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BACKGROUND DATA ON PHYSICIAN REIMBURSEMENT UNDER MEDICARE

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ROBERT J. DOLE, *Chairman*

AND THE

COMMITTEE ON WAYS AND MEANS
DAN ROSTENKOWSKI, *Chairman*

AND

COMMITTEE ON ENERGY AND COMMERCE
JOHN D. DINGELL, *Chairman*
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I. INTRODUCTION

Physician reimbursement policies under Medicare have fostered concerns on the part of patients, physicians, and those involved in the development of program policy. Many patients have difficulty understanding how Medicare determines payment amounts. A number have been faced with high, and in many cases unanticipated, out-of-pocket costs in connection with their doctor bills. At the same time, many physicians contend that Medicare's reimbursement levels have failed to adequately keep pace with their charges. From a policy maker's point of view, there is concern that current payment calculations may have perpetuated and magnified payment imbalances between various geographic areas, physician specialties, types of procedures, and health care settings. The continued substantial annual increases in program expenditures for physician services, coupled with Federal budgetary constraints, have emphasized the need to examine both the impact of existing policies and possible alternatives.

Medicare payments for physicians' services are made on the basis of "reasonable charges" as defined under the program. Slightly over one-half of submitted claims are paid on an "assignment" basis. This means that the payment will be made directly to the physician rather than to the beneficiary because the physician has accepted the beneficiary's assignment of his right to payment. In accepting that assignment, the physician is required to agree to accept Medicare's determination of the reasonable charge as payment in full for covered services (except for deductible and coinsurance amounts). Where the physician does not accept assignment, the patient is liable for the full charge made by the physician including any amount in excess of Medicare's reasonable charge—an amount that may cause a financial burden for some of the aged. A number of physicians have contended that their reluctance to accept assignment is directly attributable to the fact that Medicare's determination of reasonable charges often results in payments which are considerably less than their actual charges. These assertions have been countered by those who suggest that many physicians have responded to Medicare and other third-party reimbursement policies by increasing their fees faster than they otherwise would have in order to have the higher amounts considered in the base on which calculations for future years are made. There is evidence, however, that these individual physician actions will have little impact on Medicare reimbursement levels per service over time. The program's limit on year-to-year increases in recognized charges (known as the economic index limitation) is gradually leading, in effect, to the use of fee schedules under Medicare. There is concern that in the absence of program changes, these de facto schedules will reflect and lock into place existing program imbalances. Further, it has been noted that reimbursement limits

only apply to units of services; there is no limit on increases in the volume of services.

The purpose of this report is to provide an overview of physician reimbursement patterns under Medicare. It details the criteria that are employed in making reasonable charge determinations, explores the effect of these determinations on both physicians and patients, and reviews several payment modifications which are currently under discussion. The following outlines the topics covered in the report:

Part II provides general background for the reader. It includes a brief description of Medicare and provides national data on health spending for the elderly. (Note that while Medicare also provides coverage for the disabled, the primary emphasis of this report is on the aged, who constitute an estimated 90 percent of Medicare beneficiaries).

Part III details Medicare's criteria for determining reasonable charges.

Part IV describes the evolution of Medicare's reasonable charge methodology from the initial law through subsequent administrative and legislative modifications.

Part V provides a definition of "assignment" and includes data on assignment rate experience. In addition to national data, it shows variations in rates by geographic area, demographic characteristics of beneficiaries, physician specialties, and size of annual patient charges. It also notes other factors which may affect a physician's assignment decision.

Part VI shows the percentage increase in the number of claims for services for which the physician's actual charge is not recognized in full for payment purposes. Trends in this reasonable charge reduction rate as well as comparisons among physician specialties are presented.

Part VII presents data on the impact of Medicare's economic index limitation on both physicians and patients.

Part VIII shows the financial impact of Medicare's reasonable charge policies (and physicians' responses to these policies) on the elderly.

Part IX describes variations in physicians' fees under Medicare with particular attention to differentials between urban and rural areas and between primary care physicians and specialists.

Part X details the trends in expenditures for physicians' services under Medicare and notes the various factors contributing to the increases.

Part XI outlines the major alternatives which have been proposed; these include both modifications to the existing reasonable charge reimbursement system and the development of alternative systems.

The data included in this report are the most recent available. In many instances the analyses are based on 1977 and 1978 data and therefore do not reflect recent changes. However, preliminary 1980 data appear to show patterns similar to those shown by the 1977–1978 data. (See attachments A and B.)

II. BACKGROUND

A. Description of Medicare

The Medicare program, which is authorized under Title XVIII of the Social Security Act, consists of two separate but complementary types of health insurance for the aged and certain disabled persons. Part A, the Hospital Insurance Program, provides protection against hospital and related institutional costs. Part B, the Supplementary Medical Insurance Program, is a voluntary program which covers physicians' services and many other medical services. In fiscal year 1982, 25.5 million aged and 2.7 million disabled were enrolled in Part B. During that year, 17.8 million aged and 1.8 million disabled received services financed by the Part B program.

Medicare is under the overall direction of the Secretary of Health and Human Services (formerly Health, Education, and Welfare). Within the Department, the Health Care Financing Administration (HCFA) is generally responsible for policy and administrative control of the program.

Much of the day-to-day operational work of the Part B program is performed by carriers (private insurance companies and Blue Shield Plans) which have administrative responsibility, in accordance with guidelines issued by HCFA, for reviewing claims for benefits and making payments. The program generally pays 80 percent of the "reasonable charges" for covered services in excess of the deductible amount of $75 per year. Program beneficiaries are liable for the deductible and the 20 percent coinsurance. Under certain circumstances (i.e., when the physician does not accept assignment) beneficiaries are also responsible for payment of that portion (if any) of a physician's bill which is in excess of what Medicare determines to be reasonable.

Covered physicians' services under Medicare include those provided by doctors of medicine and osteopathy (M.D.'s and D.O.'s) wherever furnished including surgery, consultation, and home, office and institutional calls. Also included are services provided by the following:

> Dentists, but only when the services are of the kind which would be covered if furnished by a physician, for example, performing certain dental surgeries, setting dental fractures, or treating oral infections. [The program does not cover most dental services];
>
> Podiatrists (foot doctors) for certain services other than routine foot care;
>
> Optometrists, but only with respect to services for patients with aphakia (without natural lens of the eye); and

Chiropractors, meeting certain standards, but only for treatment involving manual manipulation of the spine to correct a condition (called a subluxation) demonstrated to exist by X-ray.

In fiscal year 1982, the Part B program paid $14.8 billion in benefit payments of which $10.7 billion or 72 percent represented payments for physicians' services. Of this amount, $9.4 billion was paid in behalf of the aged and $1.3 billion was paid in behalf of the disabled.[1] The Administration estimates that in fiscal year 1984, the Part B program will pay a total of $20.8 billion in benefit payments of which $15.3 billion or 75 percent will be for physicians' services. Of this amount, $13.5 billion will be paid in behalf of the aged and $1.8 billion in behalf of the disabled.[2]

B. Health Care Expenditures for the Elderly

1. National Health Expenditures

In calendar year 1982, national health expenditures totalled an estimated $821.4 billion. Of this amount, 57.6 percent represented private expenditures, and 42.4 percent represented public expenditures. Personal health care expenditures accounted for an estimated $287.0 billion. Of this amount, $170.8 billion (59.5 percent) represented private expenditures and $116.2 billion (40.5 percent) represented public expenditures. Federal expenditures accounted for an estimated 72.5 percent of public spending for personal health care and an estimated 29.8 percent of total spending for such services.

TABLE 1.—ESTIMATED NATIONAL HEALTH EXPENDITURES BY TYPE OF EXPENDITURE AND BY SOURCE OF PAYMENT, CALENDAR YEAR 1982

[Dollar amounts in billions]

	Total	Health services and supplies			Research and construction
		Subtotal	Personal health care	Other [1]	
Private	$185.1	$179.2	$170.8	$8.4	$5.9
Consumer	174.6	174.6	166.8	7.8	0
Patient direct	91.1	91.1	91.1	0	0
Insurance	83.4	83.4	75.6	7.8	0
Other	10.6	4.6	4.0	.6	5.9
Public	136.3	128.5	116.2	12.3	7.8
Federal	93.5	88.1	84.2	3.9	5.3
State	42.8	40.4	32.0	8.4	2.4
Total	$321.4	$307.7	$287.0	$20.7	$13.8

[1] Includes net cost of private health insurance, administration of government and philanthropic health programs, and government programs to advance the general health of the population.

Source: Department of Health and Human Services (DHHS), Health Care Financing Administration (HCFA). Unpublished tables.

[1] The Budget of the United States Government: Fiscal year 1984. Appendix, pp. I-K82 and I-K83.

[2] Ibid.

2. Personal Health Care Expenditures

In calendar year 1982, the nation spent an estimated $287 billion on personal health services, an increase of 12.5 percent over the $255 billion expended in 1981.[3]

While the elderly comprised only an estimated 11.3 percent of the total population in 1981, their personal health expenditures accounted for an estimated 32.6 percent of such spending. In that year, the aged's per capita health expenditures were $3,140 compared to $1,090 for all age groups and $828 for those under age 65 Public spending financed an estimated 68.9 percent ($2,008) of the health care bill of the elderly, more than double the 30 percent recorded in 1965, the year prior to the implementation of Medicare and Medicaid. In 1981, Medicare paid 45.3 percent of the elderly's health bill; Medicaid paid 13.7 percent and other public programs 4.9 percent. Private payments including payments made by private health insurance and out-of-pocket expenses accounted for 36.1 percent.[4] The out-of-pocket item does not include amounts paid for private health insurance premiums or Medicare premiums.

TABLE 2.—ESTIMATED PERSONAL HEALTH CARE EXPENDITURES FOR PERSONS AGE 65 AND OVER, AMOUNTS AND PER CAPITA AMOUNTS BY SOURCE OF FUNDING, 1981

[Dollar amounts in billions]

	Total amount	Percent	Per capita amount
Private	$30.0	36.1	$1,132
Public	53.2	63.9	2.008
Medicare	37.7	45.3	1,423
Medicaid	11.4	13.7	430
Other	4.1	4.9	155
Total	83.2	100.0	$3,140

Source: DHHS, HCFA, unpublished tables.

3. Expenditures for Physician Services

In calendar year 1982, nationwide spending for physicians' services totalled an estimated $61.8 billion; $44.6 billion (72.2 percent) were private expenditures and $17.2 billion (27.8 percent) were public expenditures. Medicare expenditures for the aged and disabled totalled an estimated $11.5 billion and Medicaid spending $3.0 billion ($1.6 billion, Federal; $1.4 billion, State).

In calendar year 1981, an estimated $54.8 billion was spent nationwide for physicians' services; $15.6 billion or 28.5 percent of this total was paid in behalf of the elderly. Spending for physicians' services represented 18.8 percent of total personal health care expenditures for the elderly and the third largest item of health care expense for this population group.

[3] Gibson, Robert M., and Daniel R. Waldo. "National Health Expenditures, 1981". Health Care Financing Review, September 1982, p. 1, and HCFA, unpublished tables.

[4] The breakdown between private health insurance and out-of-pocket expenses is not available.

TABLE 3.—ESTIMATED AMOUNT OF PERSONAL HEALTH CARE EXPENDITURES FOR PERSONS AGED 65 AND OVER, BY TYPE OF EXPENDITURE, 1981

[Dollars amounts in billions]

Type of expenditures	Amount	Percent
Hospital care	$36.6	44.0
Physicians' services	15.6	18.8
Dentists' services	2.4	2.9
Other professional services	2.0	2.4
Drugs and medical sundries	5.1	6.1
Eyeglasses and appliances	1.0	1.2
Nursing-home care	19.4	23.3
Other health services	1.0	1.2
Total	83.2	100.0

Source: DHHS, HCFA, unpublished tables.

Public spending on physicians' services for the aged was an estimated $9.0 billion in 1981 or an estimated 57.7 percent of the total for such services. Medicare accounted for $8.5 billion and 94.4 percent of public spending and 54.5 percent of total spending on such services for those aged 65 and over.

TABLE 4.—NATIONAL EXPENDITURES FOR PHYSICIANS' SERVICES FOR PERSONS AGED 65 AND OVER BY SOURCE OF PAYMENT, PROVISIONAL ESTIMATE, CALENDAR YEAR 1981

[Dollars amounts in billions]

	Amount	Percent
Private	$6.6	42.3
Public	9.0	57.7
Medicare	8.5	54.5
Medicaid	.4	2.6
Other	.1	.6
Total	15.6	100.0

Source: DHHS, HCFA, unpublished tables.

The percentage of total expenditures for physicians' services for the aged paid for by Medicare had declined slightly since the early years of the program from 57.3 percent in fiscal year 1968 to 54.5 percent in calendar year 1981.

4. Medicare Spending for Physicians' Services

Medicare benefit payments for physicians' services for the aged are estimated at $13.5 billion in fiscal year 1984. This represents roughly a five-fold increase from fiscal year 1974 and over 160 percent increase from fiscal year 1979. (See table 5.)

TABLE 5.—HISTORY OF MEDICARE PART B BENEFIT PAYMENTS FOR PHYSICIANS SERVICES FISCAL YEARS 1969–84 [1]

[Dollar amounts in millions]

Fiscal year	Payments		
	Aged	Disabled	Total
1969	$1,500	.....	$1,500
1970	1,771	.....	1,771
1971	1,864	.....	1,864
1972	1,997	.....	1,997
1973	2,165	.....	2,165
1974	2,235	$182	2,417
1975	2,805	221	3,026
1976	3,144	329	3,473
TQ [2]	786	91	877
1977	3,835	443	4,278
1978	4,479	546	5,025
1979	5,161	680	5,841
1980	6,331	875	7,206
1981	7,706	1,074	8,780
1982	9,424	1,297	10,721
1983 (estimated)	11,433	1,551	12,984
1984 (estimated)	13,527	1,795	15,322

[1] Physician payments in fiscal year 1967 and fiscal year 1968 not separately identified in the budget appendixes.

[2] Transitional quarter.

Source: President budget appendixes, fiscal years 1971–84.

C. Medicare Population

In fiscal year 1982, 25.5 million aged and 2.7 million disabled were enrolled in Part B. During that year, 17.3 million aged and 1.8 million disabled actually received services reimbursed under the program. The Administration estimates that in fiscal year 1984 there will be 26.6 million aged and 2.7 million disabled enrollees; 18.4 million aged and 1.8 million disabled will receive covered services.[5]

A review of demographic changes in the Medicare population over the fiscal year 1975–78 period shows that the average annual increase in the numbers of disabled enrollees was close to four times that of aged enrollees. The data also shows that the group aged 85 and over were the fastest growing segment of the aged population.

[5] Fiscal year 1984 U.S. budget appendix, p. I-K32.

TABLE 6.—NUMBER AND PERCENT DISTRIBUTION OF AGED AND DISABLED PERSONS ENROLLED UNDER MEDICARE PART B BY AGE, SEX, AND RACE, U.S., 1978

Age, sex, and race	Enrollees (in thousands)	Percent distribution	Average annual percent increase 1975–78
AGED			
U.S. total	23,343	100.0	2.3
Age:			
65 to 69	7,778	33.3	1.9
70 to 74	6,233	26.7	2.5
75 to 79	4,389	18.8	1.7
80 to 84	2,877	12.3	2.1
85 and over	2,066	8.9	5.1
Sex:			
Men	9,343	40.0	2.0
Women	14,000	60.0	2.5
Race:			
White	20,752	88.9	2.3
All other	1,948	8.3	3.5
Unknown	643	2.8	3.1
DISABLED			
U.S. total	2,511	100.0	8.9
Age:			
Under 25	68	2.7	9.4
25 to 44	537	21.4	10.1
45 to 64	1,906	75.9	8.5
Sex:			
Men	1,561	62.2	8.5
Women	950	37.8	9.5
Race:			
White	2,062	82.1	8.6
All other	406	16.2	10.9
Unknown	43	1.7	5.9

Source: McMillan, Alma, Pine, Penelope and Newton, Marilyn. Medicare: Use of physicians' services under the supplementary medical insurance program, 1975–78, DHHS, HCFA, HCFA Pub. No. 03151, March 1983. p. 3.

III. CRITERIA FOR DETERMINING REASONABLE CHARGES [6]

Reasonable charge determinations for physicians' services are made by Medicare carriers on the basis of specific requirements in law and regulations. The "reasonable charge" for a specific service in the absence of unusual medical complications or certain other circumstances, is the lowest of: (a) the physicians' customary charge for the service, (b) the prevailing charge for that service in the area, or (c) the physicians' actual charge. In applying these criteria, carriers are required to exercise their judgment, taking into account special factors that may exist in individual cases, so that determinations are reasonable and equitable. A charge that exceeds either the customary charge or the practitioner or the prevailing charge or both can only be found to be reasonable, if there are unusual circumstances or medical complications requiring additional time, effort, or expense to support such a charge, and if it is acceptable practice in the locality to make such an extra charge.

Customary and prevailing charge screens used to calculate reasonable charges are updated every July 1. The determination of the reasonable charge for a particular service must be based on the schedules in effect on the date the service was rendered.

A. Customary Charges

A physician's "customary charge" for a service is the amount which he charges in the majority of cases for a specific medical procedure or service. In determining this uniform amount, token charges for charity patients and substandard charges for low-income patients are excluded. Similarly, exceptionally high fees that are attributable to a patient's unusual ability to pay are also excluded. If a physician varies his charges for a particular procedure or service such that no one amount is charged in the majority of cases, the carrier is required to exercise judgment to establish a customary charge for such service rendered by such physician. The customary charge for a specific service, therefore, may vary from one physician to another.

The customary charges of a physician are not static amounts. When a practitioner revises his pattern of charges, new customary charges for specific procedures and services develop. When a carrier determines, on the basis of adequate evidence, that a physician has changed his charges to the public in general the resulting customary charges for that physician are recognized in subsequent reasonable charge determinations for his services. Customary

[6] This report focuses on the reimbursement of physicians providing services on a fee-for-service basis. It does not include an analysis of the special payment determinations required either in the case of services rendered in a teaching hospital or in the case of services rendered by provider-based physicians (generally radiologists, anesthesiologists, and pathologists).

charge screens are updated every July 1, and are based on the charge data developed by the carrier for the prior calendar year. Thus the customary charge screens in effect for the period July 1, 1983–June 30, 1984 are based on calendar year 1982 charge data.

B. Prevailing Charges

The second criterion governing reasonable charge determination is the "prevailing charge." A prevailing charge is the upper limit on the charges in a locality for a specific procedure which a carrier will accept as reasonable for payment purposes, unless there are unusual circumstances or medical complications. In the case of physicians' services, certain limitations, based on economic index data, have been placed on allowable increases in prevailing charge limits.

Carriers base their prevailing charge screens on the overall pattern of "customary charges" existing in a particular locality. Carriers delineate the localities on the basis of their knowledge of local conditions; these localities generally correspond to a political or economic subdivision of a State. Prevailing charges may vary from one area to another. They may also differ within a locality for physicians who engage in a specialty practice compared with other practitioners. The prevailing charge limit on the reasonable charge for a specific service is set at the 75th percentile of customary charges—i.e. at a level no higher than is necessary to cover 75 percent of the customary charges of physicians in the area. As with customary charge screens, the prevailing charge limit is updated every July 1 based on charge data obtained for the previous calendar year.

Annual increases in prevailing charge screens are further subject to an economic index limitation which is applied nationally. The increase in the index over the base value of 1.000 is the maximum allowable increase in any prevailing charge limit for a physician's service in the current year period beginning July 1 over the corresponding prevailing charge limit for the same service in the same locality in the year period beginning July 1973.[7] This percentage is calculated based on the weighted averages of: (1) changes in general earnings levels of workers, and (2) changes in expenses of the kind incurred by physicians in office practice. The two components of the index are given the relative weights shown in data on self-employed physicians' gross income. The index rates promulgated to date are as follows:

[7] Public Law 94-368 assured that application of the economic index limitation would never result in a rollback of prevailing charges below the fiscal year 1975 levels.

TABLE 7.—PROMULGATED ECONOMIC INDEX RATES USED TO LIMIT INCREASES IN PREVAILING CHARGE SCREENS

Period	Index rates	Percent increase over prior period
July 1, 1973	1.000	.....
July 1, 1975 to June 30, 1976	1.179	[1] 17.90
July 1, 1976 to June 30, 1977	1.276	8.23
July 1, 1977 to June 30, 1978	1.357	6.35
July 1, 1978 to June 30, 1979	1.426	5.08
July 1, 1979 to June 30, 1980	1.533	7.50
July 1, 1980 to June 30, 1981	1.658	8.15
July 1, 1981 to June 30, 1982	1.790	7.96
July 1, 1982 to June 30, 1983	1.949	8.88
July 1, 1983 to June 30, 1984	2.063	5.85

[1] Large increase due to delay in implementation.

Thus if the prevailing charge for a particular service was $100 in fiscal year 1978 the maximum recognized prevailing charge would be $206.30 for July 1, 1983–June 30, 1984.

At the same time the Department announced the economic index which was to be effective beginning July 1, 1983, it also reported recalculations of the index for several earlier years:

Because the Bureau of Labor Statistics has periodically retroactively revised some of the statistics and data on which earlier economic indexes were based, it was necessary for us to recompute some of the values and ratios for earlier years in order to obtain an accurate index for the current year. . . .

It should be noted that, although we have recalculated prior year indexes, this does not change the applicability of the earlier indexes as published. Rather, prior year figures were recalculated only to reflect newly available data in order to prepare an accurate index for the period beginning July 1, 1982.[8]

The revised rates obtained as a result of the recalculation are as follows:

TABLE 8.—ECONOMIC INDEX ADJUSTED FOR REVISIONS IN BUREAU OF LABOR STATISTICS (BLS) STATISTICS SINCE ORIGINAL ANNOUNCEMENT

Period	Revised index rates
July 1, 1975 to June 30, 1976	1.1784
July 1, 1976 to June 30, 1977	1.2615
July 1, 1977 to June 30, 1978	1.3326
July 1, 1978 to June 30, 1979	1.4107
July 1, 1979 to June 30, 1980	1.5104
July 1, 1980 to June 30, 1981	1.6394

[8] Federal Register, vol. 48, No. 128, July 1, 1983. p. 30460.

TABLE 8.—ECONOMIC INDEX ADJUSTED FOR REVISIONS IN BUREAU OF LABOR STATISTICS (BLS) STATISTICS SINCE ORIGINAL ANNOUNCEMENT—Continued

Period	Revised index rates
July 1, 1981 to June 30, 1982	1.7910
July 1, 1982 to June 30, 1983	1.9482
July 1, 1983 to June 30, 1984	2.0628

Source: Federal Register, Vol. 48, No. 128, July 1, 1983. p. 30460.

C. Examples of the Application of Medicare's Reasonable Charge Methodology

The preceding discussion has focused on the rules governing the calculation of reasonable charges under Medicare. As noted, in the absence of unusual circumstances, the reasonable charge is the lowest of: (a) the physician's customary charge for a service, (b) the prevailing charge for the service in the area, or (c) the physician's actual charge.

The following example illustrates the application of these principles to the calculation of reasonable charges for four individual physicians performing one specific procedure in the same locality.

Situation: the prevailing charge for a specific procedure is $100 in the locality.

Dr. A's bill is for $75, although he customarily charges $80.

Dr. B's bill is his customary charge of $85.

Dr. C's bill is for $90, although he customarily charges $80 and there are no special circumstances in this case.

Dr. D's bill is his customary charge of $125.

The reasonable charge for Dr. A is $75, since under the law the reasonable charge cannot exceed the actual charge, even if it is lower than the customary charge and below the prevailing charge.

The reasonable charge for Dr. B is $85, because it is his customary charge and it does not exceed the prevailing charge for the locality.

The reasonable charge for Dr. C is $80 because that is his customary charge. Even though his actual charge falls below the prevailing charge, the reasonable charge cannot exceed his customary charge in the absence of special circumstances.

The reasonable charge for Dr. D is $100, the prevailing charge in the locality.

IV. DEVELOPMENT OF MEDICARE'S REASONABLE CHARGE METHODOLOGY

A. The "Social Security Amendments of 1965" (Public Law 89-97)

The physician reimbursement provisions contained in the original Medicare legislation were patterned after "UCR" (i.e., usual, customary, and reasonable) plans developed by insurance organizations in the early 1960's. Under UCR plans, a physician's billed charge was paid in full if it did not exceed the amount customarily billed for the service by other physicians in the area, and if it was otherwise reasonable.

The provision incorporated in the 1965 Medicare law was intended to enable payment for beneficiary's services on a basis comparable to, but at levels no greater than, those paid by the general population. Specifically, Section 1842 of Title XVIII of the Social Security Act (as enacted by Public Law 89-97) required Part B insurance carriers to:

> Assure that, where payment . . . is on a charge basis, . . . such charge will be reasonable and not higher than the charge applicable, for a comparable service and under comparable circumstances, to the policyholders and subscribers of the carrier. . . . In determining the reasonable charge . . . there shall be taken into consideration the customary charges for similar services generally made by the physician . . . as well as the prevailing charges in the locality for similar services.

While the original statute provided general guidance for the calculation of reasonable charges, individual carriers initially developed much of their own policy with respect to specific methods for determining customary and prevailing charges.

B. Administrative and Legislative Refinements

Beginning in 1968, the Department issued a series of directives designed to refine the methods carriers used in determining Medicare's reasonable charges and to bring a greater degree of uniformity in the claims payment process. The impetus for these changes and subsequent Congressional action can, to a large extent, be attributed to the dramatic increases in physicians' fees that occurred after the implementation of Medicare. During the fiscal year 1966-71 period, physician fees increased 60 percent faster than the nonmedical items in the Consumer Price Index.

Two administrative policies, subsequently incorporated in the "Social Security Amendments of 1972" (Public Law 92-603) have been particularly significant in limiting increases in allowed charges. These policies provide that:

(1) Customary charge screens are updated every July 1 based on the physician's charges which were in effect the preceding calendar year. This represents 18 months between the midpoint of the data collection period and the midpoint of the period during which the screens are in effect.

(2) Similarly, prevailing charge screens are updated every July 1. They are set at the 75th percentile of customary charges made by physicians during the preceding calendar year. (During the initial years of the program, carriers generally defined prevailing charges in terms of the 90th percentile. In 1969, carriers were advised to set the standard at one standard deviation from the mean—roughly speaking at the 83rd percentile. Beginning in fiscal year 1971, carriers were required to set the prevailing charge screen at the 75th percentile.)

In addition to incorporating these administrative policies relating to customary and prevailing charges into Section 1842 of the Social Security Act, Public Law 92-603 also added an additional amendment to this section which reflected Congressional concern over the impact of rising physician fees on Medicare payments. Under the amendment, prevailing charge levels for fiscal year 1974 and thereafter could only be increased to the extent justified by an economic index reflecting changes in operating expenses of physicians and in earnings levels. In its report accompanying the legislation, the House Committee on Ways and Means stated:[9]

> Your Committee believes that it is necessary to move in the direction of an approach to reasonable charge reimbursement that ties recognition of fee increases to appropriate economic indexes so that the program will not merely recognize whatever increases in charges are established in a locality but would limit recognition of charge increases to rates that economic data indicate would be fair to all concerned.

The Senate Finance Committee report outlined how the Committee expected the economic indexes to be developed and what it foresaw as the expected impact of the new limitations:[10]

> It is, of course, contemplated under the bill that the Secretary would use, both initially and over the long run, the most refined indexes that can be developed. However, the committee believes that the viability of the proposal does not depend on a great deal of further refinement . . . . This is so because the indexes are not to be applied on a procedure-by-procedure basis. That would raise serious questions of equity in absence of refinements to take account of variations in the mix of factors of production among various types of medical services and to take account of changes in productivity with respect to various services. Rather, the indexes will operate as overall ceilings on prevailing fee level increases recognized in a carrier area under which adjustments permitted by the present customary and prevailing charge criteria could be made to take account of the shifting patterns and levels and actual charges in each locality. Thus, whether the new limit on prevailing charges will actually affect the determination of reasonable charges depends on the degree to which physicians' fees rise in the future. If the rise in fees in the aggregate was no more than the rise in operating expenses of physicians and in earnings, the rise in fees would be allowed in full.

Public Law 92-603 specified that the economic index provision was to go into effect in fiscal year 1974; however, due to the fact that implementing regulations were delayed, the provision first became effective in fiscal year 1976. During fiscal years 1972, 1973 and 1974, when wage and price controls were in effect over large portions of the economy, physicians' fees had increased at a slower rate than their office expenses and general earnings levels. However, significant increases in fees were recorded following the lifting

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[9] U.S. Congress. House. Committee on Ways and Means. Social Security Amendments of 1971. Report to Accompany H.R. 1, May 26, 1971. Washington, U.S. Govt. Print. Off. (92d Cong., 1st Sess., H. Rept. No. 92-231). p. 86.

[10] U.S. Congress. Sentate Committee on Finance. Social Security Amendments of 1972. Report to accompany H.R.I., Sept. 26, 1972. Washington, U.S. Government Printing Office (92d Cong., 2d session, S. Rept. 92-1230). p. 192.

of controls. Because of the delay in issuing the index regulations, the implementation on July 1, 1975 resulted in a rollback of some physicians' reasonable charges. To correct this problem, Congress included a provision in Public Law 94-182 which assured that no prevailing charge in fiscal year 1976 would be less than it was in fiscal year 1975. Subsequently, Congress enacted Public Law 94-368 which assured that operation of the economic index limitation would never result in a rollback of prevailing charges below the fiscal year 1975 levels.

In recent years, the Congress has approved additional modifications designed to stem increases in program outlays. The "Omnibus Reconciliation Act of 1980" (P.L. 96-499) included a provision altering previous administrative practice by requiring that reasonable charge determinations be made on the basis of the customary and prevailing charge schedules in effect on the date the service was rendered, not the date the claim was processed.

Public Law 96-499 also made certain modifications with respect to payments for laboratory services when services are included in the physician's bill. Prior to 1980, there had been evidence that some physicians billed the program for amounts substantially in excess of what an outside laboratory charged them for the work. Therefore, Public Law 96-499 included limitations on the amounts Medicare would recognize for laboratory services billed by physicians. If the physician's bill identifies both the laboratory and the charge made, the recognized charge is the lesser of the laboratory's reasonable charge or the amount actually charged the physician plus a nominal fee for physician handling of the specimen. If the laboratory and/or charge are not identified, the recognized charge is the lowest charge at which the carrier estimates the test could have been secured by a physician from a laboratory serving the locality.

Under provisions of the "Omnibus Budget Reconciliation Act of 1981" (P.L. 97-35) and the "Tax Equity and Fiscal Responsibility Act of 1982" (P.L. 97-248), the Congress approved limitations on recognized reasonable charges for physicians' services provided in an outpatient department of a hospital. While a physician incurs expenses for services he renders in his office, the overhead costs for services he renders in a hospital outpatient department are borne by the institution and covered under its reimbursement. Public Law 97-35 required the Secretary to issue regulations which provide, to the extent feasible, for the establishment of specific limitations on the costs or charges that would be considered reasonable for outpatient services provided by hospitals and by physicians utilizing these facilities. Charge limitations were to be reasonably related to charges in the same area for similar services provided in physicians' offices. The limitations could not be applied to bona fide emergency services provided in hospital emergency rooms. The Secretary was further required to provide for exceptions to the limitations in cases where similar services are not generally available to Medicare beneficiaries in physicians' offices in the area. Public Law 97-248 specified that the Secretary may limit the reasonable charge for physicians' services furnished in hospital outpatient departments to a percentage of the amount of the prevailing charge for similar services furnished in a physician's office. The Secretary

is to take into account the extent to which overhead costs associated with such outpatient services have been included in the reasonable cost or charge for the facility. Implementing regulations issued October 1982 set the limits at 60 percent of the prevailing charge in the locality for the same service rendered in a physician's office.

C. Joint Medicare/Medicaid Claims

An estimated 12 percent of aged and disabled Medicare enrollees are also covered by State Medicaid programs. Most State Medicaid plans pay the monthly Medicare Part B premium payment for their dual eligible beneficiaries under a "buy-in" agreement.

Eligibility for Medicaid is linked to actual or potential receipt of cash assistance. For the aged and disabled such assistance is obtained through the Federal Supplemental Security Income (SSI) program. All States cover the "categorically needy" under their Medicaid plans. In general these are persons receiving cash assistance although under certain circumstances States have the option of imposing more restrictive criteria for Medicaid eligibility than for cash assistance. A State choosing the more restrictive criteria must allow applicants to deduct medical expenses from income in determining eligibility.

States may also cover the "medically needy" under their Medicaid programs. These are persons whose income and/or resources are slightly in excess of the standards for cash assistance provided: (1) they would otherwise meet the criteria for cash assistance; and (2) their income, after deducting incurred medical expenses, falls below the State standard.

While States may "buy-in" to Part B of Medicare for both their cash assistance and medically needy populations who are eligible for Medicare, Federal matching for premium payments is available only for the cash assistance group. If a State does not buy-in for Part B coverage it cannot receive Federal matching payments for medical services which would have been covered under Medicare if there had been a buy-in arrangement.

The maximum amount that Medicaid will pay for a specific service is often lower than the reasonable charge amount recognized by Medicare. The Urban Institute conducted a survey of Medicaid claims submitted in 1979 to determine how States handled payments of program claims on behalf of their dual eligibles. Generally, most States buy into Medicare coverage on behalf of their dual eligibles. A majority of the States pay the Medicare coinsurance (generally 20 percent of the "reasonable charge") and deductible amounts in full, though some States pay lesser amounts. The following excerpt from the report summarizes the findings:[11]

> Forty-six Medicaid programs "buy-in" (i.e., pay Medicare Part B premiums) for most or all of their joint beneficiary population. Seventeen of these States, however, exclude some joint beneficiaries from their "buy-in" arrangements, including eleven States which exclude the medically needy.

[11] Gornick, Janet. Medicaid Reimbursement of Physicians' Services for Joint Medicare-Medicaid Beneficiaries, part III of Medicaid Physician Reimbursement, final report, vol. I. The Urban Institute, December 1981. pp. 18-21.

Four States—Alaska, Louisiana, Oregon and Wyoming—do not have "buy-in" programs. All Medicare eligibles must "self-enroll" into Part B in order to receive coverage.

All States, except Oklahoma, treat State- and self-enrolled populations as one for the purpose of reimbursing physicians for Medicare coinsurance and deductible payments. Oklahoma does not pay coinsurance and deductible amounts for their self-enrolled joint beneficiaries (the medically needy).

Thirty-seven States pay Medicare coinsurance in full, while seven States limit their coinsurance payments to the difference between 80 percent of the Medicare reasonable and the State's Medicaid maximum allowance for that service. In addition, Maine pays 90 percent of coinsurance, and Florida pays 75 percent of coinsurance. New Jersey pays no coinsurance for physicians' services.

All States, except Oregon, reported that physicians are prohibited from collecting any coinsurance from joint beneficiaries in the case where Medicaid does not cover coinsurance in full. Oregon, however, reported that if Medicaid makes no payment at all, the physician may bill the patient for the 20 percent coinsurance charges.

Thirty-eight States reported that they pay joint beneficiaries' Part B deductible payments in full, while eight States indicated that they apply the Medicaid maximum payment levels to reimbursements billed for prior to the meeting of the deductible. Maine pays 90 percent of the Medicare allowable until the deductible is met.

Twenty-six States reported that they will not accept claims for services that are not assigned under Medicare, while twenty States indicated that they will. All twenty States which will process claims not assigned under Medicare reported that they reimburse coinsurance and deductible amounts on these claims according to the same principles applied to assigned claims.

With the exception of Connecticut, all States which permit physicians to file claims for services that were not assigned under Medicare prohibit physicians from billing recipients of these services for amounts in excess of the Medicare maximum allowable, a practice allowed for Medicare-only recipients.

No State reported a specific State law or program policy which prohibits physicians from treating Medicaid eligibles or enrollees as private or Medicare-only patients, and billing them accordingly. Arkansas commented that this practice is becoming more frequent.

Thirty-eight States reported that physician service claims for joint beneficiaries are automatically exchanged by Medicare and Medicaid so that the physician is normally required to submit only one claim. The most common method of exchange, reported by 29 States, is the transfer to Medicaid of magnetic tape payment records.

States reported various, and often multiple, means of checking that claims are processed first by Medicare. Thirty-eight States reported that physicians are required to submit proof of Medicare billing, and 36 indicated rejecting claims if proof is absent.

V. ASSIGNMENTS

A. Definition of "Assignment"

Payment for physician services under Medicare is made by the Part B carrier either to the doctor or to the beneficiary depending upon whether the physician has accepted assignment for the claim. In the case of non-assigned claims, payment is made directly to the beneficiary on the basis of an itemized bill, paid or unpaid. The beneficiary is responsible for paying the physician's bill in addition to the deductible and coinsurance amounts he is liable for any difference between the physician's actual charge and Medicare's reasonable charge. Alternatively the beneficiary may assign (i.e., transfer) his rights to payment to the physician provided the physician is willing to accept Medicare's reasonable charge determination as payment in full for a covered service. If the physician accepts assignment, the physician bills the program directly and is paid an amount equal to Medicare's allowed charge less any deductible and coinsurance. The physician may not charge the beneficiary (nor can he collect from another party such as a private insurer) more than the applicable deductible and coinsurance amounts.

A physician may accept or refuse assignment: on a bill by bill basis. For example, he may accept assignment on some visits and refuse assignment on other visits for the same patient. However, the physician is precluded from "fragmenting" bills for the purpose of circumventing reasonable charge limitations; he must either accept assignment or bill the patient for all of the services performed on one occasion.

When a physician treats a Medicare patient who is eligible for Medicaid, he may not bill the beneficiary for amounts in excess of the reasonable charge. Therefore, he is essentially required to accept assignment. This is often referred to as "mandatory assignment". As noted in Part IV, subpart C, total reimbursement for services provided to such dual eligibles is equal to the Medicare payment (i.e., 80 percent of the reasonable charge less any deductible) plus any Medicaid amount (i.e., the Medicare deductible plus all or a portion of the coinsurance).

When a physician accepts assignment, the beneficiary is protected against having to pay any difference between Medicare's determined reasonable charge and the physician's actual charge. Further, in assignment cases the patient never has to handle the paperwork in connection with the claim (though many doctors will also do this for the patient in the case of non-assigned claims). Only about half of Medicare's claims are paid on an assignment basis. In the remaining cases, the beneficiary is liable for any difference between the actual charge and Medicare's reasonable charge—an amount that can sometimes pose a financial burden. These

amounts may be difficult to budget for since a beneficiary may not always be sure of whether a physician will or will not accept assignment on a particular claim or the amount of any additional charges involved. While these charges are a liability of the beneficiary, no information exists on what portion remains unbilled or uncollected due to the beneficiary's inability to pay.

The law specifies that a physician who knowingly, willfully, and repeatedly violates his assignment agreement is guilty of a misdemeanor. The penalty for conviction is a maximum $2,000 fine, up to 6 months' imprisonment, or both.

B. Assignment Rate Experience

A number of considerations influence a physician's decision as to whether or not to accept assignment. These include general attitudes toward the program, relationship with his patients, the ability of patients to pay, and claims payment experience. The following sections present recent assignment rate experience and highlight some of the factors which may play a role in physician decisionmaking. The primary factor generally believed responsible for assignment decisions, namely Medicare's computation of reasonable charges, is discussed in Part VI of this report.

1. National Data

The total number of assigned claims as a percentage of total claims received by Medicare carriers is known as a the total assignment rate. The net assignment rate is computed in the same manner except that it omits provider-based physicians [12] and group-practice prepayment plans which are considered assigned by definition. The net assignment rate declined between 1968, the year the Department of Health, Education, and Welfare (now the Department of Health and Human Services) began reporting this data and 1977. Since 1977, the rate appears to have leveled off at roughly 50 percent. Very recently the rate has increased slightly. The following table shows the net assignment rates for calendar years 1968–82. Comparable data on the percent of total charges assigned is also provided.

TABLE 9.—NET ASSIGNMENT RATES, BY YEAR, 1968–82

[In percent]

Year	Net assignment rate (based on number of claims)	Net assignment rate (based on dollar value of charges)
1968	59.0	NA
1969	61.5	NA
1970	60.8	NA
1971	58.5	53.8
1972	54.9	50.3
1973	52.7	48.1

[12] Provider-based physicians are those who practice primarily in the hospital or institutional setting and paid by or through the hopsital, e.g., pathologists.

TABLE 9.—NET ASSIGNMENT RATES, BY YEAR, 1968–82—Continued

[In percent]

Year	Net assignment rate (based on number of claims)	Net assignment rate (based on dollar value of charges)
1974	51.9	47.8
1975	51.8	47.7
1976	50.5	47.6
1977	50.5	48.2
1978	50.6	49.6
1979	51.3	50.7
1980	51.5	51.7
1981	52.3	53.0
1982	53.0	54.1

Source: Ferry, Thomas P., et al. Physicians' Charges Under Medicare: Assignment Rates and Beneficiary Liability. Health Care Financing Review. Winter 1980, p. 50, and Department of Health and Human Services, Health Care Financing Administration, Bureau of Program Operations, Part B Carrier Workload Reports: June 1982; December 1982; and conversation with HCFA official.

The statistics in Table 9 are nationwide data. There are however substantial variations from these rates in various parts of the country, among different classifications of beneficiaries, and among physicians of different specialties. Further, it should be noted that assignment rate data reflects experience for all claims including joint Medicare-Medicaid claims for which assignment is considered mandatory. An Urban Institute study of 1975 claims experience for the fourth quarter of fiscal year 1975 in California showed that when such joint claims were removed from the sample, assignment rates fell considerably. Total assignment rates were 60 percent for general practitioners, 56 percent for general surgeons, and 40 percent for internists. However, the voluntary assignment rates were only 33⅓ percent for general practitioners, 37 percent for general surgeons, and 22 percent for internists.[13] Similarly a study of fiscal year 1978 claims data from Colorado showed that the voluntary assignment rate for medical services provided by general practitioners, internists and general surgeons was 31.3 percent compared to a total rate of 45.2 percent.[14]

2. Geographic Variations

In 1981, the net assignment rate ranged from a high of 66.9 percent in the Boston region to a low of 30.5 percent in the Seattle region. The 1981 rate represented a decline over that recorded in 1969 in 8 out of 10 regions of the country. In comparison to 1980, four regions registered declines, five registered increases and one recorded no change.

[13] Holahan, John et al. Physician Pricing in California: Executive Summary. Health Care Financing Grants and Contracts Report (pursuant to contract No. SSA 600-70-0054) n.d., p. 9.

[14] Rice, Thomas and McCall, Nelda. Factors Influencing Physician Assignment Decisions Under Medicare. Health Policy Research Series Discussion Paper No. 82-82. SRI International. April 1982, p. 3.

TABLE 10.—NET ASSIGNMENT RATES, BY REGION, 1969, 1980 AND 1981

[In percent]

Region	1969[1]	1980[2]	1981[2]	Change in percent	
				1969–81	1980–81
Boston	73.7	67.4	66.9	−9.2	0.7
New York	48.7	51.8	54.0	10.9	4.2
Philadelphia	57.3	61.6	62.5	9.1	1.5
Atlanta	58.8	52.3	53.2	−9.5	1.7
Chicago	54.5	47.6	48.8	−10.5	2.5
Dallas	71.1	50.3	52.0	−26.9	3.4
Kansas City	63.8	40.4	40.2	−37.0	−0.5
Denver	73.0	39.5	38.0	−47.9	−3.8
San Francisco	70.5	53.2	53.2	−24.5	.....
Seattle	64.8	31.3	30.5	−52.9	−2.6

[1] Department of Health, Education, and Welfare, Social Security Administration, Office of Research and Statistics. DHEW pub. No. (SSA) 72-11702, HI-33, Jan. 10, 1972. p. 6.
[2] Department of Health and Human Services, Health Care Financing Administration, Bureau of Program Operations, Analysis of Medicare Part B Assignment Rates: Calendar year 1981, n.d.

The variations in assignment rates are even more dramatic when comparisons are made between individual carriers. For example, in 1981, Rhode Island Blue Shield was the carrier with the highest net assignment rate (82.2 percent) among the single State-wide carriers, while the lowest such rate was experienced in the State of Wyoming by the Equitable Life Assurance Society (18.8 percent). Table 11 shows the net assignment rate by carrier for 1980 and 1981. Four carriers experienced a decrease in net assignment rates between 1980 and 1981 of four percent or more. However, 13 carriers experienced an increase of four percent or more over the period.

TABLE 11.—NET ASSIGNMENT RATES OF PART B CARRIERS AND PERCENT CHANGE BY HHS REGION, CALENDAR YEARS 1980 AND 1981

Carrier	1980	1981	Percent change
Total	51.5	52.3	1.0
Boston region	67.4	66.9	−.7
Connecticut—General	44.1	44.9	1.8
Maine-Massachusetts B/S [1]	67.8	65.8	−2.9
Massachusetts B/S	77.9	77.6	−.4
New Hampshire-Vermont B/S	51.1	49.2	−3.7
New Hampshire	48.3	46.7	−3.3
Vermont	56.2	54.1	−3.7
Rhode Island	81.6	82.2	.7
New York region	51.8	54.0	4.2
New Jersey—Prudential	48.6	50.0	2.9
New York B/S—Binghamton	56.7	57.7	1.8

TABLE 11.—NET ASSIGNMENT RATES OF PART B CARRIERS AND PERCENT CHANGE BY HHS REGION, CALENDAR YEARS 1980 AND 1981—Continued

Carrier	1980	1981	Percent change
New York B/S—New York	53.8	56.7	5.4
New York—Group Health	39.2	42.6	8.7
Puerto Rico B/S	48.5	52.8	8.9
Puerto Rico	48.5	52.9	9.1
Virgin Islands	35.8	39.0	8.9
Philadelphia region	61.6	62.5	1.5
Delaware [2]	64.0	62.8	−1.9
District of Columbia B/S [3]	59.6	61.2	2.7
Maryland B/S	61.9	63.1	1.9
Pennsylvania B/S	65.7	66.9	1.8
Virginia—Travelers	52.6	51.9	−1.3
West Virginia—Nationwide	51.0	51.7	1.4
Atlanta region	52.3	53.2	1.7
Alabama B/S	63.9	63.6	−.5
Florida B/S	38.4	40.4	5.2
Florida—Group Health	69.5	73.0	5.0
Georgia—Prudential	59.6	59.6	0
Kentucky—Metropolitan	54.1	53.2	−1.7
Mississippi—Travelers	63.8	63.1	−1.1
North Carolina—Prudential	52.9	54.5	3.0
South Carolina B/S	57.8	56.5	−2.2
Tennessee—Equitable	54.0	52.6	−2.6
Chicago region	47.6	48.8	2.5
Illinois—EDSF	43.8	45.7	4.3
Indiana B/S	31.7	31.6	−.3
Michigan B/S	72.8	74.9	2.9
Minnesota B/S	23.8	26.2	10.1
Minnesota—Travelers	32.8	35.1	7.0
Ohio—Nationwide	37.9	38.6	1.8
Wisconsin B/S	36.2	37.4	3.3
Dallas region	50.3	52.0	3.4
Arkansas B/S	56.0	57.9	3.4
Louisiana—Pan American	46.9	46.1	−1.7
New Mexico—Equitable	44.5	44.2	−.7
Oklahoma—Aetna	17.8	18.2	2.2
Oklahoma—SRS	97.0	96.8	−.2
Texas B/S	52.8	55.3	4.7
Kansas City region	40.4	40.2	−.5
Iowa B/S	35.9	35.8	−.3
Kansas B/S	49.1	48.0	−2.2
Missouri B/S	41.0	41.7	1.7
Missouri—General American	40.1	40.0	−.2
Nebraska—Mutual of Omaha	33.6	32.7	−2.7
Denver region	39.5	38.0	−3.8
Colorado B/S	47.9	47.6	−.6
Montana B/S	24.5	24.0	−2.0
North Dakota B/S	30.8	29.8	−3.2

TABLE 11.—NET ASSIGNMENT RATES OF PART B CARRIERS AND PERCENT CHANGE BY HHS REGION, CALENDAR YEARS 1980 AND 1981—Continued

Carrier	1980	1981	Percent change
North Dakota	33.3	32.4	−2.7
South Dakota	27.0	25.9	−4.1
Utah B/S	44.2	35.5	−19.7
Wyoming—Equitable	18.0	18.8	4.4
San Francisco region	53.2	53.2	0
Arizona-Nevada—Aetna	31.6	34.2	8.2
Arizona	28.1	31.4	11.7
Nevada	46.7	47.2	1.1
California B/S	65.1	53.8	−17.4
California—Occidental	44.1	57.7	30.8
Hawaii—Aetna	41.0	41.8	2.0
Seattle region	31.3	30.5	−2.6
Alaska-Oregon—Aetna	23.4	23.9	2.1
Alaska	48.8	52.6	7.8
Oregon	22.7	23.1	1.8
Idaho—Equitable	21.3	20.3	−4.7
Washington B/S	37.1	35.8	−3.5
Railroad Retirement Board—Travelers	41.8	43.4	3.8

[1] B/S means Blue Shield.
[2] Represents operations under Pennsylvania Blue Shield beginning Aug. 1, 1981.
[3] Represents operations under Pennsylvania Blue Shield beginning Oct. 1, 1981.

Source: DHHS, HCFA, Bureau of Program Operations. Analysis of Medicare Part B Assignment Rates: Calendar year 1981. n.d.

Individual carrier administrative practices are believed to have some impact on Medicare assignment levels; however, a HCFA analysis revealed no apparent relationship between net assignment rates and mean claims processing times.[15]

3. Demographic Variations

Certain demographic characteristics of program beneficiaries appear to have some effect on physicians' decisions regarding assignments. A recent review of 1975–78 data shows that significant variations occurred when beneficiary age and race, were taken into account. Relatively minor differences were recorded between acceptance of assignment for male versus female patients.

In 1978, acceptance of assignment was considerably lower for services provided to the aged than those provided to disabled beneficiaries. Estimated assignment rates for the aged were 47.4 percent of services and 48.7 percent of total charges.[16] The estimated rates for the disabled were 62.8 percent of services and 65.5 percent of total charges.

[15] DHHS, HCFA, Bureau of Program Operations. Analysis of Medicare Part B Assignment Rates: Calendar year 1981, n.d.
[16] Assignment rates based on services measure the total number of procedures (for which a separate reasonable charge determination is made) on assigned claims as a percentage of the total number of procedures on all claims received.

Data collected for 1977 shows that for aged beneficiaries, physicians' acceptance increased with successively older age groups ranging from 42.6 percent of services for those aged 65–69 to 58.8 percent for those 85 and over. An earlier analysis of comparable 1975 data[17] indicated that higher acceptance rates for older persons reflect several factors including the increased willingness of physicians to accept assignments for patients of long-standing or for those with diminished resources and assets. It was also attributed to the fact that the older population was more likely to participate in Medicaid for which assignment is mandatory. Similarly the higher Medicaid participation rate for non-white versus white beneficiaries was believed to account for much of the difference in assignment rates by race.

Among the disabled population, physicians' acceptance of assignment decreases successively for older age groups. In 1977, 85.7 percent of services were assigned for persons under age 25 dropping to 59.1 percent for those aged 45–64. Differences in rates recorded between white and non-white disabled beneficiaries showed similar patterns to that recorded between white and non-white aged.

TABLE 12.—MEDICARE BENEFICIARIES: ASSIGNMENT RATES FOR AGED AND DISABLED BENEFICIARIES BY AGE, SEX, AND RACE, 1977

Age, sex, and race	Aged		Disabled	
	Percent of services assigned	Percent of total charges assigned	Percent of services assigned	Percent of total charges assigned
Total	47.1	48.4	62.2	64.9
Age:				
Under 25			85.7	84.6
25 to 44			74.7	76.9
45 to 64			59.1	61.6
65 to 69	42.6	44.0		
70 to 74	43.9	45.9		
75 to 79	47.5	49.5		
80 to 84	51.5	52.5		
85 plus	58.8	59.1		
Sex:				
Male	46.3	47.4	63.0	65.4
Female	47.7	49.2	61.3	64.2
Race:				
White	44.9	46.3	58.2	60.9
All other races	77.9	78.3	85.8	87.4

Note: Date for Texas incorrectly coded and therefore omitted.

Source: McMillan, Alma, Pine, Penelope and Newton, Marilyn. Medicare: Use of Physicians' Services Under the Supplementary Medical Insurance Program, 1975–1978. DHHS, HCFA, HCFA Pub. No. 03151, March 1983. p. 91.

[17] Ferry, Thomas P., et al., Physicians Charges Under Medicare: Assignment Rates and Beneficiary Liability, in Health Care Financing Review, Winter 1980. p. 51.

4. Variations Among Physicians

Surveys have indicated that an estimated 18-19 percent of physicians always accept assignment, 28-30 percent never accept assignment, and the remaining 52-53 percent make their decisions on a case-by-case basis.[18]

One study found that individual physicians generally always or never accept assignment.[19] Another report found that physicians accept or decline assignment predominantly on a patient-by-patient basis rather than a claim-by-claim basis.[20]

The acceptance of assignment also appears to vary with the specialty of the physician. In 1977, net assignment rates for aged beneficiaries ranged from 22.8 percent for services by chiropractors to 61.2 percent for services by pathologists (See Table 13). With respect to the major specialty groups, surgeons accepted assignment on services more frequently than did internists or general practitioners.

TABLE 13. MEDICARE: NET ASSIGNMENT RATES FOR AGED AND DISABLED PERSONS, BY PHYSICIAN SPECIALTY, UNITED STATES, 1977

Physician Specialty	Aged		Disabled	
	Percent of services assigned	Percent of total charges assigned	Percent of services assigned	Percent of total charges assigned
Major specialties [1]:				
Internal medicine	39.3	44.1	53.5	61.5
General practice	41.9	44.6	54.5	57.2
General surgery	46.5	50.5	61.6	66.5
Radiology [2]	59.0	56.1	69.8	67.9
Other specialties:				
Family practice	44.3	46.2	56.3	57.8
Cardiovascular disease	47.8	51.7	54.5	57.7
Dermatology	38.3	44.3	56.0	57.6
Otology/rhinology/laryngology	29.3	37.6	45.0	53.6
Ophthalmology	28.7	37.9	49.2	52.4
Orthopedic surgery	42.4	48.0	52.7	53.6
Urology	39.1	43.6	57.4	60.4
Anesthesiology [2]	46.9	46.1	61.3	60.9
Pathology [2]	61.2	61.5	65.7	65.8

[18] Burney, Ira L. et. al. "Medicare and Medicaid Physician Payment Incentives" in Health Care Financing Review, Summer 1979, p. 66; and Janet B. Mitchel and Jerry Cromwell. Physician Behavior Under the Medicare Assignment Option. Final report. Jan. 30, 1981. p. 68.

[19] Markel, Gene A. A Study of Physicians' Services Market in Pennsylvania, Draft final report. Pt. IV. Physician Participation in Insured Medical Programs. Pennsylvania Blue Shield Research Report R-419-F(4) (pursuant to HCFA contract No. 6001-76-0146 (modification 5), June 1982.

[20] Sulvetta, Margaret, "An Analysis of Changes in Physicians' Medicare Revenues", Aug. 1981. p. 47.

TABLE 13. MEDICARE: NET ASSIGNMENT RATES FOR AGED AND DISABLED PERSONS, BY PHYSICIAN SPECIALTY, UNITED STATES, 1977—Continued

Physician Specialty	Aged		Disabled	
	Percent of services assigned	Percent of total charges assigned	Percent of services assigned	Percent of total charges assigned
Chiropractor	22.8	25.3	38.8	42.1
Podiatry	59.2	66.6	75.7	80.9
All physicians	47.1	48.4	62.2	64.9

[1] Denotes categories of physicians serving the largest number of Medicare patients.
[2] Data is incomplete for services rendered by hospital-based physicians.

Note: Data for Texas incorrectly coded and therefore omitted.

Source: McMillian, Alma, Pine, Penelope and Newton, Marilyn. Medicare: Use of Physicians' Services Under the Supplementary Medical Insurance Program, 1975–78, DHHS, HCFA, HCFA Pub. No. 03151, March 1983. p. 93–97.

When the dual factors of physician specialty and census region were taken into account, the disparities in assignment rates were even greater. For both the aged and disabled populations, assignment rates for the four most frequently used specialties are generally the highest in the Northeast and lowest in the North Central Region.

TABLE 14.—MEDICARE BENEFICIARIES: ASSIGNMENT RATES FOR AGED AND DISABLED BENEFICIARIES BY SELECTED SPECIALTIES AND CENSUS REGION, 1977

Physician Specialty	United States		Northeast		North-Central		South		West	
	Services assigned	Charges assigned	Services assigned	Charges assigned	Services assigned	Charges assigned	Services assigned	Charges assigned	Services assigned	Charges assigned
Aged:										
Internal medicine	39.3	44.1	54.0	57.7	27.3	34.3	32.8	35.8	38.8	42.4
General practice	41.9	44.6	46.6	50.1	29.8	34.0	48.7	49.3	43.8	46.6
General surgery	46.5	50.5	60.0	65.1	32.7	37.1	49.6	49.2	43.5	47.1
Radiology	59.0	56.1	77.8	71.5	46.7	45.2	61.4	55.8	54.1	52.6
Disabled:										
Internal medicine	53.5	61.5	69.1	75.0	44.8	55.1	44.8	50.9	55.0	63.6
General practice	54.5	57.2	61.2	62.6	48.0	51.7	54.0	55.5	58.5	61.5
General surgery	61.6	66.5	69.4	76.0	53.1	59.3	62.5	63.4	61.6	67.1
Radiology	69.8	67.9	85.6	82.7	60.6	57.6	70.8	68.0	64.5	64.6

Note: Data for Texas incorrectly coded and therefore omitted from South and U.S. totals.

Source: McMillan, Alma, Pine, Penelope and Newton, Marilyn. Medicare: Use of Physicians' Services Under the Supplementary Medical Insurance Program, 1975–78, DHHS, HCFA, HCFA Pub. No. 03151, March 1983. p. 97–99.

5. Variations by Size of Annual Patient Charges

Under the Medicare claims payment system, if a beneficiary accumulates several bills from the same physician and then submits them together, they become one "claim". Thus, both the amount of and the percent reduction recorded for unassigned claims reflects the way beneficiaries submit bills. It is therefore difficult to correlate the size of the bill with the physician's decision on whether or not to accept assignment.

Data is available, however, which indicates that the percent of assigned charges increases quite steadily as beneficiaries' total annual charges from physicians increase. For example, in 1978, assigned charges represented 44.6 percent of total charges for the aged receiving some program reimbursement for physicians services. The figure ranged from 30.3 percent for persons with total annual charges of less than $100, dropping to 27.9 percent for persons with annual charges of $100-149 and then gradually increasing to 52 percent for persons with annual charges of $2,500 or more. In that year 25.4 percent of the aged population who received some reimbursement for physicians' services had annual charges below $100, 12.4 percent had charges of $100-$149; only 3.7 percent of this population group had charges of $2,500 or more. The pattern of a gradual percentage increase in assigned charges as total annual charges per user increased was repeated for general practitioners, internists and general surgeons; however, no clear pattern was evidenced for radiologists. Comparable assignment patterns were observed for the disabled population.[21]

6. Other Variables

In addition to the factors mentioned in the preceding sections, certain other factors appear to be associated with higher assignment rates. A recent analysis [22] of Medicare claims experience in Colorado showed several significant determinants of whether a Medicare service was provided on an assigned basis. A review of physician characteristics indicated that female physicians, osteopaths and hospital-based physicians tended to accept assignment more frequently than their counterparts. On the other hand, services provided by medical specialists (primarily internists) and by board-certified physicians tended to be provided on an assigned basis less often than those provided by other physicians. Surgical procedures were associated with assignment less frequently than medical procedures; however, rights to payment for radiology procedures were assigned more often. Several beneficiary characteristics also proved to be determinants of assignments. Assuming all other characteristics to be equal, factors associated with higher assignment rates included beneficiaries who were in poorer health status, were more alert, died during the year, had a regular source of care, and were males. Persons residing in small metropolitan areas or counties adjacent to a large SMSA had services assigned

[21] Alma McMillan, et al, Medicare: Use of Physician's Services Under the Supplementary Medical Insurance Program. p. 106-107.

[22] Rice, Thomas and Nelda McCall. Factors Influencing Physician Assignment Decisions Under Medicare. Health Policy Research Series Discussion Paper No. 82-2 (pursuant to HCFA Grant No. 95-P-97150/9-04). SRI International, Menlo Park, Calif., April 1982.

less often than those in rural or semi-rural counties. Beneficiaries who had supplemental health insurance policies (i.e., so-called Medigap policies) received services on an assigned basis less often than other beneficiaries. This study further determined that when other factors were held constant, beneficiary income or physician experience or graduation from a foreign medical school were not significant determinants. Other analyses have, however, noted that foreign medical school graduates are more likely to accept assignment.[23]

[23] Mitchell, Janet B., and Jerry Cromwell. Physician Behavior Under the Medicare Assignment Option. Final report. Jan. 30, 1981.

VI. REASONABLE CHARGE REDUCTIONS

A. Reasonable Charge Reduction Rates

The primary factor affecting a physician's decision not to accept assignment is generally believed to be the "reasonable charge" levels determined by Medicare. Several limitations on allowable increases in reasonable charges were incorporated in the program after passage of the original Medicare legislation. These limitations have been accompanied by a substantial increase in the reasonable charge reduction rate—i.e., the percentage of claims for which the physician receives a reduced payment, because his billed charge is greater than the reasonable charge determined by the carrier. During the third quarter of 1969, the reasonable charge reduction rate for assigned claims stood at about 22 percent.[24] This meant that about one in five approved assigned claims resulted in a payment to a physician of an amount less than his billed charges. For fiscal year 1982, the reasonable charge reduction rate among assigned claims (excluding those from hospital-based physicians) had reached 88.1 percent. In other words, over four-fifths of all assigned claims resulted in reduced payments for billed charges. On the average the reduction amounted to $29.32 per approved claim. Physicians who do not accept assignment are not affected by possible reductions in payments for billed charges because the beneficiary is liable for the difference. The reasonable charge reduction rate for unassigned claims (excluding those from hospital-based physicians) during fiscal year 1982 was also sizeable—85.6 percent. The amount reduced per approved claim was $28.10.[25]

The following table shows recent trends in reasonable charge reductions for Medicare Part B claims.

[24] Department of Health, Education, and Welfare, Social Security Administration, Office of Research and Statistics. Assignment Rates for Supplementary Medical Insurance Claims, Calendar Years 1970-72. DHEW Pub. No. (SSA) 78-11702, HI-46, June 30, 1973, p. 7.

[25] Department of Health and Human Services, Health Care Financing Administration, Bureau of Program Operations. Part B Carrier Reasonable Charge and Denial Activity Report: July-September 1982; January 1983.

TABLE 15. REASONABLE CHARGE REDUCTIONS FOR MEDICARE PART B (EXCLUDES CLAIMS FROM HOSPITAL-BASED PHYSICIANS AND GROUP-PRACTICE PREPAYMENT PLANS) FOR ASSIGNED AND NOT ASSIGNED CLAIMS, FISCAL YEARS 1973–1982

	1973	1974	1975	1976	1977	1978	1979	1980	1981 [1]	1982 [1]
Percentage of claims reduced:										
Assigned	51.5	61.0	68.3	73.1	72.8	73.4	75.8	80.0	82.7	83.1
Not Assigned	63.5	70.6	75.6	78.4	77.1	77.2	79.9	83.7	85.7	85.6
Percentage reduction in charges for covered services:										
Assigned	11.4	13.0	16.4	19.0	19.4	19.8	20.8	22.5	23.9	24.3
Not Assigned	12.4	13.6	16.6	18.8	19.1	19.1	20.3	22.3	23.7	24.1
Amount reduced per approved claim:										
Assigned	$6.95	$8.24	$11.13	$13.74	$14.93	$16.11	$18.34	$21.81	$25.84	$29.32
Not Assigned	$9.34	$10.44	$13.45	$15.75	$16.53	$16.76	$18.64	$21.96	$25.13	28.10

[1] Data excludes Texas Blue Shield.

Source: Department of Health and Human Services, Health Care Financing Administration, Bureau of Program Operations, Part B Reasonable Charge and Denial Activity Report: Fiscal year 1982, August 1983.

B. Variations by Carrier

Part V of this report showed that there were dramatic differences between carriers in terms of assignment rates. The differences among carriers in terms of reasonable charge reduction rates are less pronounced. Further, there appears to be no consistent correlation between net assignment rates and reasonable charge reduction rates. Though one might assume that carriers with higher assignment rates might have lower reduction rates this is not always the case. For example, Rhode Island Blue Shield, the statewide carrier with the highest net assignment rate in 1981, had one of the highest reasonable charge reduction rates—92.1 percent. Conversely, Wyoming Equitable, the statewide carrier with the lowest net assignment rate, had a reasonable charge reduction rate below the national average—79.2 percent versus 82.8 percent (however, the percentage reduction in terms of the dollar value of the charges reduced was slightly above the national average). Table 16 shows net assignment rates and reasonable charge reduction rates by carrier.

TABLE 16.—NET ASSIGNMENT RATES AND REASONABLE CHARGE REDUCTIONS (EXCLUDING HOSPITAL-BASED AND GROUP PRACTICE PHYSICIAN CLAIMS), BY CARRIER, 1981

Carrier	Net assignment rate	Reasonable charge reduction	
		Percent claims reduced	Percent charges reduced
Total [1]	52.3	82.8	24.0
Boston region	66.9	87.3	25.5
Connecticut-General	44.9	85.9	20.2
Maine-Massachusetts B/S [2]	65.8	86.3	21.8
Massachusetts B/S	77.6	86.9	26.4
New Hampshire-Vermont B/S	49.2	85.7	21.5
Rhode Island B/S	82.2	92.1	32.1
New York region	54.0	86.5	26.1
New Jersey-Prudential	50.0	88.2	24.0
New York B/S-Binghamton	57.7	81.8	20.2
New York B/S-New York	56.7	88.1	28.8
New York-Group Health	42.6	86.1	25.1
Puerto Rico B/S	52.8	75.2	22.5
Philadelphia region	62.5	79.1	24.6
Delaware B/S [3]	62.8	63.0	23.0
District of Columbia B/S [4]	61.2	86.3	35.2
Maryland B/S	63.1	41.0	15.3
Pennsylvania B/S	66.9	84.1	24.7
Virginia-Travelers	51.9	84.3	24.9
West Virginia-Nationwide	51.7	81.5	24.5
Atlanta region	53.2	79.3	22.2
Alabama B/S	63.6	65.3	22.0
Florida B/S	40.4	81.2	20.1

TABLE 16.—NET ASSIGNMENT RATES AND REASONABLE CHARGE REDUCTIONS (EXCLUDING HOSPITAL-BASED AND GROUP PRACTICE PHYSICIAN CLAIMS), BY CARRIER, 1981—Continued

Carrier	Net assignment rate	Reasonable charge reduction	
		Percent claims reduced	Percent charges reduced
Florida-Group Health	73.0	75.4	22.5
Georgia-Prudential	59.6	83.9	23.6
Kentucky-Metropolitan	53.2	75.7	20.1
Mississippi-Travelers	63.1	83.3	26.6
North Carolina-Prudential	54.5	80.7	23.0
South Carolina B/S	56.5	86.4	22.5
Tennessee-Equitable	52.6	84.3	24.0
Chicago region	48.8	83.4	24.2
Illinois-EDSF	45.7	77.4	19.6
Indiana B/S	31.6	80.9	23.0
Michigan B/S	74.9	86.3	28.0
Minnesota B/S	26.2	89.1	22.0
Minnesota-Travelers	35.1	86.1	20.6
Ohio-Nationwide	38.6	80.0	23.1
Wisconsin B/S	37.4	86.7	21.3
Dallas region[1]	52.0	84.6	24.2
Arkansas B/S	57.9	84.4	21.3
Louisiana-Pan American	46.1	74.2	23.4
New Mexico-Equitable	44.2	80.3	20.3
Oklahoma-Aetna	18.2	84.7	23.2
Oklahoma-SRS	96.8	77.2	25.5
Texas B/S [1]	55.3	91.4	26.6
Kansas City region	40.2	81.2	22.4
Iowa B/S	35.8	79.3	26.3
Kansas B/S	48.0	83.7	21.6
Missouri B/S	41.7	80.8	21.6
Missouri-General American	40.0	81.5	20.9
Nebraska-Mutual of Omaha	32.7	77.6	22.3
Denver region	38.0	62.1	17.4
Colorado B/S	47.6	45.0	14.5
Montana B/S	24.0	83.5	17.6
North Dakota B/S	29.8	91.1	25.8
North Dakota B/S	32.4	92.6	23.3
South Dakota	25.9	88.3	30.7
Utah B/S	35.5	86.1	19.6
Wyoming-Equitable	18.8	79.2	24.9
San Francisco region	53.2	85.6	23.8
Arizona-Nevada-Aetna	34.2	80.6	21.3
California B/S	53.8	85.4	22.7
California-Occidental	57.7	86.1	24.9
Hawaii-Aetna	41.8	91.0	24.7

TABLE 16.—NET ASSIGNMENT RATES AND REASONABLE CHARGE REDUCTIONS (EXCLUDING HOSPITAL-BASED AND GROUP PRACTICE PHYSICIAN CLAIMS), BY CARRIER, 1981—Continued

Carrier	Net assignment rate	Reasonable charge reduction	
		Percent claims reduced	Percent charges reduced
Seattle region	30.5	85.9	20.6
Alaska-Oregon-Aetna	23.9	81.2	18.1
Idaho-Equitable	20.3	79.4	23.5
Washington B/S	35.8	88.2	21.7
RRB-Travelers	43.4	81.5	24.4

[1] Due to a systems conversion, Texas Blue Shield could not supply accurate reasonable charge data from July 1, 1981, through Dec. 31, 1981. Therefore, these missing data are not reflected in other calculations.
[2] B/S means Blue Shield.
[3] Represents Delaware Blue Shield operations through July 16, 1981. Effective Aug. 1, 1981, Pennsylvania Blue Shield began serving the State of Delaware.
[4] Represents District of Columbia Blue Shield operations through Sept. 22, 1981. Effective Oct. 10, 1981, Pennsylvania Blue Shield began serving the District of Columbia.

Source: DHHS, HCFA, Bureau of Program Operations, Analysis of Medicare Part B Assignment Rates, calendar year 1981.

C. Variations by Physician Specialty

An analysis of assignment data indicates that the average percent reduction on submitted charges for physicians' services varies somewhat by physician specialty. This variation reflects differences in rates of increases in physician charges by various specialty groups over time.

In 1978, total charges submitted by all physicians were reduced 19.9 percent for the aged and 21.1 percent for the disabled. For the aged, the average percent reduction for selected specialties ranged from a low of 16.5 percent for pathologists to a high of 29.0 percent for anesthesiologists. For the disabled, the range was from 15.5 percent for pathologists to 29.9 percent for anesthesiologists. The percent reductions were higher for assigned than for unassigned claims with the exception of anesthesiologists, radiologists, and pathologists.

The 1978 rates of reduction represent a slight increase over the 1975 rates for both assigned and unassigned claims for most physician specialties.

TABLE 17.—AVERAGE PERCENT REDUCTION OF TOTAL CHARGES FOR AGED AND DISABLED PERSONS FOR ASSIGNED AND UNASSIGNED SERVICES BY SELECTED PHYSICIAN SPECIALTY, UNITED STATES 1978

Physician specialty	Aged, average percent reduction			Disabled, average percent reduction		
	All charges	Assigned charges	Unassigned charges	All charges	Assigned charges	Unassigned charges
General practice	20.3	20.9	19.7	21.3	21.4	21.2
Family practice	20.2	20.7	19.7	20.7	20.8	20.5
Internal medicine	19.2	20.1	18.5	20.5	21.3	19.3
Cardiovascular disease	19.3	19.6	19.1	19.9	20.4	19.5
Dermatology	17.5	19.1	16.3	18.7	19.0	18.2
General surgery	20.8	21.6	20.1	21.4	22.1	20.2
Otology/rhinology/laryngology	21.7	24.0	20.7	23.6	24.0	23.6
Ophthalmology	17.6	19.4	16.7	18.4	19.4	17.5
Orthopedic surgery	21.5	22.4	20.9	22.5	23.0	22.2
Urology	19.5	20.8	18.8	20.9	20.7	21.0
Anesthesiology	29.0	28.5	29.3	29.9	29.2	30.8
Pathology	16.5	15.9	17.4	15.5	14.2	17.9
Radiology	16.9	16.5	17.5	17.4	17.0	18.0
Chiropractor	16.7	19.4	15.9	18.2	20.4	16.7
Podiatry	22.2	25.1	18.4	24.4	25.6	21.6

Note: Data is incomplete for services rendered by hospital-based physicians.

Source: McMillan, Alma, Pine, Penelope and Newton, Marilyn. Medicare: Use of Physicians' Services Under the Supplementary Medical Insurance Program, 1975–78, DHHS, HCFA, HCFA Pub. No. 03151, March 1983. p. 103.

D. Demographic Variations

Certain minor variations have been recorded in reasonable charge reductions when the factors of age, sex, and race are taken into account. Table 18 presents the data for 1978.

TABLE 18.—PERCENT REDUCTION IN TOTAL MEDICARE PHYSICIANS' CHARGES FOR THE AGED AND DISABLED BY AGE, SEX, AND RACE, UNITED STATES 1978

Demographic factors	Percent reduction in total charges	
	Aged	Disabled
U.S. total	19.9	21.1
Age:		
Under age 25	NA	22.7
26 to 44	NA	22.3
45 to 64	NA	20.8
65 to 69	20.3	NA
70 to 74	20.0	NA

TABLE 18.—PERCENT REDUCTION IN TOTAL MEDICARE PHYSICIANS' CHARGES FOR THE AGED AND DISABLED BY AGE, SEX, AND RACE, UNITED STATES 1978—Continued

Demographic factors	Percent reduction in total charges	
	Aged	Disabled
75 to 79	19.6	NA
80 to 84	19.7	NA
85 and over	19.6	NA
Sex:		
Male	20.0	20.9
Female	19.8	21.4
Race:		
White	19.8	20.9
All other	20.7	21.9
Unknown	20.1	22.2

Source: McMillan, Alma, Pine, Penelope and Newton, Marilyn. Medicare: Use of Physicians' Services Under the Supplementary Medical Insurance Program, 1975-78, DHHS, HCFA, HCFA Pub. No. 03151, March 1983. p. 11.

E. Comparison with Private Plans

A question which has frequently been raised about Medicare reimbursement policy is whether Medicare's "reasonable charges" are comparable to those recognized by Blue Shield and commercial policies. A 1975 study [26] comparing national average Medicare reasonable charges with payments under the most generous Blue Shield plan for seven common procedures showed that Medicare levels averaged at least 92 percent of the highest Blue Shield levels for five of the procedures. Both Medicare and Blue Shield levels averaged about 75-80 percent of what physicians reported they usually charged.

A 1979 GAO report to the Subcommittee on Health, Committee on Ways and Means,[27] compared physician charges and allowances under private plans with those under Medicare. Based on a sample of four commercial and two Blue Shield carriers, the report concluded that while physicians usually charge Medicare patients the same as other patients they are generally allowed less for the same procedure under Medicare. Private plan allowed charges were generally higher for the four commercial carriers and one of the Blue Shield carriers. Further, private plan allowed charges usually exceeded Medicare allowed charges by more than 10 percent. The GAO report also reviewed reasonable charge reductions. For the four commercial carriers, such reductions ranged from 0 to 7 percent of the private claims reviewed. In the case of the Blue Shield plans, one carrier made reductions in 27 percent of its private

[26] Burney, Ira L. et al. "Medicare and Medicaid Physician Payment Incentives", in Health Care Financing Review, Summer, 1979. p. 66.

[27] U.S. General Accounting Office. Comparison of Physician Charges and Allowances Under Private Health Insurance Plans and Medicare. Report by the Comptroller General of the United States. Report No. 79-111. Sept. 6, 1979.

claims while the other made reductions in 56 percent of its private claims. However, a sample of Medicare claims processed by the commercial and Blue Shield carriers showed reasonable charge reductions in 64 to 83 percent of the claims.

A more recent analysis is not available.

VII. IMPACT OF THE ECONOMIC INDEX

The Urban Institute issued several reports in 1981 which estimated the impact of the economic index. The analyses were based on a sample of solo practice physicians and physicians practicing in single specialty groups in California. Five specialities were chosen for review. These were general practice, general surgery, internal medicine, orthopedic surgery, and ophthalmology. The material in this section is based on the Urban Institute reports.

A. Impact of Program Costs and Beneficiary Liability

Data [28] for the first quarter of 1978 showed that the economic index had the effect of slightly reducing Medicare (as well as Medicaid) outlays; at the same time overall beneficiary liability rose (See Table 19). For example, program outlays associated with services provided by solo practice general practitioners were 2.99 percent less compared to what would otherwise have been spent. Total increased costs to beneficiaries for these services were 6.06 percent over what they would otherwise have been required to pay; increased beneficiary costs associated with non-assigned claims (roughly 85 percent of total costs excluding mandatory assigned claims) totalled 6.84 percent. Similar results were recorded for group practice general practitioners; program costs were reduced by 3.26 percent while beneficiary expenses increased by 6.35 percent.

[28] Paringer, Lynn. The Medicare Economic Index: Impact on Program Costs and Beneficiary Liability. Working Paper 1306-01-03, (pursuant to HCFA grant, no. 95-P-97178/3). The Urban Institute. June 1981.

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TABLE 19.—IMPACT OF THE MEDICARE ECONOMIC INDEX ON PROGRAM AND BENEFICIARY COSTS FOR SOLO PRACTICE AND GROUP PRACTICE PHYSICIANS (BASED ON SAMPLE FIRST QUARTER 1978 CLAIMS DATA FOR CALIFORNIA)

[Dollars in thousands]

Physician specialty	Solo practice physicians				Group practicing physicians			
	All claims	Assigned claims		Nonassigned	All claims	Assigned		Nonassigned
		Mandatory	Voluntary			Mandatory	Voluntary	
General practice:								
Program cost:								
Without index	$2,948.0	$967.8	$281.3	$1,696.9	$1,847.2	$838.4	$172.6	$834.9
With index	$2,860.0	$940.1	$274.1	$1,643.8	$1,786.9	$810.5	$168.5	$806.5
Percent change	−2.99	−2.87	−2.54	−3.13	−3.26	−3.33	−2.40	−3.39
Beneficiary costs:								
Without index	$846.7	NA	$70.3	$776.4	$429.6	NA	$43.2	$386.4
With index	$898.0	.....	$68.5	$829.5	$456.9	.....	$42.1	$414.8
Percent change	6.06	.....	−2.54	6.84	6.35	.....	−2.40	7.33
Medicaid cost:								
Without index	$242.0	$242.0	NA	NA	$209.6	$209.6	NA	NA
With index	$235.0	$235.0	.....	.....	$202.6	$202.6	.....	.....
Percent change	−2.87	−2.87	.....	.....	−3.33	−3.33	.....	.....
General surgery:								
Program cost:								
Without index	$1,930.0	$513.4	$366.1	$1,049.2	$1,019.6	$227.1	$243.0	$546.7
With index	$1,828.1	$483.6	$349.8	$993.6	$979.2	$218.7	$231.9	$525.4
Percent change	−5.23	−5.79	−4.48	−5.30	−3.96	−3.69	−4.51	−3.89
Beneficiary costs:								
Without index	$610.7	NA	$91.5	$519.2	$322.3	NA	$60.7	$261.6
With index	$662.2	.....	$87.4	$574.8	$340.8	.....	$58.0	$282.8

Percent change	8.43	.....	−4.48	10.71	5.71	.....	−4.51	8.13
Medicaid cost:								
Without index	$128.3	$128.3	NA	NA	$56.8	$56.8	NA	NA
With index	$120.9	$120.9	.....	.....	$54.7	$54.7	.....	.....
Percent change	−5.79	−5.79	.....	.....	−3.69	−3.69	.....	.....
Internal medicine:								
Program cost:								
Without index	$5,080.2	$1,203.9	$668.0	$3,205.2	$4,722.6	$1,115.5	$989.6	$2,616.4
With index	$4,934.6	$1,170.0	$645.9	$3,115.9	$4,573.0	$1,080.1	$957.1	$2,534.2
Percent change	−2.87	−2.82	−3.31	−2.79	−3.17	−3.12	−3.29	−3.14
Beneficiary costs:								
Without index	$1,702.7	NA	$167.0	$1,535.7	$1,461.0	NA	$247.4	$1,213.6
With index	$1,786.5	.....	$161.5	$1,626.1	$1,535.1	.....	$239.3	$1,295.8
Percent change	4.92	.....	−3.31	5.82	5.07	.....	−3.29	6.77
Medicaid cost:								
Without index	$301.0	$301.0	NA	NA	$278.9	$278.9	NA	NA
With index	$292.5	$292.5	.....	.....	$270.2	$270.2	.....	.....
Percent change	−2.82	−2.82	.....	.....	−3.12	−3.12	.....	.....
Orthopedic surgery:								
Program cost:								
Without index	$735.3	$179.6	$147.6	$407.5	$1,786.9	$366.8	$297.9	$1,120.9
With index	$689.9	$167.7	$138.1	$383.4	$1,672.5	$343.5	$276.8	$1,051.2
Percent change	−6.17	−6.61	−6.44	−5.93	−6.40	−6.36	−7.08	−6.22
Beneficiary costs:								
Without index	$212.9	NA	$36.9	$176.0	$574.0	NA	$74.5	$500.0
With index	$234.7	.....	$34.5	$200.1	$638.5	.....	$69.2	$569.3
Percent change	10.23	.....	−6.44	13.73	11.23	.....	−7.08	13.96
Medicaid cost:								
Without index	$44.9	$44.9	NA	NA	$91.7	$91.7	NA	NA
With index	$41.9	$41.9	.....	.....	$85.8	$85.8	.....	.....
Percent change	−6.61	−6.61	.....	.....	−6.36	−6.36	.....	.....

TABLE 19.—IMPACT OF THE MEDICARE ECONOMIC INDEX ON PROGRAM AND BENEFICIARY COSTS FOR SOLO PRACTICE AND GROUP PRACTICE PHYSICIANS (BASED ON SAMPLE FIRST QUARTER 1978 CLAIMS DATA FOR CALIFORNIA)—Continued

[Dollars in thousands]

Physician specialty	Solo practice physicians				Group practicing physicians			
	All claims	Assigned claims		Nonassigned	All claims	Assigned		Nonassigned
		Mandatory	Voluntary			Mandatory	Voluntary	
Ophthalmology:								
Program cost:								
Without index	$1,332.7	$281.7	$183.7	$863.7	$1,036.1	$227.1	$177.0	$630.5
With index	$1,298.9	$273.3	$179.1	$842.9	$1,021.3	$224.5	$174.7	$620.7
Percent change	−2.54	−2.95	−2.51	−2.41	1.43	−1.13	−1.31	−1.55
Beneficiary costs:								
Without index	$448.5	NA	$45.9	$402.6	$373.5	NA	$44.3	$329.3
With index	$448.2	.....	$44.8	$423.4	$382.7	.....	$43.7	$339.0
Percent change	4.38	.....	−2.51	5.17	2.46	.....	−1.31	2.97
Medicaid cost:								
Without index	$70.4	$70.3	NA	NA	$56.8	$56.8	NA	NA
With index	$68.3	$68.3	.....	.....	$56.1	$56.1	.....	.....
Percent change	−2.95	−2.95	.....	.....	−1.13	−1.13	.....	.....

Note: Totals may not add due to rounding.

Source: Paringer, Lynn. The Medicare Economic Index; Impact on Program Costs and Beneficiary Liability. Working Paper 1306–01–03 (pursuant to HCFA Grant No. 95–P–9717813). The Urban Institute, June 1981. Tables 2–5.

The Institute survey recorded similar findings for other specialties. For solo practice physicians, program savings were 5.23 percent for general surgeons, 2.87 percent for internists, 6.17 percent for orthopedic surgeons and 2.54 percent for ophthamologists. Net increases in beneficiary costs associated with these services were 8.43 percent for general surgeons, 4.92 percent for internists, 10.23 percent for orthopedic surgeons and 4.38 percent for ophthalmologists. For group practice physicians program savings were 3.96 percent for general surgeons, 3.17 percent for internists, 6.40 percent for orthopedic surgeons, and 1.43 percent for ophthalmologists. Net increases in beneficiary costs were 5.73 percent for general surgeons, 5.07 percent for internists, 11.23 percent for orthopedic surgeons, and 2.46 percent for ophthalmologists. The Institute report noted that program costs were reduced more for surgical procedures than for other procedures as a result of the application of the economic index.

The impact on beneficiaries depends on whether services are provided on an assigned or unassigned basis. Reductions stemming from application of the index will result in reduced beneficiary liability for copayments in the case of assigned claims. Parallel reductions in Medicaid outlays will occur in the case of joint Medicare/Medicaid claims. Conversely, in the case of non-assigned claims, reductions in recognized Medicare reasonable charges translate into increased beneficiary costs. Increases in liability for this group ranged from 2.97 percent for services of group practice ophthalmologists to 13.96 percent for services of group practice orthopedic surgeons. Beneficiary liability increases went as high as 17.34 percent for orthopedic surgery.

B. Impact of the Economic Index Over Time

Since physicians' fees rise at a faster rate than the economic index, an increasing number of claims will become subject to the prevailing charge limitation. An Urban Institute report[29] on the claims payment experience in California over the 1978–1980 period suggests that the constraining effect is magnified over time. For the period studied, surgical and anesthesiology fees were more constrained by the index than those for office and hospital visits. The impact of the index itself did not appear to be any different across regions or specialties for the same procedure.

Table 20 presents 1978 and 1980 data from the Urban Institute report on the relationship of physicians' customary charges to both the indexed prevailing charges and the prevailing charges which would have been in effect in the absence of the index (i.e., unindexed prevailing charges) for 10 procedures. Forty-three percent of the general practitioners in the study group had customary charges which exceeded the prevailing charge for limited exam office visits in 1978; this figure rose to 46.6 percent in 1980. In the absence of the index, 25 percent of the practitioners would have exceeded the prevailing level in 1978 and 23.1 percent would have exceeded the level in 1980. However, an additional 18.1 percent exceeded the

[29] Paringer, Lynn. The Effect of the Medicare Economic Index on Reasonable Fees: Evidence from California. Working Paper 1306-01-04 (pursuant to HCFA Grant No. 95-P-9718/13), The Urban Institute, Washington, D.C. July 1981.

level in 1978 and an additional 23.5 percent exceeded the level in 1980 as a result of the index. General surgeons, internists, orthopedic surgeons and ophthalmologists had similar patterns for office visits; for this group, internists were most affected by the index.

The impact of the index on reasonable charges for initial comprehensive hospital exams was less than that for office visits. However, for limited exam hospital visits, there was both a notable increase with respect to the percent of physicians with customary charges exceeding the prevailing level and a substantial increase in the proportion of physicians with customary charges falling between the indexed and unindexed prevailing level.

Table 20 further shows that the impact of the index on surgical fees was substantial. For example, in 1978, 67 percent of general surgeons had customary charges exceeding the indexed prevailing charges for colectomies; 46.3 percent had customary charges above the indexed prevailing but below the unindexed prevailing fee. In 1980, 72 percent of general surgeons had customary charges exceeding the prevailing charge with 57.4 percent between the indexed and unindexed prevailing charge.

The Urban Institute report noted that of the five specialties surveyed, anesthesiologists were most affected by the index. In 1978, only 5.6 percent of anesthesiologists' customary charges were below the indexed prevailing charge; this figure dropped to 0.3% in 1980. Approximately the same percentage of physicians had customary charges exceeding the unindexed prevailing level in 1978 and 1980—22.7 percent in 1978 and 22.9 percent in 1980. The proportion of anesthesiologists constrained by the index rose from 71.7 percent to 76.8 percent over the same period.

TABLE 20. PERCENT DISTRIBUTION OF PHYSICIANS BY RELATION OF CUSTOMARY CHARGES TO INDEXED AND UNINDEXED PREVAILING CHARGES, CALIFORNIA, 1978, AND 1980

Procedure and speciality	1978			1980		
	Customary less than indexed prevailing	Customary between indexed and unlimited prevailing	Customary greater than indexed prevailing	Customary less than indexed prevailing	Customary between indexed and unindexed prevailing	Customary greater than unindexed prevailing
Office visit; limited exam:						
General practice	56.9	18.1	25.0	53.4	23.5	23.1
General surgery	46.2	22.1	31.7	48.3	28.0	23.7
Internal medicine	55.4	24.2	20.4	42.7	34.4	22.9
Orthopedic surgery	49.3	27.3	23.5	45.9	36.7	17.4
Ophthalmology	61.8	14.6	23.6	57.0	24.2	18.8
Hospital visits, initial comprehensive exam:						
General practice	63.0	18.0	19.0	65.6	16.6	17.8
General surgery	53.1	26.9	20.0	62.9	21.8	15.3
Internal medicine	53.1	26.0	20.8	52.3	30.9	16.8
Orthopedic surgery	58.8	20.4	20.8	62.7	24.5	12.8
Hospital visit, limited exam:						
General practice	77.5	5.1	17.4	63.0	16.4	20.6
General surgery	70.4	10.5	19.1	60.9	17.3	21.8
Internal medicine	65.0	14.6	20.4	49.5	31.6	19.0
Orthopedic surgery	68.5	11.6	19.9	55.4	26.2	18.3
Ophthalmology	79.9	7.2	12.9	72.0	17.2	10.8
Chest X-ray, two views:						
General practice	73.1	12.4	14.4	72.7	14.5	12.8
General surgery	71.6	12.7	15.7	70.8	10.4	18.8
Internal medicine	72.9	8.7	18.4	71.7	13.6	14.7
Radiology	74.6	13.9	11.4	73.4	17.6	9.0

TABLE 20. PERCENT DISTRIBUTION OF PHYSICIANS BY RELATION OF CUSTOMARY CHARGES TO INDEXED AND UNINDEXED PREVAILING CHARGES, CALIFORNIA, 1978, AND 1980—Continued

Procedure and speciality	1978			1980		
	Customary less than indexed prevailing	Customary between indexed and unlimited prevailing	Customary greater than indexed prevailing	Customary less than indexed prevailing	Customary between indexed and unindexed prevailing	Customary greater than unindexed prevailing
Eye examination: Ophthalmologists	70.9	8.0	21.1	75.5	13.4	11.1
Colectomy, partial with anastomosis: General surgeons	33.0	46.3	20.7	28.0	57.4	14.6
Herniorraphy, inquinal: General surgeons	43.5	35.3	21.2	35.3	47.2	17.5
Eye surgery, extraction of lens: Ophthalmologists	65.9	18.9	15.2	55.8	33.0	11.2
Femur fracture, open reduction with internal fixation: Orthopedic surgeons	19.5	65.4	15.0	12.4	73.0	14.6
Basic anesthesiology: Anesthesiologists	5.6	71.7	22.7	.3	76.8	22.9

Source: Paringer, Lynn. "The Effect of the Medicare Economic Index on Reasonable Fees: Evidence from California," Working paper 1306–01–04 (pursuant to HCFA grant No. 95–P–9718/13) the Urban Institute, Washington, D.C., July 1981. p. 14.

VIII. IMPACT OF MEDICARE POLICIES ON THE AGED

A. Distribution of Expenditures for Physician Services

Total expenditures for physicians' services provided to the aged rose from $2.3 billion in fiscal year 1968 to $14.2 billion in fiscal year 1981. Although expenditures for covered Medicare services declined from 89.6 percent to 76.4 percent of the total over the period, the amount actually reimbursed by the program has remained relatively constant accounting for approximately 55 percent of expenditures for physicians' services. The portion attributable to beneficiary payments for deductibles and coinsurance has declined from 32.3 percent to 20.8 percent over the period. This is primarily attributable to the fact that the deductible remained fixed at $60 from 1973 through 1981.

Counterbalancing the declining percentage that deductibles represent of total physicians' expenditures is the significant increase in the percentage attributable to "noncovered services" to program enrollees. The percentage of the total attributable to these items rose from 7.2 percent of the total in fiscal year 1968 to 21.9 percent in fiscal year 1981. Noncovered services to program eligibles is defined in table 21 as including both reasonable charge reductions for nonassigned claims and uncovered services. Recent data is not available on the distribution of expenditures between these two categories. However, earlier data shows that the percentage of total expenditures for reasonable charge reductions for nonassigned claims rose from 2.2 percent in fiscal year 1968 to 9.6 percent in fiscal year 1976; the percentage attributable to noncovered services rose from 5.0 percent to 6.4 percent over the same period. The portion of expenditures for persons not enrolled in the program declined slightly from 3.2 percent in fiscal year 1968 to 1.7 percent in fiscal year 1981. Table 20 shows the distribution of total expenditures for physicians' services for the aged from fiscal year 1968 to fiscal year 1981.

TABLE 21. EXPENDITURES FOR PHYSICIANS' SERVICES FOR THE AGED: AMOUNTS (AND PERCENTAGE DISTRIBUTION) COVERED AND NOT COVERED BY MEDICARE, FISCAL YEAR 1968–81

[Dollars in millions]

Physicians' services covered and not covered by medicare	1968		1969		1970		1971		1972	
	Amount	Percent	Amount	Percent	Amount	Percent	Amount	Percent	Amount	Percent
Total	$2,307	100.0	$2,595	100.0	$2,803	100.0	$3,039	100.0	$3,323	100.0
Covered physicians' services	2,068	89.6	2,326	89.6	2,477	88.4	2,655	87.4	2,898	87.2
Medicare reimbursements	1,322	57.3	1,496	57.6	1,619	57.8	1,734	57.1	1,910	57.5
Beneficiary payments for:										
Deductibles	421	18.2	462	17.8	460	16.4	494	16.3	518	15.6
Coinsurance	325	14.1	368	14.2	398	14.2	427	14.1	470	14.1
Noncovered physicians' services	239	10.4	269	10.4	326	11.6	384	12.6	425	12.8
Services to enrollees	166	7.2	212	8.2	268	9.6	319	10.5	350	10.5
Reasonable charge reductions for unassigned claims	50	2.2	81	3.1	126	4.5	166	5.5	182	5.5
Services not covered	116	5.0	131	5.0	142	5.1	153	5.0	168	5.1
Services to those not enrolled	73	3.2	57	2.2	58	2.1	65	2.1	75	2.3

Physicians' services covered and not covered by medicare	1973		1974		1975		1976		1977	
	Amount	Percent	Amount	Percent	Amount	Percent	Amount	Percent	Amount	Percent
Total	$3,594	100.0	$3,931	100.0	$4,905	100.0	$5,862	100.0	$7,229	100.0
Covered physicians' services	3,102	86.3	3,336	84.9	4,071	83.0	4,799	81.9	5,810	80.4
Medicare reimbursements	2,022	56.3	2,209	56.2	2,726	55.6	3,243	55.3	3,985	55.1
Beneficiary payments for:										
Deductibles	584	16.2	587	14.9	678	13.8	764	13.0	829	11.5

Coinsurance	496	13.8	540	13.7	667	13.6	792	13.5	996	13.8
Noncovered physicians' services	492	13.7	595	15.1	834	17.0	1,063	18.1	1,419	19.6
Services to enrollees	412	11.5	511	13.0	730	14.9	936	16.0	1,280	17.7
Reasonable charge reductions for unassigned claims	214	6.0	269	6.8	415	8.5	562	9.6	N.A.	.....
Services not covered	198	5.5	242	6.2	315	6.4	374	6.4	N.A.	.....
Services to those not enrolled	80	2.2	84	2.1	104	2.1	127	2.2	139	1.9

Physicians' services covered and not covered by medicare	1978		1979		1980		1981	
	Amount	Percent	Amount	Percent	Amount	Percent	Amount	Percent
Total	$8,159	100.0	$9,701	100.0	$11,713	100.0	$14,157	100.0
Covered physicians' services	6,548	80.3	7,704	79.4	9,141	78.0	10,813	76.4
Medicare reimbursements	4,547	55.7	5,440	56.1	6,559	56.0	7,866	55.6
Beneficiary payments for:								
Deductibles	864	10.6	904	9.3	942	8.0	981	6.9
Coinsurance	1,137	13.9	1,360	14.0	1,640	14.0	1,966	13.9
Noncovered physicians' services	1,611	19.7	1,997	20.6	2,572	22.0	3,344	23.6
Services to enrollees	1,458	17.9	1,819	18.8	2,363	20.2	3,096	21.9
Reasonable charge reductions for unassigned claims	N.A.	.....	N.A.	.....	N.A.	.....	N.A.	.....
Services not covered	N.A.	.....	N.A.	.....	N.A.	.....	N.A.	.....
Services to those not enrolled	153	1.9	178	1.8	209	1.8	248	1.7

Note.—Totals may not add due to rounding.

Sources: Gibson, Robert M. and Charles R. Fischer, "Age Differences in Health Care Spending, Fiscal year 1977," in Social Security Bulletin, January 1979, vol. 42, No. 1. p. 16, and HCFA, unpublished tables.

B. Variations in Medicare Reimbursement[30 31]

1. Per Capita Payments

The previous table shows the distribution of expenditures for physician services for the aged nationwide. Considerable variation exists in the average per capita Medicare payment according to demographic and geographic characteristics of program beneficiaries. A HCFA sample of 1975–1978 Medicare claims for the aged shows that actual medicare payments per beneficiary increased for each older age cohort ranging from $152 for the group aged 65–69 to $259 for those 85 and over; the nationwide average was $197, a 50.4 percent increase over the 1975 figure of $131. The higher payments for the older population reflect both the greater number of persons in this group meeting the deductible and a greater number of services per user. Per capita payment was $214 for men compared to $186 for women. Certain disparities were also recorded among various categories of the disabled population. Per capita payments for this group increased 62 percent over the 1975–1978 period. Table 22 shows variations in per capita payments for physicians services for the aged and disabled populations by age, sex, and race.

TABLE 22.—MEDICARE REIMBURSEMENTS PER ENROLLEE FOR PHYSICIANS' SERVICES TO AGED AND DISABLED PERSONS, 1978

	Reimbursement per enrollee	
	Aged	Disabled
U.S. total	$197	$222
Age:		
Under 25	NA	184
25 to 44	NA	188
45 to 64	NA	233
65 to 69	152	NA
70 to 74	195	NA
75 to 79	223	NA
80 to 84	238	NA
85 and over	259	NA
Sex:		
Men	214	199
Women	186	259
Race:		
White	201	226
Other	153	204

Source: McMillan, Alma, Pine, Penelope and Newton, Marilyn. Medicare: Use of Physicians' Services Under the Supplementary Medical Insurance Program, 1975–78, DHHS, HCFA, HCFA Pub. No. 03151, March 1983, p. 23.

[30] All data in this section are from: McMillan, Alma, Pine, Penelope and Newton, Marilyn. Medicare: Use of Physicians' Services Under the Supplementary Medical Insurance Program, 1975–78, DHHS, HCFA, HCFA Pub. No. 03151, March 1983.

[31] The definition of "physicians services" in the McMillan report includes services of practitioners and suppliers.

The HCFA study showed marked disparities by race in average program reimbursements. For aged white individuals the per capita payment was $201 compared to $153 for aged non-white individuals. The disparities are partially offset by higher utilization rates and reimbursement levels for hospital outpatient care by non-whites compared to whites.

Average Medicare reimbursements also varied considerably according to the geographic residence of the beneficiary. By region, the lowest per capita payment for aged enrollees was in the South ($165) while the highest was in the West ($265). By census division the lowest payment per enrollee was recorded in the West South Central Division ($118) while the highest rate was recorded in the Pacific Division ($282). Similar disparities were recorded for disabled enrollees. (See Table 23.)

TABLE 23.—MEDICARE REIMBURSEMENTS PER ENROLLEE FOR PHYSICIANS' SERVICES TO AGED AND DISABLED PERSONS, 1978

Area of residence	Reimbursement per enrollee	
	Aged	Disabled
U.S. total	$197	$222
Northeast	221	240
New England	196	227
Middle Atlantic	230	244
North Central	171	212
East North Central	180	215
West North Central	154	202
South	165	182
South Atlantic	199	219
East South Central	149	181
West South Central	118	115
West	265	300
Mountain	213	233
Pacific	282	319

Source: McMillan, Alma; Pine, Penelope; and Newton, Marilyn. "Medicare: Use of Physicians' Services Under the Supplementary Medical Insurance Program, 1975–78, DHHS, HCFA," HCFA Pub. No. 03151, March 1983, p. 25.

2. Reimbursements and Allowed Charges

Physicians submitted approximately $7.8 billion in charges for services rendered to aged persons and $0.9 billion in such charges for disabled persons in 1978. Allowed charges (i.e. reasonable charges) totalled $6.3 billion for the aged and $0.7 billion for the disabled; these figures reflected reasonable charge reductions of 19.9 percent for the aged and 21.1 percent for the disabled. Actual Medicare payments totalled $4.6 billion (58.8 percent of billed charges) for the aged and $0.6 billion (59.4 percent) for the disabled. Payment as a percent of total charges varied little by age, sex, race, or census region.

Approximately 38.4 percent of allowed charges for the aged and 41 percent of such charges for the disabled were for medical care. Inpatient surgery accounted for an additional 24.3 percent of allowed charges for the aged and 21.7 percent for the disabled. Thus, 62.7 percent of the allowed charges for each population group was for medical care or inpatient surgery. (The remaining 37.3 percent included such services as diagnostic X-ray or laboratory services, outpatient surgery, and anesthesia).

3. Payments for Persons Exceeding the Deductible

In 1978, 56 percent of aged Medicare enrollees exceeded the deductible and actually received Medicare reimbursements for physicians' services. The proportion of these "users" increased significantly by age group rising from 46 percent of the age 65-69 population to 71 percent of those aged 85 and over. Fifty-eight percent of the female enrollees met the deductible and received reimbursements compared to 54 percent for male enrollees. By race, the proportion was 57 percent for whites and 47 percent for nonwhites. The range in the percentage for Part B aged beneficiaries with payments varied considerably by region with 63 percent of those in the West exceeding the deductible followed by the Northeast (59 percent), South (53 percent), and the North Central region (53 percent). In fifteen States (including Washington D.C.) at least 60 percent met the deductible. Only two States recorded rates below 40 percent (in both these States the reported data was incomplete).

In 1978, roughly one-quarter of aged enrollees who met the deductible, i.e., "users", received less than $50 in reimbursement for physicians' services; 52.9 percent of users received less than $150 in such reimbursements. Of the remaining users, 27.2 percent had reimbursements between $150-$499 and 19.9 percent had reimbursements of $500 or more. Comparable distributions were recorded for the disabled. There was little difference in the percentage of enrollees receiving reimbursements by specified dollar categories by age, sex, and race.

For aged enrollees exceeding the deductible and receiving payments, the use of services was as follows: medical care services (52 percent), diagnostic laboratory services (35 percent), diagnostic X-ray services (28 percent), non-inpatient surgery (16 percent), inpatient surgery (12 percent), consultation (10 percent), anesthesia (7 percent), radiation therapy (3 percent), assistants at surgery (2 percent), and other services (11 percent). Comparable distributions were recorded for the disabled.

The average number of services billed in 1978 in behalf of persons who met the deductible and received program reimbursements was 24.4 for the aged and 29.4 for the disabled. (This includes a count of those services which may have gone toward meeting the deductible). It should be noted that a service is any procedure having a separate reasonable charge determination; several services may be rendered during the course of a single physician visit. The average number of services billed in 1978 in behalf of persons receiving program reimbursement was similar between census regions though considerable variations existed among the States. For example, for the aged the average number ranged from 18.0 in

Kansas to 31.7 in Montana (three years earlier Montana recorded the lowest rate at 17.1).

The average number of physicians' services (excluding those of suppliers) billed in 1978 in behalf of aged persons receiving program reimbursement was 21.4. The comparable number for the disabled was 25.2. Tables 24 and 25 present this information by physician specialty according to various beneficiary characteristics.

TABLE 24.—AVERAGE NUMBER OF SERVICES PER REIMBURSED USER FOR THE AGED, BY PHYSICIAN SPECIALTY, AND BY AGE, SEX, RACE, AND CENSUS REGION, U.S., 1975–78

Physician specialty	Services per reimbursed user													
	U.S. total	Age					Sex		Race		Census region			
		65–69	70–74	75–79	80–84	85+	Men	Women	White	Other	NE	NC	South	West
All physicians [1]	21.4	19.8	21.4	22.3	22.5	22.4	22.2	20.9	21.4	21.5	20.4	21.5	22.3	21.1
General practice	11.5	10.2	11.2	11.8	12.4	12.8	11.2	11.6	11.3	13.3	10.1	12.3	12.3	10.4
Family practice	10.5	9.4	10.1	11.1	11.6	11.5	10.3	10.6	10.4	12.2	9.7	10.8	11.4	8.9
Internal medicine	12.9	11.9	12.7	13.6	13.5	13.9	13.0	12.9	12.9	13.5	13.2	13.3	12.6	12.6
Cardiovascular disease	8.5	7.6	8.7	8.9	9.2	8.4	8.5	8.5	8.5	7.7	9.3	8.3	7.7	8.4
Dermatology	4.0	3.9	4.0	4.0	3.8	4.4	4.3	3.8	4.0	5.4	3.8	3.6	3.7	4.8
General surgery	6.2	5.6	6.1	6.4	6.6	6.9	6.0	6.3	6.1	7.8	5.8	6.5	6.6	5.6
Otology/laryngology/rhinology	3.0	3.3	3.3	2.7	2.7	2.4	3.0	3.0	3.0	3.8	2.8	2.8	3.3	3.2
Opthalmology	2.6	2.5	2.5	2.6	2.6	2.5	2.7	2.5	2.5	3.0	2.5	2.5	2.6	2.7
Orthopedic surgery	4.9	5.0	4.9	4.9	4.9	4.6	4.7	4.9	5.8	6.4	4.7	4.5	5.0	5.3
Urology	5.7	5.6	5.6	5.8	5.5	5.9	5.8	5.3	5.6	7.0	5.2	5.1	5.9	6.6
Anesthesiology [2]														
Pathology [2]	14.2	14.5	14.0	12.5	15.0	16.1	15.4	13.3	13.8	18.2	8.5	15.0	14.3	15.6
Radiology [2]	4.3	4.2	4.3	4.3	4.5	4.4	4.6	4.1	4.3	4.8	4.0	4.6	4.5	4.0
Chiropractic	11.9	12.0	12.0	11.8	11.5	10.8	11.3	12.2	11.9	11.2	12.6	13.0	11.3	10.8
Podiatry	4.6	5.0	5.0	4.7	4.3	4.0	4.5	4.6	4.5	5.5	4.9	4.0	4.9	4.1
Multispecialty	9.4	9.3	9.5	9.4	9.4	9.2	9.7	9.2	9.4	8.9	8.1	9.4	9.4	10.2
Unknown	7.9	7.6	8.0	7.8	7.8	8.7	7.7	8.1	8.0	6.4	12.3	9.5	3.2	2.7
All other	7.1	7.2	7.1	7.1	6.9	6.7	7.6	6.8	7.0	7.5	7.3	6.8	7.3	6.7

[1] Total excludes suppliers.

[2] Data for hospital-based physicians are incomplete because of billing and reimbursement procedures.

Source: McMillan, Alma; Pine, Penelope; and Newton, Marilyn. "Medicare: Use of Physicians' Services Under the Supplementary Medical Insurance Program, 1975–1978, DHHS, HCFA," HCFA Pub. No. 03151, March 1983, p. 79.

TABLE 25. AVERAGE NUMBER OF SERVICES PER REIMBURSED USER FOR THE DISABLED, BY PHYSICIAN SPECIALTY, AND BY AGE, SEX, RACE, AND CENSUS REGION, U.S., 1975–78

Physician specialty	Services per reimbursed user											
	U.S. total	Age			Sex		Race		Census region			
		Under 25	25–44	45–64	Men	Women	White	Other	NE	NC	South	West
All physicians [1]	25.2	31.5	25.2	25.1	24.0	26.8	25.0	26.6	24.5	26.0	26.3	23.4
General practice	11.9	7.7	9.9	12.3	11.2	12.8	11.8	12.6	11.0	12.3	12.8	10.4
Family practice	11.0	5.9	8.8	11.5	10.8	11.4	10.9	11.4	10.9	10.9	11.9	8.9
Internal medicine	15.1	24.8	14.8	15.0	14.6	15.7	14.8	16.8	15.3	14.6	15.6	14.3
Cardiovascular disease	8.3	4.6	6.2	8.6	8.4	8.2	8.6	6.9	9.1	7.7	7.8	8.7
Dermatology	4.4	4.6	4.5	4.3	4.3	4.5	4.3	5.5	4.0	4.1	4.0	5.3
General surgery	6.5	5.9	6.1	6.5	6.1	6.8	6.5	6.4	6.6	6.3	6.8	5.7
Otology/laryngology/rhinology	3.6	2.8	4.0	3.5	3.5	3.6	3.6	3.3	3.6	3.2	4.0	3.3
Ophthalmology	2.8	2.6	2.9	2.7	2.8	2.7	2.7	3.3	2.6	2.7	2.8	2.9
Orthopedic surgery	5.8	3.7	6.2	5.8	5.8	5.9	5.9	5.6	5.6	5.1	6.3	5.9
Urology	6.8	5.2	7.3	6.5	6.5	6.9	6.5	7.5	8.8	5.6	5.7	7.1
Anesthesiology [2]	—	—	—	—	—	—	—	—	—	—	—	—
Pathology [2]	17.8	—	19.9	17.0	17.5	18.2	17.4	19.5	10.5	24.8	16.7	14.2
Radiology [2]	4.6	4.9	4.4	4.7	4.6	4.7	4.6	4.8	4.3	4.6	5.0	4.3
Chiropractic	12.9	15.6	12.9	12.9	12.4	13.5	13.0	12.2	14.9	13.5	13.2	11.5
Podiatry	5.1	5.8	5.0	5.1	5.1	5.1	5.0	5.7	5.9	4.4	4.9	4.5
Multispecialty	10.1	8.8	10.2	10.2	9.9	10.5	10.1	9.9	9.9	10.5	9.7	10.1
Unknown	13.0	27.3	21.5	10.8	13.7	12.1	11.0	27.2	27.4	14.9	3.7	3.0
All other	11.4	19.1	13.9	10.3	11.7	11.0	10.8	14.9	10.4	12.6	12.0	10.0

[1] Total excludes suppliers.
[2] Data for hospital-based physicians are imcomplete because of billing and reimbursement procedures.

Source: McMillan, Alma; Pine, Penelope; and Newton, Marilyn, "Medicare: Use of Physicians' Services Under the Supplementary Medical Insurance Program, 1975–1978, DHHS, HCFA," HCFA Pub. No. 03151, March 1983. p. 79.

C. Beneficiary Liability [32] [33]

1. Liability Per Enrollee

As noted earlier, Medicare reimbursements covered approximately 55.6 percent of total physician expenditures for the aged in fiscal year 1981. An additional 20.8 percent represented beneficiary cost-sharing charges (6.9 percent deductible and 13.9 percent copayments). However, since beneficiaries are also responsible for Part B premium payments and reasonable charge reductions in connection with unassigned claims, their liability is actually higher than these figures indicate.

A recent HCFA study examined 1978 data to determine actual beneficiary liability for physician services which were covered in part under Medicare. Charges above allowed charges on assigned claims, charges for uncovered services and services for persons not enrolled were excluded from consideration. Medicare reimbursements accounted for 63.8 percent of total physicians' charges while 36.2 percent of such charges were the liability of the beneficiary (deductibles, coinsurance, and reasonable charge reductions). However, net Medicare reimbursement (total payments less prorated Part B premiums [34]) represented only 40.3 percent of total physicians' charges; prorated premiums accounted for 23.5 percent bringing total beneficiary liability to 59.7 percent. Table 26 shows net Medicare contribution and beneficiary liability for physicians' services by age cohort, sex, race, and census region of the beneficiary.

Net Medicare contributions as a proportion of physicians' charges to aged enrollees increased from 30.8 percent to 40.3 percent over the 1975–1978 period. Two principal factors accounted for the increase. First, beneficiary cost-sharing charges did not rise as rapidly as physicians' charges. Second, the deductible remained at $60 throughout the period.

While the previous discussion has focused on beneficiary liability, it should be noted that such liability cannot be equated with out-of-pocket expenditures. Some aged beneficiaries are also covered under State Medicaid programs which generally cover the Part B premiums and other charges not reimbursed by Medicare. In addition, over half of the elderly have some form of supplementary health insurance (commonly referred to as Medi-gap policies) which may cover some or all of the charges not reimbursed by Medicare. However, premiums for such policies are of course a liability of the insured. Further, Medi-gap policies almost never cover amounts in excess of Medicare-determined reasonable charges (i.e., reasonable charge reductions for physician's services.)

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[32] Data in this section is from McMillan, et. al. "Medicare: Use of Physicians' Services Under the Supplementary Medical Insurance Program."

[33] The definition of "physicians' services" in the McMillan report includes services of practitioners and suppliers (except where otherwise noted).

[34] The part B premium figure used in the calculation is a prorated figure based on reimbursements for physicians' services as a percentage of total part B reimbursements.

TABLE 26.—MEDICARE: TOTAL PHYSICIANS' CHARGES TO THE AGED AND DISABLED, AMOUNT OF LIABILITY PER ENROLLEE, AND NET MEDICARE CONTRIBUTION PER ENROLLEE, BY AGE, SEX, RACE, AND CENSUS REGION, 1978

Age, sex, race, and census region	Physicians charges per enrollee[1]		Liability per enrollee						Net medicare contribution per enrollee[3]	
			Total		Premium		Deductible, coinsurance, and liability on unassigned claims			
	Dollars	Percent	Dollars	Percent	Dollars	Percent	Dollars	Percent	Dollars	Percent
AGED										
U.S. total	$308.87	100.0	$184.42	59.7	$72.50	23.5	$111.92	36.2	$124.45	40.3
Age:										
65–69	242.18	100.0	162.82	67.2	72.50	29.9	90.32	37.3	79.36	32.8
70–74	308.70	100.0	185.78	60.2	72.50	23.5	113.28	36.7	122.92	39.8
75–79	348.00	100.0	197.54	56.7	72.50	20.8	125.04	35.9	150.46	43.3
80–84	367.87	100.0	202.52	55.0	72.50	19.7	130.02	35.3	165.35	45.0
85 and over	395.13	100.0	208.50	52.8	72.50	18.4	136.00	34.4	186.63	47.2
Sex:										
Men	331.89	100.0	190.48	57.4	72.50	21.8	117.98	35.6	141.41	42.6
Women	293.52	100.0	180.39	61.5	72.50	24.7	107.89	36.8	113.13	38.5
Race:										
White	316.96	100.0	188.15	59.4	72.50	22.9	115.65	36.5	128.81	40.6
Other races	225.97	100.0	145.30	64.3	72.50	33.1	72.80	31.2	80.67	35.7
Census region:										
Northeast	334.83	100.0	186.00	55.6	72.50	21.7	113.50	33.9	148.83	44.4
North Central	275.64	100.0	176.96	64.2	72.50	26.3	104.46	37.9	98.68	35.8
South	264.19	100.0	171.53	65.9	72.50	27.4	99.03	37.5	92.66	35.1
West	412.31	100.0	219.57	53.3	72.50	17.6	147.07	35.7	192.74	46.7

TABLE 26.—MEDICARE: TOTAL PHYSICIANS' CHARGES TO THE AGED AND DISABLED, AMOUNT OF LIABILITY PER ENROLLEE, AND NET MEDICARE CONTRIBUTION PER ENROLLEE, BY AGE, SEX, RACE, AND CENSUS REGION, 1978—Continued

Age, sex, race, and census region	Physicians charges per enrollee[1]		Liability per enrollee						Net medicare contribution per enrollee[3]	
			Total		Premium		Deductible, coinsurance, and liability on unassigned claims			
	Dollars	Percent	Dollars	Percent	Dollars	Percent	Dollars	Percent	Dollars	Percent
DISABLED										
U.S. total	329.00	100.0	157.56	47.9	50.56	15.4	107.00	32.5	171.44	52.1
Age:										
Under 45	296.06	100.0	131.99	49.1	50.56	18.8	81.43	30.3	137.07	50.9
45–64	348.01	100.0	165.65	47.6	50.56	14.5	115.09	33.1	182.36	52.4
Sex:										
Men	295.33	100.0	146.66	49.7	50.56	17.2	96.10	32.5	148.67	50.3
Women	384.40	100.0	175.53	45.7	50.56	13.2	124.97	32.5	208.87	54.3
Race:										
White	337.76	100.0	162.57	48.1	50.56	14.9	112.01	33.2	175.19	51.9
Other races	286.29	100.0	132.68	46.3	50.56	17.6	82.12	28.7	153.61	53.7
Census region:										
Northeast	344.02	100.0	154.41	44.9	50.56	14.7	103.85	30.2	189.61	55.1
North Central	326.88	100.0	155.85	47.7	50.56	14.5	105.29	33.2	171.03	52.3
South	275.34	100.0	143.81	52.2	50.56	18.4	93.23	33.8	131.55	47.8
West	443.86	100.0	194.27	43.8	50.56	11.4	143.71	32.4	249.59	56.2

[1] Excludes charges above allowed charge on assigned claims.
[2] Prorated premium based on reimbursements for physicians' services as a percentage of total part B reimbursements.
[3] Excluded prorated premium contributions. Source of funds is primarily general revenues.

Source: McMillan, Alma, Pine, Penelope and Newton, Marilyn. "Medicare: Use of Physicians' Services Under the Supplementary Medical Insurance Program, 1975–1978, DHHS, HCFA," HCFA Pub. No. 03151, March 1983. p. 129–131.

2. Liability Per "User"

In 1978, over three-fourths of the aged population who received Medicare payments for physicians' services (i.e., "users") had some liability from unassigned claims. About 15 percent had a liability of $100 or more. Oregon was the State with the highest percentage of aged users affected by unassigned claims and Alaska had the highest percentage of users with liability of $100 or more. A slightly smaller percentage of disabled users was affected by unassigned claims. However, there was little difference in the percent of disabled users with a liability of $100 or more (See Table 27).

In addition to liability from unassigned claims, Part B enrollees were liable for deductible and coinsurance charges. The 13.1 million aged users who exceeded the Part B deductible in 1978 had an average liability of $191 for the deductible, coinsurance, and unassigned claims. There were minor differences in the average liability for various age cohorts; greater differences were recorded by sex and race. The average liability for aged men was 19 percent higher than for aged women. The average liability for aged whites was 34 percent greater than nonwhites. Significant variations were also recorded by geographic residence ranging from $121 in New Hampshire to $430 in Alaska.

TABLE 27. PERCENT OF AGED AND DISABLED USERS WITH UNASSIGNED CLAIMS, BY STATE, 1978

Area of residence	Aged		Disabled	
	Percent of users with unassigned claims	Percent of users with liability of $100 or more on unassigned claims	Percent of users with unassigned claims	Percent of users with a liability of $100 or more on unassigned claims
U.S. total	77.9	14.9	62.6	13.5
Northeast	72.6	10.7	55.6	9.5
New England	63.4	6.9	45.2	5.8
Maine	60.8	5.6	40.5	2.9
New Hampshire	74.6	6.1	66.7	9.7
Vermont	71.1	7.4	45.1	3.7
Massachusetts	53.8	4.8	33.1	3.0
Rhode Island	50.9	3.3	37.0	4.3
Connecticut	84.4	13.0	72.0	13.5
Middle Atlantic	75.9	12.0	58.8	10.6
New York	76.8	14.4	57.6	11.6
New Jersey	83.8	13.7	66.6	13.6
Pennsylvania	69.0	6.8	55.3	7.0
North Central	82.2	16.9	65.2	14.7
East North Central	82.0	17.5	64.1	14.7

TABLE 27. PERCENT OF AGED AND DISABLED USERS WITH UNASSIGNED CLAIMS, BY STATE, 1978—Continued

Area of residence	Aged		Disabled	
	Percent of users with unassigned claims	Percent of users with liability of $100 or more on unassigned claims	Percent of users with unassigned claims	Percent of users with a liability of $100 or more on unassigned claims
Ohio	87.6	19.5	72.9	17.7
Indiana	89.0	18.1	78.8	17.8
Illinois	83.6	20.7	62.5	17.4
Michigan	68.9	10.2	52.0	8.8
Wisconsin	82.6	19.1	59.9	13.1
West North Central	82.6	15.5	68.3	14.9
Minnesota	82.1	15.0	67.4	16.1
Iowa	87.6	18.5	69.8	15.5
Missouri	82.0	15.9	70.5	15.2
North Dakota	85.7	14.1	65.2	14.8
South Dakota	85.6	17.5	75.0	12.9
Nebraska	86.5	17.1	62.1	14.2
Kansas	74.6	10.6	63.3	11.6
South	(1)	(1)	(1)	(1)
South Atlantic	78.8	14.6	66.4	13.4
Delaware	69.1	8.6	46.6	3.4
Maryland	72.4	9.3	53.2	9.0
District of Columbia	61.7	9.5	28.3	5.9
Virginia	72.2	12.1	57.3	10.5
West Virginia	72.1	12.1	65.1	12.6
North Carolina	73.8	11.4	64.1	11.4
South Carolina	55.9	3.7	51.5	4.0
Georgia	68.9	13.6	60.2	12.1
Florida	89.9	19.2	84.4	20.6
East South Central	69.1	14.3	64.5	14.0
Kentucky	74.6	17.6	72.1	17.8
Tennessee	76.6	17.4	65.7	15.3
Alabama	62.8	10.7	57.5	10.5
Mississippi	58.3	10.0	63.3	12.4
West South Central	(1)	(1)	(1)	(1)
Arkansas	72.5	12.9	69.3	14.3
Louisiana	69.2	12.0	66.5	11.7
Oklahoma	82.0	20.2	76.2	21.2
Texas	(1)	(1)	(1)	(1)
West	77.5	17.3	56.4	14.3
Mountain	84.6	18.1	74.7	17.0

TABLE 27. PERCENT OF AGED AND DISABLED USERS WITH UNASSIGNED CLAIMS, BY STATE, 1978—Continued

Area of residence	Aged		Disabled	
	Percent of users with unassigned claims	Percent of users with liability of $100 or more on unassigned claims	Percent of users with unassigned claims	Percent of users with a liability of $100 or more on unassigned claims
Montana	90.1	19.6	74.9	14.9
Idaho	90.5	18.5	81.0	19.0
Wyoming	91.0	25.7	89.6	20.9
Colorado	77.5	15.0	64.8	14.4
New Mexico	81.6	17.1	67.3	14.0
Arizona	90.4	21.7	87.3	21.9
Utah	76.8	13.2	57.4	10.3
Nevada	83.1	15.7	73.1	15.9
Pacific	75.4	17.1	51.9	13.6
Washington	83.5	14.2	65.7	14.3
Oregon	92.5	18.5	82.7	16.5
California	72.0	17.3	47.4	13.3
Alaska	89.1	32.6	73.1	23.1
Hawaii	78.6	16.9	56.1	13.1

[1] Data for Texas incorrectly coded.

Source: McMillan, Alma, Pine, Penelope and Newton, Marilyn. "Medicare: Use of Physicians' Services Under the Supplementary Medical Insurance Program, 1975–1978, DHHS, HCFA," HCFA Pub. No. 03151, March 1983, pp. 115–117.

In 1978, the average Medicare payment in behalf of the aged was $352; this reflected a range from $132 in North Carolina (based on incomplete data) to $483 in California and $773 in Alaska.

Tables 28–29 present data on average liability and average Medicare payments for aged and disabled users according to various demographic and other factors.

TABLE 28.—AVERAGE USER LIABILITY AND AVERAGE MEDICARE REIMBURSEMENT FOR AGED AND DISABLED PERSONS USING PHYSICIANS' SERVICES WHO EXCEEDED THE DEDUCTIBLE, BY AGE, SEX, AND RACE, 1978

Demographic factors	Aged		Disabled	
	Average liability	Average reimbursement	Average liability	Average reimbursement
U.S. total	$191	$352	$206	$445
Age:				
Under 25			232	642
25 to 44			199	480
45 to 64			207	434

TABLE 28.—AVERAGE USER LIABILITY AND AVERAGE MEDICARE REIMBURSEMENT FOR AGED AND DISABLED PERSONS USING PHYSICIANS' SERVICES WHO EXCEEDED THE DEDUCTIBLE, BY AGE, SEX, AND RACE, 1978—Continued

Demographic factors	Aged		Disabled	
	Average liability	Average reimbursement	Average liability	Average reimbursement
65 to 69	186	332	.....	.....
70 to 74	193	349	.....	.....
75 to 79	196	363	.....	.....
80 to 84	194	366	.....	.....
85 and over	186	367	.....	.....
Sex:				
Men	212	399	204	445
Women	178	323	210	446
Race:				
White	195	354	211	441
Other	145	328	177	473
Unknown	192	346	211	444

Source: McMillan, Alma; Pine, Penelope; and Newton, Marilyn. "Medicare: Use of Physicians' Services Under the Supplementary Medical Insurance Program, 1975–1978, DHHS, HCFA," HCFA Pub. No. 03151, March 1983. p. 119.

TABLE 29.—MEDICARE: DISTRIBUTION OF AGED AND DISABLED ENROLLEES WHO USED PHYSICIANS' SERVICES WHO EXCEEDED THE DEDUCTIBLE AND RECEIVED REIMBURSEMENTS, AND AVERAGE REIMBURSEMENT BY AMOUNT OF USER LIABILITY, U.S., 1978

Amount of total user liability	Aged		Disabled	
	Percent of reimbursed users	Average medicare reimbursement	Percent of reimbursed users	Average medicare reimbursement
U.S. total	100.0	$352	100.0	$445
$0 to $50	15.2	45	19.4	47
$51 to $75	16.0	56	15.4	68
$76 to $100	16.6	93	14.3	111
$101 to $150	18.1	180	16.1	210
$151 to $200	9.0	314	8.6	362
$201 to $250	5.5	452	5.3	499
$251 to $300	3.8	593	3.8	635
$301 to $400	5.0	772	4.9	823
$401 to $600	5.1	1,090	5.2	1,206
$601+	5.6	2,094	7.0	2,748

Source: McMillan, Alma; Pine, Penelope; and Newton, Marilyn. "Medicare: Use of Physicians' Services Under the Supplementary Medical Insurance Program, 1975–1978, DHHS, HCFA," HCFA Pub. No. 03151, March 1983. p. 123.

IX. VARIATIONS IN PHYSICIANS' FEES

A. Variations for Assigned Versus Non-Assigned Services

A HCFA study, based on a five percent sample of 1978 data, shows that for most physician specialties the average charge per service was higher for assigned services than for unassigned services. The ratio of assigned to unassigned charges varied considerably by specialty with a range of 0.88 to 1.60 for the aged and 0.85 to 1.36 for the disabled (see Table 30).

TABLE 30.—AVERAGE SUBMITTED CHARGE PER SERVICE TO AGED AND DISABLED PERSONS FOR ASSIGNED AND UNASSIGNED SERVICES BY PHYSICIAN SPECIALTY, 1978

Physician specialty	All services	Assigned services	Unassigned services	Ratio of assigned to unassigned
	Aged: Average submitted charge			
General practice	$14.55	$15.90	$14.23	1.12
Family practice	14.32	15.41	14.15	1.09
Internal medicine	19.73	22.96	18.37	1.25
Cardiovascular disease	31.18	34.02	30.06	1.13
Dermatology	25.78	31.43	24.35	1.29
General surgery	57.00	64.02	57.15	1.12
Otology/rhinology/laryngology	34.46	51.27	32.02	1.60
Ophthalmology	69.53	99.03	72.20	1.37
Orthopedic surgery	73.56	86.72	71.22	1.22
Urology	56.19	69.50	55.50	1.25
Anesthesiology [1]	(2)	(2)	(2)	(2)
Pathology [1]	6.09	6.14	5.99	1.03
Radiology [1]	22.47	21.29	24.27	.88
Chiropractic	11.33	12.28	11.14	1.10
Podiatry	22.98	26.55	20.70	1.28
	Disabled: Average submitted charge			
General practice	$14.30	$15.38	$13.71	1.12
Family practice	14.32	15.51	13.71	1.13
Internal medicine	21.46	24.93	18.30	1.36
Cardiovascular disease	35.67	37.85	35.05	1.08
Dermatology	20.95	21.73	21.10	1.03
General surgery	62.75	70.59	58.99	1.20
Otology/rhinology/laryngology	45.92	56.79	42.58	1.33
Ophthalmology	68.56	80.69	70.21	1.15
Orthopedic surgery	58.84	61.07	61.47	.99
Urology	44.19	46.30	46.53	1.00
Anesthesiology [1]	(2)	(2)	(2)	(2)

TABLE 30.—AVERAGE SUBMITTED CHARGE PER SERVICE TO AGED AND DISABLED PERSONS FOR ASSIGNED AND UNASSIGNED SERVICES BY PHYSICIAN SPECIALTY, 1978—Continued

Physician specialty	All services	Assigned services	Unassigned services	Ratio of assigned to unassigned
Pathology [1]	5.37	5.55	4.99	1.11
Radiology [1]	21.54	20.55	24.19	.85
Chiropractic	11.46	12.25	11.11	1.10
Podiatry	26.97	29.64	24.00	1.24

[1] Data incomplete for hospital-based physicians.
[2] N.A.

Source: McMillan, Alma; Pine, Penelope; and Newton, Marilyn. "Medicare: Use of Physicians' Services Under the Supplementary Medical Insurance Program, 1975–78, DHHS, HCFA," HCFA Pub. No. 03151, March 1983. p. 101.

It should be noted that the preceding table presents aggregate data for the Medicare program and represents billing decisions for the total mix of program patients, services and physicians. The table does not reflect individual determinations with respect to assignment. (See Part V, and Attachments A and B for a discussion of assignments.)

B. Geographic Variations [35]

As noted previously, significant variations exist in physician fees recognized as reasonable under the Medicare program. Differences occur between urban and rural areas, among the States and between various regions.

In 1982, HCFA issued an analysis of Medicare prevailing charges for the fee screen years beginning July 1976 through that beginning July 1980. For fee screen year 1980, HCFA selected five common procedures and presented the highest and lowest prevailing charge levels for each contractor. HCFA stated that the procedures were selected because they represented a wide variety of procedure types; they accounted for a large percentage of Part B expenditures; and, according to the literature, they may be subject to overutilization. The procedures selected were: brief follow-up hospital visit, hysterectomy, extraction of lens, transurethral electrosection of the prostate, and chest X-ray, single view. Tables 31–35 show the range of highest locality charge and lowest locality charge for each carrier.

[35] In 1975, HCFA conducted a survey of Medicare fee patterns and developed indexes based on comparisons between counties. The survey showed that, after adjustment for cost-of-living differences, Medicare fees in the largest SMSAs averaged 17 percent above the national average while those in the smallest counties averaged 8 percent below. Medicare fees (after cost-of-adjustments) were 8 percent higher in metropolitan counties than in nonmetropolitan counties. The fee indexes also tended to be higher in counties with the high physician to population ratios compared to those with lower ratios. The 1975 county comparisoins have not been updated. For a further discussion of the findings from that analysis, see House Ways and Means Committee Print No. WMCP 96-77, "Physician Reimbursement Under Medicare: Current Policy, Trends, and Issues."

The HCFA data reveals a commonality in the prevailing charge levels among several of the carriers. In its analysis, the agency reported that the clustering was generally not attributable to geographic congruity or organizational relatedness. It suggested that a partial explanation was the locking in place through the economic index of relative levels based on previously suggested medical association charge schedules or insurance industry reimbursement guidelines.

TABLE 31.—MEDICARE PREVAILING CHARGES BY CARRIER FOR BRIEF FOLLOWUP HOSPITAL VISIT PROVIDED BY AN INTERNIST, FEE SCREEN YEAR 1980

Carrier	High [1] locality charge	Low [1] locality charge	Range	Ratio of high to low
New York BC/BS of Greater New York [2]	33.10	25.00	$8.10	1.32:1
Florida Group Health	30.00	30.00	.....	.....
Alaska Aetna	24.00	24.00	.....	.....
New York Group Health	23.00	23.00		
Connecticut General Life	22.90	15.00	7.90	1.53:1
California Physician Services	22.50	12.26	10.24	1.84:1
Arizona Aetna	21.30	12.50	8.80	1.70:1
Florida BS	20.00	15.00	5.00	1.33:1
California Occidental Life	20.00	15.30	4.70	1.31:1
Massachusetts BS	19.90	15.30	4.60	1.30:1
Louisiana Pan-American	18.40	15.00	3.40	1.23:1
Texas Group Medical	18.40	8.00	10.40	2.30:1
Missouri BS of Kansas City, Mo	18.40	15.30	3.10	1.20:1
New Jersey Prudential	18.40	15.30	3.10	1.20:1
District of Columbia Medical Service	18.40	18.40	.....	.....
Nevada Aetna	18.40	11.50	6.90	1.60:1
Illinois EDS Federal	18.30	8.80	9.50	2.08:1
Ohio Nationwide	18.00	12.30	5.70	1.46:1
Michigan BC/BS	17.20	14.30	2.90	1.20:1
Pennsylvania BS	17.00	12.00	5.00	1.42:1
Alabama BC/BS	16.70	11.10	5.60	1.51:1
Minnesota Travelers	15.40	15.40	.....	.....
Wisconsin Physician Service	15.40	7.00	8.40	2.20:1
Oklahoma Aetna	15.40	10.75	4.65	1.43:1
Wyoming Equitable	15.40	15.40	.....	.....
Kansas BS of Kansas City, Mo	15.40	15.00	.40	1.03:1
Maryland BS	15.40	15.00	.40	1.03:1
Virginia Travelers	15.40	10.75	4.65	1.43:1
Hawaii Aetna	15.40	9.40	6.00	1.64:1
Rhode Island BS	15.33	15.33	.....	.....
North Carolina Prudential	15.30	11.50	3.80	1.33:1
Georgia Prudential	15.30	14.70	.60	1.04:1
Iowa BS	15.30	10.70	4.60	1.43:1
Delaware BC/BS	15.30	15.30	.....	.....
Missouri General Amercian	15.20	11.50	3.70	1.32:1
Kentucky Metropolitan	15.00	10.70	4.30	1.40:1

TABLE 31.—MEDICARE PREVAILING CHARGES BY CARRIER FOR BRIEF FOLLOWUP HOSPITAL VISIT PROVIDED BY AN INTERNIST, FEE SCREEN YEAR 1980—Continued

Carrier	High [1] locality charge	Low [1] locality charge	Range	Ratio of high to low
New Hampshire-New Hampshire-Vermont BS	15.00	15.00	.....	.....
Indiana Mutual Medical	15.00	10.70	4.30	1.40:1
Utah BS	15.00	15.00	.....	.....
West Virginia Nationwide	15.00	9.20	5.80	1.63:1
Washington Physician Service	15.00	13.80	1.20	1.09:1
South Carolina BS	13.89	13.89	.....	.....
Maine BS of Massachusetts	13.80	12.00	1.80	1.15:1
New York BS of Western New York	13.30	11.00	2.30	1.21:1
Nebraska Mutual of Omaha	13.10	9.20	3.90	1.42:1
Oregon Aetna	13.10	10.00	3.10	1.31:1
Tennessee Equitable	12.30	12.30	.....	.....
Vermont New Hampshire-Vermont BS	12.30	12.30	.....	.....
Arkansas BC/BS	12.25	12.25	.....	.....
Colorado Medical Service	12.10	12.10	.....	.....
New Mexico Equitable	11.90	11.90	.....	.....
Mississippi Travelers	11.50	7.60	3.90	1.51:1
Kansas BS	11.50	11.50	.....	1.51:1
Idaho Equitable	11.50	11.50	.....	.....
Montana Physician Service	11.00	11.00	.....	.....
Minnesota BC/BS	10.70	10.70	.....	.....
North Dakota BS	9.20	9.20	.....	.....
South Dakota Medical Service	9.20	9.20	.....	.....

[1] Identical high and low locality charges indicate that the jurisdiction has only one locality.
[2] BC means Blue Cross; BS means Blue Shield.

Source: HCFA, "Medicare Parts B Charges; Overview and Trends, Fee Screen Years 1976–1980," Feb. 3, 1982, pp. 34–35.

TABLE 32.—MEDICARE PREVAILING CHARGES BY CARRIER FOR EXTRACTION OF LENS BY AN OPHTHALMOLOGIST, FEE SCREEN YEAR, 1980

Carrier	High [1] locality charge	Low [1] locality charge	Range	Ratio of high to low
New York BS of Western New York [2]	$1,390.70	$624.00	$766.70	2.23:1
California Physician Service	1,300.00	783.06	516.94	1.66:1
California Occidental	1,300.00	929.00	371.00	1.40:1
Alaska Aetna	1,200.00	1,200.00	.....	.....
New York BC/BS of Greater New York	1,149.75	805.70	344.05	1.43:1
New York Group Health	1,073.10	1,073.10	.....	.....
Connecticut General Life	1,000.00	660.00	340.00	1.52:1
Nevada Aetna	996.40	840.00	156.40	1.19:1
Iowa BS	940.00	536.60	403.40	1.75:1
Hawaii Aetna	919.80	707.40	212.40	1.30:1

TABLE 32.—MEDICARE PREVAILING CHARGES BY CARRIER FOR EXTRACTION OF LENS BY AN OPHTHALMOLOGIST, FEE SCREEN YEAR, 1980—Continued

Carrier	High [1] locality charge	Low [1] locality charge	Range	Ratio of high to low
New Jersey Prudential	919.80	766.50	153.30	1.20:1
Illinois EDS Federal	900.00	583.50	316.50	1.54:1
Florida Group Health	843.10	843.10	.....	.....
Alabama BC/BS	829.20	650.00	179.20	1.28:1
Arizona Aetna	808.00	766.50	41.50	1.05:1
District of Columbia Medical Service	804.70	804.70	.....	.....
Missouri General American	779.90	645.50	134.40	1.21:1
Wisconsin Physician Service	770.00	613.20	156.80	1.26:1
Washington Physician Service	766.70	665.00	101.70	1.15:1
Maryland BS	766.70	613.40	153.30	1.25:1
Massachusetts BS	766.50	766.50	.....	.....
Ohio Nationwide	766.50	536.60	229.90	1.43:1
Louisiana Pan-American	766.50	613.20	153.30	1.25:1
Texas Group Medical	766.50	600.00	165.50	1.28:1
Pennsylvania BS	766.50	689.90	76.60	1.11:1
Oregon Aetna	766.50	728.20	38.30	1.05:1
Indiana Mutual Medical	750.00	613.20	146.80	1.22:1
Michigan BC/BS	750.00	613.20	146.80	1.22:1
Minnesota BC/BS	750.00	613.20	146.80	1.22:1
Idaho Equitable	750.00	575.00	175.00	1.30:1
New Mexico Equitable	746.60	746.60	.....	.....
Montana Physician Service	705.20	705.20	.....	.....
Maine Blue Shield of Massachusetts	700.00	615.30	84.70	1.14:1
Wyoming Equitable	696.50	696.50	.....	.....
Delaware BC/BS	689.90	689.90	.....	.....
Virginia Travelers	689.90	600.00	89.90	1.15:1
North Dakota BS	689.90	689.90	.....	.....
North Carolina Prudential	689.90	689.90	.....	.....
Rhode Island BS	689.85	689.85	.....	.....
Minnesota Travelers	689.80	689.80	.....	.....
Kansas BS of Kansas City, MO	689.80	625.00	64.80	1.10:1
Missouri BS of Kansas City, MO	689.80	650.00	39.80	1.06:1
Georgia Prudential	674.50	613.20	61.30	1.10:1
West Virginia Nationwide	662.25	597.20	65.05	1.11:1
Colorado Medical Service	644.00	644.00	.....	.....
Kentucky Metropolitan	613.20	600.00	13.20	1.02:1
Mississippi Travelers	613.20	600.00	13.20	1.02:1
South Carolina BS	613.20	613.20	.....	.....
Oklahoma Aetna	613.20	536.50	76.70	1.14:1
Kansas BS	613.20	613.20	.....	.....
New Hampshire-New Hampshire/Vermont BS	600.00	600.00	.....	.....
Vermont-New Hampshire/Vermont BS	600.00	600.00	.....	.....
Utah BS	600.00	600.00	.....	.....
Tennessee Equitable	583.70	583.70	.....	.....
Nebraska Mutual of Omaha	536.60	536.60	.....	.....

TABLE 32.—MEDICARE PREVAILING CHARGES BY CARRIER FOR EXTRACTION OF LENS BY AN OPHTHALMOLOGIST, FEE SCREEN YEAR, 1980—Continued

Carrier	High [1] locality charge	Low [1] locality charge	Range	Ratio of high to low
Arkansas BC/BS	536.50	536.50		
Florida BS	([3])	([3])		
South Dakota Medical Service	([3])	([3])		

[1] Identical high and low locality charges indicate single locality jurisdictions.
[2] BC means Blue Cross; BS means Blue Shield
[3] Not reported.

Source: HCFA, "Medicare Part B Charges; Overview and Trends, Fee Screen Years 1976–1980," Feb. 3, 1982. p. 36–37.

TABLE 33.—MEDICARE PREVAILING CHARGES BY CARRIER FOR TRANSURETHRAL ELECTROSECTION OF THE PROSTATE, FEE SCREEN YEAR 1980

Carrier	High [1] locality charge	Low [1] locality charge	Range	Ratio of high to low
California Occidental	$1,410.40	$981.10	$429.30	1.44:1
California Physician Service	1,410.36	858.40	551.96	1.64:1
New York BC/BS of Greater New York [2]	1,264.70	1,149.75	114.95	1.10:1
Nevada Aetna	1,200.00	840.00	360.00	1.43:1
Alaska Aetna	1,167.00	1,167.00		
New York Group Health	1,149.80	1,149.80		
New York BS of Western New York	1,111.40	690.00	421.40	1.61:1
Florida BS	1,034.80	766.50	268.30	1.35:1
Florida Group Health	1,034.70	1,034.70		
District of Columbia Medical Service	996.40	966.40		
Connecticut General Life	996.40	735.80	260.60	1.35:1
New Jersey Prudential	980.00	766.50	213.50	1.28:1
Hawaii Aetna	919.80	663.20	256.60	1.39:1
Arizona Aetna	900.00	833.90	66.10	1.08:1
Washington Physician Service	858.70	736.10	122.60	1.71:1
Wisconsin Physician Service	858.50	613.20	245.30	1.40:1
Maryland BS	850.00	640.00	210.00	1.33:1
Illinois EDS Federal	850.00	539.75	310.25	1.58:1
Georgia Prudential	809.40	574.90	234.50	1.41:1
Alabama BC/BS	800.00	613.40	186.60	1.30:1
North Carolina Prudential	800.00	800.00		
Maine BS of Massachusetts	800.00	738.40	61.60	1.08:1
Ohio Nationwide	797.20	613.20	184.00	1.30:1
Minnesota BC/BS	780.00	735.80	44.20	1.06:1
Massachusetts BS	766.50	613.20	153.30	1.25:1
Louisiana Pan-American	766.50	613.20	153.30	1.25:1
Texas Group Medical	766.50	613.20	153.30	1.25:1
Delaware BC/BS	766.50	766.50		
Pennsylvania BS	766.50	680.00	86.50	1.13:1
New Mexico Equitable	760.00	760.00		

TABLE 33.—MEDICARE PREVAILING CHARGES BY CARRIER FOR TRANSURETHRAL ELECTROSECTION OF THE PROSTATE, FEE SCREEN YEAR 1980—Continued

Carrier	High [1] locality charge	Low [1] locality charge	Range	Ratio of high to low
Oregon Aetna	748.04	674.30	73.74	1.11:1
Vermont-New Hampshire/Vermont BS	735.80	735.80	.....	.....
Indiana Mutual Medical	735.80	620.90	114.90	1.19:1
Michigan BC/BS	735.80	689.80	46.00	1.07:1
North Dakota BS	735.80	735.80	.....	.....
Missouri BS of Kansas City, MO	735.80	689.80	46.00	1.07:1
Virginia Travelers	735.80	475.25	260.55	1.55:1
West Virginia Nationwide	735.80	613.20	122.60	1.20:1
Montana Physician Service	705.20	705.20	.....	.....
New Hampshire-New Hampshire/Vermont BS	700.00	700.00	.....	.....
Colorado Medical Service	690.00	690.00	.....	.....
South Dakota Medical Service	690.00	690.00	.....	.....
Wyoming Equitable	690.00	690.00	.....	.....
Iowa BS	690.00	690.00	.....	.....
Rhode Island BS	689.85	689.85	.....	.....
Kansas BS of Kansas City, MO	689.80	689.80	.....	.....
Oklahoma Aetna	689.80	613.20	76.70	1.13:1
Minnesota Travelers	689.80	689.80	.....	.....
Tennessee Equitable	674.70	674.70	.....	.....
Kansas BS	674.50	674.50	.....	.....
Missouri General American	660.70	613.40	47.30	1.08:1
Arkansas BC/BS	651.50	651.50	.....	.....
Utah BS	640.00	640.00	.....	.....
Idaho Equitable	613.40	613.40	.....	.....
Nebraska Mutual of Omaha	613.40	613.40	.....	.....
Kentucky Metropolitan	613.20	613.20	.....	.....
Mississippi Travelers	613.20	613.20	.....	.....
South Carolina BS	613.20	613.20	.....	.....

[1] Identical high and low locality charges indicate single locality jurisdictions.
[2] BC means Blue Cross; BS means Blue Shield.

Source: HCFA, "Medicare Part B Charges; Overview and Trends, Fee Screen Years 1976–80," Feb. 3, 1982. p. 38–39.

TABLE 34.—MEDICARE PREVAILING CHARGES BY CARRIER FOR A HYSTERECTOMY PERFORMED BY AN OBSTETRICIAN-GYNECOLOGIST, FEE SCREEN YEAR 1980

Carrier	High [1] locality charge	Low [1] locality charge	Range	Ratio of high to low
California Physician Service	$1,305.10	$766.50	$538.60	1.70:1
New York BC/BS of Greater New York [2]	1,303.10	843.20	459.90	1.55:1
California Occidental	1,303.10	990.00	313.10	1.32:1
Alaska Aetna	1,167.00	1,167.00	.....	.....

TABLE 34.—MEDICARE PREVAILING CHARGES BY CARRIER FOR A HYSTERECTOMY PERFORMED BY AN OBSTETRICIAN-GYNECOLOGIST, FEE SCREEN YEAR 1980—Continued

Carrier	High [1] locality charge	Low [1] locality charge	Range	Ratio of high to low
New Jersey Prudential	950.00	728.20	221.80	1.31:1
Illinois EDS Federal	918.80	547.10	371.70	1.68:1
Nevada Aetna	901.30	735.00	166.30	1.23:1
Florida BS	878.60	750.00	128.60	1.17:1
Florida Group Health	863.40	863.40	.....	.....
Hawaii Aetna	858.50	660.20	198.30	1.30:1
Texas Group Medical	858.50	654.60	203.90	1.31:1
New York Group Health	843.20	843.20	.....	.....
Louisiana Pan-American	825.00	613.20	211.80	1.35:1
Washington Physician Service	789.70	613.40	176.30	1.29:1
Wisconsin Physician Service	772.60	536.60	236.00	1.44:1
Maryland BS	766.70	690.00	176.70	1.11:1
District of Columbia Medical Service	766.50	766.50	.....	.....
Arkansas Aetna	766.50	667.60	98.90	1.15:1
New Mexico Equitable	760.70	760.70	.....	.....
Colorado Medical Service	756.00	756.00	.....	.....
Michigan BC/BS	756.00	574.80	181.20	1.32:1
Connecticut General Life	750.00	689.80	60.20	1.09:1
Wyoming Equitable	746.20	746.20	.....	.....
Oregon Aetna	735.80	536.50	199.30	1.37:1
Virginia Travelers	700.00	536.50	163.50	1.31:1
North Carolina Prudential	700.00	643.90	56.10	1.09:1
Maine BS of Massachusetts	700.00	700.00	.....	.....
Massachusetts BS	700.00	689.90	10.10	1.02:1
Missouri BS of Kansas City, Mo	700.00	636.10	63.90	1.10:1
Nebraska Mutual of Omaha	690.00	536.60	153.40	1.29:1
Alabama BC/BS	690.00	690.00	.....	.....
Pennsylvania BS	689.90	600.00	89.90	1.15:1
West Virginia Nationwide	689.90	689.90	.....	.....
Georgia Prudential	689.90	689.90	.....	.....
Kentucky Metropolitan	689.90	536.60	153.30	1.29:1
Mississippi Travelers	689.90	625.00	64.90	1.10:1
New Hampshire-New Hampshire/Vermont BS	689.90	689.90	.....	.....
Indiana Mutual Medical	689.90	613.20	76.70	1.13:1
Ohio Nationwide	689.90	689.90	.....	.....
Oklahoma Aetna	689.90	594.00	95.90	1.16:1
Kansas BS of Kansas City, Mo	689.90	636.10	53.80	1.09:1
Minnesota Travelers	689.80	689.80	.....	.....
Montana Physician Service	685.25	685.25	.....	.....
Delaware BC/BS	668.10	668.10	.....	.....
Missouri General American	660.70	613.40	47.30	1.08:1
Kansas BS	653.10	653.10	.....	.....
Rhode Island BS	650.00	650.00	.....	.....
Arkansas BC/BS	650.00	650.00	.....	.....
Minnesota BC/BS	643.90	613.20	30.70	1.05:1

TABLE 34.—MEDICARE PREVAILING CHARGES BY CARRIER FOR A HYSTERECTOMY PERFORMED BY AN OBSTETRICIAN-GYNECOLOGIST, FEE SCREEN YEAR 1980—Continued

Carrier	High [1] locality charge	Low [1] locality charge	Range	Ratio of high to low
North Dakota BS	643.80	643.80	.....	.....
New York BS of Western New York	636.20	594.00	42.20	1.07:1
Tennessee Equitable	613.40	613.40	.....	.....
Idaho Equitable	613.40	613.40	.....	.....
Iowa BS	613.20	536.60	76.60	1.41:1
Utah BS	613.20	613.20	.....	.....
South Carolina BS	613.20	613.20	.....	.....
Vermont-New Hampshire/Vermont BS	550.00	550.00	.....	.....
South Dakota Medical Service	536.60	536.60	.....	.....

[1] Identical high and low locality charges indicate single locality jurisdictions.
[1] BC means Blue Cross; BS means Blue Shield.

Source: HCFA, "Medicare Part B Charges; Overview and Trends, Fee Screen Years 1976–80," Feb. 3, 1982. p. 40–41.

TABLE 35.—MEDICARE PREVAILING CHARGE BY CARRIER FOR CHEST X-RAY (SINGLE VIEW) PERFORMED BY A RADIOLOGIST, FEE SCREEN YEAR 1980

Carrier	High [1] locality charge	Low [1] locality charge	Range	Ratio of high to low
New York Group Health	$35.00	$35.00	.....	.....
Pennsylvania BS [2]	30.70	15.00	15.70	2.05:1
New York BC/BS of Greater New York	30.70	23.00	7.70	1.33:1
Nebraska Mutual of Omaha	30.00	16.70	13.30	1.80:1
New Jersey Prudential	27.50	25.00	2.50	1.10:1
California Physician Service	27.00	18.00	9.00	1.50:1
California Occidental Life	27.00	18.00	9.00	1.50:1
Ohio Nationwide	26.10	8.50	17.60	3.07:1
Georgia Prudential	25.00	10.50	14.50	2.38:1
Florida Group Health	25.00	25.00	.....	.....
Massachusetts BS	25.00	23.00	2.00	1.09:1
Illinois EDS Federal	25.00	15.30	9.70	1.63:1
Alaska Aetna	24.50	24.50	.....	.....
Virginia Travelers	24.50	14.00	10.50	1.75:1
Missouri BS of Kansas City, MO	24.30	15.40	8.90	1.58:1
Connecticut General Life	24.20	15.40	8.80	1.57:1
Texas Group Medical	24.00	12.25	11.75	1.96:1
Montana Physician Service	23.00	23.00	.....	.....
Iowa BS	23.00	15.00	8.00	1.53:1
Missouri General American	23.00	15.40	7.60	1.49:1
Maryland BS	23.00	18.00	5.00	1.28:1
West Virginia Nationwide	23.00	12.30	10.70	1.87:1
Arkansas Aetna	23.00	15.00	8.00	1.53:1
Nevada Aetna	22.90	17.50	5.40	1.31:1

TABLE 35.—MEDICARE PREVAILING CHARGE BY CARRIER FOR CHEST X-RAY (SINGLE VIEW) PERFORMED BY A RADIOLOGIST, FEE SCREEN YEAR 1980—Continued

Carrier	High [1] locality charge	Low [1] locality charge	Range	Ratio of high to low
Louisiana Pan-American	22.90	18.00	4.90	1.27:1
New York BS of Western New York	22.82	17.80	5.02	1.28:1
Washington Physician Service	21.50	15.00	6.50	1.43:1
Idaho Equitable	21.00	21.00	.....	.....
Alabama BC/BS	20.00	17.00	3.00	1.18:1
Florida BS	20.00	19.00	1.00	1.05:1
Maine-Maine BS of Massachusetts	20.00	17.60	2.40	1.14:1
Oklahoma Aetna	20.00	15.00	5.00	1.33:1
Kansas BS	20.00	20.00	.....	.....
Kansas BS of Kansas City, MO	20.00	15.40	4.60	1.30:1
Delaware BC/BS	19.90	19.90	.....	.....
Hawaii Aetna	19.80	14.60	5.20	1.36:1
Oregon Aetna	19.00	15.40	3.60	1.23:1
New Mexico Equitable	18.77	18.77	.....	.....
Utah BS	18.75	18.75	.....	.....
North Carolina Prudential	18.40	18.40	.....	.....
District of Columbia Medical Service	18.40	18.40	.....	.....
Wisconsin Physician Service	18.40	8.40	10.00	2.19:1
Indiana Mutual Medical	17.50	15.30	2.20	1.14:1
Wyoming Equitable	17.50	17.50	.....	.....
Arkansas BC/BS	17.00	17.00	.....	.....
Kentucky Metropolitan	17.00	15.00	2.00	1.13:1
North Dakota BS	16.90	16.90	.....	.....
Minnesota Travelers	16.90	16.90	.....	.....
Mississippi Travelers	15.40	15.40	.....	.....
Rhode Island BS	15.33	15.33	.....	.....
Minnesota BC/BS	15.30	15.30	.....	.....
Michigan BC/BS	15.00	15.00	.....	.....
Tennessee Equitable	15.00	15.00	.....	.....
New Hampshire-New Hampshire/Vermont BS	8.00	8.00	.....	.....
South Carolina BS	7.67	7.67	.....	.....
South Dakota Medical Service	7.50	7.50	.....	.....
Colorado Medical Service	5.80	5.80	.....	.....
Vermont-New Hampshire/Vermont BS	5.50	5.50	.....	.....

[1] Identical high and low locality charges indicate single locality jurisdictions.
[2] BC means Blue Cross; BS means Blue Shield.

Source: HCFA, "Medicare Part B Charges; Overview and Trends, Fee Screen Years 1976–1980," Feb. 3, 1982. p. 42–43.

The HCFA analysis also showed a substantial range in prevailing charges for localities throughout the country in fee screen year 1980. For a brief followup hospital visit, the highest locality charge of $33.10 was 473 percent of the lowest locality charge of $7.00. For extraction of lens by an ophthalmologist the charges ranged from $536.50 to $1,390.70 (259 percent of the lowest charge). For an elec-

trosection of the prostate by a urologist the highest prevailing charge of $1,410.40 was 297 percent of the lowest locality charge of $475.25. For a hysterectomy performed by an obstetrician/gynecologist the range was from $536.50 to $1,305.10 (243 percent of the lowest charge). The widest variation was for a chest X-ray, single view; the highest locality charge of $35 was 636 percent of the lowest such charge of $5.50.

The HCFA data for fee screen years 1976–1980 showed a widening in both absolute and relative terms between the high and low charge screens for all procedures with the greatest growth in nonsurgical procedures. Over the period, the range between the national high and low charges for a brief follow-up hospital visit went from $11.48 to $26.10 reflecting an increase in the ratio of the high to low charge from 2.71:1 to 4.73:1. Over the same period, the relative and absolute difference for hysterectomies grew from 2.13:1 to 2.43:1 and from $450 to $768.70 respectively. (See Table 36.)

TABLE 36.—HIGH AND LOW PREVAILING CHARGES IN LOCALITIES FOR FIVE SELECTED PROCEDURES, FEE SCREEN YEARS 1976–80

Procedure/fee screen year	Locality prevailing charges			
	High	Low	Range	Ratio
1. Brief follow-up hospital visit by an internist:				
1976	$18.18	$6.70	$11.48	2.71:1
1977	20.04	7.00	13.04	2.86:1
1978	35.00	6.80	28.20	5.15:1
1979	35.00	7.00	28.00	5.00:1
1980	33.10	7.00	26.10	4.73:1
2. Extraction of lens by an ophthalmologist:				
1976	900.00	412.56	487.44	2.18:1
1977	902.14	425.00	477.14	2.12:1
1978	1,174.75	400.00	774.75	2.94:1
1979	1,234.50	499.10	735.40	2.47:1
1980	1,390.70	536.50	854.20	2.59:1
3. Electrosection of prostate by a urologist:				
1976	862.70	356.46	506.24	2.42:1
1977	963.05	400.00	563.05	2.41:1
1978	1,248.44	420.70	827.74	2.97:1
1979	1,311.92	442.10	869.82	2.97:1
1980	1,410.40	475.25	935.15	2.97:1
4. Hysterectomy by an obstetrician/gynecologist:				
1976	850.00	400.00	450.00	2.13:1
1977	1,113.00	400.00	713.00	2.78:1
1978	1,200.00	400.00	800.00	3.00:1
1979	1,212.10	499.10	713.00	2.43:1
1980	1,305.20	536.50	768.70	2.43:1
5. Chest X-ray single view by a radiologist:				
1976	25.00	4.00	21.00	6.25:1
1977	30.00	5.00	25.00	6.00:1

TABLE 36.—HIGH AND LOW PREVAILING CHARGES IN LOCALITIES FOR FIVE SELECTED PROCEDURES, FEE SCREEN YEARS 1976–80—Continued

Procedure/fee screen year	Locality prevailing charges			
	High	Low	Range	Ratio
1978	30.00	5.00	25.00	6.00:1
1979	35.00	5.70	29.30	6.14:1
1980	35.00	5.50	29.50	6.36:1

Source: HFCA, "Medicare Part B Charges, Overview and Trends, Fee Screen Years, 1976–1980," Feb. 3, 1982. p. 44–48.

An analysis of prevailing charge levels over time indicates that the relative standing of a charge locality does not necessarily remain constant. The HCFA analysis showed cases where the locality reporting the lowest prevailing charge for a specified medical procedure in one fee screen year became the locality with the highest charge in the next fee screen year. Such changes could be accounted for by a number of factors. In a few instances the carrier consolidated its various charge localities into a single carrierwide locality. In other cases, a carrier may have shifted its recognized procedural codes; for example, in one year it may have three classifications for office visits while in the next year it may consolidate them. Singular large increases might be related to the economic index limitation; when the allowable increase is not fully utilized in one year a catch up may occur in the following year.

C. General Practitioners versus Specialists

Considerable variation also exists in fees recognized by the program for certain medical services performed by physicians in general practice versus fees recognized for similar services performed by specialists. For the fee screen year 1982 (i.e., July 1981–June 1982), Medicare carriers recognized specialty reimbursement differentials in all areas of the country except for Florida, Kansas, North Dakota, South Dakota, and the area of New York served by Blue Shield of Western New York.

Differentials between general practitioners and specialists were already recognized by many private insurance plans at the time Medicare was enacted. Over the years there has been some concern that the general policy among third parties, including Medicare, of recognizing such fee differentials has tended to encourage increased specialization. However, it has been suggested by some that specialists may provide a different type or higher quality service.

Table 37 presents preliminary data for fee screen year 1982 comparing prevailing charge data for 30 procedures performed both by general practitioners and by specialists. For all but three procedures, the weighted mean prevailing charges were higher for specialists than for general practitioners.

TABLE 37.—FEE SCREEN YEAR 1982 PREVAILING CHARGE SUMMARY DATA FOR PROCEDURES PERFORMED BY BOTH GENERAL PRACTITIONERS AND SPECIALISTS

Description of procedure	General practitioners		Specialists		Ratio: Specialists/ general practitioners
	Frequency	Weighted mean [1]	Frequency	Weighted mean [1]	
Initial limited office visit	2,538,063	$16.09	3,173,791	$21.70	1.35
Initial comprehensive office visit	402,021	39.75	1,196,781	52.09	1.31
Minimal F/U office visit [2]	3,352,811	14.56	11,103,575	22.28	1.53
Brief F/U office visit	8,788,214	11.78	13,325,197	15.81	1.34
Limited F/U office visit	5,020,313	14.30	10,134,697	17.41	1.22
Intermediate F/U office visit	3,141,366	16.60	8,382,357	19.71	1.19
Extended F/U office visit	674,576	26.04	3,949,837	21.29	0.82
Comprehensive F/U office visit	322,151	42.82	1,072,693	44.74	1.04
Brief F/U home visit	720,815	22.09	696,552	25.79	1.17
Intermediate F/U home visit	183,854	22.24	140,441	25.08	1.13
Brief F/U nursing home visit	2,151,739	14.10	1,667,027	17.95	1.27
Inital brief hospital visit	1,226,624	25.88	4,030,410	28.79	1.11
Initial comprehensive hospital visit	602,374	52.43	1,945,495	68.38	1.30
Brief F/U hospital visit	10,976,737	14.62	31,275,491	19.85	1.36
Limited F/U hospital visit	3,912,613	17.21	12,864,705	20.56	1.19
Intermediate F/U hospital visit	1,348,199	18.44	8,581,544	21.89	1.19
Limited consultation	141,472	37.99	563,000	66.52	1.75
Chiropractic office visit	2,209,610	12.27	6,595,462	13.03	1.06
Electrocardiogram (EKG)	1,041,263	28.75	5,439,522	30.06	1.05
EKG—Interpretation report only	713,510	12.53	3,685,431	12.12	0.97
Arthrocentesis major Joint	185,119	22.69	336,627	29.33	1.29
Appendectomy	7,567	397.73	22,525	468.30	1.18
Diagnostic cystourethroscopy	148,300	63.80	288,188	79.02	1.24
Electrosection-prostate (TUR)	93,162	869.34	221,728	918.26	1.06
Extraction of lens	107,887	908.84	137,563	871.59	0.96
Chest X-ray, single view	314,081	23.45	840,067	25.94	1.11
Chest X-ray, 2 views	734,847	28.49	1,732,862	29.75	1.04
X-ray upper GI tract	127,600	66.24	311,185	75.86	1.15
Radiation therapy, low volt	49,723	26.47	87,924	27.29	1.03
Radiation therapy, super volt	471,517	28.05	335,809	39.10	1.39

[1] The weighted mean is the product of the prevailing charge for each locality multiplied by the frequency at each charge level divided by the total frequency.
[2] F/U means followup.

Source: Unpublished charts received from the Health Care Financing Administration and calculations based on these charts.

The preliminary 1982 prevailing charge data also highlights the concentration of Part B benefit expenditures on various types of services. Of particular interest is the high frequency of brief, limited, and follow-up office and hospital visits.

D. Variations by Place of Performance

Physician services provided in an inpatient hospital setting are generally associated with higher reimbursement levels. As Table 38 shows, national weighted mean prevailing fees were higher in a hospital than in an office for certain medical visits; this was true both for general practitioners and for specialists.

TABLE 38.—MEDICARE WEIGHTED MEAN PREVAILING CHARGES FOR MEDICAL VISIT, 1982

Procedure	General practitioner	Specialist
Initial comprehensive office visit	$39.75	$52.09
Brief follow-up office visit	$11.78	$15.81
Limited follow-up office visit	14.30	$17.41
Initial comprehensive hospital visit	$52.43	$68.38
Brief follow-up hospital visit	$14.62	$19.85
Limited follow-up hospital visit	$17.21	$20.56
Ratios:		
Initial comprehensive visit: Hospital/office	1.32	1.31
Brief follow-up visit: Hospital/office	1.24	1.26
Limited follow-up visit: Hospital/office	1.20	1.18

Source: HCFA, unpublished tables.

While hospitalized patients may require more intensive care, the physician bears none of the associated office costs associated with inpatient care. Since practice expenses amount to an estimated 40 percent of physicians' gross revenues the difference between the net value of office reimbursement rates compared with hospital reimbursement rates is even more pronounced. These observations do not take into account the time required to perform the hospital visits or the time and costs involved in the physician's travel to and from the hospital.

There are also differences in associated practice costs between physician services performed in a hospital outpatient department and similar services performed in an office setting. The "Tax Equity and Fiscal Responsibility Act of 1982" (P.L. 97-248) provided that the Secretary may limit the reasonable charge for services furnished in a hospital outpatient department to a percentage of the prevailing charge for similar services furnished in an office. The implementing regulations set the limit at 60 percent.

For a number of years attempts have been made to quantify the value of various procedures and services in relation to each other. A comprehensive effort to develop a means for pricing each medical or surgical service relative to each other service was the California Relative Value Study (CRVS) first published in 1956. The initial relative values were based upon existing median charges of California physicians. Subsequent modifications were based in part on the results of negotiations among specialists. In April 1979, the Federal Trade Commission issued a consent notice which required the California Medical Association to cease publishing, promulgating or participating in the use of relative value schedules; further, previously issued schedules had to be withdrawn.

Hsiao and Stason[36] attempted to develop an alternative methodology to determine the relative values of surgical procedures and medical office visits on the basis of resource costs. The professional time expended and the complexity of service (based on intensity of

[36] Hsiao, William C. and Stason, William B. "Toward Developing A Relative Value Scale for Medical and Surgical Services," in Health Care Financing Review, Fall 1979. p. 23-38.

effort and degree of skills represented) were viewed as the most critical variables. Based on a study of selected surgical procedures in Massachusetts, the authors concluded that for one-half of such procedures the relative values based on resource costs were not greatly different from those of the CRVS or existing Medicare charges; however, for the remaining procedures, significant variations occurred. The major finding of the study was that considerable discrepancies exist between current reimbursement levels and resource cost values for office visits compared to surgical procedures. Based on resource cost values, office visits on the average are undervalued (or surgical procedures are overvalued) from four to five fold. For example, after standardizing for complexity between various procedures, the prevailing Medicare charges expressed in terms of standardized hourly rates were $40 per hour for a general practitioner, $180 per hour for an ophthalmologist performing a lens extraction, and $150–$200 per operating room hour for general surgeons.

X. PHYSICIAN EXPENDITURES

A. National Data

The major factor affecting the increase in physician expenditures is the inflation in physicians' fees. These fees have generally risen more rapidly than prices in the economy as a whole. From 1950–1982, physicians' fees increased 492.6 percent, medical care prices as a whole rose 512.1 percent and nonmedical care prices increased 301 percent.

TABLE 39. ANNUALIZED RATES OF CHANGE IN THE CONSUMER PRICE INDEX (CPI), 1950–1982

	CPI, all items less medical care [1]	Medical care	CPI, physicians' services [1]
1950–1955	2.1	3.8	3.5
1955–1960	2.0	4.1	3.3
1960–1965	1.2	2.5	2.8
1965–1970	4.1	6.1	6.6
1970	5.8	6.3	7.5
1971	4.1	6.5	6.9
1972	3.3	3.2	3.1
1973	6.4	3.9	3.3
1974	11.1	9.3	9.2
1975	8.9	12.0	12.3
1976	5.5	9.5	11.3
1977	6.2	9.6	9.3
1978	7.6	8.4	8.3
1979	11.4	9.3	9.2
1980	13.6	10.9	10.6
1981	10.3	10.8	11.0
1982	5.9	11.6	9.4
Total percentage change, 1950–82	301.0	512.1	492.6

[1] From 1950–60, all items including medical care.

Source: Council on Wage and Price Stability—A Study of Physicians Fee, March 1978, p. 3 and communications with HCFA and the Bureau of Labor Statistics.

Increases in physicians' fees do not translate into identical increases in earnings. The 1982 continuing survey of physicians'

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income conducted by "Medical Economics" magazine [37] showed that physicians's income growth nearly halted in 1981. The survey of office-based physicians in 16 major specialties showed that while gross receipts were up 7 percent their earnings after expenses rose only 3 percent, the smallest rise in a decade. The 3 percent increase was considerably lower than the 9.1 percent figure reported for 1980 and 12.8 percent reported for 1979. The leveling off in income growth was primarily attributed to the decline in patient visits, not a stabilization in fee levels. The survey reported that during a representative work-week, fee-for-service physicians saw 6 percent fewer patients than a year earlier and 14 percent fewer than a comparable week in 1979. The downward trend was partly due to patients seeing their doctors less frequently during recessionary times and partly due to competition from a still-expanding surplus of physicians. A followup report [38] suggested that some of the specialties surveyed were also moderating their fee increases for selected services (e.g., office revisits) during the early part of 1982. However, as noted above, physician fee increases still outpaced overall CPI increases in 1982.

Despite the leveling off in income growth, one in ten practitioners netted at least $150,000 in 1980 versus the one in 12 figure reported in 1979. Over the same two year period, the proportion of surveyed doctors netting at least $60,000 before taxes climbed from 68 percent to 75 percent. Of the 16 office-based specialties surveyed, the top ten earnings categories were either surgical or "hospital-based" (radiology, anesthesiology, and pathology). The median earnings were $86,210 for all fields, $83,800 for non-surgical specialists, and $111,860 for surgical specialists.[39]

TABLE 40.—NET PRACTICE EARNING OF PHYSICIANS NATIONWIDE FROM 16 SPECIALTIES, SURVEY RESULTS, 1981

Specialty	Median earnings
Neurosurgeons	$135,690
Orthopedic surgeons	134,670
Radiologists	127,310
Plastic surgeons	119,210
Thoracic surgeons	116,670
Anesthesiologists	108,950
OBGYN Specialists	105,140
Pathologists	104,620
Ophthalmologists	96,740
General surgeons	95,560
Neurologists	90,000
Internists	79,710
Psychiatrists	70,350

[37] Owens, Arthur. "Where Do You Fit In?" in Medical Economics, Sept. 13, 1982. p. 246-253.
[38] Kirchner, Merian. "Fee Increases: Restraint Takes Over", in Medical Economics, Oct. 11, 1982. p. 218.
[39] Median net practice earnings for unincorporated physicans represent income from practice minus tax-deductible professional expenses, but before income taxes. For incorporated physicians, median net practice earnings represent total compensation from practice (salary, bonuses, and retirement set-asides).

TABLE 40.—NET PRACTICE EARNING OF PHYSICIANS NATIONWIDE FROM 16 SPECIALTIES, SURVEY RESULTS, 1981—Continued

Specialty	Median earnings
Family practitioners	69,760
Pediatricians	65,380
General practitioners	63,950
All surgical specialties	111,860
All nonsurgical specialties	83,800
All fields	86,210

Source: Owens, Authur, "Where Do you Fit In?" in "Medical Ecomonics", Sept. 13, 1982. p. 249.

The Continuing Survey showed that the typical office-based doctor received two-thirds of his gross practice income from third parties. On the average, 21 percent came from commercial health insurance, 20 percent from Blue Shield, 17 percent from Medicare, and 8 percent from Medicaid.[40] Table 41 shows the breakdown of gross practice income from Medicare by specialty. Medicare income represented 18 percent of gross income for solo incorporated physicians, 19 percent for physicians in incorporated multiphysician practices and 16 percent for all unincorporated physicians (including solo practicing physicians, those practicing under expense sharing arrangements and those in partnerships or groups).

TABLE 41.—GROSS MEDICARE EARNINGS OF PHYSICIANS NATIONWIDE FROM 16 SPECIALTIES, SURVEY RESULTS, 1981

Specialty	Medicare income	Percent of total gross income
Anesthesiologists	$32,790	22
Family practitioners	21,220	15
General practitioners	21,170	18
General surgeons	43,750	25
Internists	39,630	29
Neurologists	37,390	24
Neurosurgeons	37,310	18
Obstetricians/gynecologists	8,530	5
Ophthalmologists	49,010	24
Orthopedic surgeons	43,220	17
Pathologists	28,000	21
Pediatricians	1,170	1
Plastic surgeons	18,780	12
Psychiatrists	6,370	6
Radiologists	49,730	28
Thoracic surgeons	72,420	35

[40] Owens, Authur. "How Much of Your Income Comes from Third Parties?" in Medical Economics, Apr. 4, 1983.

TABLE 41.—GROSS MEDICARE EARNINGS OF PHYSICIANS NATIONWIDE FROM 16 SPECIALTIES, SURVEY RESULTS, 1981—Continued

Specialty	Medicare income	Percent of total gross income
All surgical specialists	38,910	20
All nonsurgical specialists	24,660	17
All physicians	27,490	17

Source: Owens, Arthur. "How Much of Your Money Comes from Third Parties?" in Medical Economics, Apr. 4, 1983. p. 262.

B. Historical Trends for Medicare

Physicians expenditures under Medicare have increased substantially since the inception of the program. Incurred reimbursement amounts per aged enrollee (i. e., after application of cost-sharing) rose from $59.02 in the 12 month period ending June 30, 1967 to $324.88 for the 12 month period ending June 30, 1981. Incurred reasonable charges rose from $103.44 to $436.12 over the same period. Thus while incurred reimbursement amounts for aged enrollees increased 450 percent incurred reasonable charges increased only 321 percent. This increase reflects the fact that the deductible (which has been increased only twice since the program's inception) represents a smaller percentage of charges each year; reimbursement, therefore, rises faster than reasonable charges.

TABLE 42.—INCURRED REIMBURSEMENT AMOUNTS PER ENROLLEE AND INCURRED REASONABLE CHARGES PER ENROLLEE FOR PHYSICIANS' SERVICES UNDER MEDICARE, 1967–1981

Year ending June 30	Incurred reimbursement amounts per enrollee [1]		Incurred reasonable charges [1] per enrollee	
	Dollars	Percent increase	Dollars	Percent increase
Aged:				
1967	59.02	.....	103.44	.....
1968	74.45	26.1	119.10	15.1
1969	85.63	15.0	132.68	11.4
1970	89.98	5.1	138.32	4.3
1971	95.01	5.6	144.93	4.8
1972	101.59	6.9	153.59	6.0
1973	107.94	6.3	164.42	7.1
1974	117.40	8.8	178.81	8.8
1975	136.20	16.0	201.86	12.9
1976	156.19	14.7	226.15	12.0
1977	179.21	14.8	254.67	12.6
1978	206.98	15.5	289.50	13.7
1979	233.65	12.9	322.79	11.5
1980	274.80	17.6	374.41	16.0
1981	324.88	18.2	436.12	16.5

TABLE 42.—INCURRED REIMBURSEMENT AMOUNTS PER ENROLLEE AND INCURRED REASONABLE CHARGES PER ENROLLEE FOR PHYSICIANS' SERVICES UNDER MEDICARE, 1967–1981—Continued

Year ending June 30	Incurred reimbursement amounts per enrollee [1]		Incurred reasonable charges [1] per enrollee	
	Dollars	Percent increase	Dollars	Percent increase
Disabled (excluding end stage renal disease population):				
1974	97.67	.....	145.02	.....
1975	125.82	28.8	180.87	24.7
1976	148.52	18.0	208.86	15.5
1977	174.88	17.7	241.77	15.8
1978	203.09	16.1	278.26	15.1
1979	240.73	18.5	325.53	17.0
1980	288.24	19.7	384.67	18.2
1981	337.99	17.3	446.84	16.2

[1] Includes (beginning April 1968) inpatient radiology and pathology services which were reimbursed at 100 percent of reasonable charges until Oct. 1, 1982.

Source: 1983 Annual report of the board of trustees of the Federal Supplementary Medical Insurance Trust Fund, tables A1 and A2.

The rate of increase in physicians' fees recognized by Medicare during fee screen years 1967–1981 was less than the rate of increase in the physician fee component of the Consumer Price Index (CPI). This was principally due to the lag in updating customary and prevailing charges and the effect of the economic index. While these Medicare policies have tended to somewhat depress the amounts, other factors have resulted in total recognized charges per enrollee increasing faster than the CPI increase in physician fees. The Board of Trustees of the Federal Supplementary Medical Insurance Trust Fund has attempted to quantify the factors contributing to the rise in total recognized charges per enrollee. For example, for the year ending June 30, 1981, the total increase over the previous 12 month period in recognized charges per aged enrollee was 16.2 percent, of this amount 8.4 percent was attributable to price changes and the remaining 7.8 percent was attributable to other factors including more physician visits per enrollee, increasing use of specialists, and more expensive techniques. Since July 1974, factors other than price charges have represented at least one-quarter the total increase in recognized charges per enrollee.

TABLE 43.—COMPONENTS OF INCREASES IN TOTAL RECOGNIZED CHARGES PER ENROLLEE FOR PHYSICIAN SERVICES: HISTORICAL

[In percent]

Year ending June 30	Increase due to price charges				Increases due to residual factors			Total increase in recognized charges per enrollee
	Increase in physician fee component of CPI	Reduction due to fee screens		Net increase in reasonable charges	Gross residual factors	Effect of denial	Net residual factors	
		Cumulative effect	Yearly changes					
AGED								
1967	7.6	−2.6						
1968	5.9	−3.6	−0.7	5.2	9.5	−1.4	8.1	13.3
1969	6.2	−5.0	−1.4	4.8	3.2	−0.4	2.8	7.6
1970	6.7	−7.5	−2.8	3.9	3.2	−3.1	0.1	4.0
1971	7.5	−10.1	−3.0	4.5	3.7	−3.2	0.5	5.0
1972	5.2	−11.2	−1.2	4.0	2.2	0.4	2.6	6.6
1973	2.6	−11.7	−0.5	2.1	5.7	−0.6	5.1	7.2
1974	5.0	−13.2	−1.6	3.4	6.1	−0.6	5.5	8.9
1975	12.8	−16.2	−3.6	9.2	3.8	−0.3	3.5	12.7
1976	11.4	−18.6	−2.9	8.5	2.9	0.1	3.0	11.5
1977	10.2	−19.5	−1.0	9.2	3.3	0.1	3.4	12.6
1978	8.9	−19.4	0.5	9.4	3.8	0.1	3.9	13.3
1979	8.6	−20.0	−0.6	8.0	3.8	−0.3	3.5	11.5
1980	11.5	−22.1	−2.4	9.1	6.8	0.1	6.9	16.0
1981	11.1	−24.5	−2.7	8.4	7.1	0.7	7.8	16.2

DISABLED (EXCLUDING ESRD)								
1974	5.0	−13.2						
1975	12.8	−16.2	−2.6	10.2	15.5	−0.3	15.2	25.4
1976	11.4	−18.6	−2.6	8.8	6.4	0.1	6.5	15.3
1977	10.2	−19.5	−0.7	9.5	5.5	0.1	5.6	15.1
1978	8.9	−19.4	0.6	9.5	5.8	0.1	5.9	15.4
1979	8.6	−20.0	−0.2	8.4	8.7	−0.3	8.4	16.8
1980	11.5	−22.1	−2.2	9.3	8.9	0.1	9.0	18.3

Source: 1983 Annual Report of the Board of Trustees of the Federal Supplementary Medical Insurance Trust Fund, table A3.

Program actuaries expect that total increases in recognized reasonable charges per enrollee for physicians' services will continue at double-digit rates for the next couple of years.

C. Changes in Volume and Intensity

Establishment of fees is only one category of actions affecting expenditures for physicians services. Changes in volume and intensity also play an important role. For example, evidence obtained during the Economic Stabilization Program (ESP) indicated that while price controls were effective in slowing increases in unit prices, they were not successful in constraining the increase in expenditures for physicians' services. During this period physicians countered attempts to control expenditures by increasing the volume of services provided and changing to a more complex service mix. Two Urban Institute studies of the experience in California showed that the gross Medicare incomes of physicians actually increased more during the two years of price controls than in the following year. The first study [41] showed that in the first year of ESP controls, gross revenues of general practitioners increased 11.9 percent; those of general surgeons increased 10.1 percent and those of internists increased 12.1 percent. During the second year of controls, gross revenues increased 12.4 percent, 15.6 percent and 19.3 percent respectively. A small portion of the change was attributed to increased enrollments (2.5 percent per year) and a change in service intensity. However, the major change was the substantial growth in the number of physician services. In both 1973 and 1974, services provided by physicians increased by 10 percent per year. During the year after the year the controls were lifted, physicians' Medicare incomes grew by 3.6 percent for general practitioners, 9.1 percent for general surgeons, and 12.3 percent for internists. The increase in revenue during this year was mainly attributable to the increase in reasonable charge screens. The volume of services provided during this period fell almost 8 percent for general practitioners and rose by only 1.3 percent for general surgeons and 2.5 percent for internists. Medicare enrollment increased by 2.6 percent over the same period.

The second Urban Institute study [42] presented parallel findings with respect to the specialties of ophthalmology, orthopedic surgery, radiology, and anesthesiology. The study found that physicians responded to price controls in two major ways. They increased the number of services provided and shifted to a more complex mix of services for procedures such as office visits. With the exception of anesthesiology, the number of non-assigned services provided grew substantially faster than the number of assigned services. The report noted that the net result of these actions was that physicians' revenues from Medicare increased markedly during the ESP program. Revenues increased between 12 percent and 27 percent in each of the specialties during the first year of

[41] Holahan, John and William Scanlon: "Physician Pricing in California: Price Controls, Physician Fees and Physician Incomes from Medicare and Medicaid." Health care financing grants and contracts report (Pursuant to contract No. SSA 600-76-0054) nd. p. 5-6, 84-85, and 100.

[42] Paringer, Lynn. "Price Controls, Physicians' Fees, Output and Revenue from Public Medical Programs: Evidence for Five Specialties." Working paper 1250-02 (pursuant to grant No. 18-P-97008/3), Urban Institute, November 1979.

controls and between 12 percent and 20 percent in each of the specialties during the second year. In the year following controls, Medicare revenue for every specialty but orthopedic surgeons declined.

Physician supply has also been found to have an impact on total volume of services provided. For example, a recent study [43] of surgical utilization for the population as a whole found that holding other factors constant, fees and the number of surgical procedures performed were higher in surgeon rich areas. A ten percent increase in the number of surgeons per capita led to a one percent increase in total surgery rates and a 1.3 percent increase in elective surgery rates.

[43] Mitchell, Janet B. and Cromwell, Jerry. "Physician-Induced Demand for Surgical Operations: Final Report" (pursuant to grant No. 95-P-97245/2-01). Center for Health Economics Research, December 1980.

XI. POSSIBLE ALTERNATIVES

Recent discussions of physician reimbursement under Medicare have focused on three main issues—the impact of assignment policies on beneficiaries, the appropriateness of the program's reasonable charge methodology and the overall increase in program costs.

Reasonable charge reductions on unassigned claims, and the resultant financial burden on beneficiaries, has been a major issue of concern. A number of physicians have stated that their reluctance to accept assignment is directly attributable to the fact that Medicare's determination of reasonable charges often results in payments which are considerably less than the actual charges. It has been suggested that certain incentives should be included in the program in order to encourage higher assignment rates.

The appropriateness of Medicare's reimbursement methodology has also been questioned. The reasonable charge structure employed by the program is similar to some private insurance fee-for-service models. Concern has been expressed that this approach provides incentives for physicians to locate in high-income, physician-dense metropolitan areas and to choose speciality over primary care practice. Further, it has also been suggested that this approach may encourage physicians to treat patients in hospitals rather than outpatient settings and to perform surgical rather than medical procedures. These tendencies are not unique to Medicare. However, it is generally believed that they have had an inflationary impact on the Medicare program.

A further topic of concern has been the rapid rise in Part B trust fund outlays in recent years. Total Part B outlays increased an estimated 145 percent over the five-year period, fiscal year 1977–fiscal year 1982, while expenditures for physicians' services (which account for over 70 percent of Part B benefit payments) rose an estimated 150 percent.

In response to these concerns, a number of persons have suggested possible modifications in Medicare's physician payment policies. Recommended changes have included proposals to increase physician assignment, modify reasonable charge calculations, implement alternative reimbursement policies, and place additional limits on allowable cost increases. The following sections outline the major approaches which have been suggested.

A. Modification in Assignment Policies

1. Participating Physicians

A number of persons have recommended altering Medicare's approach to assignment. This would be accomplished either alone or in concert with modifications in the program's reimbursement methodology. The principal strategy which has been suggested is

that of "participating physician." Under this concept, a physician would voluntarily and formally agree to accept the Medicare-determined charge as payment in full for all covered services rendered to his patients. He would bill the program directly and could only bill the patient for any deductible and coinsurance amounts. The principal advantage of this approach is that beneficiaries would be able to determine in advance that a particular physician would accept assignment for all covered services; they would therefore not be liable for any charges in excess of Medicare-determined reasonable charges for covered services rendered by these physicians.

In order to make the participating physician concept more attractive to physicians, both reimbursement and administrative incentives have been suggested. These include the following:

Simplified billing.—The Secretary would establish procedures whereby participating physicians could submit claims on a simplified basis, such as a multiple listing basis with claims given priority handling by the Part B carrier. It has, however, proven difficult to devise special billing arrangements that would have significant advantages for the physician over the present billing arrangements.

Payment of an "administrative" cost-savings allowance.—Payment of a specified amount, e.g., $1 per eligible patient, would be made in conjunction with all services included in a multiple billing listing. Certain restrictions would apply including a prohibition against multiple allowances for multiple listings of items normally included in a single visit or service. Also prohibited would be separate allowances for different services provided to the same patient within a 7-day period. Further, it is suggested that for services rendered in a hospital (on an inpatient or outpatient basis) administrative allowances would only be payable in the case of physicians whose principal office and place of practice was outside of a hospital and only where such physicians ordinarily bill and collect directly for their services.

Higher reimbursement.—Participating physicians would receive higher payment amounts than nonparticipating physicians. For example, the economic index limitation might be waived or the percent of reasonable charges paid by the program could be raised. This approach could have the potential for substantially increasing program outlays.

Payment of 100 percent of claim.—Full payment for covered services would be made by the carrier to the physician. The carrier rather than the physician would bill the patient directly (and perhaps his private supplemental insurance, if any) for any deductible and coinsurance amounts. This could, however, prove difficult and costly to administer and would place the carriers, and thus the progam, in the role of a collection agent.

Periodic interim payment.—Under this approach, participating physicians with substantial Medicare caseloads would be paid a fixed amount on a regular basis (e.g., bi-weekly or monthly) based on estimates of the services provided. This approach is intended to address any problems physicians may currently be facing as a result of the delay between the time the service is billed and payment is received. The payments would be periodically adjusted to reflect actual billings and revised estimates of volume of service.

Continuing Education Payments.—Participating physicians would accumulate reimbursement credits based on the number of Medicare patient hours; these credits could be applied toward continuing medical education expenses.

Under the participating physician concept, consideration would need to be given to payment for services rendered by so-called non-participating physicians. First, non-participating physicians could continue to accept assignment on a selective basis as under current law. Unless this approach were accompanied by changes in reimbursement for participating physicians, it is unlikely that increases in assignment would result.

The second approach would bar non-participating physicians from submitting any claims on an assignment basis (except for dual Medicare-Medicaid claims). Some physicians might decide to participate in the program out of concern that certain patients might not pay their bills. However, it is likely that a number of physicians who now accept assignment on some or even most of their claims might refuse to become participating physicians either because they objected to the concept of participation or they did not wish to take assignment on all claims. The overall result could therefore be a reduction in the total assignment rate.

A recent simulation study [44] analyzed the potential impact on an "all-or-nothing" assignment requirement; under this approach, physicians would decide whether to accept all of their patients on an assignment basis or none of them. The simulations suggested that assignment rates would fall almost 10 percent nationwide. The total volume of assigned visits would also decline by almost 6 percent or an estimated 5.4 million visits per year. The study determined that the single most important factor influencing the "all or none" decision was the physician's current assignment rate. It suggested that a two tier medical system (i.e. one for the poor and one for the rest of the population) would not result since there did not appear to be a difference in the credentials between physicians choosing the "all or none" options. However, access to some specialist services could be limited for patients seeking a participating physician. For example, only one out of five internists indicated they would take all patients on an assignment basis compared with two out of five general surgeons. The simulation indicated that assigned visits would increase for 11 percent of general practitioners while declining 12–25 percent for all other specialties. Further, the volume of assigned visits, while declining overall, would increase in nonmetropolitan areas and in the West.

The third option for dealing with non-participating physicians would essentially be to bar their patients from receiving program payments. Since beneficiaries would not be eligible for any program payment for services provided by non-participating physicians, considerable pressure would be placed on these physicians to participate. An additional incentive would be the fact that they could not otherwise bill the program directly in cases where they doubted a patient would make payment. However, if a significant number of physicians in a particular specialty refused to partici-

[44] Janet B. Mitchell, and Jerry Cromwell, "Impact of an All-or-Nothing Assignment Requirement Under Medicare" in Health Care Financing Review, v. 4, no. 4, Summer 1983.

pate, beneficiary access to covered care could be severely hampered.[45]

The Senate Finance Committee reported H.R. 934 during the 96th Congress which included a provision incorporating the participating physician concept. The legislation provided that the Secretary would establish procedures and forms whereby: (1) participating physicians could submit claims on one of various simplified bases and such claims would be given priority handling by the Part B carrier; and (2) such physicians would obtain signed forms from their patients, effective for a specified time period, making assignment for all services furnished them and authorizing release of medical information needed to review the claim. Non-participating physicians would continue to submit claims and receive payment as under current law. The bill further authorized five to ten pilot projects to experiment with ways of encouraging physicians to accept assignment with priority given to projects in States with low assignment rates. Demonstrations could include: (1) payment of cost savings allowances to physicians who submitted claims on multiple listing forms; (2) provision of incentive payments for those accepting Medicare's reasonable charge determination; (3) payment by Medicare of 100 percent of the reasonable charge (with Medicare collecting deductibles and coinsurance from the beneficiary); and (4) use of prospective reimbursement to physicians on a periodic basis based on prior claims.

At its meeting on April 25, 1983, the Advisory Council on Social Security, which this year is focusing on the Medicare program, tentatively approved a recommendation to establish the participating physician concept. Under this approach, participating physicians would enter agreements to accept assignments for all Medicare claims. Agreements would be on an annual or biannual basis and be automatically renewable in the absence of 90 days advance notice. Non-participating physicians would continue to have the option of determining whether or not to accept assignment on a bill-by-bill basis. Special incentives would be available to participating physicians. The Council tentatively approved two billing incentives, multiple listing for claims and automated billing. They also tentatively approved recommending publication of a physician directory identifying participating physicians. The Council deferred action on potential payment incentives.

On July 25, 1983, the Senate Finance Committee reported S. 951, "Health Care for Unemployed Workers." One section of this bill requires the Secretary to annually prepare lists containing the complete names and addresses, assignment ratios and volume of services of each physician. The Secretary could limit the list to those physicians who accepted assignment on a certain percentage of their billings.

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[45] A 1977 survey of office-based physicians indicated that 56 percent would oppose mandating assignment as a condition of program participation. Over half of this group indicated they would drop out of the program under such conditions. Rosenberg, Charlotte L. "Will Doctors Tolerate Another Medicare Squeeze?" in Medical Economics, v. 54, Oct. 17, 1977, p. 122.

2. Mandatory Assignments

An extension of the concept of covering only those services provided by participating physicians is that of mandating Medicare assignments. This generally means that physicians would be required to accept assignment for all covered services rendered to all their Medicare patients. However, it is questionable whether physicians could be legally barred from billing Medicare patients directly (and receiving out-of-pocket payments from them) for services rendered. It has been suggested that one means of implementing mandatory assignments would be to tie it in with the conditions of participation for hospitals; i.e., participating hospitals would be required to have written agreements from all physicians with staff privileges which state that they would accept assignment for all inpatient or both inpatient and outpatient services. If the requirement were restricted to inpatient services, increases in charges for outpatient services appears likely. In either instance, hospital availability to Medicare patients could be placed in jeopardy if a substantial number of medical staff (particularly in physician shortage areas) refused to sign the agreement.

B. Modifications in Reasonable Charge Calculations

1. Liberalization in Reasonable Charge Methodology

a. possible modifications

It has been suggested that a voluntary increase in assignment rates could only be achieved through liberalizations in Medicare's computation of reasonable charges. There are several ways this could be accomplished. A frequently mentioned approach would be to reduce the lag in updating customary and prevailing charge screens. Currently, there is an 18 month span between the midpoint of the data collection period and the midpoint of the period when the screens are in effect. Liberalizations in allowed fees might also be achieved in certain instances by raising the prevailing fee level above the 75th percentile.

The principal means for achieving a liberalization in reasonable charges would be to eliminate or modify the calculation of the economic index. The increase in this index is based on weighted averages of changes in general earnings levels in the labor force and increases in the cost of maintaining an office practice. It has been noted that this in effect limits increases in the earnings component of recognized fees to a level based on general (not medical care) earnings increases.

As discussed in Part VII, an increasing number of physicians' fees become subject to the limitation from year to year. In the absence of other changes, the economic index will in effect lead to the use of fee schedules by Medicare. These fee schedules will reflect and lock into place existing imbalances between various geographic regions and among physician specialties. The variations will become more pronounced each year as the single index rate is applied to high versus low fee levels. The long term effect of the economic index, in the absence of any changes in payments for physician services to private patients, would appear to be a negative

impact in terms of a decrease in the assignment rate and an increase in beneficiary liability on unassigned claims. Another consequence of the limit may be an increase in the number of physician visits and/or in service intensity.

B. IMPACT ON ASSIGNMENT RATES

Several recent studies have examined the relationship between reimbursement and assignment rates. These studies have concluded that if other factors are held constant, increases in reimbursement rates result in higher assignment rates.

A regression analysis[46] of Colorado claims showed that the ratio of the physicians' billed charge to the Medicare determined reasonable charge is a significant determinant of whether a service is assigned. When other factors are held constant, physicians who charge higher prices accept assignment less often than those who charge lower prices. In addition, higher reasonable charges resulted in the higher likelihood of assignment.

One study[47] using an empirical model showed that a 1 percent increase in reasonable fees would yield a 5.1 percent increase in voluntary (i.e. non-Medicaid) assignment rates and 1.4 percent increase in total assignment rates for physicians not participating in Medicaid. A similar increase in billed charges would reduce the voluntary assignment rate by 6.0 percent and the total assignment rate by 2.0 percent. Assignment rates for physicians also participating in Medicaid showed similar but smaller responses to changes in revenue variables. For these physicians, a one percent increase in reasonable fees will increase the voluntary assignment rate by 1.7 percent, but will not significantly affect their total assignment rate. An equivalent increase in billed charges would reduce the voluntary assignment rate by 2.8 percent and the total assignment rate by 0.6 percent.

Another econometric analysis[48] showed that assignment rates were very sensitive to Medicare's reimbursement and administrative practices. In this study, a 10 percent increase in the prevailing charge raised assignment by 14.7 percent.

Though assignment rates are sensitive to Medicare payment amounts, the impact of changes in Medicare's rates are not uniform for all services. One study[49] noted that changes in the Part B rates are a positive determinant of changes in physician assignment rates for medical, laboratory, and radiology services; however, they appeared less important with respect to surgical services. Changes in assignment rates for laboratory and radiology services appeared to be determined by changes in payment levels for medical services. Thus, physicians determined not only their medical as-

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[46] Thomas Rice and Nelda McCall. "Factors Influencing Physician Assignment Decisions Under Medicare." Health Policy Research Series. Discussion paper No. 82-2 (pursuant to HCFA grant No. 95-P-97150/9-04). SRI International, Menlo Park, Calif. April 1982.

[47] Paringer, Lynn. "Medicare Assignment Rates of Physicians: Their Response to Changes in Reimbursement Policy," in Health Care Financing Review. Winter 1980. p. 88.

[48] Janet B. Mitchell and Jerry Cromwell, "Physician Behavior Under the Medicare Assignment Option." Final report (pursuant to HCFA contract No. 500-78-0051). Jan. 30, 1981. p. iv.

[49] Rice, Thomas. "Determinants of Physician Assignment Rates: An Analysis by Type of Service." Health Policy Research Series. Discussion paper No. 82-8. SRI International (pursuant to grant No. 1 R03 HS04729-01 from National Center for Health Services Research). October 1982.

signment rates, but also their laboratory and radiology assignment rates according to their reimbursement rates for medical services.

Increasing allowed charges would increase overall Medicare outlays and result in higher payments for many doctors whose assignment behavior remained unchanged. Holding other factors constant, increases in assignment rates could be anticipated. However, this does not necessarily translate into improved access and reduced financial liability for all Medicare patients. While the relative position of non-assigned patients generally improves as the difference between the allowed charge and the physician's fee is narrowed, an analysis [50] of the implications of this strategy concluded that the benefit could be short-lived if physicians raise their usual fees as demand increases. On the other hand, the relative position of assigned patients could be worse. Voluntary assigned patients will experience increases in coinsurance charges which in certain cases could serve as a barrier to services. In the case of both voluntary and mandatory assigned patients, there is the potential that access may be reduced if assigned output falls. Patients who would be the best off as a result of the policy change would be those who converted from an unassigned to assigned status.

2. Modifications in Specialty Calculations

Some have suggested the possibility of reducing Medicare's costs by eliminating specialty differentials in the calculation of reasonable charges. Most carriers have incorporated these differentials in their calculations to reflect actual charging practices. There is some evidence that the specialist/generalist differential may be higher than warranted by differences in quality and intensity of care provided, though some distinctions, not easily quantified, may be warranted by the presumed superior training and experience brought to the physician/patient encounter.

Neither Medicare, nor the medical community generally, have established a single uniform definition for the term specialist. Several items have been cited to support the contention that the existing generalist/specialist distinction does not always reflect differences in training or services provided. For example, a physician may not be board certified in his primary specialty (though he may be board eligible). In 1980, 48.7 percent of the nation's non-Federal physicians were not board certified in their primary specialty. [51] Similar findings have been reported for physicians providing services to Medicare patients. Preliminary results from a General Accounting Office (GAO) survey of three Medicare carriers suggest that roughly 50 percent of physicians classifying themselves as specialists are not board certified. For those physicians classifying themselves in one subspecialty of internal medicine, roughly one quarter were not certified in internal medicine. [52]

The type of services provided by a specialist may not in all cases be more intensive than that provided by a generalist. An estimated

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[50] Mitchell, Janet B. and Cromwell, Jerry. "Physician Behavior Under the Medicare Assignment Option: Final Report" (pursuant to HCFA contract No. 500-78-0051). Center for Health Economics Research. January 1981. p. 70-78.

[51] Bidese, Catherine and Danais, Donald. "Physician Characteristics and Distribution in the U.S.," 1981 edition, American Medical Association. Survey and Data Resources, 1982.

[52] Conversation with GAO official, April 1983.

20 percent of patients of all ages receive continuing general medical care from a specialist physician. An examination of physician practice encounters by specialty shows that (excluding the specialties of pediatrics and obstetrics/gynecology) from 16.7–68.9 percent of all patient encounters with specialists are in the principal care category (i.e. care provided to a regular patient by a physician who provides the majority of the patient's care. Consultative care provided at the request of another physician accounts for 15.3–54.4 percent of patient encounters, depending on specialty. Specialized care encounters represent between 1.7 percent and 47.5 percent of encounters by specialty.[53]

Preliminary results from a GAO sample of three Medicare carriers found that a significant amount of a specialist's work involved ailments unrelated to his particular specialty.[54] In this sample, between 18 percent and 52 percent of the physicians, depending on specialty, were providing services for diagnoses which did not require the skills of the specific specialist. For between 11 percent and 33 percent of the claims, categorized by specialty class, adequate care could have been provided by an internist, family practitioner or general practitioner. For between 2 percent and 20 percent of the claims, categorized by specialty class, adequate care could have been provided by a physician of another specialty.

In view of the variations in both documented qualifications of, and actual services rendered by, physicians classifying themselves as specialists, it has been suggested that the specialist/generalist distinction should be eliminated. While this approach could potentially rationalize some aspects of the existing system, limited savings could be anticipated. Preliminary results from a GAO simulation suggests that elimination of the differential would not result in additional program outlays and could in fact save up to an estimated 1 percent in outlays for physician services if a rollback in fees was permitted.[55] A simulation study[56] in Queens, New York showed that elimination of specialty differentials would slightly reduce program outlays (about 2 percent). Revenues would remain the same for 45 percent of physicians, increase for 20 percent of them (on the average of 2 percent) and decrease for 36 percent (on the average of 2 percent). Individual specialties would be affected in different ways. Elimination of specialty differentials would also result in an increase (averaging 17 percent) in out-of-pocket expenses for approximately half of the beneficiaries. The study also examined the impact of an average charge payment system (based on charges in a previous period) calculated without specialty differentiations. Such a system, which incorporated a stipulation that no physician reimbursements be reduced, would have little net effect on program outlay, physician revenues, and beneficiary burden.

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[53] Mendenhall, Robert C., "Medical Practice in the United States," Special report of the Robert Wood Johnson Foundation, 1981.

[54] Conversation with GAO official, April 1983.

[55] Conversation with GAO official, April 1983.

[56] Mueller, Charlotte F. and Otelsberg, Jonah. "Alternative Approaches to Physician Reimbursement Under Medicare: A Simulation," final report prepared by the Center for Social Research, Graduate Center, City University of New York (pursuant to HCFA grant No. 95-P-790012-01), Aug. 5, 1979. p. 1-15.

3. Modifications in Geographic Calculations

Variations in Medicare payment rates for urban versus rural areas are attributable to differences in charging patterns. It has generally been felt that a certain degree of difference is justified by the varying costs of practice in different localities. However, the magnitude of the difference in fees, and, therefore reasonable charges between those localities with high prevailing charges and those with low prevailing charges appears to be in excess of the amount warranted by cost-of-living differences.

H.R. 934, as reported in the 96th Congress by the Senate Finance Committee, included a measure directed at reducing locality differentials. The proposal required the calculation of statewide median charges (in any State with more than one locality) and provided that no local prevailing charge be increased in the annual update to the extent that it exceeded the statewide median by more than one-third. While no reductions would take place with respect to current levels, automatic increases in charge levels substantially above the median would be precluded. In addition, the proposal would have permitted a new physician in a locality which is designated as a physician shortage area to establish his customary charges at the prevailing level (rather than at the 50th percentile as under existing guidelines.)

In 1976, the State of Colorado, which previously had computed prevailing charges for 10 separate localities, moved to a single statewide locality. This reimbursement change led to a relative increase in prevailing charges for physicians in small urban and non-urban areas of the State and a relative decrease for physicians in major urban areas. An analysis [57] of the impact of these changes showed that physicians whose reimbursement rates declined following the changes (primarily those in Denver/Boulder area) billed for more-intensive medical services, had lower assignment rates, and charged lower prices than they would have in the absence of the change. Conversely, those physicians in small urban and non-urban area whose rates increased provided less-intensive services, had higher assignment rates and charged higher amounts than they would have otherwise. However, the analysis did not find that physicians responded to the reimbursement modification by altering the number of laboratory tests and X-rays provided.

C. Stemming Increases in Federal Outlays

During the 97th Congress, both the Senate and House considered measures directed toward curtailing the growth in physician expenditures. The Senate passed version of the "Tax Equity and Fiscal Responsibility Act of 1982" (TEFRA) specified that: (1) the increase in the economic index that was effective on July 1, 1982 would not be in effect for charges for services rendered on or after October 1, 1982; (2) the increase allowed for the 12 month period beginning July 1, 1983 could not exceed five percent; and (3) the Secretary of the Department of Health and Human Services (HHS)

[57] Rice, Thomas and McCall, Nelda. "Changes in Medicare Reimbursement in Colorado: Impact on Physicians' Economic Behavior," in Health Care Financing Review, June 1982, v. 3, No. 4, p. 67.

would be required to report to the Congress changes in the rate of assignment and in costs paid by beneficiaries as a result of changes made in physician reimbursement.

The House Committee provision considered during the conference on TEFRA specified that: (1) the increase in the economic index for prevailing fees effective July 1, 1982 would be reduced to 4 percent effective October 1, 1982; (2) physicians who agreed to accept assignment on all their bills would not be subject to the reduction; and (3) the date of the annual update in customary and prevailing charge screens would be delayed from July 1, to October 1 of each year starting in 1983. The "Tax Equity and Fiscal Responsibility Act of 1982," as enacted contained neither the Senate-passed nor House Committee provisions.

The President as part of his fiscal year 1984 Budget proposals recommended postponing the annual updating of both the customary and prevailing charge limits that would otherwise occur on July 1, 1983 for the period July 1, 1983 through June 30, 1984. This proposal is incorporated in S. 643 introduced by Senator Dole (by request).

In its fiscal year 1984 report [58] on various deficit reduction strategies, the Congressional Budget Office (CBO) noted that restricting the growth rate in allowable charges to the growth in the overall Consumer Price Index (CPI) could reduce program outlays by $3.6 billion over the fiscal year 1984–fiscal year 1988 period.

D. Alternative Payment Methodologies

The reasonable charge system incorporated in the original Medicare legislation was patterned after the reimbursement methodology used by some private insurers. Subsequent regulatory and legislative changes have resulted in certain limitations being placed on allowable Medicare fees which are more restrictive than those applicable in the private market. However, the basic fee-for-service methodology, based on customary and prevailing charges, still remains. The resulting system has been criticized for failing to meet what many believe should be the primary objectives of the Medicare reimbusement system, namely the provision of adequate financial protection for beneficiaries, promotion of rational payment patterns for physicians' services, and the containment of inflationary tendencies. Therefore, it has been suggested that in lieu of modifications to the existing system, an alternative payment methodology should be adopted.

1. Fee Schedules

The principal alternative payment method which has been suggested is that of negotiated fixed fee schedules. This approach has the advantage of being easy for patients and physicians to understand and easy for carriers to administer. Depending on the design of the system, it also has the potential for rationalizing allowable payment rates and stemming inflationary tendencies. However, fixed fee schedules offer no assurance to patients that the allow-

[58] Congressional Budget Office. "Reducing the Deficit: Spending and Revenue Options." A report to the Senate and House Committees on the Budget—part III, February 1983. p. 110.

able fees will be reasonably related to physicians' actual charges. Unless physicians are required to accept the fee schedule amounts as payment in full, patient liability for non-assigned claims could become more of a problem than under present law. If fee schedules do not keep pace with increases in actual charges, assignment rates could further decline.

Establishment of a fee schedule would require the development of a mechanism which accurately reflects the relative values of all the various medical procedures, the attachment of dollar values to these services, and the gaining of a consensus among the various parties involved.

The basic outline of a negotiated fixed fee schedule approach involves the development of a uniform system of procedural terminology and negotiation of payment rates for use on a State-by-State or area-by-area basis. The uniform system of procedure coding terminology would be developed by HCFA in consultation with the medical profession, other large purchasers of health care and other interested parties. Once the system was established, the actual amounts payable could be negotiated by HCFA and representatives of the medical profession; schedules would be periodically updated based on an appropriate index.

Several issues would need to be addressed if the fee schedule approach were adopted. The first relates to the value assigned to services performed by primary care physicians versus specialists and the degree to which existing fee differentials should be reflected in the new system. The second issue relates to the extent to which existing urban-rural and regional variations in fees should be lessened or eliminated. A single fee per procedure applicable to an entire State would represent a way of equalizing Medicare fees between urban and rural physicians and between different geographic areas in a single State. Alternatively, fee schedules could be established on an area-by-area basis. The impact of this approach on existing fee variations would depend on the size and composition of the designated areas and the extent to which disparities between comparable medical service areas were reduced or eliminated.

The major consideration in the design of a fee schedule payment system is the initial level at which fees are established. Some have suggested that the total costs generated by any fee schedule should not exceed that which would have been paid under the current system. However, this would mean that some physicians would have to accept a reduction in recognized fees. Another option would be to hold recognized fees constant (or allow them to increase at a slower rate) while the lowest recognized fees would be allowed to increase at a faster rate until they were equivalent. Alternatively, the schedule could be set at the upper range of the current distribution of fees. In the short run, this would represent a significant increase in program expenditures.

While fee schedules have the potential for stemming the growth in allowable fees, there is some question whether they are as effective in containing total expenditures for physicians' services. As noted in Part X, experience under the Economic Stabilization Program and the Colorado experience shows that when limits are

placed on allowable fees, increases in both intensity and volume may result.

An additional factor which would have to be taken into account if the fee schedule approach were adopted is the difficulty of negotiating rates where only an estimated 17 percent of total physician expenditures are involved. In order to encourage increased use of assignments (or agreements to become participating physicians) a higher schedule would probably have to be adopted than if all, or a larger percentage, of payment sources were involved.

In its fiscal year 1984 report [59] on various deficit reduction strategies, the CBO noted that fee schedules could be incrementally introduced, beginning with surgical procedures. Establishment of a schedule which resulted in a 10 percent reduction in allowed charges for surgical procedures would reduce Federal outlays by $180 million in fiscal year 1984 and $8.6 billion over the fiscal year 1984–1988 period. The report noted that fee schedules could be structured in such a manner as to encourage certain physician responses, such as movements of physicians into specialties, such as primary care, which have been traditionally characterized by low reimbursement levels. The report noted that these changes, particularly if coupled with mandated assignment, could be met with considerable physician resistance.

2. Diagnosis Related Groups

Public Law 98-21, the "Social Security Amendments of 1983" provides for the establishment of a prospective payment system for inpatient hospital services. Under the new system, hospitals are to be paid an established amount for each type of case (e.g., appendicitis) with cases classified according to diagnosis related groups (DRGs). Prospective rates are to be phased in over a three-year period.

The prospective payment system established under Public Law 98-21 applies to payments made for hospital services reimbursed under the Part A program. It does not apply to those physicians' services which are currently reimbursed on a fee-for-service basis under the Part B program. Public Law 98-21 does, however, require the Secretary to begin in fiscal year 1984 the collection of data necessary to compute by DRGs the amount of physician charges furnished to hospital inpatients classified in those DRGs. Further, the Secretary is required to report to the Congress in 1985, recommendations concerning the advisability and feasibility of providing for the determination of payments based on a DRG-type classification for physicians' services furnished to hospital inpatients.

3. Other Approaches

It has been suggested that as the supply of physicians increases relative to the total population, competitive forces could operate to encourage more physicians to accept assignment and/or alter their delivery patterns. One example cited is that of multispecialty geri-

[59] Congressional Budget Office. "Reducing the Deficit; Spending and Revenue Options." A report to the Senate and House Committees on the Budget—part III, February 1983, p. 111-112.

atric care associations which have been established in several areas. These entities offer citizens access to at least one primary care physician and a wide range of specialists, all of whom take assignment.

Several approaches have been offered for enhancing the forces of competition in the health care marketplace as a means of holding down medical costs. Given the fact that physicians are the central decision makers for the use of 70 percent of all health care services, it has been suggested that doctors should have a financial stake in what these services cost. One model is an arrangement under which primary care physicians share the risk for services provided to their patients. Each patient chooses his primary care physician who becomes the financial manager and coordinator for the entire spectrum of services provided. This physician must refer individuals for all nonemergency hospital and specified care. He authorizes payment from his account for such services and shares in any deficit or surplus remaining at the end of the year. Experience with such forms of medical organizations has been limited. In certain instances, financial problems have been encountered due to the difficulties these arrangements have had in establishing effective controls over volume and prices.

Another competitive approach to reducing Medicare's expenditures could involve the use of so-called "preferred provider" arrangements. The program would enter into agreements with individual or groups of physicians to provide services at the most competitive rates possible, negotiated in advance. Beneficiaries would not be required to obtain services from these physicians. However, they would be encouraged to do so through certain financial inducements, for example, the reduction or elimination of coinsurance charges.

The preceding discussion has focused on various possible modifications or alternatives for reimbursing physicians under Medicare. Other approaches could be considered. However, many would entail more broad scale modifications in health service delivery patterns and/or population groups served and are thus outside the scope of this report.

ATTACHMENT A

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, D.C., July 30, 1983.

MEMORANDUM

To: Sheila Burke.
From: Marilyn Moon.
Subject: Physician reimbursement tables.

I am enclosing a set of tables on physician reimbursement based on 1980 data from Medicare Bill Summary records.

Some caveats and explanations are necessary. First, these data represent a subsample of the Bill Summary records which HCFA uses in its published tables. Although there may be some minor differences, this extract nonetheless has 700,000 bills, over 530,000 of which are for physicians' services. In this memorandum, only physicians' services are examined; these include all services for which the specialty code indicated that a physician (including dental surgeons and osteopaths) provided the service. A small number of physician services are excluded when the specialty was coded as unknown. The tables contained here use reasonable charges as the base.

This memorandum concentrates on the proportion of reasonable charges accounted for by various subsets of physician services to illustrate the potential impact of changes in physician reimbursement on selected portions of physicians' services. These simple disaggregations do not tell the whole story, however, since physicians may have some discretion about how services are categorized. For example, if inpatient services are singled out for more restrictive reimbursement policies, some physicians might—at the margin—do more follow-up treatment in the office after the patient has returned home.

Specialty of Physician

On the bill summary, physician specialty is coded by the carrier using local directories which indicate what the physicians themselves consider their major specialties. Only a portion of those specialties are listed here, representing some of the largest groups. The last category, specialized surgery, combines all those codes listing surgery associated with a particular specialty (such as orthopedic surgery).

Table I summarizes some general information about physicians by specialty. Physicians specializing in internal medicine account for over one-fifth of all reasonable charges for physicians. Another fifth is for services by physicians specializing in surgery. Average submitted and reasonable charges here are shown for two types of services: "medical care" and surgery. The medical care category is a catchall including all general physician services such as office visits and diagnostic services. Differences by physician specialty consequently represent both potential differences in reimbursements for the same procedures and variations in the mix of procedures performed by physicians in each specialty group. An even greater variation in reasonable charges exists across specialties for surgery, probably largely reflecting differences in the complexity of surgical procedures performed.[1] (For some specialties, such as anesthesia and radiology, most reasonable charges are not in the medical care or surgery categories.)

Type and Place of Service

Separating reasonable charges by type and place of services also represent possible ways to make selective changes in physician reimbursement policy. The tables presented here focus only on office visits, and inpatient and outpatient hospital services. Treatment at home or in an institutional setting represents only a small

[1] The prevailing charge directory which shows limits for specific procedures indicates much smaller differences between reasonable charge amounts allowed for specialists and general practice.

proportion of reasonable charges. The type of service category is also limited here to medical care, surgery, and consultation services, which together represents over three-fourths of reasonable charges.

Three-fifths of all reasonable charges are for inpatient hospital services, but less than half of that amount represents inpatient surgery (see Table 2). Almost half of medical care services are performed in an inpatient setting. Medical care and surgery each account for more than one-third of all physician services.

Assignment

Another way of selectively changing physician reimbursement would be to distinguish between services where assignment would be accepted and where it would not. Data are not readily available on what proportion of physicians always accept assignment. Rather, the results presented here consider only the share of reasonable charges where assignment is accepted. Since the results discussed here are based on reasonable charges, that portion of reasonable charges attributable to meeting the deductible is not classified by whether assignment is accepted or not. Consequently, the percentages do not sum to 100. (It is of interest, however, to note that this is particularly true for office visits. Once patients are hospitalized, they have evidently already exceeded the SMI deductible.) Behavioral assumptions about the response of physicians to charges based on acceptance of assignment would be particularly important for determining the ultimate impact of any change.

The proportion of reasonable charges for which assignment is accepted shows considerable variation by type and place of service (see Table 3). Overall, office visits display the lowest proportion of charges where assignment is accepted and outpatient services have the highest proportion. The differences across these places are greater for services categorized as "medical care." Moreover, the relatively high 52 percent of reasonable charges accepted for inpatient services are particularly affected by a 57 percent acceptance for medical care as opposed to surgery. This is somewhat at odds with the common belief that it is the expensive services such as surgical procedures which display the highest assignment rates. The results are similar when acceptance of assignment is disaggregated by whether or not there has been a Medicaid buy-in.

TABLE 1.—SHARE OF REASONABLE CHARGES AND AVERAGE SUBMITTED AND REASONABLE CHARGES BY SELECTED SPECIALTIES

Speciality	Percent of all reasonable charges	Average submitted charges		Average reasonable charges	
		Medical care [1]	Surgery [2]	Medical care [1]	Surgery [2]
General practice	9.2	$17.82	$46.69	$13.66	$36.43
Internal medicine	21.7	25.84	70.33	19.99	54.99
Family practice	4.1	18.48	42.47	14.08	32.19
Cardiovascular	4.1	31.51	261.20	24.20	207.24
Urology	5.1	21.29	245.05	16.87	187.77
Radiology	6.9	28.04	105.45	21.56	82.36
General surgery	10.6	20.63	319.60	15.67	244.43
Specialized surgery	10.8	24.89	458.95	18.59	343.83
Anesthesiology	4.9	25.53	126.25	18.79	91.16
All physicians	100.0	23.18	181.92	17.80	139.50

[1] "Medical care" here refers to general physician services excluding surgery and consultation.
[2] Surgery includes those procedures recognized in the surgical section of current procedural terminology published by the AMA.

Source: Extract from 1980 Bill Summary.

TABLE 2.—PERCENTAGE OF REASONABLE CHARGES BY SELECTED TYPES AND PLACES OF SERVICE, 1980

Place of service	Type of service			All
	Medical care	Surgery	Consultation	
Office	17.4	3.6	0.5	29.4
Inpatient hospital	19.5	27.0	2.4	59.8
Outpatient hospital	1.0	1.1	0.1	3.6
All	40.1	33.6	3.2	100.0

Source: Extract from 1980 Bill Summary.

TABLE 3.—ACCEPTANCE OF ASSIGNMENT BY SELECTED TYPE AND PLACE OF SERVICES

Selected types and places of services	Percent of reasonable charges where		
	Assignment accepted		Assignment not accepted
	With medicaid buy-in	And no medicaid buy-in	
All services	10.5	36.5	49.0
Office visits	9.0	23.4	56.6
Inpatient hospital	10.9	41.4	47.4
Outpatient hospital	10.8	50.6	33.7
Medical care	12.2	33.4	47.4
Office visits	9.3	19.3	57.1
Inpatient hospital	13.3	44.0	42.4
Outpatient hospital	17.2	51.3	24.5
Surgery	9.1	37.9	51.9
Office visits	8.4	34.5	51.0
Inpatient hospital	9.4	37.9	52.5
Outpatient hospital	7.1	47.5	44.6

Source: Extract from 1980 Bill Summary.

ATTACHMENT B

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, D.C., July 25, 1983.

MEMORANDUM

To: Shelia Burke.
From: Marilyn Moon.
Subject: Additional physician reimbursement information.

I am enclosing three tables highlighting some of the data on physician reimbursement you asked me to provide. These tables contain information on size of average reasonable charges per service and on the growth of reimbursements by physician speciality.

Tables 1 and 2 focus on the size of reasonable charges. Table 1 looks only at surgery. In general, the smaller the average charge, the more likely it is that the surgery was performed either in an outpatient hospital or office setting. About 40 percent of all reasonable charges for surgery averaged over $1,000 per service (in 1984 dollars). In that range, the proportion of reasonble charges where assignment was accepted and no Medicaid buy-in was involved is less than for services where average charges are smaller.

Table 2 summarizes the distribution of all charges by size of the average charge per service. Nearly two-thirds of the total amount is accounted for by services where charges are less than $100. In this case, "voluntary" acceptance of assignment is slightly lower than average. As was the case with surgery, however, this acceptance rate increases only at first, declining again for charges averaging very large amounts.

Table 3 summarizes growth in reimbursements by selected specialities between 1975 and 1980. Highest rates are for physicians specializing in family practice, cardiovascular disease, and pathology. In each of these cases, however, the specialty—even after growing faster than others—commands a relatively small share of total reimbursements. On the other hand, reimbursements to physicians listing general practice as their specialty grew much more slowly than average so that the share received by such physicians in 1980 was much smaller than in 1975. The last two columns of Table 3 show acceptance of assignment as a proportion of total reimbursements. (This varies slightly from percentages calculated against reasonable charges as shown in Tables 1 and 2.) There does not seem to be any particular relationship between acceptance of assignment and rate of growth in reimbursements by specialty.

TABLE 1.—ASSIGNMENT RATES AND SHARE OF REASONABLE CHARGES BY SIZE OF AVERAGE REASONABLE CHARGE PER SERVICE FOR SURGERY

[In percent]

Average size of reasonable charge per service for surgery (in 1984 dollars)	Share of all reasonable charges for surgery	Share of all reasonable charges	Proportion of reasonable charges where assignment is accepted and no medicaid buy-in [1]
Less than $100	11.3	3.9	37.7
$100 to $499	20.8	7.0	43.5
$500 to $999	23.8	8.0	39.9
$1,000 to $1,499	20.3	6.8	36.8

TABLE 1.—ASSIGNMENT RATES AND SHARE OF REASONABLE CHARGES BY SIZE OF AVERAGE REASONABLE CHARGE PER SERVICE FOR SURGERY—Continued

[In percent]

Average size of reasonable charge per service for surgery (in 1984 dollars)	Share of all reasonable charges for surgery	Share of all reasonable charges	Proportion of reasonable charges where assignment is accepted and no medicaid buy-in [1]
$1,500 to $1,999	10.9	3.6	31.6
$2,000 and above	12.9	4.3	35.7
All	100.0	33.6	38.3

[1] The denominator used to calculate this percentage omits the share of reasonable charges applied to the deductible.

Source: Extract from 1980 Bill Summary.

TABLE 2.—ASSIGNMENT RATES AND SHARE OF REASONABLE CHARGES BY SIZE OF AVERAGE REASONABLE CHARGE PER SERVICE

[In percent]

Average size of reasonable charge per service (in 1984 dollars)	Share of all reasonable charges	Where assignment is accepted and no medicaid buy-in [1]
Less than $100	63.2	36.5
$100 to $199	5.3	48.1
$200 to $299	3.3	46.3
$300 to $399	2.3	45.2
$400 to $499	2.3	41.9
$500 to $999	8.6	40.5
$1,000 to $1,499	6.9	37.0
$1,500 to $1,999	3.7	31.7
$2,000 and above	4.4	35.8
All	100.0	38.0

[1] The denominator used to calculate this percentage omits the share of reasonable charges applied to the deductible.

Source: Extract from 1980 Bill Summary.

TABLE 3.—SIZE AND GROWTH OF SELECTED PHYSICIAN SPECIALTIES AND ACCEPTANCE OF ASSIGNMENT

(In percent)

Physician specialty	Percentage of total reimbursements		Annual compound rate of growth in reimbursements 1975–80	Percentage of reimbursements where assignment accepted	
	1975	1980		With buy-in [1]	With no buy-in
General practice	13.5	8.2	6.6	15.9	30.2
Family practice	1.3	3.7	44.9	16.4	31.0
Internal medicine	20.3	21.0	18.6	10.5	37.6
Cardiovascular disease	2.9	4.1	26.9	9.2	43.0
Ophthalmology	6.2	8.0	23.8	8.7	29.5
Urology	5.3	5.3	17.8	8.7	35.3
General surgery	11.9	10.9	15.8	10.5	40.6
Orthopedic surgery	5.7	6.3	19.9	9.6	34.9
Anesthesiology	4.5	5.1	20.6	9.4	34.9
Radiology	5.8	7.8	25.0	10.2	50.3
Pathology	1.1	1.5	25.8	13.9	51.9
All physicians	100.0	100.0	17.8	11.1	38.7

[1] Buy-in refers to whether medicaid purchases part B premiums for its beneficiaries. In such cases acceptance of assignment is mandatory for the physician.

Source: Extract from 1980 Bill Summary and "Medicare: Use of Physicians' Services Under the Supplementary Medical Insurance Program, 1975–1978."

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