

## HOW SHOULD COST-CONTAINMENT BE ATTAINED? CONGRESS FORGES A PLAN

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**C**ontinually rising health care costs take a bigger bite out of the United States gross national product each year, leaving the government and third party payers scrambling for ways to cut expenditures. While nearly everyone admits that the increasing financial pressure on the government's health care programs must be relieved, not everyone is convinced that the government's proposals to do so will be the most beneficial and cost effective. Many of the latest efforts attempt to stem increases in payments to physicians.

Congress this term debated many proposals put forth to attack the “monster” of physician payments — expenditure targets, relative value scales, limits on balance billing, practice guidelines, technology assessment, reductions in reimbursement for “overpriced” procedures, and ownership referral prohibitions are among them. With the passage of the Budget Reconciliation Bill on November 21, which President Bush is expected to sign, Congress decided the fate of these cost-containment strategies, at least until the next budget reconciliation.

### Resource-Based Relative Value Scale (RBRVS) Advances

One strategy the government seems bent on implementing is a relative value scale (RVS) payment system for physicians (see *Newsline* March 1989, p. 271). As part of the Budget

### Partial Exemption For Nuclear Medicine

Effective April 1, 1990, reimbursement for nuclear medicine physicians for whom nuclear medicine services account for at least 80% of the total amount of charges made under Medicare Part B will be calculated as follows:

**For the remainder of 1990:**

$\frac{1}{3}$  of Radiology Fee Schedule +  $\frac{2}{3}$  of 101% of the 1988 prevailing charge

**For 1991:**

$\frac{2}{3}$  of Radiology Fee Schedule +  $\frac{1}{3}$  of 101% of the 1988 prevailing charge

Reconciliation Bill, Congress adopted an RBRVS-based payment schedule to be implemented transitionally starting January 1, 1992, with the full fee schedule to be in force in 1996. In 1992, no payments within the schedule will be raised or lowered more than 15% of the 1991 prevailing charge level. For subsequent years, there will be a blended schedule (based on the 1992 rate and the actual RBRVS payment schedule) as follows: 1993, 75-25%; 1994, 67-33%; 1995, 50-50%; and the full payment schedule will be in place in 1996. The non-participating payment schedule will be 95% of the participating physicians payment schedule. There will be no specialty differentials. The geographic adjustment will apply to the practice cost component, the malpractice cost component, and to one quarter of the work component. The Secretary of

Health and Human Services (HHS) will continue to use the existing Radiology RVS, developed by the American College of Radiology (ACR), and the anesthesia fee schedule but will be required to make adjustments so that similar services performed by other specialties are comparable. The RBRVS will be reviewed in total no less than once every five years.

Now in its second phase of study, the Harvard RBRVS, which was mandated by Congress in 1985 and is funded by the Health Care Financing Administration (HCFA), will restructure the physician payment system and purportedly lessen discrepancies in payment among the medical specialties practiced in the United States. While the RBRVS would be implemented initially for government-funded health care, third party insurers typically follow HCFA's lead and are expected

to reimburse in a similar manner. Nuclear medicine, which is among the specialties being reviewed in phase two of the project, is currently included in the ACR RVS. However, a provision included in the reconciliation legislation partially removes nuclear medicine from the Radiology RVS through 1991 (see box p. 13A).

Updating the RBRVS and outlining its rationale during the Economics of Diagnostic Imaging Symposium, held in October in Washington, District of Columbia, William C. Hsiao, PhD, the Harvard University Professor of Economics and Health Policy who heads the project, told attendees that physician charges are distorted compared to other market charges for a number of reasons: insurance covers physician services, making patients and providers less conscious of cost; insurance coverage is uneven; payment rates are not lowered when new, relatively risky technologies become more commonplace; and often physicians provide services in situations where the patient is in a life threatening condition or acute pain and has no opportunity to choose. The RBRVS, he continued, attempts to mimic fees that would have been produced in a competitive market without these distorting inflationary factors. According to Dr. Hsiao, the system is based on the principle that "in a reasonably competitive market, the price or fee of services or goods will always come down to the resource cost. . . . If the RBRVS method is used to produce a fee schedule," he added, "then you will provide a level economic playing field for clinical decision-making. . . . [and] let physicians be physicians."

### Qualified Support and Opposition

While Congress, the Physician Payment Review Commission, the Bush Administration and many medical societies give at least qualified support to the project, many groups steadfastly oppose it. The Heritage Foundation,

a conservative Washington, DC based think tank, recently released a critical report on the RBRVS, indicating that the RBRVS would disrupt rather than promote traditional competition in the medical marketplace. The Foundation writes, ". . . because the proposed system excludes the market forces of supply and demand in determining the value and price of medical services, it will distort medical care prices even further and create shortages of medical care (1)."

The American Medical Association (AMA) subcontracted with Harvard on the RBRVS study, providing technical expertise, but continues to refrain from unqualifiedly endorsing the study. James H. Sammons, MD, executive vice president of the AMA told symposium attendees, "We reserve the right to withdraw support if they don't remove inequalities. . . . that were in the draft. Some of the things that Congress has looked at have been infinitely worse than the RBRVS."

### RBRVS Measurement of Work

When they set out to develop the RBRVS, the Harvard researchers attempted to answer some basic questions, said Dr. Hsiao: "What are the relative costs [resources] of physician services? Can those relative costs be measured? . . . and do these results conform with reality?"

The RBRVS's resource costs consist of three major parts, explained Dr. Hsiao, total work, amortized value for education, and relative specialty practice costs. Total work is equal to the time spent performing the task multiplied by the intensity of that work. Intensity is made up of mental effort, judgment, physical effort, technical skill, and stress. To assess the work involved in providing a given service, the Harvard group uses a statistical technique known as magnitude estimation and compares about 23 services or procedures to a procedure that is set as a reference standard.

Regarding the study's measurement of work, Dr. Hsiao admitted, "We may have gotten something which we think is the work required to perform physicians' services, but we might be wrong." He noted, however, that there was "a high degree of agreement among physicians as to how much work it takes to perform a given service — how much mental effort, how much technical skill, how much stress." In addition, according to Dr. Hsiao, the Harvard group demonstrated validity using statistical regression analyses. "For most specialties . . . the variation in the parts that make up work can explain 98% or 99% of the variation in the rating of work," which, he said, was evidence of internal validity, at least within the specialties.

Specialties are then "cross-linked" by comparing procedures that are done across specialties and procedures that involve similar work expenditures. When confronted with skepticism about the accuracy of the cross-linking mechanisms during the symposium, Dr. Hsiao acknowledged potential problems and outlined the ways that the Harvard group may address them, which include comprising the study's physician panels of double-boarded specialists, who would be better able to compare work between the two relevant specialties, and comprising the panels of salaried physicians, such as Veterans Administration Hospital physicians, who would be less financially affected by changes in the reimbursement structure.

### Expenditure Targets Rejected

Beyond changes in the overall Medicare reimbursement structure, Congress also looked at expenditure targets, a limit on the amount of government money physicians can spend through the Medicare program. Initially, there was support for such targets from the House Ways and Means Committee and the Bush Administration, but Congressional conferees did not include expenditure tar-

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gets during the budget reconciliation legislation process. In their stead, Congress established a Medicare Volume Performance Standard (MVPS). The MVPS, which is advisory and is only one of several factors that Congress may consider in setting future updates of the RBRVS, establishes a desired benchmark for Medicare Part B expenditures — payments to physicians — but does not allow for automatic recovery of fees for expenditures that exceed the MVPS, as a strict expenditure target would have.

Strict expenditure targets were what the Ways and Means Committee had proposed. Representative Fortney H. (Pete) Stark, chairman of that Committee's Subcommittee on Health, submitted a paper at the Economics of Diagnostic Imaging Symposium on his subcommittee's proposed physician payment reform package, with its provision on expenditure targets. He wrote, “Under the proposed plan, Congress would set a target rate of increase in total payments, based on recommendations by the President and the independent Physician Payment Review Commission. If doctors' charges grow too fast, the increase in fees in the following years can be reduced. If costs grow slower than the target, fees could be increased. Not all fees would necessarily be changed. The Secretary of Health and Human Services could adjust fees by specialty, geographic region, or areas of over-

utilization. The Secretary could also *increase* fees for underserved areas.

“Contrary to AMA scare tactics, expenditure targets are not rationing: they could only result in a reduction of the yearly increase in physician charges. No provision even alludes to limits on the number of services provided. In past years, when we've reduced certain fees, the doctors responded by doing more procedures — not less.”

To determine whether such claims of physicians increasing volume to counteract reductions in fees are accurate, the MVPS process requires the Secretary of HHS to identify, analyze, and report to Congress the sources of volume increases in Part B expenditures. This will supply hard data for the first time, rather than rely on sub-

jective measures.

Organized medicine was strongly opposed to strict expenditure targets. Dr. Sammons of the AMA told symposium attendees, “Maintaining good health care is expensive — but its worth every penny of the cost. Placing arbitrary limits on health care expenditures is no more acceptable or humane than placing arbitrary limits on the quality of care or on human life itself. In fact,” he added, “this is what limits on health care expenditures do — they restrict the continual development of quality health care and [restrict the] accessibility [of] people who need it — especially those on the lowest rungs of the socioeconomic ladder.”

#### **The Problem is Access**

Delineating the roles and responsibilities of providers and the government in the provision of health care, he said “The problem is access... not the quality of health care, but the quality and availability of the social services that support access to care... In the United States, as in every nation, it is the responsibility of government at all levels to facilitate access to [health] care for those who cannot afford it and for whom access is a problem... It is paradoxical, then, that the very government officials we have elected to serve the public are trying to impose restrictions on health

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### The Fate of the Stark Bill

The issue of physician investments in businesses reimbursed under Medicare was raised by Rep. Stark in legislation commonly referred to as the Stark Bill (see *Newsline* October 1989, p. 1579). Provisions in the budget reconciliation legislation include certain — though not all — of the prohibitions on referrals offered by Rep. Stark. The adopted provisions, effective January 1992, which include referrals to a clinical laboratory in which a physician, or his or her immediate family member, has an ownership interest, prohibits billing by the lab or physician investor for services provided by such a referred lab to that physician's patients. There are exemptions for rural practices, group practices, in-office services, and certain other arrangements. For all other services, beginning October 1, 1990, entities which provide Medicare services and in which physicians or their immediate families are investors must provide the Secretary of HHS with the names and provider numbers of those investors.

Discussing the proposed legislation during the symposium, David Abernathy, a staff person on Rep. Stark's Subcommittee on Health, told attendees, the referrals bill is “not attempting to legislate morality” but is designed “to curb the explosive development of partnerships involving physicians. . . . In our view, they are kickbacks under another name.”

Arnold S. Relman, MD, editor-in-chief of *The New England Journal of Medicine*, professor of medicine at Harvard Medical School, agrees that such relationships constitute “a thinly veiled form of kickback” and strongly supported Congressional initiatives designed to curb self-referrals. Dr. Relman told symposium attendees, “it's very clear — the public image of

the medical profession is being tarnished.” He said physicians are provided with a “subsidized medical education” and a “licensed monopoly in exchange for a commitment to serve our patients first. . . . there's a tacit assumption that you don't go broke, but that's not what's happening. The fact is that physicians in this country make a pretty good living.”

Dr. Relman responded to several criticisms lodged against an outright ban on self-referrals. More utilization review is one possible alternative. Dr. Relman said that there was “no way that we're going to be able to have adequate peer review” for as extensive a program as Medicare. He noted that if such facilities are necessary, physician dollars are not needed because there are “businessmen by the thousands to invest in that sort of thing. Clearly they don't need the physician's money because the physicians often just sign a note.” He called “ridiculous” the claim that quality cannot be controlled without an equity interest, saying, “that's like saying I can't control quality at [Massachusetts] General [Hospital] because I don't own it.”

In contrast, Robert L. Phillips, president of Health Business Development, Inc., and vice president of the American Imaging Association, told attendees, strict self-referral legislation “would prohibit centers that would provide low cost, effective health care and prevent fragmentation that would

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lead to overutilization.” He added that it didn't matter if the Stark Bill passed or not, “a perspective is ingrained in the Federal government to lower health care spending, rather than promote the kinds of incentives that will address the problem of providing the best care at the lowest cost.”

### Limits on Balance Billing

As part of the Budget Reconciliation Bill, Congress set limits on physicians' ability to balance bill, or charge patients above the amount Medicare reimburses for a service. In 1991, balance billing will be limited to no more than 125% of the prevailing charge levels. There is no mandatory assignment in the budget reconciliation agreement, and it maintains current maximum actual allowable charge (MAAC) provisions through 1990. (MAACs are the limits on actual charges of non-participating physicians set in the Omnibus Budget Reconciliation Act of 1986.) Physicians whose MAACs are less than 125% of the prevailing charge will have their MAACs frozen. In 1992, the limit will be 120% of the blended fee schedule for nonparticipating physicians; and in 1993, 115% of the nonparticipating physicians payment schedule. In Rep. Stark's words, “. . . if the Relative Value Scale reduces the amount Medicare pays, a doctor could raise his fee to his patients, sticking

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them for the difference. The [Ways and Means] package limits the amount a physician's actual fee can exceed Medicare's payment." The Bush Administration had supported "unspecified curbs on balance billing" (2).

In another aspect of the reconciliation package, Congress established an agency to promote, support, fund, and conduct research into practice guidelines, outcomes assessment, and technology assessment and to disseminate the results.

During the October symposium, William R. Hendee, PhD, vice president of science and technology for the AMA, discussed the role of medical societies in technology assessment. "Organizations such as these," he said, "have access to the practice environment and clinical judgment required to evaluate the effectiveness and appropriateness of particular technologies in the patient setting. . . . Without an effective counterbalance to efforts to control costs through restrictions on . . . reimbursement of medical technologies, further limitations can be anticipated on the access of patients to quality health care."

Other provisions in the bill include:

- An extension of the 2% reduction in

Medicare Part B payment amounts under the current Gramm-Rudman sequestration will continue for services provided through March 31, 1990. After that, Congress would extend the sequestration at 1.4% through September 30, 1990.

- The Part B premium remains at 25% of program costs.
- The Medical Economic Index (MEI) increase for 1990 will be delayed until April 1. There will be a 4% decrease in the radiology fee schedule. The partial exemption fee schedule for nuclear medicine physicians is a blend of the Radiology RVS and 1988 prevailing charges. (Primary care services will receive a full MEI update (5.3%) and other services will receive a 2% increase.)
- Approximately 250 procedures were listed as overpriced; no nuclear medicine procedures were identified.
- Anesthesiology services will be paid by actual time, rather than rounding to the nearest quarter hour.
- New physician customary charges will be 85% of the prevailing charge.
- For surgery, radiology, and diagnostic physicians services performed by more than one specialty, the prevailing charge may not exceed the prevailing charge or fee schedule for

that specialty performing the service most frequently.

- For clinical laboratory services, the new maximum fee schedule will be 93% of the average of all current fee schedules across the country.
- Part B providers will be required to submit claim forms for their Medicare patients, whether or not the claim is assigned, for services provided on or after September 1, 1990, within one year of the service.
- Peer review organizations must notify physicians of the right to reconsideration of substandard care denials and must provide such reconsideration if requested, prior to informing a patient of the denial.
- Congress increased the responsibility of physicians regarding "patient dumping" and specified that physicians who are on call could be sanctioned for failure to meet on-call requirements and see a patient.

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## References

1. RBRVS will boost costs, conservative think tank says. *American Medical News*, Nov 17, 1989, p. 12.
2. Administration unveils plan for physician payment reform. *American Medical News*, Nov 3, 1989, p. 1.

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## NEWS BRIEFS

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### Referring Physician's Provider Number

The Health Care Financing Administration (HCFA) has been requesting that physicians provide referring/ordering physician identification numbers on Part B of Medicare claim forms since April 1, 1989. This has caused difficulties for physicians because a great deal of time is spent calling referring/ordering physician's offices, and further delays ensue when these offices are unable or unwilling

to provide the requested identification numbers.

In order to alleviate these delays, HCFA has been studying how to get these numbers into the public domain. HCFA's Office of General Counsel has ruled that the provider numbers assigned by the carriers may be released to others. Physicians may write to the Freedom of Information Officer at each carrier's address and request a list of the carrier's physician identification numbers.

HCFA also announced, in September 1989, that carriers should not delay or deny claims that are made without this identification number, although HCFA does request that physicians provide this number when it is known. HCFA expects that in the Spring of 1990 it will start to require these referring/ordering physician numbers on claims.

HCFA is still in the process of distributing a unique physician identification number (UPIN) to every physician