RECORD OF SOCIETY OF ACTUARIES
1991 VOL. 17 NO. 3A

EFFECT OF RESOURCE-BASED RVS IN MEDICARE ON PRIVATE HEALTH INSURANCE

Moderator: ALLEN J. SORBO
Panelists: JAY P. BOEKHOFF
HARVEY SOBEL
Recorder: MARY P. RATELLE

- What is resource-based relative value scale (RBRVS)
- Impact on:
  - MD fee trends (Medicare and Non-Medicare)
  - MD specialization
  - Utilization
  - Medicare supplement plans
  - Employer plans (active and retired)
  - HMOs
  - Physicians and senior citizens

MR. ALLEN J. SORBO: I am in the Minneapolis office of Tillinghast. Harvey Sobel is in the New York office of William Mercer where he consults for employers, Blue Cross/Blue Shield plans, and HMOs in all areas of health care. Jay Boekhoff is with Reden & Anders, and also a health care specialist, particularly in the Medicare product area. Harvey Sobel will be talking about some of the technical aspects of the resource-based RVS and its impact on the medical community. Jay will be talking about similar issues and impacts on employer medical products and Medicare products. I will be wrapping up with impacts on the HMO industry.

MR. HARVEY SOBEL: I must give you a disclaimer that the views you are about to hear are my own. They do not necessarily reflect those of my employer.

When the President of the United States signed the Omnibus Budget Reconciliation Act of 1989, he set into motion a series of changes in physician reimbursement. I would like to talk to you about the three major changes: the RBRVS, the volume performance standards and the ban on balanced billing. Collectively, these three provisions will tighten the noose around the physician's neck and potentially mean no more doctor in the house.

The first of the reforms is the move to the RBRVS. When Medicare was initially enacted, physicians were promised they would get their full fee or reimbursement based on their full fee. As we progressed into the 1980s, that promise was changed, and fees were held down. However, during this time, fees bore some resemblance to the market. As we move to the RBRVS, we move away from the market. We move towards using resources to determine price. Those resources are work effort, office expenses and malpractice insurance. I will give you an example of how the resources determine the price the physician will be paid.

The Medicare fee schedule formula is:
$MFS_{ij} = CF \times (\{W_i \times [.75 + (.25 \times GW_j)]\} + (O_i \times GO_j) + (M_i \times GM_j))$
Where: MFS_{ij} = Medicare fee schedule for service i in locality j;
CF = conversion factor;

W_i = work relative value for service i;
GW_j = geographic practice cost index for work in locality j;
O_i = office expense relative value for service i;
GO_j = geographic practice cost index for office expense in locality j;
M_i = malpractice insurance cost relative value for service i;
GM_j = geographic practice cost index for malpractice insurance costs in locality j.

The first component is work, which receives a 25% geographic weight, since the House and Senate could not come to a compromise on the weighting. One branch wanted 50% and the other wanted no weight – they ended up with 25%.

The second component is office expenses – rent and supplies the physician uses. Office expense has its own geographic adjustment factor.

The third piece is the malpractice insurance which has its own geographic adjustment factor. This was separately carved out because it operates a bit differently than the office expenses.

Let's look at Table 1. This is the preliminary RBRVS for cataract surgery in Manhattan for 1991. I stress *preliminary* because the Health Care Financing Administration (HCFA) just came out with a revised fee schedule that is not reflected in any of my comments. However, I think this example will illustrate how the RBRVS and some of the other provisions operate. For each of the components – work, office expense and malpractice insurance – the relative value is multiplied by a geographic adjustment factor. The products are summed and multiplied by a conversion factor.

TABLE 1
Preliminary RBRVS Cataract Surgery – Manhattan

	RVS	Geographic Factor	Product
Work	476.7	1.059	505
Office expense	750.5	1.255	942
Malpractice insurance	63.0	1.865	117
Total	1,290.2		1,564
Conversion factor			$1.07
Preliminary fee			$1,673

The work component geographic factor of 5.9% is lower than the others because it reflects the 25% weight. The conversion factor is really, at this point, my estimate. What this example shows is that, if you use the RBRVS, an ophthalmologist practicing in Manhattan would receive $1,673 when the RBRVS is fully phased in, based on 1991 dollars. The RBRVS starts in 1992 and will not be fully phased in until 1996.

When you compare the RBRVS reimbursement to the doctor's usual fee in Table 2, you will notice a big disparity. The doctor's current fee is $4,300 for non-Medicare patients. Currently, Medicare pays this doctor $1,800 for the procedure, which is down from the 1989 level of $2,200. The HCFA has cited cataract surgery as one of the overpriced procedures, and, in anticipating the RBRVS, it has already started

TABLE 2
Example – Hypothetical New York City
Ophthalmologist Cataract Surgery Reimbursement

Doctor's usual fee	$4,300
Doctor's current Medicare allowance: 1989	$2,200
1991	$1,800
1996 Medicare fee Schedule (in 1991 dollars)	$1,673
Percent drop from 1989	-24%

cutting fees. The $1,673 represents a 24% decrease from the $2,200 the physician received a few years ago.

The RBRVS will redistribute reimbursement to primary care doctors primarily in the cognitive areas, and reduce reimbursement for the specialists. For example, limited office visit reimbursement is estimated to increase 30%, whereas reimbursement for hip replacement, coronary artery bypass and cataract surgery will go down 14%, 34% and 22%, respectively. Overall, the RBRVS is supposed to be revenue neutral.

In addition, the RBRVS will redistribute money for overpaid areas to underpaid areas. The combined effect of this shift with the geographic adjustment factors, and the work component not receiving 100% weight, will produce payment rates substantially different from those currently in place. In Table 3 you can see that Manhattan will lose reimbursement, whereas areas like rural Alabama will see a 22% increase.

TABLE 3
Sample Effect On Selected Localities
Based on 1988 National Data

Manhattan	- 27%
Rural Alabama	+ 22
Chicago	+ 7
Rural Arizona	- 5

Left unpublicized are numerous technical problems that have been swept under the rug. For example, take office expenses. One of the biggest single components of office expenses is rent. There is no index of commercial rents available for the government to use. Instead, the government turns to an index of residential rents. However, a complication occurs in Manhattan where rent controls are in place, so residential rents are not a very good indicator of commercial rent. What does the HCFA do? It goes up to Westchester to get its value. There are hundreds of these technical decisions made.

Fundamentally I would argue that using something other than prices is flawed. Friederich Engels wrote, in 1902,

> Society can simply calculate how many hours of labor are contained in a steam engine, a bushel of wheat or a hundred yards of cloth. Society will not

> assign values, that is, prices, to the products. The useful effects of the various articles of consumption compared with one another and with the quantities of labor required for their production will in the end determine their plan. People will be able to manage everything very simply without the intervention of the much-wanted value.

I cite Engels and Marx as the two big contributors to the current collapse in the Soviet Union economy. It is an attempt to manage the economy without prices.

An example here in the United States was in *The Wall Street Journal* recently. The headline read: "Big farmers in the West get subsidized water despite the drought crisis. Many divide their holdings to elude federal rules that limit allotments, raising cotton in the desert." The article discusses federal price controls on water that have distorted the marketplace in California and in the West. Other articles abound. There was an article recently on the distortion caused in the production and distribution of milk due to federal price supports. There are examples out there other than looking at communist nations.

The second major component is the volume performance standards. Congress each year enacts an increase in the Medicare fee schedule. However, what the volume performance standards state is that, if Congress fails to act, then there is an algorithm for determining the increase. The increase is determined by the Secretary of Health and Human Services, and basically what is going to happen is a target will be set. In 1990, the target was established at a 9.1% increase (see Table 4). This means the federal government would like Part B to go up no more than 9.1%. However, there are several pieces to the Part B increase: a fee schedule increase, legislated benefit changes, enrollment growth and past utilization and intensity of services, which are adjusted downward by a performance standard factor. In this case it was 0.5%, and it is going to go up to 2% by the year 1996. It is an arbitrary factor reflecting the government's desire to cut back on reimbursement and contain utilization. This target is established for 1990, and then, based upon what actually happens in 1990, reimbursement for 1992 will be adjusted, again absent congressional action.

TABLE 4
1990 Target
(To Adjust 1992 Reimbursement)

Fee schedule increase		2.3%
Legislated benefit changes		(1.7)%
Utilization/intensity		
Historical	7.3%	
Performance standard factor	(0.5)	
		6.8
Enrollment growth		1.7
Total		9.1%

The 1990 experience data was 10.6%. We exceeded the budget. The 1.5% excess will be used to reduce the 1992 fee increase (the Medicare Economic Index -- HCFA's estimate of what physician fees should increase by). The 1.5% is compared to the 2% maximum reduction, so fees are reduced by 1.5%. If the excess had

been 2.5%, the Medicare Economic Index would have been reduced by only the 2% cap (see Tables 5 and 6).

TABLE 5
What Happened?

Actual trend	10.6%
Target trend	-9.1
Excess	1.5%

TABLE 6
Medicare Economic Index Reduced by the Excess, but by No More Than:

1992-93	2.0%
1994-95	2.5
1996 & Later	3.0

The Secretary of Health and Human Services has already come out with his proposal for 1992, which is a 3.7% increase, absent the volume performance standards (see Table 7). He is talking about a 2.2% proposal since the Part B side experience was unfavorable.

TABLE 7
1992 HHS Proposal
Fee Schedule Increase

Unadjusted increase	3.7%
Volume Performance Standards (VPS) adjustment	(1.5)
Adjusted increase	2.2%

Thus, our hypothetical New York City ophthalmologist is going to see his participating allowance reduced another 1.5% to about $1,650 - $1,648.

Having collective punishments like this is probably as effective in controlling costs as all of us going out to lunch and splitting the bill 250 ways! It probably will not work in terms of holding individuals accountable.

If we only had the move to the RBRVS or volume performance standards, I probably would not be giving this talk. It is the third piece of the Medicare physician reform that concerns me the most -- the ban on balance billing. Under prior law, Medicare beneficiaries were entitled to go to any physician. If the doctor participated in Medicare, the doctor accepted the Medicare payment as payment in full; otherwise, the Medicare beneficiary was free to seek care from a nonparticipating doctor who would be able to balance bill at any amount he wanted. That privilege was restricted starting in 1984 with the maximum actual allowable charge (MAAC).

The ban on balance billing severely restricts the right of the physician to balance bill (see Table 8). In 1991, nonpar doctors are not able to bill in excess of 125% of the nonpar allowance, and that is going to drop to 115% by the year 1993 and later.

TABLE 8
Maximum Balance Billing Permitted

Year	% of Nonpar Allowance
1991	25%
1992	20
1993 & Later	15

Using the same example in Table 9, the physician was receiving $1,648 as a participating allowance. Currently, as an inducement to get doctors to participate, Medicare reduces the nonpar allowance by 5%. Medicare, in conjunction with the beneficiary paying deductibles and coinsurance, could pay no more than $1,566 (95% of $1,648). If the nonpar doctor wants to balance bill, by the year 1996, he or she can balance bill no more than 115% of the $1,566. In other words, the maximum fee he or she is allowed to charge is $1,800. If you compare that to the $4,300, the doctors receive 42% of their usual fee.

TABLE 9
Hypothetical New York City Ophthalmologist
1996 Nonpar Cataract Surgery Reimbursement
(In 1991 Dollars)

Par allowance	$1,648
	x 95%
Nonpar allowance	$1,566
	x 115%
Maximum fee	$1,800
Maximum fee as percent of usual fee	42%

Doctors are not faced with pleasant choices now, and I believe we will see a change in physician practice patterns. Some will attempt to treat Medicare beneficiaries medically, not surgically, because they are going to receive reduced reimbursement for the surgeries; we will see an increase in procedures wherever possible, particularly in office visits. Third, doctors will make up lost revenue by charging their commercial patients yet higher fees. Take a look at a simple example of a doctor who gets half his revenue from Medicare, half from the commercial side (see Table 10). If Medicare reimbursement is cut by 5%, and the doctor requires an 8% increase in total fees in order to stay whole, a 21% increase in the fees of the commercial patients will be needed.

TABLE 10
Example of Cost Shifting

	Percent of Revenue	Increase
Medicare patients	50%	-5%
Commercial patients	50	x
Total	100%	+8%
Implies x = 21%		

What about the elderly? We are going to see some cost savings in the short run because Medicare is going to be reducing reimbursement. In the long run, the elderly will have trouble finding physicians willing to treat them, as doctors opt out of the Medicare system. There will be delays in nonemergency surgery, not unlike what we see in Canada and Great Britain. We will actually see some seniors, the more affluent seniors, opting out of Medicare in order to get care from doctors.

We are going to see the growth of the black market in medicine. Doctors will ask patients to slip them money on the side in order to have procedures performed. In the Soviet Union, the black market mechanism deals with price rationing. In New York City, it is well known that, in order to get an apartment, you have to slip landlords money on the side in order to have access to a rent-controlled apartment. I think doctors will gravitate away from treating Medicare patients as the reimbursement reduces. Also, new doctors will gravitate away from the geriatric specialties.

Another thing that is scary is the prospect of technology being cut back. Suppose a doctor invents a new procedure -- laser surgery for performing cataract removal. Under a market-based system the doctor can increase his fees right away; under RBRVS, the doctor has to petition Washington to let it know there is a new procedure, and he is entitled to more reimbursement. This may seem far-fetched, but it is happening already on the Part A side. With hospital reimbursement, there are debates right now whether Medicare should reimburse hospitals for the cost of the TPA. GE recently announced it is going slow on a new diagnostic technology called positron emission tomography (PET) because of reduced or limited Medicare reimbursement.

Obviously, the government is not going to take this standing still. We are going to see continued budget pressures, forcing the federal government to ratchet down on fees. That is absent the volume performance standards. The HCFA will try to continue to steer patients to low-cost PPOs, similar to the Medicaid mills.

Some state governments have already enacted more restrictive increases. For example, New York is going to make it illegal for a doctor to balance bill in excess of 110% of the Medicare allowance (5% less than the federal controls). Now, we are faced with the prospect of not only federal bureaucrats promulgating rules, but state bureaucrats as well.

Perhaps the most ominous of what will happen is the federal government compelling doctors to treat Medicare patients. Doctors will be labelled greedy by the politicians. They will be charged with having a duty to serve, a duty to treat, particularly if they want to treat non-Medicare patients. The compulsion of the doctors was foreseen by Ayn Rand in 1957 when she wrote her brilliant novel *Atlas Shrugged*. She wrote,

> I quit when medicine was placed under state control some years ago. I have often wondered at the smugness with which people assert their right to enslave me, to control my work, to force my will, to violate my conscience, to stifle my mind, yet what is it that they expect to depend on when they lie on an operating table under my hands? Their moral code has taught them to believe that it is safe to rely on the virtue of the victims. Well, that is the virtue I have withdrawn. Let them discover the kind of doctors that their system will now produce.

When Medicare was enacted, it was held out to the doctors as strictly a financing vehicle that would not interfere with their rights to practice medicine. As we can see, Medicare has turned into an entitlement program that promises Medicare beneficiaries the coerced labor of the medical care community as their right. But for how long?

MR. JAY P. BOEKHOFF: What I would like to do in the next portion of the presentation is take the concepts that Harvey has outlined and establish a structure for considering the effects that the physician reforms will have upon insurance plans.

I will start by looking at the effects that prior Medicare payment reforms have had -- in particular, the results of the 1984 Medicare physician fee freeze. Also important in quantifying what the impact of the payment changes will be for 1992 are the modifications that have been made for 1991.

Next, I will share my opinions with you regarding the potential physician responses to the fee changes and how those responses may be translated into costs for Medicare supplements in 1992. Finally, I will consider what effects these changes may have on the active employee plans.

MEDICARE PHYSICIAN PAYMENT FREEZE

It seems that, nearly every year since I have been in health insurance, there have been some changes to Medicare benefits, covered services, or physician payment methods. The new Medicare fee schedule will be to physician reimbursements what catastrophic care was to the benefit structures (hopefully with longer lasting results). During the last few months, I have been struggling with the issue of anticipating the physician response to the most recent Medicare fee schedule changes in anticipation of pricing Medicare supplement policies for 1992. As you have heard already, there is significant uncertainty regarding actual responses from what, in many cases, will be major payment modifications. As we struggle to anticipate this unknown, it is clear that we are in good company.

Lauren LeRoy is deputy director of the Physician Payment Review Commission (PPRC). As you know, the PPRC is the commission that championed the whole issue of physician payment reform before Congress. In her words: "First of all, I think it's very unclear . . . what kinds of volume assumptions should be incorporated in the calculations for the conversion factors."

One problem the PPRC foresees is that "data are not good; the studies that have been done do not really definitively support the kind of assumptions that have been used until now."

Clearly if the PPRC, which has devoted its last four years to studying this issue, has uncertainty of the expected effects of behavioral response, we can be forgiven for some uncertainty also. HCFA has used a 50% offset in the past for purposes of estimating expected expenditures after fee modifications. This assumption has been derived by observing past physician responses to fee adjustments.

One of the most major of these adjustments is the 1984 fee freeze. You will recall that at that time, Congress froze Medicare fees, implemented the 5% variance in the Medicare allowable charge based on whether a physician is a participating physician,

and placed a cap on the total charges that physicians treating Medicare patients could bill. This last charge is the MAAC. The physician response to the cap on fees is now fairly well understood. Despite limitations on the actual fee levels, in the three-year period from 1983-86, physician care increased substantially (Table 11).

TABLE 11
Medicare Expenditures for Beneficiary 1986 Versus 1983

Procedure	Change
Medical specialty	15.7%
Surgical	35.3
Anesthesia	29.6
Radiology	36.4

Source: Reprinted with permission from *Health Affairs* Spring 1989, Janet Mitchell, "Medicare Physician Fee Freeze: What Really Happened?"

These data are taken from a study by Janet Mitchell based on physician response in four states chosen to be reflective of the total national experience.

During this time, lens procedures (that is, replacement of lenses generally as a result of cataracts) increased 49.9%; knee replacements increased 38.5%; colonoscopies increased over 100%; upper GIs increased over 40%; cardiac catherization increased 85%. I will come back to these procedures in the context of the more recent Medicare payment reform. It is interesting to see how they pop up again.

The study found that the coding of office visits also substantially changed during the freeze period.

Look at the change in Medicare physician payments resulting from the RBRVS, the situation is clearly different from what was experienced in 1984 and 1986. It is worthwhile keeping this experience in the back of our minds, since the real questions concerning the impact of payment reform hinges upon how physicians may respond.

TABLE 12
Physician Fee Freeze
Three-Year Change in Office Visits by Type
(Change in Visits Per Thousand)

Type	Change
Minimal/brief	-35%
Limited	50
Intermediate	75
Total	0

1991 CHANGES

Before we get to these changes in 1992, remember that the changes proposed by the PPRC in the 1989 report to Congress were begun almost immediately. In 1991 the following were put into policy through OBRA 89 and OBRA 90:

- a cap on the balance billing charges at 125% of the prevailing rate (this was later modified to 140% for evaluation and management services);

- fees for primary care services in low-cost areas were brought up through an increase in the floor of charges to a level of 60% of the national average; and finally,

- the process of limiting fees for medical procedures with high marginal physician profit was begun.

Laboratory fees used to be reimbursed based on a geographic-specific fee schedule subject to a ceiling set at 93% of the national median fee for each service. This fee schedule was permitted to increase only 2% in 1991 rather than the full consumer price index percentage. Also, the ceiling was decreased to 88% of the national median average.

Radiology services were also paid under a fee schedule that was specific to each location. In 1991, this rate has been based on a blended rate of the locality and a national average, and fees for certain services, such as MRI and CAT scans, are cut an additional 10%. The prevailing charge for anesthesiology and pathology services will be reduced by 7% and the increase for many services has been capped at 2% for 1991.

These changes limit reimbursement in a manner that varies by medical specialty. Before adjustment for utilization, these factors are 5.6% for the medical specialties, 10.1% for surgical, 9.5% for other and an average 8% over all specialties based on the Congressional Budget Office data. Since some of the projections of the effects of the RBRVS consider the impact before the OBRA 90 changes, it is important to keep these in mind in projecting the total cost impacts for 1992. The question of how the fee schedule changes will affect private insurance is equivalent to the question of how physicians will respond to the changes.

POTENTIAL PHYSICIAN RESPONSES

Harvey has already touched upon the first potential response, that is, increased utilization. This could take a variety of forms.

First, physicians could increase the number of procedures or visits per individual. I have to admit my first inclination was that this was less likely for surgical services based on a naive supposition that surgery was either indicated or not. Clearly the data proves that the physician has substantial opportunity to change incidence rates for surgeries. Also, even if the actual number of surgeries does not change, there is currently considerable latitude and variation in physician billing practices concerning preoperative and postoperative visits. Some physicians include all of these in a global surgical fee, while others split them out. Currently the Medicare intermediaries that pay for the services have varying standards by geographic area.

The second possibility for increased utilization is upgraded procedures, such as we saw earlier, concerning office visits. The PPRC and HCFA are attempting to deal with this potential by standardized coding for office visits and universal definitions of global surgical charges. In the past, the need for national standards has not been as

important, since the coding practices were generally reflected in the prevailing charges as well. For example, if a certain geographic area had a higher tendency towards more comprehensive office visits, this should have been reflected in the charge per visit in that area. Under the revised payment standard, a uniform resource (i.e., time) is assumed nationally for each procedure. Therefore, the need for standardized coding becomes more important. Also, the volume performance standards are devised to provide incentives for physicians against upgrading procedures, since these will ultimately be reflected in the future conversion factors. I will have more to say about the volume performance standards later.

Clearly the trend towards more tests, particularly at physician-owned facilities, is likely to continue as physicians seek other forms of reimbursements. Finally, in the area of utilization, there will be greater interest by physicians in identifying new procedures that may be performed more efficiently than anticipated by the Medicare fee schedule (MFS). Consequently, the markup or marginal profit for the procedures will be greater.

INCREASED EFFICIENCIES

The second avenue of potential physician responses is increased efficiencies. The RBRVS values have been determined based upon "average" physician time associated with certain procedures. Physicians may increase their marginal profit by improving their personal efficiencies and outperforming the average. This may be accomplished through sharing resources and is likely to continue the trend towards group practices. A further advantage of group practices would be the increased peer review and the capacity for reducing malpractice exposure through greater practice controls. Also, technical improvements, in particular office automation and improved medical tools, are likely to yield higher paybacks for physicians now that the margin for overheads is being equalized among procedures.

ALTERNATE REVENUE SOURCES

With the squeeze on direct fee income associated with their medical practices, physicians will have strong interest in expanding into other revenue possibilities. One particular possibility is free-standing surgical centers owned in conjunction with hospitals. Because of the likelihood of diminished surgical procedures in the hospital resulting from the reduced payment schedules, hospitals are very interested in maintaining their income by establishing these forms of free-standing facilities. Although the marginal profit to the surgeon performing the surgery may be diminished, the surgeon can continue to supplement his or her income by obtaining a portion of the facility charge associated with the surgery. The diminished profit for surgeries may also motivate physicians or surgeons toward alternate sources of revenues – such as greater partnership with insurance companies and managed care review for employers in wellness promotion programs.

PRACTICE RESTRUCTURING

Harvey also alluded to the great potential for practice restructuring among physicians whose fees are being cut back by the new Medicare fee schedule. This restructuring could take the form of reduced time spent with certain procedures, diminished interest in the Medicare market, increased time in patient evaluation and management that now has an improved profit margin for physicians, or a gradual change in specialty choices toward primary care.

STANDARDIZED PROCEDURE CODING

Finally, while not necessarily a physician response, a beneficial outcome of the process will be the improvement in the coding practices for office visits and surgeries. These standardized coding policies may translate into physician treatment practices. For example, in the past, certain postoperative visits have been allowed to be billed individually; if this is not allowed, the tendency for these visits may diminish.

ESTIMATING THE EFFECTS FOR 1992

Now, let's turn to the issue of what the effects of the fee schedule changes in 1992 will mean to group Medicare supplement costs. Harvey has already shared with you some general information about the effects of the fee schedule by medical area and specialty. Before translating these into medical costs, there are four additional bits of data that I want to show you.

First, remember those surgeries that increased the most during the physician fee freeze? These are some that are in for the largest fee decreases under the RBRVS: lens replacements –22%; knee arthroscopy –21%; colonoscopy –25%; and coronary bypass –34%.

Now there are two possibilities: the Harvard researchers could have vindictively targeted these surgeries based on the physician response to the fee freeze; or these surgeries could be precisely the ones that had the highest marginal profit for physicians. Therefore, like any business, when times get tough, the products with the highest marginal profit get emphasized.

This is the aspect of the RBRVS that is most intriguing to me. We will now be able to measure the ratio of RVS fees to actual billings in a ratio that is comparable to an insurance plan loss ratio. What we do with it remains to be seen, but, as they say, measurement precedes management.

Also, by way of background, we need to better understand how the 1992 fee levels will be determined. To do this we need to establish a couple of new acronyms. We have already heard of the MFS. The constrained Medicare fee schedule (CMFS) will be the basis for most of the payments for 1992, which will be based upon the Medicare fee schedule values and the historical payment basis (HPB) using the following formula. If the Medicare fee schedule is within 15% of the historical payment basis, then the constrained Medicare fee schedule will be the actual Medicare fee schedule amount. This will apply to approximately 40% of the charges. For the remaining 60% of the charges, the constrained Medicare fee schedule amount will move from the historical payment basis towards the Medicare fee schedule amount by 15%. Values will step closer in 1993 until eventually, in 1996, the Medicare fee schedule will be the total basis for physician reimbursement.

Also, the total impact on either retiree or Medicare supplement costs is obviously dependent upon what portion of the costs are associated with the changes. For an average retiree, Part B co-pays are approximately 20-25% of the total medical costs. Balance billing costs will vary substantially. On an average, they may also be about 25%, but they could vary from very little, in a state such as Massachusetts which does not allow balance billing, to almost 50% of the total cost.

The effects of the RBRVS on the Medicare allowed charges also vary substantially by state. The high medical cost states (California, Texas, Florida and New York) will have the largest reduction in physician fees. Clearly the Midwestern and Rocky Mountain states will have the largest average increase in physician fees resulting from the RBRVS. This means if you are a small Medicare supplement insurer with the primary emphasis in the Midwest, you will be in for the largest increases in your physician fee copayments.

How does all of this translate into trend factors? A reasonable process for quantifying the effect will look like this:

Medicare Volume Performance Standard
The Medicare volume performance standard is a useful starting point for determining the trends for next year. This incorporates both the 1991 changes and the proposed 1992 changes with adjustments for expected utilization or behavioral modification resulting from the fee schedule adjustments. This is a national number, however, and will need to be adjusted based on the mix of business for the specific block, whether it is an employer group or Medicare supplement plan.

Demographic Adjustments
Unfortunately, Medicare Part B expenses and supplement policies have had trends in a rate substantially higher than the rated change in the underlying Medicare Part B costs. This is probably a result of the improved reporting of supplement claims, demographics of individuals with Medicare supplement coverage, and the effects of full physician payment upon utilization. Whatever the cause, an additional adjustment beyond the Medicare performance standard is probably indicated.

Adjustment for Sequestered Amounts
Finally, since the experience period is likely to include some of 1990, consideration needs to be given for the sequestered amounts for Medicare for physician payments which was extended through September 30, 1990. This resulted in reduced physician payments by 1.4%. Some plans picked up this sequestered reduction as part of the obligation of the coinsurance.

When these factors are combined, it is likely that Part B trends nationally will be 2-3% higher than otherwise, but as indicated earlier, this will vary substantially by geographic area.

BALANCE BILLING
The situation for plans that cover balance billing will probably be more significant. This would include plans like the new Medicare Supplement Plans F, H and higher and most employer-sponsored retiree plans. Balance billing charges will be affected by the change in the cap from 125% to 120%, the cap applying to the CMFS rather than the prevailing fee, and the increase in assignment rates, reduced by whatever portion of the total expense balance billing charges comprise. These factors could depress balance billing costs by 10-12% nationally.

SPILLOVER TO UNDER AGE 65 POPULATION

I will briefly touch on a couple of the issues associated with the spillover to the under age 65 population. Most of what I have to say to you are opinions about what the effects might be, and, as you will see, I have more questions than answers.

Harvey has already painted somewhat of a pessimistic picture regarding expected impact. The critical issue is whether the volume performance standards will actually work. Clearly, they will work from the federal perspective since they will create expenditure targets that will eventually offset the total reimbursement to physicians with a two-year delay. The impact upon active employees will depend upon whether physicians feel constrained by the volume performance standards. If the physician community develops meaningful practice guidelines, it is possible that the spillover to the under-age 65 population could actually have a positive effect. However, without these, I agree with Harvey that it is likely physicians will increase their treatment practices for patients over age 65, and these will consequently spill over to the under-age 65 population as well.

The second potential adverse effect is the one where physicians restructure their practice towards the private paying market. This is an issue that the PPRC and HCFA are watching very closely. In my opinion, there will be no greater impetus towards national health care than if the surgeons of this country restrain access to their services to the Medicare-eligible population. While it is certainly likely some physicians may restructure their practices somewhat towards the under-age 65 market, I do not believe it is likely that a major restructuring will occur.

One area that does concern me is the potential for a new round of medical technology. The basic characteristic of the revised Medicare fee schedule is a diminished emphasis on the procedure orientation of medicine. However, we are a procedure-demanding population for our medical care. If we reduce the physician incentives for certain procedures (i.e., surgeries), it would not surprise me to see an increase in other highly technical therapy procedures in which physician profits could result not only from a direct professional component, but profits through ownership of technical assets.

To end on a more optimistic note, I think there is potential for the RBRVS to have some positive impacts for the under age 65 population as well. The RBRVS values will, for the first time, give private insurers a measure of the basic physician costs associated with the procedures which we reimburse. This will have a role in physician fee schedule negotiations which is analogous to the dealer invoice costs in purchasing a new car.

Finally, the uniform coding of office visits and global surgical bills will standardize an area that has long been a potential concern to insurers and managed care providers.

How each of these factors are quantified remains to be seen, but clearly they present interesting challenges for us as we project costs in the future years.

MR. SORBO: I will comment briefly on the potential impacts of physician payment reform in the HMO business. Many, particularly individual practice association (IPA) HMOs, that have been in this business for quite a while have effectively implemented

fee schedules that mimic what Medicare is now doing with physician payment reform. They have substantially reduced payments and discounted charges for procedures to surgeons and specialists generally to a much greater degree than they have for cognitive services. They have felt the impact of these adjustments internally through utilization changes within their own organizations. This has been an evolving process during the decade of the 1980s. Certainly early on, many plans developed fee schedules that were normative across specialty lines. It was only as they felt competitive pressures that they started to make significant changes by specialties.

I think the RBRVS will have relatively little impact on utilization patterns within the HMOs in HMO-dominated markets. In markets where HMOs do not have a lot of clout in terms of their negotiations with their physicians, the impact will be different. In the HMO-dominated markets (California or Twin Cities), the HMOs will not be too sympathetic to the specialists who are feeling the pinch of cuts in their fees on Medicare. Maybe people who are from Cigna, Aetna or the Travelers can tell me whether these companies are going to be increasing caps to help offset the physician loss of income due to the RBRVS in California. Those physicians will feel the pinch, but it is a very competitive market.

Many HMOs are increasing caps that they pay to medical groups and IPAs 7-8% a year, with little attention paid to actual utilization patterns, which are probably going up at rates that may be slightly less than fee-for-service indemnity. It is probably more appropriate to say here that the total cost incurred by HMOs for physician services will not be significantly impacted by this programmatic change by Medicare, in HMO-dominated markets where the HMOs have a lot of clout.

Another possible side effect might be that certain specialties might find salary positions within HMOs more appealing -- especially the specialties with substantial fee cuts. Of course, the salaries for those specialties may drop. HMOs will probably reevaluate the pay for those positions over time.

This next point may be a little controversial (but if any of you have been following the trend in participating physician rates over the last three to four years, it probably is not too controversial). I believe we will see 90-95% of physicians opt for Medicare participating status by 1995. For example, the participating physician rate in Florida just in the last year increased from below 50% to nearly 70%. I think we will see some dramatic changes over the next couple of years in this direction. What does that mean for HMOs? I think one thing it means is that HMOs will need a two-tier fee schedule, particularly if they want to compete in the Medicare market either under a risk contract, a traditional cost contract, or a straight fee-for-service-type supplement product. If the HMOs want that business, they will have to switch to a Medicare fee schedule, which may be quite a bit lower than what they pay their physicians in the commercial market.

An interesting question is whether the economics of Medicare risk contracts for HMOs will be affected, or how. Again, most HMOs are paying their physicians more than Medicare fees in most markets, with the possible exception of California and a few other areas. If you want to look at very competitive markets where capitation is the primary means of payment, you can see that the net impact of those capitation payments is something on par with Medicare fee schedule levels.

I analyzed results for a plan in what I consider to be a relatively low-cost Medicare market. For those of you not familiar with the process, this is a very brief, abbreviated format for coming up with the Medicare-adjusted community rate. Plans take their commercial experience and apply certain adjustment factors for frequency and cost difference to derive the Medicare cost.

Starting with the existing assumptions, which reflect their own built-in fee schedule and payment arrangements with physicians for the commercial business, adjusted to the Medicare-allowed fee level, would save approximately 10% on physician fees (if they switched over to a fee schedule that at least reproduced Medicare's effective rate of discount). Adding in some factor for administration and surplus, and then looking up in the 1991 rate table for this particular area what the government would pay the plan, adjusting for demographic mix, you would come up with a rate for the subscriber of $98. It just proved to me, at least for this particular area, that the Medicare risk contract still is not going to be very feasible, even if this plan were to shift entirely to a Medicare fee schedule. In some markets it may increase the feasibility of Medicare risk contracts. An HMO cannot afford to pay physicians for Medicare patients the same amount that they are paying for commercial patients (if the commercial fees are much greater than Medicare fees). It will not work. If they do, the HMO will never be able to compete in that business.

If Medicare risk contracts do not work, very popular contracting mechanisms for HMOs have been health care prepayment plan (HCPP) arrangements and Medicare cost contracts. To some extent, depending on the type of plan, the HCFA pays HMOs for the costs they incur for caring for that population. Congress has been trying to eliminate these options from the legislation, and there is continued talk that they are going to deal with that this year. I would think, to the extent it remains an option, it will be a more attractive option than risk contracts.

Another area where HMOs will piggyback on the federal changes is probably that of global billing for surgical procedures (to the extent Medicare addresses this within the new legislation and regulations). The amount paid for pre- and post-surgical services is going to be affected by the Medicare mechanisms.

Virtually none of these changes are going to impact Kaiser, except perhaps for some of its smaller plans where it has to contract for referral services to a significant degree. That is not to say physicians may not want more from the HMOs for their services to offset the impact of Medicare. Certainly HMOs and fee-for-service medical groups are not going to be immune, particularly the physician-owned plans. There are a number of medium-sized medical groups around the country that are going to have a difficult time grappling with these issues because, in those programs, the physicians who own the plan are certainly going to have an interest in raising their fees charged to fee-for-service patients and the capitation received from the HMO.

MR. DAVID W. WILLE: Harvey, you said the communists are wrong because they do not have a market price for services, that it should be set on supply and demand. Given the history of medical care in this country, I wonder if we can ever go to a market price system. To get there you have to have an informed consumer who understands the quality of care, the price, and selects a doctor on the basis of an

informed decision. However, with the system we have, can we ever get to a market price?

MR. SOBEL: Given the fact that we have creeping national health insurance already — look at Medicare, Medicaid, the Veterans' Administration and coverage of the American Indians – I am very pessimistic about the ability to privatize any or all of those programs. Everything you hear right now is for more government controls; therefore, I am very pessimistic about the ability to go to a market. However, markets do work. Markets respond to incentives. I would cite cosmetic surgery as an area where it has been basically left to the market to operate. We do not have the hue and cry about reimbursement for cosmetic surgery at this point. If people were to recognize that the market could work, I think there is hope. That is not to say there are not some other problems. I have not tackled all of the problems in the health care system, and there are more than just the market. Certain things have to be done more than just allowing fees to float when you have certain things like licensing laws restricting others besides physicians allowed to practice. There are things other than the market, but I am not optimistic; I am very pessimistic. I think we are going to see more controls rather than less.

MR. HOBSON D. CARROLL: Harvey, how many physicians are in your extended family? I was going to write a letter to the editor for your article in *Contingencies*, but maybe I can just express my comments here. I, by no means, want to be an apologist for the Medicare system and the RBRVS and what the government is trying to do to contain these costs. We are dealing with an occupation class here which, as Governor Lamm pointed out, has the highest wage multiple of the average income in the United States. By the way, the after-expense but before-tax income level of physicians went up 15% in excess of the CPI from 1980-90, while the average wage stayed about the same. Thus, they actually increase their gain without anyone stopping to ask, Why should these guys get paid this money? The appeal to Ayn Rand liberalism might work if, in fact, we had a free market economy in medicine. I think all the studies have shown that it just simply has not worked even during the time periods when it could. Perhaps the indication of whether Randism applies today is best exemplified by the fact that the person who I believe was perhaps the highest profile Rand supporter during her heyday is now the chairman of the Federal Reserve Bank. That shows the difference between people who thought they could get away without government control and how they have come about. The appeal to medicine might work if it was like a hundred years ago where I think medicine was an art more than a science. I think we have come so far the other way that we have gone through science, and it has become a technology. As recent studies have also shown, it needs to challenge the heretofore unchallenged assumption that the practice of medicine equates with the rip-off of society by a greedy, power-hungry, self-centered, self-seeking occupation class that no longer deserves to be called a profession.

MR. SOBEL: I think I detect multiple questions there. Let me answer the easy one first. I have no direct family members who are doctors. My uncle is a dentist. My brother-in-law is a radiologist. However, I do not have any immediate physician members in the family. In terms of your comments about the doctors getting richer and everyone else getting poorer, I suppose that we could make the same argument about actuaries, and I do not think people here would take too kindly to some federal

bureaucracy setting our salaries! One of the things I like about being in the profession is that we tend to get reimbursed pretty well with the market. I am concerned that, when I or my children or my children's children need care, there will be someone creating a Jarvik heart, that there will be someone performing cataract surgery in a new way. I do not take that as a given; that these doctors are just going to do it, that it is all easy and that there is nothing left to be discovered. I think it would be very nice if we had someone come up with a miracle AIDS cure. That is not going to happen if the incentives are not there.

MR. JOHN M. BERTKO: I have an observation for Harvey and a question to follow. The first observation is that, while your comment on Medicaid mills certainly applies to several of the states in the 1970s, I have some personal experience. I think a number of states (certainly Oregon and Ohio), have had fairly successful prepaid Medicaid programs operating. Allen, you may have some experience with some of the programs the Midwest where they are delivering prepaid care that is government financed through private HMOs and being reasonably effective in that. Perhaps the comment that you made, Harvey, reflects programs that are a little bit out of date. The real question I have for you is, if you look to Governor Lamm's comments, that we may have 120,000 excess physicians by the year 2000, with most of those being already in the pipeline, how do you square that with your comment that doctors will be turning away Medicare patients? I seem to think they may need to find those patients somewhere.

MR. SOBEL: I would say excess physicians as determined by whom? By the market? To answer your question directly, though, doctors are going to try to hang onto their Medicare business as long as they can. I think the doctors that will hang on will be the ones where the reimbursement level is not being ratcheted down as much. They will try to hang on, but they will gradually phase out of it as they have the opportunity to, and that may take the form that they just do not hire that extra doctor into their practice to cover the patient load. They may just decide to trim back and have more leisure activity. Doctors prize leisure activity. I do see doctors turning away, and some of them may go into other areas. The fact that there is an excess of physicians (if there is an excess) does not necessarily mean there will be an excess for Medicare beneficiaries. By the way, this has already happened on worker's comp in some states.

MR. SORBO: I think it is interesting to look at California in terms of what is happening there or what has been happening over the last several years. My understanding is there has been a huge formation of medical groups. It is a very much HMO-dominated market and the HMO cap rates are not very generous. Physician groups that are being formed are very anxious to buy the business and are generally accepting the HMO cap rates. If they are going to survive at those relatively low cap rates, then they are going to have to change their practice pattern. To some extent, from talking to some of my associates out there, that is happening. Physicians are reevaluating how they practice in those markets which is kind of interesting. That has not happened in all markets, of course, and it has not happened to a great degree in all HMO-dominated markets. I think it is an interesting direction that may indicate how things are going to change in some other cases.

MR. SOBEL: There are various magazines that cover the medical community, and there have been some articles in them that talk about doctors fleeing Medicare private practice, going into HMOs because they do not want to manage the paperwork. My fear is while there may be doctors out there, they will not necessarily be the finest doctors that we can get, that reimbursement does drive people to produce, and that, if you take away incentives to produce, you will not have production.

MR. JEFFREY L. SMITH: Jay, you compared utilization of procedures before and after the physician freeze in Part B Medicare. Then, you also mentioned the effect of the potential pricing of the RBRVS on the specific procedures, and then bridged that to the potential for alternative physician responses. One of the things that was indicated is that, through a potential increase in office visits, a physician can direct services and dictate how care is rendered. What kind of techniques are doctors going to use to get you in the office to increase office visit frequency?

MR. BOEKHOFF: Your question is, how are physicians going to get you there in the first place? My response would be that you do not necessarily have to get that many more people in for the initial visit. If you prescribe enough follow-up visits, once you have them in, I think you will see substantial utilization increases -- the sick people will continue to go see a physician of one kind or another. However, the issue is how many additional follow-up visits they will have once they have had their initial contact. I think that is the opportunity for increased utilization.

FROM THE FLOOR: What do you see indemnity insurers doing in anticipation of the coming RBRVS changes for the under age 65 market?

MR. BOEKHOFF: The action that should be taken is closer monitoring of the RBRVS values as opposed to the current fee schedule. I think there will be a movement, as Harvey pointed out, to piggyback on RBRVS to implement PPO arrangements that utilize fee schedules and parallel the RBRVS values. Other than that, I am not sure I see a great deal of response.

MR. SOBEL: I would just like to add that I have had some conversations with some claim approvers about the maximum actual allowable charge, and, depending upon which insurance company you are talking to, some claim approvers are not even aware there are controls upon the nonpar balance, since the maximum actual allowable charge is not well understood. It is a physician-specific, procedure-specific calculation. As we move to the ban on balance billing, I believe carriers will increasingly, if they do nothing else, take steps to ensure that they adjudicate the claim at the balance bill restriction.

MS. JULIA T. PHILIPS: There is going to be a phase-in of the RBRVS over a period of time. Does anyone have a feeling for whether that is going to be kind of a linear impact or whether there will be a greater impact in the first year, trailing off, or perhaps a lesser impact and then increasing?

MR. BOEKHOFF: As I noted with respect to those charges that were within 15%, they will be going immediately to the RBRVS value, and the others outside of that range will take a step in at 15% the first year. I do not know what the average is in total, but, after that, in the next year, it is 25% of the difference, and it is going to go

down by essentially that amount for the remaining four years, until 1996, when we ultimately get to the value.

MS. PHILIPS: From that, I cannot figure out what the answer to my question is without knowing the distribution of how many charges are within 15%, how many are between 15-25%, etc.

MR. BOEKHOFF: Yes. I do not have the data handy, but I would recommend the August issue of the *Journal of the American Medical Association*. It had an interesting article showing precise data, how much was within 15%, how much was 15-30%, etc.

MR. SOBEL: I would like to add that what happens to physician reimbursement over the next few years will be a combination of all of the changes of the RBRVS as well as whatever Congress enacts in terms of increases in reimbursement. It will all be considered RBRVS, but, in fact, you have things moving that are divorced from RBRVS. For example, in 1994, if Congress decides to actually have no increase in the Medicare allowances because of budgetary constraints, it will have more of a distorting effect in 1994 than it would in other years, even though it is not necessarily the RBRVS, per se, that was the reason for the change. Having said that, I believe we will start to see a big impact -- not in the first year but in the second year -- as doctors sit down with their accountants and realize what their reimbursement has been, and start to adjust their behavior accordingly.

MR. CARROLL: What would you feel like if actuaries were restrained by the government? We are, in effect, every time someone talks about national health with any kind of serious reality. I mean it strikes some fear into the hearts of a health actuary, although I figure maybe I can switch into some other subspecialty. You could reduce the average income of every actuary, let alone every health actuary, in the country from $50,000 or whatever it is to $10,000 and have no impact on the health care crisis in this country. For people who are over 65 and active employees of employer groups, is it possible for someone to take the position on claims that reasonable and customary for these people is or will be the RBRVS schedule and the diagnostic related groups (DRGs) at the hospital? It seems to me we could make a very definitive and legally defensible argument that, in fact, for this class of people reasonable and customary is what the government pays because 90% of the people have fallen into that class.

MR. SOBEL: That would not square, at least with my understanding of the current legal arrangement; these people are not on Medicare, and therefore, they are not entitled to the Medicare allowance. I think the answer would be no. A 67-year-old active is not entitled to the Medicare fee.

MR. BOEKHOFF: More importantly, the hospitals are not obligated to take that as payment in full. Certainly an employer could do that, but the hospitals could look back to the employee for the balance amount. Most employer plans are written to provide coverage for reasonable and customary expenses.

MR. SOBEL: I would just like to add, though, I did have a conversation with someone at the HCFA about the TEFRA actives. Apparently the government does track

the usual and customary amounts because, if a doctor is billing in excess of the maximum actual allowable charge, the HCFA sends its team of auditors out, and they can have sanctions against the doctor for exceeding the balance billing. This is true even under the old law. Apparently their computer programs were not able to distinguish the TEFRA actives from the Medicare eligibles. It was causing a problem; doctors were getting dunned for exceeding the fee controls when, in fact, there were no fee controls.

MR. TIMOTHY M. ROSS: I think an analogy with the RBRVS is, if you go in to get your car worked on, there is a shop rate, a book rate, of how many hours it takes to do a particular procedure on a car. I think you can make that analogy with physicians' procedures. A distasteful effect of the RBRVS is saying what the shop rate should be. In other words, should it be $50 an hour? I see that as a necessary step in conjunction with what Jay mentioned, that the coding may become – and hopefully will become – more standardized so that what you get when you code something as an office visit, 90050, is a particular brand of office visit. I see that as a necessary step, then, to ask for a given diagnosis (and I think this is key) what procedures are done and what is the outcome as a result of those procedures? As we go forth with formulating a national health policy, the issue is going to be what is appropriate care? Having a framework for evaluating the building blocks going into appropriate care and then evaluating the outcomes on that basis will be very important in the national debate.

MR. BOEKHOFF: I do not know that there is a question and answer in that. One of the pieces you mentioned that is worth observing is that the fifth leg of the stool of the changes that are taking place in 1992 is the beginning of the process for outcomes analysis. Besides the three things that Harvey mentioned and the standardization of coding practices, Congress is authorizing evaluation of the whole outcomes analysis area. I think that will be a significant long-term tool in developing a total health care policy.