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**RESOURCE-BASED RELATIVE VALUE SCHEDULE (RBRVS)  
FROM A MEDICARE PERSPECTIVE**

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MR. WILLIAM J. LONDON: I am an actuary with the Health Care Financing Administration (HCFA), and we also have Richard Swift from Aetna, and Woody McDonald from Tillinghast. We're going to discuss the Medicare physician fee schedule and the Medicare volume performance standards, which are the expenditure targets for Medicare, and also the other part of physician payment reform or balance billing limits.

I'm going to start off discussing more from a Medicare perspective. I took the data in Table 1 right out of *The Federal Register Notice*. Table 1 is a page from *The Federal Register Notice* that shows for the procedure codes under Medicare how much is paid for each procedure. The biggest part of physician payment reform was putting physician services on a fee schedule. Medicare has already put just about everything else on a fee schedule under Part B. Lab services have been on a fee schedule. Durable medical equipment and supplies have been on fee schedules. In terms of physician fees, really the only big thing that's been on a fee schedule before besides some radiology services is anesthesiology. Physician payment reform, which was passed as part of the Omnibus Budget Reconciliation Act of 1989 and which went into effect last year, January 1, 1992, puts all other physician services on a fee schedule.

To calculate the fee schedule payment you first take the number of relative value units (RVUs) for each procedure. You have RVUs split out between work, practice expense, and malpractice. So these RVUs capture the physician's expenses for these three units. Basically the work is the physician's pretax profit. Then you multiply each of these three RVUs by a geographic adjustor to recognize the fact that the cost of practice is higher in certain areas, for instance New York, and high cost areas pay more than low cost areas. So each of these three get multiplied by a geographic adjustor and then we multiply it by a conversion factor which puts it into dollar units. Then the product of those components represent the fee schedule payment to the physician. Right now they're in transition. This fee schedule transitions payments from the usual, customary, and reasonable (UCR) charge system which Medicare uses and Blue Cross plans generally use. In 1996, claims get paid completely on the fully implemented fee schedule. But in the intervening years, from 1992-96, there's a weighted average that we use which grades in the UCR payments to the fee schedule payments.

Another thing that was standardized in terms of Medicare payments were the global fee periods. For instance, on Table 1 if you look at, say, 62294, it'll say, "Ninety days and global fee." This means that for 90 days after this procedure is done, the doctor cannot bill for other services or visits that are related to this procedure. So it's

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RECORD, VOLUME 19

a means to bundle services together and make one payment. In the far right column you can see the surgical/nonsurgical indicator. The conversion factor which we multiply times the RVUs and geographic adjustment to get the final payment is different for surgical services compared to nonsurgical services.

TABLE 1  
Relative Value Units and Related Information

HCPCS*	Mod. Status	Description	Work RVUs	Practice Expense RVUs	Mal-Practice RVUs	Total RVUs	Global Fee Period	Surgical/ Non-surgical Update
62194	A	Replace/irrigate catheter	2.88	1.92	0.29	5.09	010	N
62200	A	Establish brain cavity shunt	13.57	17.94	3.16	34.67	090	S
62201	A	Establish brain cavity shunt	12.39	9.00	1.76	23.15	090	S
62220	A	Establish brain cavity shunt	12.35	17.55	3.19	33.09	090	S
62223	A	Establish brain cavity shunt	13.12	17.00	3.09	33.21	090	S
62225	A	Replace/irrigate catheter	4.82	4.91	0.60	10.33	090	S
62230	A	Replace/revise brain shunt	9.95	10.07	1.86	21.88	090	S
62256	A	Remove brain cavity shunt	6.05	6.54	1.20	13.79	090	S
62258	A	Replace brain cavity shunt	13.93	15.14	2.61	31.68	090	S
62268	A	Drain spinal cord cyst	3.96	3.05	0.36	7.37	000	N
62269	A	Needle biopsy spinal cord	4.17	1.79	0.28	6.24	000	N
62270	A	Spinal fluid tap, diagnostic	1.15	0.73	0.06	1.94	000	N
62272	A	Drain spinal fluid	1.39	1.03	0.12	2.54	000	N
62273	A	Treat lumbar spine lesion	2.20	1.14	0.26	3.60	000	N
62274	A	Inject spinal anesthetic	1.82	0.76	0.17	2.75	000	N
62275	A	Inject spinal anesthetic	1.83	0.61	0.19	2.63	000	N
62276	A	Inject spinal anesthetic	2.09	1.26	0.23	3.58	000	N
62277	A	Inject spinal anesthetic	2.20	0.86	0.23	3.29	000	N
62278	A	Inject spinal anesthetic	1.55	1.00	0.26	2.81	000	N
62279	A	Inject spinal anesthetic	1.62	0.84	0.24	2.70	000	N
62280	A	Treat spinal cord lesion	2.64	0.73	0.14	3.51	010	N
62281	A	Treat spinal cord lesion	2.67	0.89	0.28	3.84	010	N
62282	A	Treat spinal canal lesion	2.34	1.74	0.41	4.49	010	N
62284	A	Injection for myelogram	1.58	2.29	0.34	4.21	000	S
62287	A	Percutaneous discectomy	4.24	15.93	2.72	22.79	090	S
62288	A	Injection into spinal canal	1.78	1.14	0.24	3.16	000	N
62289	A	Injection into spinal canal	1.68	1.03	0.29	3.06	000	N
62290	A	Inject for spine disk X-ray	3.67	1.90	0.24	5.81	000	N
62291	A	Injection into disk lesion	7.17	1.82	0.40	5.20	000	N
62292	A	Injection into disk lesion	7.17	13.12	2.18	22.47	090	S
62284	A	Injection into spinal artery	8.25	5.98	0.70	14.93	090	S
62298	A	Injection into spinal canal	2.25	1.06	0.13	3.44	000	N
63001	A	Removal of spinal lamina	14.85	19.63	3.51	37.99	090	S
63003	A	Removal of spinal lamina	14.98	18.37	3.31	36.66	090	S
63005	A	Removal of spinal lamina	13.86	18.32	3.17	35.35	090	S
63011	A	Removal of spinal lamina	11.38	10.23	1.91	23.52	090	S
63012	A	Removal of spinal lamina	14.56	18.51	3.22	36.29	090	S
63015	A	Removal of spinal lamina	16.99	23.75	4.29	45.03	090	S
63016	A	Removal of spinal lamina	17.85	22.90	4.21	44.96	090	S
63017	A	Removal of spinal lamina	16.24	23.42	4.09	43.75	090	S
63020	A	Neck spine disk surgery	12.84	18.96	3.46	35.26	090	S
63030	A	Low back disk surgery	12.40	16.28	2.88	31.56	090	S
63035	A	Added spinal disk surgery	3.23	4.36	0.78	8.37	000	S
63040	A	Neck spine disk surgery	17.99	24.30	4.41	46.70	090	S
63042	A	Low back disk surgery	17.69	25.13	4.49	47.31	090	S
63045	A	Removal of spinal lamina	15.68	24.77	4.49	44.94	090	S
63046	A	Removal of spinal lamina	14.96	25.52	4.69	45.17	090	S
63047	A	Removal of spinal lamina	13.07	26.49	4.59	44.15	090	S
63048	A	Removal of spinal lamina	3.34	5.95	1.05	10.34	ZZZ	S
63055	A	Decompress spinal cord	21.18	24.31	4.29	49.78	090	S
63056	A	Decompress spinal cord	19.57	22.37	3.85	45.79	090	S
63057	A	Decompress spinal cord	3.07	5.36	0.87	9.30	ZZZ	S
63064	A	Decompress spinal cord	23.80	24.42	4.19	52.41	090	S
63066	A	Decompress spinal cord	3.34	2.54	0.47	6.35	ZZZ	S
63075	A	Neck spine disk surgery	20.25	18.00	3.29	41.54	090	S
63076	A	Neck spine disk surgery	4.15	5.61	0.99	10.75	ZZZ	S
63077	A	Spine disk surgery, thorax	20.75	18.87	3.25	42.87	090	S
63078	A	Spine disk surgery, thorax	3.36	2.67	0.47	6.50	ZZZ	S
63081	A	Removal of vertebral body	22.62	26.90	4.61	54.13	090	S
63082	A	Removal of vertebral body	4.48	7.39	1.25	13.12	ZZZ	S
63085	A	Removal of vertebral body	25.68	28.05	4.80	58.53	090	S
63086	A	Removal of vertebral body	3.27	6.14	1.09	10.50	ZZZ	S
63087	A	Removal of vertebral body	28.24	28.94	4.96	62.14	090	S
63088	A	Removal of vertebral body	4.44	7.16	1.21	12.81	ZZZ	S
63090	A	Removal of vertebral body	26.84	29.93	5.04	61.81	090	S
63091	A	Removal of vertebral body	3.10	2.80	0.48	6.38	ZZZ	S

\* All numeric CPT HCPCS Copyright 1992 American Medical Association.  
Source: *Federal Register*, Vol. 57, No. 228, Wednesday, November 25, 1992, Rules and Regulations, pg. 560.

## RRVS FROM A MEDICARE PERSPECTIVE

The reason for that is because each year the increase in surgical and nonsurgical services is measured against the expenditure target, for each of those two types of services. To the extent that the actual services exceed or are less than the expenditure target the fees two years later are raised or lowered by that amount under the statute. That'll be the case unless Congress decides before the beginning of the year to do something different, so in 1990, physician services came in above the expenditure target. Therefore, in 1992, the update was lowered and the difference was 0.9%. That's how much they came in over their target and so in 1992 fees were lowered 0.9%. In 1991, surgery met its target. It came in lower and nonsurgical services came in higher than their target, and therefore in 1993, this year, the update was higher for surgery than nonsurgery.

Table 2 displays the geographic practice cost indices that I was referring to before, and you multiply each of these three components by their respective RVUs to account for the cost of practice being different in different areas. There's one for each of the localities in the country. There's over 200 Medicare localities all together, so this is just one page from that.

Table 3 displays codes subject to the outpatient limit. Once again, this is just a partial listing. If procedures can be and often are done in a doctor's office but the doctor decides to do it in the outpatient department of the hospital, we only pay half of the overhead part of the fee schedule payment since Medicare under a different part of Part B, Outpatient Payments, will be reimbursing the hospitals for their facility charges. So this is to eliminate some of the duplication of payment for overhead and it's to encourage physicians, if they can, to do these procedures in their office instead of the hospital.

Table 4 displays the facility-based procedures for which additional payment will be made for supplies if they're done in the doctor's office. This is sort of the opposite of the other situation. These are oftentimes done in the hospital, and therefore, when they are done in the hospital, Medicare will reimburse the hospital for their outpatient facility charges. But if the doctor does it in his office, he incurs charges for surgical trays and so forth, and so Medicare will make extra payments to recognize that.

Table 5 represents another part of the new Medicare rules for payment. Let's consider for example where it says, "Eye," second from the bottom, and over on the right it says, "Twenty percent postoperative." For a cataract surgery, a lot of times the ophthalmologist will do the surgery and the follow-up visits. But in some areas, the optometrist will do the followup. But Medicare doesn't want to make extra payments because of that. Cataract surgery has a 90-day global period. So if a different doctor, an optometrist, bills for visits after a cataract surgery, it's still in the 90 days, but it's a different doctor. So to avoid duplicate payments this table shows, if it's an eye procedure, of which cataract is the biggest example, 20% of the global fee will be paid to the optometrist if the physician and the ophthalmologist indicate on their bills that a different doctor, an optometrist, is going to do the follow-up visits.

Table 6 shows that, when we came out with the fee schedule, the idea that Congress had in mind was that procedures were being reimbursed too much, and evaluative and management (or cognitive services) were being reimbursed too little in

RECORD, VOLUME 19

comparison. So the expected outcome of all this was to shift money to family practice and general practice and primary care services and away from other specialties.

TABLE 2  
Geographic Practice Cost Indices by Medicare Carrier Locality

Carrier Number	Locality Number	Locality Name	Work	Practice Expense	Malpractice
660	1	Lexington & Louisville, KY	0.984	0.917	0.667
660	3	Rest of Kentucky	0.974	0.875	0.667
660	2	SM cities (city limits) KY	0.976	0.898	0.667
528	7	Alexandria, LA	0.985	0.889	0.808
528	3	Baton Rouge, LA	0.991	0.966	0.808
528	6	Lafayette, LA	0.982	0.928	0.808
528	4	Lake Charles, LA	0.975	0.907	0.808
528	5	Monroe, LA	0.979	0.880	0.808
528	1	New Orleans, LA	0.994	1.003	1.185
528	50	Rest of Louisiana	0.972	0.880	0.824
528	2	Shreveport, LA	1.003	0.940	0.808
21200	2	Central Maine	0.942	0.903	0.716
21200	1	Northern Maine	0.947	0.912	0.716
21200	3	Southern Maine	0.956	0.980	0.716
690	1	Baltimore/surr. countries, MD	1.027	1.040	0.927
690	3	South & east shore MD	1.011	1.010	0.820
690	2	Western Maryland	1.006	1.013	0.843
700	2	Mass. suburbs/rural (cities)	0.997	1.072	0.855
700	1	Massachusetts urban	1.002	1.131	0.855
710	1	Detroit, MI	1.059	1.091	1.736
710	2	Michigan, not Detroit	1.010	0.971	1.196
720	00	Minnesota (Blue Shield)	0.999	0.971	0.748
10240	00	Minnesota (Travelers)	0.999	0.971	0.748
10250	1	Rest of Mississippi	0.960	0.838	0.650
10250	2	Urban MS (city limits)	0.966	0.902	0.650
740	3	K.C. (Jackson County), MO	0.978	0.964	1.179
740	2	N. K.C. (Clay/Platte), MO	0.978	0.964	1.179
11260	3	Rest of MO	0.950	0.847	1.179
740	6	Rural northwest counties, MO	0.953	0.866	1.179
11260	2	SM. E. cities, MO	0.954	0.838	1.179
740	1	St. Joseph, MO	0.950	0.867	1.179
11260	1	St. Louis/LG. E. cities, MO	0.988	0.964	1.352
751	1	Montana	0.967	0.926	0.718
655	00	Nebraska	0.960	0.883	0.435
1290	3	Elko & Ely (cities), NV	0.984	1.026	1.144
1290	1	Las Vegas, et al (cities), NV	1.036	1.082	1.144
1290	2	Reno, et al (cities), NV	1.008	1.141	1.144
1290	99	Rest of Nevada	1.020	1.079	1.144
780	40	New Hampshire	0.962	1.011	0.602
860	2	Middle New Jersey	1.034	1.070	1.153
860	1	Northern New Jersey	1.040	1.131	1.153
860	3	Southern New Jersey	1.016	1.030	1.153
1360	5	New Mexico	0.981	0.925	0.767
801	1	Buffalo/surr. counties, NY	1.006	0.942	0.963
803	1	Manhattan, NY	1.059	1.255	1.647

Source: *Federal Register*, Vol. 56, No. 227, Monday, November 25, 1991, Rules and Regulations, pg. 597.

RBRVS FROM A MEDICARE PERSPECTIVE

TABLE 3  
 Procedure Codes Subject to the Outpatient Limit (Partial List)  
 1993 New Code

HCPCS*	Description
17010	Destruction skin lesion(s)
17100	Destruction of skin lesion
17101	Destruction of second lesion
17102	Destruction of added lesions
17104	Destruction of skin lesions
17105	Destruction of skin lesions
17110	Destruction of skin lesions
17200	Electrocautery of skin tags
17201	Electrocautery added lesions
17250	Chemical cautery of wound
17304	Chemosurgery of skin lesion
17305	2nd stage chemosurgery
17306	3rd stage chemosurgery
17307	Followup skin lesion therapy
17310	Extensive skin chemosurgery
17340	Cryotherapy of skin
17360	Skin peel therapy
19000	Drainage of breast lesion
20000	Incision of abscess
20500	Injection of sinus tract
20520	Removal of foreign body
20550	Injection treatment
20600	Drainage joint/bursa/cyst
20605	Drainage joint/bursa/cyst
20610	Inject/drain joint/bursa
20615	Treatment of bone cyst
21030	Removal of face bone lesion
24650	Treat radius fracture
25500	Treat fracture of radius
25600	Treat fracture radius/ulna
26010	Drainage of finger abscess
26600	Treat metacarpal fracture
26720	Treat finger fracture, each
28001	Drainage of bursa of foot
28010	Incision of toe tendon
28108	Removal of toe lesions
28124	Partial removal of toe

\* All numeric CPT HCPCS Copyright 1992 American Medical Association.

Source: *Federal Register*, Vol. 57, No. 228, Wednesday, November 25, 1992, Notices, pg. 561.

The fee schedule payments do not vary by specialty. They only vary by procedure code. But the impacts, of course, do vary by specialty to the extent that they do different numbers of primary care and procedures. So this table is giving an idea based on the 1991 mix of services that we used to set the original conversion factors, how much payments would have increased or decreased to different specialties. You can see that family practice and general practice make out the best, because they do a high percentage of visits, and visits by far had the biggest increases in payments under the fee schedule going from UCR to the RBRVS.

RECORD, VOLUME 19

TABLE 4

Facility-Based Procedures for Which Additional Amount for Supplies May Be Payable if Performed in a Physician's Office

HCPCS*	Description
19101	Biopsy of breast
19120	Removal of breast lesion
20200	Muscle biopsy
20205	Deep muscle biopsy
20220	Bone biopsy, trocar/needle
20225	Bone biopsy, trocar/needle
20240	Bone biopsy, excisional
25111	Remove wrist tendon lesion
28290	Correction of bunion
28292	Correction of bunion
28293	Correction of bunion
28294	Correction of bunion
28296	Correction of bunion
28297	Correction of bunion
28298	Correction of bunion
28299	Correction of bunion
32000	Drainage of chest
37609	Temporal artery procedure
38500	Biopsy/removal, lymph node(s)
43200	Esophagus endoscopy
43202	Esophagus endoscopy, biopsy
43220	Esophagus endoscopy, dilation
43226	Esophagus endoscopy, dilation
43234	Upper GI endoscopy, exam
43235	Upper GI endoscopy, diagnosis
43239	Upper GI endoscopy, biopsy
43245	Operative upper GI endoscopy
43247	Operative upper GI endoscopy
43251	Operative upper GI endoscopy
45378	Diagnostic colonoscopy
45379	Colonoscopy
45380	Colonoscopy and biopsy
45382	Colonoscopy, control bleeding
45383	Colonoscopy, lesion removal
45385	Colonoscopy, lesion removal
49080	Puncture, peritoneal cavity
57520	Biopsy of cervix
58120	Dilation and curettage
62270	Spinal fluid tap, diagnostic
85095	Bone marrow aspiration
85102	Bone marrow biopsy
96440	Chemotherapy, intracavitary
96445	Chemotherapy, intracavitary
96450	Chemotherapy, into CNS

\* All CPT codes and descriptors, Copyright 1991 American Medical Association  
 Source: *Federal Register*, Vol. 56, No. 227, Monday, November 25, 1991, Rules and Regulations, pg. 598.

## RRVS FROM A MEDICARE PERSPECTIVE

**TABLE 5**  
**Postoperative Percent of Total RVUs by Procedure Family**

Family	Procedure Codes	Postoperative Percentage
Integumentary	10000-19499	21
Musculoskeletal	20000-29909	21
Respiratory	30000-32999	13
Hemic and lymphatic	38100-38999	16
Mediastinum	39000-39599	7
Digestive	40490-49999	12
Urinary	50010-53899	17
Male genital	54000-55980	15
Female genital	56000-58999	15
Maternity	59000-59899	22
Endocrine	60000-60699	9
Nervous	61000-64999	14
Eye	65091-68899	20
Auditory	69000-69979	8

Source: *Federal Register*, Vol. 56, No. 227, Monday, November 25, 1991, Rules and Regulations, pg. 596.

In Table 7 we have simulations by state. Whereas with the specialties the impacts had to do more with what types of services physicians performed, on the impacts by state, the results had to do more with the geographic practice cost indices. The way that Medicare set the geographic practice cost indices, we hired consultants to look at different areas and see how much more, for instance, doctors in New York should be getting compared to Montana or Utah. They did studies on the cost of living, the cost of staff salaries, the cost of office rent and malpractice insurance. So once that was done, you can see that there were, especially in some states, big distributions in payment amounts by state because of these new geographic practice cost indices.

Now we get to the refinement process (Table 8). Basically Bill Hsiao, who's an actuary and an economist at Harvard took the lead in coming up with the relative value scale, and there were panels of physicians who were used in developing the relative values. There are over 8,000 codes, and so there was only so much the panels could do on the first time around. Each year there's a refinement process where we have medical societies that look at the codes and decide which ones should be increased or decreased. The first step is, though, the specialty societies themselves have to ask for certain codes to be increased or decreased. That's the first step. Then they submit their list of which of their codes they think are basically underpaid. We received very few requests for lowering payments. I think we received over 600 requests for increasing payments, and we received about 30 requests for decreasing payments. What happens, for example, you can see what the 1992 work RVUs were, and basically that's all they can comment on is work. We handle overhead and malpractice separately. The specialty societies can just comment on how much they think their services are worth in terms of how much resources they put into them. You can see a second column shows how much they requested and this is once again just a partial list. You can see how much they requested for their work values, and then you can see how much was actually given to them.

TABLE 6  
Physician Fee Schedule Impact by Specialty

Specialty	Percent Change in Allowed Charges for Fee Schedule Relative to CPR				Percent Increase in Total Budget Outlays Under Fee Schedule**	
	Year 1 (1992) change in:		Year 5 (1996) change in:		Avg. Annualized 1991-96	Cumulative 1991-96
	Payments Per Service	Payments*	Payments Per Service	Payments*		
All physician specialties	-3%	0%	-6%	0%	12%	74%
Family Practice	15	16	28	30	18	125
General Practice	17	18	27	29	17	124
Cardiology	-9	-3	-17	-8	10	59
Dermatology	-1	0	0	2	12	77
Internal Medicine	0	1	5	7	13	85
Gastroenterology	-10	-4	-18	-9	10	58
Nephrology	-6	-2	-9	-5	11	66
Neurology	-4	-2	-4	-2	11	71
Psychiatry	-2	-1	3	5	13	82
Pulmonary	-3	-1	-2	0	12	74
Urology	-6	-2	-8	-4	11	67
Radiology	-10	-4	-22	-11	9	55
Anesthesiology	-11	-4	-27	-14	8	50
Pathology	-10	-4	-20	-10	9	57
General Surgery	-8	-3	-13	-7	10	62
Neurosurgery	-10	-4	-18	-9	10	58
Ophthalmology	-11	-4	-21	-11	9	55
Orthopedic Surgery	-8	-3	-11	-5	10	64
Otolaryngology	2	3	3	5	13	83
Plastic Surgery	-8	-3	-13	-6	10	63
Thoracic Surgery	-14	-5	-27	-14	8	50
Clinics	-1	0	-1	1	12	75
Optometry	20	21	41	43	20	148
Chiropractic	12	13	26	28	17	122
Podiatry	6	7	14	16	15	102

\* Includes changes in payments per service as well as anticipated volume/intensity responses.

\*\* Incorporates changes in payment per service and anticipated volume/intensity responses to payment changes for that specialty. In addition, for each specialty, we have assumed the same volume/intensity baseline, growth in patient population, and payment updates.

Note: Assumes some physicians will submit charges below the fee schedule amounts.

Source: *Federal Register*, Vol. 56, No. 227, Monday, November 25, 1991, Rules and Regulations, pg. 596.

In the Office of the Actuary, we set the conversion factors. We also do the Medicare volume performance standard, and we also do the refinement process. So we just take all the refinements, and of course, they are on the whole, big increases in payments, but then we apply a budget neutrality adjustment factor, which lowers all payments across the board to make the whole thing budget neutral.

Table 9 just shows that once we do the refinements each year, we show the anticipated impacts on each specialty. Once again family practice and general practice made out on this one, because the visit codes were again increased under the refinement process.

Just briefly, there are three basic parts of physician payment reform. The first is the fee schedule. The second is the limiting charge. Doctors can only charge, starting in 1993 and beyond, 115%. If they don't participate, they can only charge 115% of the nonparticipating fee schedule. The nonparticipating fee schedule is 95% of the participating fee schedule. So the balance billing limit is 9.25%.



RBRVS FROM A MEDICARE PERSPECTIVE

TABLE 7  
Physician Fee Schedule Impact by State

State	Percent Change in Allowed Charges for Fee Schedule Relative to CPR				Percent Increase in Total Budget Outlays Under Fee Schedule**	
	Year 1 (1992) change in:		Year 5 (1996) change in:		Avg. Annualized 1991-96	Cumulative 1991-96
	Payments Per Service	Payments*	Payments Per Service	Payments*		
All States	-3%	0%	-6%	0%	12%	74%
Alabama	-4	-1	-6	-2	11	72
Alaska	-10	-2	-19	-6	11	65
Arizona	-6	-1	-13	-4	11	68
Arkansas	-4	-1	-7	-2	11	71
California	-5	-1	-14	-4	11	68
Colorado	2	4	9	11	14	94
Connecticut	-4	-1	-8	-2	11	71
Delaware	-2	0	-4	-1	12	73
District of Columbia	-3	-1	-7	-2	11	71
Florida	-8	-2	-17	-5	11	66
Georgia	-3	-1	-6	-2	11	72
Hawaii	-8	-2	-16	-5	11	67
Idaho	0	2	6	8	13	88
Illinois	-3	-1	-5	-1	12	73
Indiana	-2	0	-2	0	12	76
Iowa	0	2	9	11	14	94
Kansas	-3	-1	-4	-1	12	73
Kentucky	-1	1	0	2	12	78
Louisiana	-4	-1	-7	-2	11	71
Maine	-1	1	1	3	12	80
Maryland	-4	-1	-10	-3	11	70
Massachusetts	-4	-1	-3	-1	12	73
Michigan	0	2	4	6	13	85
Minnesota	0	2	7	9	14	91
Mississippi	1	3	12	14	15	99
Missouri	-1	1	1	3	12	80
Montana	-2	0	-2	0	12	75
Nebraska	-1	1	1	3	12	80
Nevada	-9	-2	-20	-6	10	64
New Hampshire	-1	1	6	8	14	88
New Jersey	-2	0	-4	-1	12	73
New Mexico	-3	-1	-9	-3	11	70
New York	-4	-1	-8	-2	11	71
North Carolina	-3	-1	-2	0	12	74
North Dakota	-4	-1	-5	-2	11	72
Ohio	-3	-1	-7	-2	11	72
Oklahoma	-2	0	-3	-1	12	74
Oregon	-2	0	-2	0	12	75
Pennsylvania	-2	0	-4	-1	12	73
Rhode Island	0	2	1	3	12	80
South Carolina	-2	0	4	6	13	85
South Dakota	-2	0	0	2	12	79
Tennessee	-3	-1	-2	0	12	75
Texas	-4	-1	-11	-3	11	69
Utah	-1	1	5	7	13	87
Vermont	-1	1	2	4	13	81
Virginia	-1	1	4	6	13	85
Washington	-1	1	-1	1	12	76
West Virginia	-3	-1	-7	-2	11	71
Wisconsin	-2	0	-1	1	12	77
Wyoming	1	3	8	10	14	92

Includes changes in payments per service as well as anticipated volume/intensity responses.

\*\* Incorporates changes in payment per service and anticipated volume/intensity responses to payment changes for that state. In addition, for each state, we have assumed the same volume/intensity baseline, growth in patient population, and payment updates.

Note: Assumes some physicians will submit charges below the fee schedule amounts.

Source: Federal Register, Vol. 56, No. 227, Monday, November 25, 1991, Rules and Regulations, pg. 596.

RECORD, VOLUME 19

TABLE 8  
Codes Included in the Refinement Process (Partial List)

HCPCS*	Description	1992 Work RVU	Requested Work RVU	1993 Work RVU**	Basis for Decision
21452	Treat lower jaw fracture	1.59	2.93	1.89	2
21465	Repair lower jaw fracture	6.61	12.74	11.40	2
21490	Repair dislocated jaw	5.33	12.74	11.35	2
21610	Partial removal of rib	6.30	11.46	8.75	3
21627	Sternal debridement	4.25	10.61	6.21	2
21630	Extensive sternum surgery	16.41	20.48	X	1
21633	Extensive sternum surgery	10.61	20.48	16.21	2
21740	Reconstruction of sternum	12.74		15.80	2
22210	Revision of neck spine	19.11	26.88	23.06	2
22612	Lumbar spine fusion	16.98		22.80	2
22802	Fusion of spine	22.58		32.08	2
22810	Fusion of spine	23.35	46.7	29.71	2
22842	Insert spine fixation device	15.19		X	1
23130	Partial removal, shoulderbone	7.48	13.09	X	1
23420	Repair of shoulder	13.28	19.00	X	1
25440	Repair/graft wrist bone	10.48	16.80	X	1
25810	Fusion/graft of wrist joint	10.32	18.00	X	1
26121	Release palm contracture	7.74	13.71	X	1
26123	Release palm contracture	9.11	16.75	X	1
26356	Repair finger/hand tendon	7.43	18.28	X	1
26536	Revise/implant finger joint	8.29	10.32	6.21	2
27134	Revise hip joint replacement	25.86	34.41	X	1
27487	Revise knee joint replace	22.86		X	1
27610	Explore/treat ankle joint	7.66	8.50	X	1
27612	Exploration of ankle joint	6.56	8.11	X	1
27650	Repair Achilles tendon	7.61	9.56	9.29	2
27652	Repair/graft Achilles tendon	8.19		9.86	3
27654	Repair of Achilles tendon	9.83	10.20	X	1
27675	Repair lower leg tendons	7.15	9.00	X	1
27676	Repair lower leg tendons	8.29	9.50	X	1
27695	Repair of ankle ligament	6.42	8.40	X	1
27696	Repair of ankle ligaments	8.14	8.80	X	1
27698	Repair of ankle ligament	7.76	10.20	9.09	2
27700	Revision of ankle joint	9.14	10.00	X	1
27704	Removal of ankle implant	7.59	9.76	X	1
27870	Fusion of ankle joint	10.99	13.50	X	1
28113	Part removal of metatarsal	4.31	4.46	X	1
28120	Part removal of ankle/heel	6.92	8.92	4.92	2
28285	Repair of hammertoe	3.77	4.90	4.52	2
28296	Correction of bunion	9.17	9.90	X	1
28299	Correction of bunion	8.91	10.50	X	1
28415	Repair of heel fracture	9.89	13.32	13.61	2
28420	Repair/graft heel fracture	11.92		16.19	3
28705	Fusion of foot bones	11.27	15.25	14.58	2
28715	Fusion of foot bones	10.36	13.75	12.48	2
28725	Fusion of foot bones	9.14	12.00	11.12	2
28730	Fusion of foot bones	8.22	12.00	10.15	2

\* All numeric CPT HCPCS Copyright 1992 American Medical Association.

\*\* Reflects downward adjustment of 2.8% for budget neutrality.

Source: *Federal Register*, Vol. 57, No. 228, Wednesday, November 25, 1991, Notices, pg. 559.

## RBRVS FROM A MEDICARE PERSPECTIVE

It's 115% of 95%, so physicians can get an extra 9.25% if they don't participate and they choose to balance bill. Of course, if they don't participate, they don't have to balance bill. They can accept assignment, but that's the maximum that they can get.

Previous to physician payment reform, there was something called a maximum allowable charge (MAAC) limit, which was a balance billing limit, but the limiting charge under physician payment reform brought it way down. Physician payment reform brought the limiting charge in 1991 down to 140% of the nonparticipating prevailing charge for evaluative and management services and 125% for all others. In 1992 the limiting charge was 120%, and in 1993 and beyond, it's 115%. Then the final part of physician payment reform is the Medicare volume performance standard or the expenditure target.

**TABLE 9**  
**Physician Fee Schedule Refinement Impact by Specialty**

Specialty	Percent Change in Allowed Charges (Payments per Service)*	
	Year 1 (1993)**	Year 4 (1996)***
All physician specialties	0.0%	0.0%
Family practice	0.2	0.7
General practice	0.2	0.6
Cardiology	0.5	1.3
Dermatology	0.5	1.5
Internal medicine	0.2	0.7
Gastroenterology	-0.3	-0.7
Nephrology	0.5	1.4
Neurology	1.3	2.6
Psychiatry	1.6	2.4
Pulmonary	0.0	0.0
Urology	-0.8	-1.8
Radiology	-1.0	-2.6
Anesthesiology	-1.0	-2.6
Pathology	1.6	3.7
General surgery	0.2	0.5
Neurosurgery	-0.5	-1.0
Ophthalmology	-0.2	-0.7
Orthopedic surgery	-1.1	-2.1
Otolaryngology	-0.3	-0.6
Plastic surgery	-0.3	-0.7
Thoracic surgery	0.3	0.7
Clinics	0.2	0.5
Optometry	-0.7	-1.4
Chiropractic	4.9	9.9
Podiatry	-0.4	-0.9
All Other	0.4	0.8

\* Although behavioral responses are anticipated (changes in volume and intensity in response to changes in payments per service), the overall effect of these changes on physician payments is expected to be negligible. Thus, behavioral responses by specialty are not reflected in the percentages displayed here.

\*\* Transition asymmetry effect was negligible.

\*\*\* Fee schedule fully effective.

Source: *Federal Register*, Vol. 57, No. 228, Wednesday, November 25, 1992, Notices, pg. 559.

As I was discussing before there's a two-year delay, so right now for instance we're looking at 1992 expenditures to see to what extent we would increase or decrease the 1994 update. Right now it looks like it's going to be an increase, because as is generally known the 1992 expenditures under Medicare, under the first year of physician payment reform, have an unusually low increase compared to past trends. We feel a lot of that may have to do with the standardization of payment rules, for instance, the 90-day global periods for all major procedures, 10-day global periods for minor procedures, and outpatient limits, and just in general standardizations. In the past, all the contractors basically did their own thing. There was no standardization of payment rules, and we think that had a lot to do with it.

Right now I'm going to introduce Richard Swift to talk about his experience at Aetna. Richard's been at Aetna for seven years. He's been involved with managed-care operations and provider reimbursement. Prior to that he was with the Blues for six years developing managed-care plans and provider reimbursement arrangements.

MR. RICHARD E. SWIFT: I'm going to present a little bit about RBRVS and its implications. I think the key here is for people to recognize that there is a fundamental difference between a reasonable and customary (R&C) arrangement that most insurers – Blue Cross plans, Medicare – previously used versus an RBRVS or a fee schedule arrangement. I think there's some opportunities for payers to switch to an RBRVS or a fee schedule approach. RBRVS is one of a number of options, but there are certainly some risks as well that need to be considered.

RBRVS – what does it really mean? If you talk to some physicians and some people, they perceive it as Real Bad Reimbursement Very Soon. When you look at the way the medical environment works now and physician services, physicians work outside of what are typically the laws of economics. People don't comparison shop for physician services. They don't find out what Dr. Jones and Dr. Smith charge and factor the perceived quality or the outcome of the care with the cost of it. They look at who the doctor is, and oftentimes they even equate the highest cost with the highest quality. That may or may not be true and probably not germane to this, but essentially the physicians have no real parameters with which to set their fees. They set them in a vacuum, and so they use a lot of intuitive steps in charging for what they perceive the complexity of the service is. It may not be truly how complex it is to the average practitioner, but how complex it is to them: how long it takes them, what their overhead is, what they think Dr. Smith down the street is charging for it, and last and probably the most important what they think they're going to get paid for it. So when they factor those together, you end up with a situation where physician fees truly vary all over the ballpark in a single marketplace. For example, consider one particular medical service provided in one geographic part of the country. I've rounded an actual example a little bit to make it flow a little better, but essentially the charges range from \$5 to roughly \$325 for the same service. Yes, you can say, "Gee, there are some coding errors in there. A doctor really didn't do that." Impossible as it may be, an Aetna claim processor may have actually coded a wrong number and it may not be that service. So if you threw out a few at the low and the high end, you can still look comfortably at a range of \$25-300 for the same service. Are the physicians doing the same thing for that service? Maybe not all of them, but a whole lot of them probably are. The AMA has defined medical services by 7,500-8,000 procedure codes, and those are what the physicians are supposed to be using.

## RBRVS FROM A MEDICARE PERSPECTIVE

So this is a single procedure code. So truly they're all over the ballpark. Like I said, a large part of that wide range is because the cost is what the physicians think the service is worth, and they don't really have any direction as to what the going rate is.

In terms of how payment options are developed, some payers are paying bill charges. There are fixed fees. People who've been in the business for a long time may recall an old flat fee schedule where every surgery was paid at \$300 for a certain class of surgeries and another class of surgeries was paid at \$500. There's R&C, which most everyone uses and last, but not least, the fee schedule approaches. R&C goes by a number of names: usual, customary, and reasonable; reasonable and customary; customary prevailing. Different payers use something different, but essentially they're all the same thing. The way they're really calculated is charges are arrayed from lowest to highest. There's an allowance, a target percentile, that's set. It could be the 80th. It could be the 90th. It could be the 95th. Whatever it happens to be, that becomes the target that that payer uses in setting fees. Then they go through typically by geographic area and set them. Many people may get them from the Health Insurance Association of America (HIAA), essentially the same thing, where they use an expense area and there may be 230-280, something like that, throughout the country, each one with its own fee. Then the key is that any claim that comes in above that amount is reduced back to that limit. They're updated on a fairly regular basis, sometimes annually, sometimes every six months. Again, it depends on the payer, but the bottom line is they're highly inflationary. They were designed years ago when the key was an employee benefit. Let's minimize how much that employee's going to have to pay out of pocket so let's try and make it high enough that we don't have lots of complaints from our employees, but at the same time we can have it so we eliminate those real egregious, high charges that just seem unreasonable. If, in fact, the physician did something that warranted that fee, then he or she should come back and explain it.

So really that's where the R&C came from. Like I said, it's inherently inflationary. Every six months, every 12 months, whenever the period is, those calculations get re-run, the allowances go up, and there isn't much that a payer can do about it other than to go back through and redefine how they're setting it. The other thing is that physicians are no dopes. They know how the system works. All they do is they decide how much they want to get paid next year – it requires a little bit of planning on their part – so they jack their fee up this year and it gets factored into the calculation for next year. It's not very difficult to do and the flipside is that, when we go to a physician and they bill over the limit and then they write off the balance, we think they're heroes. We think they've done a wonderful job because that insurance company out there isn't paying enough. So all of a sudden we think the doctor is in the right boat there.

By contrast, fee schedules are designed to set a value for a service, and that's a real key difference, the value for the service. It's no longer automatically what the physician charges for the service, but independently what that service is worth. Changes in technology reduce the value for services. Physicians don't lower their charges when new equipment comes out that makes their job easier to do. The other side of it is it makes it easier for the payer to determine how much it wants to pay for that service.

In terms of how the value is set, there are a lot of mechanisms. Dartboard is certainly one of them. There are numerous outside vendors that set value, analyzing claim studies. Hsiao and the folks at Harvard who did it for Medicare did many samples and surveys and focus groups with physicians as to what was involved in providing a particular service. Then as they did that for each specialty, they integrated those together so that a unit for one service was comparable to a unit for another.

But the bottom line is determination of the payment has shifted from the provider to the payer. Physicians can jack up their fees all they want, but if the unit value stays the same and if the conversion factor stays the same or the conversion factor is negotiated or set by the payer, then the physicians are not getting paid more. In fact, setting a fee schedule with a conversion factor gives a payer or an employer the opportunity to actually put the physician payment on the table as an employee benefit item. A conversion factor can be negotiated just like a wage increase. An employer can offer an increase in the conversion factor equivalent to the CPI and one rate for the wage increase, or it just goes back and forth and that can be a collective bargaining alternative. So there are certainly some opportunities there, as well, for that to be used.

In terms of the impact on physicians, we can get into some Aetna information and what we found. Clearly the danger from a fee schedule is balance billing. Some may or may not consider that a danger, but there's clearly an impact that may occur and probably will occur if a fee schedule is set, particularly if it's an RBRVS where there is a definitive tilt from surgical and specialty services to office visit and cognitive or nonprocedural services. The allowances, the payments for the surgical specialty services, which also typically happen to be the high cost ones, will start to decrease dramatically at the expense of the medical services, and the employees will see some balance billing. There's a lot of people who don't necessarily think that's bad. In fact, we have some customers who have said to us, "I don't care about the balance billing. That's all I can afford, and it gives my employees some opportunity to be a little cost conscious. They'll look and think a little bit about how much those services are going to cost, and we hope make some economic decisions on what provider they decide to get their care from. If we know that there are some providers who will accept that fee schedule amount, then great. We can de facto shift our employees to those physicians. Physicians will be happier, and we can be saving cost as well."

In terms of the impact this will have on Aetna data, we've looked at RBRVS for a number of sites around the country and compared that to Aetna's own claim data (Tables 10-13). We looked at the average charge and Aetna's R&C charge for each of those markets. In aggregate for site A, the first site, our average charge is more than double what Medicare's fee schedule is in the marketplace (Table 10). If you look at the R&C amount, again, this is our fee maximum not our average payment, we're talking 2.7 times what Medicare is. So essentially if you were to convert this back to Medicare's \$31 conversion factor in site A, our R&C would have a conversion factor somewhere around \$80-85. As you can see by these four sites that's not all that typical. In site B (Table 11) our average charge is 2.2 times above. R&C is 2.8 times above. The best site out of the lot is site D, where our average charge is only 60% above Medicare's fee maximum and our R&C is only a little more than

RBRVS FROM A MEDICARE PERSPECTIVE

double. So in that case Aetna's conversion factor in that market to again equate to where our R&C is would be somewhere in the neighborhood of \$65.

TABLE 10  
Site A

	Radiology	Pathology	Medicine	Surgery	Composite CF
Ratio of R&C to Medicare Equivalent CF	2.43	3.77	1.96	3.2	2.68
Impact of RBRVS to R&C	75.69	117.00	61.00	101.00	84.42
	0.1	-0.39	0.28	-0.2	

TABLE 11  
Site B

	Radiology	Pathology	Medicine	Surgery	Composite CF
Ratio of R&C to Medicare Equivalent CF	3.06	3.60	2.06	3.28	2.81
Impact of RBRVS to R&C	95.04	111.90	64.00	104.00	88.24
	-0.08	-0.27	0.27	-0.18	

TABLE 12  
Site C

	Radiology	Pathology	Medicine	Surgery	Composite CF
Ratio of R&C to Medicare Equivalent CF	2.30	2.90	2.01	2.34	2.25
Impact of RBRVS to R&C	71.60	90.30	62.38	74.40	70.79
	-0.01	-0.28	0.12	-0.05	

TABLE 13  
Site D

	Radiology	Pathology	Medicine	Surgery	Composite CF
Ratio of R&C to Medicare Equivalent CF	2.24	2.80	1.72	2.30	2.11
Impact of RBRVS to R&C	70.00	87.46	53.00	73.00	66.39
	-0.05	-0.32	0.20	-0.10	

The differences here are attributable to how Aetna's charge patterns, the charges that we're seeing come in the door, how those compare or maybe converge with the geographic factors that HCFA has come up with for their areas. For example, for whatever reason they've decided relatively speaking that site D is more high cost than

## RECORD, VOLUME 19

maybe our charges are showing, and so as a result in site D the charges don't look nearly as bad as they do in some of the other sites.

FROM THE FLOOR: Is this just a random sample from your base or is it just range from top to low or why these four sites?

MR. SWIFT: These happen to be four sites where we had customers located who expressed an interest, so it's somewhat of a random sample. We didn't specifically pick them, but this isn't a high or low. There could be some substantially higher or lower. They seem to be somewhat close to one another. Like I say, they're not way out of the mark from one another, so my expectation is that any other site would probably be reasonably similar to this. Although I don't know which site is which, they happen to vary based on geographic location around the country, size of the market, what you might perceive as the cost pattern in those markets – some that were perceived as high cost, some that were perceived as lower cost.

Looking specifically at one site, this is site D. If you break it out by specialty, and again this is the R&C piece of it only, you can see that again in aggregate we're at 2.11 times that Medicare conversion factor. If you look at it as it breaks down by the major physician components, it tends to be much higher for radiology, pathology, and surgery, and much lower for medicine. That's a generally stable pattern that happens in virtually every site we've looked at. So if you could set up conversion factors by service, what you'd have is a \$70 conversion factor for radiology, \$87 for pathology, and \$73 for surgery. Again, those all compare with Medicare's \$31 and change conversion factor. I skipped medicine deliberately. Medicine's \$53. When you average those together, you're at \$66 and change. If you were to apply that \$66 conversion factor to the entire site, on average you'd start shifting your cost between those specialty areas. On average your medicine services would go up by 20%. That's your office visits, EKGs, cardiac catheterization, physical therapy services, and mental health services. Those are the things that tend to be in your office in your medicine range. To offset those increases, all your surgeries go down 10%. Pathology, although admittedly that's a small sample, goes down 30%. Radiology goes down 5%. The percents vary site by site, but generally the results are the same. Medicine goes up, everything else goes down. If you look at it based on an average charge rather than an R&C, again, the average unit cost for each service, for each claim in that market, those all tend to still be substantially similar. Medicine is up 22%. Surgery, which is the other big one, is down 16%. Again, we're still talking here about \$50 – I think it was 1.5 or 1.6 times the Medicare conversion factor, so in this case \$50.

Let me drill down that example one step further and have you look at specific services. These happen to be specific common services, again in site D, for different aspects. By the way, these all assume the full transition of the Medicare fee schedule. We haven't even tried to parallel that transition over the five-year period. For this X-ray service, Medicare's going to pay \$20. Aetna's average charge for that service is \$39, and if we were to go to an RBRVS schedule, it would come down to \$31 as the average payment for that service. For the medicine service, they tend to go up. Medicare's at \$31, Aetna's at \$35, and when we finish shifting out, Aetna will pay \$49. Skip down to some of these surgeries down here. Medicare's at \$2,100 and change. Aetna's at \$3,700. When you shift to RBRVS, all of a sudden the payment



## RBRVS FROM A MEDICARE PERSPECTIVE

drops or that budget neutral now would shift to \$3,300, a \$400 reduction which because, obviously, these tend to be high cost services, those tend to be for the member potentially large dollar balance billings that they're going to be faced with, and so that's the real downside that I want to impress on you if you wanted to go with something like this. Again, it depends on the fee schedule you were to go with, but the balance billing tends to be indicative of the RBRVS because of Medicare's particular slant to nonprocedural services or cognitive services as Medicare refers to them.

MR. LONDON: Woodrow McDonald is a principal of Tillinghast, and he's manager of the Kansas City office. He's also the Tillinghast Health national marketing coordinator for hospital clients. Prior to joining Tillinghast in 1986, Woody was with Businessmen's Assurance Company for 15 years as vice president of group marketing, and he was responsible for group product development. Woody serves a diversity of clients including hospitals, commercial insurers, reinsurers, Blue Cross, HMOs, and third-party administrators.

MR. WOODROW H. MCDONALD: My presentation will cover a number of topics. I'll discuss Medicare volume performance standards and Medicare payments 1991, 1992, 1996. I present an example to give you a feel for some of the payments that the doctors are getting paid. How are physicians going to respond to the effect on their income? What impact is all of this having on hospitals? What impact are the fee schedules having on the non-Medicare payers? We will talk very briefly about national health care and RBRVS. I'd be interested in anybody else's perspective on this currently. Basically we've been getting updates almost daily on what's going on in Washington and, believe me, my perspective changes in terms of whether I think national health care is coming or not coming. Then I'll discuss a few of the current private sector uses of fee schedule, either that I'm aware of or that we've been helping clients with just to give you a feel of some of the ways you might want to consider with a particular organization and what your situation is. How can we at least start thinking about RBRVS given that it likely is going to be here for a long time?

The components of the fee schedule comprise the relative value scale, the geographic adjustor, and the monetary conversion factor. As already mentioned in 1992 there was one conversion factor, 31.001. In 1993 you have one for surgery, 31.962, and one for nonsurgery, 31.249. All of a sudden we've gone from one conversion factor to two. I think there is discussion going on. I think PTRC, for example, would like to go back to one, but it's a system that's complicated and getting a little more complicated by having the two conversion factors for 1993. But basically that's all I wanted to say on that one.

The Medicare volume and performance standards are where you have the increase in the medical care costs. They aren't going to do an adjustment. This is government's attempt to reflect overutilization and that sort of thing, but there are some limits in terms of how much the standards can impact the increase in medical costs.

The decrease in 1993 was the most the standards could actually decrease the amounts that were going to be increased. In other words, the increase in medical cost could only be offset by a maximum 2% decrease because of the overutilization,

RECORD, VOLUME 19

let's say. But at least it is something that is recognized, and there is an attempt under RBRVS to look at overutilization.

Table 14 shows payments for cognitive services. Table 15 shows payments for procedural services. Just for a particular area of the country, what is going to be paid? What was paid in 1991? What would be paid in 1992, 1993, and then 1996? There is an increase consistent with what Bill's already said and Richard has said. On the cognitive services there is an increase. The only one I'd point out here is critical care first hour. Bill had mentioned there are some increases to the ENAM codes. Generally it seems to be the middle and upper level codes that were increased in 1993. In 1992 the payment was at \$119. That's been increased by another \$12 for 1993, and it goes up to \$163 in 1996 and I believe that number a year ago, before the changes made effective for 1993, the 1996 number, I think, was \$124, at least for this area. So you can see over the transition period, Medicare has in fact increased what they're going to pay on some of those middle and upper level visit codes.

TABLE 14  
Average Medicare Payments for Certain Medical Services

Cognitive Services	1991	1992	1993	1996
Office Visit - Established Patient	\$ 21	\$ 22	\$ 22	\$ 22
Office Visit - Pelvic Exam	40	46	47	47
Initial Inpatient Consultation	87	100	104	113
Second Opinion, Comprehensive	74	85	88	93
Critical Care, First Hour	104	119	131	163

TABLE 15  
Average Medicare Payments for Certain Medical Services

Procedural Services	1991	1992	1993	1996
Insert Pacemaker AV Sequential	\$1,068	\$ 930	\$ 880	\$ 643
Double Coronary Artery Bypass	2,985	2,569	2,487	2,004
Total Hip Replacement	2,399	2,030	2,038	1,874
Biopsy of Liver, Wedge	438	370	372	345
Repair Inguinal Hernia	474	407	408	375

On the procedural services, again here you can see what's already been talked about. You look at 1991, 1992, 1993, and 1996. If you look at that double coronary artery bypass, for example, we're talking about a payment of \$2,985 in 1991. It's going to reduce to \$2,004 by 1996. The only other point that I would make in looking at Table 15 is that, if you'll notice 1991-92, you have a \$400 drop and then another \$500 by the time we get to 1996. The first year there was a significant drop just in the first year under RBRVS in terms of particularly some of these surgical procedures, specialist procedures. They didn't wait and phase this thing in gradually over five years. They really did sock it to some of the procedures that are being performed, at least on the specialist side. Just like on the cognitive side, some of those increases that have occurred have occurred fairly quickly. That's different than what the government did under diagnostic related groups (DRGs) with the hospitals where it

## RBRVS FROM A MEDICARE PERSPECTIVE

really was more of a five-year phase-in. So in terms of what the doctors are seeing and the impacts they're experiencing, they're seeing the effects a lot sooner than I think some of the hospitals saw.

Table 16 shows the effect of RBRVS on physicians' income. Again, this table happens to be our analysis on a client situation we had, an HMO, where we looked at some of its physician utilization and costs and what would the physicians have been paid in 1992 versus 1996 and the percent change from 1991. What we did is to look at that compared to what the government was saying the relationship would be in 1992 versus 1996 and we came out fairly close. HCFA's prediction on cardiothoracic surgery for example was minus 14 in 1992 and ours is minus 13, and ours was minus 29 in 1996 versus minus 27 for HCFA.

TABLE 16  
RBRVS Effect on Physicians' Income  
Percent Change from 1991 Per Procedure

Service	1992	1996
Cardiothoracic Surgery	-13%	-29%
Internal Medicine	12	32
Cardiology	-8	-15
General Surgery	-8	-20
Family Practice	9	24

Where we had a difference was on internal medicine where you can see a plus 12% and plus 32% and HCFA's prediction was a zero and a plus 5%. We looked more closely on this one, and it happened to be an internal medicine doctor that was performing procedures more like a primary-care physician than even a primary-care physician was expected to perform under the government's assumption, so that's why he was getting paid so much more. In other words, he had a lot more cognitive services than normally would be seen by an internal medicine doctor. So for a particular individual physician, they're certainly going to be impacted uniquely, depending on what their procedures are. So in terms of where they're headed and how they are going to be impacted, you will see doctors changing their patterns of practice, certainly, as they realize how they get reimbursed better under certain ways of performing their practice. In other words, they will increase the cognitive services, if they can, versus the procedural services.

How will the doctors respond? Obviously increasing the utilization of services is one possibility. Certainly some doctors will do that. Adding more patients if they're lucky and can find more patients, is certainly another possibility. They may do more cognitive services, as I just mentioned. You may see some of them doing that. They may reduce the number of Medicare patients. If they can afford to do that, certainly you may see that. A more likely scenario would be that, if you have a group practice, let's say, that they would at least try to put a limit on the number of Medicare patients that they are going to continue to see. If they're already at their comfort level, they may not add many more Medicare patients. I believe there have been some studies on this by the government looking at what kind of changes have been going on, and I don't think that there's been anything come out that would

indicate that the government any way is seeing a drastic reduction in the seeing of patients by physicians. In other words, there doesn't seem to be a drastic drop by particular physicians who had Medicare patients, over 1992 anyway. So it probably won't be an immediate thing, but just in terms of something that you may see some of them do. There may, at least, be a limit on the number of patients.

Changing clinical conclusions would be a borderline situation. We hope there won't be too much of this going on, but it would be where physicians would get paid more if they actually went and did certain more complicated procedures or performed the surgery, where in the past they might not have performed that surgery.

Physicians may charge more to non-Medicare patients. We looked at a cardiothoracic surgeon just to get a feel for his particular situation; he happened to have a substantial amount of Medicare business (Table 17). Sixty percent of it was Medicare. In 1991 he had \$230,000 in income from Medicare. What would he be paid in 1992? He would have had \$200,000. In terms of his Medicare and non-Medicare total, it was \$383,000 versus \$410,000 in 1992, if in fact he wanted to have a reasonable increase in income of, say, 7%. That's what this is illustrating. His income would have had to have gone on the non-Medicare side from \$153,000 to \$210,000, that's a 37% increase in income on the non-Medicare side. So however he's going to get there, that's what that particular physician was faced with in 1992 given his Medicare population if he were to perform exactly the same procedures in 1992 that he had performed in 1991. So if you had a physician with the same procedures and you had 50% Medicare business, you see that he'd need a 27% increase on the non-Medicare side versus 40% Medicare business, he would have needed a 20% increase in his non-Medicare income. So in terms of being concerned about what's going to happen, certainly there are concerns. Depending on whether you're a primary-care physician or whether you're a specialist, you're obviously going to do things differently, and the primary-care physician is going to be needing to worry less about his non-Medicare income than the specialist.

TABLE 17  
Cardiothoracic Surgeon

(60% Medicare)			
Source of Income	1991	1992	Percent 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%			

There will be more participating physicians because the most a nonparticipating physician is going to get is a 9.25% increase based on the balance billing limits that are in place now. The government is working hard to make sure that the nonparticipating physicians have a much more difficult time in billing their patients beyond the balance billing limit in terms of notifying patients how much they should be billed by

## RRVS FROM A MEDICARE PERSPECTIVE

the doctor. So I think you're going to see, perhaps, more physicians falling into the participating category.

Will there be more inpatient procedures? There's really encouragement to go outpatient, but there are some anomalies for example, detached retina repair. If a physician were to perform that on an inpatient basis under the 1992 schedule, he would have been paid \$721 for that procedure whereas if he had done it on an outpatient basis, he would have been paid \$488. So there are certain procedures where the doctor would be paid more on an inpatient than on an outpatient basis. I just want to point that out to you as one anomaly. Obviously the assumption there is that, if it's done inpatient, it's a more complicated procedure than if it's done outpatient. At least I assume that's what part of the reasoning was in coming up with that.

Will there be more primary-care physicians? I think the reason we say that is, it's just obvious that's going to happen based on the reimbursement system in place and the fact is there just are too few primary care physicians in this country. They are now only 35% of the total doctors in the U.S., whereas in Canada 50% of total doctors are primary care physicians. In the United Kingdom it's 70%. There just frankly are too many specialists, and there just are not enough primary care physicians. The government is trying to incent doctors to move into the rural areas. They have some ways that they've built into the system to encourage doctors by paying them more and narrowing the gap in the geographic indices that they're using from the rural to the urban. That gap is narrowing based on the Geographic Practice Cost Indices (GPCIs) that they're now using under the RBRVS system.

There will be improved productivity. I think you're going to find physicians become much more bottom-line oriented. They'll be downloading more to nurse practitioners, and they're going to be more concerned about their bottom lines, especially those who have a majority or close to a majority of their patients on the Medicare side. They just are not going to have any choice. You're going to see strange phenomena like specialists moving into managed care. You're going to find relationships developing between specialists and primary care physicians because the primary care physician, as we move towards national health care, is clearly going to be directing patients to specialists more and more. There are going to be a lot of things happening in the future, and some of it will be government forced. Some of it'll be just the payment mechanism and the payments that are made by the government, but my prediction is you are going to be seeing a lot of new things happening and the doctors having to think differently. They will certainly cut staff and maybe do that as a last resort, but there will be a lot of things going on in the doctors' offices.

As far as the impact on a hospital, there will be a short-term increase in the number of surgeries. We are already seeing some of that just in terms of a specialist needing to perform more in order to have more income, that kind of human-nature-type of thing. But long term that's probably not going to be the result as there are fewer and fewer specialists. But on the other hand, that one's hard to predict right now. But anyway, you can at least expect an increase in the short term. Long term there may well be a reduction in the number of surgeries done in the hospital as the reimbursement mechanism encourages more to be done outpatient and as there are fewer specialists. So there are going to be certain challenges that a hospital is going to be faced with as we go on here, and there are fewer and fewer procedures that are

actually going to be done in the hospital. There are going to be things like imaging centers developed by physician groups that were formerly referred to hospitals. Lancaster General is a hospital in Pennsylvania where the largest physician group in Lancaster is actually developing its own imaging center where all of that work had been referred to the hospital in the past. I think some hospitals believe that the overhead costs that go with physicians picking up testing and those kinds of things, they are going to find that it becomes too costly. But I think as physicians become more and more bottom-line oriented, there are going to be those that will be in that business if they haven't been in the past. The bottom line is I think you're going to see less and less of it done in certain hospitals, and therefore a concern for those hospitals in terms of "How do we make up for the loss of some of that income?"

Staff registered nurses will be doing more follow-up. I think that goes along with just the downloading, and the physicians are not going to be able to afford to do all of that themselves. The greater competition for surgeons – here I think you're going to see at least the key surgeons, specialists, the hospitals trying to keep them happy. We're all hearing about PHOs and a lot of things, POs, PHOs, whatever you want to call them. A lot of things going on. You'll see them giving help to the specialists on how do you even analyze RBRVS. "How do I make up for that income?" A lot of that's been going on in 1992. You'll probably see more of it in 1993. The hospitals are in tune with this and becoming more and more in tune with it and trying to strategically determine how to relate better to the physicians and what is it we need to do to keep the key physicians happy. You'll see more and more of that going on.

The impact on the non-Medicare payers will certainly include cost shifting. The other indicators would just be that you have 70-75 times the number of providers here versus DRGs and we certainly had proof of cost shifting at least two years after DRGs were in place with the hospitals. There's no doubt there's going to be cost shifting. You have 15 times the number of codes, and there's no other way to look at it.

My sense is there's not been a real negative impact in 1992 on a lot of the Medicare supplement, private sector Medicare supplement plans, and that's probably not a surprising result with the balance billing limits and some of the things that actually are going on. There are things positive, things negative, but overall I would expect you're going to see huge negative results on the individual Medicare supplement and in fact may well be seeing some of those positive results.

There's a lot of things we could talk about on legislation. The state of Washington, as an example, in terms of its state employees, Medicaid, and workers' compensation, in many ways is using RBRVS. There are a lot of other states looking at it from the workers' compensation end of it. We could talk a little bit more about what's going on in the federal government. Champus is looking at RBRVS as how they're going to use it as a basis of payment. On the Medicaid side, there are nine states that have adopted RBRVS as their method of payment. There are seven others looking at it, and from a government standpoint, RBRVS definitely seems to be something that is getting increasingly used and looked at on a payment mechanism to the physicians.

## RBRVS FROM A MEDICARE PERSPECTIVE

What about national health care and RBRVS? I mentioned to you earlier that I've been getting messages on voice mail on a regular basis from our folks in Washington. We've all been reading what's going on. A lot of those publications seem to be at least a couple of days behind what's going on. But what is it that we're hearing, at least, and what is it that we might expect to come out of this? What the plan looks like now is probably nothing near what the version will look like come the deadline. They're dropping the term managed competition. It probably has something to do with what we at least think managed competition has to do with as the Jackson Hole group has defined it, but I just very recently heard that the task force is going to drop the name managed competition because it doesn't want to use anybody else's terminology. That also means the term health insurance purchasing cooperative (HIPC) is gone and we're going to hear something called a Health Alliance. I've also heard that as far as RBRVS and price controls, clearly there's going to be a lot of movement down to the states. That clearly seems to be what the leaks are showing. It definitely sounds, according to the leaks that are coming out right now, that the states are going to be asked to do an awful lot, which means to me there are going to be a lot of different versions probably of RBRVS out there before too many years pass. I think you're going to see targets, as best I can tell.

The states will get targets that they're going to be asked to get to over a period of years and as part of those targets I think the task force is going to look at RBRVS as a way to help the states at least get started towards meeting those targets whatever year they're supposed to be meeting them by. But I don't think that the government, the states, or the federal government will have much choice but to consider RBRVS very seriously right now as at least a starting point on how they're going to reimburse a physician. Just like I'm not sure that they can look at anything but DRGs right now as far as hospital reimbursement if they're going to try to get to some sort of a budget control at some point.

Florida has just recently passed its own health care initiative, and it is hoping to jump the gun and get the federal government to model after Florida's. For those of you who are from Florida, I'm sure you know more about this than I do. But the only point I want to make here is, there are no price controls in the Florida version right now. So there is no RBRVS as such.

What this is is just how do we get to this on the private sector side? We took the high and 90th percentiles, which most of you, I assume, can relate to in terms of a usual and customary (U&C), at least that what it was a few years ago. It may have reduced, but let's talk about 90th percentiles. We took all the HIAA body systems as they combine current procedural terminology (CPT) codes and put them into different body system categories, and we came up with our own conversion factor for the 90th percentile for what we'll call area A (Table 18). So you can see the conversion factors, and they're similar to what Richard was talking about. You notice at the bottom that nervous is 122.88, which again that's four times the Medicare conversion factor of 31. So in terms of, if you really wanted to adopt Medicare's conversion factor, its levels of payment, you have some hard battles to fight. I'm afraid on a U&C basis whether you're going to balance bill an individual or negotiate a contract with a provider, whatever you're going to do, it's a tough row to hoe.

RECORD, VOLUME 19

Then continued on Table 18, again, we have more conversion factors, and you can see as you get down towards the bottom, you get into the cognitive service conversion factors, which come closer to the 31, but you never do get there. What we also have is a global conversion factor of 68. You remember Richard talked about his 66 in site D. Ours for the 90th percentile comes out to be 68. At the bottom, again, there is just a reference point. It shows you what the 1993 conversion factors are under Medicare and then the 1992 conversion factor. Just as a basis for where we start when we're a private carrier or a Blue Cross organization or an HMO or a PPO, how do we take advantage of RBRVS and all the work the government's done for us? This is one of the obstacles we obviously have to overcome.

TABLE 18  
RBRVS Based UCRs for Area A  
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
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: Nonsurgical 31.249 Surgical 31.962 (1993)	31.00 (1992)

Table 19 just gives you an idea of what some of those payments are. It gives you, again, an idea of what you'd actually be talking about in terms of payments. You have a feel for what we're talking about. The only one I'd point out is the last one.

Let's discuss some current private sector users now. In terms of the Blues, and again, there are those of you in the audience who probably know more than I do in terms of what some of the Blues may be doing, but I am aware of a few things.



RBRVS FROM A MEDICARE PERSPECTIVE

TABLE 19  
1993 RBRVS Based UCRs for Area A  
Equivalent to HIAA 90th Percentile

CPT	Description	HIAA 90th	Multiple CFs	Global CF
11100	Biopsy of skin lesion	100	100	92
15120	Skin split graft procedure	1,376	1,182	1,088
29405	Apply short leg cast	166	150	119
26445	Release H/F tendon	964	677	537
33510	Coronary artery bypass	4,362	3,887	3,372
33212	Insert pulse generator	800	952	826
45330	Sigmoidoscopy, diag.	203	211	160
59510	Cesarean delivery	2,800	2,858	2,334
59412	Antepartum manipulation	400	266	217
66984	Remove cat., insert lens	2,500	2,331	1,913
67904	Repair eyelid defect	2,000	1,511	1,240
73630	X-ray exam of foot	69	61	53
71250	Cat scan of chest	843	590	512
99213	Office/outpatient visit	52	49	66
99175	Induction of vomiting	86	87	94

The Blue Cross Association did a survey in 1992 of the Blues organizations, and it found that 29 of the 37 that responded have plans to implement RBRVS at some point in time. Three have already been implemented. Nine plan to be in 1993. I am aware of Minnesota and Oregon, and I believe the third one is probably either Utah or New York. I'm not sure. It is probably Utah.

Now we're going to talk a little bit about Oregon. What I am aware of on Oregon is that in 1991 it had a maximum 15% decrease on 144 surgical codes. Then in 1992 Oregon was up to 3,600 codes.

Oregon had somehow modified them in some form or another. Minnesota has gone to an RBRVS fee schedule on a majority of its business, and the way Minnesota did it is to move into it gradually. The first thing Minnesota did is find out what its current payment level is to a doctor on a particular CPT code and compare that to what it would have paid under an RBRVS fee schedule. If that ratio of the current to the RBRVS is greater than 50%, then Minnesota would go with an adjustment to its current fee maximum of 20%. So Minnesota built a table and if it's between minus ten to plus 10% of the RBRVS fee, Minnesota just went to RBRVS. So this was its attempt at going to an RBRVS fee schedule and trying not to totally alienate the physician population in Minnesota. Minnesota's maximum increase on a procedure that was less 100% of what RBRVS said it should be would be 100% increase essentially in the payment level. So in other words, that's the maximum increase that they would get, regardless of the relationship to RBRVS.

In Table 20 you can see for some of Minnesota's particular procedures how the adjustment works out. Again this is consistent with what we've already talked about regarding how close you are on the office visit side, for example. The numbers were only 1% off and so they had an adjustment that put them at RBRVS and increased it

RECORD, VOLUME 19

1%. Whereas you can see on the laser cholecystectomy, a 52% difference, the numbers were off by 52%. The government's saying, "You shouldn't be paying that high," so it has reduced what it is paying by 20%.

TABLE 20  
BCBSMN RBRVS Fee Schedule\*  
Results  
Sample Adjustments

CPT4	Description	% Difference	% Adjustment
99213	Est. patient office visit	- 1%	1%
99203	New patient office visit	-19	10
43235	Upper G.I. endoscopy	34	-15
58200	Abdominal hysterectomy	25	-15
49311	Laser cholecystectomy	52	-20

\* Reproduced with permission of BCBS of Minnesota

The commercial side basically is managed care, individual and small group. On the managed care side, for example, let me just talk first in terms of a report in the February 1993 issue of *Employee Benefit News* that Prudential, Aetna, John Hancock, Travelers, and Massachusetts Mutual are looking at new plan design in relation to RBRVS. When they're looking at managed care offerings, whether it's a point-of-service product or going into a new area or whatever, they are looking at how they can use RBRVS and are experimenting with the use of it in their managed care new plan design, at least on a testing or an experimental basis. The other way that you might see this happen is on individual and small group. This same report said that Massachusetts Mutual, Aetna, and John Hancock were looking at this on an individual and small group basis, and here what they were looking at is developing a new RBRVS fee schedule product. For example, giving an individual or a small group an opportunity to buy a lower-priced product that has RBRVS as a payment level, recognizing there's going to be a lot of balance billing. But if they want to provide something that is better than nothing, then one opportunity to do that is to go with an RBRVS-based fee schedule product and perhaps offer it at a much lower premium. That way there is the sale. At the time of sale, the buyer understands that they're not going to get full reimbursement for what the physician bills. There are some experiments going on on the commercial side with products like that.

Other possibilities would be to at least look at using RBRVS as an additional charge screen, and use it for reasonableness. You're still paying on an UCR basis, and you're already looking at it in a number of ways to see if your payment is appropriate. You could add this to the claim department screen as another screen that you want to at least have them within a certain range of RBRVS, and if it's not, that throws up a red flag. That's one possibility. Then use it to identify services that are either under- or overvalued. It's at least as good from a relative value perspective, what the government has done. You at least have something to argue with the physicians about, so there are organizations that are looking at it that way.

On the PPO side, one possibility, again, would be in a new product. We're working with several PPOs where they're coming out with a new exclusive provider organization (EPO) product or point-of-service product. They're working with new

## RBRVS FROM A MEDICARE PERSPECTIVE

organizations, and they want to have providers at risk differently than they did in the past. It can become a basis for a fee schedule. The big issue is, how do you get the specialists and the primary-care physicians on board, and in some organizations that's going to vary in terms of how important that is, but that's a critical question to be answered by any organization that's trying to look at an RBRVS-based fee schedule, and that's where you get back to looking at how these conversion factors work and where you want to end up when you're done. You can do this sort of thing on a PC and do a lot of what-if games, and if you don't like the way it came out the first time, you can go back and do it differently; and there are a lot of organizations doing things like that right now.

One of our clients wanted to look at these particular categories and this happened to be what the clients historical payment showed as far as what its conversion factors came out being with these categories, where you combine the CPT codes in the medical, surgical, radiology, pathology, and then what the total is (Table 21). For this particular organization the client had a reasonably low conversion factor in the aggregate, so the first thing we did was to look at the client's actual conversion factors based on its own experience.

TABLE 21  
RBRVS Based Fee Schedule Conversion Factors  
Client Billed Charges and Case Mix for Area "X"

Percentile	Med.	Surg.	Rad.	Path.	Agg.
Historical payments	30.60	55.82	47.93	57.47	42.17
Maximum Allowable Schedule	34.28	61.40	54.65	62.64	45.94

Then we compared the data for reasonableness with HIAA to basically see with their client case mix how did the conversion factors come out against HIAA (Tables 22 & 23). Comparing Table 21, 22, and 23, our conclusion was when we then looked at HIAA bill charges and HIAA case mix that where the client was coming out, if in fact it wanted to sell this to all its various physicians, it was at a reasonable point when you looked at the various conversion factors using HIAA versus using the client's own experience.

TABLE 22  
RBRVS Based Fee Schedule Conversion Factors  
HIAA Billed Charges with Client Case Mix for Area "X"

Percentile	Med.	Surg.	Rad.	Path.	Agg.
Mean	35.63	61.93	58.38	64.14	47.52
50th	35.14	60.53	58.25	63.24	46.75
70th	39.35	67.60	61.86	70.44	51.95
80th	42.05	72.38	65.81	73.67	55.52
90th	46.94	78.93	69.24	80.80	60.89

So this one example of a way an organization is trying to look at how can we adopt RBRVS. The bottom line on this one is that the organization has not yet adopted RBRVS, because when the organization presented it to the physicians, the primary care physicians were upset that they were even thinking about going to more than

one conversion. They're saying, "The government has one conversion factor. You ought to be using one conversion factor." So, again, it depends on the organization what you're going to be able to see and not sell.

TABLE 23  
RBRVS Based Fee Schedule Conversion Factors  
HIAA Billed Charges and Case Mix for Area "X"

Percentile	Med.	Surg.	Rad.	Path.	Agg.
Mean	37.68	62.97	58.42	67.22	47.93
50th	37.33	61.44	58.92	66.12	47.13
70th	41.76	68.68	62.35	75.92	52.67
80th	44.86	73.50	65.44	79.59	56.45
90th	49.45	80.09	68.79	86.81	61.81

On the HMO side, there are a lot of things going on there, even where there are capitations. I know of one large staff model HMO that has primary care physicians, but they're using RBRVS for their specialists, and they have four areas where they're using a percentage, in each area that's different, a percentage of the RBRVS fee schedule to base payment to their specialists. Obviously, some are higher and some are lower cost areas, but that's basically the way that they're doing it. There's a large APA I'm aware of that used it to develop and maintain proper capitation rates. They're just using it as a guide just like you can use it on a U&C basis. You could also use RBRVS as a guide even if you have a capitation product. You could also tie it to salaries and base what you pay to a particular physician as a result of his performance on that. For example, the best doctors get RBRVS plus 20%. The worst doctors get RBRVS minus 10% or whatever percentage the organization decides to go with. The key really, I think, on any organization is with the specialists, because that's where you're going to have a lot of discussions going on that the specialists still need to have some autonomy in the process. As long as they feel like they have some autonomy, I think you can work with them. But the important thing is to bring them in early on in the process, and you're going to have more success. It is my hope, and I strongly believe this in spite of what we have going on at the federal level, that rational behavior can restore a viable system.

FROM THE FLOOR: I have two questions. One is in analyzing the overall effect of RBRVS on a national level, that would indicate that there might be some tables of frequency rates by CPT code available. Are they available, and if not, how is the government analyzing the overall effect to make the annual adjustments? That's the first question. My second question would be the discussion of using RBRVS for the working population, if you will, the employer market, how does it really compare when the values were developed for the Medicare population? Is it really an appropriate use of the fee schedules developed for the elderly in the working population?

MR. LONDON: Let me handle the second question first. There has been a lot of criticism among physicians themselves, a lot of concern along those lines. As a matter of fact, when the fee schedule was being developed, the concern was that we were looking at payment amounts -- when Bill Hsaio did his work at Harvard, doctors were looking at scenarios of cases or saying, "If a patient presents with such-and-such symptoms and so forth, how much is this worth?" A lot of physicians were saying, "Well, that's in a general population that these scenarios are being considered, but Medicare patients are sicker." Basically the decision that they made

## RRVS FROM A MEDICARE PERSPECTIVE

was that by and large the relative values would be appropriate for Medicare or non-Medicare patients. If a patient is sicker, for example, for established patient office visits, there are five levels of visit codes, and so for a sicker patient who requires more time, the doctor would bill a higher level, and it corrects for itself in that respect. If there's an operation for which one payment is made, then it's true that a sicker patient, for instance a Medicare patient, may or may not be sicker. The argument was dismissed, so I guess the idea was that if somebody's sick, they're sick. There is a modifier that you can use which is in the CPT book which is extenuating circumstances, if this was an extra-long case or whatever. Doctors can submit that with documentation, and then Medicare will pay more for it.

Medicare does not have enough experience with obstetrics. I think it's coming out that the values are too low for obstetrics. Pediatrics is another area where Medicare does have disabled people who are under 65, 10% of the enrollment, and so there is some pediatrics, but not enough. More work has to go into that also.

I think the first question was in terms of measuring the volume performance standard, how is that done? Yes, what we do there is we set a target and then we measure the actual experience against that target, and when we set the target each year, then there's a two-year lag. So for instance in 1994, later on this year we'll be saying how the experience was in 1992 compared to that target. We are looking at the actual increase from one year over the other. We allow for the nonrisk HMO enrollment change, because we only do this for fee-for-service. We allow for the price increase which is the Medicare Economic Index (MEI) adjusted by the Medicare volume performance standard adjustment, and we allow for changes in laws and regulation. For example, in 1992 Congress decided that we weren't going to pay for EKG interpretations any more. So changes in laws and regulations are included. So basically what it gets down to is that generally the difference between the Medicare volume performance standard and actual experiences theoretically comes out on the volume side, and for that the statute allows for a certain volume increase which is a five-year historical average on a default basis unless Congress picks a different number for any particular year. Really it's the extent to which that varies from the actual volume that's the basis for the Medicare volume performance standard adjustment.

MR. MCDONALD: The only thing I would add on the second question that I had meant to say is, whenever you're looking at trying to adopt RBRVS, there are a number of things you need to understand about the RBRVS payment system that are weaknesses – I guess they could be considered that. One of them certainly is what you mentioned. Others are there are a number of codes not in RBRVS, such as preventive codes and anesthesiologists, some of those kinds of procedure codes. So when you're trying to figure out how to use RBRVS, you need to take those things into account. One example is the Oregon situation where they used the maximum of 15% up or down. I mean, you could start with, "What does the RBRVS value give me?" and then if it's outside the range, then you stay within the range.

FROM THE FLOOR: I've been told by somebody who had been in a discussion with Bill Hsiao that he felt there's only about a 10-15% overlap in appropriate use of the RBRVS in the working population, and it sounds like from what you're saying that may be a misunderstanding or a misquoting of him. That's concerned me in moving over to using the RBRVS in a working population if that was true.

RECORD, VOLUME 19

MR. MCDONALD: I was at a session in January 1993 where there were several government representatives there and I think someone who had worked on the study group was saying much the opposite, that that person felt like most of this did apply and I thought the government was even saying it was looking at this as an under age 65 when it came up with these values.

MR. LONDON: When Bill Hsaio was coming up with the basic scale, it was for all ages, except that once again some of the areas that Medicare didn't deal too much with. Like for instance in the refinement process, we didn't really spend too many resources with obstetrics and pediatrics, because we don't have enough experience with it. As Woody was pointing out, anesthesiology is on a relative value guide. They have base and time units, so what we did with anesthesiology was we rescaled anesthesiology to be consistent with the rest of the scale in terms of resources required, but they don't have RVUs.

FROM THE FLOOR: I wanted to find out on the Medicare volume performance standard adjustment, you said they set targets and then adjust relative to that target, what are those targets and how are they determined?

MR. LONDON: As a matter of fact, I have an example here. Targets basically are under the default rule in a statute. There are five factors. There are inflation, enrollment increase, changes in laws and regulations, volume increase, and then a performance standard factor where you simply take off, let's say 2% - it varies each year - which is just meant to bring down expenses from the historical average. So that's how it's set, but we combine those factors together, and then we measured against that. Now the Secretary of Health and Human Services also has to make a recommendation each year that doesn't have to be based on a formula, and also the Physician Payment Review Commission (PPRC) has to make a recommendation each year, and then Congress can pick and choose which one to use. Was that basically the question?

FROM THE FLOOR: Really from a less technical standpoint are these anticipated to essentially tie to a general CPI, medical cost index, or something else?

MR. LONDON: Basically on the default when we set the Medicare volume performance standard, for instance we're setting the Medicare volume performance standard later this year for 1993, and we'll put in there the projected enrollment increase and inflation or the CPI. We'll use the MEI, and then we'll increase that by the anticipated amount that we think that in 1992 doctors went under their target. That would be the inflation increase.

FROM THE FLOOR: Finally, when this is set for 1994, how and when is that published?

MR. LONDON: That has to be set in the last two weeks of October 1993 on a default basis. The recommendations go out right now and they'll be going to Congress soon, the Secretary's and PPRC recommendations. But in October, that's when they have to be put out, and so probably in November they'll be published in *The Federal Register*.