depend upon the capacity of HMOs to accommodate elderly and disabled patients, plans' willingness to do business with the program, and beneficiaries' willingness to receive care under these arrangements. Inadequacies in the current payment method have impeded plans' participation in Medicare. Changes in this methodology are needed and should be considered a first step in encouraging a more substantial role for managed care within Medicare. The Commission has made a number of recommendations in this area which would enhance program performance and help Medicare capitalize on innovative changes in the health care market.

Issues Identified. Inadequacies of the current Medicare payment policies have created problems of limited HMO participation, low beneficiary enrollment rates, and higher costs per enrollee than their fee-for-service costs would have been. These payment problems include:

- payment rates that are tied to Medicare fee-for-service expenditures, so that low HMO costs do not result in savings for Medicare;
- wide geographic variation in payment rates due to local variations in fee-for-service patterns of use;
- volatility of county-level payment rates, particularly for those with small Medicare populations;
- inadequate risk adjustment methods; and
- unrestricted movement between risk and cost contracts, resulting in HMOs with risk contracts attracting patients with less expensive patterns of use.

In addition, the current enrollment policy with its lack of coordination in enrollment periods may have contributed to low enrollment and risk selection. The Commission is recommending that a more structured enrollment process be established that provides for coordinated open enrollment periods and furnishes beneficiaries with objective, comparative information to allow them to make informed choices for HMO enrollment. Permitting beneficiaries to disenroll at the end of any month allows individuals

to leave managed care plans when they require more services. This policy should be reevaluated, weighing benefits of reducing opportunities for risk selection by locking beneficiaries in over a longer period against the risk of beneficiaries being unable to "vote with their feet" in response to poor service and quality.

In the Commission's view, the first step in expanding managed care should be improving payment policy for risk contracts by correcting flaws in current capitation rates (referred to as adjusted average per capita costs or AAPCCs). If Congress fails to address these problems, a greater role for managed care will not necessarily lead to cost savings. Building upon this foundation, additional managed-care choices (such as Medicare SELECT and other preferred provider or point-of-service options) could be expanded. In addition, other approaches that would create competition among both *fee-for-service* and managed-care options within Medicare could also be explored.

Capitation payment rates should be improved so that they (1) cover costs of an efficient HMO, (2) are better adjusted for risk selection, and (3) are predictable from year to year. The Commission suggests two approaches for improving capitation payments: competitive pricing methods and refinements to the current AAPCC geographic adjustment method. Because competitive pricing would be effective only in markets with multiple HMOs, both approaches are needed in the short-term. Also important is the need for payment adjustments that mitigate the financial impact of adverse risk selection (having a patient population with higher than average health care use) and reduce the incentives for HMOs to select good risks. Given the inadequacies of current risk adjustment methods, partial capitation methods that base HMO payment partly on a capitation rate and partly on actual experience could also be tested. Each of these is discussed below.

Competitive Pricing. Competitive pricing would uncouple HMO payment rates from Medicare *fee-for-service* expenditures, using market mechanisms to establish payments that reflect the costs for an efficient HMO. The process could work as follows. First, HMOs meeting the qualifying conditions for risk contracts would submit offers of the minimum payment rate they would be willing to take. Then the Health Care Financing Administration (HCFA) would establish a payment rate based on the bids submitted. To create incentives for plans to bid low, plans that bid higher than the final rate should be penalized, perhaps by requiring these plans to charge the balance of their bid to beneficiaries in the form of premiums.

Whether Medicare would save money from using competitive bidding would depend upon how the final payment rates established from the bidding process compare with the level of the AAPCCs in those markets. Because it is not clear how competitive bidding might affect Medicare costs, some have proposed using payment limits. One approach would be to use the national average per capita cost as an upper limit. (This rate should be adjusted for local input prices and possibly for some variation in service use.) Such an approach is not an ideal one, however, because it would reintroduce the very problems that competitive pricing was intended to correct and distort competition by preventing the established price from reflecting local market conditions.

To enhance prospects for successful implementation, the Commission recommends that HCFA be given sufficient authority and flexibility to introduce competitive bidding in markets with the best chances for success (e.g., those with high HMO penetration) and gradually increase the number of markets as competitive conditions change.

Refinements to the AAPCC Geographic Adjustment Method. Because competitive pricing would be effective only in competitive markets, there will continue to be a need for the AAPCCs or some other form of administered payment rates in the foreseeable future. AAPCCs also might be used during an interim period in locations designated for competitive pricing, until the new method was ready to implement.

Adjustments are currently made for differences in costs across geographic areas by taking the ratio of county-level per capita costs to the national average. This method is flawed because it establishes payment rates that are unstable over time and are susceptible to extreme geographic variation in service use patterns. It also creates an incentive for HMOs to choose to serve those counties within their service area with the highest payment rates.

Theoretically, geographic variation could be addressed by making payment adjustments that recognize input price factors that HMOs cannot control, such as local wage rates, and the portion of service use variation that is attributable to differences in health status. The current AAPCC reflects all service use variation, a portion of which reflects service underuse or overuse, and we are not able to measure the individual components accurately. Until more direct measures are developed, the Commission

recommends that a blended AAPCC be used, which is a weighted average of the AAPCC and the national average per capita cost (USPCC) adjusted for local differences in input prices.

To reduce payment volatility, two possible approaches are suggested. The first is to define geographic areas with larger Medicare populations, to obtain a more stable base of health care expenditures for calculating AAPCCs. The second is to use a statistical technique (called a shrinkage estimator) to establish county-level payment rates that are based partly on the county's AAPCC and partly on the payment rate for a larger area that contains the county.

Partial Capitation. When an HMO assumes full risk for its enrollees' health care costs under capitation, its financial results could range widely from large gains to large losses. Partial capitation would minimize these potential swings by having Medicare share risk with HMOs that had losses or gains outside specified thresholds. Two different partial capitation methods could be used (1) blended rates based on a weighted average of a capitation payment and fee-for-service payment for actual health care services provided, using existing Medicare payment rates, and (2) risk corridor payments that would adjust capitation rates in proportion to an HMO's net financial gains or losses exceeding established thresholds.

Despite its promise, partial capitation could be difficult to administer. Before using this method widely, therefore, demonstrations are needed to test different models and their data requirements for HMOs, and to develop needed information for setting risk thresholds and risk sharing percentages.

The Role of Cost Contracts. Cost contracts have long been made available to HMOs that do not want risk contracts. While this flexibility has ensured that a range of options is available to Medicare beneficiaries, it has also contributed to favorable selection for risk-contracting HMOs with increased costs to Medicare. In markets where competitive pricing or partial capitation are implemented, limits should be placed on the use of cost contracts.

Coverage Decisions

The report also considers the processes Medicare uses to determine coverage for new technologies and treatments, decisions which ultimately affect the cost and quality of care available to its beneficiaries. Medicare, like all health plans, has been grappling with coverage issues, such as the exclusion of experimental treatment and the role of information about cost and comparative efficacy of alternative treatments. Because most Medicare coverage decisions are made by carriers, they are often inconsistent. In addition, critical information to assess new technologies is often lacking.

The Commission recommends that Medicare take the initiative in addressing these difficult issues, setting an example for other payers. It has some advice for steps HCFA should take to reduce variation in coverage decisions. It also proposes a series of options for provisional coverage to balance the desire to provide access to new promising technologies with the need to evaluate their benefits and safety in high-quality clinical studies.

Access for Medicare Beneficiaries

As the Medicare Fee Schedule nears full implementation, access to care remains good for most Medicare beneficiaries. Few beneficiaries have had trouble getting care and most are satisfied with the care they receive. In addition, physician participation in Medicare continues to grow. Finally, there has been no systematic drop in service volumes where Medicare payment levels have been reduced since 1991.

Vulnerable populations who experienced restricted access prior to payment reform, however, continue to face barriers to care. Beneficiaries who are African American or who live in both urban poverty areas and urban Health Professional Shortage Areas have access problems including low use of primary care services, high use of emergency rooms and hospital outpatient departments, and high mortality rates.

The range of access problems experienced by these individuals suggest that a multipronged approach must be pursued to maintain and expand service delivery for underserved Medicare beneficiaries. These approaches cover a broad range of policies including ensuring the appropriate number and distribution of health professionals; paying providers, including qualified nonphysician health professionals who serve these beneficiaries; and making certain that these beneficiaries have access to new health care delivery systems.

Also of concern to the Commission is the gap between Medicare and private payer rates. If Medicare rates fall too far below private sector levels, physicians may be less likely to serve Medicare

beneficiaries, limiting their access to care. Even if Medicare payments cover the cost of care, physicians may prefer to accept patients with private insurance over those with Medicare.

Medicare's 1995 payment rates are projected to be 68 percent of private rates, averaged across indemnity and managed-care payers. In its 1994 annual report, the Commission estimated that Medicare's 1994 rates were 59 percent of the average private insurers' rates. Five percentage points of the difference between the 1994 and 1995 estimates are due to using more recent data for 1994 showing a reduction in inflation of private payment rates after 1991, and including a correction for HMO payments. Thus, a more accurate 1994 estimate would be 64 percent. The previous estimate of 59 percent is outdated and should no longer be used. The remaining 4 percentage points of the difference between the 1994 and 1995 estimates is the result of the high 1995 Medicare fee update.

The Commission has found no evidence that the current gap is causing an access barrier. It is possible, however, that a substantially larger gap could affect physicians' willingness to treat Medicare patients, but the point at which that might occur is unclear.

Development and Use of Practice Guidelines

Because the quality of care provided to Medicare beneficiaries, as well as to the general population, depends upon the availability of information to physicians on best practices, the report includes analyses and recommendations to facilitate use of practice guidelines to reduce uncertainty and promote cost-efficient practice. Mere dissemination of guidelines is insufficient; appropriate incentives and implementation in an environment that supports their use is also critical.

Given significant activity in both the public and private-sectors in this area, the Commission has some specific recommendations to build on and strengthen the role of the Agency for Health Care Policy and Research so that its activities complement and support those in the private sector. It should facilitate guideline development and use by (1) publishing and updating summaries of scientific evidence on salient medical conditions and services, (2) coordinating a public-private partnership for developing a clearinghouse to evaluate and disseminate guidelines, and (3) strengthening the research infrastructure needed to improve guideline development and use.

Looking Ahead: Medicare and the Market

The Commission's report also provides some advice to the Congress about the role of Medicare in the changing health care market. It is important to recognize that as a public entity, Medicare faces significant handicaps in keeping up with the pace of change in the health care market. What employers can accomplish through contracting and negotiation, the Medicare program must do with the much slower processes of legislation and rulemaking. Where employers can restrict choice of insurer or institute significant financial incentives for cost-conscious choices, the Medicare program has historically maintained beneficiaries' freedom of choice of provider and has had more limited influence in encouraging beneficiaries to use managed-care systems.

While these aspects of the Medicare program make it slower to respond to the changing market, they serve as a significant protection for Medicare beneficiaries. These protections are especially important for the elderly and disabled, many of whom have both substantial health care needs and longstanding relationships with particular physicians. The challenge that lies ahead will be to accelerate use of managed-care providers while preserving beneficiaries' access to high-quality care.

Medicare cannot remain unchanged if the markets and organizations with which it deals are evolving rapidly. Given the growth in managed-care organizations, Medicare currently risks becoming the last large fee-for-service program with unrestricted choice of physician. As a first step, the Medicare program might assess ways to monitor developments in the market over time. Markets may continue to change at a rapid pace, and Medicare needs to be able to adapt to both the current state of affairs as well as to any trends that are expected to continue.

Chairman THOMAS. Thank you, doctor. You can be assured that we will make sure that it continues in the nonpartisan fashion that it has in the past. In addition to that, the second half of your testimony was almost a review of the recent hearings that we have had over the question of medical education payments, methods of payments, new procedures, and especially in the medical practice guidelines. We look forward to exploring in more depth those particular areas which clearly will lead us to not only reviewing but changing the way in which practitioners are compensated. The gentleman from Nevada will inquire.

Mr. ENSIGN. Thank you, Mr. Chairman. Dr. Eisenberg, I want to explore a little bit on what you talked about with the HMOs and putting this out to competitive bid. You talked a little bit about having a blend between capitation and fee-for-service. I just want to have you explain that a little further because the argument obviously against HMOs in this area would be that especially on a competitive bid, there would be incentive for them to deny services. So explain exactly how you think that that would work where you would not have that incentive to just deny maybe unnecessary service, as least as far as the physician and the patient feels is necessary where the HMO does not feel that it is necessary.

Dr. EISENBERG. Right. Right. Well, let me explain the theory, and then we can talk about how it might be implemented. The theory is that there is some equilibrium between paying the capitation rate that would give the HMO a certain amount for taking care of a patient for a year, and a fee-for-service rate which would pay for the services provided. And that some balance of the two would, as you point out, offset those two competing incentives. We do not know what the right percentage is. We do not pretend to know what the right percentage is, and we joke with one of our commissioners who is an economist who has done work in this area that it is typical of economists who say that they can come up with an idea in theory. Now let us just go see if it works in practice.

But we believe that this is a promising idea that we ought to try, and I would not pretend to be able to tell you what percentage it ought to be, but let us say it is 75 percent capitation and 25 percent fee-for-service. The advantage is that the HMO would then be able to be paid extra, if it happens to have a substantial number of very sick patients, we believe that that would reduce the aversion to taking high-risk patients. On the other hand, it does not encourage the HMO to churn patients and to see more of them.

It does present a serious problem in terms of data because it does require that the managed care organization collect data on utilization of individual services that some of them do not currently collect because they do not have to since they do not deal with fee-for-service medicine, but we would be happy to work with the Congress to think about some of the details. Our sense is that perhaps some demonstration projects first might be tried but then that we might move forward if they were to work. David, do you want to add to that?

Mr. COLBY. No.

Mr. ENSIGN. What we are looking at here with the whole health care reform debate is the graduate medical program, the physician payments, and hospital payments. It seems to me that we are com-

ing up with government solutions to government problems, and that because the government was so heavily involved in all of this in the first place instead of the market forces we are having to have very burdensome and complex government type problems where the marketplace without so much government involvement seems to be much more efficient in other areas of our economy at solving some of these problems. Your comments?

Dr. EISENBERG. You are right that a part of the problem that we have with the large number of residents is because the mechanisms whereby Medicare has paid for graduate education have encouraged hospitals to increase the number of residents, and a substantial number of them are residents who did not go to U.S. medical schools but will stay in the United States afterward. So you are right. In some ways this was a government problem or government induced problem. Your question effectively is "Will the marketplace or could the marketplace solve this problem?" I think you have to divide the marketplace into two different markets. One is the market for physicians. The market for physicians does seem to be changing. Primary care physicians seem to be more in demand. Subspecialists and other specialties seem to be in less demand, and yet we still have threefold differences and there are three- to fourfold differences in their average income. We are looking at changes, but the amount of change that we would have to have in order to equilibrate the different incomes would have to be much more substantial than what we have seen.

There are many people who are skeptical that the market alone will solve that although it is addressing that problem. I think more problematic is the market not for physicians but the market for residents. The market for residents is such that the residents in the specialties that are relatively undersupplied will by and large will be the least attractive residents for the training programs, especially if hospitals continue to be the major site for education. This is because those residents are mostly working in ambulatory or should be working in ambulatory settings, not providing service in the hospital, and we are convinced as a commission, and I am even more convinced as an individual, that the market will definitely not solve the problem of the market for residents. There will also continue to be inflationary incentives for hospitals to continue to recruit individuals to work in this country and then to potentially stay in this country.

We are one of the few countries in the world that allows as many individuals to train as we do, and it causes problems for other countries, brain drain problems for other countries as well. So my response to your question is, yes, the market might help us with demand for physicians, and that might influence American medical school students in which specialty they enter. It will not address the problem of the excessive number of residency positions, in my opinion. I do not think that weighting will make a big difference. I do not think that freezing the number of years of training at 3 years will make a big difference. I think that this is not just a government problem created by government decisions. It is a national problem, and I am personally not convinced that the marketplace will solve it by itself.

Mr. ENSIGN. Thank you, Mr. Chairman.

Chairman THOMAS. The gentleman from California will inquire. Mr. STARK. Thank you, Mr. Chairman. John, you went over this in your statement, the issue of Medicare reimbursement as compared to private reimbursement. And I come back to that with you. Were you suggesting that currently Medicare is no longer in the fee-for-service structure the lowest payer in time? Is that what you were getting at, suggesting that you saw the changes in the way the reimbursement structure is as between the private and Medicare?

Dr. EISENBERG. Well, the direct implication of our comment is that the gap between Medicare payments on average and private payment on average is narrowed. We have not looked at whether or not Medicare is the lowest payer in town, but we do know from reports that we have had that in many parts of the country Medicare is not the lowest payer in town. That, in effect, the conversion factor is lower in some parts of the country than the private sector. What we know as a commission is that in almost every State, Medicaid is lower than Medicare.

Mr. STARK. Yes.

Dr. EISENBERG. So Medicare has not been the lowest payer in town for a long time. Medicaid has.

Mr. STARK. Excuse me. I guess I should leave Medicaid out. The question is that whether or not with the growth in many areas of managed care plans, whatever, however you care to define those, that the savings has largely been borne by the providers who have been bargained down, if you will, by the large purchasers.

Dr. EISENBERG. Right.

Mr. STARK. And that as a result, the physician's fees paid by the major insurance companies are often lower than those fees now paid by Medicare.

Dr. EISENBERG. Right.

Mr. STARK. Is that a fair assessment of what you are suggesting to us?

Dr. EISENBERG. Yes. I think it is important to distinguish the impact of managed care in two different ways. One is that many managed care programs offer integrated systems of care, coordinated care. Some simply negotiate prices with physicians. And those price discounted HMOs are, I think, the ones that are bringing in some areas the price below that for Medicare, and that is what the market will bear.

Mr. STARK. We are going to hear today from a variety of groups, pros and cons on the three existing volume performance categories, if you will, and also some questions about how we calculate the component for overhead. My own sense is that those pros and cons will largely be driven by the presumed increase or reduction in payments for overhead or payments for fees. Is there anything else in that argument that I am missing? In other words, I am sure that those who think their fees will go up if we go to a blended payment volume performance group will be for it. Those who think they will lose money will be against it. And the same thing. Those who suspect that their overhead payments would go down will oppose it, and those who think they can squeeze a little more overhead payment out of us will support the change. Am I missing any-

thing else in there other than a pretty straight economic relationship to the support or opposition of these changes?

Dr. EISENBERG. Well, I think you are right. To some extent, this is a pie that is going to be divided up among the various types of physicians, and I think we will see the forces that you are describing as we talk about whether or not there ought to be separate standards, separate performance standards. But the other part of this problem that we have addressed, which is embedding the 4-percentage point reduction into the VPS, affects all physicians. So it really does not matter which group you are in for that factor.

Mr. STARK. Just one final question. One of the things we considered long and hard was how you divide up whether it should be by specialty, and the only reason really we did it was the AMA fought us and some of the good specialists helped us on the condition that we would give them separate payments, which is all right with me. But one of the things that has not come back for discussion is the issue of doing this State by State, and, in effect, regionalizing it. Practice habits are different, we find, State by State anyway. Is there any reason that we could not turn this over in a sense to the State medical associations or some other group, and do it regionally? Is this something that you have no longer considered in your performance standard groupings?

Dr. EISENBERG. Well, it is interesting that you bring that up because there is a table at the beginning of the PPRC report in which we describe some of the reasons why we needed reform in the first place, and one of the reasons we needed reform was because of extremely disparate payment rates across different parts of the country that you could not explain except that they were embedded in history. And our sense was that one of the important contributions that the Congress made in 1989 was in developing a national fee schedule so that those unexplained differences across States or across regions could be eliminated.

Since then we have worked with you to try to figure out if there are justifiable differences based upon the cost of living or based upon the cost of practice in different areas, and we think that that is appropriate. In general, as the commission looked at this issue when we first dealt with it, our sense was that there are certainly regional differences in practice patterns, but that by and large the practice of medicine is a national phenomenon.

And the literature that guides practice is a national phenomenon, and we did not think that it would be wise to have different payment schemes State by State. And a second issue is that there is a need for a database in order to guide the Congress in determining how these updates ought to be calculated, and the best database that we have now, in our opinion, is the Medicare database and it has improved substantially over the past several years. Now that could be divided up State by State, and you could give each State their data, but we think that it has been a major advantage to be able to have a national database that we can use.

Mr. STARK. Thank you. Thank you, Mr. Chairman.

Mr. ENSIGN [presiding]. The gentleman from Texas, Mr. Johnson.

Mr. JOHNSON. Thank you. Well, I do not like your idea that it is a national problem, and it tells me that you think you can say more about how medical care is delivered in this country than the

doctors on the local scene can, and I am appalled that you are saying that quite frankly, but I am glad that you are considering some sort of regional program, and I thank the gentleman from California for bringing that up. I would like to ask you did the PPRC recommend increasing the deduction to 4-percentage points originally, and where did that proposal come from, and what was the rationale behind it?

Dr. EISENBERG. Well, first let me respond to the first part of your comment. I want to discriminate between two different issues, and my response about a national problem was addressing the work force issue, that I believe that the work force problem, the surplus of physicians and the surplus of many specialists, is a national problem.

Mr. JOHNSON. Well, does that mean, if I can interrupt you, that you are going to tell the States and the State schools how many doctors they can put in training each year because it is a State-defined problem, is it not?

Dr. EISENBERG. Right. Well, that is exactly the problem. The problem that we have is not the number of medical students in training in the United States. The problem that we have is the number of residency positions that we and our hospitals pay for, which is 140 percent of the number of U.S. graduates. My concern—now I will speak as an individual—my concern is that we deny some American students the opportunity to go to medical school. There are not slots in medical school for them, but there are plenty of residency positions for people other than U.S. graduates to do residencies and then practice medicine in this country. And I think your point is well taken.

Mr. JOHNSON. Well, are you suggesting then that we try to stop aliens from coming in or immigrants of any sort—

Dr. EISENBERG. It is not an issue—

Mr. JOHNSON [continuing]. Until we can resolve it locally?

Dr. EISENBERG. I think that we ought to have a limit on the number of residency positions in the United States.

Mr. JOHNSON. Well, why do you not make that recommendation?

Dr. EISENBERG. We have. We made it last year. We made it the year before, and we stand behind that recommendation that there ought to be a limit to the number of residency positions that are funded.

Mr. JOHNSON. An immigration policy, so to speak?

Dr. EISENBERG. Well, your point was earlier that we have a Federal problem because of some Federal mistakes that were made in the past.

Mr. JOHNSON. Right.

Dr. EISENBERG. I'm agreeing with you that this is a phenomenon that was created by Federal policy, and I think we can address it by Federal policy. The other issue has to do with practice patterns. I could not agree with you more that the right way to influence physicians' practices is at the local level, but I think you will hear from all the national organizations who will follow me today that local physicians will be able to influence each other best if they have good solid research data from the Federal Government and from their national professional societies that help them to teach each other at the local level. That is why I think it is a national

issue. Each individual doctor and his colleagues are not going to be able to do the research on what works and what does not. They need the government and they need their professional associations to help them with that.

To the point of the 4-percentage point reduction, that was a decision which was reached for budgetary reasons. That is my understanding, and it was not based on a recommendation from the Physician Payment Review Commission. In fact, our hope was that the Congress would make decisions on a year-by-year basis which were based upon the rate of growth and what the Congress felt was affordable rather than getting locked into a formula that would tie the hands of the Congress in terms of the amount of growth that it thought would be justified.

Mr. JOHNSON. Well, are you saying that that was not based on empirical data then?

Dr. EISENBERG. The 4 percent. No, I suspect—

Mr. JOHNSON. It was just an out of the air number?

Dr. EISENBERG. I think at the beginning it was better than out of the air because of the rate of growth in physician services was perceived to be intolerable. And something had to be done to get it down, and I think you did what needed to be done to get it down. Now we are locked into a default formula which ties us to a solution for a problem in 1989 that does not seem to be a problem in 1995.

Mr. JOHNSON. I got you. Thank you for your comments.

Dr. EISENBERG. OK.

Mr. JOHNSON. Thank you, Mr. Chairman.

Mr. ENSIGN. The gentleman from Maryland, Mr. Cardin.

Mr. CARDIN. Thank you, Mr. Chairman. Dr. Eisenberg, let me join my colleagues on the committee in congratulating you for your service on the commission and the help that you have been not only to the committee and Congress but to this Congressman's office in supplying information that has helped us in dealing with our responsibilities here. You will be missed.

You have also, I think, pointed out over the time that you have been with the commission the fact that the philosophy of just discounting rates and that Medicare trying to get the lower rate in and of itself is not going to save costs for the Federal Treasury, that we need to take a look at more sophisticated ways. I come from Maryland, as you know, and we do not believe in discounting rates for hospitals. We believe that we can save money by reviewing and managing utilization and other ways rather than trying to get discounts or allowing different entities, including the Federal Government, to get discounts.

So we need to take a look at other methods and you have been helpful to me and to the committee in looking at how to achieve that. I wanted, though, to change gears a little bit. In your testimony, you deal with a problem that evidently has now surfaced in Maryland with clinical trials and the need for Medicare to allow beneficiaries to benefit from clinical trials and new technology. I have heard from Johns Hopkins that they no longer are going to include Medicare beneficiaries in clinical trials for cardiac devices because of a recent change in the interpretation of Medicare's coverage rules.

I am wondering whether your commission has made any decisions as to how we could modify the Medicare rules to make sure that Medicare beneficiaries will not be discriminated against by being excluded from these very important types of new technologies?

Dr. EISENBERG. Right. We have recommended to you in what is chapter 6 of this year's report some specific ways in which we believe that you can assure that both Medicare beneficiaries will have access to trials and that the Medicare program can help to foster appropriate evaluation of medical services. So what we have suggested is that when a new service is being evaluated that Medicare should pay up to the standard amount of care that would be provided for that patient in the normal setting, and the fact that the patient gets an experimental treatment should not nullify the entire cost of care that Medicare would reimburse.

And second, we would like to encourage the Medicare program to work with what might be considered centers of excellence or centers where evaluation can be carried out so that new technology gets evaluated quickly with large numbers of patients so that we understand quickly what the safety and efficacy of those services are. By doing that, we believe that we can avoid the current situation which is sort of akin to a dam breaking, that for awhile nobody pays for a service and then all of a sudden Medicare pays, but in a somewhat indiscriminate fashion, for the service anywhere by any physician in any hospital.

We believe that what ought to happen is, and this is my analogy, not the commission's, but that the dam ought to let the water out in a more controlled fashion so that we can be sure that as the new technology is disseminated, it is disseminated in an appropriate way and that we gather data on side effects and on the effectiveness of those services. Now I will not speak specifically to Johns Hopkins, but I would guess that Johns Hopkins would be considered by at least some a center of excellence, and that we would see some of these trials being carried out in Baltimore.

Mr. CARDIN. I am wondering whether you have had discussions with the academic centers or the centers of excellence as to whether that type of recommendation would take care of most of the concerns that they are currently having with HCFA regarding Medicare reimbursement.

Dr. EISENBERG. During our hearings, many of the organizations who represent academic health centers weighed in with their opinion on this and on other issues. By and large, though, our discussions on this issue have not been so much with the academic medical centers as with the people who are expert on technology assessment, who feel that we need an improved method of assessing new technologies and allowing Medicare to participate in that process. In general, I think the academic medical centers were supportive but our input was really much more from those who were concerned about getting the technology evaluated appropriately.

Mr. CARDIN. Well, I thank you for bringing forward the recommendation. I think it is an important recommendation, and I hope we will move on it. Thank you.

Mr. ENSIGN. Mr. Houghton.

Mr. HOUGHTON. Thank you, Mr. Chairman. Doctor, good to see you. Thank you for being here. I know that your primary emphasis is in terms of physician payments, but there are a couple of other issues in your report. Maybe I could ask you about them on pages 11 and 17. One, it really concerns the rural areas. This is something which I am particularly concerned with, and then also it involves specifically the network development in telemedicine. A lot of people come to me because I do represent a rural area and say, you know, with all this great planning that goes on that we are afraid that the concentration is going to be in the metropolitan areas.

And with so many economic problems visited upon the teaching hospitals we fear that we are going to be forgotten. I would appreciate any comments you have on two areas, network development, and telemedicine, which I happen to be interested in.

Dr. EISENBERG. OK. Well, as you may know, chapter 7 of this year's report deals with telemedicine. The way the commission has usually dealt with new issues is that for 1 year we will try to understand the issue as best we can but not issue a recommendation, and that is really where we are with telemedicine. We are concerned, however, because of the fact that telemedicine is here. In one form or another telemedicine is here, but Medicare's rules for payment require that the physician and the patient have personal interaction which, of course, makes telemedicine extremely difficult for reimbursement. So we have met with the Health Care Financing Administration to hear what they are thinking, and our staff has thought a lot about this issue, and I cannot tell you today that we have a solution, but I will say that we are concerned about the potential that Medicare's reimbursement scheme would get in the way of appropriate dissemination of telemedicine.

Mr. HOUGHTON. If I could just interrupt a moment. I would urge you to take another close look at this thing. The technology is there. The need is there. And there will be a communications bill coming out which will pour enormous amounts of investment into this country because of the interlocking of cable and telephone and what other services you have. This is something which is not only important for the patient, but also it is important economically for the areas because it enables you to keep hospitals open and physicians in small communities which you could not do if you did not have access to this type of thing.

Dr. EISENBERG. Right. I agree with you, and, in fact, we are very interested in the fact that several components of the Federal Government are dealing with this issue. You know the Office of Rural Health Policy has some grants out for evaluating and disseminating telemedicine, and we are looking forward to working with those groups, and I assure you the commission will continue to deal with that. We also have struggled with the other issue that you addressed, which is the ability to get physicians to work in rural areas, and we recognize how difficult this is to achieve.

And the solutions that we have recommended have included increases in payment of relatively modest amounts for physicians who practice in rural underserved areas. We would like to find some better solutions and would like to work with you to that end. We do not know whether or not the small increase in Medicare

payment to physicians to go into rural areas has had a big difference in their going there, but at least we will assume it has not hurt.

Mr. HOUGHTON. Thank you.

Mr. ENSIGN. The gentleman from Wisconsin, Mr. Kleczka.

Mr. KLECZKA. Thank you, Mr. Chairman. Dr. Eisenberg, let me shift gears again on you and address some of my concerns and questions about managed care. In your statement, you do address the issue. In fact, you indicate that one of these days we should look at improving the payment policy for risk contracts, but with that being said and aside, the reason I bring up the managed care issue is because I recall reading yesterday some news accounts where Speaker Gingrich addressed the AMA and called for either an investigation or a complete review of managed care programs and systems in this country. It is my recollection that the chairman of this committee is going the other way, saying that maybe we should be looking at, and I do not want to put words in his mouth especially since he is not here, but words to the effect that maybe we should be looking at moving more of these Medicare recipients into managed care programs. Give me your broad view of the effectiveness, of the criticism, and your views on continuation or expansion of managed care.

Dr. EISENBERG. One of the problems with managed care is that it is such a heterogeneous group of payment mechanisms, and in our report, this year and last year, we have tried to address this problem by pointing out that what we call managed care ranges all the way from group model HMOs that are fully capitated with salaried physicians to very loose organizations who by and large negotiate fee discounts. And therefore when you look at the research data in this area, it is very important, I think, to be sure that you are interpreting the research data in light of the kind of HMO or the kind of managed care program that you are considering.

Our commission has been concerned about the degree, for example, the degree to which beneficiaries understand the contract that the HMO has both with the physician and the contract the HMO has with the Medicare beneficiaries themselves because they are very confusing. We are also concerned about some of the issues of enrollment. For example, Medicare will allow an HMO to choose between a cost contract and a risk contract. Well, the odds are that a managed care organization that believes that it is going to make money in the risk contract will move to the risk contract, but still has the option of having a cost contract, cost-based contract if it would like to offer its services to Medicare beneficiaries. Well, that is really not limiting Medicare's financial exposure by going through the managed care organization, and we believe that those cost contracts ought to be eliminated except perhaps in some areas where there otherwise would be limited access to managed care organizations.

As we have looked at this literature, there probably are gains for many of the better managed care organizations in this country, cost saving potential, as well as the opportunity for Medicare beneficiaries to have access to the various new kinds of health care delivery systems in their region, and for that reason we believe that Medicare beneficiaries ought to have access to managed care pro-

grams. But we are concerned about the diversity of managed care organizations, and we also are concerned about the literature that we have seen which suggests that the savings in managed care might not be as great as some have felt because it may be the case that Medicare beneficiaries who have signed up with managed care organizations are less ill. The literature suggests that they are younger and that their previous expenditures are less than the rest of the Medicare rolls.

Mr. KLECZKA. Well, I might point out, doctor, that the committee recently went through the issue of Medicare Select and the extension of that program, and we did find during our discussion that there was a savings to the patient, to the beneficiary. However, that same savings was not realized by the government itself.

Dr. EISENBERG. Right.

Mr. KLECZKA. So by saying managed care we should not think of saving oodles of dollars and everything is going to be okey-doke.

Dr. EISENBERG. We do not think it is a panacea, but it does have promise to help with access and cost.

Mr. KLECZKA. Depending how it is formulated and how it is—

Dr. EISENBERG. Exactly.

Mr. KLECZKA. OK. Thank you very much. Thank you, Mr. Chairman.

Mr. ENSIGN. The gentleman from Illinois, Mr. Crane.

Mr. CRANE. No questions.

Mr. ENSIGN. Mr. McCrery.

Mr. MCCRERY. Thank you, Mr. Chairman. Dr. Eisenberg, thinking about the three separate performance standards, and you talk about that in your testimony. And you say that the existence of more than one standard has resulted in distortions in the pattern of relative payment, and that is the problem we were trying to get at with the Medicare fee schedule. Can you elaborate on how these distortions are impacting the program and maybe how long you think it will take to get us back to where we were before we made the adjustments?

Dr. EISENBERG. Sure. You will receive soon, tomorrow, I believe, a copy of the report. And table 3 and 4 gives the answer to your question. In 1992, the conversion factor was \$31 across the board. In 1995, our estimate is that the conversion factor will be \$34.62 for nonsurgical; primary care will be \$36.38; and surgical will be \$39.45. So that surgical payments will be about 10 percent higher than the payment to primary care. If we had one single conversion factor, then we would have a conversion factor that would be \$36.63. So that it would be \$36.63 compared with surgical \$39, primary care \$36, and other nonsurgical \$34.

Mr. STARK. Would the gentleman yield?

Mr. MCCRERY. Sure.

Mr. STARK. Would the Chairman consider unanimous consent to extend him some extra time?

Mr. MCCRERY. Sure.

Mr. STARK. And I might ask a question about this point?

Mr. MCCRERY. Sure. Be glad to yield.

Mr. STARK. Is not the \$39, which is higher than the \$34 and the others, for the surgeons partially a bonus or a reward for holding down volume?

Dr. EISENBERG. Partially, yes. And may I expand upon that?

Mr. STARK. Sure.

Dr. EISENBERG. There has been a reduction in the volume of surgical services. There are two services that account for a large portion of that, a decrease in cataract extractions and a decrease in transurethral resections of the prostate, in both of which there have been some major technical changes over the past few years, and a big increase several years ago in cataract extractions because of some very impressive advances. So that we may have seen a blip in the cataract extractions and we may be coming back to normal.

The second factor here is a very important one, which is that the baseline rate of growth, against which these rates of growth for the three different categories is measured, is the same. If you were to use three different baselines and three different rates of growth, then what you would see is less of a difference than we currently have, and I believe we have that in the report, and maybe, David, if you can find it for me, that would be helpful.

Mr. STARK. I just wanted to ask the gentleman to yield. I guess what I hear you saying then perhaps is that we are not getting that much benefit or differentiation out of this benefit or incentive pay. That really these differences are a result of changes in practice, and I hope, Mr. Chairman, you will yield him some more time, but I am not sure of that myself. And I am just curious—

Mr. MCCRERY. Yes. No, I am glad you asked that.

Mr. STARK [continuing]. If you intended that if you reduced your volume, it would give you a higher index. And I am just trying to find out whether we think that is working or whether it is too early to tell.

Dr. EISENBERG. Well, about half of the difference is due to a difference in baseline given our data, and about half of the difference is due to the decreased rate of growth among surgical services, and it is a judgment call as to whether or not that decrease in the rate of growth of surgical services is because of those couple of services that I mentioned or because of overall changes. I think the surgical community has done an excellent job of communicating with surgeons about the need to be more cost effective. And when we have looked at data on interviews with physicians about whether or not their professional societies have communicated with them, surgeons know that this is an issue. So at least a part of this is because the surgical community has been responsible and tried to get the rate of growth down. Does that address your question?

Mr. MCCRERY. Yes, it does. What about the impact of increased emphasis on primary care? Does that not also have some effect on the volume of specialty care?

Dr. EISENBERG. On the volume of specialty care?

Mr. MCCRERY. It could indirectly have an effect on the volume of specialty care, at least in the long term. It is hard to know in the short term what the effect of changing primary care payment is going to be on specialty care. You could, I think, argue it both ways, and I do not know of data that would answer your question specifically. Do you, David?

Mr. COLBY. No.

Mr. MCCRERY. OK. Thank you, Mr. Chairman. Oh, new Mr. Chairman.

Chairman THOMAS. The gentleman from Washington will inquire.

Mr. MCDERMOTT. Thank you, Mr. Chairman. Dr. Eisenberg, first of all, I want to be on the record as saying your service to the country in terms of sitting on the commission and educating this committee, is unmatched, and you should be recognized for that.

Dr. EISENBERG. Thank you.

Mr. MCDERMOTT. And I came down here because I wanted to hear you talk some more about this capitation idea. Take my 5 minutes and explain how you think it might work.

Dr. EISENBERG. The partial capitation idea?

Mr. MCDERMOTT. Partial capitation, yes.

Dr. EISENBERG. OK.

Mr. MCDERMOTT. Because I think it is an idea that people on the committee, do not totally understand how you envision it working.

Dr. EISENBERG. The way it would work is in one of two fashions, as we have thought this issue out. One of them would be a mechanism whereby some percentage of the total dollars that are paid to a managed care organization would be prospective and capitated, and some portion would be based upon the amount of services that that organization and its physicians and associated hospitals provide to the Medicare beneficiaries. Now what that specifically would boil down to in terms of a percentage, I wish I could say, but I cannot, and I also wish that we had more than 1 page of our report that deals with this issue because you obviously, the committee obviously finds this interesting, and we will be dealing with it more in the future.

But this idea of a blended rate implies that there is an appropriate mix, which we would not pretend to be able to tell you in terms of the percentage, but an appropriate mix of fee-for-service payment and capitation payment to an organization that allows it both to protect itself against the cost of having adverse risk selection—that is the term that is used—which means that they would have more ill patients signing up with them, and having the risk that, even if unintended, they might limit services to their enrollees because of the incentives that are implicit in full capitation.

Mr. MCDERMOTT. The idea being that if they did not actually deliver the service, they would not get the money?

Dr. EISENBERG. Exactly.

Mr. MCDERMOTT. So they would get 50 percent of what they would expect on a capitated rate up front, and then the other would be if they delivered the service or some percentage thereof?

Dr. EISENBERG. Exactly. Right. Whatever percentage you decide or HCFA decided to use.

Mr. MCDERMOTT. Now right now not all of medicine is organized in HMOs. So how would that work with the people who are not presently primarily involved in HMO arrangements where they are still operating as standard fee-for-service stand-alone clinics or individuals?

Dr. EISENBERG. It would not affect them. They would still be in the standard traditional Medicare system. This is simply an alternative way of paying managed care organizations that we believe has some potential.

Mr. McDERMOTT. Explain to me the benefits of it. Why would you want to use this blended rate? I think I might be able to read your mind, but I would rather have you say it.

Dr. EISENBERG. Let me read it to you. I will read you from the report because this way I will get it exactly right.

To varying degrees, all of these methods would mitigate risk selection at the expense of capitation's efficiency incentives. That is, if you just simply paid managed care organizations something that reflected their utilization. Capitation reduces costs by creating incentives for HMOs to control the price they pay providers and to achieve a less costly service mix. Some partial capitation model would weaken only the incentive to achieve service mix efficiencies while others would weaken the incentives associated with both price and service mix components.

I am not sure that really helped, but let me try it out myself. I think what we are trying to do—

Mr. McDERMOTT. That is why I asked you.

Dr. EISENBERG. Yes, right. I should have just said it rather than read it. What we are trying to do is to reach some compromise between what we believe to be competing perverse incentives of fee-for-service medicine and capitated medicine. We all agree fee-for-service medicine has a perverse incentive to overutilization. We all agree that managed care with full capitation has a potential perverse incentive to underutilization. Now if that is the case, theory would lead you to think that some combination of those two would allow you to offset those two potentially perverse incentives.

Joe Newhouse, who is a member of the commission, has written about this in scholarly journals, but this really is a theory right now. And I have to say that.

Mr. McDERMOTT. Can I ask you one followup question. Would it make the point-of-service option by an HMO more likely or less likely?

Dr. EISENBERG. Well, I think it would make the point-of-service more feasible.

Mr. McDERMOTT. Feasible.

Dr. EISENBERG. Yes.

Mr. McDERMOTT. Maybe that is a better word.

Dr. EISENBERG. One reason for that among others is that the HMO, the managed care organization, is going to have to have data on utilization, and point-of-service plans provide a mechanism whereby managed care can get that data about the utilization of services by its enrollees.

Mr. McDERMOTT. Mr. Chairman, with your indulgence may I ask one more question?

Chairman THOMAS. Sure. Because I am going to continue this line of questioning so if you ask then I may not have to.

Mr. McDERMOTT. Well, I was going to shift a little bit, but there are certainly more questions on this issue. But one of the questions you raised was this whole business of the experimental threshold, something rises up to a level where it is no longer experimental. Cardiac surgery is probably the place where you see it most, but there are other places.

Dr. EISENBERG. Yes.

Mr. McDERMOTT. What kind of standard or by what kind of process do you decide about clinical efficacy without respect to whether the FDA has made a decision or not, but in terms of frequency, and what the journals say? I mean how do you make a decision as to

what should be paid that might be still in some people's minds experimental?

Dr. EISENBERG. It is extremely difficult if it is not something which the FDA deals with because the FDA has a gate that it opens and says you are no longer experimental, and before that gate is opened, you are experimental. What happens today unfortunately is that payer has to decide if the service is sufficiently experimental.

Mr. MCDERMOTT. So you are talking about the intermediaries in the various States. In our State it is Aetna. Aetna decides whether this is experimental without respect to the FDA. If enough of them are done in Washington State, they—

Dr. EISENBERG. That is one way in which it can be done. It is the way in which it is done today, but there are such huge differences across the country in which the intermediary decides when a service is experimental that we have recommended at least as a first step that there be a national clearinghouse, a national database where you and the Health Care Financing Administration understand these differences in the decisions about what is going to be considered experimental. But the gap between allowing every intermediary to make this decision on its own and having an agency like the FDA that makes these decisions is a huge gap.

Mr. MCDERMOTT. Yes.

Dr. EISENBERG. And there is nothing in between so far as we can tell except practice guidelines and perhaps the Agency for Health Care Policy and Research working with the Health Care Financing Administration to evaluate these technologies as they come out. And that is our concern is that we have done very little as a nation to deal with figuring out how new services, new technologies, should be disseminated. We have just left it up to the carrier medical directors or to the payers. We, and I think the medical community in general, and certainly the beneficiary community, are not satisfied with that.

Mr. MCDERMOTT. Thank you, Mr. Chairman, for your indulgence.

Chairman THOMAS. Oh, certainly, because what you are doing is wrestling with all the decisions that we are going to wrestle with. At the beginning of your statement, I was transported to, oh, pick any number of hearings in which Alan Greenspan has appeared in front of whichever committee talking about this business of shortening lag time, of not overreacting in one direction or another in terms of trying to either overheat or cool off the economy.

I mean we are always faced with this in macroeconomics when we have a relatively arbitrary figure that we are trying to move toward without over- or undercompensating. It is that swing concern that you focused on, and we do have to worry about that, but I also want to make sure that we worry about getting right while we are worried about controlling the swing. The AAPCC is rather an imperfect tool, and obviously we are looking for ways to deal with that. That is why I think you will find that this subcommittee is very interested in the concept of partial capitation, which would give us not only the ability to perhaps control some swing, but maybe a better chance of getting it right. At the same time I think we have all begun to feel that creating an adverse risk selection adjustment mechanism is harder than we thought it was. Its a little

bit like Lucy and Peanuts when she looked down the sidewalk and saw that it came to a point, and Lucy was going to walk down to look at the point. The next box of the cartoon was "Whoa, it's farther than I [Lucy] thought it was."

It is something that has eluded us for more than a decade, and the idea of perhaps some kind of a blended rate will mitigate or minimize the adverse risk selection while at the same time the fears of those who in a managed care structure, in a capitated structure, would not put emphasis on particular things that we thought were important, can be emphasized by those particulars while at the same time providing a point-of-service option more likely in those specific preferred service areas that we might want to support. So it has a lot of attraction to us obviously in trying to come up with it.

And then a comment that you made to the gentleman from Washington about needing a national database pops up virtually every time we try to look at these numbers. We have got to get not just that database but a structure in which we can retrieve information from that database in a shorter period of time. It is very frustrating with the kinds of changes that are going on to look at data that is 2 years old. Even data that is 1 year old, in today's dynamics, makes it very, very difficult for us to nail this down. So your testimony has been very helpful to us primarily by piquing our continued interest in "solutions" that may be out there that we can agree on in a bipartisan way to create a better Medicare, and I appreciate your comments very much, doctor.

Dr. EISENBERG. Thank you very much.

Chairman THOMAS. Any additional questions from the panel? Thank you very much.

If I could ask the second panel to come up, please. Dr. Johnson, Dr. Ebert, Dr. Graham, Dr. Weaver, and Dr. Nelson. I thank the panel for coming, and I would say that any written testimony that you have will be made a part of the record without objection. And that we will simply begin with Dr. Johnson and move along the dias in terms of your presentation. But before I ask you to begin, Dr. Johnson, I believe there is a home State pride exhibiting itself to my immediate right, and I would recognize the gentleman from Louisiana.

Mr. MCCRERY. I thank the Chairman for allowing me to welcome to the committee Dr. Johnson, who is from the New Orleans area in Louisiana. I have gotten to know Dr. Johnson because of our instate unity and even though I am from the north in the State, which sometimes is described as a different State, still we are in the geographic boundaries of the State of Louisiana, and I have gotten to know Dr. Johnson because of that. I have a lot of respect for him and the integrity with which he approaches the issues that we deal with in this Congress. So I want to welcome Dr. Johnson, who is the speaker of the House of Delegates for the American Medical Association, and look forward to your testimony as well as the testimony of each of you who are before us today.

Chairman THOMAS. With that, Dr. Johnson, if you would like to proceed in any way you see fit to inform this subcommittee in the 5 minutes that you have.

**STATEMENT OF DANIEL H. JOHNSON, JR., M.D., SPEAKER,
AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES**

Dr. JOHNSON. Thank you, Mr. Chairman, and before I begin, I thank you for your courtesies and particularly for the courtesies of Mr. McCrery. The Congressman is very well appreciated in our State, and I thank him for his kind remarks. Mr. Chairman and members of the subcommittee, my name is Daniel H. Johnson, Jr. I am a practicing diagnostic radiologist and serve as speaker of the House of the Delegates of the American Medical Association. On behalf of the AMA, I appreciate the opportunity to testify before you this morning. My remarks will address the PPRC's recommended revisions to the medicare volume performance standards (MVPS), related conversion factor projections, and the implications of Medicare part B cuts.

We have several concerns about the MVPS. First, the annual HCFA and PPRC MVPS recommendations have not reflected the original intent of the MVPS to be a true estimate of needed Medicare spending. Unfortunately, both HCFA and PPRC have used the MVPS primarily as a deficit reduction tool.

Second, the baseline projections of expenditure of growth in the MVPS do not allow for forecasting uncertainty. Historical differences between actual and predicted physician payments under Medicare have sometimes been quite large. We support the use of an MVPS range rather than a single number.

Third, we have consistently opposed splitting the MVPS into surgical and nonsurgical categories and conversion factors. We also oppose divisions of the nonsurgical category into primary care and nonsurgical/nonprimary care categories. Such differentials have undermined the premise of the RBRVS that relative payments should reflect relative resource costs. Therefore, we agree with the PPRC's recommendations that separate MVPSs and updates be eliminated.

Last, revisions in OBRA 1993 further eroded the volume and intensity component of the MVPS. These changes further reduced its volume factor with arbitrary budget-based assumptions, not rational judgments about the health care needs of our Medicare patients.

Under the current system, unless volume growth each year goes down 4 points from the previous year, physicians will face a conversion factor cut of at least 2 percentage points each year. Does it really make sense, that, no matter how much volume is reduced, the MVPS asks physicians to reduce volume by 4-percentage points?

Underlying these concerns are disturbing conversion factor projections. Under current law, the Medicare conversion factor is projected to fall steadily after a small projected increase in 1996 from nearly \$36 in 1995 to about \$30 by the year 2005. The real inflation adjusted conversion factor for that year in 1995 dollars will be even lower at \$24.67. This represents a 31-percent reduction in value. The PPRC has recommended a series of changes to the MVPS. Like the commission, we believe that these changes should not be used to further reduce the Medicare conversion factor in order to generate budget savings.

Indeed, the AMA supports most of the PPRC's proposals including the general recommendation to replace the current MVPS default volume factors that includes the 4-percentage point deduction,

with a formula linked to GDP plus 1 or 2 points. We think this additional factor should be at least 2 points.

However, the AMA has consistently and strongly opposed the cumulative MVPS. It is simply a tool to lower the conversion factor. Congress could have enacted a cumulative MVPS in 1989. It did not. Changing the rules in midstream, we believe, is unnecessary and unfair.

We want to emphasize that not all of the problems of the cumulative MVPS and associated corrections have been fully identified.

Mr. Chairman, we recognize that this subcommittee will be searching for additional Medicare budget savings this year as you continue your efforts to reform the Medicare program. The answer is not another round of huge Medicare physician payment budget cuts. Physicians, who account for 23 percent of Medicare outlays, have absorbed 32 percent of Medicare payment cuts over the last decade. OBRA 1990 imposed 32.9 billion in cuts over 5 years, and OBRA 1993 imposed an additional 47.4 billion in provider cuts over 5 years. Physicians have succeeded in actually holding down the volume increases below that predicted for 1992 and 1993, thus saving the program billions of dollars. The MVPS formula as modified by OBRA 1993 will impose annual cuts of 2- to 3-percent each year in physician payments even without any further congressional action.

Moreover, because of continuing transition and OBRA 1993 cuts, even if the Congress were to freeze the conversion factors for 1996, physicians would feel an additional 2 to 3 percent reduction in payments.

We urge you to acknowledge physicians' recent success in moderating growth in Medicare expenditures for physician services. According to the PPRC, average spending growth fell to 3.8 percent between 1991 and 1993. These increased costs are still being driven primarily by new technology, increased rate of use of services by enrollees, insulation of the enrollees from the cost, and flawed financing structuring.

In conclusion, physicians should be recognized for the savings we have accomplished and should not be forced to shoulder unjust burdens in another round of budget cuts. Mr. Chairman, Medicare payments that lose their value year after year pose a real threat to patient access to care. In the weeks and months ahead, we look forward to continued work with the subcommittee and with the Congress on long-term Medicare reform strategies. Thank you.

[The prepared statement and attachment follow:]

STATEMENT
of the
AMERICAN MEDICAL ASSOCIATION
to the
Committee on Ways and Means
Subcommittee on Health
U.S. House of Representatives

RE: Physician Payment Review Commission's 1995 Recommendations

Presented by Daniel H. Johnson, Jr., MD

March 30, 1995

Mr. Chairman and Members of the Subcommittee:

My name is Daniel H. Johnson, Jr., MD. On behalf of the American Medical Association (AMA), I appreciate the opportunity to testify before you this morning. I am a practicing diagnostic radiologist and also serve as Speaker of the AMA's House of Delegates. The AMA commends your examination of the important issues relating to the Physician Payment Review Commission's (PPRC) 1995 recommendations to Congress. My remarks today will principally address the PPRC's recommended revisions to the Medicare Volume Performance Standards (MVPS), related conversion factor projections, and further implications for Medicare Part B cuts.

THE MEDICARE VOLUME PERFORMANCE STANDARDS

Background

The MVPS was a central element of the physician payment reform legislation enacted as part of the Omnibus Budget Reconciliation Act of 1989 (OBRA 1989) and was viewed as an improvement over more stringent expenditure targets that were proposed at that time. The MVPS is a projected goal for Medicare Part B spending growth. When actual spending exceeds (or is less than) the MVPS target, the Medicare physician payment schedule conversion factor is reduced (or increased.)

The MVPS can be viewed as a budgeting tool that helps improve predictability in Medicare expenditures by relating physician payment levels to the growth in volume and intensity of physicians' services. By April 15th of each year, the Secretary of the Department of Health and Human Services is required to recommend an MVPS for the following year. The recommended MVPS is supposed to incorporate the effect of changes in enrollment, aging, the impact of new technology, access to care, and the degree of unnecessary or inappropriate care. The PPRC is then required to comment on the Secretary's recommendation. Under current law, separate volume performance standards are established for primary care, surgical, and other non-surgical services.

If Congress does not explicitly establish an MVPS, then it is determined by a default formula. The default formula is calculated as the product of the percentage change in these four factors: (1) Medicare payments; (2) Medicare non-risk plan (i.e. HMO enrollment); (3) the five year trend in volume and intensity (V/I) for physician services; and (4) Medicare physician spending due to changes in law and regulation. This figure is then reduced by a "performance standard factor" that is currently 4.0 percentage points.

Conversion factor updates under the default formula are equal to the change in the Medicare Economic Index (MEI) plus the relevant MVPS minus the actual change in spending for that year. The downward adjustment to the conversion factor is limited to five percentage points in any one year; there is no upward limit on adjustments.

The current MVPS represents a series of compromises that were made in 1989 by the Congress, Administration officials, physicians, and Medicare patients. The AMA was pleased at that time that important elements of the MVPS differed substantially from the arbitrary expenditure targets that

were under consideration. We were especially appreciative of the fact that there was a 3% floor (since increased to 5%) on MVPS-associated reductions from the MEI that was the starting point for annual payment updates. We also welcomed the legislative intent for the Congress to act each year based on all available data rather than relying on an automatic formula.

AMA Concerns

The AMA believes that the annual Health Care Financing Administration (HCFA) and PPRC MVPS recommendations have not reflected the original intent of the MVPS to be a true estimate of the expected Medicare spending on physician services needed to meet current demands for care, based on full consideration of all of the statutory factors. Unfortunately, both HCFA and PPRC have used the MVPS as a deficit reduction tool without taking into account the gap between Medicare and private insurance rates.

A second major area of AMA concern with the approach used by HCFA and the PPRC is that the baseline projections of expenditure growth and the MVPS do not allow for forecasting uncertainty. Historical divergences between actual physician payments under Medicare and predicted levels have sometimes been quite large. This large margin of error in year-to-year projections should be incorporated into MVPS-related deliberations through use of an MVPS "range" rather than a single MVPS number.

Third, we have consistently opposed the initial split of the MVPS into surgical and non-surgical MVPSs and conversion factors, as well as the later division of the non-surgical category into primary care and non-surgical/non-primary care categories. Such differentials undermine the fundamental premise of the resource based relative value scale (RBRVS) that relative payments should reflect relative resource costs. They do not reflect the substitutions across types of service inherent in medical practice, nor can they be readily supported by underlying forecasts and data. **We agree with PPRC's recommendations contained in the Commission's draft report that separate VPSs and updates should be eliminated. If separate categories are retained, they should use category-specific volume data.** In addition, budget scoring rules have resulted in causing the "default" MVPS and payment increases to be the ceiling on annual updates.

Last, MVPS revisions in OBRA 1993 further eroded the volume and intensity component of the MVPS by reducing the MVPS historical volume factor four percentage points (and increasing the maximum conversion factor reduction) based on arbitrary budget-based assumptions, rather than rational judgments about the health care needs of Medicare beneficiaries.

The AMA is pleased that over the past two years, the MVPS process has helped meet the original commitment made in 1989 that the MVPS would correct for any errors in establishing the initial 1992 Medicare conversion factor. The 1994 and 1995 updates and the probable default update for 1996 reflect the fact that the initial 1992 conversion factor was artificially depressed by an excessive reduction for projected volume growth, as well as by technical errors in the initial HCFA baseline. These recent updates help correct for these initial mistaken estimates.

A misleading picture has been painted in the press of the 1995 payment updates. It is true that the conversion factor updates were 12.2% for surgical services, 7.9% for primary care services, and 5.2% for other nonsurgical services, with a weighted average increase of 7.7% for all services. The conversion factor is, however, only one component of a complex formula for determining payments. An AMA analysis of the 1995 Medicare Payment Schedule (MPS) indicates that total Medicare payments for physicians will increase by 5.3% (rather than 7.7%) in 1995. This lower actual update is due to the RBRVS transition as well as to the continuing effects of the practice expense cuts enacted as part of OBRA 1993. Also, these factors tend to have the greatest impact on surgical services. Thus, for many surgical services and specialties, the 12.2% "conversion factor" update will be largely offset by reductions due to the transition and other legislative changes. This more accurate estimate of the 1995 update makes even more worrisome the projected downturn in Medicare physician payments.

With respect to these seemingly "high" updates, we concur with the PPRC's draft statement that was set forth in its recommendations to Congress for the 1995 conversion factor. The PPRC stated that "[w]hile this update would be very large by historical standards, it should be viewed in the context of the sharp erosion of Medicare payment rates relative to private insurers. Between 1989 and 1994 Medicare payment rates relative to those of private insurers declined from 68 percent to 59 percent. Further declines might adversely affect Medicare beneficiaries' access to care." The PPRC has recently revised upward somewhat its estimate of the ratio of Medicare to private payments.

However, it is essential to recognize that the precise size of this gap is far less important than the fact that it is large and projected to grow after 1997 given the default conversion factor projections. The high 1994-1995 updates are essentially short term corrections.

Moreover, we believe that the PPRC analysis embodies some subjective adjustments to its private sector data base that tend to reduce the estimated payment gap between Medicare and the private sector. For example, the analysis assumes no private sector payment inflation during the 1993 to 1995 period.

CONVERSION FACTOR PROJECTIONS

The attached figure illustrates the projected downward spiral of the Medicare conversion factor under current law. It is based on AMA simulation. It is consistent with, although slightly different from, PPRC projections due to use of different assumptions. **Under the Medicare actuary's volume assumptions, the Medicare conversion factor is projected to fall steadily from nearly \$36.00 in 1996 to \$30.07 by 2005.** It should be noted that the Congressional Budget Office forecasts that this downturn begins in 1998, but the basic pattern is the same.

The real inflation adjusted conversion factor for that year in 1995 dollars will be even lower at \$24.67, a 31% reduction in value. This analysis translates into a projection that Medicare payments would fall from the PPRC's estimated 67% of private levels in 1995 to 56% by 2005 if there is no growth in private payments during this period. If there is a modest 3% growth in private payments, the gap is even larger, with Medicare at 41% of private payments. **This will dramatically undermine physician and beneficiary confidence in the Medicare program.** The need for revisions to the MVPS formula must be viewed in this context.

PROPOSED MVPS REVISIONS

At its February meeting, the PPRC agreed to recommend a series of revisions to the MVPS that refine similar proposals in the Commission's 1994 Annual Report to Congress. The AMA supports most of these proposals, with one important exception -- the "cumulative MVPS." Our support is also conditioned on the PPRC's 1994 and 1995 perspective that these MVPS revisions should **not** be used to further reduce the Medicare conversion factor in order to generate budget savings. Indeed, in its 1994 Annual Report to Congress, the Commission stated that such revisions should not be used to secure further payment cuts. The current PPRC recommendations as we understand them, and the associated AMA positions, are as follows:

PPRC Recommendation

Eliminate separate MVPSs and conversion factors for the three service categories -- surgical, primary care, and non-surgical/non-primary care. If categories are kept, they should reflect volume trends for each category; separate updates should be in effect for one year only.

AMA Position

The AMA supports these recommendations. We have opposed multiple MVPSs since 1989 and continue to believe that, as demonstrated by empirical analyses, these separate MVPSs have distorted the RBRVS, introducing arbitrary differentials in place of resource cost data.

PPRC Recommendation

Replace the historical volume/intensity factor and the four percent performance standard factor with a formula linked to projected growth of real gross domestic product (GDP) per capita. An additional factor of one to two percentage points should be added to projected GDP growth to allow for "advances in medical capabilities."

This policy would produce a higher V/I allowance than current law and would credit physicians for lowering V/I growth. If implemented with the current MVPS formula, a V/I factor of GDP +2 would substantially, although not completely, offset the current forecast downward spiral of the Medicare conversion factor. Annual conversion factor reductions after 1996 would still occur under current volume projections.

AMA Position

The AMA has reluctantly agreed that the current MVPS V/I and performance standard factors should be replaced by a formula linked to growth in real GDP. Linkage to economic performance is not necessarily logical since the demand for health services is not dependent on the state of the economy. The AMA has, therefore, generally opposed linking expenditures to GDP. Although GDP growth is an exceedingly arbitrary measure of appropriate V/I growth, the current MVPS as modified by OBRA 1993 is also arbitrary and flawed. A formula that uses GDP as a base, with an appropriate additional factor to reflect real patient needs, can potentially be less arbitrary than the current MVPS historical volume factor.

PPRC Recommendation

If Congress enacts a single MVPS and links the MVPS to GDP, it should implement what has been called the "cumulative MVPS." Updates would be based on a comparison of total actual and total MVPS-allowed spending since a particular base year. A ceiling on MVPS-related conversion factor adjustments of MEI plus five percent would also be enacted. The PPRC also recommends several complex technical adjustments to the simple cumulative MVPS model to reduce the volatility of annual updates and to eliminate unjustified conversion factor reductions that would result only from the switch to the new system.

AMA Position

The AMA has consistently and strongly opposed the cumulative MVPS on technical, practical, and fairness grounds. The cumulative MVPS would only amplify projected payment reductions, further threatening the viability of Medicare Part B and access to care. The PPRC has recommended several complex technical "fixes" to make the cumulative MVPS "work," although at the expense of clarity. We are not convinced, however, that all of the technical properties of the cumulative MVPS and associated corrections have been fully identified.

From a practical standpoint, the cumulative MVPS reverses much of the benefit of a V/I factor of GDP+2. Under current volume projections, the PPRC's combined policies are apparently forecast to cut the conversion factor even more than current law through 2005.

From the standpoint of fairness, the technical virtue of the cumulative MVPS -- that it holds spending to a fixed baseline, allowing the recapture of all excess spending -- may be true but is irrelevant. Even without its various technical problems, the cumulative MVPS is simply a tool to lower the conversion factor below where it would have been under the broad MVPS approach enacted as part of OBRA 1989. Congress could have enacted a cumulative MVPS in 1989; it did not, recognizing that the MVPS was unprecedented in the U.S. and must be approached with care. Changing the rules in mid-stream simply to achieve lower spending is unjustified, especially given that this change would reduce even further the extent to which physicians could understand the linkage between the conversion factor update in a particular year and a previous year's MVPS.

ADDITIONAL MEDICARE PART B PHYSICIAN CUTS

We recognize, Mr. Chairman, that this subcommittee will be searching for additional Medicare budget savings this year as you continue your efforts to reform the Medicare program. Consistent with the view of the PPRC both last year and this year, we oppose the use of MVPS revisions in order to cut spending.

The Congressional Budget Office recently issued a report, Reducing the Deficit: Spending and Revenue Options, that discussed one option that would implement the PPRC's 1994 version of the MVPS revisions. This option would produce savings of \$6.6 billion over five years, far less than most of the other eight major Part B budget savings options discussed in the report. We must emphasize, however, that the PPRC's 1995 version of the MVPS revisions would probably not produce even this level of savings given the strong caveats attached to its current version of the cumulative MVPS -- that this policy would require a complex series of technical revisions.

Greater cuts could seriously harm Medicare patients. The answer is **not** another round of huge part B Medicare payment cuts. By any measure, physicians have contributed at least their fair share to

recent deficit reduction efforts. Consider, for example, the following facts: physicians, who account for 23% of Medicare outlays, have absorbed 32% of Medicare provider cuts over the last decade. Between 1981 and 1993, budget reconciliation has been the vehicle for reducing Medicare baseline expenditures by some \$98 billion. In this process, Medicare projected physician payments have been cut by \$39 billion. The Omnibus Budget Reconciliation Act of 1990 (OBRA 1990) imposed \$32.9 billion in Medicare Part A and Part B cuts over five years. OBRA 1993 alone imposed an additional \$47.4 billion in provider cuts over five years for Medicare, including conversion factor cuts for 1994 and 1995. Physicians have succeeded in actually holding down the volume increases below that predicted for 1992 and 1993, thus saving the program billions of dollars. Moreover, the MVPS formula as modified by OBRA 1993 will impose annual cuts of 2% to 3% each year in physician payments even without any further congressional action.

We urge you to recognize physicians' recent success in moderating growth in Medicare expenditures for physician services. HCFA data indicates that Medicare expenditures for physician services increased by only 4.5% during FY 1993. In the two years preceding that, the average annual rate of growth for Medicare physician spending was only 5.8%. Lower rates of growth in physician spending between 1989 and 1993 have reduced the Medicare baseline by \$50 billion, nearly as much as the total 1992 outlays for physician spending. Physicians should be recognized for these savings and not be forced to shoulder inequitable burdens in another round of budget cuts.

Medicare payments that lose their value year after year, with the likelihood of a widening gap between Medicare and private sector payments, pose a real threat to patient access to care. Current data strongly suggests that further reductions in Medicare and Medicaid provider payments will have an adverse impact on access to high quality care for some of the most vulnerable segments of the population. We are aware, for example, of numerous anecdotal reports that new Medicare patients are experiencing delays in scheduling physician office visits. Increased Medicare costs are being driven primarily by an increasing number of enrollees, an aging population, new technology, increased per capita rate of use of services by enrollees, and flawed financing structures.

We certainly agree with PPRC Chairman John Eisenberg, MD, who was quoted in the New York Times this past summer as saying that "[t]he problems in access to physicians' services for Medicare beneficiaries are just below the surface. People in areas underserved by doctors, members of minority groups and poor people already have the beginning of a problem. This should be a red flag."

In considering the potential impacts of these changes on access, we must be realistic. A future of year in and year out conversion factor reductions, in the face of steadily rising practice costs, can transform Medicare into a Medicaid-like program. Practice modes would have to shift radically to adjust to the growing disparity between payment levels and physician cost structures. Our patients can only suffer from such a transformation. It should be noted that an October 7, 1994, CBO analysis of steep Medicare cuts that were contained in health system reform legislation stated that the:

...growing disparities in rates between Medicare and the private sector [that would result from these cuts] could impair the access of Medicare beneficiaries to health care. . . . Although access for Medicare beneficiaries has not, apparently, been adversely affected by the drop in Medicare's payments (relative to those of private payers) that has occurred since the mid-1980s, there is probably a point at which access would be threatened.

When public health programs are under-reimbursed, costs are shifted to other payors. An increasing portion of private payor costs are due to under-reimbursement from Medicare and Medicaid to providers. To make up for the under-reimbursement, the shortfall is typically shifted to private payors. Government underfunding creates a hidden tax on businesses that provide health care benefits.

CONCLUSION

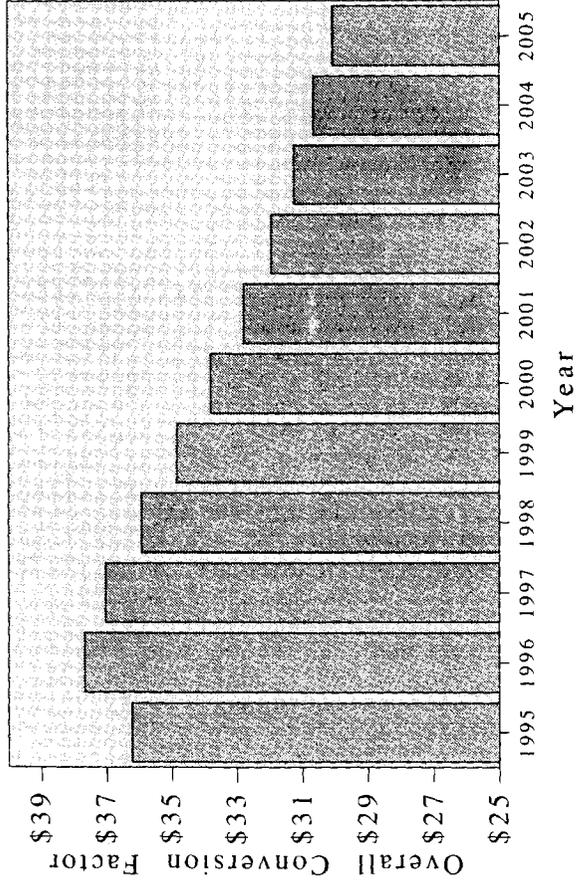
The AMA would like to pursue MVPS revisions that would more accurately reflect patient needs and, at the same time, place future Medicare payments on a more reasonable path. We also find noteworthy that CBO has acknowledged that further Medicare physician cuts will not be nearly sufficient to place the Medicare program on a sound financial footing.

Americans can no longer postpone tackling fundamental reform of the Medicare program. Failure to do so is certain to prove even more costly for the millions of Americans who expect to be able to rely

on this program in the future. Continuation of past stop-gap measures, such as chopping away at rates paid to providers in hopes of getting more services for less money, will ultimately divorce the Medicare system and its beneficiaries from the mainstream of American medical care.

Americans who depend on the Medicare program for their health care, as well as those who will rely on it in the future, should not have to worry about whether benefits promised them will be forthcoming. In the weeks and months ahead, the AMA pledges to work with the Subcommittee, the Committee on Ways and Means, and the Congress to convince the American people that long-term reform is necessary and in the nation's best interest in order to keep the Medicare promise.

Conversion Factor Simulation Baseline/Current Law



Source: American Medical Association

Mr. MCCRERY [presiding]. Thank you, Dr. Johnson.
Dr. Ebert, director of the American College of Surgeons.

**STATEMENT OF PAUL A. EBERT, M.D., FACS, DIRECTOR,
AMERICAN COLLEGE OF SURGEONS**

Dr. EBERT. Thank you very much, Mr. Chairman. I think I sit here to be the minority voice on the MVPS. But I would like to make just a few comments. Historically in the eighties, increased spending for surgical services was really considered the cause of the rate of growth or at least part of the rate of growth problems of the Medicare program. It was very obvious then when the MVPS was created, it was really called an expenditure target. Its creation made sense at that point, for when the relative value scale came forth, there was concern that there might be overusage of medical services. At that time, the surgical community went at-risk and took our chances, saying that we did not think that the volume of surgical service would increase.

I would just like to comment that I do not know which trackline one uses, but each specialty within each MVPS, so to speak, was asked each year to give an assessment to HCFA and to PPRC regarding the anticipated rate of growth within their particular specialty, based on age and population, new technology, et cetera. So these trend lines certainly had opportunity to be modified. I do not know whether others did, but we did submit a report each year providing such assessments. We even pointed out that we thought cataract operations would decrease in volume. However, I would just like to say I do think these incentives being offered to the profession are like line item budgeting. If you had one budget line for the entire government, it probably would be difficult to control it.

I can see having 20 MVPS, or 20 budget lines. How you address them is your issue. I have difficulty saying if we have one MVPS, we felt we would be victims of a proliferation of services which could increase in volume where we did not think surgery could. We support the concept that this 4-percentage point reduction in the fee update formula has to be looked at very seriously. I would just like to read you the one small section of our testimony, because we think the problem with the default mechanism is that it really contains duplicative mechanisms for restraining increase in volume and intensity.

The explicit 4-percentage point reduction that was legislated in OBRA 1993 and the 5-year rolling average for volumes and intensity were included in the original physician payment reform law. While the second adjustment really was originally intended simply to reflect prior historical trends for volume and intensity, which many observers assumed would continue at these high rates, the changes that have occurred in physician spending since 1989 have reduced this 5-year average.

I think by taking both adjustments, the default mechanism way overshoots the mark and creates targets for volume and intensity that are really totally unrealistic. We do not even think that they are realistic for surgical services, even if we see them continue to decrease, because we have no way of keeping up with that 4-percent reduction.

Two weeks ago, we talked about the fact that the college has always been concerned about the overregulatory nature of the Medicare fee schedule (MFS). We noticed in the report this time, for instance, that PPRC recommends legislative changes that would provide a transition period for the introduction of so-called resource-based practice expense relative values into the MFS.

If we really look at that, all Congress has said so far is to do a study and see and then evaluate the results. Now PPRC is jumping the gun, we think, a little bit in saying let's put that out and have a transition into it. We think we have always favored using a single number for determining physician reimbursement. We did not like the fact relative values could be broken down into multiple components. We have great concern yet about the relativity of the relative value scale. The problem seems still to be that there is a tendency to augment for cost containment the relative values. This is probably more prevalent in surgical services than in others and, because of the MVPS, does not really affect the other specialties or the others sitting at the table today.

We are basically still without a reference list of surgical procedures that relate between surgical specialties. It is said now that we are going to repeat, so to speak, the mistakes of William C. Hsiao. That is, we are going to do all the vertical integration, so to speak, within each specialty and then figure out how to compare them. We recognize and even HCFA recognizes that their reference procedures, so to speak, probably are inaccurate. Trying to compare them first would make much sense to begin with, because then you could build vertically upon established comparative values.

We support the commission's conclusion that it really is incorrect to achieve budget neutrality, so to speak, through changes in the RBRVS. I think Dr. Eisenberg made a very important point when he said many private carriers are picking up the RBRVS, and thus every discrepancy that is in it makes it less accurate. We certainly appreciate the opportunity of making comments to the subcommittee. Thank you.

[The prepared statement follows:]

**STATEMENT
of the
AMERICAN COLLEGE OF SURGEONS**

to the

**SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES**

presented by

Paul A. Ebert, MD, FACS

RE: PPRC Recommendations

March 30, 1995

Mr. Chairman and members of the Subcommittee, I am Paul A. Ebert, MD, FACS, Director of the American College of Surgeons. I am pleased to appear before you once again to share the College's views on the Physician Payment Review Commission's (PPRC's) 1995 report and its recommendations regarding the Medicare program. Of course, we have not yet had an opportunity to review in detail the final version of that report; nonetheless, we are prepared to offer comments on a number of issues that were included in draft chapters of the report that were circulated by the Commission last month.

Medicare Volume Performance Standards (MVPS)

The College is especially concerned about the Commission's recommendations regarding the Medicare Volume Performance Standards (MVPSs) and methodologies for updating the Medicare fee schedule (MFS). As I indicated in previous testimony before the Subcommittee, the American College of Surgeons has been a strong advocate of policy devices, like the MVPS, that provide performance-based incentives to meet explicitly set spending targets for surgical and other physicians' services. These targets also involve physicians and physicians' organizations, like the College and the surgical specialty societies, in efforts to address growth in the costs and in the volume of services provided to Medicare patients.

From the beginning, however, the College's support for the MVPS approach has been premised on the need for a separate, identifiable standard for surgical services. We believed then, as we do now, that if the nation's surgeons are to be held accountable for meeting expenditure growth targets, then a separate performance standard for surgical services is also indicated.

We took no position about whether other service categories should have a separate MVPS, although we did urge Congress to favorably consider requests made by physicians' organizations to establish other appropriate MVPS service categories. In fact, we testified before this subcommittee in 1993 in favor of a separate MVPS and fee schedule update for primary care services. We believed that such a change would allow policymakers to consider volume issues relating to justifiable increases in the number of primary care visits under a separate standard, at least until definitive medical necessity criteria, practice guidelines, and/or a workable system of physician profiling could be developed to judge the appropriate utilization of those services.

However, the Commission has repeatedly opposed the use of more than one standard for setting targets for very broad categories of quite distinct kinds of physicians' services. Instead, PPRC recommends eliminating separate volume performance standards and fee schedule updates for the various categories of physicians' services. Further, the Commission urges that, if the current system of standards and updates is retained, it should be based on the recent trends in volume and intensity growth for each service category. In addition, the

Commission states that any differential fee schedule updates should be in effect for only one year, and that any such differential should be eliminated after that year is over. The College does not support these recommendations, since they will only dilute the incentives that are, in fact, working to influence the rate of growth in the volume and intensity of surgical and other services included in broadly-defined, yet distinctly different, MVPS service categories.

In a related recommendation, the Commission proposes replacing the current method for setting default volume performance standards, which involves consideration of historical trends in volume and intensity growth and an arbitrary statutory percentage reduction, with a formula linked to the projected growth of real gross domestic product (GDP). In addition, estimates of the growth in the real GDP should, according to the Commission, be increased by 1 or 2 percentage points.

The College agrees that the current default mechanism needs to be reexamined. At present, the performance standard default formula takes a fixed deduction of 4 percentage points from the historical trend for the prior five-year period. This automatic deduction is made regardless of the sort of changes in physician service volumes that may actually be occurring over time. Thus, even if all surgeons and physicians succeed in reducing the number and the intensity of their services, they will have to further reduce service volumes by an additional 4 percentage points or face arbitrary reductions in fees. PPRC notes that, depending on the assumptions made, this formula could lead to several years of "negative updates"--in other words, fee cuts unrelated to realistic performance expectations. We are certain that such an outcome was never intended by Congress.

As we see it, the problem with the default formula is that it contains two essentially duplicative mechanisms for restraining increases in volume and intensity: (1) the explicit 4 percentage point reduction that was legislated in OBRA '93; and (2) the five-year rolling average for volume and intensity that was included in the original physician payment reform law. While the second adjustment was originally intended simply to reflect prior historical trends for volume and intensity, which many observers assumed would continue at the relatively high levels reflected in the 1980s, the changes that have occurred in physician spending since 1989 have reduced this five-year average as they were factored into this rolling average. By including both adjustments, the default mechanism "overshoots the mark" and creates targets for volume and intensity that are unrealistic, even for surgical services, for which Medicare spending has actually decreased in the past few years.

The College is also concerned about the Commission's proposal to link performance standards and fee updates to the GDP index. This is essentially the same approach that the Clinton Administration included in the Medicare portion of its massive health system reform plan. The use of the GDP index as the formula proxy to adjust for volume and intensity to set a single MVPS target, as the PPRC proposes, means that Medicare would disregard actual trends in the demand for most physicians' services. Instead, real growth in the economy, plus a 1 or 2 percentage point add-on, would become the standard for determining how much should be spent on physicians' services in tomorrow's Medicare program. If adopted, this provision further underscores a shift in Medicare spending policy from finding cost-effective ways to pay for the care older Americans actually need, to financing their care solely on the basis of what the economy can afford.

Medicare Fee Schedule Issues

In testimony before you last month, I pointed out the enormously complex and regulatory burden that has been created in connection with the Medicare fee schedule. Over the years, an incredibly complex administered pricing system has been developed for determining payment amounts for services covered by the Medicare program. The Commission's report on the physician fee schedule further highlights just how regulatory and unnecessarily complex this process has become.

The report contains recommendations affecting complex calculations relating to work values in general and the five-year review of those values under the fee schedule; practice

expense relative values and the complex work needed to make these calculations for more than 7,000 services; changes in relative values for the professional liability component of the MFS; geographic adjustment factors; service-level site-of-service payment differentials, and so on. The current level of government micromanagement in connection with Medicare is amazing and certainly ought to be reconsidered at some point.

However, given the nature of this regulatory process, we feel obliged to offer views on a number of the Commission's proposals affecting the fee schedule. First, PPRC's draft report recommends legislative changes that would provide a transition period for introduction of so-called resource-based practice expense relative values in the MFS. Present law requires the Secretary to conduct a study and report back to Congress on the methodology that would be used to develop these relative values before any plan is expected to go into effect, while also giving the Health Care Financing Administration (HCFA) the authority to implement its proposal unless Congress intervenes.

Obviously, we are very concerned about the potential impact that such changes may have on payment for surgical services, especially in light of the very significant payment reductions previously made for these services as a result of using a resource-based approach to set physician work values. The Commission has already noted that, based on its analysis, resource-based practice expense relative values could redistribute as much as 26 percent of Medicare payments for such expenses, or about 11 percent of total Medicare spending for physicians' services. A disproportionate share of these reductions would fall on many surgical and other physicians' services. We hope that this subcommittee and the Congress will weigh very carefully the research work of Medicare program managers before allowing any such plan to be implemented. In any case, if such a proposal goes forward after Congress has reviewed it, we think that, as a matter of principle, the implementation of almost any change in the design of Medicare should be phased-in over a transition period that will minimize disruption to the program and to those who participate in it.

The Commission's report also describes expected activities associated with the five-year review of the relative value scale. The report confirms HCFA's plans to rely on a small-group refinement process in collaboration with the AMA/Specialty Society RVS Update Committee (RUC) to complete this review. In our February appearance before this Subcommittee, we expressed our concern that HCFA's approach to the five-year review does not include a thorough examination of the issue of cross-specialty linkages between services or the validity of the current reference service list that will be used in proposing refinements to the fee schedule. The draft PPRC report warns that, "An important flaw in the process is that the reference set of services contains cross-specialty comparisons that have not been validated . . . (and) Further, the reference services themselves were not necessarily chosen because their values were thought to be correct."

According to the Commission, comparisons of services across specialties will be deferred until the last stages of the refinement process. Absent a thorough review of such services and linkages, the results of the five-year review may be just as flawed as was the initial process for determining work values in the original Harvard project. We again urge that at least some effort be made to examine the validity of the reference service list at the beginning, and not at the end, of the refinement process.

Finally, Mr. Chairman, we would like to support the Commission's proposal that HCFA be authorized to achieve budget neutrality or implement legislative directives for savings through the conversion factors used under the fee schedule, rather than through changes in relative values. We believe that such adjustments will help reduce unnecessary disruption to the relative value scale and could be applied, in the case of work value changes, for example, to the conversion factor applicable to the appropriate MVPS category of physicians' services.

Thank you, once again, for the opportunity to present the College's views. I would be pleased to answer any questions you may have.

Mr. McCrery. Thank you, Dr. Ebert.
Dr. Graham.

**STATEMENT OF ROBERT GRAHAM, M.D., EXECUTIVE VICE
PRESIDENT, AMERICAN ACADEMY OF FAMILY PHYSICIANS**

Dr. GRAHAM. Thank you, Mr. Chairman, members of the panel. I am Dr. Robert Graham, the executive vice president of the American Academy of Family Physicians. We represent some 80,000 family physicians, residents, and medical students across the country. Since much of what is in our testimony has already been discussed with the committee, let me try to just briefly place some of that within the context of our general concerns about the evolution of the Medicare program, and how we are able to provide services to Medicare beneficiaries.

There is no question that family physicians and general internists provide the bulk of services to Medicare beneficiaries. Yet, as we have seen the changes in the program over the last 10 to 20 years, it has become increasingly difficult for many of these physicians to maintain that level of service or to make decisions which will allow them to accept new Medicare patients. The heart of that problem has been the Medicare payment system. When the original attempts were made to institute the relative value schedule, we had some hopes that it would take the first steps toward rebalancing what had become considerable inequities in payments within the physician community for Medicare beneficiaries.

We think now that with 5 or 6 years of history, we have to say that we have only partially addressed those primary issues of concern for us, and indeed we continue to hear from our practicing members that it is difficult for them to provide services to Medicare beneficiaries, particularly if they have a large number of beneficiaries in their practice because for the office visit to a family physician, quite frankly, the reimbursement of that is less than the actual cost for running the office for the family physician. I suspect that it is similar for many of the general internists also.

The particular issue for us is the service to beneficiaries in rural areas. Preponderantly, the physicians in rural areas are family physicians. There are a higher percentage of Medicare beneficiaries in rural areas. We see that as becoming a real issue in the coming years. Therefore, the recommendations before you from the PPRC that would address some of the evolving difficulties in the reimbursement schedule we think are worthy of your careful consideration. I will not go through the full list. You have already had a long discussion with Dr. Eisenberg about that. They are detailed in our testimony. I would simply single out two of them to make sure you know where we stand. We think that there is greater wisdom in having one conversion factor than multiple conversion factors.

That is where we were in the original debates in the late eighties. The decision of the Congress at that point was to split them into two conversion factors. That was so inequitable that we did support the later change to three conversion factors, but we saw that as a temporary step. The practice of medicine and the practices of individual physicians between generalists and subspecialists are seamless. A lot of the changes that have taken place in surgical volume, we think, has to do with the changes in overall

medical practice, not just the decision of the surgeons. We treat ulcer disease. We treat prostate disease very differently now than we did 5 or 6 or 7 years ago. So the fact that the recommendation before you is now to look at having a single volume performance standard we think is one of merit.

You have also heard comments already about using the GDP factor in terms of the update rather than the 4-percent default. We also think that this is a proper evolutionary decision to be made. We have enough experience in history. We recognize that that original factor was based upon what may have been a very atypical period of time in American medicine in terms of the way volume and expenses were rising. We now have that sort of tied around our neck. We think the PPRC's recommendation in this area is very well taken.

Other specific recommendations to you and comments on the PPRC testimony are in our comments in the written form. Those are before you, and I will yield the rest of our time so that we may have questions and answers.

[The prepared statement follows:]

**TESTIMONY OF ROBERT GRAHAM, M.D.
AMERICAN ACADEMY OF FAMILY PHYSICIANS**

Introduction

My name is Robert Graham, M.D., and I am Executive Vice President of the American Academy of Family Physicians. On behalf of the Academy's 80,000 members, I appreciate the opportunity to comment today on Medicare physician payment, including several proposals in the Physician Payment Review Commission's 1995 Report to Congress.

I note at the onset that the Ways and Means Committee must consider a wide range of proposals to lower Medicare expenditures. This Committee faces the challenge of developing Medicare policy recommendations necessary to reach the House leadership's balanced budget goal. In facing this task, we urge you to recognize that many Medicare reform proposals hold some theoretical possibility of reducing program expenditures, but there is only one factor that has been consistently proven to hold down per capita Medicare outlays: **the availability of primary care services**. Your long-range success in controlling Medicare outlays will be directly related to your success in improving beneficiary access to primary care services. Accordingly, we ask you to weigh the Commission's proposals according to how they support access to primary care services.

Primary Care and Medicare

As you may already know, the Council on Graduate Medical Education applies the term "primary care physician" to family physicians and general practitioners, general pediatricians, and general internists only. These primary care physicians deliver health care services more efficiently and in a less costly manner than subspecialists. Family doctors, for example, treat directly 85 - 90 percent of the presenting conditions of an undifferentiated patient population and assume responsibility for managing the care of those patients who are referred for subspecialty services.

Extensive medical literature supports the conclusion that primary care is cost-effective. Several of these studies are specific to the Medicare population. For example:

- There is an inverse relationship between the extent to which a nation's primary care system is developed and the per capita cost of health care. (Starfield, JAMA, October 23/30, 1991).
- Per capita health expenditures decrease as the proportion of family and general physicians increases. A systematic evaluation of variations in Medicare expenditures for physician services across the U.S. concluded that a higher proportion of primary care physicians in a metropolitan statistical area is associated with a significantly less expensive practice of medicine overall, for both in-hospital and out-of-hospital care. (Welch, et al; NEJM, March 4, 1993).
- A study of per beneficiary Medicare expenditures for physician services found that the most important factor explaining lower expenditures in rural areas is the mix of physician specialties. Expenditures are significantly lower when the proportion of general and family physicians is higher and

expenditures are significantly higher when the proportion of subspecialists is higher. (Dor and Holahan, *Inquiry*, Winter, 1990).

- Increased availability of primary care services for low-income populations reduces the inappropriate and expensive use of emergency departments. In one study, nearly half (45 percent) of patients waiting for emergency department care cited unavailability of primary care services as their reason for using the emergency department. Only 13 percent of those waiting had conditions clinically appropriate for the emergency department; 38 percent were willing to trade the emergency department visit for assurances of an appointment with a primary care clinic within 3 days. (Grumbach, et al; *AJPH*, March 25, 1992).

These studies illustrate a glaring reality of American medicine: it is overly specialized and overly costly, and the two factors are directly linked. No matter which Commission proposals the Congress may choose to adopt, **the cost explosion in the Medicare program will not be brought under control until Congress improves the availability of primary care services.**

Beneficiary Access to Medicare Services

As the studies mentioned above demonstrate, the Medicare program generates savings when primary care physicians in general, and family physicians in particular, are available to and used by beneficiaries. Such favorable prospects for savings stand in stark contrast to Medicare's inadequate reimbursement for primary care services. It troubles the Academy greatly to know that more than one-quarter of family physicians nationwide no longer accept new Medicare patients. In some areas more than 35 percent of family physicians do not take new Medicare patients.

Inadequate reimbursement is the most commonly cited reason for this problem. Simply put, family physicians are finding it more and more difficult to accept new Medicare patients, because to do so jeopardizes the financial stability of their practices. On average, it costs approximately \$134 per hour to operate a family practice, while Medicare payment for visit services is less than \$100 per hour.

Of additional concern is that PPRC predicts that Medicare fees will continue to plummet downward as a percentage of private sector rates. Because of cuts already mandated in OBRA93, the PPRC estimates that Medicare fees will drop to 54 percent of private sector rates. It is even possible that Medicare fee levels could sink to 43 percent of the private sector--below current Medicaid rates--if tens of billions of cutbacks proposed last year are adopted by this Congress in an effort to achieve a balanced budget. The disparity between program versus private fee rates may force even more family physicians to consider closing off their practices to new Medicare patients. Hence, we are genuinely concerned that further reductions in Medicare physician fees may create real access problems for elderly patients especially those in rural and inner-city areas.

This Congress must take the necessary steps now to prevent an access crisis that could occur as early as the turn of the century. In this vein, the Academy would like to thank this committee for its support of an earlier PPRC recommendation favoring a resource-based practice expense (RBPE) component in the Medicare fee schedule. Enacted as part of OBRA93, this shift in Medicare's method of paying for overhead expenses should bring practice expense payments up to their actual costs for office-based services--the sort performed most often by family physicians. It is actions such as adoption of the resource-based practice expense

policy that will enable generalists to continue delivering services to elderly patients.

Changes in the Medicare Fee Schedule

A Single Conversion Factor and a Single Volume Performance Standard (VPS)

The AAFP supports the PPRC recommendation that the three separate conversion factors and VPSs be discarded in favor of a single conversion factor and VPS applicable to all medical services. Such a policy would correct a flaw that undermines the integrity of Medicare physician payment.

Under the current VPS system, a performance standard or expenditure target is determined for a given year. Two years later, actual expenditure growth for the year is compared to the performance standard. Updates to the fee schedule are reduced or increased by the amount the actual expenditure growth exceeds or falls below the performance standard. Under the default formula that determines the annual updates, the Medicare Economic Index, which is a measure of inflation in the cost of medical practice, is used to set the conversion factor update. The MEI is increased or decreased depending on how actual expenditures compare to the VPSs. If expenditures exceed the VPS, the MEI can be reduced by a maximum of five percentage points.

The VPS takes into consideration a number of factors that contribute to the increase in Medicare expenditures for physician services. These factors include increases in fees, increases in the average number of Part B enrollees, the impact of changes in laws and regulations, and the average annual percentage growth in the volume and intensity of physician services for the previous five years. This last factor is automatically reduced by a performance standard factor of four percentage points.

The MFS was established with the passage of OBRA89. As originally conceived, the resource-based fee schedule put all physician services on a common scale. Relative reimbursement for all services would have been based on a single conversion factor, and physicians would have been collectively responsible for controlling expenditures for all physician services. During the negotiations leading up to passage, a separate conversion factor for surgical services was established. This created a problem for primary care physicians, because primary care services were combined with other non-surgical services, expenditures which were increasing rapidly. Because at that time Congress was unlikely to reverse itself and establish a single conversion factor, the Academy supported the creation of a third conversion factor for primary care services. The third primary care category was created in OBRA93.

Separate VPSs and fee updates for three categories of services has led to distortions in the worth of relative values so that they no longer reflect resource-based relative values. The RVUs in each category are no longer worth the same amount. Currently, the conversion factor for surgical services is 8.4 percent and 14.0 percent higher than the conversion factors for primary care and other non-surgical services, respectively. Because the conversion factor updates are permanent, consecutive higher updates for surgical services are compounded.

The distortion in relative value is exacerbated by HCFA's use of a single pooled trend line for the growth in volume and intensity in all three categories of service. In other words, instead of the a separate volume and intensity factor being calculated for each of the three categories of service based on the average

increase in expenditures for services within each category, HCFA applies uniformly an all-service average to all three categories. OBRA90 requires that a separate volume and intensity trend be used for each category. But, for several reasons mostly having to do with the availability of data, HCFA has continued to use a pooled volume and intensity factor. With the continued use of a pooled volume and intensity factor, the discrepancy in conversion factors becomes virtually perpetual. Surgical services, which have experienced the lowest expenditure growth, will always compare favorably to the pooled expenditure growth and, therefore, always receive a higher update.

The Physician Payment Review Commission projects that discrepancies between the conversion factors may soon become large enough to erase the redistribution in payments from surgical and other non-surgical services to primary care services that was supposed to occur under the MFS.

For these reasons, **the Academy endorses the adoption of a single, all-service conversion factor and a single VPS for all services.** As it was originally intended, the VPS system provided an incentive for physicians in all specialties to exercise collective responsibility for reducing inappropriate care. Theoretically, establishing a single conversion factor would recognize the substitution of services that occurs between categories of service. For example, in peptic ulcer disease, advances in medical care have led to the substitution of endoscopy (a service that is in the other non-surgical service category) and office visits (services that are in the primary care category) for surgery. Another example would be the substitution of watchful waiting, which results in more office visits, for surgery in the care of prostate disease. In both examples, medical advances have led to a decrease in surgical volume and an increase in volume in the other two categories of service. These examples illustrate that responsibility for increases or decreases in expenditures within a category of services cannot be claimed by the physicians in any particular specialty. However, because Medicare services are artificially divided into three different categories, primary care physicians are penalized for these appropriate increases in expenditures for visit services through reductions in the update for the primary care conversion factor, and surgeons receive a bonus for a decrease in surgical volume for which they had little responsibility. Primary care physicians should not have to "pay" for advances in medical care that reduce the need for surgery any more than surgeons should have to "pay" for the increased volume due to innovative new surgical procedures.

Using Five Year Trends to Estimate Volume and Intensity

By taking a fixed four percentage point reduction from the five-year trend in volume and intensity, the performance standard factor unlinks the volume and intensity factor from actual trends in health care delivery. Regardless of how much physicians reduce the volume and intensity of services, volume and intensity must be reduced by an additional four percentage points or the updates will be reduced. In addition, using historic growth rates will eventually undermine the incentive to control volume and intensity. Lower growth rates initially yield higher updates, but as they are incorporated into the rolling five-year averages, the VPS will be lowered.

PPRC has estimated the impact of the current default formula utilizing various estimates of future expenditure growth. In all cases, updates beginning in 1997 are negative. Within the next five to seven years, Medicare fees will drop below their current level, even without considering inflation. The large penalties in the updates would occur, in part, because of the low rates of growth from 1992 to 1996 will be reflected in the five-year average growth of volume and intensity.

Considering that Medicare payment rates are already below cost for most of the services provided by family physicians, these current-law reductions cannot be sustained.

PPRC recommends that projected increases in per capita gross domestic product (GDP) plus one or two percentage points substitute for the five-year rolling average growth in volume and intensity. The extra one or two percentage points are meant to reflect advances in technology. This recommendation is intended, in part, to link Medicare expenditure growth to the rest of the economy. **The Academy believes that the Commission's recommendation for calculating volume and intensity is preferable to the present formula as modified by OBRA93.**

On a theoretical level, support for this option hinges largely on its linking increases in Medicare expenditures to growth in the rest of the economy, with provision for advances in medical care. Since this recommendation affects the VPS calculation only, there would still be allowance for increases in enrollment and prices and for changes in law and regulation. Furthermore, medical inflation, as measured by the MEI, would still be incorporated in the update.

Budget-neutrality Adjustments

In a matter related to revision of the formula for calculating Medicare fees, the Academy is concerned about HCFA's current practice of making adjustments to relative values in order to maintain budget neutrality in the Medicare physician fee schedule. **The Academy supports PPRC's recommendation that such adjustments be made in the conversion factor rather than the relative values.**

HCFA institutes across-the-board reductions in all relative value units to compensate for increases in aggregate relative work values added to the resource-based relative value scale (RBRVS) by the Relative Value Update Committee process and the HCFA "refinement" process. These reductions maintain the statutorily-mandated budget neutrality of the fee schedule.

While it may be necessary at times to manipulate Medicare payment to achieve defined policy objectives, such as budget neutrality, the AAFP believes these objectives should be met without distorting the relative value scale. Although not perfect, the RBRVS goes a long way toward describing the appropriate relationship between several thousand physician services. Accordingly, adjustments to relative values should only be related to changes in resource consumption. Other adjustments, unrelated to changes in resource consumption, will only distort the RBRVS. Thus, the AAFP believes that budget-neutrality should be accomplished through manipulations in the conversion factor or by establishing a new budget neutrality adjustment factor.

Furthermore, **the AAFP believes that in the budget-neutrality process, evaluation and management (E/M) services should be protected from changes in the relative values of other services**, since such services are more likely to be reduced as a result of the "RBRVS creep" associated with procedural services. Ideally, protection of E/M services would be accomplished by a separate budget-pool for E/M services. E/M services would be subject to budget-neutrality resulting from relative value refinements within their own pool. However, this would require a change in the law.

HPSA Bonus Payments

By whatever measure you might employ, this nation suffers from a severe shortage of primary care physicians, and some geographic areas are particularly underserved. Since 1986, the number of federally designated primary care health professions shortage areas has increased from 1949 to 2492, and the number of primary care physicians needed to eliminate these shortages has grown from 4314 to 4677.

Since 1989, physicians who treat Medicare patients in HPSAs have been entitled to bonus payments equal to 10 percent of the amount Medicare pays for services. In theory, the bonus payments act as incentives to attract new physicians to underserved areas and to discourage physicians in those areas from leaving. However, as noted by PPRC, the Council on Graduate Medical Education, and the HHS Inspector General's Office confirm, Medicare bonus payment program is not well structured for this purpose. Almost half of the bonus payments accrues to physicians who provide little or no primary care. In addition, almost 15 percent of bonus payments go to urban, hospital-based subspecialists.

As the Inspector General noted in a June, 1994 report, providing "incentive" payments to non-primary care physicians who fail to deliver primary care services or who practice in attractive environments is both unnecessary and inconsistent with Federal priorities. Congress should modify the Medicare incentive payment program to target it more effectively to primary care. **The Academy supports the Inspector General's recommendation that the program be changed to provide 20 percent bonuses to physicians providing services in HPSAs and eliminate bonuses for non-primary care services in urban areas.** The increase in the size of the payments would make them more effective incentives. The elimination of incentives for specialty services in urban areas would more effectively target the program to primary care. The Health Care Financing Administration has also expressed support for these changes.

Geographic Adjustment Factor (GAF)

The AAFP has long advocated the elimination of the geographic adjustment factor, which is a differential in physician fees based on practice location. Instead, there should be a single fee for the same service regardless of the geographic location of the physician providing the service. This position is based on the premise that equivalent service should result in equivalent compensation. Further, this position is consistent with federal policies that incorporate uniform national rates. For example, uniform national rates apply to federal income tax, social security payments, and the Medicare Part B premium. A policy of uniform payment should only be modified to achieve explicit policy goals (e.g., targeted adjustments for demonstrated shortfalls in access to care).

The impact of the GAF can be seen in by comparing the Medicare allowable amount for a mid-level established patient office visit across geographic payment areas. For example, the Medicare allowable amount for this service in Oakland, California is \$38.87 while Medicare allows only \$31.75 for the same service in Nebraska. The allowance for the physician in Oakland is 22 percent more than the allowance for the physician in Nebraska.

And, the GAF's impact is not limited to practice costs. In the example above, Medicare allows \$20.71 for the physician work component in Oakland, but only \$19.13 in Nebraska. By definition, the work is the same, but Medicare pays physicians differently simply based on where they practice.

The GAF is based on a set of geographic practice cost indices (GPCIs) developed by the Urban Institute and the Center for Health Economics Research (UI/CHER). With the exceptions of malpractice insurance costs, for which HCFA maintains a national data set, and equipment, supplies and other costs, for which HCFA assumes there are uniform national prices, the UI/CHER indices utilize proxy data assessing geographic variation in costs.

The current GPCIs allege that there is substantial geographic variation in physician practice costs. This variation in practice costs corresponds with community size. Specifically, the indices show urban communities as having higher costs and rural areas as having lower costs.

The large variation in practice costs suggested by the GPCIs means that their use in adjusting the Medicare physician fee schedule has a substantial impact on physician payments. That impact is to perpetuate a substantial portion of the geographic differential in Medicare prevailing fees which existed before HCFA implemented the Medicare physician fee schedule. Given the impact of a geographic differential on the maldistribution of physician services, it is of essential policy importance to verify the accuracy of the current GPCIs.

There are several grounds on which to challenge the ability of the GPCIs to accurately and appropriately reflect true and legitimate differences in physician practice costs (i.e., those differences that are not attributable to practice style for which adjustment would be inappropriate).

Physician surveys conducted by Medical Economics and the American Medical Association (AMA) provide a sharply contrasting picture of the geographic variation in physician practice costs. These surveys tend to show the cost of rural physician practice to be as high or slightly higher than in urban locations. Medical Economics has reported higher practice costs for rural physicians in recent years.

While neither the AMA nor Medical Economics surveys provide a definitive picture of geographic differences in physician practice costs, they are consistent and reliable. These data suggest that the finding of higher urban than rural practice costs may be erroneous and provide further evidence of the need to validate the current indices.

We note that eliminating inappropriate geographic differentials was a major focus of Medicare physician payment reform because geographic differentials proved to be a strong disincentive in regard to physicians choosing a rural practice location. HCFA has not systematically and verifiably demonstrated significant differences in the cost of practice, which might be used to justify continuing geographic differentials in the Medicare fee schedule. We believe that eliminating geographic differentials from a Medicare physician fee schedule is likely to have a significant and positive impact on the availability of medical care to rural beneficiaries. If a GPCI is to be utilized, we feel it incumbent on HCFA to validate any geographic index that it proposes to use in modifying physician fees.

Conclusion

The stakes are extremely high as this Committee begins the important task of determining how Medicare outlays will be reduced to help eradicate the federal budget deficit. At the end of this legislative session, we must be able to assure older Americans that their access to comprehensive, cost-effective health care services has not been compromised by Medicare reform efforts. Although reconciling deficit reduction with a high level of beneficiary services may seem

contradictory on its face, this is not necessarily so. Revising the Medicare fee schedule to boost primary care services--as intended by the authors of the resource-based relative value system--serves the purpose of controlling Medicare expenditures.

The studies cited above demonstrate conclusively that the availability of primary care services improves access for Medicare beneficiaries while lowering program expenditures. Indeed, support for primary care positions the Medicare program to interface effectively with the marketplace as it shifts to integrated systems of care. Moreover, improvements in the fee schedule that narrow the gap between reimbursement levels for primary care and other families of services would ensure access to the very type of service on which managed care is built.

These beneficial goals can be achieved in part by enactment of several important recommendations in the 1995 PPRC Report, including a single conversion factor and VPS applicable to all services. The Academy strongly supports this policy recommendation as an overdue, reasonable step towards eradicating confusion and inaccuracy in the fee schedule while restoring its original intent. Likewise, the Academy also urges you to replace the current performance standard factor formula with one based on projected GDP per capita plus one or two percentage points. This approach is preferable to the present formula as modified by OBRA93.

Let me close by noting that the PPRC recommendations noted in my comments provide excellent guidance for your efforts. As you work to craft a Medicare reform policy that achieves the goals of the Contract with America, please do not hesitate to call upon the American Academy of Family Physicians for counsel and input. Family physicians are eager to work with you on this challenging undertaking.

Thank you for this opportunity to speak with you about the PPRC's 1995 Report. At this time, I would be happy to answer your questions.

Mr. McCrery. Thank you, Dr. Graham.
Dr. Weaver.

**STATEMENT OF KATHLEEN M. WEAVER, M.D., PRESIDENT,
AMERICAN SOCIETY OF INTERNAL MEDICINE, AND ALAN R.
NELSON, M.D., EXECUTIVE VICE PRESIDENT**

Dr. Weaver. Thank you, Mr. Chairman. My name is Kathleen Weaver. I am a practicing internist from Portland, Oreg., and president of the American Society of Internal Medicine. With me is Dr. Alan Nelson, ASIM's executive vice president. Internists are concerned that cuts in Medicare fees will do great harm to the elderly's access to medical care. The PPRC projects that because of the changes enacted in OBRA 1993, Medicare fees will start declining in 1997 and will continue to experience annual reductions for the foreseeable future. As a result, Medicare payments in the year 2005 will be lower than they were in 1992, and after adjusting for inflation, payments would be reduced by 36 percent from 1992 to 2005.

Because the overhead costs of running a physician's office cannot be reduced to offset this cut, ASIM estimates that this will translate into a 61-percent cut in net payments for a typical midlevel office visit. I do not know many primary care physicians who can afford a cut of 60 percent or more in net revenue from Medicare over the next 10 years. Many of my colleagues are already closing their practices to new Medicare patients. Those of us who are in our fifties and have a practice dependent on Medicare, and as you get older, your patients get older, and I am in that age group, we are thinking more and more about retiring early. When we retire and close our practices, who will take care of our Medicare patients who are left behind?

I think it is unlikely that our younger colleagues will choose to take on large numbers of Medicare patients knowing that Medicare fees are steadily dropping and will barely cover their costs. Those who conclude that because there is no widespread access problem today there is no reason to fear one in the future remind me of my 45-year-old patient who smokes three packs a day, drinks a six-pack, and says, "I feel fine." The patient may believe and convince himself that he is fine, but as his physician I know that the odds are overwhelming that the damage being inflicted today will cause a medical crisis not too long in the future.

Likewise, I firmly believe that the damage being inflicted now by cutting the Medicare program will lead to an access crisis in the near future. Our concerns are exacerbated by flaws in the current method for determining these fee updates. ASIM strongly supports the commission's recommendation of a single volume performance standard and update for all categories of services. Let me give you four good reasons why the current policy of separate categories for surgical procedures, primary care services and all other nonsurgical services should be changed.

First, the current policy will magnify and accelerate the access problems resulting from budget cuts. Because the conversion factors for primary care and other nonsurgical services start out so much lower than for the surgical procedures, further cuts will disproportionately hurt access to primary care physicians. Second, it

is contradictory to the intent of the resource-based relative value scale. The RBRVS was intended to pay physicians the same amount for services that involve equal physician work, but the current policy of different conversion factors has resulted in physicians being paid 25 to 30 percent more for their surgical procedures than for a nonsurgical service requiring the same amount of work. Third, it encourages inefficiency by penalizing some physicians for changes in practice patterns that may reduce Medicare expenditures while rewarding others for reductions in volume over which they have no direct control.

Medicare saves money and patients benefit when physicians can substitute less costly nonsurgical treatments for more expensive surgical ones. Unfortunately, when nonsurgeons find ways to treat patients and avoid the need for surgery under the current policy, they are penalized for providing more nonsurgical services. A single VPS would reward physicians and encourage us to collaborate to control volume rather than the current policy of basing rewards and penalties on shifts in the number of services provided in each category that have no rational relationship to physician performance.

And fourth, the current policy is overcomplicated. A single VPS and conversion factor would be a more important step toward simplifying the Medicare fee schedule. However, we agree with the commission that if separate categories are maintained, they should be based on recent trends for each category. In conclusion, ASIM appreciates the difficulty of reducing the Federal deficit and at the same time honoring Congress' 30-year-old contract with America's elderly which guaranteed access to quality medical care through the Medicare program. We recognize the debate on reforming Medicare is imperative, but the purpose should be to develop proposals that would guarantee that Medicare remains solvent rather than on focusing on short-term cuts.

For example, ASIM supports creation of a voucher program that would expand the health plan choices available to beneficiaries and we would be pleased to work with the committee on the development of such a program. Mr. Chairman and members of the subcommittee, I would be pleased to answer any questions. Thank you.

[The prepared statement follows:]

Testimony to the Ways and Means Committee
on the
1995 Report of the Physician Payment Review Commission
by the American Society of Internal Medicine

March 30, 1995

Introduction

My name is Kathy M. Weaver, MD. I am a practicing internist in Portland, Oregon and President of the American Society of Internal Medicine. With me is Dr. Alan Nelson, ASIM's Executive Vice President.

My comments today will focus on two related issues that are addressed in the Commission's report to Congress. Those issues are access to care for Medicare beneficiaries and the methods used to determine payments under the Medicare fee schedule.

Internal medicine is the nation's largest medical specialty. As specialists in adult medical care, internists also take care of more Medicare patients than any other specialty. Our members are acutely aware of how changes made in Washington affect access to care for their elderly patients. They are extremely concerned that the changes made by Congress in 1993 in the way that Medicare fee updates are calculated, and any additional changes that may be made by the 104th Congress to reduce payments for physician services, will do great harm to the elderly's access to medical care, and especially, access to primary care services. I will explain in today's testimony why we have reached this conclusion, and present our recommendations for changes that would reduce, but not entirely eliminate, the adverse impact on access to internists' services.

Background on Medicare Fee Schedule Updates

Under current law, there are three separate volume performance standards (VPSs), or target rates of growth, for surgical procedures, primary care services, and all other nonsurgical services. There are also three separate conversion factors—the dollar multiplier which translates resource based relative values into fees—for surgical procedures, primary care services, and other nonsurgery. Prior to 1993, there were only two separate VPSs and conversion factors, one for surgical procedures and one for all other nonsurgery.

In OBRA 93, Congress amended this to add a category for primary care services—office, nursing home, home, and emergency room visits—in addition to the other two categories. Although the creation of a separate primary care category was intended to moderate any adverse impact on primary care services of other changes made by OBRA 93 that would lower payments for physician services, all services paid under the Medicare fee schedule—including primary care services—will begin experiencing payment reductions in the next two years and beyond, as explained in detail later in this testimony. The reductions will occur because OBRA 93 also tightened the way the VPSs for all three categories are calculated, by doubling from two to four percent the required "performance standard reduction" that is subtracted from the five year historical rate of increase for physician services. The changes made by OBRA 93 were intended to slow the rate of growth in physician services. Finally, OBRA 93 increased the maximum amount that fees could be reduced in any calendar year.

Access to Care

The Commission's report to Congress provides ample reasons to be concerned that access to care for the elderly is at risk. The report projects that because of the changes enacted in OBRA 93, Medicare fees will start declining in 1997. According to the report, if the volume of physician services increases to six percent, **under current policy the conversion factors will decline by 2.2 percent in 1997, 3.0 percent in 1998, 3.0 percent in 1999, 3.0 percent in 2000, 2.7 percent in 2001, 2.5 percent in 2002, and 2.0 percent per year from 2003 to 2005.** Even under assumptions that volume growth slows down to 3 or 4 percent per year, the Commission projects that the conversion factors will begin to decline in 1997, will experience reductions of approximately three percent per year from 1998-2000, and will experience further reductions of two percent annually thereafter. The Congressional Budget Office (CBO) has similarly projected that the reductions mandated by OBRA 93 will cause an annual reduction in the conversion factors beginning in 1997.

These reductions do not take into account the effects of inflation. **If the inflation rate is 3 percent per year from 1996-2005, the reductions (in constant 1996 dollars) in the conversion**

factors will be approximately 5.2 percent in 1997, 6 percent per year from 1998-2000, and between 5 and 5.7 percent per year in 2001-2002 (depending on volume assumptions), and another 5 percent per year from 2003 to 2005.

As a result of the cuts in the conversion factors, **Medicare payments in the year 2005 will be lower than they were in 1992, even before the effects of inflation are taken into account.** The Commission estimates that if volume and intensity growth rates rise to six percent, the conversion factor would be only \$29.84 in 2005, or \$23.17 in 1995 dollars (after adjusting for inflation). **For a mid-level established patient office visit that in 1995 is paid \$36.38, this would represent a 36 percent cut in constant 1995 dollars.**

As bad as this sounds, the impact on physician net revenue from Medicare will be even worse. The Medicare fee schedule allocates approximately 40 percent of the payments for each service on the fee schedule to the overhead costs of providing the service. For a mid-level established patient office visit that is paid \$36.38 in 1995, this results in overhead costs of \$14.55 per office visit. (The Commission has previously reported that the method used to allocate overhead costs underestimates the overhead costs of office visits and other evaluation and management services, so the estimate of \$14.55 overhead per office visit represents a very conservative, low estimate of actual overhead). In the year 2005, the same office visit will be paid \$23.17 in constant 1995 dollars. **Because the overhead costs are fixed—meaning that the dollar costs of rent, utilities and supplies needed to run a physician office will be at least as high in 2005 as in 1995 and therefore cannot be reduced to offset the cut in Medicare fees—the net reimbursement to physicians for a mid-level office visit in the year 2005 would be less than nine dollars (\$23.17-\$14.55=\$8.62), which represents a 61 percent cut in net payments from 1995 to 2005.**

I don't know many primary care physicians who can afford a cut of 60 percent or more in net revenue from Medicare over the next ten years. Many of my colleagues are already closing their practices to new Medicare patients. Those of us who are in our fifties and have a practice dependent on Medicare are thinking more and more about retiring early. When we retire and close our practices, who will take care of our Medicare patients who are left behind? I think that it is unlikely that our younger colleagues will choose to take on large numbers of Medicare patients, knowing that Medicare fees are steadily dropping and will barely cover their costs.

Congress should take no comfort in the Commission's chapter that suggests access "appears to be good" mid-way through implementation of the Medicare fee schedule. For one thing, there is growing evidence that new Medicare patients are having trouble finding primary care physicians. Moreover, the Commission's analysis on access is nothing more or less than a snapshot of the way things are now. It tells us nothing about how access will fare two, three, five or ten years from now as the cuts mandated by OBRA 93, plus any new cuts that may be imposed this year, take their full effect.

I worry that some may conclude that because there is no evidence of a widespread access problem today, there is no reason to fear one in the future. This kind of thinking reminds me of the 45 year old patient who smokes three packs of cigarettes and drinks a six pack of beer daily and says he feels fine. Although my patient may believe (and convince himself) that he's fine, as his physician I know that the odds are overwhelming that the damage being inflicted today will cause a heart attack or other medical crisis not too long in the future. Likewise, I firmly believe that even though the elderly's access for now may seem fine, the damage being inflicted by cutting the Medicare program now will lead to an access crisis in the near future.

Spending on Physician Services Compared to Other Medicare Expenditures

Additional cuts in payments to physicians might be understandable if physician fees were out-of-control or if we hadn't already been cut more than our fair share. **But the fact is that Medicare expenditures for physician services have already dropped from double-digit rates in the mid-1980s to only 3 percent in FY 1994, and are now increasing at a rate that is slower than for any other category of Medicare spending.** Average annual expenditures on physician services increased by only 6.34 percent from 1989-1993, compared to over 60 percent for skilled nursing facilities, 58 percent for hospital outpatient departments, almost 40 percent for home health, and over 12 percent for inpatient hospital services. Physician services are also a declining portion of total Part B expenses: in 1985, physician services constituted 75 percent of total Part B expenditures; in 1993, they constituted only 63 percent of Part B spending. Physician services have also been cut disproportionately more than other categories of spending: from 1981-1993, physician services absorbed 32 percent of the Medicare cuts, even though they constitute only 23 percent of total Medicare expenditures.

My plea to you is to consider the impact of proposed cuts in Medicare on the ability of the elderly to continue to have adequate access to physician services. The cuts that were enacted in 1993 will soon drive down fees to the point where many physicians, but especially primary care physicians, will have no choice but to limit the number of Medicare patients they can afford to treat. Additional cuts will threaten the economic survival of physicians who have large Medicare practices. Especially since expenditures for physician services have already been cut more—and are growing at a much slower rate—than any other category of Medicare spending, there is no justification for further cuts that will endanger access to care.

Medicare Fee Schedule Recommendations

ASIM's concern about the impact of Medicare cuts is exacerbated by the fact that the current formula for determining Medicare fee schedule updates, as modified by OBRA 93, will have a greater adverse impact on primary care and other nonsurgical services than on surgical procedures.

More specifically, the current formula, as modified by OBRA 93 has had two consequences that are disadvantageous to primary care and other nonsurgical services. As noted earlier, the reduction in the allowed rate of growth under the volume performance standards, and the increase in the maximum cuts that are possible in any calendar year, will result in payment reductions for all services, including primary care and other nonsurgical services. The impact on primary care and other nonsurgical procedures, however, will be worse than for surgical procedures, because the policy of separate VPSs and targets (and flaws in the way that HCFA has calculated the VPSs), have resulted in the conversion factors for primary care and other nonsurgical services being much lower than for surgical procedures.

To correct the flaws that will otherwise worsen the impact on primary care and other nonsurgical services, ASIM strongly supports the following recommendations in the Physician Payment Review Commission's 1995 Report to Congress:

A single volume performance standard and update for all categories of services should be adopted. If separate standards and updates by categories of services are retained, they should be based on the recent trend in volume and intensity growth for each category as called for by the Omnibus Reconciliation Act of 1990, and differential updates should be in effect for one year only.

The 104th Congress has pledged to change federal policies that are irrational, inefficient, overly complex and contradictory. The existing method for determining the Medicare fee updates and VPSs is precisely the kind of irrational, inefficient, complex and contradictory government policy that should be changed. Let me give you four good reasons why it should be changed to require a single VPS and conversion factor:

First, the current method for determining the fee updates and VPSs will magnify and accelerate the access problems resulting from budget cuts. The elderly depend on primary care physicians for their access into the Medicare system. Primary care is therefore the first place where access problems will begin to become evident. The Physician Payment Review Commission estimates that under the current formula, the 1997 conversion factor for surgical procedures will be 26.7 percent higher than for primary care services and 29 percent higher than for other nonsurgical services. Because the conversion factors for primary care and other nonsurgical services start out so much lower than for surgical procedures, any additional cuts in the conversion factors will disproportionately hurt primary care physicians and other medical specialists. It is patently irrational to have in place a policy that is inherently disadvantageous to primary care when access to primary care is at the greatest risk of being reduced.

Second, the method for determining the VPSs and fee updates is inherently contradictory to the intent of the resource based relative value scale (RBRVS). The RBRVS was intended to pay physicians the same amount for services that involve equal physician work. But the current policy of different conversion factors has resulted in surgeons being paid 25-30 percent more for their surgical procedures than primary care physicians are paid for a non-surgical service requiring the same amount of time, mental effort and judgment, technical skill and stress. The Commission states that "determining separate performance standards and fee updates for different categories of service leads to distortions in the relative payments which no longer reflect the resource based relative value scales." The Congressional Budget Office agrees. In its 1995 report Reducing the Deficit: Spending and Revenue Options, the CBO states that

"[the PPRC's proposal to re-establish resource based relative values for payment rates and maintain them by using a single target and update for all services, eliminating separate

targets and updates now existing for primary care, surgical, and other nonsurgical services) would restore the integrity of the resource based relative value scale that was the foundation for the Medicare fee schedule, which was put in place to rationalize the basis for Medicare's payment rates. One of the objectives of the MFS was to improve payment rates for primary care in relation to specialists' services, in part because health care was expected to be less costly in a system less dominated by specialists. That objective has been undermined in recent years by the default update process, which has produced higher payment rate increases for specialists' services than for primary care services."

It is precisely the kind of contradictory federal policy exemplified by the VPS method that has led to widespread distrust and dissatisfaction with way that Washington does things. Consistency and fairness should dictate that Congress end this contradiction by adopting the PPRC recommendation for a single conversion factor.

Third, the current method encourages inefficiency, since it penalizes many physicians for changes in practice patterns that may reduce Medicare expenditures while rewarding others for reductions in volume over which they have no direct control. Some have argued that the policy of maintaining separate VPSs and conversion factors should be supported because it "rewards" surgeons for reducing volume by more than other physicians. The evidence suggests, however, that the reduction in surgical volume is due principally to changes in practice patterns, such as the substitution of less expensive forms of treatment by internists for conditions that used to require surgical intervention and a predictable reduction in the need for certain surgical procedures.

One of the objectives of physician payment reform was to encourage physicians to reduce the need for high cost surgical treatments by increasing payments for evaluation and management services, such as visits and consultations, and by encouraging the substitution of less costly treatments for more expensive ones. The shift in practice patterns to less invasive outpatient treatments that has occurred over the past several years is dramatically lowering the demand for surgical procedures. Unfortunately, when non-surgeons find ways to treat patients that avoid the need for surgery, they are penalized under the current VPS and update methods for providing more services, even though those services allow patients to be treated more efficiently by reducing the need for surgery.

To illustrate, many heart patients that in the past may have eventually required coronary bypass surgery can now be treated through medication and careful management by an internist of their diets and lifestyles, and when necessary, by a procedure called angioplasty that can clear blocked arteries without resorting to more invasive (and costly) bypass surgery. Under the current VPS methods, internists and cardiologists are penalized because substituting visits and less invasive nonsurgical treatments for surgery increases the "volume" of primary care and nonsurgical services. Cardiac surgeons receive a reward for the reduction in the number of coronary bypass procedures, even though the reduction in volume was due to changes in practice patterns over which they had no control.

Similarly, the Physician Payment Review Commission, citing the Agency for Health Care Policy and Research, reported in 1994 that "Reductions in the volume of prostate-related procedures mostly reflect changes in treatment through increased use of drugs, less invasive surgical procedures, and watchful waiting" (PPRC, Fee Update and Medicare Volume Performance Standards for 1995, May 15, 1994). If Congress' goal is to increase efficiency, it makes absolutely no sense to penalize physicians for substituting less costly evaluation and management services and other nonsurgical treatments for more costly surgical interventions.

The evidence also suggests that much of the reduction in surgical volume is due to an inevitable "bottoming out" of the number of patients who have a need for cataract surgery and several other surgical procedures that experienced explosive growth in the mid-1980s. In the same 1994 report from the PPRC that is cited above, the Commission noted that "The period of greatest growth in volume for a new medical procedure or technology is often the first few years following introduction, largely because it is during this period of diffusion that patients with existing indications are treated along with those newly identified."

In the mid-1980s, the volume of new technologies such as cataract surgery was growing at double-digit rates, because there were tens of millions of patients who needed--and could benefit--from those treatments. As time has passed, however, the demand for such procedures has naturally declined. As the Commission noted in last year's report on the 1995 Volume Performance Standards:

"Cataract lens replacement surgery provides an illustration [of how the demand for technology can decrease over time because fewer patients require the procedure]. Lens implant improvements and new surgical techniques transformed cataract surgery in the 1980s into a safe, rapid, and convenient cure for cataracts. In 1988, however, the volume of cataract surgery began to decline on a per person basis . . . this decline may have indicated that the backlog of potential lens implant recipients created by the improved surgical technology had largely been depleted. In its 1990 report, the Commission noted that if this hypothesis were correct, the volume of cataract surgery should be expected to be level or possibly declined over the next few years. Noting the large percentage of total surgical volume associated with cataract surgery, the Commission observed that such a reduction in growth of this surgery, if not offset by increases in other types of surgery, would substantially reduce the growth of total surgical volume.

Analysis of Medicare claims data supports the validity of the Commission's prediction. Volume of cataract lens replacement services declined by 7.0 percent from 1992 to 1993. These procedures, along with other eye-related surgical procedures, continue to account for a substantial portion of Medicare expenditures for surgery—currently about 30 percent. This decline in cataract surgery has had a substantial impact on growth in total surgical volume."

It makes no sense to maintain a policy of separate VPSs that rewards some physicians for changes in practice patterns over which they have no control, such as the reduction in the number of patients needing cataract surgery and the substitution of nonsurgical treatments for surgical procedures.

Nor does it make sense to penalize other physicians for changes in practice patterns that have led to increases in the number of nonsurgical treatments for conditions that in the past would have required surgery. The VPS should reward physicians as a whole for taking steps to control volume, rather than the current policy of basing rewards and penalties on shifts in the number of services provided in each category that have no rational relationship to physician performance.

Fourth, the current method is overly complicated. A single VPS and conversion factor would greatly simplify the method of determining Medicare payments. Currently, HHS must calculate three separate VPSs, monitor expenditure trends in each category, and determine three separate dollar multipliers, which are then transmitted to each Medicare carrier for use in calculating what is in essence three different fee schedules, depending on the type of service being billed. By contrast, under a single conversion factor, all resource based relative values would be multiplied by the same dollar multiplier. Physicians would know and be able to collectively respond to the same VPS (target rate of growth), and there would be no possibility of physicians being unfairly rewarded or penalized because of the substitution of one kind of medical treatment for another. The 104th Congress has rightly called for simplification of government rules. Moving to a single VPS and conversion factor would be one important step toward reducing the complexity of the Medicare fee schedule.

There is one other argument that has been offered in support of maintaining the current policy of separate VPSs that must be addressed. The argument made by some is that Congress should not eliminate the separate VPSs because this would be inconsistent with the intent of the 1989 law. But Congress never intended for the provisions of the 1989 law to be inviolate, and has in fact modified them on numerous occasions since then. The 1989 law specifically provided for a five year transition to the full Medicare fee schedule payment rates because Congress wanted the opportunity to enact "mid-course" corrections. Since then, Congress has changed the law by reducing the updates (OBRA 90 and 93), increasing the performance standard reductions and lowering the floor on minimum updates (OBRA 93), mandating reductions in practice expenses for procedures determined to be overvalued (OBRA 93), and mandating development and implementation of a resource based method for determining practice expenses (1994). The 104th Congress will likely be considering other major changes in the Medicare fee schedule. There is no reason that Congress should feel any greater obligation to preserve the policy of separate VPSs and updates than it has for other parts of the 1989 law. Further, Congress also made a promise in 1989 to pay physicians the same amount for services requiring equal work and to create incentives for primary care. That commitment is being violated each year that the separate VPSs and conversion factors are allowed to continue.

ASIM strongly urges Congress to adopt the Commission's recommendation for a single VPS and conversion factor for all services. A single VPS for all services should be required for fiscal year 1996. Budget neutral adjustments should be made in the current separate conversion factors until a single conversion factor is attained for all services. The Commission suggests that this might be accomplished by establishing differential updates that would bring each category to a common

conversion factor. We believe that a shift to a single conversion factor should be accomplished as expeditiously as possible, since we see no reason or justification for a lengthy transition period to a single conversion factor.

Other Changes in the VPSs

Although ASIM's strong preference is for a single VPS and conversion factor, we agree with the Commission's recommendation that if separate categories are maintained, they should be based on the recent trends in volume for each category, as required by OBRA 90, and the differential updates should be in effect for one year only. The PPRC argues that:

"The distortion of relative payments is further exacerbated by the method the Health Care Financing Administration uses to determine the performance standards under the default formula. Although OBRA 90 requires the use of separate five-year historical trends to estimate the growth in volume and intensity for each category of service, HCFA uses a single historical trend in volume and intensity growth for all services combined. As a result, the performance standard for each category of service reflects a single pooled historical trend in volume and intensity growth rather than the growth for that particular category of service. Using a single pooled trend instead of separate trends leads to more favorable updates for the category with the lowest volume and intensity growth. For this category, the pooled historical trend results in a higher target than it would have had otherwise. When the conversion factor update is determined two years later, the separate expenditure growth rate for this category of service is compared to the target based on the pooled historical trend . . . Use of a pooled historical trend therefore leads to an ever-increasing distortion in relative payments across service categories. In 1995, for example, payments for surgical procedures are \$39.42 per RVU, while those for primary care are \$36.38 and other nonsurgical services, \$34.62. This discrepancy . . . becomes systematic because most surgical services, which have the lowest five-year historical trend in volume and intensity growth, in most years will compare favorably to the pooled historical trend and thus get higher updates than are warranted. **Eventually, the discrepancy between surgical services and primary care services may become large enough to erase the relative gains for primary care and other evaluation and management services that were integral to physician payment reform.**" [Emphasis added by ASIM].

ASIM and 22 other primary care and medical specialty groups recently wrote to HCFA and urged that it follow the requirements of OBRA 90 by withdrawing the 1995 VPS, published in December 1994, and recalculating and republishing it based on separate volume trends for each category; propose default fiscal year 1996 VPSs that are based on separate volume trends for each category; and make a recommendation to Congress on calendar year 1996 conversion factor updates that would bring the conversion factors to the levels that would have occurred had HCFA followed the OBRA 90 requirements for the 1993 and 1994 VPSs. If separate VPSs are maintained, we strongly urge Congress to direct HCFA to use separate volume trends, as required by OBRA 90, and to enact updates for calendar year 1996 that would bring payments to the levels intended under the OBRA 90 policy.

The Commission has also proposed that the current formula—five year historical trends minus a four percent performance standard reduction—be replaced by per capita GDP, plus an additional factor of one or two percent. Although ASIM has strong reservations about the concept of linking growth in expenditures on physician services to the performance of the economy as a whole, we believe that the Commission's recommendation may be preferable to the current formula as modified by OBRA 93. The Commission makes a persuasive case that the current formula will result in annual reductions in payments for the foreseeable future, because

"under any scenario that projects a steady rate of volume and intensity growth, such as the slowdown to 3 percent and 4 percent, the five year historical trend used to determine the VPS equals the actual trend. The default formula for the VPS, however, continues to deduct four percent. The update to the conversion factor, therefore, would remain -2 percent indefinitely . . . Regardless of the eventual level of growth in volume and intensity, these reductions would persist as long as there was no change in the rate of growth."

The Commission believes that its recommendation to convert to a GDP plus one or two percentage point default formula would result in increased expenditures, and therefore would not be budget neutral. It suggests that budget neutrality could be maintained by making a one-time reduction in the 1996 conversion factors. ASIM believes that if budget neutrality rules require that the current conversion factors be reduced, this change should be accomplished in a manner that does not further distort the RBRVS and that is consistent with the objective of moving to a single

conversion factor for all services, such as by reducing the surgical conversion factor by more than the primary care and other nonsurgery conversion factors.

ASIM opposes the Commission's recommendation that the VPSs be made cumulative. This would mean that changes in payment levels would reflect whether total actual spending had exceeded targeted spending since a base year. Since this change has the potential of greatly magnifying any of the reductions that otherwise may occur, it should not be accepted by Congress.

Future of the Physician Payment Review Commission

It is our understanding that Congress may be considering eliminating authorization or funding for the Commission or consolidating its functions with those of other advisory bodies. Although ASIM has not always agreed with the Commission's recommendations, we do believe that it has provided valuable, objective, and independent advice to Congress. The 1994 PPRC report to Congress shows how important the Commission's analysis is in framing the decisions that need to be made on the Medicare fee schedule. The Commission has also provided a means for physicians to express their views on Medicare fee schedule issues without having to take our case directly to Congress. Eliminating the functions of the Commission in its entirety would force Congress to rely more on analysis by HCFA and the administration, which inevitably is affected by the administration's political agenda, and may reduce the input physicians have into decisions that affect payments for their services.

ASIM understands the need for Congress to reduce spending, but would prefer that the PPRC continue to receive full funding and be preserved as a separate, independent advisory group to Congress. But if changes are made, we urge the Ways and Means Committee to assure that the essential functions of the Physician Payment Review Commission—providing an independent source of advice and analysis on technical Medicare fee schedule issues, with strong physician representation and input—are not lost in the desire to consolidate functions or reduce expenditures.

Conclusion

ASIM appreciates the opportunity to present testimony to the Ways and Means Committee. We fully understand the magnitude—and difficulty—of the responsibilities you've accepted. Reducing the federal deficit and simplifying government rules and programs are admirable objectives, and ones in which you will have the support of the medical profession. As you act on the Contract with America, we believe it is essential that Congress also honor the Contract with America's elderly—which promised continued access to affordable care—that was made by your predecessors when Medicare was enacted thirty years ago.

We urge that you not enact further cuts payments for physician services because of our concern that access will suffer as a result. We believe that since expenditure growth on physician services is already much lower than any other category of Medicare spending, there is no justification for seeking additional cuts in this area. If additional cuts are enacted, they should be focused on areas that are having more explosive growth, provided that savings can be achieved without sacrificing access, and extreme care must be taken to assure that any cuts that may be made in payments for physician services do not further distort the resource based relative value scale (i.e. they should close—not widen—the gap between surgical procedures and primary care and other nonsurgical services).

ASIM recognizes that a debate on reforming Medicare is imperative. Virtually all experts agree the program cannot remain solvent for much longer. The focus of such a discussion should be on developing a package of proposals that would guarantee the continued solvency of the program, rather than on short-term cuts that would ask beneficiaries and physicians to contribute more than their fair share to deficit reduction or financing tax cuts. For this reason, we do not advocate increases in beneficiary cost-sharing if the savings are to be used for purposes other than maintaining the long-term solvency of Medicare. ASIM would support changes in beneficiary contributions and adjustments in the age of eligibility as part of a balanced plan to preserve Medicare solvency.

ASIM also supports creation of a voucher program that would expand the health plan choices available to beneficiaries, and would be pleased to work with the Committee on the development of such a program. Over the next several months, we intend to develop detailed recommendations for your consideration on how to expand choices for Medicare patients while continuing to assure access to high quality care.

Finally, if other changes are insufficient to assure the continued viability of Medicare, it may be necessary to initiate a process for putting priorities on the benefits available under the program. As an internist from Oregon, the only state that has attempted to do this for its Medicaid program, I can tell you that such a process can work and enjoy broad support from the public and the medical profession.

I'd be pleased to answer any questions from the committee.

Mr. McCRERY. Thank you, Dr. Weaver.

I would like to thank all the members of the panel who were kind enough to appear before the subcommittee today. Unfortunately, we have a vote on the floor in which we have about 3 or 4 minutes left to get over there to vote, and then we have a series of 5-minute votes following this one. So all of your written testimony will be made a part of the record.

Dr. WEAVER. Thank you.

Mr. McCRERY. Once again thank you very much for appearing before us today. We will look forward to working with you further as we go through some difficult times ahead in terms of our Medicare system and our health care system generally. We look forward to sharing our views with you—

Dr. WEAVER. Thank you.

Mr. McCRERY [continuing]. And hearing more of yours in the future. Thank you.

[Whereupon, at 12:10 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

**STATEMENT OF THE AMERICAN SOCIETY OF CLINICAL ONCOLOGY
IN RESPONSE TO RECOMMENDATIONS OF
THE PHYSICIAN PAYMENT REVIEW COMMISSION**

Interest of ASCO

The American Society of Clinical Oncology (ASCO) represents more than 9,300 physician researchers involved in cancer treatment and research. Many ASCO members participate in the extensive clinical trials network established under the auspices of the National Cancer Institute (NCI). Treatment given in the context of high quality, peer-reviewed clinical trials like those sponsored by NCI often represents the best available care for patients diagnosed with life-threatening cancer.

Position of Third-Party Payers on Investigational Therapy

Many third-party payers, both public and private, exclude from coverage patient care costs incurred in connection with clinical trials. As a result, clinical investigation is deterred, appropriate reimbursement is frequently denied, and patients with serious or life-threatening disease are deprived of the best available care. Automatic exclusion from coverage of investigational therapy for critically ill patients represents a form of insurance abuse that denies policyholders (and in the case of Medicare, beneficiaries) the value of their insurance.

Problems with PPRC Recommendation

Rather than recognize that investigational therapy is an integral part of care for many cancer patients, the Physician Payment Review Commission (PPRC) suggests that some -- but not all -- research should be financed through a separate budget specifically designed for that purpose. This approach denies the value of investigational therapy for cancer patients and creates opportunity for disparate treatment of similarly situated beneficiaries. At least in cancer care, clinical investigation is not an unnecessary adjunct to standard therapy, but instead is a reasonable alternative, and one that is as likely to be successful for a patient with life-threatening disease as standard care.

ASCO Recommendation

ASCO has long recommended that third-party payers, including Medicare, provide reimbursement for all patient care costs incurred in those clinical trials when all of the following is demonstrated:

- Treatment is provided with a therapeutic intent^{1/};
- Treatment is being provided pursuant to a clinical trial which has been approved by the National Cancer Institute (NCI), any of its cancer centers, cooperative groups or community clinical oncology programs; the Food and Drug Administration in the form of an investigational new drug (IND) or investigational new device (IDE) exemption; the Department of Veterans Affairs; the Department of Defense; or a qualified nongovernmental research entity as identified in the guidelines for NCI cancer center support grants (such as the American Cancer Society or the Leukemia Society of America);

^{1/} Treatment with a therapeutic intent may be aimed at improving patient outcome relative to either survival or quality of life.

- The proposed therapy has been reviewed and approved by a qualified institutional review board (IRB);
- The facility and personnel providing the treatment are capable of doing so by virtue of their experience or training;
- There is no noninvestigational therapy that is clearly superior to the protocol treatment; and
- The available clinical or preclinical data provide a reasonable expectation that the protocol treatment will be at least as efficacious as noninvestigational therapy.

This recommendation was reflected in a number of health care reform proposals introduced in the 103rd Congress. We believe that imposing the ASCO standard as a requirement will advance medical research and improve patient care at little or no incremental cost in most cases.



AMERICAN
SPEECH-LANGUAGE-
HEARING
ASSOCIATION

**Statement
of the
American Speech-Language-Hearing Association
to the
Committee on Ways and Means
Subcommittee on Health**

For the Record of the Public Hearing - March 30, 1995

Submitted April 13, 1995

Re: 1995 Annual Report to Congress
Physician Payment Review Commission

The American Speech-Language-Hearing Association (ASHA) represents more than 75,000 audiologists and speech-language pathologists, most of whom are qualified to render Medicare-covered services. ASHA appreciates this opportunity to comment on the 1995 Annual Report to Congress of the Physician Payment Review Commission (PPRC).

Medicare Payments to Non-Physicians. ASHA was concerned that the 1995 report contained little or no discussion regarding payment to non-physicians such as audiologists, nurse practitioners and psychologists. While these services do not represent a large percentage of total Medicare expenditures, thousands of practitioners are affected. ASHA has voiced strong concerns to the Health Care Financing Administration (HCFA) that gross inequities are created in the payment system because some professions are not paid from the professional component or (work relative value units or RVUs). This practice totally excludes a portion of the fee schedule from independent practitioners even though the non-physician provides the total service. HCFA is currently examining the legality of recognizing additional professions in the work component. The PPRC should be calling for legislation, if necessary, to allow non-physicians (such as audiologists and psychologists) to be paid on an equal categorical status with other non-physicians (such as physical therapists and occupational therapists) that are paid from RVUs. ASHA believes that the statute regarding the resource-based relative value scale should be amended so that non-physicians providing covered services are appropriately reimbursed.

Medicare HMOs - Inadequate Rehabilitation Services (Chapter 5). The PPRC is clear in its understanding that "HCFA executes annual contracts with HMOs and CMPs to provide all Medicare-covered services for enrolled beneficiaries (both Part A and Part B) . . ." (p. 90) [emphasis added]. This full range of services is required by 42 CFR 417.414(b)(1):

. . . an organization [HMO/CMP] must furnish to its Medicare enrollees (directly or through arrangements with others) all the Medicare services to which those enrollees are entitled that are available to Medicare beneficiaries who reside in the organization's geographic area but are not enrolled in the organization.

It is of concern to ASHA that no reference is made to data that shows that the full scope of Medicare coverage is often not provided. ASHA has received reports of services in Medicare HMOs curtailed dramatically below the Medicare medical review guideline standards for reasonable and necessary speech-language pathology services. Such abuse should be investigated as it probably occurs in other covered areas as well.

Improving Medicare Coverage Decisions (Chapter 6). The Subcommittee on Health should know that PPRC's call for standardization of coverage policies applies to fiscal intermediaries as well as carriers. The statement, "Coverage policies can differ because criteria and processes for making them vary among carriers (p.119)," equally applies to intermediaries. ASHA joins in PPRC's support for more coverage decisions at the national level based on formal technology assessments. The Office of Health Technology Assessment has an annual budget that permits only five full-time staff, a severe limitation. This limitation has resulted in the absence of a formal evaluation of a cost-effective alternative to a radiologic procedure used to evaluate swallowing disorders. ASHA is concerned because some carriers consider the alternative fiberoptic procedure to be "experimental" or "investigational," absent a national coverage decision. This will often result in a higher expenditure for the radiologic procedure.

Medicaid Demonstration Programs (Chapter 8). Regarding waivers granted under Section 1115 of the Social Security Act, the report criticizes some demonstrations for lacking merits such as adequate planning and appropriate systems to monitor access, quality and marketing. ASHA members have substantiated much more severe shortcomings. In particular, HCFA should be questioned on how its own policies and procedures could allow the TennCare program to be implemented with such gross inadequacies regarding information and services not available to beneficiaries. This includes TennCare's reluctance to deliver comprehensive services under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program (ages 0-20) even though EPSDT requirements were not waived by HCFA. It is hoped that revised procedures are in place at HCFA to prevent such failures from occurring again.

Statement of
the Association of American Physicians and Surgeons
to the Subcommittee on Health
of the House Ways and Means Committee

With Reference to: Recommendations of the Physician's Payment Review Commission presented on March 30, 1995

The Association of American Physicians and Surgeons was founded in 1943 to preserve and promote private medicine and the sanctity of the patient-physician relationship.

The AAPS recognizes the need to cut back on government subsidies. As predicted, they are bankrupting the nation. We are not requesting preferences for our members.

With respect to physician payment, AAPS takes the position that it is pointless to revise the Resource-Based Relative Value Scale because it is fundamentally flawed in concept, practice, and result. Instead, we propose alternate solutions to our dual problems of spiraling expenditures combined with restrictions on medical care.

Problems with the Resource-Based Relative Value Scale (RBRVS)

The concept of the RBRVS is that of the Marxist Labor Theory of Value, i.e. that the value of the service depends only upon the cost of production. This idea has been thoroughly discredited (for example, in its related form of "comparable worth").

Even if this theory were correct (it is wrong to the point of absurdity), the RBRVS is flawed in practice because it cannot accurately calculate the cost of production. The tables of costs are derived from subjective evaluations by a small panel, data (such as apartment rents) that may be completely inapplicable, and arbitrary extrapolations. The tables disregard variations in cost due to location, type of practice, individual abilities and training of the practitioner, individual complexity of the patient's case, and uncontrollable fluctuations in the marketplace for goods and services. Even if the data could be vastly improved, the tables of values would still give an erroneous price in every single individual instance because they are based on broad averages.

The result of the RBRVS is to restrict the provision of medical services. This is because the RBRVS is not simply a flawed means of calculating government reimbursement for Medicare beneficiaries. Rather, it is combined with restrictions on balance billing and thus imposes price controls on medical services rendered to all Medicare beneficiaries (as well as to retirees under the FEHBP). Like every example of price controls imposed over forty centuries of recorded history, it inevitably leads to market distortions, with shortages, dilution of quality, corruption, and destruction of incentives for excellence and progress.

Restrictions on Medical Care

Surveys undertaken by the PPRC have been cited to show that care is "still" available to Medicare beneficiaries. However, it is misleading to say that "only" 4% of patients had difficulty obtaining medical care and 0.3% of patients surveyed had difficulties finding a new physician. At any given time, most Medicare beneficiaries are either healthy or already under the care of an established physician. In addition, patients may not be aware of services that a

physician might have offered in a free market but simply fails to mention when he knows he cannot provide them without incurring a loss.

Furthermore, many physicians are in a marginal situation. A slight increase in the pressures that they have so far managed to endure could lead to a sudden increase in retirements or dramatic changes in practice patterns.

Testimony before this Subcommittee by the American Academy of Family Physicians stated that in some locations more than 35% of family physicians are not accepting Medicare beneficiaries. We believe the problem is actually far worse than that. In a 1993 survey by AAPS (see below), 60% of respondents reported restricting services to Medicare patients in some way, even if they did accept some new Medicare patients.

A Washington State survey conducted by AAPS of statewide physicians showed that about one quarter contemplated leaving the state or the practice of medicine if they were forced into government-run managed-care programs.

Proposed Solutions

Solutions must look beyond fine-tuning of the RBRVS. AAPS proposes the following for consideration:

▶ **Allow and encourage private insurance alternatives.**

AAPS believes that the long-term solution to the problem is to enable most younger persons to fund their own retirement medical insurance without being forced into government dependency. This means that market-based alternatives to Medicare must be allowed to develop, the burden of taxation must be eased, and savings mechanisms (such as Medical Savings Accounts) must be encouraged. Savers must be confident that the fruits of their prudence will be protected from governmental "recapture."

▶ **Establish fiscal solvency for Medicare.**

In order to preserve fiscal solvency of Medicare for those who are already dependent upon it, the demands on the program must be diminished. The only way to accomplish this without severe rationing (which will lead to the functional equivalent of involuntary euthanasia) is to allow private contracting and balance billing. The private marketplace could then partly compensate for the distortions that occur in any governmentally fixed reimbursement system.

▶ **Minimize fraud and abuse.**

Fraud and abuse are believed to be rampant. Draconian enforcement cannot eliminate this problem, not even by terrorizing all practitioners and depriving them of their constitutional rights. The current system rewards and facilitates fraud and abuse. Until the easy profits are removed, the skillful gamblers of the system will thrive. Medicare should stop paying providers directly and should reimburse patients only.

▶ **Reduce regulatory and administrative cost.**

To enable physicians to serve patients at a more reasonable cost, the government should immediately repeal all regulations that serve no demonstrable purpose of protecting public health. This includes regulations under the Clinical Laboratory Improvement Act and the Occupational Safety and Health Administration, other than those that have been scientifically shown to produce benefits justifying their cost.

Medicare must also reduce the tremendous clerical costs incurred in the claims-filing and documentation requirements. Many of these costs would be eliminated if payments were to be made only to beneficiaries. In addition, the system could be greatly simplified by increasing

patient deductibles while eliminating the copayment requirement. No claims need be filed until (and unless) the deductible is exceeded. After that point, Medicare should pay an indemnity for services. (The PPRC could continue to advise on the amount of the indemnity, preferably by some means other than the flawed RBRVS.) The patient would be responsible for the balance, which could be less than 20% (even 0%) or more than 20%, depending on the individual circumstances of both patient and provider, and determined without the need for costly and intrusive bureaucratic intervention.

Conclusions

AAPS states no opinion regarding the specific amount that any physician should be paid; in a free market, payments may be determined only by the provider and the recipient of a service. We do note that members report receiving on the average about 50% of the usual price when caring for a Medicare beneficiary, and that this must inevitably have an impact on the quality and availability of service.

We expect that the implementation of the suggestions above would lead to a substantial drop in Medicare expenditures, with preservation or improvement in the quality of care.

Attachment: Survey of physicians' response to Medicare

Responses to AAPS survey on attitudes toward Medicare and its impact on patient care. About 3000 questionnaires were distributed, with self-addressed, nonstamped envelope, and 480 were returned by the time responses were tallied. If the same question was asked in 1990, the response at that time is tallied for comparison. (Compiled May, 1993)

Question	% positive responses (% who circled option or answered "yes")			
	1993 all (N = 480)	1993 FP,IM (N = 209)	1993 surg (N = 116)	1990 (N = 922)
1. Accept new Medicare pts?				
A prefer	1	0	3	8
B same basis as others	56	43	75	67
C special circumstances only	30	37	19	17
D not at all	12	19	3	8
2. Restrict services to Medicare pts?	51	60	41	16
<i>If services restricted, why?</i>				
A Limits on balance billing	58	58	63	
B Cut in reimbursement	71	74	83	
C Physician must submit claim	45	46	46	
D New coding requirements	40	45	40	
E Hassles and threats from Medicare	71	71	69	
3. Have you received:				
A Refund demand (service "unnecessary")	38	48	31	36
B Refund demand for coding errors, etc.	39	40	39	NA
C Notice of "substandard quality"	5	8	6	8
D Sanction threat	15	20	17	21
4. Any difficulty making referrals?	37	36	35	
5. Consider retiring earlier than you would have thought possible 5 yrs ago?	73	70	74	74
6. Your position on caring for Medicare-eligible patients outside the system:				
A Do offer, or plan to offer such care	22	25	19	
B Would like to work outside system but fear government reprisals	56	54	59	
C I'd do it but patients uninterested	15	15	18	
D Oppose this option	2	4	0	
7. Mean number of years in practice	21	22	19	21
8. Mean percentage of practice that involves Medicare	33	34	38	
9. Percentage of regular fee received in caring for a Medicare patient	49	53	54	61



