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**EFFECT OF RBRVS IN MEDICARE ON PRIVATE HEALTH INSURANCE**

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- Resource Based Relative Value Scale (RBRVS): Where is it and where is it going?
- Effect on trends
- Medicare supplemental coverage
- Indemnity plans
- Health cost projections

MS. ROSEMARY MONTGOMERY: Our panelists represent a variety of backgrounds, and I'm hoping that they'll be able to give you a different perspective on this issue. We're going to cover the evolution of the system, how it's gotten to where it is today, and then go into what the impact is going to be on various groups. We're going to start with Joel Miller who is the director of professional services with the Health Insurance Association of America (HIAA).

MR. JOEL E. MILLER: Now we wouldn't be a workshop if we didn't have some audience participation or tests. So the first test is, what is an RBRVS? Many have said that it's a recreational vehicle. Now Medicare's original basic physician payment rules resemble those used by some private insurers in the 1960s who paid the usual and customary charges billed by doctors on a service by service basis. Under this approach, Medicare compared the fees normally billed by a specific physician with the fees generally charged for the same services by other physicians in the same locality. And Medicare payment calculations were based on the lower of these two amounts. Made sense? Or did it? In the years immediately following the implementation of Medicare in 1966, physicians sharply increased their fees. Consequently, government managers and Congress moved to control overspending by limiting the level of physician charges they would recognize as appropriate. Amendments approved in 1972 reduced the maximum charge level to a specified percentile of the community norm. In addition, the Medicare Economic Index (MEI) was established to limit annual increases in the prevailing charges paid by physicians in each payment area.

Now despite the 1972 controls on Medicare payment rates, spending for physician services continued to rise sharply, and in early 1980 budgetary actions focused on physicians services under Medicare. But few major physician payment changes

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occurred before 1984. It was in 1984 that Congress approved the first of two direct fee freezes on physician payments under Medicare. Also adopted at that time was a new "participating program," or PAR program built on the original assignment concept.

Now Congress approved another important set of limits in 1986 by actually specifying the maximum charges that nonPAR physicians could bill their patients. These are known as Maximum Allowable Actual Charge Limits (MACCs) which were based on the 1984 physician charging practices. Now MACC limits established an overall ceiling on the fees charged to Medicare patients in nonassigned cases. Consequently, this also set a limit on balance billing. So, not only have we covered 21 years of Medicare payments, but with the advent of the usual, customary and reasonable (UCR) and Medicare Economic Index (MEI), we've almost covered the entire alphabet as well.

Now despite all of these MEIs, PARs and MACCs, program expenditures for physician services increased steadily. Critics of Medicare's traditional UCR fee for the service model approach to physician payment, with all of its excess regulatory baggage, raised several objections to its continued use. It encouraged a provision of an ever increasing per capita use of services. This method contains no incentive to constrain physician charges. The Medicare payment methodology incorporated fee distortions in the physician marketplace. And finally, fees for some services, namely surgery, have been criticized by many, including some physician groups, to be overvalued as compared with other physician activities, such as patient evaluation and management services. Thus, it was argued that Medicare's historical approach pays too much for certain surgical and procedural activities, and it creates payment inequities among various categories of physicians. The critics said payment reform should address these concerns.

So federal legislation in 1986 and 1987 was enacted, directing that studies be conducted to recommend alternative policies for physician services reimbursement. Congress expressed particular interest in developing a fee schedule for doctor's services using a Resource Based Relative Value Scale where the amount of resources devoted to producing the service serves as the basis for payment.

Now Congress also established, at that time, the Physician Payment Review Commission for advice in developing a Medicare fee schedule. Other legislative directives called for ways to adjust a fee schedule for physician services to take into account geographic differences and cost of maintaining a practice and cost-of-living considerations.

Now since 1987, most of government's interest in physician payment reform focused on the design of the RBRVS for potential use in the Medicare fee schedule. A relative value scale (RVS), established a relative worth of a particular physician's service compared to the worth of other services. By itself, an RVS is not a fee schedule, but rather an index of relative values that must be multiplied by a conversion factor to establish an actual fee.

So in the fall of 1988, the government released initial results of its RBRVS study that was conducted by the Harvard School of Public Health. Now according to Harvard

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researchers, their initial results confirmed the view that current physician billed charges were not closely related to the resource cost needed to produce those services. In general, patient evaluation, counseling, and management services, also known as cognitive services, were reported to be significantly undervalued when compared with procedural activities such as surgery. As a result of the Harvard study, the Physician Payment Review Commission endorsed development of a Medicare fee schedule using an RBRVS.

So in November 1989, the Congress passed the Omnibus Budget Reconciliation Act of 1989, which includes fundamental reforms in physician payment policies under Medicare. That new reform plan consisted of three elements: (1) adoption of a Medicare fee schedule with RBRVS to be phased in over a five-year period, which began January 1, 1992; (2) the establishment of Medicare value and performance standards for physician's services and their use in the process of updating the new fee schedule; and (3) new limits on actual charges that doctors may bill Medicare patients above the fee schedule amounts. Now, in addition, this legislation directed the Health and Human Services (HHS) secretary to conduct and support a new research program on clinical outcomes and effectiveness.

So, in January 1992, the Medicare program began to replace the current payment system with a fee schedule that reflects the resources used in providing efficient patient services. Now over a five-year transition period, a blended fee schedule will determine what physicians are paid. Then, in 1996, payments will be based on the fee schedule. This year the rate is based on 75% of the UCR amount, and 25% of the RBRVS amount.

Now, as I mentioned, setting payment under the fee schedule begins with a relative value scale that indicates the value of each service relative to other services. The RVS is translated into a geographic adjustment factor and a conversion factor dollar that indicates how fees should vary from one locality to another. The RVS has three cost components as reflected in the 1989 legislation. First is physician work, which reflects the time and intensity of the physician's effort in providing a service. Second is practice expense, which includes costs such as office rent, salaries, equipment, and supplies. Malpractice, reflects professional liability premium expenses.

The geographic adjustment will reflect the full variation in a cost item index. This includes office rent, nonphysician employee salaries and malpractice premiums. And this adjustment will result in less geographic variation in Medicare payment rates.

In the first year of the transition, the conversion factor is set so that the estimated expenditures other than those in the 1992 fee schedule equal expenditure estimates of the current payment system. Subsequently, the fee schedule will be adjusted for inflation and other factors through annual conversion factor updates. The Medicare volume performance standard policy (MVPS) will be used to update the fees, and I will talk about that later.

The fee schedule payment amounts in our computer were first contained in the September 4, 1990, Federal Register Notice, and that was updated through the November 25, 1991, Federal Register Notice, which was the final rule and regulation on this system. The fee schedule payment amounts are the product of three

elements: a relative value for each service, a geographic adjustment factor for the locality, and a nationally uniform dollar conversion factor. The law also provided for separate adjustment of the work, overhead, and malpractice components of the total relative value units, by a geographic adjustment factor appropriate to that component. These geographic practice cost index values (GPCIs), are used to fulfill the statutory requirement for geographic adjustment factors. Under the Medicare value performance standard policy, the fee schedule conversion factor will be updated on the basis of how expenditure increases compare to a previously determined goal. The MVPS policy expressed Congress's determination to slow the growth of overall expenditures to an affordable rate. The MVPS will be the principal federal tool to control aggregate spending on Medicare physician services.

Medicare has always allowed physicians to balance bill. The payment reform legislation places stricter limits on what physicians can charge. The policy standardizes the percentage by which charges can exceed the fee amount, replacing a complicated system of MACCs. This policy is expected to reduce the number and size of balance bills.

Okay, let's talk about the implications of the reform initiative. The fee schedule seeks to rationalize the payment pattern by making physician incentives nearly neutral. Physicians currently have financial incentives to perform procedures, rather than to provide evaluation and management services. They are encouraged to specialize in the procedure components of medicine. Effectiveness and outcomes research generates a second force to rationalize care. As effective practice research increases, the information can be translated into clinical practice guidelines and disseminated. Physicians may take this opportunity to improve their practices, and education may be reinforced by utilization and quality review using improved criteria consistent with the guidelines.

The reforms do not discourage capitated systems such as HMOs. HMOs have a structure that reverses the incentives of fee-for-service medicine. Physicians in both groups can benefit from effectiveness research and practice guidelines. The competition between fee-for-service and HMO payment will continue based on which sector can do a better job of controlling costs while satisfying patients and physicians.

Now roughly half of the nation's 74 Blue Cross plans have privately engaged in studies, which is the first step toward adapting RBRVS for some private insurers. Twenty-seven Blue Cross plans are participating in a national Blue Cross and Blue Shield Association study designed to assess the impact of applying RBRVS to private insurance. The study will help identify where cost shifting may result from Medicare's RBRVS payment schedule. Twelve other plans are working on a similar project with the Center for Health Policy Studies, which is a private research firm in Maryland. The studies will not develop private RBRVS fee schedules for the local plans, but will help them develop, evaluate, and implement their own RBRVS payment system. The Blue Cross plans are trying to identify the relationship between the RBRVS and their client's business. RBRVS also can be used to identify specific procedures that plans deem too expensive.

Also, in 1990-91, Blue Cross and Blue Shield of Rochester, New York, signed a contract with the CHPS project called the multiplan study of physician costs which

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was designed to determine how switching to RBRVS without increasing total payments would affect individual physician revenues. The project began with a simulation of a budget neutral implementation of RBRVS. Also, Blue Cross of Oregon is pursuing a partial movement towards relative values in its participating physician program. In other plans, the Medicare RVS is likely to become a reference point in physician negotiations.

Let's discuss some of the potential problems the RBRVS system may cause. Physician payment reform may generate momentum towards the use of fee schedules. However, if Medicare fee levels under the new system are considered inadequate by physicians, they may try to recover the loss by charging more to private sector payers. This shift of liability to the private market could mean increased spending on physician services for employers and employees. However, analysts do not agree on the amount of cost shifting that will occur. So it will be important to monitor the results to see whether non-Medicare payers feel any adverse effects.

Also, primary care physicians whose fees will increase under the Medicare RBRVS system may increase their fees to all payers even if private payers do not adopt a formal fee schedule or an RBRVS system. This increase could create special problems for insurers who have adopted the strategy of using primary care physicians as gatekeepers in managed care systems. Insurers who adapt RBRVS as a reimbursement norm may see their health care expenditures increase immediately.

Those that continue to pay according to reasonable and customary charges may see their expenditures increase more slowly, but their insureds will have a balanced billing problem until UCR catches up with the RBRVS system.

Also, not adopting a reimbursement strategy is another potential option. However, if insurers simply pay charges, they could be paying the new higher fees for primary care physicians, and the old higher fees for specialists and surgeons.

Now the major barrier to the incorporation of elements of the Medicare fee schedule into indemnity plans is balanced billing. In plans where payments are low and balanced billing is already extensive, insureds may be indifferent to the fact that increases in balanced billing for surgery and technical procedures are offset by decreases for evaluation and management services. But insureds might react negatively to high payment levels and balanced billing. The balanced bills for procedural services that are encountered for the first time may be interpreted as a reduction in insurance coverage.

Now insurance companies must evaluate their own circumstances in order to develop specific strategies to cope with the new physician reimbursement environment. RBRVS will not affect all payers in the same way. So, some insurers may consider taking the following actions. Educate your corporate benefit managers on the system and other physician payment reform components. Examine use and charge patterns and watch the impact of payment reform on the income of specialty groups with the goal of identifying evidence of cost shifting through fee inflation or physician changes. Simulate the impact on policyholders' annual expenses over the next couple of years by using RBRVS instead of past, reasonable and customary charges. Also, you can simulate the impact on policyholders' out-of-pocket expenses if physicians had been

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reimbursed according to RBRVS. And then, based on these actions, determine the impact of RBRVS and its applicability to individual benefit packages.

Now some insurers are considering partial incorporation of the Medicare RVS through an additional charge screen under their UCR systems, and this is comparable to the approach that Medicare took in 1989 and 1990. Data from preliminary versions of the Medicare fee schedule were used to reduce prevailing charge screens for overvalued procedures. In addition, primary care service fees were raised at that time. Now, under this structure, insurance companies can decide the pace and extent to which the Medicare RVS is incorporated into their payment system, and whether to use these data in a budget neutral context, or to raise or cut the overall level of payment.

Some other reactions could be considered either a selective or intermediate approach to incorporating RBRVS. Based on an examination, insurers could consider targeting specific services where the fee schedule could be applied on a selective basis. Or, one strategy could be to establish a surgical fee schedule somewhere between UCR and RBRVS, which I call the intermediate approach. Managed care is also another vehicle for adopting the RBRVS schedule.

Implementation of RBRVS may encourage more payers and corporations to negotiate reimbursement levels with physicians in order to minimize cost shifting and balanced billing limitations. RBRVS could become the starting point for negotiations. A negotiated fee schedule may be based on RBRVS with a percentage add-on.

Combining RBRVS with quality indicators and performance-based incentives may be another potential strategy. And negotiations over fees may include the right to audit medical records and to minimize improper coding, upcoding or code creep.

RBRVS does provide several advantages for private payers. It offers a convenient way to pay physicians more equitably and sensibly for their services. It's an independent valuation of specific physician services. And it offers insurers an opportunity to negotiate more aggressively with providers because it gives insurers more information than they've had before. And RBRVS could decrease administrative costs rather than trying to constantly update UCR schedules.

RBRVS also has its limitations. Any classification system encompasses some variation within its classes, and this system is based on the system of Current Procedural Terminology (CPT) for classification. The severity of patients' conditions within a given code may differ systematically from one physician to another. Also, the RBRVS does not directly address volume of services. Adopting RBRVS would establish a basis for developing reasonable prices, but it would do nothing to control the quantity of services provided by physicians.

So it will be very important for insurance companies to apply their utilization management techniques to assure that utilization does not change in inappropriate ways and to conduct retrospective provider profiling. Also, the RBRVS does not take into account the quality of those services.

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RBRVS measures only resource inputs. The outcomes of those services are not considered or known under the system.

So RBRVS is a potential new tool for containing cost. But it only addresses one part of the problem. Fifty percent of health care cost increases are due to expanded utilization and intensity of services. Insurers cannot ignore RBRVS, however. RBRVS will provide insurance companies with more information about physician fees, and it can be used for fee negotiations and managing health care costs. However, before insurers develop their own physicians and strategies concerning RBRVS, they need to have a good understanding of its potential and its likely impact on physician's practice patterns and billing practices.

MS. MONTGOMERY: Our next speaker is Woody McDonald, who is a consulting actuary with Tillinghast.

MR. WOODROW H. MCDONALD: What I want to talk about first is what is RBRVS anyway? We saw some options that Joel presented to us, and I would present to you that it's just a matter of perspective: who are you, where have you been, and where are you going?

For example, the government has considered RBRVS to be a resource based relative value system. And they've been considering that for years. However, if you're a physician, and you've been hearing about this for the last year, then perhaps what you've been considering it to be is Really Bad Reimbursement Very Soon, and believe me, I've heard a lot of physicians call it just that.

On the other hand, if you're a private sector health insurer in 1992, you're probably believing RBRVS means the following: React Before Ratcheted with Very much Shifting. We've heard Joel talk a little bit about shifting, and I for one believe there will be cost shifting.

Basically I want to cover the purpose of RBRVS, components of the fee schedule, and MVPS, which Joel has talked about. Then, I think it's important to talk a little bit about what is exactly going to happen to the doctors before we talk about the impact on payers. So in terms of the effect and the outcome and the impact on the doctors, I'll just give you a few illustrations.

And then we'll talk about the impact on the non-Medicare payers. I'll give a sample, RBRVS fee schedule as Joel was discussing. I'm not suggesting that all of you need to go out and adopt it, but I'll just give you an idea of one way you could get to RBRVS.

As far as the purpose of RBRVS, procedural has been considered to be too high, and cognitive services are too low. That's basically one of the major effects that RBRVS is having.

One of the measures in this thing, if you look at it closely, is that the government is basically saying that they feel like a doctor's time is worth about a \$120 an hour. I think that's a lot lower than what any of us are used to seeing, but basically this is kind of the norm of where the government values the doctor's services.

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As far as the components of the fee schedule, there's the relative value scale. We already discussed the geographic adjuster. I'm going to talk primarily about the monetary conversion factor. You might just keep in mind the number 31.001. That is Medicare's conversion factor for 1992, and that's the number that you can do things with to develop your own RBRVS fee schedules if you so desire.

The Medicare Volume and Performance Standards are going to be used to adjust the national conversion factor, and basically it's to reflect overutilization that we all project. The government concluded that the physicians will have overutilization. In 1993, for example, the maximum decrease that you will see to the conversion factor as a result of overutilization has been pegged at 2%. But they have tried to take into account that they are expecting overutilization by the doctors.

Okay, let's take a look at the doctors. First, Table 1, shows some selective cognitive services. This is in the Jacksonville, Florida area. This is what in 1991, 1992 and 1996, you can expect to receive if you're a physician. For an office visit, for example, there's not much difference between before RBRVS and after RBRVS. If you'll look though at the initial inpatient consultation, you can see that between 1991 and 1992, it's going from \$87 to \$100. And then between 1992 and 1996 it goes up another \$12. The point I want to make here is there is an increase, and the increase between 1991 and 1992 is as significant an increase as you're going to see for the rest of 1993-96.

**TABLE 1**  
Average Medicare Payments for Certain Medical Services  
(Jacksonville, Florida)

Selected Cognitive Services	1991	1992	1996
Office Visit -- Established Patient	\$ 21	\$ 22	\$ 22
Office Visit -- Pelvic Exam	40	46	46
Initial Inpatient Consultation	87	100	112
Second Opinion, Comprehensive	74	85	95
Critical Care, First Hour	104	119	124

Having even more impact will be some selected procedural services (Table 2). But let's look at the double coronary artery bypass. In 1991-92 there's going to be a \$416 drop for a physician for this particular procedure. Between 1992 and 1996 it's \$534. Again you can see the dramatic drop is going to actually occur in 1992. So in terms of RBRVS, it is here; there is no question about it. Some of the doctors haven't realized it yet, but believe me it is here. You can see that a total hip replacement is even more dramatic. There's a \$369 drop in 1991-92 and only \$161 drop between 1992 and 1996.

How do you compare this to diagnostic related groups (DRGs)? In DRGs, on the hospital side, there really was a phase-in during about a five-year period. However, it's going to be a fairly dramatic phase in occurring fairly quickly on the RBRVS side. Not much of a phase in at all.



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TABLE 2  
Average Medicare Payments for Certain Medical Services  
(Jacksonville, Florida)

Selected Procedural Services	1991	1992	1996
Insert Pacemaker AV Sequential	\$1,068	\$ 930	\$ 657
Double Coronary Artery Bypass	2,985	2,569	2,035
Total Hip Replacement	2,399	2,030	1,869
Biopsy of Liver, Wedge	438	370	345
Repair Inguinal Hernia	474	407	331

If you're a Med Supp carrier, one of the concerns would be what is going to happen to your Med Supp programs in 1992, in particular, those Med Supp programs where you are paying above Medicare allowables? I would be concerned, and I would monitor very closely, what is going on with RBRVS and how much you're having to pay under a Med Supp program.

Okay, let's talk about the effect on physician's income. The general practitioners who do more cognitive services are at least realizing some gains, and there are variations based on the services provided by a particular physician. And then the surgeons are clearly being impacted negatively.

Table 3 illustrates several specialties. Again, we looked at Jacksonville, Florida. One of the pieces of information that we had to gather in order to look at 1992 is something called the adjusted historical payment basis. And you can obtain this by going to the Medicare intermediary, and for a nominal fee, you can collect this information. So we actually did testing here on some actual physicians. And our numbers came out fairly close to what the Health Care Finance Administration (HCFA) was predicting for these various specialties. For example, HCFA, for the cardiothoracic surgery predicted a -14 in 1992 and a -27 in 1996.

TABLE 3  
RBRVS Effect on Physicians' Income  
(Jacksonville, Florida)

Service	Percent Change from 1991 per Procedure			
	1992		1996	
	Actual	HCFA Prediction	Actual	HCFA Prediction
Cardiothoracic Surgery	-13%	-14%	-29%	-27%
Internal Medicine	12	0	32	5
Cardiology	-8	-9	-15	-17
General Surgery	-8	-3	-20	-13
Family Practice	9	15	24	28

I want to comment a little bit on cardiology. We're showing here a -8 and a -15. When we first did this, our numbers for this particular physician were showing a +5 and a +7. When we went back in and analyzed what was going on here, because

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this is not what Medicare was predicting, we learned that, for this particular physician, he has been billing his visits separately from his surgeries. Under Medicare, there now is what is called a global fee payment, and this surgeon will no longer receive payment for those separate office visits. So even if he bills them separately, he's not going to receive payment from Medicare. So, in fact, instead of a 5-7% positive gain, this particular physician is going to realize in 1992 as you can see a negative 8%.

The only other comment I have on Table 3 pertains to the internal medicine. This happened to be a physician who did a lot of cognitive services and, in fact, probably did more than your normal general practitioner. HCFA was predicting that the internal medicine folks will come out somewhere around, break-even, 0% in 1992 and about +5% in 1996. As you can see, this particular physician is making out like a bandit because of the cognitive services that are included in his repertoire.

Okay, how will the doctors respond? First of all, there will definitely be an increase in utilization of services. The people that are consulting with physicians are looking at ways to enable them to do that. Medicare will be doing audits to make sure when they do submit charges that those charges are justified. Obviously they can't audit everybody, but as part of those audits, they're going to be looking to see how consistent they are from patient to patient. That includes Medicare versus non-Medicare patients. Obviously if they're going to be trying to increase their utilization of services on the Medicare population, it's also going to have to carry over to the non-Medicare population. So, you will see an increase in utilization.

Doctors will probably try to add more patients. Now that one's going to be tougher to do for some doctors than for others. But there clearly will be a desire to add more patients, and if they can add more patients they'll be looking to add more non-Medicare rather than Medicare patients.

They will obviously try to do more cognitive services. You will see specialists, at least some of them, actually spending 15 minutes with patients, because they will be paid based on 15-minute increments by Medicare.

They also will reduce the number of Medicare patients. And one way they'll do this is probably at least put a cap on the percentage of Medicare patients that they'll desire to see in the future. I was on an airplane with a head of a psychiatric unit tied in with a hospital recently. He was mentioning that he's had several physicians on his staff who were trained in geriatric psychiatry who are no longer going to treat geriatric patients. They are just going to treat non-Medicare patients. They happen to have the luxury of high enough patient load that they can do that. You're going to see some of those things occurring. There will be a movement away from Medicare by those physicians who are able to bring in other patients.

There will be a change in clinical conclusion. In borderline situations you will likely see a doctor who might or in the past have said, "No, I don't think we need to do this additional procedure or operate," having a different opinion in the future. That is predicted.

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And then a concern of everybody here probably is charging more to the non-Medicare patients. We went back to our Jacksonville cardiothoracic surgeon to give you a feel for what happens with him (Table 4). His income from Medicare in 1991 was \$230,000. In 1992, it's predicted that he'll have a 13% drop if he performs those same procedures. He will in fact have a 13% drop on his Medicare population down to \$200,000 of his total business in 1991, 60% of it was Medicare, 40% of it was non-Medicare. In this particular example, the total is \$383,000. If this particular physician would like to achieve, about a 7% increase in his fees, his non-Medicare revenue is going to have to jump up by 37%. Now there are different ways of getting there. He can obviously work a lot harder. He can go out and get more patients. But this can demonstrate for you just how dramatic the effect of RBRVS is going to be on some of these physicians and what impact it could have on our non-Medicare business.

**TABLE 4**  
Cardiothoracic Surgeon

60% Medicare			
Source of Income	1991	1992	% Change
Medicare	\$230,000	\$200,000	-13%
Total	383,000	410,000	+7%
Non-Medicare	153,000	210,000	+37%
50% Medicare			+27%
40% Medicare			+20%

Likewise, what if his business were 50% Medicare? You'd see a 27% increase needed on his non-Medicare, and if it was 40%, you see a 20% increase would be needed.

It's also predicted that there'll be more participating physicians. One reason being that Medicare is putting a cap on what they're saying physicians can charge to their patients if they're nonparticipating. Starting in 1993, they will be paid 95% of what a participating physician would be paid. In addition to that, they will not be able to charge the patient. They will not be able to collect from the patient more than 115% of that 95% or 109% more than if they had just been a participating physician in the first place. So there is a prediction that you will see more and more participating physicians in the future. And that should be good news for those who are paying above Medicare allowables.

On the one hand they are trying to encourage the doctor to perform more services in his office and less in an outpatient department and certainly less in a hospital. But there happens to be some procedures in which Medicare will actually pay the doctor more if he hasn't done inpatient, or outpatient. For example, we looked at what it would cost for a detached retina, and what the physician would be paid for an in- and out-of-hospital procedure. Inpatient and outpatient. For an inpatient, he would get \$721 in 1992, for an outpatient, he'll get \$488. So there will be some incentives for doctors to actually put people in the hospital again.

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There is a prediction that there'll be more primary care physicians as a result of the new payment system Medicare is implementing. Since the early 1980s the number of primary care physicians (PCPs) in this country has declined dramatically. Now, only 35% of the total doctors in this country are PCPs as opposed to Canada where it's 50%, and in the United Kingdom it's 70%. So there is certainly room for more primary care physicians in this country and Medicare is trying to see that that happens.

Perhaps there'll also be more rural physicians. Because of the way that Medicare is going to be encouraging payment to people who go to lower cost areas, we do anticipate there may well be more physicians in rural areas and a move in that direction.

The doctors will try to improve productivity. It will take a while for them to figure out they need to do that, but they will be downloading services to their nurse practitioners etc., and you'll see more services done by the nurse practitioner. Doctors realize they're going to need to be doing that in order to get more patients in the door. And they will become more bottom-line oriented. They will be forced into doing that as time goes on. So you will definitely see some of that going on indirectly at least.

I might just add that at the current time it appears to us, in working with some of the physician groups and some of their consultants, that number one, they've always been and still are skeptical of what hospitals tell them. They're also skeptical of what some of their medical management consultants are telling them in terms of what the impact of RBRVS is going to be on their practice, even though both of these organizations have been attempting to try and show them and illustrate to them what affect it will have. But it is here, and they will be seeing it in 1992. And as soon as they start seeing it, then they will realize what kind of an impact it's going to have.

When discussing the impact on non-Medicare payers, the first item is obviously cost shifting. In the earlier examples I showed you how we will see some cost shifting. I don't think there's any way around it. Hopefully it won't be a magnitude of 37% on everybody's insured plans, but there will be cost shifting. Utilization increases will occur. There will be more cognitive services.

Let's discuss RBRVS versus DRGs. The government was paying out more on DRGs than they intended to, so the hospitals didn't immediately react to a decrease in revenue back in the mid-1980s. However, after the government realized they were paying too much and drastically cut their DRG payments, you can see a sharp rise. And it's occurred yearly, at least on a per-day basis, in the inpatient revenues on the non-Medicare side of the business. I would anticipate that you're going to see that happening a lot faster with RBRVS than you saw it happening with DRGs.

There's 70-75 times the number of providers when you look at physicians versus hospitals, and there's about 15 times the number of codes that we're dealing with for RBRVS and CPTs than there are with DRGs.

Regarding the impact on non-Medicare providers, there are Medicare supplement plans. I would not anticipate major increases or decreases on those plans that aren't

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paying above Medicare allowables. If you do have a Medicare allowable plan, you have to be aware of some of the things that could happen to you.

Let's talk a minute about non-PAR physicians. HCFA has adopted its limitations that a non-PAR physician can not charge more than 115% of the 95% that he's going to be paid in 1993. That's all fine and good. And those of you who do pay above Medicare allowables might say, well that ought to take care of things. There's a bit of a problem with that. Thirty-three states, the last time I looked, have said that if you have a Medicare supplement plan, then you must pay the benefits of that plan. What HCFA is saying is that they will fine doctors if they charge patients more than their limiting charges, that is, in excess of those charges. It isn't necessarily saying that it's not okay for that insurance company to pay those excess charges. So there's a lot of confusion right now in terms of the limiting charge and what insurance companies are going to be able to do about it. HCFA has been pretty silent on it. Hopefully there'll be some direction coming out, but that is an item right now that needs some attention. In the meantime, you're probably going to end up paying for it if you're a Medicare payer.

In Pennsylvania, there is a movement under foot on the workers' compensation side to adopt an RBRVS fee schedule that would pay 110-113% of RBRVS, Medicare's 31.001 conversion factor. You are probably going to see more and more of that at the state level, at least on the workers' compensation side. On the federal level, it's quoted in the March 23 issue of *Modern Health Care*, that in Congressman Rostenkowski's health care reform bill, he is promoting the use of Medicare DRGs and RBRVS as the payment mechanism. He's calling it his cost-containment approach. I'm not suggesting that his bill will pass by any stretch of the imagination, but I am suggesting to you that, at the federal government level, legislators, and very influential legislators, are certainly looking at RBRVS already. How can we move beyond the Medicare side of the House over to the non-Medicare side and adopt something like RBRVS?

Okay, let's move to RBRVS. Joel has hit on what's going on in the Blue's organizations. I'm sure there are large, medium, and probably small size insurance companies too that are already looking at what RBRVS means and what's happening, especially if you're a Medicare intermediary and have that information coming in right now.

There are managed care plans that are certainly looking at what can they do with RBRVS. *And we're working with clients right now that are adopting RBRVS fee schedules on one basis or another.*

Let's look at an example of how you might consider and one of the ways to work with a client in a move to an RBRVS fee schedule (Table 5). The premise would be that you're an organization and you're now paying at the 90th percentile of HIAA, and you don't want to change it. In this particular illustration, we've done it by body system. You can develop an RBRVS conversion factor for each of the body system elements. In Table 5 as you move down, you see these are for surgical procedures. You can see what the relative conversion factor is for various body system type procedures. And by the time you get down to nervous, it's at 122.88. So in other words your conversion factor would have to be 122 versus 31.01 which is what Medicare is paying. So this table gives you an idea of how much reduction there's

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going to be in some of the procedures that have been performed for some of the body types in the past.

TABLE 5  
RBRVS Based UCRs for Jacksonville, Florida

Equivalent to HIAA 90th Percentile	
Body System	CF
Integumentary	74.03
Musculoskeletal	85.90
Respiratory	88.90
Cardiovascular	78.50
Hemic & Lymphatic	81.35
Mediastinum & Diaphragm	75.79
Digestive	90.11
Urogenital	98.52
Maternity Care & Delivery	83.40
Endocrine	90.50
Nervous	122.88

But if you are a PPO, and you want to adopt something that's related to RBRVS, you can go through and develop conversion factors like this and go ahead and continue to pay on the same basis you're paying now, assuming you're paying at the 90th percentile of HIAA.

One way to do it is you could develop a global conversion factor. In Table 6 we took the global factor you end up with for each of those body systems when you run it through. In other words, what is the equivalent HIAA payment? And in this case it would be a 68.11 conversion factor. So in other words, if you had a conversion factor of 68.11 instead of the 31, you would be paying out essentially on the same basis that you are now paying under the 90th percentile of HIAA.

TABLE 6  
RBRVS Based UCRs for Jacksonville, Florida

Equivalent to HIAA 90th Percentile	
Body System	CF
Eye & Ocular	82.97
Auditory	107.33
Radiology	78.51
Laboratory & Pathology	76.18
Visitations	50.72
Psychiatric	55.72
Cardiovascular & Pulmonary	54.56
Other Medical	63.46
Global	68.11
Medicare	31.00

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The reason it's 68 by the way (and you see so many of those procedures above 68), is because of the volume. The frequencies of some of those office visits and procedures are near the bottom of the table.

Table 7 shows some of the specific procedures for Jacksonville, Florida. A biopsy of a skin lesion is the first one. HIAA is at the 90th percentile. And then if you use the multiple conversion factors (i.e., the separate conversion factor by body type versus the global conversion factor) and you wanted to pay equivalent to HIAA, you would be paying out \$88 versus \$81 under the global approach.

TABLE 7  
RBRVS Based UCRs for Jacksonville, Florida

Equivalent to HIAA 90th Percentile				
CPT	Description	HIAA 90th	Multiple CFs	Global CFs
11100	Biopsy of Skin Lesion	90	88	81
15120	Skin Split Graft Proc.	1,350	1,216	1,119
29405	Apply Short Leg Cast	150	154	122
26445	Release H/F Tendon	1,162	698	553
33510	Coronary Artery Bypass	4,750	4,400	3,818
33212	Insert Pulse Generator	1,200	980	850
45330	Sigmoidoscopy, Diag.	189	217	164
42405	Biopsy of Salivary Gland	670	457	346
59510	Cesarean Delivery	2,700	2,783	2,273

The main purpose of this slide is to show you the difference, or reduction in payments under this approach for frequent versus infrequent procedures. We've kind of alternated frequent and then infrequent. If you look at the first one, that's a more frequent procedure. Next one, an infrequent procedure. So in other words, you can see that HIAA would pay \$13.50 for the skin split graft procedure, the multiple conversion factor would pay at \$12.16.

Why the RBRVS might be a reasonable approach to be considering is that there has been an extensive study done by the government to come up with these relative values. And if there's one thing that the doctors seem to be okay about right now is where the relative values are coming out within a subspecialty. So one thing you could do is you could adopt an RBRVS-type approach, and for something like a skin lesion for example, you would feel comfortable with what your RBRVS values are. You would also feel comfortable with what the HIAA values are. But, on some of the HIAA slots where there are infrequent procedures, you could look at what the RBRVS value is. For example, on the skin split graft, it might be more appropriate to be paying this at \$12.16 than it is to be paying it at \$13.50. The government will have helped you get there, because they have looked at what the appropriate relative values are. So in other words, if you are comfortable with paying \$88 on the \$111, then you would have some comfort in paying at \$12.16 on the next procedure. So this is one way that companies are looking at trying to adopt an RBRVS schedule.

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Table 8 is just some more procedures. If by now I haven't lost you, I'll lose you at the very last procedure which is induction of vomiting. So I apologize for everything we've talked about tonight.

TABLE 8  
RBRVS Based UCRs for Jacksonville, Florida

Equivalent to HIAA 90th Percentile				
CPT	Description	HIAA 90th	Multiple CFs	Global CF
59412	Antepartum Manipulation	450	274	224
66984	Remove Cat., Insert Lens	2,500	2,398	1,968
67904	Repair Eyelid Defect	1,733	1,554	1,276
73630	X-Ray Exam of Foot	61	63	55
71250	Cat Scan of Chest	708	606	526
80019	19 or > Blood/Urine Tests	40	39	35
80090	Antibody Panel	125	99	89
90060	Office/Outpatient Visit	50	49	66
99175	Induction of Vomiting	86	90	96

In Table 9 I'm showing that you could develop a separate conversion factor for each of your subspecialties within a network of providers. For example, you might have a different conversion factor for your cardiac surgeons than you do for your Primary Care Physicians (PCPs). I illustrated here, by using the multiple conversion factors that you saw earlier, or the global conversion factor if you wanted to get back to the HIAA payment level, you could easily do it, and you could do it on a physician-by-physician basis.

TABLE 9  
RBRVS Based UCRs

Sample Doctors	Billed	HIAA 90th	Multiple CFs	Global CF
Card. Surg.	\$383,000	380,000 99%	369,000 96%	356,000 93%
Internist	\$224,000	221,000 99%	224,000 100%	223,000 100%

To summarize, there will be cost shifting, and I will say no more. Joel has mentioned the possible decrease in administrative cost. I think our private system has come under heavy criticism right now, any relief with the administrative costs I think we'd all welcome and would encourage. There might be some relief here in that area. However, at the same time I say that, I believe there will also be an increase in the total health care costs of our system. Unfortunately, I don't think the savings from administrative costs are going to more than offset the shifting to the private sector. So, I do believe that you are going to see an overall increase, at least in the short term.



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I predict there will be a move to RBRVS and national health care with a question mark. One thing I would propose to you here is just like Rostenkowski is looking at RBRVS as a possibility, it will certainly make things easier for the government to consider various proposals if you do have some kind of a system already in place that has been tried and the doctors haven't just rebelled against. I would suggest if it's not RBRVS, it will be something close to that. This will be a catalyst that gets us closer to some sort of national health care.

In closing I've got one last definition for you of RBRVS and I'd say this whether I were talking to payers or providers, health actuaries or other managed care executives. It is that Rationale Behavior can Restore a Viable System.

**MS. MONTGOMERY:** Our next speaker is Connie Rennaker. Connie is a supervisor of cost containment with the Aetna Medicare Claims Administration.

**MS. CONNIE RENNAKER:** I've been asked to talk to you a little bit about the carrier perspective for RBRVS. Aetna happens to be a Medicare carrier for the states of Arizona and Nevada, and we work directly with the Health Care Financing Administration in administering the Part B Medicare claims processing system. That includes all physician services, supplier services, items such as clinical diagnostic laboratory services, ambulance services, etc.

The impact on RBRVS has been a long process for us. We began educating and learning about the system back in September 1990, when Phase I of the Harvard study first became available. This study looked at about 1,400 CPT codes, and was published in a *Federal Register* in September 1990. We began educating our physicians on the upcoming event with RBRVS.

In June of 1991, the federal government published the Notice of Proposed Rule Making, and that redefined the original 1,400 CPT codes and added approximately up to about 4,000 CPT codes. This was the tool with which the physicians and the physician communities, societies, and associations could take a look at the proposed impact of RBRVS. That's the document for which HCFA received 95,000 comments from physicians, congressional offices, and associations across the country.

Once that was in place, HCFA took a look at all of those 95,000 comments and came up with the model fee schedule, the final ruling. Now the final ruling was published on November 25, 1991, and it included the relative value unit (RVUs) for all 7,000 CPT codes. There was about 450 codes for which they had not defined RVUs; however, HCFA worked on coming up with those RVUs at a later date. And these codes or RVUs, are what HCFA calls initial RVUs. So, the physicians have the option or the ability to make comment on the practice expense component. That comment process was 120 days long, and it closed on March 25.

When I had spoken with HCFA last, I sat in on a conference call last week, and they said they had over 4,000 responses to that final fee schedule. So HCFA is now taking a look at those and will come up with final determinations and maybe make some changes for 1993.

As a carrier, the impact for us has been enormous. In the past two years, we've been doing all kinds of presentations for the physicians and the medical societies to make sure they all understand how RBRVS will affect them. Some things have changed with RBRVS. One of the major changes that affected RBRVS was the elimination of the CPT codes for office services and that type of thing. They have moved to new evaluation and management services. They redefined and clarified the type of cognitive services for the physicians. There is no longer a brief office visit, it is now based on a history, an exam, and a decision-making skill. The physician must work in performing that particular service. So along with RBRVS, we've had to educate the physicians on the new evaluation and management codes.

Also, along with RBRVS, HCFA has implemented a global surgery policy. Previously, there were 38 Medicare carriers across the country, and there were probably 37 different ways of handling a global policy. The standardization that has been undertaken over the past year has been amazing. HCFA defined a certain global surgery policy for a major procedure and it has a flat 90-day follow-up. Woody talked about a cardiologist that had been previously billing for office services. He can no longer do that within that postoperative period. So that has a major impact on the money coming to that physician.

Also, along with the global policy, and major surgery, they took a look at minor surgical procedures, procedures that can be performed in the office or within an ambulatory surgical center, and have defined a zero- to ten-day follow-up period. So with this type of impact, along with RBRVS, the physicians have had to make some major changes in the way that they're sending claims to us.

Overall, the implementation of RBRVS has gone relatively smoothly. It went into effect January 1, and so far, the physicians, have accepted RBRVS very well. The problems that they have, have been with some of the other items that have come along with RBRVS: the global surgery, the new evaluation and management services. Also, HCFA defined certain procedures that can be performed within an office, and if they're performed in an outpatient hospital, the practice expense would be reduced for those particular services.

Also, as of January 1, a major impact for cardiologists, internal medicine physicians, and even family practitioners, is Medicare will no longer pay for interpretation of an electrocardiogram. It will only pay for a professional or a technical component. So they took the amount that Medicare was paying out, and it was billions of dollars a year for the interpretation of EKGs, and have bundled it into the office visit, the hospital visit, or the consultation. That was a major change. And that's something that Congress is seriously looking to possibly change back in 1993.

Also, Medicare began making payment different on the nonself-administrable drugs that beneficiaries receive from physicians. HCFA identified a list of additional 40 to 50 procedures for which we would pay for supplies if that service is performed in the doctor's office. That left an awful lot of services for which we had previously been paying supplies, whether it be a surgical tray or something along that line. That had a large impact on the physicians. So as you can see, the undertakings that went along with RBRVS are major changes for the physicians, which ultimately, I'm sure will be past on to other insurers and to other types of health care insurance.

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Now one of the items that Rosemary had asked me to talk about was the Medicare Volume Performance Standard. Basically this is an overall acceptable rate of growth in spending for physician services each year. The object of the standard is to control increases in the Medicare expenditures. The standard will be compared with actual experience and could determine future increases or decreases in payment rates. These increases or decreases would be based in part on the effect of the Medicare Economic Index, or the MEI, and the conversion factor which translates the relative values for services into an actual dollar amount, which we talked about previously.

In order to put the Medicare Volume Performance Standard in place, the Secretary of Health and Human Services must establish an annual performance rate of increase for expenditures and volume of physicians' services. The process begins with the Secretary's recommendation of an acceptable performance standard rate of increase to Congress by April 15, which is the same time the Secretary recommends an update to the conversion factor for the next year.

There are a number of factors that the Secretary must take into consideration in making his recommendation to Congress. Regarding the volume performance standards, consideration must be given to inflation, the change in the size of the beneficiary population, the numbers of enrollees in Medicare, inappropriate utilization of physician services, and changes in medical technology. For the conversion factor, we must look at the percentage changes in the Medicare Economic Indexes, the comparison of the actual performance to the Medicare Volume Performance Standard for the past fiscal year, and the changes in volume and intensity of physician's services along with other appropriate factors. These all need to be looked at when making the recommendation.

After the recommendation is made, Congress will have the opportunity to set a Medicare Volume Performance Standard based on the recommendation or it may take another amount, whatever it picks out.

If they do not act, the statute does call for a default calculation. In short, the update will equal the Medicare Economic Index, adjusted by the amount of the actual expenditures for the previous fiscal year that were greater or less than the performance standard rate of increase for the fiscal year. Did I lose everybody at that? That's where I lose all the physicians.

Just to give you an example. Let's say the Medicare Volume Performance Standard is set at 9.1%, and the fiscal year expenditures come in at 11.1%. That's a 2% increase. HCFA or the Secretary of Health and Human Services sets a Medicare Economic Index at 4%. So they take that 4% increase, deduct the 2% which is over the expenditure amount, and that leaves a 2% increase.

That can also work in another way. Let's say that the volume performance standard is set at 9.1% and the expenditures only come in at 7.1%. That's a 2% decrease. You still have a 4% MEI increase. So you can add that additional 2% on to the Medicare Economic Index and come up with a 6% increase in expenditures. Now that, I'm sure, is where Congress will make a decision and act on it. I'm sure they would not allow a 6% increase.

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Now there are limits on the downward adjustment for 1992-93; it's -2%; for 1994-95 it's 2.5%; and for 1996 and thereafter it's 3%. And there is no limit on the upward adjustment.

The actual 1991 Medicare Volume Performance Standard came in at 3.3% for surgical procedures, and 8.6% for all other services. So this came to a blended rate of 7.3%.

HCFA is currently reviewing the data for the separate Medicare Volume Performance Standards for 1992, and it will be making its recommendation to Congress very soon. So the board concept underlying the update is that it will be linked to performance under the target, whether meeting or falling below it, and how explicit that link is depends upon Congressional action.

One other area and that's basically the third component to the Medicare physician payment reform is the beneficiary of limitations, or the balance billing limit. The object of the balance billing limit is to bring down the nonparticipating physician billed amount closer to the limiting charge, MACCs are now called limiting charges. The goal is to bring that down to no more than 115% of the nonparticipating fee schedule amount for 1993.

MR. LEWIS M. BORGENICHT: The 7% and 9% that you mentioned when you were talking about the volume performance standard approved in the prior year affects the MEI. Exactly what are the 7% and 9% numbers?

MS. RENNAKER: The 9.1% was an example of a volume performance standard and the 7.1% was an example of the amount of expenditure.

MR. BORGENICHT: Right, but what are those numbers measuring? Increase in service counts?

MS. RENNAKER: The volume performance standard is the number that the Secretary of Health and Human Services uses to make a recommendation to Congress, and then Congress either agrees with it or disagrees and sets their own number. So that is the volume performance standard.

MR. BORGENICHT: My question though is, say they set it at 7% or 9%, what do they mean by that 9%?

MS. RENNAKER: That is the number that they're looking at for an increase in expenditures.

MR. BORGENICHT: In total dollars?

MS. RENNAKER: In total dollars.

MR. BORGENICHT: Okay.

MR. RONALD E. BACHMAN: Maybe Mr. McDonald could answer this. You talked about the Medicare supplement policies, and it seemed like the major impact would

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be positive in the limiting of the excess billing to the 115% over the nonparticipating reimbursement level. But you also seem to allude to the fact that there could be some real problems that would more than offset that positive as far as lower reimbursements. Now I was trying to get a better handle on what you might have been referring to there. What's the net impact that you would expect an increase in services that are provided or intensities, would have for Medigap policy experience and employers who are providing retiree coverage for above age 65?

**MR. MCDONALD:** Let's start with the first part of your question regarding what am I anticipating? Clearly, I believe there will be an increase in the number of services provided that will impact the Medicare side of the House. The concern I have about the 115% for those plans that are paying above Medicare allowables. So if you're not paying Medicare allowables and you're a Medicare Supplement plan, I would be concerned about physicians changing practice patterns. Connie had mentioned there's a change in office visit procedure codes. There's definitely confusion out there right now in terms of how they are going to get paid under those codes? You're going to see some of those things carry over to the non-Medicare side. So that's what I anticipate. In terms of measuring the impact, I truthfully have not attempted to do that at this point. I don't know what the impact will be. I would just encourage everyone who can to monitor what's going on with your own blocks of business, because I do have concerns in terms of what that total impact could be. And I think the illustration that I gave was the best that I'm able to do right now in terms of how a particular doctor is likely to be impacted in his particular payment by Medicare. Therefore, based on past history, we can translate that to mean there is certainly going to be a significant impact on the non-Medicare side.

**FROM THE FLOOR:** As part of the legislation that was passed in 1989, Congress included the provisions that established a new agency to start collecting information on effectiveness and outcomes and translating that clinical information into practice guidelines. With the concern that it knew there would possibly be incentives to increase utilization and increase intensity under the RBRVS system, they want to develop this kind of database so that the peer review organizations (PROs) and other organizations, the federal government that monitors utilization of quality, could try to tie this information back into the payment rates. So that's the long-term goal. In addition, the private sector, can use that information as well as part of their utilization management programs.

**MR. RICHARD E. ULLMAN:** My question is to all the panelist, but perhaps in particular to Woody McDonald. In a company that has a very large PPO with a large number of participating doctors under a favorable schedule of allowances (that's favorable from the employers point of view), it would seem like it's going to be quite a juggling act to manage that schedule in the next few years. I wonder how you would recommend that it be managed. If you don't increase cognitive services, then the general practitioners will say we're not keeping up with Medicare. On the other hand, the surgeons will say, "We're suffering from Medicare, and now if you cut us or if you don't increase us, we won't be able to cost shift to you." So how would one manage that PPO schedule to maintain the doctors and at the same time keep cost containment working?

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MR. MCDONALD: You raise a good point and I don't think there's any one answer for the universe. I think it's going to depend on each organization looking at their particular situation. We're working with a fairly large PPO right now. Those are exactly the questions that we're dealing with in terms of what is the appropriate conversion factor or factors for us to adopt in order to move to an RBRVS-type fee schedule? And it gets into the way their board of directors is made up and the dynamics of it. They're really the ones that are making the decisions in terms of what the appropriate conversion factors are. Do you want to end up budget neutral? Do you not want to end up budget neutral? And this PPO also has an exclusive provider organization (EPO) where there are physicians at risk and those kinds of things. How do you want to rate their performance this year versus next year and is increased utilization to be expected from the PCPs, etc? I think it's a very difficult issue.

One of the main points I want to make, though, is that general acceptance of the RBRVS approach does seem to exist. The conversion factor is receiving the most resistance. As soon as you talk about Medicare or RBRVS to a board of directors, of a PPO, for example, there's immediate resistance until you educate them on what you're really talking about. And you're not talking about paying at the same level as Medicare. But you know, again, there's going to be resistance and there are going to be a lot of those tough questions to be answered as time goes on. I don't have all the answers at this point. I'm sorry. But we are working with organizations and with each one, you know, we are trying to look at what's appropriate for their particular organization.

MR. ULLMAN: Just let me ask one further question. Is there any thought being given to a model of physician behavior? Something similar to a model that one would make of flexible benefits? How will the high-risk people behave and how will the low-risk people behave?

MR. MCDONALD: I haven't at this point. It sounds like a good suggestion to me.

MR. MILLER: I think the physician payment review commission is trying to do that, but I don't see anything on the horizon for at least a couple of years. I think they're going to be looking at how physicians try to behave under the system over the first year or so, then maybe try to pull some of that data together in terms of trying to do some modeling, but I think it's premature.

MR. MCDONALD: Let me just add I think one of the other reasons that you will see RBRVS more accepted and become of more interest to an organization like a PPO or to other managed care organizations is, they have all of these different fee schedules for which they're signing up. And they really don't list, except when they actually get a payment from an insurance company let's say, what kind of fee schedule they're under. If you're a physician group or an HMO or a PPO, CIGNA, for example, the conversion factor for this group, or our global conversion factor, is 62.3, and for Aetna it's 51.6. And there'll be some decisions made in terms of what organizations particular networks will sign up with in the future or discussions they'll have with some of those organizations. So in terms of where some of this is coming from and the impetus on the provider's side, I think that's an issue that all of us will be faced with in the future.

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MR. SRINIVASA RAMANUJAM: We're a rating organization for workmen's compensation in the nation serving 33 states. When the RBRVS was in the initial stage, they reported savings of \$1 billion, and then afterwards they thought of equity considerations, and they switched, raising the fees for the physicians. And the latest target is more or less like 0% saving, so as to be cost neutral. It's luring the physician to the rural areas and then giving them more money, etc. Consequently, I would assume that there's no real saving per se for the government because it is going to be more equity oriented for the services. That's a question you can answer at the end. I've got a couple of more. I think I'm really thankful to Mr. McDonald, for alluding to the fact that it's going to impinge on the workmen's compensation too, because Arkansas' Rule 30 which is going to be effective on April 1 or so, is saying to adopt the RBRVS to the workmen's compensation. Same thing Rhode Island is considering. So this is not going to just to stop at the health care insurance. It's going to be an influence on other types of insurance. The RBRVS seems to be big; somebody has already done lot of work so a lot of other states are thinking why don't we do that? In cost shifting, the workmen's compensation insurers are seriously worried because of the first dollar on unlimited medical. So there is a worry that maybe the workmen's compensation insurance may be hit more with the utilization services. By the way, the utilization increase written about in the literature I have come across is anecdotal that there will be an increase in utilization. In one of the readings, for every one person the utilization is over 50% more. Consequently, the reduction will be retarded. I'm asking Mr. McDonald, if he has any literature where it specifically says how much of the utilization will occur? Will there be overutilization by the physicians because of the decreased revenue, especially for the surgeons? Will they have that type of increased utilization? Is there any actual documented study as opposed to anecdotal comments saying that there will be more utilization?

MR. MCDONALD: Not that I've seen, other than what the government, has done. And they clearly are predicting utilization increases. I mean they've predicted it in 1992 and built that into their schedule. No, I don't have anything currently. We will be doing that.

MR. MILLER: Yes the Physician Payment Review Commission has done a study on that. And it's included in either the 1990 or 1991 annual report. The whole debate and discussion was about providing some kind of incentives or offsets on the utilization side or on the fee side to offset increased utilization. So the government has maneuvered and manipulated a lot of different numbers at this time to try to offset what they believe will be an increase in utilization. And it spurred a whole debate and controversy with the American Medical Association (AMA) and other medical groups.

MR. RAMANUJAM: Mr. Miller, are my associates right that the RBRVS is certainly not going to be any cost containment measure per se? It's going to try to keep it neutral.

MR. MILLER: It is a bunch of neutral systems. I think the goal of Congress, and the goal of the Physician Payment Review Commission, in a nutshell, is long-range cost containment. They may not see any quick fix. But I think they're looking at possibly a movement towards more primary care physicians as opposed to physicians going into specialties, and more of an emphasis on cognitive services rather than the high

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tech surgical procedures that have dominated the Medicare scenes, you know, thus far. So I think they're looking long range that the incentives under the system will move physicians into primary care and into services that are not high tech or expensive surgical procedures.

MR. JOSHUA JACOBS: I'd like to ask a question about this cost shifting. I notice Mr. McDonald put on the screen an example of the physician who had 50% or 40% Medicare business and how much he'd have to make up. But isn't it true that the physicians vary a lot among themselves as to what percentage of their business is Medicare? I take it that none of it's going to influence pediatricians or obstetricians because they don't have any Medicare patients. There's no cost shift there. Now among those that do have some Medicare patients, if somebody had 90% Medicare, he couldn't very well pick up what he loses on the 10%. And do you expect each physician to try and make up whatever he loses? And if not, won't there be some leveling because of competition among physicians? In other words, some that don't need to pick up as much as others won't have to raise their fees to the non-Medicare section as much. And won't that prevent those that are on the Medicare section from raising that much more on the private section? Are you absolutely convinced that doctors want to keep up their lifestyle? They want to have the same number of Cadillacs or something? Or aren't they really trying to get as much as they can in their environment no matter what? Are you convinced that they're going to make up whatever they lose on the Medicare RBRVS dollar for dollar?

MR. MCDONALD: Let's cover the second question first. No, I'm not convinced that they are going to try and make it up. I'm basing my comments primarily on what I've seen occur in the past and I guess what we probably all sense physicians do try to do. That is, they like to keep the level of lifestyle that they have and continue that into the future. I do know that physician groups have consultants that help them with things like this. There are reimbursement specialists out there. That's all they do is try to help physician groups with the coding so that they maximize the amount of income that they get. And if they're used to a certain revenue level this year, one of the big jobs those reimbursement specialists are going to have is to figure out how their income doesn't decrease in 1992 or 1993, particularly if they have a large Medicare population.

I do agree with you that there are going to be certain types of physicians that are not affected whatsoever by RBRVS. The only purpose of my illustration was to give people a feel for a particular doctor who does have a significant amount of Medicare patients, and what he's going to be faced with. He must either find other ways to make up for income that he is going to lose on the Medicare side or accept that he's going to have less income in the future than he has in the past. I wasn't suggesting that all doctors are going to be out to get the non-Medicare side as much as they can and maximize revenues on the Medicare side. However, I would say, and I think I mentioned this, that there will be audits. Medicare will be auditing what doctors are doing and expect them to comply. As part of those audits, they will be having to demonstrate that their procedures are customary. So, in other words, for their non-Medicare patients, they're going to need to demonstrate similar procedures as they do for Medicare. So if they increase their procedures on the Medicare population, they're probably going to increase what they're doing on cognitive procedures on the non-Medicare population also.