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PHYSICIAN PAYMENT REFORMS

HEARING

BEFORE THE

SUBCOMMITTEE ON
MEDICARE AND LONG-TERM CARE

OF THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ONE HUNDRED FIRST CONGRESS

FIRST SESSION

JUNE 16, 1989

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FRIDAY, JUNE 16, 1989

U.S. SENATE,
SUBCOMMITTEE ON MEDICARE AND LONG-TERM CARE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 9:34 a.m. in room SD-215, Dirksen Senate Office Building, Hon. John D. Rockefeller IV (chairman of the subcommittee) presiding.

Also present: Senators Bentsen, Baucus, Mitchell, Daschle, Packwood, Chafee, Heinz, and Durenberger.

[The press release announcing the hearing follows:]

[Press Release No. H-33, June 5, 1989]

FINANCE SUBCOMMITTEE TO HOLD THIRD HEARING ON PHYSICIAN PAYMENT REFORM

WASHINGTON, DC—Senator John D. Rockefeller IV (D., West Virginia), Chairman of the Senate Finance Subcommittee on Medicare and Long Term Care, announced Monday that the Subcommittee will hold the third in a series of hearings on the issue of physician payment reform under the Medicare program. This hearing will focus on volume issues, specifically, expenditure targets, practice guidelines, and utilization review.

The hearing is scheduled for *Friday, June 16, 1989 at 9:30 a.m.* in Room SD-215 of the Dirksen Senate Office Building.

Chairman Rockefeller said, "This third hearing on physician payment reform will focus on issues relating to the volume of physician services. The rapid growth in the number and intensity of physician services provided under Part B of Medicare, combined with evidence of unnecessary care, is cause for concern. A primary goal of the physician payment reform process must be to ensure that high quality care is available at an affordable cost to the Medicare program and its beneficiaries."

Senator ROCKEFELLER. This hearing will come to order.

The chairman of the full committee, Senator Lloyd Bentsen, has a statement.

OPENING STATEMENT OF HON. LLOYD BENTSEN, A U.S. SENATOR FROM TEXAS, CHAIRMAN, SENATE FINANCE COMMITTEE

The CHAIRMAN. Thank you very much, Mr. Chairman.

I want to congratulate you on holding these hearings. I am very appreciative of the fact that Dr. Sullivan is here as we talk about this physician payment reform. I am particularly interested in hearing what the administration's point of view is in regard to this.

As you know, the Physician Payment Review Commission has done a great deal of work on this particular issue and made a number of recommendations.

I suppose the most controversial of those recommendations is to try to establish some kind of an expenditure target. That gives me some concern, too, as to just how it is going to be accomplished,

and how it is going to be enforced, and how it is going to put the pressure on and the incentives on the individual physician. Rather than saying, "Well, I am going to get mine this year, and I will worry about the rest next year and let that be spread over the entire Physician Payment group." So, I am interested in seeing how that works.

This committee has been very cognizant of the need for structural reforms in Part B of Medicare. There is no question but what it has been going up much faster than inflation itself, and we have been called on every year to reduce the rate of increase in the expenditures under the program. But we are equally concerned with seeing that these beneficiaries get excellent health care and have access to it.

As we proceed this morning to look at proposals to control the volume of physician services, we must focus on the need to balance those two interests off and what we can do to bring that about.

If we are to legislate fundamental reform of the Physician Payment System, then we must also consider the need to have the time to do the structural changes, to meet those things that we had not anticipated as we go along the way.

When we brought about the major reforms of the Hospital Payment System back in 1983, there were all kinds of implementation problems that came about, that were encountered, and the system had to be modified as we went along, and I want to be sure that we have that kind of time to play it out.

I must say that, a more recent vintage, I find the same kinds of problems with catastrophic illness. So we are revisiting that one, to see what modifications might or should be made in regard to that.

But again, Mr. Chairman, I am very pleased that you are proceeding on this, and I look forward to hearing the statements of the witnesses.

Senator ROCKEFELLER. Thank you, Senator Bentsen.

The majority leader is here and, as might be expected, has a lot to do today and every day, and I would welcome any comments that the majority leader might want to make.

OPENING STATEMENT OF HON. GEORGE J. MITCHELL, A U.S. SENATOR FROM MAINE

Senator MITCHELL. Thank you very much, Mr. Chairman.

I commend you for holding this hearing to focus on the issue of volume of physician services and the overall discussion of physician payment reform.

I appreciate your willingness to accommodate my interest in the role the development of practice guidelines might play in this discussion.

Representing a rural State, I have long been aware of the inequity in the system of physician reimbursement under Medicare. This inequity contributes to the shortage of primary care physicians in rural areas of Maine and other States, and I am sure the Chairman's State, as well.

I commend Dr. Hsiao and his research team at Harvard for the development of the resource-based relative value scale. Their work provides us with valuable information which will allow the Con-

gress to begin serious work in their review and reform of the current physician payment system.

I am grateful for the recommendations made by the Physician Payment Review Commission. The Commission made important statements regarding the current inequity between primary care and surgical procedures, and also addressed the critical issue of geographic inequity in physician payment. The implementation of these recommendations can affect access to quality health care for all Medicare beneficiaries, particularly those living in under-served areas.

The Commission has addressed the difficult issue of utilization control. The escalating costs of physician services under Part B are caused in part by the increase in utilization of services. We must address this issue along with the question of equity of reimbursement by procedure.

I support the recommendations of the Commission with regard to effectiveness research.

Earlier this year I introduced legislation, S. 702, intended to improve the Patient Outcomes Assessment Research Program. The goal of this legislation is to improve the quality, effectiveness, and appropriateness of health care. The bill includes a provision which establishes a Practice Guidelines Development Program to help provide guidance to physicians to manage their patients' health condition.

My interest in the subject of outcomes research and the development of practice guidelines was sparked by the work of the Maine Medical Assessment Foundation, which has been at the forefront of such efforts. The data they have gathered are important in helping physicians improve the quality of care for their patients, encouraging patient participation in decisionmaking and contributing to controlling the cost of services.

The Maine experiment is providing useful insights into the problem of quality versus cost-containment. The Maine physicians involved in this program are committed to providing care uncompromised by economic concerns. Their work has demonstrated that quality can be preserved, or even enhanced, while reducing health care expenditures.

I believe we must include volume controls as part of any overall physician payment reform. I remain open about the best way to achieve utilization control in physician services; I hope the development of practice guidelines can play a role in any proposal the Congress may develop.

I look forward to working with you, Mr. Chairman, and my other colleagues, and with the medical community to develop a fair and equitable system for physician reimbursement under Medicare.

I apologize to the witnesses that I will not be able to stay for the entire meeting, especially the witness who you added at my request, but I did want to make this statement and express my interest in this subject.

Thank you, Mr. Chairman.

Senator ROCKEFELLER. Thank you, Senator Mitchell. I will make a statement at this point.

OPENING STATEMENT OF HON. JOHN D. ROCKEFELLER IV, A U.S. SENATOR FROM WEST VIRGINIA

Senator ROCKEFELLER. As you all know, this is the third of the subcommittee hearings we have had on this general subject. Our first two hearings provided a general review of payment reform, and then a relatively in-depth discussion of issues relating to a Medicare fee schedule based upon a resource-based relative value scale.

From the first two hearings I think we learned some very important lessons: One, there is widespread dissatisfaction with the present Medicare physician payment system; it produces inequitable differences in payment for similar services in similar areas of this country; it incorporates perverse financial incentives that distort medical decisions; and our present payment system appears to have little relationship to the value of medical services as measured by their resource costs.

In addition, from a financial perspective, the Medicare program, like the entire health system, is simply out of control, which leaves us with no option to not act. Spending under the Part B program is growing between 15 and 17 percent annually. The cost of Medicare doubles every 5 or 6 years. It is an enormous program to begin with. Each year the Congress is forced to go through the unpleasant process of cutting physicians' fees, and yet, even when we have frozen fees entirely, the costs continue to rise.

So, we asked for some studies, and some very important studies. I am extremely pleased at the work that has been produced by Dr. Hsiao, by the Physician Payment Review Commission in cooperation with the American Medical Association, and many other physician societies.

Now we have within our grasp a new and better way for physician payment as a system, a fee schedule based on some rational measures that will correct many inequities and the perverse financial incentives that I mentioned.

This is a tremendous opportunity for constructive reform. I intend to work closely with Senator Durenberger and, obviously, with the chairman of the full committee and my other colleagues on this fine subcommittee, to take this opportunity and to make this thing work.

I hope that we can enact legislation this year to get the Medicare Physician Payment Reform process started. Clearly, we have to proceed with care. We must avoid abrupt changes that could produce access problems or sudden increases in beneficiaries' financial burdens, we must preserve the ability to make refinements, and we must preserve the ability to make mid-course corrections, and we must continue to study and to learn. That is the purpose of today's hearings.

A key component of the Physician Payment Reform recommendations made to this committee were the proposals to control the volume of unnecessary and inappropriate medical services.

Not surprisingly, these volume control proposals have been the most controversial. On the one hand, there is the danger of continued unchecked medical inflation, which threatens to bankrupt the Medicare program. On the other hand, the specter of rationing has

been raised. Speaking for myself, I will not be a party to any change which denies needed medical services to Medicare beneficiaries; nor will I do anything to seriously under-fund the Medicare program or otherwise relegate it to a second-class health insurance plan, as, unfortunately, has become the case in so many of the State Medicaid programs.

Medicare must continue to be a promise of health care and security to senior citizens and the disabled. That promise is a national badge of honor. This subcommittee and this Congress will defend it.

In order for the promise of Medicare to be affordable to taxpayers, we cannot tolerate waste or a substandard quality of care. Unfortunately, Congress cannot legislate good medicine. The best we can do is to work with physicians, cooperatively, to establish the necessary systems, incentives and protections that enable them, help them, to make good decisions and to deliver good care.

Today we are fortunate, starting with the Secretary, to have an excellent group of panelists and experts, and I will look forward to proceeding to that.

Mr. Secretary, if you will bear with us a few moments longer, I would like to call now on the ranking member of this committee, who is an extremely fair, wise, good person. His name is David Durenberger.

Senator DURENBERGER. Mr. Chairman, thank you very much. I am going to be fair and defer to my colleagues who were here on time for this hearing, on the Republican side. [Laughter.]

Senator PACKWOOD. I didn't recognize who the chairman was talking about until he mentioned the name. [Laughter.]

Senator ROCKEFELLER. I saw them straighten up, myself. [Laughter.]

Senator PACKWOOD. I have no statement, Mr. Chairman. Thank you.

Senator HEINZ. Would Senator Rockefeller like unanimous consent to revise and extend his remarks? [Laughter.]

OPENING STATEMENT OF HON. JOHN HEINZ, A U.S. SENATOR FROM PENNSYLVANIA

Senator HEINZ. Mr. Chairman, first let me commend you on holding these hearings. Obviously, we are all concerned about the fact that costs under the Part B program have been spiralling—some 16 percent a year—and it is a spiral that literally picks the pockets of both taxpayers and Medicare beneficiaries through increased premiums and copayments.

Furthermore, as I know you know, Mr. Secretary, the Health Care Financing administration tells us these cost increases reflect a some 44-percent increase in volume of services. Many of us have concern that that volume and too many of the services provided may be unnecessary or inappropriate, or may actually pose a risk to the patient. An example that comes to mind is cardiac catheterization, which, according to the information I have received, is overutilized, potentially damaging, and costs literally hundreds of thousands, even millions, of dollars annually.

We will be focusing today, more than ever before, on our means of controlling that volume. There are three means that we have identified:

One is, of course, expenditure targets. The House has adopted those in their subcommittee deliberations. They are necessarily controversial.

The second is practice guidelines. Senator Mitchell and I and others have done a lot of work both with you, Mr. Secretary, and the General Accounting Office to lay the groundwork for an effective effectiveness initiative leading to practice guidelines. The medical community has also studied those initiatives and realizes that it is very advantageous to have them result in practice guidelines.

Mr. Chairman, I would like to include correspondence on our request for a GAO study on effectiveness in the record at this point.

[The correspondence appears in the appendix.]

The third is improved methods of utilization review.

I trust we will be able to really focus on those three kinds of options. They are critical. But I would only like to state for the record that I think I can say for every member of this subcommittee two things:

One, whatever it is we finally choose to do, that we don't intend to end up padlocking the physician's black bag and prevent them from giving proper medical care. We are not going to force them to substitute an aspirin for an x-ray if the patient has a broken leg.

Second, we do not intend to in any way deny the Medicare beneficiary their access to absolutely needed, necessary, quality medical care.

I think the committee will be very faithful to those two principles, and certainly they will be of importance to me.

Thank you, Mr. Chairman.

Senator ROCKEFELLER. Thank you, Senator Heinz.

Senator Durenberger?

OPENING STATEMENT OF HON. DAVID DURENBERGER, A U.S. SENATOR FROM MINNESOTA

Senator DURENBERGER. Mr. Chairman, thank you.

I guess, just for openers, I would make this contribution to the discussion:

I have looked over the statements of the witnesses, and they vary depending on where the particular organization fits in the whole area of delivering health care services, and that is why you are having this hearing today, because we need to focus on the variety.

But one of the things that is sort of missing, perhaps, from the whole discussion as we talk about a fee schedule, and we talk about practice guidelines, and we talk about other things, is where as a nation we would like to be.

I hope, Mr. Secretary, not necessarily in your prepared remarks but maybe in response to questions, you can help us focus on the fact that whatever we are talking about here in terms of restraint on runaway whatever is really dealing with a problem that has developed over a long period of time. And in and of itself, practice guidelines are not the answer to how Americans buy health care or how physicians or anybody else delivers health care in this coun-

try, any more than DRG's were the answer to how hospitals ought to operate in this country. They are just a means to some end.

It continually strikes me as I have sat on this committee, in particular, and even more so now that I am also over on Labor and Human resources, that we kind of desperately need to focus on where we would like to be, if it is different from where we are today, rather than only focusing on the solution that is being offered or the variety of solutions being offered to a problem.

I spent a day and a half this week in Canada—not because I wanted to go and look at a Canadian health system but because I had to go give a speech on acid rain on Monday night, which was just a wonderful coincidence, because our President cooperated, and the Canadians thought I was terrific. But I used most of my time wanting to go to a baseball game at this wonderful new stadium in Toronto and the other to talk to various people, including Dr. Detsky who is with us today, and came to the conclusion that you can't come to a conclusion unless somehow you define where it is you would like your society's health care system to be.

I have my own thoughts on that, and some of us are going to be focusing on that in the Pepper commission and the bipartisan commission, because part of what we are talking about here today is major changes in the way we deliver and finance health care here in the United States.

I know there are a lot of angry doctors in Chicago waiting for the House of Delegates or the American Medical Association to meet, because they see Canada coming to the United States. And if we don't assure them that we are not going to let Canada come to the United States, they are going to start a campaign around the country on rationing and things like that, and it is kind of too bad, I guess, that too much focus is on the means and not enough definition on the end.

So I hope that, as we on this committee, and this subcommittee in particular, deal with the volume issues—both in this subcommittee and in the future—we will have your guidance and that of the administration and the President, in particular, about where we would like to be say 5 years from now or 10 years from now and what, over time, we need to do in order to get there.

Senator ROCKEFELLER. Senator Baucus?

Senator BAUCUS. I have no statement, Mr. Chairman.

Senator ROCKEFELLER. Mr. Secretary, we are very grateful for your presence. We know that you have an extremely busy day today—I am fully aware of that—and I am very grateful that you are here in person to deliver testimony on behalf of your department and the administration.

You may proceed, sir.

STATEMENT OF HON. LOUIS W. SULLIVAN, SECRETARY, DEPARTMENT OF HEALTH AND HUMAN SERVICES, ACCOMPANIED BY LOUIS B. HAYS, ACTING ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION

Secretary SULLIVAN. Thank you very much, Mr. Chairman and members of the subcommittee.

I am accompanied today, also, by Mr. Louis Hays, who is the Acting Administrator of our Health Care Financing Administration.

I am pleased to come before you today to outline the administration's views on Medicare payments to physicians. The administration strongly supports a three-part framework for physician payment reform.

The trilogy we support includes a resource-based fee schedule, an expenditure target for Medicare physician services, and beneficiary protections.

However, because the resource-based fee schedule alone does not control growth in the volume and intensity of physician services, and indeed could exacerbate it, the administration would not support such a fee schedule if it is not linked to a volume control mechanism such as an expenditure target.

Further, because of the administrative complexity of the various components of a comprehensive reform package, and because the research being conducted by Dr. Hsiao has not been entirely completed or analyzed, a gradual transition period over several years is necessary, as several of you have indicated.

In the interim, the resource-based relative value system is sufficiently developed now to be useful in identifying and reducing Medicare payments for overpriced procedures.

While my prepared statement addresses the major issues in some detail, I will confine my remarks to several essential points:

First, the most profound challenge we face with regard to physician payment reform is controlling physician expenditures. Medicare physician spending has increased at compound annual rates of 16 percent over the past 10 years. And in spite of our best efforts to control volume and reign in expenditures, Medicare physician spending is currently out of control.

Since increases in volume and intensity of physician services accounts for the largest portion of the growth in expenditures, any reform package must squarely confront the volume problem, or it will be haunted by the same flaws which plague the current system.

Second, since a resource-based relative value scale alone does not control volume, and indeed may exacerbate the current situation, the administration opposes its implementation unless it is linked to an expenditure target for Medicare physician services.

An expenditure target—or perhaps we should call it "a volume adjustment"—for a physician payment update sets an acceptable level of growth in the volume and the intensity of physician services. This volume factor is only one of many factors, including the rate of inflation and the growth and aging of the Medicare population, which would be taken into account in calculating the payment update.

It is a great leap of faith to assume, as some have, that an expenditure target as we envision it would promote rationing of medical care.

Third, I must point out that implementation of any new payment system will be an enormously complex undertaking, much more complex than, for example, implementation of the Prospective Payment System for hospitals, as Senator Bentsen has indicated.

In this light, the administration prefers a gradual implementation of a national fee schedule over several years, perhaps beginning implementation on January 1, 1993.

In addition, I hope that this committee will give serious consideration to adopting a full geographic practice cost index, one which takes into account overhead practice costs and physician income. This option minimizes the shift in payments across geographic areas, and therefore contributes to a less disruptive implementation.

I would note that this approach would help avert unintended consequences of the new payment system, would minimize the potential risk to access, would provide physicians and beneficiaries an opportunity to adapt to changes in payment, and allow for mid-course corrections should serious problems develop.

Fourth, since Medicare's foremost commitment is to assure access and financial protection for its beneficiaries, the administration supports some limit on extra billing. In addition, we favor continuation of the participating physician program. Medicare has historically been quite successful in purchasing access to care for beneficiaries, and today I am pleased to announce that between January and March of this year over 80 percent of all physician services were rendered on an assignment-related basis—an all-time high.

But we must keep in mind that among our major goals is structural reform of Medicare physician payments. Expenditure targets for physician payments attempt to bring those payments under control, in the same way that in 1983 prospective payment reform brought hospital spending under control.

The administration favors secretarial authority to set differential targets and updates for physician groups based on the groups performance. Such carve-outs are an important concept. They allow physicians to choose their own business partners and strengthen their incentives to practice efficiently.

In this context, we will be continuing and extending our encouragement of HMO's and other managed care plans. Increases in the per capita payment to HMO's will be sought, as part of the broader effort to implement needed Medicare reforms.

To conclude my remarks, let me emphasize my personal commitment to our citizens in rural America and to those who live in inner-cities that they will have access to quality health care. In this regard, you can be sure that I will be personally vigilant about the potential effect of any new payment system on access to care in medically-undeserved areas. And I hope you will also keep in mind the need for flexibility in providing bonus payments to physicians who practice in medically undeserved areas.

Thank you very much, Mr. Chairman. I would be pleased to respond to questions.

[The prepared statement of Secretary Sullivan appears in the appendix.]

Senator ROCKEFELLER. Thank you very much, Mr. Secretary.

We will start with the Chairman of the full committee, Senator Bentsen.

The CHAIRMAN. Thank you very much, Mr. Chairman.

In your testimony, you are talking about physicians' payments under Medicare exceeding the rate of inflation, population growth, changes in technology. So, when you call for a target, that means that you also have to have a means for determining what that target should be and how you evaluate it. I think that is a rather difficult task. Could you give me some idea of how you intend to try to accomplish that objective?

Secretary SULLIVAN. Yes, Mr. Bentsen.

What we envision is this: First of all, we will set the experience of that area as a base line, and then we will include in the target the rate of inflation, growth in the population as well as aging of the population, as well as allowing for advances in new technology. It is, admittedly, a complex system with a number of variables, but these will be the ingredients that will go into the formula.

The CHAIRMAN. Well, as I mentioned earlier in my opening statement, when you are talking about errors or excesses by individual physicians, and then you were talking about penalizing all physicians for those individual excesses, peer groups have a tough time disciplining people in their own profession. We see the problems here in the United States Congress in peer review, we see the problems among attorneys, and doctors have those same kinds of problems.

How do you bring about that kind of discipline on the individual by penalizing the entire group? What changes do you anticipate insofar as peer review?

Secretary SULLIVAN. We will be continuing our peer review process, Mr. Bentsen. Indeed, we believe that this will really strengthen that process, because, along with the ongoing effectiveness research which will certainly, in time, help to contribute to this, but not in the early years because of the time needed for this research to be beneficial, and given the fact that we are fully aware of the fact that we have excess procedures in many areas—the problem we have, of course, is really in determining the parameters whereby we will make the determinations of what is the best procedure or the most appropriate procedure. But given the fact that the expenditure targets will set limits on the funds available, we believe that this will strengthen the need for strong peer review within the profession itself.

The CHAIRMAN. Well, I hope you are right on that.

Now, you talk about a geographic index being applied to the entire physician's fee, the Physicians Payment Review Commission recommended that only a portion of that fee be indexed, and that it would reflect overhead costs. Can you explain to me why you differ on that point? Because it is my understanding that the PPRC recommendation would be more beneficial in raising fees in rural and under-served areas. I have much of that in the State which I represent, as does the Majority Leader, as he commented on in his opening statements.

Would you give me a feel for that?

Secretary SULLIVAN. Yes.

The system will have considerable variability among some regions, to be sure; but we believe that the full geographic cost index would really minimize the disruption that would exist across different geographic areas.

Now, we are aware that some areas will experience have a greater impact, but we also emphasize this is one of those instances where some secretarial discretion is needed to try and be sure that we do not implement a system that is overly disruptive.

Second, we have emphasized the need for phasing in the system over a period of several years. This will give us an opportunity for mid-course corrections as we gain more experience with the system.

The CHAIRMAN. Thank you.

Mr. Chairman, I want to thank you again for calling these hearings on such an important subject. Unfortunately, I have to attend another committee meeting this morning, so I will have to leave at this point. Thank you.

Senator ROCKEFELLER. Thank you very much, Senator Bentsen. Thank you for stopping by.

Mr. Secretary, I really did not expect the fee schedule phasing period to start in 1993. That is 4 years from now. We talked about 1991 or 1992, but 1993—I mean, PPRC wants to start it next Spring. What is the magic in the 4-year delay?

Secretary SULLIVAN. The reason for this request, Mr. Chairman, is because this is indeed much more complex than the implementation of the prospective payment system for hospitals. We have 7,000 hospitals in the country; whereas, we have more than 500,000 physicians. The number of procedures that would be indexed is also quite extensive. And in viewing the complexity of that with members of my staff, it is our desire to be sure that, when this system is implemented, we have in place the best possible controls and best possible system there.

To implement this in 1991, we believe, would be rushing this considerably, and will strain resources.

Senator ROCKEFELLER. What about 1992? That is three years.

Secretary SULLIVAN. Well, I will ask Mr. Hays to add to my comments.

We indeed are aware of the thought of 1992; but, again, what we have felt we needed to do in coming before this committee today is to give you what we believe is a realistic best estimate of what is going to be required to indeed get a complex system in place, as well as the fact that Dr. Hsiao has not yet completed his study, and we would like to have the benefit of all of those studies before proceeding to put the system in place.

Senator ROCKEFELLER. But your concern is not so much the 1993; what you want to do is to get a system in place that will work. It is not that you are locked into making 1993; it is that you feel at this point it is a hard process and will take some time.

Secretary SULLIVAN. That is correct.

Senator ROCKEFELLER. Let me ask a question with regard to the fee schedule. The surgeons have testified at an earlier hearing here that they would favor a fee schedule that is a blend of RBRVS and a charge-base RVS. Does the administration favor the using of a charge-base RVS fee schedule?

Secretary SULLIVAN. I am going to ask Mr. Hays to comment on that issue.

Mr. HAYS. Generally speaking, Mr. Chairman, we prefer the approach recommended by the Physician Payment Review Commis-

sion and the approach that is also being considered by the other body.

Senator ROCKEFELLER. Prefer? Prefer strongly?

Mr. HAYS. I would say fairly strongly prefer.

Senator ROCKEFELLER. To follow up on Senator Bentsen's question, you have testified, Mr. Secretary, in favor of this geographic based cost-of-practice index. That, I would think to Senator Durenberger and myself, would be a matter of very, very substantial concern, because you want to adjust both for variations in overhead costs and for physician incomes.

Now, the PPRC and others have made the argument that the physician time and the physician effort is geographically neutral; it should be, in other words, compensated, reimbursed uniformly. I mean, the time of a doctor in Los Angeles and the time of a doctor in West Virginia, the time that they spend, I fail to understand where the Los Angeles one's time is more valuable, more costly, more reimbursable than the one's in West Virginia. In fact, if the Los Angeles physician decided to move to West Virginia, his or her time would become, then, by definition, less valuable. And then, to the point that the Chairman of the full committee made, in a sense you are going against what the purpose of this is all about, because it discourages an urban doctor from moving to a rural area; or more specifically, it seems to me, it encourages those in medical schools, if that is their future, not to stay in a rural area. I think it would cost under-served and rural areas physicians. Don't you?

Secretary SULLIVAN. Well, the geographic index, Mr. Chairman, is intended to recognize that, as it presently exists, there are significant differences in costs of living. Were we to implement the system without taking that into account, this, frankly, would be one of those major disruptions that we were alluding to, and therefore we would want to phase in the system over a period of time.

But in our proposal we are also proposing a bonus of 5 percent for physicians who practice in medically-undeserved rural areas and inner cities, because we do recognize the fact that there are those imbalances that exist now, and we do want to try to assist the rural areas and inner cities to get more physicians by providing those kinds of bonuses.

Senator ROCKEFELLER. And what is that bonus?

Secretary SULLIVAN. The 5-percent bonus.

Senator ROCKEFELLER. I would be interested for the record—we will all find this out later, but for the record—what the 5-percent bonus is relative to the "gpci", so to speak, factor.

Senator Durenberger?

Senator DURENBERGER. Let me sort of till that same ground that the Chairman plowed up.

A resource-base relative value scale is premised on the idea that all physicians should be paid equally for an hour of their time. One of the things it does not take into consideration, or among the things it does not take into consideration, is the therapeutic effectiveness of the service, the greater skill or experience of the physician involved, nor the severity of the illness which is involved, which is something we have learned in hospitals.

Unless we get into these convertibles that we are going to use, or conversion factors, it doesn't do very well with this other problem

we have in America, which is the inequity across parts of the country where the services of those who can't afford to pay get picked up in some individual practice.

If we adopt this flat resource-base relative-value scale and do not make adjustments, our rural communities come out very well, as the Chairman has already pointed out. And I think, at least the data that I have shows that if we didn't do some kind of a practice cost adjustment, New York City physicians would lose about 40 percent of their revenue. I am assuming it would get picked up in West Virginia and rural Minnesota. [Laughter.]

If you applied this practice cost adjustment to the entire fee as you are recommending, I understand that reduction would be reduced to about 22 percent. If you applied the geographic cost index only to overhead items, it would be reduced by about 32 percent. So, it gives you sort of a measure of the reduction. I want to lay that out so we are all on sort of the same ground in terms of the consequence of what we are doing here.

One of the things that I know bothers you, Mr. Secretary, and it bothers us, is that when you talk about New York City, or that area, it is apples and oranges, because I am told New York City's inner-city hospitals are operating at anywhere from 97 to 102 percent of capacity.

I would guess that the physicians that are willing to practice in the inner-cities of this country are doing an awful lot of unpaid work, and I know that is happening in rural America.

So, as we make these adjustments and we make these decisions about what kind of conversion factors to use, do you have some advice for us on how best we deal with this whole business of the unsubsidized or unpaid care which distinguishes the inner-city and the rural areas from suburbia? I mean, the frustration about living six years with the DRG system is that we have been rewarding suburban hospitals all over the country and not doing much for the inner-city hospitals, and certainly not doing anything at all for the rural hospitals.

But as we implement this schedule in some way, are we operating somewhat differently with regard to the urban and suburban and rural situation as it relates to these subsidies? Or should we just forget about the subsidies and deal with that by, for example, a national fee schedule that all third-party payors would adopt? Rather than just Medicare, let us say this got adopted to Medicaid, and it got adopted to everything else. Because I suppose the possibility is, if we do this as a Medicare-only, then the doctors that are hurt are going to have to go and get their money someplace else, like take it out of Blue Cross, or take it out of somebody else somewhere else in the system.

Secretary SULLIVAN. Well, Senator Durenberger, there are several points I will make.

First of all, one of the reasons for requesting some Secretarial discretion is to indeed allow for those differences, Manhattan, for example, where there can be a difference of 3 miles between an area that is affluent, with a number of physicians, high costs, and then Harlem which is close by, where we have too few physicians and indeed too few medical resources. The fact is, we don't have a

system, a formula, that would really take into account that variation.

But secondly, one of the reasons that we request sufficient time to phase a program in is to allow other carriers to indeed look at the system to see if indeed they would choose to adopt a similar, national system, so that we don't have these shifts occurring.

Then the final comment I would again make, coming back to the bonus—while I mentioned 5 percent before, we have actually been looking at 5 to perhaps even as much as 10 percent for a bonus for physicians in medically under-served rural and inner-city areas. In other words, it is our intent and our commitment to try to have a system that begins to correct those inequities and tries to help those professionals who have chosen to practice in those areas with that bonus kind of payment, to help address some of the manpower-shortage areas that you have alluded to.

Senator ROCKEFELLER. Senator Heinz?

Senator HEINZ. Mr. Chairman, thank you.

Dr. Sullivan, as I understand the logic behind expenditure targets, it is that they would only work if the medical community nationwide organized itself in a way to better control the volume and the cost of the care they deliver.

If there is not a totally organized effort, it seems to me that what we will get—as we have in every other program where we have tried to limit payments—is everybody fending for themselves. For example—and it may seem to you perhaps a strange analogy—but we used to go through heroic efforts in the Congress to reduce the milk price support as a means of reducing the volume of milk, which we have in surplus. Not surprisingly, many dairy farmers in Pennsylvania got the hint, "Milk more cows." "Make it up on volume," as they say.

So it seems to me that, without a totally organized effort by the medical community, there are going to be the kinds of effects Dave Durenberger talks about. Or, maybe David, despite the fact that it sounded pretty convincing to me, will be wrong; but you can be sure that there will be some very serious unintended effects without what I have just described.

Canada, of course, has gone about this a little bit differently. Being a much smaller country, nonetheless they have organized all of this at the provincial level, and there is an elaborate system of negotiation and compromise and working these things out before anything happens.

My question to you is this: Given the fact that, as far as I can tell, if the medical community is organized, it is organized along State lines, how on earth can they get organized between now and October 1?

Secretary SULLIVAN. Well, Senator Heinz, I think that question had best be addressed to organized medicine. But I would say that, while the physicians are organized in State societies, really the American Medical Association is a national organization.

Senator HEINZ. To which less than half the physicians belong.

Secretary SULLIVAN. That is true; but if you have half or 40 percent, or what have you, I believe that still represents a significant number who can have a tremendous influence on the system.

But I would also comment that we have other structures as well. As I alluded to in my testimony, we are committed to Health Maintenance Organizations. These are organizations for which we propose some carve-outs because of their important role, and increasing role, in providing health care for our Medicare beneficiaries. There are, indeed, these as well as other alternative structures.

I believe and hope, certainly as a physician and as a member of the American Medical Association, that we don't lose sight of the fact that really what we are talking about is providing health care for our citizens. Physicians, like anyone else, deserve to be paid, but——

Senator HEINZ. We all agree on that. I am just asking a very practical question: Is it really, under the best of circumstances, conceivable to move into expenditure targets very quickly, for fiscal 90–91? Is that not right?

Secretary SULLIVAN. No, Senator. We propose implementing the system January 1, 1993.

Senator HEINZ. No, that is RVS.

Secretary SULLIVAN. I am sorry. Let me correct that. We would indeed have expenditure targets prior to that time, yes.

Senator HEINZ. That is right, and we are supposed to make those decisions very quickly here, is that not right?

Mr. HAYS. Senator, could I just expand upon the Secretary's response? That is, first, to note that most likely the expenditure target that is established for the first year, and for future years for that matter, will be a relatively modest restraint on growth. We are not talking about cutting——

Senator HEINZ. It is not a question of whether it is modest or not; the question is, can we realistically have in place a system that works?

My time has almost expired. I do want to ask you, Dr. Sullivan, one additional question on a different subject.

As you know, Senator Mitchell and I and others are most interested in your effectiveness initiative. President Bush has proposed $52 million in his budget; Senator Mitchell and I $54 million. You will have to start spending that money, and spending it wisely and well, in just a little over 3 months. My question to you is: Do you at this point have a specific strategy of how you are going to spend that money? If you do, could we have it? And if you don't, when could you give it to us? Because to us it is critical that we know that that money is going to be not only well and faithfully but thoughtfully and aggressively employed.

Secretary SULLIVAN. Yes, Senator Heinz.

What we have done in the Department, first of all, is to identify our Assistant Secretary for Health as our lead official to coordinate this effort, along with our administrator.

Senator HEINZ. That is Mr. Mason. Is that correct?

Secretary SULLIVAN. Yes. Dr. Mason, along with HCFA and Mr. Hays. I will have him comment on some more of the specifics; but we will be looking, as we have been in some of the research that we have funded thus far, at specific high-volume procedures where we don't have the data that they really provide a true benefit.

We have been surprised, as you are probably aware, at the findings concerning the use of TPA versus the coronary artery bypass.

It shows that long-term survival appears to be about the same in those two procedures, at a great difference in costs for them. But we will be looking at other procedures like this as a beginning.

Again, going back to my testimony, this is one of the reasons that it is going to take us several years to have a sufficient volume of effectiveness research completed for it to have a major impact on controlling costs.

Senator HEINZ. Dr. Sullivan, I don't doubt that.

Just a question: Will you be able to give us, prior to the onset of the fiscal year, October 1, a specific schedule of how you intend to commit the money? Will you be able to do that?

Secretary SULLIVAN. Yes, we will get that to you.

Senator HEINZ. All right, thank you.

My time has expired. I appreciate your response.

Senator ROCKEFELLER. Senator Packwood?

Senator PACKWOOD. Mr. Hays, let me ask you a technical question so I am sure I understand something.

This relative value scale fee schedule is more or less going to replace the "usual and customary" payment, and is going to be a fixed value for a procedure.

Mr. HAYS. Yes, sir, that is correct.

Senator PACKWOOD. All right. Now, for the moment, in answering this question, presume a static behavior; assume that the doctor doesn't double the number of tests he or she does when we drop the value in order to try to maintain the same total income from Medicare. Just assume that they will do the same thing.

Mr. HAYS. I am not sure that is an assumption I am willing to make.

Senator PACKWOOD. It is not a valid assumption; it has not been a valid assumption. But for purposes of answering this question, let us presume it.

Let us say a relative value scale assigns a certain procedure a value of $100, after we have added up all of the points and multiplied it by a conversion factor, say $10.

Mr. HAYS. Well, actually, the RVS itself does not assign the dollar factor.

Senator PACKWOOD. No, I realize that. It assigns points.

Mr. HAYS. Relative to the procedures.

Senator PACKWOOD. Right. And then we multiply it by a factor and get how much Medicare pays?

Mr. HAYS. There is a conversion factor to get to dollars.

Senator PACKWOOD. All right. So let us say the relative value scale times the conversion factor makes this procedure worth $100. And if Medicare pays 80 percent of it, and the doctor takes assignment, the doctor can charge $20 more. Is that right?

Mr. HAYS. The physician that takes assignment cannot balance-bill.

Senator PACKWOOD. Not even the $20?

Mr. HAYS. The beneficiary's liability is no more than the amount that Medicare will pay.

Senator PACKWOOD. I believe the beneficiary is still liable for the 20 percent Medicare does not pay.

Mr. HAYS. The beneficiary in an assigned claim, either under RVS or today, the beneficiary is protected and cannot pay more than 20 percent of the Medicare-approved price.

Senator PACKWOOD. I believe the beneficiary is still liable for the 20 percent Medicare does not pay.

Mr. HAYS. Yes.

Senator PACKWOOD. All right.

Now let us say we now go to the expenditure target approach, and we just don't have enough money next year to pay 80 percent, and we say to the doctors, "You are going to get 70 percent of the project costs for providing the service this year."

Mr. HAYS. I am sorry, Senator, that is just not the way the expenditure target works.

Senator PACKWOOD. How does it work?

Mr. HAYS. It is not a cap. It is not a cut. Actually, expenditure targets are annual increases in physician spending. What we are talking about is a reduction in the amount of growth that would occur in the absence of expenditure targets, and particularly in the first year of an expenditure target, there would not be any reduction if aggregate spending were to exceed—let us say in the first year the expenditure target were a 10 percent increase over a base period. And if physician spending comes in at 10 percent, then in the year two there is no further effect from year one. If physician spending is below 10 percent, presumably they would get an additional amount in year two. It is only if physician spending exceeds 10 percent in year one that there would be in year-two a reduction in the expenditure target to take that into account.

Senator PACKWOOD. A reduction in the percentage we would pay for the particular procedure.

Mr. HAYS. No.

Senator PACKWOOD. No?

Mr. HAYS. No.

Senator PACKWOOD. Because the money had not grown as fast as the spending? The money we had to pay had not grown as fast as the claims that we have to pay, percentage-wise?

Mr. HAYS. In terms of the initial approach of a national expenditure target, the only issue is the amount by which total physician spending will grow in each year. We are talking about a relatively modest reduction in the expenditure target in comparison to what would happen in the absence of expenditure target.

Senator PACKWOOD. Let me rephrase my question. I am not asking it right, then.

Let us say that Medicare has $80 billion to pay to physicians this year, and it pays $80 billion on $100 billion worth of claims, i.e., it pays the 80 percent. Let us say that next year Medicare has $90 billion to pay—it is up 110 percent from $80 billion—but the claims are now up 130 percent to $130 billion. You would still only pay out the $90 billion, would you not, if that is what you had in the Federal budget, which would presumably be based on the expenditure target?

Mr. HAYS. No, that is just essentially not the case.

Senator PACKWOOD. All right. Then, I don't understand it. Where would we get the extra money to pay out?

Mr. HAYS. First of all, the hypothesis of the question is that each year in fact total physician spending is going to exceed the target, and in fact we hope that that is not the case, and we have a lot of things built into the proposal to try to avoid that from happening. It is not like we are going to stop utilization review tomorrow, for example. We hope that HMO's and managed care will continue to grow, and there will continue to be a lot of restraints in the system against growth.

Senator PACKWOOD. You are telling me more than I need to know. With respect to my question, you are saying you are never going to reduce the amount that the physician will receive for the procedure.

Mr. HAYS. We think, over time, the effect of expenditure targets will be to restrain volume and intensity, and it is not going to result in a rationing kind of system.

Senator PACKWOOD. I am not even getting to the issue of rationing.

Senator HEINZ. Mr. Chairman, I don't understand what the witnesses are saying.

Senator PACKWOOD. I don't, either.

Senator ROCKEFELLER. The chairman cannot be responsible for that. [Laughter.]

Senator HEINZ. It may be our fault we don't understand.

Senator PACKWOOD. I understand his theoretical answer, that expenditure targets will prevent an increase in volume and intensity and therefore there won't be a reduction in payments to the physicians.

Senator HEINZ. If I may, I thought you asked a good question, Senator Packwood, which is how do we recoup when the expenditure target is limited? And I heard either, "That is not going to happen," or, "If that does happen—" and then I just lost contact.

Senator PACKWOOD. I think I would like Senator Heinz to answer my question, if I might. [Laughter.]

Mr. HAYS. Senator, if I could go back to the original basis of your question——

Senator PACKWOOD. All right.

Mr. HAYS. The point of how much Medicare pays for a particular procedure.

Senator PACKWOOD. Yes.

Mr. HAYS. What we are talking about is, we are not talking about reducing the amount that Medicare pays for procedure X. We are talking about reducing the increase in the amount that Medicare will pay for procedure X. We really are talking at the margin. If in year one it is $100, in year two it is $110, in the year three it is $120, perhaps the result of the expenditure target would be, instead, it would be $100 in year one, $108 in year two, and $115 in year three, as opposed to what would have happened in the absence of the expenditure target.

Senator PACKWOOD. I will come back to this question in the second round. I just want you to assure me of this: Under this system, there will be no reduction in the amount that physicians receive for procedures, even if there is an increase in volume and intensity so great that it exceeds the amount needed to increase fees for services in the next budget.

Mr. HAYS. It is difficult to conceive of getting to the point where we would have to reduce the amount paid for a procedure, as opposed to limiting the amount by which we would increase payment for the procedure.

Senator ROCKEFELLER. Mr. Hays, let me interrupt the schedule here just to say, on that point, in a sense I understand precisely what they are trying to get. Maybe initially, at least, there ought to be a floor below which fees cannot fall. And potentially, I suppose the question should be should we limit the impact of ET's to, in a sense, at worst freezing fees, but not cutting them.

Secretary SULLIVAN. Mr. Rockefeller, if I might comment on it?

Senator ROCKEFELLER. Yes, Mr. Secretary.

Secretary SULLIVAN. This is a system, obviously, where we are trying to restructure how we are reimbursing physicians and controlling costs. There are going to be shifts, I think, of necessity. However, we are very sympathetic to the view that there should not be radical shifts, and therefore there should be some limitations as to how much might occur during any one year. We would think that should be really in the range of a 10 percent, maximum, either decrease or, on the other hand, increase in fees. So we are concerned about that. But again, that is a reason we feel this system needs to be implemented over a period of several years before it is fully operational.

Senator ROCKEFELLER. Thank you, Mr. Secretary.

I interrupted Senator Daschle.

Senator DASCHLE. Thank you, Mr. Chairman.

I guess I am still confused a little with regard both to the relative value scale and the expenditure target schedule for implementation. You just now made reference to several years before implementation, and I thought your answer to Senator Heinz was that expenditure targets would be implemented within the next couple of years, not several years. Is that correct?

Mr. HAYS. Senator, if I might, one of the benefits here is that we are not talking about something that is yet locked into concrete; we are at the beginning stages. The other body has taken the initial steps to propose such a package that the Secretary has endorsed, and that particular package under consideration in the other body would begin expenditure targets very soon—I believe, theoretically, on October 1 of this year—with the relative value scale portion being implemented within a year or so after that.

We have two basic premises; that is that the RVS portion, to do it right, will take a fairly lengthy period of time before we can implement it, and once we begin implementation, we want it to be phased in.

Second, we strongly feel that we need expenditure targets as well, and those expenditure targets can be implemented in advance of RVS itself. But precisely when we would want to begin implementing expenditure targets, whether it is October 1 of this year or January 1, 1990, those are things that are not cast into concrete.

Senator DASCHLE. Well, I am encouraged by that answer. I guess I am still confused, and I don't want to use my time at this point to argue or debate the matter of relative value scale implementation; but it seems to me that you are talking about something entirely different here than what you were talking about with regard to

DRG's. You are talking about the values associated with certain procedures, values that are clearly understood—I should say "assessed." And as I say, that is arguable. But to say that you can't interpret value for 4 years really defies what I think is most people's appreciation of the element of complication here. But I am going to save that debate for another time.

Mr. HAYS. Senator, if I could just make one point, in fact they are not complete. Much of this work is coming from Dr. Hsiao at Harvard, and only a portion of this material is complete. At best, we do not expect to get all of his material until July 1990.

Senator DASCHLE. Let me switch to something Senator Durenberger was asking about, regarding rural reimbursement.

You said that you support a 5-percent increase for physicians working in rural areas and in the inner cities. We have that in law right now. Are you suggesting that we would see an additional 5 percent over what we have right now?

Secretary SULLIVAN. Yes.

Senator DASCHLE. So you would support a 10-percent differential? Is that correct?

Secretary SULLIVAN. Yes. What we are proposing, Senator Daschle, is indeed further incentive to help correct some of the geographic distributional problems in health manpower.

Senator DASCHLE. So, over and above the 5 percent, it would be 10 percent?

Secretary SULLIVAN. Yes.

Senator DASCHLE. Now, in Canada, as you know, rural and urban physicians are reimbursed roughly equally. They start out with the same reimbursement rate and then are given an additional 5 to 10 percent increase, depending on the Province. We don't have that in this country. We start out with a significant deficit for physicians in rural areas. So, the 5 to 10 percent sometimes only brings us up to parity and sometimes even brings us to below that level.

Would you be prepared to do what the Canadians have come to the realization they have to do? That is, start physicians at parity, and then provide the 5 to 10 percent increase to make the incentive a real one? If we don't do that, we really are fooling ourselves; we are not providing anything at all. A 5 or 10 percent still puts physicians at a deficit from what they are provided in compensation in other areas.

Secretary SULLIVAN. Senator Daschle, what we are dealing with here is the present reality of the system, as well as the fact that we do have a complex system which could very well have a number of unanticipated or unintended consequences. We can't correct these inequities in 1 year. What we are proposing is that, over time, with these differential reimbursement rates and percentages, this system will begin to come in balance.

Senator DASCHLE. Well, the point is not whether it is practical today, but would you, Dr. Sullivan, support as a matter of policy eliminating the differential between urban and rural physicians, and thereby provide an incentive, beyond the parity level, to physicians to come to rural areas? As a matter of policy, would you support that?

Secretary SULLIVAN. As a matter of principle, that is really what we are driving toward. I think it is a question of strategy and timing as to when that would really be fully implemented.

So, if I understand your question correctly, as I believe I do, I believe we are in agreement here, that an appendectomy in South Dakota should be the same as an appendectomy in New Orleans. We do have a system now, that has developed over years, that doesn't reimburse in that way. But we cannot correct that discrepancy within a period of 1 year.

Senator DASCHLE. But your answer is yes?

Secretary SULLIVAN. Yes.

Senator DASCHLE. Good.

Thank you.

Senator ROCKEFELLER. Mr. Secretary, we have a lot of folks still coming, but I have one question and a half for you.

You have stated that the administration's position is that this is part of a triage—was that your word?

Secretary SULLIVAN. Trilogy.

Senator ROCKEFELLER. A trilogy. All right. And that all three parts have to be involved—beneficiary protection, the physician payment reform, and expenditure targets. Is what you are saying that the President will veto any legislation that does not include expenditure targets?

Secretary SULLIVAN. We have not said that, Mr. Chairman. What we have said is that we believe we could exacerbate the system, could actually make our present system worse, if we don't have all three components there.

On the issue of a presidential veto, that specific issue we have not discussed. I think I would have to look at a system that did not have all three parts very carefully. And if indeed it would appear to be a system that was unwise, I would not hesitate to recommend a veto to the President. But we have not looked at this system to really come before you today and make such an unequivocal statement as that.

Senator ROCKEFELLER. But that your own advice to the President would be strongly guided by efficacy within the volume control component?

Secretary SULLIVAN. Yes. We think this is a system where we need to enact all three components. If we do not do that—again, if we don't have the volume control—indeed, we believe that we could end up with certain physicians working to make up an income level by increasing volume. So, we are concerned that without a volume control we could actually end up with greater expenditures than at present.

Senator ROCKEFELLER. I have one question which I would ask that you only respond to in writing. I have a number of questions that I will put to you in writing, but this is one that goes back to our earlier argument about a geographic-based cost-of-practice index.

In RBRVS there are two components. One is the physician's time and effort. The other is the overhead costs, which are salaries, rents, malpractice insurance, et cetera. The other part—the overhead costs—is where your cost of doing business in Los Angeles is higher. Right?

Secretary SULLIVAN. Yes.

Senator ROCKEFELLER. That is included already in the overhead costs, in the RBRVS approach. What I don't understand is why this additional geographic-based adjustment is necessary. Why would we make a geographic-based adjustment for the physician's time if an adjustment for the so-called cost of doing business in Los Angeles or New York or Chicago, whatever, is already included? I would just ask if you would be willing to respond to that in writing, sir.

[The following information was subsequently received for the record:]

RESPONSE TO SENATOR ROCKEFELLER'S QUESTION

On balance, we support a full GPCI over a half GPCI, because the full GPCI minimizes very wide swings in payment levels (essentially, the winners do not win as big, and the losers do not lose as big). Since payment swings will be moderated somewhat under a full GPCI, we believe that it will contribute to a more orderly implementation of a resource-based national fee schedule.

To assure access in rural areas under such a fee schedule, we also support bonus payments to physicians practicing in these areas.

Senator ROCKEFELLER. Senator Durenberger?

Senator DURENBERGER. Mr. Secretary, in 1983 when we did a similar kind of good deal for hospitals, the DRG System, we promised the folks that we were trying to reform, that we would reward them in some way if they were good boys and girls. Instead, we did an expenditure target, and we have been doing it every year. It is called "reconciliation," and we in effect have placed a flat budget amount on hospitals in this country. I think there is every reason to believe that we got a lot of good efficiencies out of it. But it is not a good experience for the docs, when they go to Chicago and talk about how awful expenditure targets are, to see how we have treated the hospital.

Now, what is being suggested to us is that we do something very similar to physicians, a national expenditure target. But physicians are not like hospitals. Hospitals are institutions, and somehow when hospitals can make decisions—a predictable decision that is very difficult to ask a person to make—if in fact you tell the physicians of this country that you are going to do for them what you did for hospitals, then I know in my State of Minnesota the conservatives, the ones that want reform, the ones that are willing to reduce their utilization of unnecessary services and so forth, when they look at how they are going to be treated inside a national system, if we aren't doing something in Miami and all the other places they usually pick on, so that for their good behavior they are going to get penalized rather than rewarded, they aren't going to go along with this system.

So, I guess my question of you is—and I know that information and data is imperfect today—do you really favor a national expenditure target, or whatever you want to call it? Or do you really think, in your heart of hearts, that we ought to be getting down someplace closer to where the physician can actually be rewarded for his good behavior rather than fearing punishment for somebody else's bad behavior? And if so, what is that level? Or isn't it even appropriate to think that way?

Secretary SULLIVAN. Well, certainly the intent is not to punish good behavior. What we are attempting, Senator Durenberger, is to bring runaway physician costs under control. I think we are all agreed that we as a nation simply cannot afford a 16-percent annual increase in physician costs. We also know that we have some procedures that we are not sure really benefit the patients. So, our effectiveness research over time will help us assess that much more clearly than we are now able to do.

We believe that a system with appropriate interactions, with all the components, with the physicians, with continued utilization review and PRO's, that this system can work. So, that is what we are committed to, to having a system that doesn't bankrupt the country, that does provide services to our population and provides appropriate rewards to the physicians and other participants. So, clearly that is our intention, and that is what we would be committed to, working to see that the system has that kind of outcome.

Senator DURENBERGER. Thank you.

Now let me try to take on Bob Packwood's problem. Either of you can respond to it. Let us suppose you have a cataract surgeon who is doing 1,000 cataracts a year at $500 apiece and gets $500,000—that is his income.

My question is going to be: Can the expenditure target ever reduce somebody's payment? Because you implied, I think, Lou, that, no, you never get your payments reduced. Now I am going to give you a situation and ask you to respond to it.

You do 1,000 cataracts a year at $500 apiece. That is $500,000. If you continue to get paid $500 per cataract, in the following year you might get a 10-percent increase, you will get $550,000 if you get a $550 procedure. But that is not the way the RBRVS is going to work. The way the RBRVS is going to work—and I will just take a hypothetical figure—is we are only going to pay $400 for each of these cataracts, rather than $500 for each of these cataracts. Now, that means that the surgeon is going to end up with $400,000 at the end of the year if he only does 1,000 surgeries.

Now, the reason for the expenditure target, as I understand it, is they can't live on $400,000 after he pays all of his expenses. He can only live on $500,000. So what? He is going to do 200 more cataracts. Are they necessary? We don't know. We will never know. And that is what worries us, because the impetus is to force him or her up to that point.

Now, let us say they do 1,200 of these surgeries to get the $500,000, and everybody does this all over the country, and you end up breaking the bank, exceeding the expenditure target. So, in that case, in that following year somebody is going to get penalized. Somebody is going to get reduced, even if you have a 10-percent overall increase, because instead of coming up with the $440,000 for all of these cataract surgeons, you have come up with $500,000, which is quite a bit over, say, 10 percent. What happens with an expenditure target laid on an RBRVS?

Secretary SULLIVAN. Let me make one comment before Mr. Hays responds.

Obviously, the RVS system has as its core correcting what has been an inequity in the way we value physician services. I think there is no question that, for example, in the cognitive areas pedia-

tricians, internists, family physicians have not been adequately compensated; whereas, where we have procedures, things we can count such as gall bladder surgery, or what have you, we have tended to set up systems for payment for those, because it has been much easier. We haven't had a way to recognize the value of cognitive services.

So, this system inevitably is going to cause some significant adjustments, if implemented, in the way physicians are rewarded.

Now, on the specifics of your case, I will let Mr. Hays comment on that.

Mr. HAYS. Senator, as I understand the way in which a national expenditure target would work, as opposed to, for example, an expenditure target that would focus on cataract procedures or on specialties, the effect of the expenditure target would be potentially to reduce the amount by which Medicare would each year increase payment for, in this case, cataract surgery.

Now, I guess it is theoretically possible that somewhere down the road, as the effects of either meeting or not meeting the national target gets rolled into the next year's expenditure target, you could theoretically hit the point where, instead of talking about how much you are going to increase the payment for cataract surgery, you could talk about how much you are going to decrease it.

Senator DURENBERGER. Well, we are not going to do it. I just used this in trying to get to a simple example. The answer is, we are not going to do it; we are passing the buck to the physicians to do it. We are saying, "Here is how many dollars you have got to spend." Now, inside the AMA or whatever—if you even get it down the local level as they do in Canada. They have 10 physicians sitting on some kind of a board, and they sort of shuffle this stuff around inside the system. They say, "Yeah, you guys in cataract surgery, look, you can do this stuff in 17 minutes. You know? You have been overcharging." So they persuade them to stay down. But they have got somebody else who has got a relatively new, what we call "high-priced" procedure, and they say, "Well, you can stay up there."

I am not knocking the system one way or another; I am just trying to get an explanation here for the benefit of some of my colleagues.

The fact of the matter is that the expenditure target is designed, in one way or another, first to save money, and then secondly to get at the so-called "unnecessary procedures" by getting the doctors themselves to deal with the difference between $1,000 and $1,200, by hurrying up with their practice guidelines, and putting in procedures, and things like that, to help us with the reality of "does he need to do 1,200, or was 1,000 all he needed?"

And we are never going to see, actually, what goes on inside the system, because in effect we are asking the profession with this combination to do these things for us.

Secretary SULLIVAN. Well, Senator Durenberger, I would say that participation by the profession I think is indeed quite desirable; that is, physicians indeed ought to be a part of this process. In theory, that has been what we have had up until now; but that has not been successful in controlling costs. I think the system tends to drive that process with a little bit more energy, and we certainly

agree that it is very appropriate for physicians to be actively involved in that process.

Senator ROCKEFELLER. Senator Heinz?

Senator HEINZ. Mr. Chairman, I will yield my time to Senator Packwood.

Senator ROCKEFELLER. Senator Packwood?

Senator PACKWOOD. Well, I am going to try again on this. Let me go from a different direction: Will you tell me what an expenditure target is?

Mr. HAYS. An expenditure target, first of all—I guess one way of answering it—is anything that the Congress wants to legislate.

Senator PACKWOOD. No, no, no. We need to make sure we understand the purpose behind the term. I think "target" is a bit of a misnomer. I think "expenditure target" means "that is all we want to spend." Am I wrong?

Secretary SULLIVAN. Senator Packwood, let me just comment here. What we have emphasized previously is this, that we as a nation are number one in per capita expenditures for health care. But in spite of those tremendous expenditures, we have very serious gaps.

Senator PACKWOOD. Doctor, I understand that. I just want to know what an "expenditure target" means.

Mr. HAYS. It means, Senator, the amount by which Medicare will increase payments in a given year, and there is a formula.

Senator PACKWOOD. Now, is that a cap?

Mr. HAYS. No, it is not.

Senator PACKWOOD. So, you can spend more than the expenditure target?

Mr. HAYS. Yes.

Senator PACKWOOD. Oh. Then what is the point of the target?

Mr. HAYS. If you exceed the target in the year in which it is in effect, then the amount by which the target is exceeded in that year will be taken into account in setting the target for the next year.

Senator PACKWOOD. Let me ask you a for-instance, then. Let us say we spent $80 billion this year, and you add up how many people are going to age, and you say the target next year is going to be $90 billion.

Mr. HAYS. The target would be expressed in terms of a percentage increase over a base period.

Senator PACKWOOD. All right, fine. Let us say the percentage increase works out to the $10 billion. Now, what happens in that next year is, instead, you pay out $96 billion in claims. You have gone $6 billion over the target. What happens the following year?

Mr. HAYS. There would be a downward adjustment in the increase for the following year to reflect the fact that the expenditure target was exceeded in the previous year. So, in year two, instead of increasing by 10 percent, if that is the way the formula would work out when you take into account price inflation, beneficiary population growth, and normal volume increase, you would reduce it by a percent or two, or whatever is necessary. So you might have an 8-percent increase in year two instead of a 10-percent increase in year two.

Senator PACKWOOD. Let me change the subject. Let us talk about the Maximum Allowable Actual Charge in the balance billing. What is the justification for the government putting a limit on what the doctor can charge his or her patient? Forget how much the government is going to pay; what is our justification for saying how much the doctor can charge a private patient?

Secretary SULLIVAN. Senator Packwood, what we are saying is just that we have to find some mechanism to really control what I think everyone agrees is an unacceptable rate of inflation in health care costs. It is for that reason that we have had, for example, the whole process of the Hsiao study trying to see what is the relative value of the procedures.

Senator PACKWOOD. No, no. Again, you are missing my question. Normally, Republicans, and especially conservative Republicans, don't like price controls. We don't like government interfering with the mechanism of what a private individual charges a private individual—not what we are going to pay, but government telling somebody, "You can only charge somebody so much." What is the justification for telling a doctor, "Assuming you take Medicare patients at all, you can only charge them so much?"

Mr. HAYS. Well, Senator, I think the answer has to be in the context of the existing system. As you know, we live today, for better or worse—and most would argue for worse—with the so-called "MAAC" limits. There is in the Medicare program today in effect a limit on how much non-participating physicians can charge their patients.

Senator PACKWOOD. I understand that. Is the answer to the question "because it is what we currently do?"

Mr. HAYS. This is a preferable substitute.

Senator PACKWOOD. To what?

Mr. HAYS. To the "MAAC" limits.

Senator PACKWOOD. Well, you are still going to have "MAAC" limits under the relative value scale fee schedule, aren't you? Or can the doctor balance-bill any amount beyond whatever the fee schedule amount is?

Mr. HAYS. The so-called "three-part package" would represent a substantial simplification in terms of the current "MAAC" limits.

Senator PACKWOOD. But is there still going to be the equivalent of a Maximum Allowable Actual Charge? Or will the doctor now be free to balance-bill anything he wants?

Mr. HAYS. The proposal would be to limit the balance-billing to some percentage, perhaps 125 percent.

Senator PACKWOOD. What is the justification for the limit, any limit? That is my question.

Secretary SULLIVAN. Senator Packwood, obviously this is a philosophical issue.

Senator PACKWOOD. Yes.

Secretary SULLIVAN. But I do think it comes back to the fact that we cannot show—no one can show—that one has, from a greater expenditure of those monies, an improved result in terms of health care. That is the problem that we are facing as a country. There are many other nations who spend less than we do.

Senator PACKWOOD. But I am asking a philosophical question about the moral legitimacy of price controls. You are telling me we

don't get our money's worth, or we are spending a lot more money, or something. That is not my question.

Secretary SULLIVAN. Senator Packwood, the one other thing I would add is that, frankly, it is difficult for the average consumer, in purchasing medical services, to really have the full information available to him or her as would be the case if that individual was purchasing an automobile.

Senator PACKWOOD. I will ask a question: Absent a limit, then, on the doctors' fees, will the doctors gouge the patients? Is that what we are saying? We can't trust them to be fair in their prices, so we have got to put a price cap on them?

Secretary SULLIVAN. No. What I think we are addressing is what has been the historical situation, what has happened here. That is, I think we all would agree that, at a rate of a 16- percent increase each year, we cannot afford that as a nation. We are trying to find some way to get at that. But as I emphasized earlier, the physicians will be a part of that system, as to how those monies will be allocated.

Senator PACKWOOD. Thank you, Mr. Chairman.

Senator ROCKEFELLER. Mr. Secretary, we all thank you very, very much, as well as you, Mr.Hays.

Senator HEINZ. Mr. Chairman?

Senator ROCKEFELLER. Senator Heinz, I am terribly sorry. You wanted to continue? I genuinely apologize.

Senator HEINZ. I haven't used my time. I wanted Senator Packwood to go first, so we could double-team here.

Senator ROCKEFELLER. Senator Heinz, could I just interrupt for a moment? There is a very fine gentleman in the audience by the name of Dr. Detsky who is living in terror of making a 12:15 airplane.

I guarantee, wherever you are, Dr. Detsky, that you will make that airplane.

So, Senator Heinz, you go ahead and proceed. [Laughter.]

Senator HEINZ. Lou, I want to come back to the line of questioning that Senator Packwood has twice tried to pursue, and maybe this will be three times lucky. And Mr. Hays, I guess this really is your ballpark. Slightly different numbers, because I find them easier to work with.

We spend $100 million on physician payments this year, and we decide that the expenditure target is forever 10 percent. Okay? Ten percent more. That is forever, so that never changes. But in spite of that, the total physician charge that Part B has to in fact finance are $115 million, not 110, which is 10 percent more than 100.

Now, as I understand what you said to Senator Packwood, at that point nothing happens, except that the overage, the 5 percent, is deducted from the increase the next year. And if you work through the mathematics of that, what happens is that you would get a 5-percent increase on the basis of 115, and that would be $121 million, which, strangely enough, is what it would have been if that hadn't happened.

But let us say that physicians don't get organized, and they keep doing what they are doing, and they have another 15-percent increase that they bill us for. So that 15 percent on top of 115 is $132

million. So they have exceeded the result of the calculations by, this time, $12 million.

Now, what happens at that point? Does anything happen? And if so, what? Or are these targets irrelevant?

Mr. HAYS. Senator, clearly they are not irrelevant.

Senator HEINZ. But how do we give meaning and effect to them under your proposal?

Mr. HAYS. It is really very similar to a process that the Congress has gone through in the past several years of deciding to limit, under Medicare, the fee increase for physicians by restricting the medical economic index that would say that physicians are going to get, say, a 5-percent increase, but making an arbitrary decision to limit to say a 2-percent increase. This really just adjusts the increase that Medicare pays for various procedures.

Senator HEINZ. But my question then is, at the end of year one, after their 15 percent instead of 10 percent, then you would adjust for year two the fees? Is that what you are saying?

Mr. HAYS. Yes.

Senator HEINZ. Thank you.

Senator ROCKEFELLER. Thank you, Senator Heinz, and I apologize to you.

Again, Mr. Secretary, we are very, very grateful to you for coming in and for being so generous with your time and helpful with your response, as also with you, Mr. Hays.

Secretary SULLIVAN. Thank you.

Mr. HAYS. Thank you, Mr. Chairman.

Senator ROCKEFELLER. The way that we are going to save Dr. Detsky's travel future is if Dr. Eisenberg would come forward with the third panel.

Dr. Eisenberg is the section chief, professor of general internal medicine, and a commission member of the Physician Payment Review Commission.

Then we will also have Dr. Detsky, who is the director of the division of general internal medicine at Toronto General Hospital; and Dr. James Todd, senior deputy executive vice president of the American Medical Association; and Dr. David Murray, member, the board of regents, American College of Surgeons.

Would all of you come forward, please?

[Pause.]

Senator ROCKEFELLER. Are you prepared, Dr. Eisenberg, to begin?

Dr. EISENBERG. I am ready.

Senator ROCKEFELLER. Please do.

STATEMENT OF JOHN M. EISENBERG, M.D., SECTION CHIEF, SOL KATZ PROFESSOR OF GENERAL INTERNAL MEDICINE, AND COMMISSION MEMBER, PHYSICIAN PAYMENT REVIEW COMMISSION; PHILADELPHIA, PA, ACCOMPANIED BY PAUL B. GINSBURG, EXECUTIVE DIRECTOR

Dr. EISENBERG. Thank you, Mr. Chairman, and members.

The Physician Payment Review Commission has three recommendations that it will make, and my comments will elaborate on each of those three recommendations:

First, that we do give physicians a collective incentive to contain costs through expenditure targets;

Second, that we increase research on the effectiveness of care, and that we develop and disseminate practice guidelines; and

Third, that we improve utilization management and utilization review by carriers and by peer review organizations.

Now, I need not review the problem in increasing volume of Medicare Part B expenditures for you; but I do just want to point out that the numbers we have been discussing today—16, 17 percent per year—are constituted by three factors:

The first is what we think is about a 2-percent explanation for the increase in the number of beneficiaries. The aging of that population adds only about 0.1 percent to the volume.

The second factor is increases in payment by Congress to recognize inflationary increases in the cost of practicing medicine, through fee increases that have occurred in the past several years. Now, those payment increases have been selective, a response by Congress to perceive the levels of appropriateness of the current prices relative to where they ought to be.

But those two explanations, the first making up about 2 percent, the second making up about 6 percent, leave about 7 percent of the increase in Medicare Part B expenditures in a sense unexplained. That is the volume increase.

Now, the volume increase, of course, is in part due to a shift from inpatient to outpatient care, in part due to newly covered services, and in part due to new technology. Part of it still can't be explained and is due to increasing numbers of services independent of those factors given to Medicare beneficiaries. The best evidence that we have been able to gather is that about 10 to 30 percent of medical services seem not to be necessary.

So, in order to protect both the public purse and to protect Medicare beneficiaries, as well as to protect the clinical autonomy of physicians and the profession's responsibility for policing itself and influencing other physicians' practices, we have recommended an expenditure target.

Now, how would this expenditure target work? I wish Senator Packwood were still here.

Senator ROCKEFELLER. He is.

Dr. EISENBERG. Oh, good. All right.

Now, the way it will work is as follows: There will be a target rate of increase for physician services that will reflect three factors. Those three factors are the same three factors I just enunciated: First, increases in practice costs, that is the cost of living, or the cost of practicing; second, the growth in the number of Medicare enrollees; and third, the appropriate rate of increase in the number of services per beneficiary.

Now, this is going to reflect a trade-off, this increase in the number of services per beneficiary. It is going to reflect not a decrease in the number of services per beneficiary but, we think, a decrease in the rate of increase in the number of services per beneficiary. And in contrast to the comment that Senator Durenberger made about disallowing Congress to pass the buck, you might think of this as allowing Congress not to pass the buck but to decide on how much the buck will be that Congress is willing to spend on

Medicare, how much, as you said, Senator Packwood, you want to spend. That is going to be a trade-off, on the one hand between beneficiary needs and technological advances and newly covered services, and on the other hand the affordability of those services.

Now, if we go to this expenditure target, the way we anticipate it would work would be as follows:

If expenditures are the same as the expenditure target, then the conversion factor would be equal to the increase in practice costs, because we have already taken into account the number of beneficiaries, and other factors such as the volume increase that Congress has already said it is willing to allow.

If, on the other hand, actual expenditures were above the expenditure target, then the increase in the conversion factor would have to be lower, as your previous discussion implied. It would have to be lower than the increase in practice costs, in order to hold total expenditures in the next year closer to the target.

If, on the other hand, expenditures are below the target, then the increase in the conversion factor could be above the increase in practice costs—a reward to physicians. This would provide an incentive for physicians to be concerned about the volume of services that are provided to Medicare beneficiaries.

If you want, later I can run through some of the numbers to give you an example of how that might work, given certain percentage increases in expenditures.

One thing we think is very important to understand about the expenditure target concept is that it really isn't all that new. The expenditure target is not really radically different from current practices. As Senator Durenberger said, the budget reconciliation process every year since 1984 has led to cuts of freezes in physician fees, the cuts have been in response to budgetary needs, after looking at the expenditures that have occurred in Medicare Part B. In fact, those increases have been, on average, less than the Medicare economic index for each of the past 7 years. But these limits in allowable fees have been based on price, not on goals of volume.

Now, since total expenditures obviously equal price times the volume, reducing price was one way, maybe the only way, that Congress had to limit expenditures.

With recent demands for savings in Medicare, the limits in the Medicare fee increases have been targeted at specific reductions—on over-valued services, or non-primary care services.

But the PPRC believes that these limits on fee increases, or even these decreases in fees, while they have been consistent with the goal of RBRVS, will not be available to us in the future. Once we have a fair pricing system based on a resource-based relative value scale, we will not want to further limit fee increases. Thus, we will have to turn to volume and away from the adjustment of prices to meet bugetary goals.

So, we believe that an expenditure target offers Congress a way to explicitly explain increases in physician fees, offers physicians a chance to respond and influence practice patterns, and, most importantly, provides gives a context for professional leadership.

An expenditure target program could lead to a range of organizational responses by organized medicine, including substantive improvements in the professional organizations' ability to work effec-

tively in areas where they currently are weak or perhaps even uninvolved. It does not involve financial incentives for individual physicians and individual patients; it provides a collective incentive for the community of physicians. It will give new incentives for physicians and their organizations to be more pro-active and involved in the development of practice guidelines and parameters and more involved in utilization review and management. It will also give individual physicians a new reason to care about what their professional organizations are doing about expenditure targets and utilization review.

We believe that we need time to develop the details of this mechanism. Thus, we recommend that an expenditure target be phased in, and that we start with a national target but then consider other mechanisms, such as regional or even specialty or procedural targets.

In conclusion, the Physician Payment Review Commission believes that expenditure targets combined with a fair relative pricing system, would provide a collective financial incentive to the medical profession to slow expenditure growth by reducing services that are of little or no benefit to Medicare beneficiaries. They would enable the leadership of medicine, I think, and the Commission believes, to become more active in influencing the practice of the physicians that it represents.

But the Federal responsibility remains clear. The Federal Government must set targets at a level that will allow Medicare beneficiaries to continue to have access to high quality care. This will include recognizing technological improvements, supporting research related to the effectiveness of various procedures, and supporting the infrastructure of peer review.

We believe that targets could replace the present implicit system that we have of limiting expenditures by budget reconciliation with a system that is prospective, consistent, predictable, and understandable, as a way to update the fees in a resource-based relative value scale.

Thank you.

[The prepared statement of Dr. Eisenberg appears in the appendix.]

Senator ROCKEFELLER. Thank you, Dr. Eisenberg.

Dr. Detsky? Incidentally, I know you didn't get in until 2:00 in the morning, and I appreciate very much your being here.

Dr. DETSKY. Well, the whole scheduling of the trip was a write-off, anyway, when I got shut out of National Airport by the curfew; so I saw Baltimore, Cleveland, and fortunately your assistant met me at the airport, which was very nice, and thank you for being considerate of my time. My plane actually isn't until 12:55, so I am not that terrified of missing it.

STATEMENT OF ALLAN S. DETSKY, M.D., PH.D., DIRECTOR, DIVISION OF GENERAL INTERNAL MEDICINE, TORONTO GENERAL HOSPITAL, AND ASSOCIATE PROFESSOR, DEPARTMENTS OF MEDICINE AND HEALTH ADMINISTRATION,, UNIVERSITY OF TORONTO, TORONTO, CANADA

Dr. DETSKY. I believe that my purpose here is to comment on this proposal within the context of the Canadian health care system. You have circulated a paper by some colleagues of mine at McMaster, that describes the Canadian system of physician payments. I think I might just balance that paper a little bit with some other comments concerning the effect of the way we pay physicians in Canada vis-a-vis this proposal.

As you know, we have had a national system of universal health insurance, funded jointly by provincial and federal governments but administered by the provincial governments, that was phased in, starting with hospital insurance in the 1950's and early 1960's, and then payment for physician services by 1971.

The mechanism by which we reimburse physicians is a fee-for-service, largely. There limited experimentation with prepaid systems. And the fee schedule is negotiated between the provincial medical associations and the provincial governments on an annual, or multiple-year basis.

The experience with expenditure targets in Canada has virtually been limited to the Province of Quebec, which brought on expenditure targets in a complex fashion starting in 1976. It is on an individual basis for general practitioners and family doctors, which are about 50 percent of the doctors in Canada and in Quebec as well. In 1977 the specialists, who negotiate separately with the government in Quebec—that is the only province that does it that way—implemented expenditure targets in toto for specialists and per sub-specialty group, which is more analogous to the fashion we are discussing this morning. The other provinces have toyed with this idea.

The other important thing to keep in mind is that the Quebec physicians negotiated this agreement themselves; they went in on this deal from the start, and they agreed to be under these kinds of targets. The other provinces have never had agreement from the physicians to do this.

The extent to which expenditure targets were brought in the other provinces was usually in a retrospective fashion, as in the Province of Ontario as a negotiating tool by the provincial government when allocating the fee increase for a subsequent year. So, the Ontario government might say, "Well, you guys want 6 percent, but last year utilization went up by 10 percent, so we would like to only give you 2 percent to account for that." And it was part of the bargaining ploy, along with a number of other factors that the provincial government would use in trying to negotiate with physicians.

Manitoba, Saskatchewan and British Columbia have tried in the 1980's to implement expenditure targets as well as limiting the granting of new "billing numbers," for physicians, to limit the growth of physician supply. These have been very short-lived efforts, and there is really not much you can say that has gone on in

those provinces. The physicians in those provinces did not go along with those targets willingly. In Saskatchewan, in particular, they fought it in the courts, and it has been back and forth. I think the current round is that the government won, but the government still has to pay doctors if they go over the target.

So, other than Quebec, we really don't use this mechanism. There is a lot of talk about it now. There has been some limited experience, some of it aborted in the western provinces; but we don't use this mechanism other than in the Province of Quebec.

How do we contain health care costs? It is not via this mechanism; it is via the way we pay hospitals. We have a single payor, as you know. The province pays roughly 95 percent of the revenues of each of the hospitals, and hospital expenditures are funded under a mechanism which is called Global Budgeting. Hospitals are given a fixed amount per year, and they can do whatever they want with it. Of course, generally what they have to do is do what they did last year. They can do some adjustment for program changes.

Yearly increases are determined by a province-wide percentage formula for all hospitals in the province, with some ability to negotiate back and forth during the year and even after the fiscal year. And it is through that mechanism of containing hospital costs that we have been able to contain health care costs, because it limits the way technology expands and diffuses throughout the country. For example, the city of Toronto, which is a city with a metropolitan area of about 3 million individuals, and a catchment area of somewhere between 5 and 8 million, depending upon how you count its market share, has only three cardiovascular surgical centers—two MRI's and one lithotripter. There are more MRI's in San Francisco than there are in all of Canada. And we limit that technology diffusion, because the government has to approve increases in operating budgets to hospitals, which is the only place where these kinds of technologies are delivered. There are no private freestanding organizations that do this. And that limits the growth of the spread of technology, which thereby limits the amount of money that we spend on health care.

To be sure, there are differences in the way we utilize those services. Since they are in limited supply in the technical side, they are obviously used much less. And there are certain procedures, such as coronary bypass surgery and cardiac catheterization, that we can look at and see that utilization rates are roughly half—that is as extreme as it is in cardiac surgery.

The question is, what is the right rate? Is the U.S. rate too high? Is the Canadian rate too low? We don't really know the answer to that question. We don't know the proportion of cases that go on in any country that need appropriate criteria. I think this is something related to effectiveness research and the efforts that are being funded here on research of appropriateness. But we don't limit expenditures on health care via the target expenditures for physicians. We do it on the hospital side, by limiting operating budgets, and that effectively cuts off the spread of technology.

["Paying Physicians in Canada," excerpt from Health Affairs, submitted by Dr. Detsky, appears in the appendix.]

Senator ROCKEFELLER. Thank you very much, Dr. Detsky.

Dr. Todd?

STATEMENT OF JAMES S. TODD, M.D., SENIOR DEPUTY EXECUTIVE VICE PRESIDENT, AMERICAN MEDICAL ASSOCIATION, CHICAGO, IL, ACCOMPANIED BY DR. JOHN KELLY, DIRECTOR, OFFICE OF QUALITY, AND BRUCE BLEHART, DEPARTMENT OF FEDERAL LEGISLATION

Dr. TODD. Thank you, Mr. Chairman.

I am Jim Todd, the senior deputy executive vice president of the American Medical Association, and with me are Dr. John Kelly, director of the AMA's Office of Quality, and Mr. Bruce Blehart of the AMA's Department of Federal Legislation.

The AMA appreciates this opportunity to discuss the issues of volume and quality of physician services as we clearly move toward major modifications in the methods by which physicians are paid.

The Physician Payment Review Commission has recommended a resource-based relative value schedule for physician payment reform, and with that we totally concur.

Without perverse manipulation of the conversion factor, however, no one should expect the RBRVS, by itself, to stabilize health care expenditures or to significantly affect utilization of health care services.

What the RBRVS will do, when used as an indemnity payment, is to establish a foundation upon which to judge the legitimacy of a physician's reimbursement, reestablish predictability for the payors, and restore equity within the profession.

Now, recognizing this, there are those who fear that the RBRVS might increase the volume of services, and there are those who favor a reduction in health care expenditures whatever the methods. And their solution is the imposition of expenditure targets, to be implemented by thus far unknown methods.

As we currently understand the various expenditure target mechanisms, all of them are calculated to control expenditures through politically determined arbitrary spending limits, leaving the physician to decide how to meet patient need and demand. No matter what is said, expenditure targets will inevitably lead to caps and the implicit rationing of health care. These targets would clearly break the commitment of the government to the elderly and replace it with a system of economic incentives to withhold services.

If you should decide to accept this radical proposal, and expenditure targets are implemented, issues that would also have to be addressed are the need for significant relief from the worries of professional liability that would follow when a physician is limiting care, and the fact that any collective activity by physicians to constrain costs might be viewed with jaundice by the Federal Trade Commission. Experience shows that that agency has not demonstrated a sensitivity to attempts to control health care expenditures through mergers or other efficiency measures.

Having seen the results of expenditure caps in Canada, and no one can have any confidence that a target will not become a cap, the medical profession in the United States is adamantly opposed to expenditure targets of any nature. Our ethical code demands that physicians not be put in the position of making rationing decisions.

Rather than ration care, we believe efforts to determine and demonstrate appropriateness, necessity, and effectiveness of health care should be accelerated, and this goal can best be achieved through the funding of research to develop scientifically and clinically-sound parameters of practice, which, when disseminated to the profession, will serve as a sound foundation upon which to assure quality care and value for the health care dollar. These parameters would still allow the flexibility needed to maintain the individual nature of care that is so essential in the physician-patient relationship. Through Dr. Kelly's efforts, the AMA has established a lead role in this activity. Professional support for this concept is indicated by the significant number of specialty societies already engaged in developing parameters and others willing to start this important activity.

Practice parameters will improve patient care by providing physicians with the most up-to-date information and indications for treatment. Ample evidence exists that physicians will respond to objective information. With parameters, geographic variations can be reduced, payors will have greater assurance that services are appropriate, and professional liability risk can be reduced.

To be effective, clinically sound, and acceptable to the profession, the development of these parameters must be a responsibility of the profession.

In conclusion, we believe that the resource-based relative value schedule and practice parameters will result in the rationalization of payment for and the provision of necessary and effective care. We at the AMA strongly support this approach. We adamantly oppose expenditure targets and resent the coupling of the two as is currently recommended by the administration.

Thank you, Mr. Chairman.

Senator ROCKEFELLER. Thank you, Dr. Todd.

[The prepared statement of Dr. Todd appears in the appendix.]

Senator ROCKEFELLER. Dr. Murray?

STATEMENT OF DAVID G. MURRAY, M.D., MEMBER, BOARD OF REGENTS, AMERICAN COLLEGE OF SURGEONS, SYRACUSE, NY

Dr. MURRAY. Mr. Chairman, I am representing the College of Surgeons as a member of the Board of Regents of the College, and as a member of the Physician Reimbursement Committee. I am also an orthopedic surgeon practicing in Syracuse, NY.

The American College of Surgeons believes that, if serious steps are to be taken to moderate spending for Medicare services, including the services of surgeons, then some workable approach must be found to strike a better balance among fee considerations, increases in volume and intensity of services, and the financial protections afforded beneficiaries under the program. This, it seems to us, is far more important than focusing attention almost exclusively on how payments should be distributed among different categories of physicians.

Up to now, only two general methods for moderating health spending have been discussed—either reducing the unit price of physicians' services or reducing the volume of those services.

The current volume of physicians' services obviously reflects judgments about medical necessity that are influenced by the state of medical knowledge, and also, in part, by the professional liability climate. Criteria are needed to make reasonable judgments about the frequency, volume, and effectiveness of both procedural and non-procedural physician activities. Ultimately, if guidelines are to influence the volume issue, it will be necessary to directly link payment policies with professionally developed criteria concerning the appropriateness and the effectiveness of various medical and surgical treatments. The American College of Surgeons is prepared to participate in these developmental and application efforts.

Those of us in surgery believe that it is impossible to effectively and efficiently address the volume issue across the entire spectrum of Medicare physicians' services. The practice of medicine is such a highly complex and diverse activity that no single approach for addressing volume questions, it seems to us, is likely to work.

In most major hospitals, for instance, the responsibilities for quality assurance and volume issues are assigned to specific departments with the experience and competence to deal with these issues in the context of specific service categories. It is for this reason that we propose to address the issue of the changing volume of services within the broad scope of physician service categories, such as for surgery. In our view, Medicare will have greater success in dealing with the volume issue if the program follows the present examples within the medical profession for evaluating the appropriateness and quality of service.

We are prepared to develop criteria to determine the appropriateness of various surgical treatments and to assist, as appropriate, in applying such criteria to determine payments for those services under Medicare.

We suggest another tool for moderating the expenditures for surgical services. Under this approach, the Secretary of Health and Human Services would calculate actual program expenditures for surgical services in a base year. The Secretary would be required to determine a national expenditure target for surgical services, subject to the surgical fee schedule.

As an aside to Senator Packwood's previous question, we view expenditure targets as a budget, for disposing of a limited amount of money available for taking care of those particular services.

In estimating this expenditure target, the Secretary, in consultation with representatives from beneficiary organizations and professional organizations of surgeons, would be required to take into account population changes, cost changes, and estimated changes in the expected demand for and volume of surgical services that are required by Medicare patients. It is essential that these calculations be as objective as possible, so that there would be no room for bias or for the use of the target plan solely to achieve predetermined budget-reduction goals.

Unless this process is seen to be reasonable by both the elderly and by surgeons, the target would have little, if any, advantage over the present ad hoc decisions now reached by Congress as part of its short-term annual budget deliberations used to set the next year's rate of increase in fees.

Under our plan, if the Secretary finds that the estimated expenditure target for surgical services covered under the plan—taking into account the factors just described—would yield a significantly lower conversion factor than would result from the process used to update the fee schedule, he would be required to submit to Congress recommendations for adjusting future updates and scheduled payment amounts applicable in later years.

The proposal would be to adjust rates in a future year, and not to cut off payments or ration services when an expenditure target is reached. A cap which would require a cut-off or rationing would create intolerable hardships for patients.

Some have expressed concerns about the potential for expenditure targets to impair the access of beneficiaries to medically necessary physicians' services. Obviously, the American College of Surgeons would not advocate an expenditure concept if it believed that access to medically necessary surgical care would be seriously impaired.

Mr. Chairman, we were pleased to learn that the Physicians Payment Review Commission also supports the concept of expenditure targets. However, there is a significant difference between one of the approaches discussed by the PPRC and that recommended by the College. Whereas the PPRC initially suggests a single target at the national level, the Commission seems to suggest that the setting of targets should eventually apply to smaller, geopolitical units—perhaps on a State-wide basis. The College believes that separate expenditure targets should be established at a national level on a specialty-specific basis, including, at a minimum, a separate target for surgical services. This is because the practice guidelines must, of necessity, be related to specific categories of physicians' services and be developed and implemented on a specialty-specific basis.

Thank you, Mr. Chairman. I would be pleased to answer any questions that you or the committee may have.

[The prepared statement of Dr. Murray appears in the appendix.]

Senator ROCKEFELLER. Thank you very much, Dr. Murray.

Dr. Eisenberg, maybe I should start with you. What is the difference between an expenditure target and an expenditure cap?

Dr. EISENBERG. A target is just that; it is something that we are shooting for. The way that the target would work would be that Congress would determine, prospectively, what its targeted expenses would be for Medicare Part B.

If, in the year subsequent to that decision, the expenditures were greater than that target, then there would be a correction made so that in the future the total expenditures would be closer to that target. But the payments to physicians for the services that they rendered during that year would not be capped; they would not be limited.

It is a bit like driving down the road and looking at the median line, and knowing that you can go over it, but it gives you a signal that you need to come back. It is a target. It is not a cap. And it guides the way in which future fee increases would be calculated.

Senator ROCKEFELLER. Is an expenditure target, in your judgment, a form of rationing, and a form of denial of services to beneficiaries?

Dr. EISENBERG. Frankly, "rationing," to me, is a term like "socialized medicine." I think it has lost its meaning because it is so value-laden.

If, by "rationing" you mean that as a nation we will decide how much money we believe we can spend on health care, and what the rate of increase in that money should be, then expenditure targets maybe close to that. If you mean, at the other end of the extreme of the definitions of that term, that the individual physician taking care of the individual patient will be asked to ration care—that is, to limit useful services to the individual patient because of a national or a regional expenditure target—then the answer is definitely not.

Senator ROCKEFELLER. What prevents an expenditure target—if I may grow parochial for the moment—from hurting my State of West Virginia, where historically, as in the case of Minnesota, payments have been low, and there have been and continue to be tremendous problems of access to care?

In a sense, I hope that fees and therefore the availability of services will increase in West Virginia under the RBRVS fee schedule. Wouldn't an expenditure target turn around and take back some of that increase?

Dr. EISENBERG. No, it would not. In fact, remember that we are proposing the expenditure target, of course, in the context of a resource-based relative value scale; so we start from a different starting point than we have right now. We would start from a starting point which would provide payment across regions that we believe would be more equitable than the current inter-regional differences that we have in payment.

The expenditure target would not necessarily take money away from any particular region and redistribute it to any other region. The way in which it would affect a particular region would depend entirely upon whether we remain with the concept of a national target or whether we go with regional targets or specialty targets, as the surgeons are suggesting, or even procedurally oriented targets.

Senator ROCKEFELLER. Don't medical practice guidelines need to be in place before we get into expenditure target processes? I mean, how are physicians going to know what services they have got to control? And how many years away are medical practice guidelines, in the first place?

Dr. EISENBERG. Senator, we do need more practice guidelines. We need better data than we have now. But there is data available now that we believe is not being used sufficiently. There are recommendations emerging from a number of specialty organizations and from a number of Federal organizations that would help serve as guides to physicians. We think that there is a lot that we can do to initiate more appropriate care, even before we get the better information that we believe we need.

Senator ROCKEFELLER. Let me focus again for a moment on an area of particular interest to me, and that is the mental health care matter.

We tend to think of practice guidelines in terms of surgical procedures or diagnostic tests. Studies, though, by the National Institute of Mental Health indicate a disturbingly high rate of mis-diag-

nosis of mental health conditions by physicians under our current Medicare program. Can practice guidelines be developed for the diagnosis and treatment of mental health disorders? And would that be the best way to get at the problem that we face today with misdiagnosis?

Dr. EISENBERG. I personally think that they are separate issues. I would think that in the context of developing practice guidelines and research on effectiveness to provide the undergirding of an expenditure target techniques would be developed for understanding better the effectiveness of medical care. These techniques would have effects far-reaching and far beyond expenditure targets. Also, I think it would help every physician understand how to define the services needed for an individual patient and how to provide them. I think that would apply to mental health services, as well as to office visits, surgery, and procedures.

Senator ROCKEFELLER. Senator Durenberger?

Senator DURENBERGER. Thank you.

Right now we have some restraints on what physicians can charge. I think it is called the Medicare Economic Index, and it measures the growth in physician office practice costs, basically. We are using that now as our current mechanism for constraining the push on our budget.

But what we haven't been able to control is the growth in intensity and the growth in volume of services. And that is what we are here about today.

Over the past 10 years, Medicare Part B spending has increased either 15 or 16 percent annually, something like that, and of that increase 12 percent came from growth of the beneficiary population; 40 percent from growth in physician and supplier fees, and 48 percent from growth in the volume and intensity of physician services.

Now, I guess there should be no question in anybody's mind but what we, all of us, are going to do something about this. And waiting for practice guidelines, I suppose, is very difficult to persuade politicians of, even those of us who are committed to financing all of the efforts.

So, the question gets to be: The work we have already spent our money on has to be used for something, and we spent a lot of money on coming up with a fee schedule. I take it from what I have heard here that everybody here believes that some kind of a resource-based, as opposed to a charge-based, fee schedule for physician reimbursement is long overdue in this country. I mean, that would be a lot better than what we are doing now. Does everybody agree to that? And that it ought to be resource-based rather than charge-based, which is a relatively important question for us to ask ourselves.

Dr. Murray, you don't agree with that?

Dr. MURRAY. No.

Senator DURENBERGER. Do you want to tell us why?

Dr. MURRAY. Well, you have used the term "charge-based." We feel that charges historically had something to do with the value of the service received.

The position of the American College of Surgeons is that the reimbursement should be based on more than simply the resources

that went into providing that service; there should be some element based on the value and the quality and the effectiveness of that service as far as the individual is concerned. Now, while that is developed, we are willing to work on the basis that charge-based data could be incorporated until there are more accurate statistics and information available on the quality-value issue.

So, to say that we are happy with the pure resource-based reimbursement schedule would be wrong.

Senator DURENBERGER. If we don't rely on charges, or we go to the resource-based, then the net effect is that we are going to reduce some of our reimbursement for some procedures, and we are going to increase reimbursement for others.

Dr. Todd, is the American Medical Association in favor of the effect of the current RBRVS proposals as they relate to certain reductions and certain increases? Or what is your current position in that regard?

Dr. TODD. I think it has been clear, Senator, over the last several years, that there has been a lack of equity in the manner in which physicians have been paid. Senator Rockefeller has talked about the rural-urban differences that have widened over the years, and our belief at the AMA is that we need a rational basis upon which to determine the appropriateness of reimbursement to a physician.

If we can develop that rational basis, and if it results in some degree of transfer between specialties, then so be it. Our main goal is not the redistribution of income, but to achieve a legitimate basis upon which to judge physician reimbursement.

Once we have done that, and if you can get the reimbursement issue off the table, you can move on to the much more important items of developing appropriateness, effectiveness, and necessity parameters for the care of patients. This has already been going on: Pacemaker studies have saved untold amounts of money; specialty societies—21 of them already—have guidelines out there ready for implementation.

Senator DURENBERGER. Dr. Todd, one of the values of going to a fee schedule is that it gives us, from a budgetary standpoint, controllable units. Now, I used the DRG analogy just a little while ago. In the whole discussion of ET versus something else, what is your view on the "something else?" Let us say we put the RBRVS in effect, and we have all of these things happen, and we sit here every year in reconciliation and rachet down all of these payments. Is that preferable to what you understand the proposals for an expenditure target to be?

Dr. TODD. We are not overjoyed by either one of them.

Senator DURENBERGER. But aren't you asking for it by endorsing a fee schedule, given the current climate in the United States of America, given what is going on?

Dr. TODD. But we are asking for two things. We are asking for a fee schedule, and we are asking for the rationalization of the manner in which health care is given in this country by defining what is appropriate care, by eliminating what may be unnecessary or of marginal value, emphasizing those things that should be done, and recognizing—as does the American public in most of the polls that we have seen—that we may have to spend, in some

areas, more money on health care than perhaps we are prepared to at the moment.

Senator DURENBERGER. I know that. I don't want to interrupt you, and I need to defer to my colleague, but I am just trying to make a point that I haven't heard made before: What strikes me, at least, is the fact that you may try to persuade everybody here—and the 80 people that aren't on this committee, and so forth—that they should wait for practice guidelines and practice parameters.

But the reality is that we meet every year. We are under pressure from beneficiaries, we are under pressure from the deficit, and so forth, and it strikes me—and I am certainly not an expert, yet, on this subject—that if we put the RBRVS in without some predictable way by which the physicians in this country are going to be involved in this process of budgeting, you are going to sit here, and we are going to do it to you. And I just raise the question as to whether or not that is the preferable way to go.

Dr. TODD. It is a difficult question; we will not deny that. But from the medical profession's point of view, we do not want the individual physician to have to decide whether or not he or she will care for a patient based on purely economic consequences. And that is what you are asking us to do. If the expenditure targets go into effect, you are shifting the responsibility to the physician to decide, "Can I give this care? Should I give this care?"

Senator DURENBERGER. That has been going on in Minnesota for 5 or 6 years—it has been going on in Pearl, West Virginia and Minnesota for 10 years, the economic consideration. I mean, with the "MAAC's" and with the "cracs" and all of the rest of the things we have been doing around here.

Dr. TODD. But we believe we can do it better by looking at appropriateness, effectiveness, and necessity, as developed through the profession.

Senator DURENBERGER. I don't disagree with you. I don't disagree with you.

Senator ROCKEFELLER. Senator Packwood?

Senator PACKWOOD. Dr. Eisenberg, you indicated that an expenditure target is not a cap. You analogized it to the line in the center of the road, which serves, when you drift over it, as a warning sign.

Absent a policeman, absent a hammer, absent something, what good is the target? I mean, so you know you are "over the line?"

Dr. EISENBERG. The target does have an incentive built into it, which is that you get more than a signal when you cross the line, and that is the signal is accompanied by a decrease in the fees that occur in the subsequent year. It is not a target on that year, but it is limit on the next.

Senator PACKWOOD. I understand that. There was a time a couple of years ago, when we were looking at Gramm-Rudman and reconciliation prospectively, where we thought about attempting to reduce Medicare payments prospectively, pro rata, based upon what we thought would be a reasonable increase. That would be a target that you put into effect ahead of time and hope that you hit it.

But it does, then, become a limit, maybe a cap, in subsequent years, based upon the fact that you went over the target in previous years.

Dr. EISENBERG. It becomes a constraint as to how much farther away from the target you would become in subsequent years; although, it obviously does not cap the total expenditures.

I have similar faith to Dr. Todd, that physicians will respond to practice parameters, guidelines, and utilization review, and I believe, as he does, that they will be responsible. Therefore, I am not as worried about the expenditure targets, nor is the Commission, if they are accompanied by appropriate utilization review and guideline development.

Senator PACKWOOD. Well, I will make you this deal, then; it is almost a bet: We think the utilization and the volume will just continue apace because it always has. If it doesn't continue apace, we all win; we don't need to worry. But if volume does expand, I don't want any explanations from you and Dr. Todd as to why the volume and the intensity have not gone down which would negate applying these financial incentives once these are in effect. Is that a fair deal?

Dr. EISENBERG. You may get explanations from us. We won't apologize, I promise you that.

Senator PACKWOOD. Okay. I am perfectly willing to try it; but I can see what is going to happen—you are going to come back, and there are going to be lots of explanations as to "good practices of medicine" and "why we can't do this" and "the re imbursement is unfair" and "the target is unfair" and "it was unrealistic" and "the target ought to be changed," and all of the hoped-for economies, whether it is a reduction in volume or a reduction in intensity, will not be realized. And, ex post facto, we will receive lots of explanations as to why we should have understood why we weren't going to get them. I just wish I understood it now. [Laughter.]

I have no other questions, Mr. Chairman.

Senator ROCKEFELLER. Well, answer that question.

Dr. EISENBERG. It was a bet, actually, not a question; so I will take him up on the bet.

I believe that you are right, that that current 7-percent increase in volume per beneficiary will not go away. And as a physician, I hope that it doesn't go away, because it represents in part, improved access to care; improved technology available to beneficiaries; and newly-covered services. It also probably represents some unnecessary services. I believe that that rate of increase can be decreased.

Senator PACKWOOD. Well, let me ask, then—and, just to be sure, I have written it down. In fact, David Durenberger's staff wrote it down, but it phrases what I want to say:

"Could volume usage ever be so great beyond the target in any one year to cause a price freeze, or even a price rollback, when applied to the dollar conversion factor used to determine payment for the doctor's services?"

Dr. EISENBERG. Well, yes. If you decide that you want to set a floor to the decreases that would occur in fees, then a decrease, of course, would not occur.

Senator PACKWOOD. But if you don't set a floor, they could occur?

Dr. EISENBERG. A decrease in fees could occur if the unexplained rate of increase were greater than the cost of living increase in the preceding year.

Senator PACKWOOD. I think that is exactly what is going to happen. And we will decide that the target is a cap on total spending, and we will reduce the payment per procedure in effect from 80 percent of the "real" costs to 75 percent, or 70 percent; and then the issue will come up as to whether or not the doctor—even if they accept assignment—can then balance-bill the patient for the amount we have reduced the fee that they were going to get from the government but didn't because of exceeding the expenditure target in the previous year. And of course, if they can, it is an increase in cost to the beneficiary.

Dr. EISENBERG. That is right.

Senator PACKWOOD. I can see that coming as sure as we are here.

Dr. EISENBERG. The Commission would recommend that, if the allowable fee decreases because of the expenditure target the balance bill, as a percentage, will remain the same. In fact, if the fee decreases, the patient's percentage will decrease, because it will be the same percentage of a smaller figure.

Senator PACKWOOD. It will decrease. But if there is a decrease, the doctor's income decreases; and if he cannot make it up by increasing his balance-billing, assuming he hasn't increased his volume of procedures, his income will go down.

Dr. EISENBERG. His income will have gone up in the preceding year by more than we would have anticipated; so, his income in fact, relative to the base year, will not go down. It may have gone up as much as it would be if——

Senator PACKWOOD. It "may" have gone up with some physicians. It would depend upon how much they were doing in volume and how much they were doing in intensity. But when the average hammer comes across all of them, it is going to "hit" those who went up and those who didn't go up.

Dr. EISENBERG. That is the reason I think this provides a wonderful opportunity for the profession to become more introspective about looking at the way that each physician is practicing.

Senator PACKWOOD. Thank you very much, Mr. Chairman.

Senator ROCKEFELLER. Thank you, Senator Packwood.

Dr. Detsky, the Health Affairs article indicates that you have had this plan in effect for a couple of years, so it may be a little bit early to say what the real effects are. It also indicates that there is some physician resistance—some physician resistance.

Why do you think that Ontario, British Columbia, Manitoba and Saskatchewan have adopted this approach, expenditure targets? And do you think that other provinces will follow?

Dr. DETSKY. Well, let me say that the provincial governments of those four provinces would like to adopt this approach. Saskatchewan tried to implement this, and then they have essentially had to be backed off by the courts. Manitoba abandoned it after three years. I am talking specifically about the target expenditures, not the fee schedule that is in negotiations.

Senator ROCKEFELLER. Right.

Dr. DETSKY. Manitoba abandoned it after three years. I think that had something to do with local politics at the time. BC, only a few years of experience with the targets.

So really, only the Province of Quebec has had this for an extended period of time.

Ontario is actively discussing this kind of proposal, the Ministry of Health. They have used this mechanism at the bargaining table, but they have not implemented this. They would very much like to implement it.

Canadian health policy has been much more progressive than U.S. health policy in some ways. It is not clear to me whether our national health insurance system is going to come here before the dome stadiums are going to come here. I think the dome stadiums will get hear ahead of it. But one of the aspects that you are discussing before you have a national system of universal health insurance.

This is the kind of proposal which the provincial governments would very much like to have, for exactly the reasons that Senator Durenberger talked about: They would like to be able to budget, prospectively, that, "We are going to spend *x* billion dollars a year on physician services, and we are not going to go over that; or, if we go over that, we are going to get it back in a subsequent year by rolling back the fee increases." That is what they do in Quebec.

So, there has been a lot of discussion of this in the other provinces. The provincial governments would very much like to have this. I don't think it is all that easy to do without physicians going along. And the reason it happened in Quebec was because the physicians themselves opted for this.

So I would say, politically, it is going to be a tough fight. My prediction on Ontario is that it will go one of two ways: Either government will impose this, because now, with the banning of balance-billing, government really is very much in the driver's seat and has demonstrated over the last four or five years that they are going to play very tough, very hard-nosed, and in the last negotiations they were that way. And we are going to end up with an arbitrary form of capping the expenditures on physicians' fees. As an alternative, the profession itself can choose to adopt the kinds of things which Dr. Eisenberg was talking about—algorithms, looking at appropriateness of care.

I kind of see it as an either/or. What you have got here is a both-together. You have got an, "Okay, guys, you come along and develop these algorithms, and here is the carrot and the stick for you to do so. If you are not successful in limiting costs and can't use these algorithms to limit costs, it is going to cost you on a fee basis. And if you are very successful, we will reward you on a fee basis." It sort of reminds me of what one of my colleagues once suggested. We were examining an NCHSR proposals on, colonoscopies, and we were looking at ways for getting people to go along with appropriate algorithms for using colonoscopies once we developed those algorithms. One of my junior colleagues said to me, "Well, in the U.S. it ought to be easy for them to figure this out; it ought to be like the farm policy—'If we can pay farmers not to grow grain, surely we can pay the gastroenterologists not to do colonoscopies.' " [Laughter.]

And that is starting to sound a little bit like part of this proposal: "If we can get them to raise their fees by doing less and doing it more appropriately, they will be better off, and maybe patients will be better off."

Senator ROCKEFELLER. It is not denial of service?

Dr. DETSKY. No, hopefully not. You see, the question is, what goes on at the margin with the individual patient. We, for example, have a limited number of slots.

An area I am familiar with is total parenteral nutrition (TPN); it is a form of feeding patients in a hospital intravenously. We have a fixed number of slots per year, a fixed number of patient days per year, that we can use TPN in one hospital. We decide, prospectively, how we are going to do that, and we have certain policies, that we do not offer that kind of service to certain kinds of patients where it is deemed to be either ineffective or marginally effective. And we live within that, prospectively.

One would hope that physicians who allocate services would behave, in a responsible fashion. There is some evidence that physicians respond to that, when they have a constraint on the total amount of services that they can provide.

I think it is somewhat silly to think that that isn't going on in this country right now. I mean, that is probably going on at this very minute at a thousand different sites. There are constrained resources for everything, and the term "rationing" to me means that you have a fixed resource, and you are going to allocate it to certain people, on some basis—need, first-come-first-served, ability to pay, connections, whether it is a friend of yours, whatever. So, that is going on. I am sure it is going on in this country. It is going on in Canada all the time. It is going on in this country in health care all the time.

What one would like to see is a mechanism for that being used in what we would view as a societal-appropriate fashion; that is, those who need it, those who can benefit from it, get it, and those who don't need it don't; or procedures that are ineffective or, worse, harmful, don't get done. That is the flavor of what I am getting here. It is a big task, though, to do that on a national level.

Senator ROCKEFELLER. You have the Threshold Program in Toronto.

Dr. DETSKY. In Ontario, yes.

Senator ROCKEFELLER. In Ontario. Has that affected your income?

Dr. DETSKY. Me, personally?

Senator ROCKEFELLER. Yes.

Dr. DETSKY. I will tell you what has affected my income. We have a nursing shortage in my hospital. I take care of a lot of medical problems in surgical patients, and there are not enough operating room slots. That has had a definite effect on me; we have had to close some wards because of a nursing shortage—not because the hospital doesn't have the money to pay for them.

The fee schedule—this year we got 1.75 percent, plus some payment for malpractice insurance—did that affect my income? I guess it did. Sure. And the extent to which government used utilization increases as their argument for that fee increase, for the limitation of that increase, might have influence. But I think that is all they wanted to pay, I think they could have come up with any argument in the world; but the most convincing argument was, "This is what we are going to pay, fellows, and this is it. We are not going to talk about it this year." And whether they used utilization increases, or a tax base, or deficits, or housing prices in To-

ronto, or nursingshortages, or having to pay more benefits to other health care workers, it didn't matter what it was; that was what they were going to offer, no matter what.

Senator ROCKEFELLER. I want to come back to this rationing matter. I got a letter from the AMA and 18 specialty societies describing your system. The letter said, "There is mounting evidence in those Canadian provinces employing expenditure targets that the policy results in rationing and long delays in obtaining necessary medical services" dot, dot, dot, "patients in Quebec are waiting eight to nine months for coronary artery bypass surgery. Emergency departments in Montreal and Vancouver frequently have no capacity to treat new patients. Our disabled and elderly populations should not be subject to this type of experiment."

Your comment?

Dr. DETSKY. There is no question that we have waiting times for specific procedures. The ones that stand out are coronary bypass surgery and hip replacement, or for access to diagnostic technology such as MRI's, or lithotripsy as a therapeutic intervention. There is no question that our waiting times for those specific procedures can, on average, be longer than what I think Americans might tolerate. There is no question in my mind. I can say in specific cases that would be true.

Whether, on average, the waiting times are specifically longer, actually I really don't know the evidence for that. But certainly my perspective as a practicing physician is that in the 29th year of Universal Health Insurance for hospital services, and the 19th year of payment of physician services from the Provincial Health Plan, we now have some shortages that I would like to see remedied. For you, that is way off into the future. You are talking about something that has happened to us way down the line.

When the medical associations have tried to document these episodes, they are mostly anecdotal. Now, we have a recent one, which we were talking with Senator Durenberger about on Monday, about a man who had his surgery delayed, cardiac surgery delayed, in Toronto 13 times and died when he got the operation. That is something that comes out in the media right away. There was an investigation into that. First of all, they determined that the reason the man died was a perioperative complication and it probably had nothing to do with his delays, and in fact his delays may have been due to the fact that he needed to be medically tuned-up before they could do the operation. So, it really had little to do with that. But that focused the attention of government, put government on the hotseat and the media on that specific issue of rationing.

There is no question that we have anecdotal information that that is going on. And if that is a downside of our system, then so be it.

I don't think, though, that that can be blamed on the concept of expenditure targets for physicians; I think it has much more to do with the containment of the hospital sites.

To answer Senator Packwood's question, if this isn't going to work in containing utilization, I think it is not going to work not because of this but because it is like a balloon—if you hold down the 20 percent or 25 percent of health care expenditures that are

physician services, and do nothing to the hospital side or the new ambulatory facilities that do what used to be done in hospitals—the growth of technology on an ambulatory basis—then that may well be the explanation, a prospective explanation, believe it or not, as to why this may not work.

We went at it the other way. We contained the hospital side; we didn't do very much on the physician side for a long, long, long time, except in Quebec.

Senator ROCKEFELLER. A final question: Do you consider that you have rationing in Canada?

Dr. DETSKY. If you use John's first definition of rationing, do I consider that we have a fixed amount of resources that we devote to health care, and we give that out with the knowledge that we want to maximize patient outcomes in general with that fixed budget, yes.

Do we have a system where we have got people lining up on the street, and five of them are going to drop dead in the next week if they don't get coronary bypass surgery, and we only have one slot left, and, "Sorry, we are going to do a lottery here, and one of you is going to be lucky"—I am not sure which one, actually—"one of you is going to be lucky, and the other four of you are going to be unlucky"? We definitely don't have that.

Senator ROCKEFELLER. How can you be so quick to say that? I mean, if there is only one slot left?

Dr. DETSKY. Although increasingly I have noticed the amount of effort that it takes to get things done, particularly in the last year—I think related to this nursing shortage business—I can't honestly say that I have ever had a circumstance where I wanted to get something done for a patient and couldn't, and had it denied, with a delay that led to a serious health consequence, in my own practice.

There is no question, though, that if I were to tell you, "You need a coronary surgery, but, sorry, I am going up to the cottage for the month of July, and the operating room is closed, and I can't give it to you until August 15th," you might not be so comfortable with that, if it was elective, which is the way that would happen. You might not be so comfortable with that. So, there may well be that price to pay on those specific kinds of services.

But I can't think of a case of urgent surgery that I needed to do that I couldn't get done within a reasonable amount of time.

Senator ROCKEFELLER. Senator Durenberger?

Senator DURENBERGER. Mr. Chairman, I am certainly not an expert on anything after brief exposures, and I am not going to make any conclusions about the comparisons between the two countries, with one exception, I guess, and that is: They have the same problem we have about what is appropriate and what is necessary, and what setting it ought to be in. It is sort of a different problem. We bled our hospitals of everybody. You have got a lot of stuff filling up your hospitals that ought to be done somewhere else, and you can't figure out how to get form here to there. Now we have all the docs in a box, and all the rest of that sort of thing, and we don't know how to restrain that.

The problem is, with a few exceptions in this country and in your country, there is nobody managing my access into this system.

But I would certainly say to that long list that Jay quoted from, and others, if you are going to launch campaigns about what is going on on the Ways and Means side, or anywhere else, don't use selected examples from anybody, including Canada; because you may do it, but I am not sure it is going to impress the folks up here, who know, as Dr. Detsky said—I am aware that we are putting him on the spot; he has got to represent everybody up there.

Dr. DETSKY. That's okay, there are only 25 million of us.

Senator DURENBERGER. But it conforms to my experience, too, that the question about the rationing was very appropriate, because that is sort of the eye-of-the-beholder thing.

I am wondering, Dr. Eisenberg, do you think that an expenditure target either could or should be imposed before we put a fee schedule in place, and we get all of this equity redistribution?

Dr. EISENBERG. No. The Commission believes the expenditure target is a part of the package, which in fact should probably be introduced later than the resource-based relative value scale, so there is a "level playing field" before physicians are asked to be conscious about the total packet of expenditures.

I think Paul Ginsburg wants to add something.

Mr. GINSBURG. I just want to say I don't think the Commission feels that the expenditure targets should start later than the fee schedule; particularly, when you start to implement a fee schedule, you have uncertainty about what the volume of services is going to be, and the expenditure target is very useful to have in place at that point.

I think if you are talking, like the administration is, about not starting the fee schedule until 1993, then starting the expenditure target this October would probably be premature. The Commission feels that that is really far too much time delay before assigning the fee schedule. When we suggested starting the adjustment of prevailing charges for 300 to 500 procedures starting next Spring, that was based on fairly careful consideration of what was administratively feasible.

The quality of the data from the Hsiao study that we have in our hands right now is such that we envisioned both starting simultaneously; now Congress may want to delay slightly the start of the fee schedule, and you might then delay the expenditure targets to that point.

Dr. EISENBERG. As long as we are defining the Commission's position as accurately as we can, let me add to what Paul has said by saying that our sense is that, if there is to be, in the concept of an expenditure target, a rate of increase in a certain year that is less than what was experienced in previous years, that that reduction in the rate of increase should not start until after the transition period has been enjoyed.

Senator ROCKEFELLER. Dr. Detsky, it is 12:15.

Dr. DETSKY. Thank you.

Senator ROCKEFELLER. Thanks a lot.

Senator DURENBERGER. The next question relates to the geographic adjuster. We have talked abut this, and I won't try to repeat a question; but, Dr. Todd, what is the AMA's position relative to the geographic conversion factor in the RBRVS?

Dr. TODD. Well, we believe there should be a geographic factor that is determined purely on the cost of providing the services, the physicians' ancillary services, and not be related to the physicians' time differential—i.e, physicians' time in all parts of the country should be essentially equally valuable, and they should be compensated equally for equal services. On the other hand, there are differences in practice costs which should be recognized and appropriately taken into account in the RBRVS.

Senator DURENBERGER. Do you favor taking malpractice out and doing that separately?

Dr. TODD. Absolutely. The level of cost of professional liability, not only in terms of the premiums that physicians pay but in the cost of the amount of care that is given in the professional liability situation must be recognized. If some relief could be obtained from that—and we think PPRC was very wise in carving this out and calling it to the attention of Congress and the American public, because there is a great deal of waste in the current judicial system—it would make it a lot easier for physicians to do some of the things you want them to do but are afraid to do today because of the legal consequences; i.e., not get that additional skull x-ray for the kid who has fallen off his bicycle.

Senator DURENBERGER. Dr. Eisenberg, what is the Commission's view on some kind of a sub-national expenditure target, other than that we don't have all the data in hand? What would be the value, or would there be any improvement in the quality of the pluses and the minimizing of the minuses in this system if we could identify sub-national limits within an overall—at least for Medicare—national limit?

Dr. EISENBERG. We have assessed that question in two ways. One is a technical way, by looking at the Medicare expenditures and the variations from region to region that exist, to try to define whether or not there are geographical areas which are homogeneous enough that they could be defined as an area that would be targeted. And we believe that sub-national regions can be identified.

We also have looked at this from a non-technical point of view, in essence looking at the way the rest of the practice environment is constructed, and we have observed five things:

First, that Medicare carriers and intermediaries are organized along State levels;

Second, that health insurance is regulated by States;

Third, that PROs are organized by State;

Fourth, that most regulation of health care is at the State board level, like licensure and certificate of need; and

Fifth, that State medical societies do exist, and that in fact in many specialty organizations State chapters exist.

So there is much to be said for sub-national organizations of expenditure targets; but we do believe we need to look into it a little bit more before we come out with a strong recommendation about exactly how the targets ought to be organized.

Senator ROCKEFELLER. Could it be refined beyond the State level, or within, downward from the State level?

Dr. EISENBERG. Technically, it could. Technically, if you look at practice variations and the degree to which they are homogeneous

in certain areas, the degree to which there are practice styles, let us say, which could be defined, both the data on geographic variations and our analysis of the Medicare data suggest that something like a metropolitan statistical area—MSA—might work.

But then we have to look at the other side, which has to do with the organization of practice and the organization of regulatory agencies, and so on, and there become difficulties there. There also are difficulties there for rural areas, which don't fit into MSA's as nicely.

Senator ROCKEFELLER. Could it be done within medical specialties?

Dr. EISENBERG. Technically, it could. We have some concerns about doing it within specialties, but really haven't investigated this thoroughly enough to come to a conclusion. But as an example, one of the problems of organizing the targets within specialties is that a number of services that are provided to patients by different specialties address the same clinical problem. A patient with a gallstone might get lithotripsy or might get surgery. You can think of lots of other examples where the solution to a problem is not specialty-specific.

And in addition to that, specialty-specific targets have the potential for locking technology into a certain style of practice, by assigning a certain problem, in essence, to be taken care of by that specialty.

We haven't had time to decide whether or not those disadvantages are outweighed by the advantages of the well-organized professional organizations; but we recognize that both sides of that argument exist.

Senator ROCKEFELLER. Senator Heinz?

Senator HEINZ. Thank you, Mr. Chairman.

First, let me say I am delighted to have Dr. Eisenberg here from the University of Pennsylvania. I must say, you have got quite a tiger by the tail with expenditure targets.

Dr. EISENBERG. Just like playing Princeton.

Senator HEINZ. Yes. [Laughter.]

Let me ask you this: Under some kind of national expenditure target—what is to prevent Medicare from being gamed by bad docs?

Dr. EISENBERG. Other docs?

Senator HEINZ. Yes, by docs who act like my dairy farmers in Pennsylvania.

Dr. EISENBERG. No, my answer is quite serious. I think the way of preventing certain bad-apple doctors from gaming the system will be their peers, will be the other physicians. I would like not to see that be a Federal responsibility; I would rather see it a responsibility that is shared by carriers, by the PROs, and by the profession.

Paul is a better economist than I, and I might ask him to comment, if he would like to, on this.

Senator HEINZ. But before he comments, the real question, it seems to me, if your suggestion on how to stop it is right, is whether or not the medical community can get themselves organized in any reasonable length of time. You heard my question to Dr. Sullivan earlier. Whatever else the AMA is, in addition to representing

a minority of doctors, the medical profession is organized, to the extent that it is organized, along State and, some would argue in my State, along county lines.

Dr. EISENBERG. That is right.

I have faith in the profession, and I have faith in Dr. Todd's comments that we as a profession can do a better job, through parameters and guidelines and utilization reviews.

Senator HEINZ. But for this to work, basically the doctors of the country, all the specialists, all the regions, all the different types of care deliverers, have to somehow—and this isn't just the AMA; I mean, they are only a piece of the action—all have to sit down and say, "Okay, here is how we are going to live with this thing that Congress," or the administration or Dr. Eisenberg, "has done to us." Under the best of circumstances, how long would that take? I gather in Canada it isn't the easiest thing in the world, even on a provincial level.

Dr. EISENBERG. Well, first, we don't have to have the organization of medicine come together into a single body to determine what the rate of increase is going to be—you are going to do that.

Senator HEINZ. No, no. We will do that.

Dr. EISENBERG. What the responsibility of the profession is, through collegial activities, is to come up with these guidelines and parameters and feedback systems to try to influence physicians' practices.

Senator HEINZ. My question was how long is that going to take, assuming they can do it.

Dr. EISENBERG. I would have to turn to my colleagues on that. Today I am not representing the professional physicians, so I can't tell you.

Senator HEINZ. I don't quite know who to ask, because everybody else has kind of a vested interest.

Dr. EISENBERG. Senator Heinz, let me start the response this way, and say I believe that unless there is a reason for the professional organizations to get together, unless there is a change in the context, a change in the environment, and a real reason to get together because we are in the same fix together—that is, that we as a nation have a limited amount that we can spend on health care—I don't think that the profession will be as likely to get together as they would be if we had a concept like expenditure targets which put some meat on the bones of utilization review and peer review.

Senator HEINZ. Let me ask kind of a different question to anybody who wants to comment on it, and it is this:

What are the relative merits of an ET approach to cost containment, whether one likes the principle or not, drawn along alternative lines? One alternative line would be by specialty group, another would be by procedural lines, a third would be by State or local geographic lines—three alternatives. Let me ask the AMA or the surgeons, how would you rank those, and why?

Dr. Murray, do you want to go first?

Dr. MURRAY. Well, we obviously favor doing it along the specialty line in terms of surgery, because we feel we have a handle on it, or can get a handle on it.

If you look at the list of the top 20 expenditure——

Senator HEINZ. What would be in second position, out of these three?

Dr. MURRAY. I don't think we have a second position right now. We obviously would have to adapt to what was promulgated.

Senator HEINZ. Well I understand what your position as an organization is, but we are here also to get your thinking.

Dr. MURRAY. That is right. Well, I think that we would then have to adapt to a geographic-tied alternative.

Senator HEINZ. That would be the second choice?

Dr. MURRAY. That would be the second choice.

Senator HEINZ. Dr. Todd?

Dr. TODD. Well, Senator Heinz, we would say they are all equally bad, because they ignore the manner in which medicine is practiced. The doctor down the street very often does not know what his or her colleagues are doing around the corner. We at the AMA have tried to curb what we consider inappropriate, misleading advertising, and we are visited by the Federal Trade Commission whenever this happens.

And when you talk about collective activity by the medical profession to try and restrain some of our errant colleagues, or to get them back in better practice, we have a whole series of impediments to that, and that is why we believe, first of all, ET's will be an administrative nightmare. The more you bring them down to the lower and lower levels, they become increasingly difficult to administer and less and less equitable in the long run.

We don't need, in the profession, this economic disincentive or incentive, call it whatever you want. Are you trying to eliminate services, period, or are you trying to eliminate unnecessary, marginal, and inappropriate services? If the latter is the case, the profession can do that. The profession wants to do that. The profession has done that and will continue to do it, and that can be organized very quickly, very effectively. As Senator Mitchell has found in his own State of Maine, when physicians are provided with appropriate medical, clinically-sound information, they will change their behavior.

We do not believe that the ET's and the accompanying economic incentives are going to convince physicians to withhold care from patients who need it.

Senator HEINZ. I have one or two more questions, but my time has expired.

Senator ROCKEFELLER. Ask another one. Go ahead.

Senator HEINZ. Thank you, Mr. Chairman.

The key one, it seems to me, given the fact that there was a 16-percent increase in costs in Part B last year, a 44-percent in volume, that a larger increase in volume is predicted if we go to resource-based relative-value scales, that waiting for what Dr. Sullivan described to my earlier question as "years" for his effectiveness research and the careful clinical studies to which you refer to be conducted, evaluated, synthesized, and developed into practice guidelines, what you are really saying is there is nothing to do for the next three years except to wait it out.

Dr. TODD. Not at all.

Senator HEINZ. Then, what do we do?

Dr. TODD. We get the RBS finished on schedule. PPRC, we believe, has done a creditable job in identifying the problems in it.

Senator HEINZ. Well, what do we do to slow this incredible increase in volume of services?

Dr. TODD. We avoid developing a big bureaucracy to study effectiveness, appropriateness, and necessity, and let the profession go out there—as it has done, through national health institutes, consensus panels, through studies of specialty-specific activities, through other cooperative studies—to come up with methods of restraining the marginal use of services and procedures.

Senator HEINZ. Doctor, don't interpret what I am about to say as any kind of put-down; if the profession is really doing its job, why do we have this huge increase in volume of services?

Dr. TODD. I think, we have these increases in Part B, for a whole variety of reasons. As DRG's cut down on the length of stays in hospitals, care has been moved out of this setting. And yes, you have gotten hospitals under control, but it has resulted in a shift from Part A to Part B. Also, more patients are getting more care, and technology has continued to advance. The product, the medical product, that patients are getting today is not the same product they were getting five years ago.

Senator HEINZ. But my question is, where has the AMA been in this?

Dr. TODD. We have been working, one, to organize—and perhaps Dr. Kelly should tell you some of the activities we have been involved in in organizing the specialty side.

Senator HEINZ. No, I mean in terms of controlling costs, as a result of the shift to DRG's. You are right, you didn't have to be any genius to figure out that, if there was an incentive to keep people out or get people out of hospitals, there was going to be a need for other kinds of care. In fact, when I was chairman of the Senate Committee on Aging, I held many hearings on that very subject. Everybody said, "They are going to get out sicker and quicker," and you didn't have to be a rocket scientist to understand that.

So, that was 5 years ago. And what have we done in the way of preparation for what we all knew was coming? The answer is, "No, not enough." And in the case of the medical profession, I can't answer what you have done; all I know is that it is your profession, not mine. We have other things to do. We can't do everything you can do.

Well, that was more of a rhetorical question.

Dr. TODD. Could I give you a rhetorical answer?

Senator HEINZ. Yes, sure.

Dr. TODD. I think you over-emphasized the ability of the medical profession or any one of its organizations, given the current legal structure in this country, to absolutely control what it is the practitioners in this country do. But I don't have to tell you, if you read American Medical News, if you read the mailings and descriptions of meetings that we have had, not one goes out that does not talk about health care costs and the need to be prudent in the provision of services and procedures.

Senator HEINZ. I want to thank Chairman Rockefeller for allowing me to continue to question, and I thank all of you for your an-

swers. I suspect we are all both sadder and wiser—wiser because of your testimony, sadder that the more one looks at this, the tougher the issue becomes.

Senator ROCKEFELLER. Dr. Todd, just a couple of questions. I apologize to the next panel; we will be here as long as it takes. At least, I will.

You care a lot about physician payment reform. and you have made that very clear. The administration has said that they are not going to do this unless it is a three-part program—obviously, the third part being expenditure targets.

How much do you care about physician payment reform, if they really mean it?

Dr. TODD. We care.

Senator ROCKEFELLER. Is there any compromise within the Society's position?

Dr. TODD. Senator, our problem is holding one hostage at the price of the other.

Senator ROCKEFELLER. Sure, it is a problem, but in reality——

Dr. TODD. As I said, we are adamantly opposed to that, because we are absolutely convinced that expenditure targets in a very short space of time will become expenditure caps, will result in severe limitation of the physician's ability to provide needed and necessary care, and the administration's proposal says nothing, neither did Dr. Sullivan this morning say anything, about necessity, effectiveness, and quality of the care that would be given. Dr. Sullivan talked about physician payment reform; he talked about expenditure targets; and he talked about beneficiary protection. He said nothing about the need and the demand and the quality of the services that might be provided under the administration's proposals.

Senator ROCKEFELLER. If Congress decided to enact an expenditure target policy which explicitly stated that the only consequence of missed targets will be a reduction in the update of fees, number one; two, that there is a floor below which fees could not be reduced; and, three, Medicare reimbursements for medical services will not be cut off, whether or not targets are met, would you be more amenable?

Dr. TODD. Probably not, because what one Congress can do another Congress can undo; once the proposition is in place, it just begins to expand. We have seen that in the DRG's for hospitals, with continuing racheting down. We do not believe that economic incentives are the appropriate way to change physician and patient behavior in this country, but it is through education and the provision of appropriate, necessary, and effective care in the proper settings—not to say that if you give too much care or if you give bad care we are going to cut your income. That has nothing to do with quality.

Senator ROCKEFELLER. Your answer, basically, is no.

Dr. TODD. Is no.

Senator ROCKEFELLER. Because of what Congress might do in the future? Well, let us say the Constitution abolished the Congress, and our last act was what I just suggested, those three points.

Dr. TODD. I can't fantasize that far, Senator. I really can't.

Senator ROCKEFELLER. Are you holding a bargaining position? Or are you holding an adamant no-compromise position?

Dr. TODD. We are essentially holding a no-compromise position on the expenditure targets, and particularly when tied to physician reimbursement. We do not want to be held hostage by the administration, because we firmly believe that expenditure targets will be bad for the patients of this country, and we have no evidence to the contrary.

Senator ROCKEFELLER. To the matter of this 15-, 16-, 17-percent increase in costs of Part B, let us say going on for another 10 years, Medicare doubling every 5 or 6 years, the possibility and some would say inevitability of the bankruptcy of our medical payment system, what would you offer as a way of solace?

Dr. TODD. Well, first of all, we don't believe that the rate we have seen over the past few years is going to continue. Indeed, there is already some evidence from the Congressional Budget Office to suggest that the slope of that curve is beginning to change. We believe it will continue to change as we move on to develop more appropriateness criteria, as we improve utilization review, and as we improve peer review.

Senator ROCKEFELLER. Gentlemen, I thank all of you very, very much. You have been extremely helpful.

Our final panel consists of Dr. Joseph Boyle, executive vice president of the American Society of Internal Medicine; Mr. Everett Bryant, senior vice president, government business, Pennsylvania Blue Shield; Dr. Michael Soper, senior vice president and national medical director, CIGNA Health Plan, who will be testifying on behalf of the Group Health Association of America; and Mr. Walter Maher, director of Federal relations, human resources, Chrysler.

When you are comfortable, Dr. Boyle, you may proceed.

STATEMENT OF JOSEPH F. BOYLE, M.D., EXECUTIVE VICE PRESIDENT, AMERICAN SOCIETY OF INTERNAL MEDICINE, WASHINGTON, DC, ACCOMPANIED BY JAMES D. NUCKOLLS, M.D., ASIM PRESIDENT

Dr. BOYLE. First let me say that we applaud all of your opening remarks and certainly are in accord with all of the objectives that you set out for your subcommittee in its deliberations.

I am Dr. Joseph Boyle. I am executive vice president of the American Society of Internal Medicine, and with me is Dr. James G. Nuckolls, M.D., who was an internist in rural practice in Galax, VA, who is president of the American Society of Internal Medicine.

As the committee is aware, the volume of medical services is estimated to have increased at a rate of about 7 percent annually, with most of this increase occurring in surgical and diagnostic procedures. There are theories abounding on reasons for this volume increase, but there are only a very few limited studies that have been conducted to try to find out why, and what is striking is how little we know about what is occurring, much less why. Until we know more, it seems only prudent that we proceed cautiously in attempting to control the volume of service.

We understand that the Congress needs to act, because of some sense of urgency. On that account, Congress is contemplating set-

ting explicit limits on expenditures. ASIM believes that there is another alternative that offers the promise of controlling the volume of ineffective services provided to Medicare patients, without curtailing access to appropriate care. That alternative is for the Congress and the medical profession to make a strong commitment to developing the scientific basis and the means for evaluating the effectiveness of different services.

National policy to expand outcomes research and to develop practice guidelines would be an appropriate part of such a strategy. By eliminating ineffective services, substantial savings to the Medicare program are likely to accrue.

The patient outcomes research bill, S. 702, introduced by Senator Mitchell as well as yourself, Mr. Chairman, Senator Daschle, Senator Durenberger, Senator Heinz, Senator Baucus, and other members of this committee represents an important and commendable initiative in establishing national policy on effectiveness research and guideline development. Positive experience from the State of Maine suggests that a leadership role provided by the profession in conducting patient outcomes research, providing information to physicians to improve the quality of patient care that they provide their patients, does work.

S. 702 would establish a strong Federal role in facilitating, guiding, and funding outcomes research and guideline development in the private sector. The bill's emphasis on outcomes research is particularly important and appropriate. Such research holds the promise of providing the data needed to improve the quality and reduce the cost of care.

This bill also would provide funding advice and support for the development of practice guidelines, without authorizing the Secretary of Health and Human Services to actually develop these guidelines.

To have credibility with physicians, the development of practice guidelines must be done by the profession, not by the government. We are pleased that this principle is incorporated into this legislative proposal.

Although most Members of Congress do not argue with the need to develop practice guidelines, there appears to be some skepticism that guidelines themselves represent a viable solution to the volume problem.

Some question whether or not the medical profession would remain committed to the development of guidelines and outcomes research if there is no mandate for expenditure targets. Others wonder whether guidelines can be developed in time to have any impact on the volume of service of expenditures. Others question whether physicians will modify their practice patterns without a direct economic incentive. Our answer to each of these questions is yes, and let me touch upon each of these very briefly:

Will the profession be committed to guideline development in the absence of expenditure targets? ASIM believes the answer is unequivocally yes. We cannot expect our patients and you, their representatives, to have confidence in our profession unless we are able to show that what we do works, and given the best scientific evidence that is available today.

We also know that Congress will hold us accountable. If we do not show an adequate commitment to guideline development, we know that Congress can always mandate fee reductions, more intrusive carrier review, less acceptable approaches to cutting costs, and the Congress can always revisit the concept of expenditure targets at a later date. We ask that you give practice guidelines a chance first.

Can guidelines be developed in a timely fashion? We believe that it can. As a matter of fact, we believe that building upon the databases already in existence which has to do with some very expensive high-tech procedures, that one can proceed in a matter of a very short period of time; and we believe it can have an impact at least as quickly as can the impact of expenditure targets, in that they would not be expected to have any impact, early on, for at least a number of years.

Will physicians change their practice patterns? We believe that if these guidelines are developed by professional groups, if they have credibility with the profession and they are accompanied by aggressive programs of peer review and education, most unnecessary services being provided today can be reduced substantially. We believe that guidelines will reduce the uncertainty that currently exists that causes many physicians to engage in practices of questionable necessity, and we also believe that they will not adversely affect patient outcomes.

Physicians also recognize that practice guidelines can be used by payors. For physicians, the important thing is that, when guidelines are used by payors, there is still the opportunity to exercise professional judgment, and we are pleased that this principle is incorporated in S. 702.

For all of these reasons, ASIM strongly urges this subcommittee and the Congress to establish a national policy on effectiveness research and practice guidelines based upon patient outcomes research, in lieu of mandating expenditure targets. Establishment of a Federal office to provide funding and advice will allow the profession to move aggressively on guideline development.

We would certainly be pleased to respond to any questions and to work with this committee in this area.

Senator ROCKEFELLER. Thank you, Dr. Boyle.

[The prepared statement of Dr. Boyle appears in the appendix.]

Mr. Bryant?

STATEMENT OF MR. EVERETT F. BRYANT, SENIOR VICE PRESIDENT, GOVERNMENT BUSINESS, PENNSYLVANIA BLUE SHIELD; CAMP HILL, PA

Mr. BRYANT. Mr. Chairman and members of the subcommittee, I am Everett Bryant, senior vice president, government business, Pennsylvania Blue Shield. I appreciate this opportunity to testify today, to discuss Pennsylvania Blue Shield's role as a Medicare carrier and our activities to ensure Medicare payments are made for appropriate and necessary services.

Pennsylvania Blue Shield serves as the Part B carrier in four areas: Pennsylvania, New Jersey, Delaware, and the District of Columbia metropolitan area. As the carrier in these areas, we are re-

sponsible for much of the day-to-day administration of the Medicare Part B program. In 1989, we will process approximately 50 million Medicare Part B claims.

Today I will focus my comments on our activities in the medical review area.

Few government expenditures produce the documented savings generated by these activities. In fiscal year 1988, Pennsylvania Blue Shield spent approximately $4 million for medical and utilization review activities. For that $4 million, we achieved a program savings of $42 million, a ratio of 11:1.

At Pennsylvania Blue Shield we have had a long-standing relationship with the physician community. Physicians are closely integrated into the medical review process. To ensure as broad a perspective as possible, physicians from whom Pennsylvania Blue Shield seeks advice and counsel represent not only all specialties of medicine but also the academic community as well as the clinical practice communities. These medical consultants, numbering nearly 400 within our service area, are selected in concert with the representative State medical societies and their component sub-specialty societies.

In addition, we have eight physicians on our staff who have the opportunity to comment on the development of medical policy and also the responsibility for its implementation through claims review. The ultimate benefit of such a process is to ensure that the beneficiaries served by Pennsylvania Blue Shield receive the best possible medical care provided in a cost effective manner.

Medical reviews are grouped into two areas:

The first is prepayment review. All medical carriers screen claims before payment to detect potential utilization problems, such as unnecessarily intense or frequent care. Claims may be suspended by our computer screens for more thorough investigation and review of medical necessity.

There are misconceptions about the use of computer screens. Carriers use such screens as a cost-effective tool to determine which services should be reviewed. There are no automatic denials. Services that do not pass the screens are suspended for individual manual review; approximately 20 to 22 percent of the claims are reviewed.

In fiscal 1988, all carriers were required to use 16 national prepayment screens. In addition to that, carriers were encouraged to set screens to focus on problems that are identified in their service areas. In 1988, Pennsylvania Blue Shield used an additional 61 carrier-initiated screens.

The other area is post-payment review, and it is intended to monitor the Medicare claims experience of all providers for services in the region. We focus on high-dollar and frequently-performed services. Aggregated data are subjected to statistical analysis in order to identify physicians or suppliers whose utilization patterns differ substantially from their peers.

By profiling physician and supplier services, we can identify patterns of overutilization, misutilization, excessive testing, and fraud and abuse. Actions that are taken include provider education of acceptable norms in billing practices, payment recovery, and design of new prepayment screens.

At Pennsylvania Blue Shield, we emphasize an educational approach in our activities. We notify doctors when their pattern of claim submission is substantially different from that of their peers. Each year we send a letter to physicians whose practice patterns differ substantially from their peers. We send this report for two reasons:

First, we want physicians to know this type of analysis exists. Second, we want them to know that some procedures were reported at unusually higher levels compared to their peers.

We also annually undertake a specialized focused review of a specific service that is frequently performed. Last year we concentrated on complex medical visits, holter monitors, ophthalmic biometry, physical therapy, and repetitive ambulance services. These in-depth reviews include an analysis of claims trends, patient surveys, consultant review of medical records, and discussion with the physician.

We are concerned about the adequacy of the funding that has been dedicated to this activity. The administration's 1990 budget proposes a 20-percent reduction in dollars for this type of activity.

The reduction of medical activity will without doubt result in the Medicare program paying for more inappropriate services, thus increasing benefit payout. Our Association has recommended a total fiscal year 1990 funding level of $1.8 billion for all contractor-initiated activities to the Senate Labor-HHS Appropriations Subcommittee. We urge your support of this recommendation.

Thank you.

Senator ROCKEFELLER. Thank you very much, Mr. Bryant.

[The prepared statement of Mr. Bryant appears in the appendix.]

Senator ROCKEFELLER. Dr. Soper, you will be next, sir. If you will, proceed.

STATEMENT OF MICHAEL SOPER, M.D., SENIOR VICE PRESIDENT AND NATIONAL MEDICAL DIRECTOR, CIGNA HEALTH PLAN, TESTIFYING ON BEHALF OF GROUP HEALTH ASSOCIATION OF AMERICA; HARTFORD, CT

Dr. Soper. Good afternoon, Chairman Rockefeller.

My name is Michael Soper, and I am a primary care physician and the national medical director of CIGNA Health Plan, an operating subsidiary of the CIGNA Corp., which is a leading provider of insurance, related financial services, and health care benefits.

CIGNA Health Plan is the largest investor-owned HMO with nearly 1.5 million members and 30 health plans, including both staff and IPA model types. In the past I have been the medical director of an IPA model HMO in Florida, and a staff model HMO in Kansas City, MO. Today, I represent the Group Health Association of America, the oldest and largest national association of HMO's.

HMO's provide comprehensive health care, including preventive health care services, for an affordable price. HMO participation in Federal programs such as Medicare and the Federal Employees Health Benefits Program provides an important alternative health care delivery option and often an enhanced benefits package. And in the private sector, HMO's have achieved consumer satisfaction while reducing employer cost.

I have been asked today to comment on how HMO's manage the volume of services to our patients without compromising quality.

It has been well documented that HMO's do achieve a lower utilization rate for certain costly medical services, particularly hospital inpatient care. HMO's manage to contain the volume of medical services towards the lower end, but still well within, the broad range of acceptable medical practice.

This result has been confirmed and reconfirmed by quality of care studies. These studies consistently report that the quality of HMO care equals or exceeds that of the fee-for-service sector. HMO's have developed systems for measuring and managing quality. These vary by health plan, but they are all aimed at assuring the appropriateness of care, including access to care. Some plans have process-oriented systems, which track compliance with standards; others have highly sophisticated systems that monitor outcomes. Still other HMO's rely on external review agencies, and many HMO's do all of these things.

The inherent nature of an HMO, with its organized delivery system, its relationship with physicians, and its application of medical management practices lends itself to prudent and appropriate medical practices.

Perhaps two features of this organized, managed approach are most noteworthy: The role of primary care physicians, and the manner of physician compensation.

HMO's establish each of their members with a primary care physician who serves as the access point to the medical care delivery system. Most medical needs of most members are satisfied directly by the primary care physician. When necessary, this physician also manages and facilitates referrals to specialists or inpatient care. This structure assures continuity and coordination.

HMO's also seek to compensate physicians in a manner other than fee-for-service. Salary is the most predominant form of physician compensation in staff model HMO's; and capitation arrangements, which are equivalent to salary in many ways, predominate in IPA models, particularly for primary care physicians. Many observers credit this removal of fee-for-service incentives as a critical attribute of the success of HMO's in managing the volume of health services without compromise in quality.

HMO's also have developed physician payment incentives, which provide opportunity to physicians for payments in addition to the basic salary or capitation rates. The most common incentive systems base the amount of this additional payment on the experience, over time, of a physician's entire patient panel, or the aggregate results of a group of physicians, or the overall results of the entire health plan. Increasingly, measures of performance relating to quality and patient satisfaction also are included in incentive arrangements.

Three years ago, Congress adopted legislation prohibiting physician incentive payments by HMO's under Medicare. The legislation wisely postponed an effective date, until April 1, 1990, in order to determine whether or not corrective measures were needed.

We understand that this legislation was initiated by an incident in which a hospital established an incentive arrangement designed to reward physicians to admit to the hospital patients who had

little need for hospital inpatient care. This practice was correctly and quickly prohibited by an act of Congress.

But HMO physician incentive payments are of an entirely different nature. In addition, recent studies by the Physician Payment Review Commission and the Government Accounting Office on physician incentive arrangements in HMO's did not find evidence that these financial arrangements have any adverse effect on quality of care.

The role of physician incentive payments in affecting physician performance must be viewed in the entire context of HMO organization and management practices. These arrangements demand and generate data, and these data provide information and feedback to physicians that is helpful in comparing and sharpening the accuracy of their medical practice.

Therefore, we urge Congress to proceed carefully as it addresses the issue of physician incentive arrangements in HMO's. Our strong preference is that this statutory prohibition be eliminated.

Finally, patient satisfaction remains at an all-time high. Recent independent enrollment surveys put HMO enrollee satisfaction in the 90 percent range.

Mr. Chairman, we constantly reevaluate the way in which we provide and pay for the health care of our members. We focus our management activities on quality and patient satisfaction as much as cost containment. We continually seek improvement and are readily willing to try new ways.

We congratulate you on your efforts in this area and will cooperate with you to the fullest.

Thank you.

Senator ROCKEFELLER. Thank you, Dr. Soper.

[The prepared statement of Dr. Soper appears in the appendix.]

Senator ROCKEFELLER. Mr. Maher?

STATEMENT OF WALTER B. MAHER, DIRECTOR, FEDERAL RELATIONS, HUMAN RESOURCES, CHRYSLER MOTORS CORP., WASHINGTON, DC

Mr. Maher. Thank you, Mr. Chairman.

My name is Walter Maher. I am director of Federal relations for Chrysler's human resource office. Prior to June 1 of this year I was responsible for Chrysler's employee benefit programs for 11 years and in running our health plan faced many of the same problems the Physician Payment Review Commission's recommendations seek to address.

Chrysler commends the work of the Commission in developing a comprehensive set of proposals to rationalize the pattern of payments to physicians by Medicare and to slow the rate of increase in Medicare costs.

As the private sector continues its struggle to bring under control the rising costs which threaten our country's competitiveness, we welcome these efforts by America's largest health benefit plan, Medicare.

Further, based on our company's experience, we believe it was most appropriate for the Commission to recommend at this time that Medicare address both the pricing and volume of services

issues. We believe these recommendations should be adopted at the earliest possible time, hopefully much earlier than 1993.

During the decade of the eighties, a substantial number of cost management initiatives have been adopted by Chrysler, and even more actions are planned. Some actions focused on price, others, such as pre-certification programs, focused on volume—albeit in a piecemeal way.

Despite these actions, Chrysler has seen its per-capita cost of providing health coverage to employees and retirees increase at an average annual rate of 8.5 percent since 1981, a rate of increase which exceeds both CPI and GNP growth. Worse, the last 2 years have seen double-digit rates of increase. In short, we and many other businesses have been running as fast as we can to combat the health care juggernaut, and we are falling farther and farther behind.

In 1989 Americans will spend almost 50 percent more per capita on health care than the second most expensive country in the world, Canada, and we are well over 100 percent more expensive than Japan. These statistics would not necessarily be so frightening if we were getting our money's worth. America, however, ranks about sixteenth in life expectancy and 17th in infant mortality.

There is virtually no health professional who does not readily admit to the existence of wastefulness in the delivery and consumption of health services. And despite all of these expenditures, there are 37 million U.S. citizens without health coverage.

My company is concerned about the competitive damage inherent in the dramatic differences between health costs in the U.S. compared with other leading countries. We must compete with foreign automakers who have a $300 to $500 per-car advantage over us due to health care costs alone.

Senator ROCKEFELLER. Five hundred dollars per automobile?

Mr. Maher. Right, 3 to 5.

American business cannot continue funding an excessively costly health care system and succeed against international competitors. Similarly, American citizens are paying a high but subtle surtax to support the health care system, since government programs and individual expenditures pay over 70 percent of America's health care bill.

The causes of this problem are legion; but a factor undoubtedly contributing to most of it is that America's health system per se has never had to cope with any semblance of a resource limit. As a result, we have a system which encourages the provision of a high volume of unnecessary or questionable medical services, we observe significant variations in physicians' practice patterns with no difference in patient outcomes, and new technology is substantially overused.

There are also many wonderful attributes of our country's health care system, and the recent recommendations to Congress by the Physician Payment Review Commission hold promise to start us on the road to recovery without detracting from the good.

The establishment of a resource-based relative value scale will correct a system which has overpriced and promoted an inappropriate volume of many surgical and technical procedures and undercompensated evaluation services.

The funding of effectiveness research and practice guidelines will help assure the delivery of quality, effective health care. Practice guidelines may not only serve to reduce unnecessary services but may also provide protection from malpractice liability for physicians who follow them.

The establishment of annual expenditure targets will help control, year over year, growth in spending for physician services. Particularly in the absence of effective practice guidelines, we believe this is a sound recommendation.

We must concern ourselves primarily, first and foremost, with paying a fair price for medically effective care, and we must not get talked into the concept that taking steps to eliminate unnecessary and ineffective care is tantamount to rationing. We should not fear rationing excess; instead, we should seek to eliminate it.

If adopted by Congress, these initiatives could help pave the way for the private sector to incorporate similar principles into their plans. While not solving all of the problems, they would represent constructive first steps.

Clearly, however, business, labor, government, hospitals, physicians, and consumer groups must quickly and in a focused manner work together to resolve what is truly a national crisis. Health care costs pose a major competitive hurdle for American business and represent a substantial drain on the resources of all Americans, and neither business nor American citizens can afford such waste if we hope to preserve our economic status and standard of living.

Thank you.

Senator ROCKEFELLER. Thank you, Mr. Maher.

[The prepared statement of Mr. Maher appears in the appendix.]

Senator ROCKEFELLER. Dr. Boyle, I want to ask a question that is in fact Senator Mitchell's question, that he asked me to pose to you.

As you know, a number of witnesses here today advocate the implementation of expenditure targets in conjunction with the development of physician practice guidelines, as a means to control the volume of physician services. ASIM is opposed to expenditure targets and advocates the use of practice guidelines alone to control volume.

In your testimony you state that a national policy to expand outcomes research and to develop and disseminate practice guidelines will result in the elimination of ineffective services, resulting in substantial savings to the Medicare system.

Do you believe that practice guidelines, which are voluntary in nature, will have significant effect in controlling the volume of physician services? That is his first question.

Do you believe the practice guidelines will have the same effect on physician behavior with regard to utilization of services as would a mandatory expenditure target, which is more punitive in its approach?

Dr. BOYLE. First of all, Senator, let me preface my remarks by making one comment, and that is: If we are to continue to provide that care which is needed by Medicare beneficiaries in this country, assuming that it is appropriate and assuming that it is being done in the most effective and economical fashion possible, then it would seem to us important that we build upon the strengths of

the system we have, without making enormous changes from which there may not be any retreat.

No matter how you look at expenditure targets, you at some point must limit service if you are going to reduce volume. It can't be any other way.

Senator ROCKEFELLER. Does that deny the possibility of unnecessary service?

Dr. BOYLE. No, no. Excuse me. You have got to reduce service, one way or the other.

We believe that the development of practice parameters appropriately applied, and we believe the technology is there today, can make certain that what we are doing is extracting from the system those services that are inappropriate or ineffective or are being provided in some inefficient or uneconomical fashion, without, at the same time, incurring the hazards of reducing services that are needed to some people at the same time.

We do believe that this can be accomplished without a mandate of expenditure targets, given what is at stake for the profession. I think that virtually every medical society, every medical specialty society, every State association, as well as the AMA, recognizes the importance of this and has all the incentives in the world to make it work.

The technology is now available. Dr. Mark Chasen, who is one of the associates of Dr. Bob Brook at Rand Corp. and UCLA, has now developed program software to allow people to go through an algorithm for certain procedures involving as many as three to four thousand different branches and come to an appropriate answer in a very short period of time.

It is possible to utilize the resources that would be provided in Senate Bill 702, to see to it that the Federal Government has a hand in assuring that priorities are identified, that the research is pursued in the most appropriate faction by those people who are best qualified to pursue that kind of research, to see to it that there is an evaluation of the results of this research and investigation into guidelines, and to be certain that they are translated into practical practice use by the medical profession, and have it reported back to the Congress as to its effectiveness.

We believe it can be done probably more practically, more usefully, more effectively, and certainly less intrusively than trying to develop the bureaucracy that would be involved in trying to implement what I listened to earlier today. I couldn't follow some of the reasoning of the administration or even the PPRC on expenditure targets.

Senator ROCKEFELLER. Let us say that the practice guidelines are attempted. What you are saying is, "We are going to do that as a matter of good faith, and we believe it will work."

No one, as I have said today and many times before, can any longer fool around with the fact that this 15-, 16-, 17-percent per year increase in Part B is allowable. The national security, in a sense, doesn't allow it—in the sense that it is coming to the point where it could bankrupt the system—and that there would indeed be, were that to be the case, a reaction within the Congress and within the administration which would be perhaps much more

severe than what is being contemplated by the administration today.

Now, you and Dr. Todd indicated that there will be good faith on the part of physicians and this can be dealt with, that we don't need expenditure targets, it is an intrusion—intrusion is philosophically unpleasant, it is practically unpleasant, and all of the rest of it. But if the good faith and practice guidelines alone are not successful in controlling volume significantly, would you not agree, as an American, that the Congress and the administration will have to reach for some further solution, approaching expenditure targets?

Dr. BOYLE. Senator, I believe that if efforts to reduce the use of inappropriate care cannot be accomplished in the fashion that we have outlined, then, yes, certainly the Congress has to accept that responsibility, and I believe that the American people would certainly support that.

To put things in proper context, we are talking——

Senator ROCKEFELLER. And would you?

Dr. BOYLE. Of course.

We are talking about 7 percent, not 16 percent, in that I gather there is a part of this that I can't control, and I don't think anybody else can. People are going to continue to get older and there are more of them. Those things we can't do anything about.

I think that we have to accept a commitment to see to it that we don't reach the point that they have in some countries, where they have explicit rationing of services to people by age, or social worth, or some other measure. Those things go on today, and we know that. We have to be convinced that we can avoid this in this country. If I weren't convinced, I wouldn't be sitting here, because I would be doing something that was more productive or useful to myself.

Senator ROCKEFELLER. What makes you so certain that practice guidelines and voluntary doctor self-restraint on a national basis is going to happen?

Dr. BOYLE. I don't believe that the physicians in Los Angeles, or in West Virginia, or in Galax, VA, are any different than they are in Maine. I don't think that physicians from one community to the other are so different in their professional goals and objectives in dealing with patient problems that they will be incapable of accepting the same kind of guidance that has in fact demonstrated that you can reduce or change physician practice patterns when it is demonstrated to a physician that what he or she is doing is inappropriate.

From my own personal experience, I can observe that there are some people who are absolutely recalcitrant. They are either recalcitrant because they refuse to conform to what is good medicine, or because somehow or another it never gets through, there is something that keeps it from happening. For those physicians, then we will need some means of making certain that their behavior does conform, and we may be back at some point to you saying, "You are going to have to give us some assistance," with the Justice Department or the Federal Trade Commission, or somebody else,"" in order to allow that to happen.

Senator ROCKEFELLER. Mr. Maher, do you share Dr. Boyle's confidence?

Mr. MAHER. I have to say that I don't, Senator. While I believe very much in practice guidelines, I think the reality is we are running up against 11 percent of the GNP which would like to be 15 percent of the GNP, and there is going to be, frankly, an instinctive rejection of being 9 percent of the GNP.

I look at the extreme gulf between the level of health service usage and cost in this country and anywhere else. I took particular note of Dr. Detsky's comment, that only in the 29th year of the Canadian hospital system and the 19th year of the physician system were they are starting to feel a little pinch.

I, frankly, think that the principle benefit of the expenditure targets would really be to put the heat on the profession to develop and put in place and use effective practice guidelines to rid our system of the cost associated with questionable and ineffective health services.

Senator ROCKEFELLER. In a sense it is like in trade, which your company cares about a lot, a 301 action; well, it is like maybe a Super-301 action. You are not saying that the doctors shouldn't participate in deciding how they should discipline themselves with respect to unnecessary procedures or expenditures or the cost to the Medicare system; you are saying that it would be desirable if they would do that.

Mr. MAHER. Very much so.

Senator ROCKEFELLER. But that you think they would have the same opportunity under an expenditure targets system to do that as they would under voluntary practice guidelines, but that there would be the national certainty involved in terms of rising costs.

Mr. MAHER. Expenditure target would hasten action, I think, on, first, getting the organization. We have heard a lot of discussion this morning on, "Gee, can the physician community get together and organize and sort things out?" You had better believe it. If we had, in effect, a national will that, "Here. This is what we think is a good-faith expenditure target. Now let us go at it," we have fair confidence that it is do-able, given the current excesses apparent in our system. And as Dr. Boyle just mentioned, the technology is there, albeit on a relatively small number of procedures, but it is there in the work that came out of HCFA-funded research at Rand and the UCLA Medical Center.

So, the tools are there to get this going. But in terms of would we get there as quickly as this country needs to get there, on a trust-me, voluntary basis, I frankly don't think so.

Senator ROCKEFELLER. Do you think that expenditure targets would lead to rationing?

Mr. MAHER. First off, I don't think I would have to worry about that for a long, long time, because, again, of the excesses in the current system. They would only—only—lead to rationing to the extent that there was a national will not to pay for it.

I mean, I liken this, frankly—not a perfect analogy, but to a defense budget. You know, we establish a budget; it is up to the generals and the admirals and the private-sector defense industry to preserve our shores. If all of a sudden there is a national calamity, there is a political will to raise the money to pay for it. And if

there is not the political will, it doesn't get paid for. It would come down to whether there is a political will to pay for an epidemic that may exceed some target. I sense that this country's values are such that it would spend the money to pay for appropriate health services.

Senator ROCKEFELLER. Do you think that there is a tendency of doctors—we understand that there is balance-billing.

Incidentally, I would make this very clear, which I have not in this hearing at all: I have nothing but reverence for doctors and reverence for hospitals, so I bring no baggage or bashing instincts in me at all. I am terrified at what is happening to our costs and to the fact that on a national deficit, although people always list it as of their greatest concern in polls, fundamentally, people really don't; what people are really saying is that, "Yes, we think it is a big problem, but don't let it mess around with our lives."

So, in a sense, the only people who really worry about the national deficit are the Federal Reserve and Congress. Everybody else talks about worrying about it; but, since they have business to accomplish and things to do, and programs to enact, et cetera, with services to receive, it isn't ultimately something that they have to worry about. It is sort of called "our job."

The DOD analogy is an interesting one, because that is the security of a nation, and the President takes an oath to defend the Constitution, defend the shores, all of this. Doctors take an oath that they have to provide service. Oaths—Hippocratic oaths, constitutional oaths. And there is a parallel between those.

Dr. Todd says that he can't, as a matter of moral conscience—he didn't use those words—accept expenditure targets, because in a sense he is acting on his Hippocratic oath; he believes that he will have to deny service. I would not impugn him by saying that he is worried about the salaries of doctors; he was talking about denial of service.

Well, the same thing is true with defense. You know, the Russians may or may not be less threatening, but there certainly was a time when they were. There has not been an increase in the defense budget in this country for the past 5 years. In fact, it is down. The defense of the Nation, the obligation of the President, is still there. But there was a decision made that there had to be an expenditure target, and it has been met and there has been no concern, rabid concern, before about insufficient defense.

I am taking this on a little bit long; but isn't there a parallel there? In other words, the Hippocratic oath is significant, but also, in that there is government money involved, and that doctors in many places make a majority of their money off of Medicare-Medicaid, and that the Hippocratic oath at some point has to understand that there is public taxpayer policy involved.

I am obviously beating you with a softball, but——

Mr. MAHER. Well, I agree with that; but also, the way these targets are proposed by the PPRC, to the extent that in honoring the Hippocratic Oath, because, let us say, the AIDS situation gets exacerbated beyond what people contemplate, and therefore expenditures and services are greater than contemplated in the target, and then we go to establish—the way it works is, there is no earthly reason for the deprivation of a service in that particular year.

Now, the question is, if we are going to establish the update for next year, those practical considerations are taken into account in deciding whether or not that was an abuse of the process, or indeed just an honoring of the need to provide truly effective services when they are needed.

Senator ROCKEFELLER. Mr. Bryant, do physicians in Pennsylvania object to your profiling a utilization review program?

Mr. BRYANT. Those that get the letters object.

Senator ROCKEFELLER. All right.

Mr. BRYANT. It is important to note here that the process we follow does not involve a sanction; it merely advises the physician that, compared to that physician's peers, that physician is exceeding the norm of practice.

Senator ROCKEFELLER. And what behavioral pattern follows that?

Mr. BRYANT. We have found, after the letter is sent, that you can track, in most instances, a rather dramatic change in behavior. We have done that with several specialties and have noted substantial change in patterns of practice as a result.

Senator ROCKEFELLER. And what are those changes? You are saying that there is a reduction in services rendered?

Mr. BRYANT. For example, if there is an identified problem in the referral for diagnostic services of a particular type for too many patients that exceed the norm—and the range is rather extensive. I think the regression analysis is like two standard deviations from the norm. So it is a rather large deviation from what the services the physician's peers ordinarily render. The physician, then, ordinarily would diminish the number of referrals for those diagnostic services.

Senator ROCKEFELLER. What percentage of doctors in Pennsylvania have received that letter?

Mr. BRYANT. In this year we sent out about 2,200 letters to Pennsylvania physicians, of which there are 19,000 practicing physicians in Pennsylvania. It is a very small percentage.

Senator ROCKEFELLER. You testified that these very specialized reviews are in depth, but that last year you focused on only five procedures.

Mr. BRYANT. Yes.

Senator ROCKEFELLER. Is it possible to do this type of profiling with that small a sample?

Mr. BRYANT. It is budget-driven. You take the available money you have, and then you focus on the areas that are most difficult.

The physician profiling is a very inexpensive process. You program your computer to run comparisons of physicians, based on the norms that you establish, and the letters are printed automatically. So, that really doesn't require a great deal of manual intervention.

Senator ROCKEFELLER. You are a former HCFA Regional Administrator.

Mr. BRYANT. I am.

Senator ROCKEFELLER. You were.

Mr. BRYANT. I were. I was. [Laughter.]

Senator ROCKEFELLER. Based on your experience in that capacity, do you think this type of review should be used regularly in the

Medicare program? And are there any pitfalls as you look at it being applied potentially on a national level?

Mr. BRYANT. No. Frankly, given the dilemma of the administrative budget, and the fact that practice guidelines, I think, are difficult and a long-time coming, it is probably the least expensive and, I think, potentially the most effective device on a post-payment basis that we can utilize.

Senator ROCKEFELLER. How many Blue Cross/Blue Shield systems use the profiling system that you have discussed?

Mr. BRYANT. The system that we use, we developed, and it is not a required process. I am not aware of any other Blue Cross/Blue Shield plans that use this.

Senator ROCKEFELLER. So, the answer is none?

Mr. BRYANT. The answer is no, to my knowledge.

Senator ROCKEFELLER. Dr. Soper, it would occur to me that an HMO in some ways is a definition of an expenditure target, in motion, constant.

Dr. SOPER. Conceptually, I guess HMO's do work under an expenditure target, in a sense; because when we look to the coming year and need to determine a prospective price, a premium, we need to project what our costs will be and do so by projecting expectations regarding utilization, unit costs to build the budget, and then establish the revenues in the form of premium pricing and copayments to meet those costs. So, we are working under a budget, in that sense, yes.

Senator ROCKEFELLER. Is that a bad thing?

Dr. SOPER. No. I think it is a part of the a prepayment approach. Obviously, sometimes your projections on costs fall a little bit shy of what they really are. If that weren't true, HMO's would never lose money, and we know that they do from time to time. But I think it is a part of the managed care process, to project what your costs will be, and develop a budget, and go forward with that to determine your necessary revenues.

Senator ROCKEFELLER. And if you exceed those on a continuing basis, you go broke.

Dr. SOPER. Yes. But I think it is a little bit different, in that we look at what the benefit package is, price out what it costs to do that, and from that budget build the necessary process. It is not the situation where someone says, "You have only this much money, and you are obligated to provide these many benefits; and now, somehow, squeeze it out in between." The budget is built by looking at our expectations from the benefits that are determined. In that sense, it sounds a little bit different, although similar in some ways, yes.

Senator ROCKEFELLER. And I don't want to force the comparison on you, it just occurs to me.

Do you have the confidence, as Dr. Boyle does, that practice guidelines would result in sufficient discipline to bring a better result on Part B expenditure growth?

Dr. SOPER. I think that "sufficient" needs a lot to be met. I do think practice guidelines are helpful, that if done correctly, if the guidelines are developed in a scientific manner that is credible to physicians, and they are used in a correct manner, for educating physicians, and are well-communicated, I do believe that physicians

would change their practice to come into compliance with credible guidelines without incentive coercions.

But I think the difficulty is having a working relationship with physicians to disseminate such guidelines. HMO's do have that type of relationship; and effective guidelines that were developed, we could use very powerfully. I think some difficulty is in developing those guidelines, because, in many cases, we just don't have enough scientific knowledge to know where in that range of acceptable behavior the best practice is. It could be low; it could be high.

I think, in the long run, if we look at practice guidelines, and do so in a scientific manner, for every time we find that the best practice is a guideline that lowers utilization, and we can disseminate that, we will find cases where the best practice is actually a guideline that is in the higher range of current variations, and that would increase costs. But it would improve the accuracy with which medicine is practiced.

Senator ROCKEFELLER. In your HMO industry, have there been problems with quality of care or dissatisfaction on the part of patients that have resulted from these incentive arrangements, restraint arrangements?

Dr. SOPER. No. That has not been seen. And as I mentioned, it has been specifically looked for. Since the effective date of the prohibition of incentive payments was postponed, during that time, both the PPRC and the GAO conducted studies looking to see the nature of incentive payments in HMO's and if there is any relationship with those two—quality of care, particularly—and they found no evidence that it had an adverse effect on quality of care.

Senator ROCKEFELLER. I would assume HMO physicians make less money than others practicing outside the system. Am I wrong?

Dr. SOPER. I don't think that is a safe assumption. I think that it varies. Obviously they are not going to make as much as the doctors making the most money out there; but neither are they going to be making as little as the doctor who is struggling out there.

Senator ROCKEFELLER. HMO doctors are satisfied?

Dr. SOPER. Yes. By and large, the HMO industry is meeting its requirements for recruiting physicians into either IPA models, where the relationship is that of an independent contractor, or into staff or group models, where it is more of a partnership or an employee relationship. In order to meet our recruitment objectives, though, for physicians, we do need to stay competitive with salary and benefits and the other aspects that that type of practice can offer to a physician.

Senator ROCKEFELLER. A final question: Do HMO's employ medical practice guidelines or parameters to help physicians decide when a service or test is needed?

Dr. SOPER. Yes, HMO's do. I think the guidelines in HMO's traditionally are strongest in the area regarding the appropriateness of setting—does this patient need to have this procedure done in the hospital? And if so, how long do they need to stay there? So, these guidelines have been a part of how HMO's have decreased hospital utilization.

As far as guidelines for the appropriateness of a procedure, HMO's are working in this area; but, in a way, developing the

guidelines requires resources, medical institutions, research knowledge that exceeds the capacity of the HMO industry by itself.

Informal guidelines develop in any group of physicians when you give them feedback data, so they can compare how they are practicing compared to their peers within that group. Out of that type of data, discussions take place, and you see something of a narrower range of consensus as to what appropriate behavior is. In that sort of informal sense, guidelines do develop in group practice in any setting. But those guidelines are guidelines; they are not restrictions or mandates, and they show a high degree of variability from locality to locality, in keeping with the variation that exists in the practice in various medical communities.

Just one final question, for anybody who wants to answer it:

There is this thing called the budget deficit, and the budget deficit affects interest rates, which affect doctors, hospitals, and everybody else in the purchasing of anything from homes to whatever.

As Medicare expenses rise, and since beneficiaries—witness the catastrophic health care experience—are not wild about footing the bill, and in that nobody contemplates that they are going to, these monies have to come from general revenues.

The reason that Senator Bentsen had to leave this morning early was he was going to a Commerce Committee hearing where they were discussing NASA. The Russians have a space station up. The chances of our being able to put a space station up will relate directly to the budget deficit.

A lot of people say that some of the work being done by the University of Alabama in electrophoresis—in other words, cancer research, and zero gravity, way, way up in the sky—that the cure for cancer may be up there, that the cure for diabetes may in fact be found up there in something called a "space program," which depends on general revenues.

So, everything intersects with everything else, ultimately, in this country; and therefore, you know, here we are in this discussion about containment of costs on Medicare, in its Part B is growing too fast.

You know, we are Congress people, and you are industrialists and physicians; so everybody gets into their little box—"I have got to pin you down; I have got to find a surreptitious motive in the American Medical Society or from Dr. Boyle." In other words, we are sparring, and perhaps we are all missing the point, that any cost restraint which can be accomplished is so inordinately in the national interest, and in fact within your own interests as physicians, those of you who are—for example, depending on the cure for cancer, the cure for diabetes, et cetera—that there is kind of a national obligation which is the opposite of the credit-card mentality that we have been living off for the last 20 years, that we all have to give something up, and that we never get what it is that we want, regardless of the oaths that we take; that is, symbolic oaths.

Does anybody find objection with that suggestion of what I have just said?

Dr. Boyle?

Dr. BOYLE. Not necessarily an objection, Mr. Chairman, but some observations:

I would hope you would expect that the oath the medical profession took, to care for people, had nothing to do with what gain there might be to the individual physician, or to the profession as a whole. At least, that is what I believe it ought to have been in the first place. I tried to practice that way for all of my life until I took this job.

I might also add one other parenthetical remark, and that is, I am not bleeding all over the rug about some poor doctors that are going to have to park cars in order to make a living. But I am concerned, in this process, since the Congress decided 25-plus years ago that it would be responsible to pay for the care of people past the age of 65, people who are disabled and people with ESRD, that the Congress now has to take very seriously the responsibility that says, "We are going to ask you, on behalf of the people whom you are pledged to serve, to make choices between which people may receive what services, under what circumstances, when they need it." That is a very difficult question to ask.

There is no question about the fact that for old people and people who are poor in this country, who look to Federal programs, their health care is in severe competition with roads, and education, and defense, paying the interest on the national debt—all of those things that are facts of life in the budget. On the other hand, the people that we are dealing with are very, very singular individuals, who may need to have angioplasty done, or who may need to have an appendectomy, or may need to have care for diabetes or chronic rheumatoid arthritis, or whatever those things are, all of which are going to require resources.

Our responsibility, collectively as a profession and individually as doctors, is to see to it that as a profession we are doing what is right for those people, that we are accepting our responsibilities as citizens to not be wasteful, to not be doing things that are inefficient or inappropriate; but, at the same time, we have to maintain a constant commitment to the micro part of the system, which is the patient who is going to be affected in the long run.

Mr. MAHER. Senator Rockefeller?

Senator ROCKEFELLER. Yes, Mr. Maher.

Mr. MAHER. I must concur. Were I you, I think I would have the same frustrations that private sector bill-payers pay when, as you have to cope with this deficit issue, you hear what we hear. I suspect that if you would have posed the question to every single physician who was on the panel here today, they would readily concur regarding the existence of unnecessary services and expenditures in health care—all kinds of villains, malpractice, and all of this; but everyone concurs that there are unnecessary services and costs out there. And you have the deficit.

That is why I say there is no need to deprive people of necessary health services in order to accomplish, in effect, the transfer of dollars to help lower the deficit.

So, I guess I concur very much with your observation. I think we have the workings of a proposal here for the country's largest health benefit plan in the PPRC recommendations.

Senator ROCKEFELLER. Gentlemen, I thank you all.

I would note, for no particular reason, that all of our witnesses this morning were men. But nevertheless, you have all been helpful, and we appreciate your patience. [Laughter.]

[Whereupon, at 1:40 p.m., the hearing was concluded.]

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APPENDIX

ALPHABETICAL LISTING AND MATERIAL SUBMITTED

PREPARED STATEMENT OF JOSEPH F. BOYLE

OVERVIEW

My name is Joseph F. Boyle, MD, executive vice president of the American Society of Internal Medicine (ASIM), With me is James G. Nuckolls, MD, an internist in private practice in Galax, Virginia and President of ASIM.

ASIM appreciates the opportunity to share with you our views on what can be done by policymakers to address the increasing number of services provided to Medicare patients. As this committee is well aware, the number of services provided to each enrollee in the Medicare program is estimated to have increased at a rate of 7 percent annually. Surgical and diagnostic procedures are primarily responsible for the overall increase in volume, with surgical procedures particularly those done on an outpatient basis—increasing 35 percent from 1983-1986, according to studies conducted for the Physician Payment Review Commission (PPRC). Similarly, radiological testing has increased 37 percent over the same period of time and non-surgical tests have increased 67 percent. The number of medical visits increased only 18 percent over the same four years. The most recent figures from the Treasury Department suggest the the rate of increase in the volume of services may be moderating somewhat, but it is not known whether this is a permanent shift or a temporary aberration.

In fact, what is striking about all this is how much we don't know. We don't know why volume is increasing, how much of the increase reflects advances in technology that benefit patient care, compared to ineffective or unnecessary services, how much is due to the effects of the prospective pricing system, the growing number of older and frailer beneficiaries, defensive medicine, an undue emphasis on technological services in the medical education system, or other factors. Theories abound on the reasons for the volume increase, and a few limited studies have been conducted to try to find out why. But until we know more, it seems only prudent that we proceed cautiously in attempting to control the volume of services.

ASIM understands, however, why Congress' is viewing this situation with considerable urgency. Faced with continued cost increases—fueled in large part by increases in volume—Congress is faced with a limited number of unpopular choices. You can raise taxes to support higher program costs, knowing that this would be opposed by many voters and that it would do nothing about the reasons for increased expenditures. You can continue to increase the premiums charged to beneficiaries. But this too would be unpopular with the voters and do nothing to slow expenditures. You can continue to increase the share of tile federal treasury going to Medicare, thus exacerbating the federal deficit and leaving less money available for other national needs. You can continue to cut fees paid to physicians, even though this undermines physician support for the program and may result in reduced access to services. You can mandate that carriers deny reimbursement for more and more services, which only further lessens physician and beneficiary confidence in the medical review process. Or you can implicitly or explicitly limit the benefits available to beneficiaries, either through expenditure targets or direct restrictions on what services Medicare patients can receive.

But there is another alternative that offers the promise of controlling the volume of ineffective services provided to Medicare patients. That alternative is for the Congress and the medical profession to make a strong commitment to developing the scientific basis—and the means—for evaluating the effectiveness of different services. A national policy to expand outcomes research and to develop practice guide-

lines, ASIM believes, will help assure that the Medicare program pays only for services that are likely to be effective in diagnosing for treating a particular patient's medical condition. By eliminating ineffective services, substantial savings to the Medicare program are likely to accrue.

ASIM is pleased that there are a number of bills being considered by the Congress that together provide a framework for establishing a national policy on effectiveness research and practice guidelines. The Patient Outcomes Research Bill, S. 702 introduced by Senator Mitchell, represents an important. and commendable initiative in this area. The bill builds on the positive experience that the state of Maine has had with the Maine Medical Assessment Foundation, which has taken a leadership role in conducting patient outcomes research, providing information to physicians to improve the quality of care that they provide patients, and encouraging patient involvement in medical decisions. The Mitchell bill would establish a strong federal role in facilitating, guiding, and funding outcomes research and guideline development in the private sector. The bill's emphasis on outcomes research is particularly important and appropriate, since such research holds the promise of providing the data needed to improve quality and reduce the costs of care.

Like the Health Care Research and Policy Act of 1989 introduced in the House of Representatives by Rep. Henry Waxman, it would do so without authorizing the Secretary of Health and Human Services to actually develop guidelines. ASIM strongly believes that in order to have credibility with physicians, the development of practice guidelines must be done by the medical profession, not the government. Consequently, we believe that the Mitchell approach is far preferable to provisions in bills introduced by Reps. Stark and Gradison that would authorize development of guidelines by HHS. More detailed comments on the Mitchell bill are presented later in this statement. We strongly encourage this committee to work with the sponsors of similar proposals in the House on developing a common legislative approach to this issue.

Although most members of Congress do not argue with the need to develop practice guidelines, there appears to be skepticism that guidelines themselves represent a viable solution to the volume problem. This skepticism seems to stem from three related concerns:

1. Unless Congress enacts expenditure targets, physicians won't be sufficiently "stimulated" to develop guidelines. This is the view of the Physician Payment Review Commission.
2. Guidelines can't be developed in time to help with Medicare's budget problems.
3. There is no assurance that physicians will change their practice patterns once guidelines are available.

Let us briefly comment on each concern.

Will the medical profession be committed to guideline development in the absence of expenditure targets? The answer, ASIM believes, is unequivocally "yes." We cannot expect our patients and you, their representatives, to have confidence in our profession unless we are able to show that what we do works, given the best scientific evidence that is available today. Outcomes research and practice guidelines offer us the means to evaluate the effectiveness of what we do for our patients, and by doing so, maintain public trust and confidence.

We also know that Congress will hold us accountable. If we do not show an adequate commitment to guideline development, we know that Congress can always mandate fee reductions, more intrusive carrier review, or other less acceptable approaches in order to cut costs. We also know that Congress can always revisit the concept of expenditure targets. But we ask that you first give practice guidelines a chance.

In other words, physicians will support the development of practice guidelines not only because it is in the public interest, but it is in our interest as well. ASIM believes that the medical profession has only a small window of opportunity to demonstrate to policymakers that we are willing and capable of objectively assessing the effectiveness of the services that we provide. If we fail to do so, then we will have no one to blame but ourselves if Congress decides that expenditure targets, or other draconian measures, are required to get volume and costs under control.

Can guidelines be developed in a timely manner? Again, the answer is yes. With an adequate commitment of federal support and funding, as mandated by the Mitchell bill, efforts to develop practice guidelines can be significantly expanded. By developing guidelines first for high volume procedures where a consensus on appropriateness may be more readily attained, it is reasonable to expect that workable guidelines can be available within the next few years, if not sooner. Since savings from expenditure targets also would not accrue for two or three years, at the earli-

est, practice guidelines can be developed—and begin having an impact—within the same time frame.

Will physicians change their practice patterns? Yes, if the guidelines are done by professional groups that have credibility with the medical profession and are accompanied by aggressive programs of peer review and education. Most of the so-called "unnecessary" services being provided today reflect uncertainty on the effectiveness of different services and procedures. Guidelines will help reduce that uncertainty and make it possible for physicians to feel more confident that by not ordering a certain test or procedure, they will not be adversely affecting patient outcomes, even though this may be contrary to what they originally learned in medical school.

Physicians also recognize that practice guidelines can and will be used by payors in making payment determinations. The possibility of future payment denials based on practice guidelines will always be there if educational efforts by themselves are insufficient. For physicians, the important thing is that when guidelines are used by payors, there still be an opportunity for physicians to exercise judgment and deviate from the guidelines for good reason—and that physicians who properly exercise professional judgment on behalf of their patients are not labeled as providing "inappropriate" or "substandard" care.

For all these reasons, ASIM strongly urges Congress to establish a national policy on effectiveness research and practice guidelines, building on S. 702 and similar approaches being considered by the House of Representatives. For the reasons discussed below, however, we urge you not to support proposals for national expenditure targets.

EXPENDITURE TARGETS: A PRESCRIPTION FOR RATIONING

As the committee is aware, the Physician Payment Review Commission has recommended enactment of a program to establish a national expenditure target. The purpose of the expenditure target approach is to limit services provided to Medicare beneficiaries. As such, it must be recognized as a form of rationing. According to the dictionary, "ration" means to restrict to limited amounts. The Commission acknowledged in its March 1988 report to Congress that "the intent of expenditure targets is to make explicit to physicians the limits of the resources society has decided to make available for health care . . ."

Presumably, the Commission intends for only "unnecessary" or "ineffective" services to be eliminated. Given the lack of data and consensus on the effectiveness of different medical services and procedures—and the inherent contradiction in attempting to set a limit on overall expenditures without any public consensus of how much *should* be spent on medical care—it takes a large and unjustified leap of faith to presume that only "waste" will be cut from the system.

Put into individual terms, expenditure targets can only work if individual doctors decline to provide certain services to their patients that they otherwise would have provided. *Without a scientific basis for making such a determination, however, it is just as likely that "effective" as "ineffective" services will be denied, particularly in grey areas where there is no clear consensus on what is the best way of treating a particular problem.* Consequently, it is the patient, not the physician, that is at risk under the expenditure target concept. This distorts the physician's traditional role as advocate of his or her patient, by placing the physician in the position of limiting services to patients in order to meet predetermined targets established by the federal government. It also means that an individual physician who practices a conservative style of medicine would still be financially penalized if overall expenditures exceed the expenditure target limit.

SPECIFIC COMMENTS ON THE PATIENT OUTCOMES RESEARCH BILL

ASIM believes that the "Patient Outcomes Assessment Act of 1989" sets the stage for improved care through funding for research, dissemination of findings, and development of practice guidelines. Since developing guidelines is the best long term approach to reducing the volume of ineffective services, and since large gaps remain in our knowledge about the effectiveness of medical services in terms of outcomes, there needs to be a substantial, coordinated effort by the public and private sectors to determine what comprises high quality, cost effective care.

We believe that the federal government's role should be to act as a catalyst for this research and to provide guidance on how such research should be conducted. Although the federal government should contribute funds to these research projects, the research should be done by entities that have credibility with the physician community. We commend Senator Mitchell for including provisions in the bill which state that the Secretary, acting through the Assistant Secretary of Health,

should oversee the development of practice guidelines, by providing funding to medical organizations and other entities to actually develop the guidelines. But we also suggest that S. 703 direct the Assistant Secretary of Health to specifically provide funding for outcomes research to entities such as representative medical organizations, universities equipped to do this kind of research, private, non-profit research organizations, and other public entities.

ASIM also recommends that the language in Section 1875A concerning the appointment of members to the Independent Advisory Committee on Managing Patient Outcomes be clarified to specifically require consultation with medical specialty societies in identifying potential nominees. In addition, Section 1875A should include language to provide for consultation with the medical specialty societies when setting research priorities with respect to specific medical conditions and treatments to be studied.

ASIM agrees with the provisions of the bill which give explicit direction to the Assistant Secretary to give immediate attention to researching and developing practice guidelines for "high volume" services reimbursed under the Medicare program, since that would be the easiest area to initially devise clinically sound guidelines and could provide significant savings if practice patterns were corrected. For instance, each year Medicare spends over $300 million on coronary bypass operations. If just 10 percent of these procedures are ineffective and were corrected or detected through the use of guidelines, Medicare could save more than $30 million.

Knowledge gained from creating procedure guidelines should be used later for developing more complex and difficult "patient problem" guidelines. Information accumulated through the use of the guidelines also should be used to determine the efficacy of indications that initially are considered equivocal.

ASIM strongly supports the provisions of the bill which require the Assistant Secretary to ensure when overseeing guideline development (1) the continued ability of physicians to exercise judgment to deviate for good cause from the protocol in a given case; and (2) a commitment to continually reevaluate the data base and the resultant protocols, to keep pace with medical innovation.

As the committee is aware, the chairman of the Energy and Commerce Subcommittee on Health and the Environment introduced legislation this week to facilitate and promote outcomes assessment research and the development of guidelines. ASIM has been working with the bill's sponsors, and believes the legislation represents a sound approach to promoting outcomes assessment research and guidelines development. We urge this Committee to work with the sponsors of this bill to develop a consistent statutory approach on this important issue.

CONCLUSION

In conclusion, ASIM strongly urges the committee to adopt a national policy to promote outcomes research and practice guidelines, building on the Patients Outcomes Research Bill and other similar proposals being considered by Congress, in lieu of mandating expenditure targets. Expenditure targets are not needed to stimulate the medical profession to develop guidelines; physicians will support practice guidelines not only because it is in the public interest, but in the interest of our own profession as well. Guidelines can be developed in a timely enough manner to begin having an impact on expenditures within the same time frame contemplated by expenditure target proposals. With aggressive peer review and educational efforts, coupled with appropriate use of guidelines in making payment determinations, physicians will modify their practice patterns based on those guidelines. Establishment of a federal office to coordinate, advise, and fund guideline development will provide the resources, expertise, and leadership needed to move aggressively on guideline development.

We also urge the committee to enact a fee schedule based on a resource based relative value scale (RBRVS). ASIM believes that an RBRVS fee schedule, while not by itself solving the volume problem, is an essential component of a comprehensive approach to this issue. It is inconsistent on one hand to ask physicians to practice more conservatively—as practice guidelines would do—while on the other hand maintaining a distorted pricing system that penalizes those who are more selective in their use of technological services. An RBRVS fee schedule would also make it possible for physicians to spend sufficient time with patients explaining, based on the relevant practice guideline and the physician's own judgment, why a certain diagnostic test or procedure is not needed. A national policy on practice guidelines,

coupled with implementation of an RBRVS fee schedule, would provide a viable, practical, comprehensive and workable strategy for controlling the volume of ineffective services—without the dangers to access and quality inherent in proposals for expenditure targets.

We'd be pleased to answer any questions from the committee.

PREPARED STATEMENT OF EVERETT F. BRYANT

Mr. Chairman and members of the Subcommittee, I am Everett F. Bryant, Senior Vice President, Government Business, of Pennsylvania Blue Shield. I appreciate this opportunity to testify today to discuss Pennsylvania Blue Shield's role as a Medicare carrier and our activities to assure Medicare payments are made only for appropriate and necessary services.

Pennsylvania Blue Shield has participated in Medicare under contracts with the Health Care Financing Administration (HCFA) since the program's inception in 1966. Today, we are the carrier in three states—Pennsylvania, New Jersey and Delaware—and the District of Columbia. As the carrier in these areas, we are responsible for much of the day-to-day administration of the Medicare Part B program. This includes processing about 47 million claims (10 percent of all Part B claims) for health care services promptly and accurately; answering calls and letters from beneficiaries, physicians and other Part B providers; performing medical reviews of claims to determine whether services are medically necessary; assuring Medicare is the secondary payer whenever appropriate; and implementing the new Medicare catastrophic legislation.

I will focus my comments on the medical review activities we conduct to protect the fiscal integrity of the Part B trust fund and to constrain the rising costs of the Medicare program.

Few government expenditures produce the documented, tangible savings of taxpayers' dollars generated by these activities. In FY 1988, we spent $4 million for medical and utilization review activities. These activities produced savings of $42 million, a return of approximately $11 for each $1 spent.

These are *hard* savings of Medicare Trust Fund dollars by anyone's definition. We and HCFA have management information systems that accumulate and report these data on a monthly basis. These savings are subject to verification by outside auditors at least once each year. Ironically, these hard-earned savings are never scored in the budget process as offsets to total Medicare Part B benefit expenditures. We believe this situation should be corrected so that budget scoring decisions properly credit congressional efforts to invest in prudent stewardship of the $45 billion Medicare Part B program.

In addition to producing documented, quantifiable savings, medical review activity also saves a large amount of benefit payments through the deterrent: effect of providers knowing their claims will be subject to review. This deterrent effect, coupled with the review findings, also serves to lower beneficiary liability for overbilled or inappropriate services.

At Pennsylvania Blue Shield, we have had a long-standing constructive relationship with the physician community. This relationship has enhanced Pennsylvania Blue Shield's reputation as a leader in the development of current sound medical policy guidelines which, in addition to addressing hundreds of medical issues including diagnostic and therapeutic procedures, is also viewed by the medical community as being fair and equitable in its application. Physicians are closely integrated into the medical policy process. To ensure as broad a perspective as possible, physicians from whom Pennsylvania Blue Shield seeks advice and counsel represent not only all specialties of medicine, but also the academic community as well as the clinical practice communities.

These medical consultants numbering nearly 400 within our service area are selected in concert with the representative state medical societies and their component subspecialty societies. Proposed medical policy representing a cooperative and collaborative effort on the part of Pennsylvania Blue Shield and its medical consultants is submitted to an oversight committee, the Medical Affairs Committee, which is a deliberative body consisting of practitioners from various specialties. An assiduous effort is made to present to the Medical Affairs Committee the collated data from the medical consultants for a fair and accurate deliberation of the merits of any proposed policy.

In addition, Pennsylvania Blue Shield's Medicare efforts are strengthened by the assimilation into the process of eight employed medical directors who not only have the opportunity to comment on the development of a medical policy, but are also

responsible for the implementation of that policy once approved. This process is a thorough endeavor which would enhance physician participation while at the same time acknowledging current state-of-the-art medical therapy practice. The ultimate benefit from such a process is to assure that the beneficiaries served by Pennsylvania Blue Shield receive the best possible medical care provided in a most cost-effective manner while disallowing reimbursement for those services which are not medically necessary or appropriate.

Medical review activities are grouped into two major areas, prepayment review and postpayment audits:

PREPAYMENT REVIEW

All carriers screen claims before payment to detect potential utilization problems such as unnecessarily intense or frequent care. Claims may be suspended by our computer screens for more thorough investigation and for review of medical necessity. These screens are based primarily on specific procedures, frequency of services, and physician-specific data accumulated from our history of previously processed services.

There are misconceptions about the use of computer screens. Carriers use such screens as a cost-effective tool to determine which services should be reviewed. There are no automatic denials. Services that do not pass our screens are suspended for individual consideration.

In Pennsylvania Blue Shield, there are several levels of prepayment review with the highest level of review performed by our physician staff. Physicians typically review the more complex, questionable cases or those appealed on the basis of payment denial which could not be resolved at other levels. We, as well as all other Medicare intermediaries and carriers, are evaluated on the accuracy and effectiveness of the medical review process through HCFA's Contractor Performance Evaluation Program.

In FY 1988, HCFA required all carriers to use 16 national screens. An example of these screens includes the requirement that carriers review more than 30 visits to the same patient by a physician in a hospital setting in a month.

In addition, carriers are allowed to set their own screens to focus on problems a carrier has identified in its service area. In FY 1988, our Plan used 61 additional carrier initiated screens. Examples of these screens include:

- *Seat Lift Chairs:* Since 1986, we had a screen for all seat lift chairs. All bills for these chairs are manually reviewed for medical necessity and to assure the device was specifically ordered by the physician. In many instances, we also contact the beneficiary to make sure the seat lift chair was necessary and met the coverage criteria provided by HCFA.
- *Ambulance Services:* Our Plan also screens all repetitive ambulance transportation services. For example, we have found inappropriate use of ambulance services by some dialysis and physical therapy patients who use these services more as a convenience than for emergency transportation. This type of service is not allowed under the Medicare regulations.
- *Extended hospital visits:* We review all claims that exceed six extended physician visits while a patient is hospitalized. While these may be appropriate, we have found this can indicate excessive volume. Our staff will review documentation of medical necessity to assure these services were necessary.

Our Plan was one of the carriers HCFA contacted last year for innovative ideas in developing medical review screening tools. Many of our own carrier-initiated screens have been reviewed by HCFA to establish national screens that are now required by all contractors. In FY 1988, we spent $2.6 million on prepayment medical review activities, which in turn saved $37 million in benefit dollars—a return ratio of $14 for every $1 spent.

POSTPAYMENT REVIEW

Postpayment review is intended to monitor the Medicare claims experience of all providers and services in a region. We focus on high dollar and frequently performed services. Aggregated data is subjected to statistical analysis in order to identify physicians or suppliers whose utilization patterns differ substantially from their peers. By profiling physician and supplier services, we can identify patterns of overutilization, misutilization, excessive testing and fraud and abuse. Examples of provider profiles include: the type of office visit (e.g. simple, intermediate or complex) billed by providers; the rate primary care physicians refer patients to specialists; the number of tests and x-rays ordered by physicians; and the number of surgeries. Profiles are done for individual providers and then are compared to the rates for the

provider's peers. Actions that are taken include provider education of acceptable norms and billing practices, payment recovery and design of new prepayment screens.

At Pennsylvania Blue Shield, we emphasize an informational and educational approach to our activities. As part of this educational function, we notify doctors when their pattern of claim submissions is substantially different from that of their peers. The concept of this approach is supported by state medical societies and the local peer review organizations.

Each year, we send a letter to physicians whose practice patterns differ substantially from their peers. We send this report for two reasons. First, we want physicians to know we have this type of analysis. Second, we want them to know that some of their procedures were reported at unusually higher levels compared to their peers. This report is a statistical indication of a potentially unusual situation, which may be the result of such factors as sub-specialty, an unusual patient population, or an incorrect peer group listing. We have also found that it often reflects a reporting problem or overutilization of services.

While there may be many reasons why procedures are reported at an unusually high frequency, we suggest that physicians analyze the use of the procedures listed and encourage them to provide a written explanation of why the statistics varied. If a physician receives this report for three consecutive years, they may be subject to an indepth utilization review. This may include a review of their supporting clinical data to determine if the medical necessity and/or frequency of these services is appropriate. If not, they may be requested to refund monies to Medicare.

Each year, we also undertake a specialized focused review of a specific service that is frequently performed. Last year, we concentrated on complex visits, holter monitors, opthalmic biometry, physical therapy and repetitive ambulance services. These in-depth reviews can last several months and include an analysis of claims trends, patient surveys, consultant review of medical records and/or discussion of our findings with the provider.

EDUCATION

In addition to the general educational efforts undertaken in the postpayment review process, we also publish a quarterly newsletter—"Medicare Report"—for all Medicare providers. This newsletter is used to notify the provider community of the ever-changing Medicare regulations before they are implemented. We also hold seminars, participate in conferences, and conduct training sessions for office staff on specific claims processing requirements.

FY 1990 BUDGET

We are concerned about the adequacy of next year's funding level for these activities. Excluding catastrophic implementation costs, the Administration's budget would cut funding for all basic Medicare administrative operating costs below FY 1989 levels, even though claims volumes are expected to grow 12 percent next year. For carrier medical review activities, the Administration's budget proposes a 20 percent cut in dollars allocated to this function.

The reduction of medical review activity will without doubt result in the Medicare program paying for more inappropriate services, thus increasing program benefit payout. In its April 1989 report to Congress, the Physician Payment Review Commission (PPRC) said it "strongly believes" that Medicare contractors "must have stable and adequate funding to conduct medical review activities effectively." The Commission indicated the Administration's proposed budget cuts "would seriously threaten progress currently being made in Part B utilization review." Our Association has recommended a total FY 1990 funding level of $1.8 billion for all contractor activities to the Senate Labor-HHS Appropriations Subcommittee. We urge your support of this recommendation.

PHYSICIAN PAYMENT REFORM

Reforms in Medicare physician payment policies need to be accompanied by a strong medical review capability. If an overall physician payment expenditure control mechanism is adopted by the Congress, utilization and medical review activities will need to play an important role in assuring Medicare payments are made for effective and appropriate services. The Physician Payment Review Commission (PPRC) has recognized the need to develop expanded practice guidelines and an improved utilization and quality review program are "complementary" to an expenditure target system.

CONCLUSION

From 1979 to 1989, Medicare Part B spending per person tripled and continues to increase at two to three times the general inflation rates. For Medicare beneficiaries, higher costs mean higher premiums, deductibles and copayments. Adequate funding for Medicare carrier medical review activities is a proven investment that will help contain these rising costs, both for the federal government and the beneficiaries the program serves. Further advances and emphasis in medical review and related efforts are needed to enhance any cost containment strategies.

PREPARED STATEMENT OF SENATOR JOHN H. CHAFEE

Mr. Chairman, I commend you for continuing these forays into the world of physician payment reform. In focusing today's hearing on controlling the *volume* of Part B services, you have really gotten at the nub of the problem. As rational and logical as the RBRVS appears to be—and as much as it would do to eliminate the perverse incentives in the current reimbursement scheme—by itself, it would do nothing to control volume or intensity. And when we are talking about reining in the costs of Part B, volume and intensity are our biggest problems, accounting for 45 percent of the growth of Part B.

We do need some kind of mechanism to control volume We have a responsibility to Medicare beneficiaries and to taxpayers to get a handle on part B costs. We need research into what works and what doesn't—along the lines of Senator Mitchell's bill—and we need practice guidelines based on this knowledge. We may need more aggressive utilization review. But I have my doubts as to whether these mechanisms alone can do the trick.

I also have my doubts about how the option at the other extreme—imposing expenditure targets—would work in practice. Whether the targets are national, local, by specialty, or by type of procedure, how do we avoid penalizing all doctors for for the practice patterns of a few?

I would be interested in exploring with today's witnesses other options that may exist between the two poles—and I will be particularly interested hearing how the Canadian experience may inform our own deliberations. Unfortunately, I will not be able to attend the entire hearing because of another Committee meeting, but I will study the record carefully.

(SUBMITTED BY ALLAN S. DETSKY)

PAYING PHYSICIANS IN CANADA: MINDING OUR Ps AND Qs

by Jonathan Lomas, Catherine Fooks, Thomas Rice, and Roberta J. Labelle

Prologue: *When Americans examine Canada's ten provincial health insurance plans, they recognize that Canadians have been far more willing to delegate to government the central role in financing and regulating health insurance for the whole population than Americans. Provincial governments and the medical profession are the instruments through which the financial ground rules of health care are established. In recent years, though, as Canada's physician population has grown and the use of medical care has risen, provincial governments have come under greater pressure to moderate the growth of health spending. Their efforts to deal with that issue—increasingly, by imposing expenditure targets or caps—have intensified the rancor between provincial governments and practicing physicians. In this paper, Jonathan Lomas, his colleagues Catherine Fooks and Roberta Labelle at McMaster University in Hamilton, Ontario, and Thomas Rice of the University of North Carolina (UNC) discuss how Canada's larger provinces have been addressing these cost problems, particularly in relation to the quantity of services provided by physicians. The quantity issue is prominent in the United States as well because the growth in the volume and intensity of services has accounted for about half the increase in Medicare payments to physicians per beneficiary. Lomas, Fooks, and Labelle all are members of McMaster's Faculty of Medicine. They hold appointments in the Department of Clinical Epidemiology and Biostatistics' Center for Health Economics and Policy Analysis. Lomas holds a master's degree in psychology from the University of Western Ontario. Fooks received a master's degree in political science from Queen's University, and Labelle has a master's degree in economics from McMaster. Rice, who studied the Canadian system while spending last summer at McMaster, is an assistant professor of health policy and administration at the UNC School of Public Health. He received a doctorate in economics from the University of California, Berkeley.*

As the 1980s wind to a close, the attention of the health policy community has focused sharply on the payment of physicians. Numerous studies have suggested various ways to control these rising expenditures, especially for Medicare.[1] It is noteworthy that as studies of fee schedules for physician payment have progressed over the past two years, there has been increasing awareness in research and policy circles that fee schedules alone may not successfully control growth in physician expenditures.[2] The reason is that while they can control *price* per service, fee schedules by themselves cannot control the *quantity* of services provided (this is the so-called "Minding Our Ps and Qs"). A number of studies have shown that freezing physician fees may result in rapid increases in the number of services physicians provide.[3]

One technique that can be used to control expenditures in a fee-for-service system is to account explicitly for changes in the quantity of services provided when updating fee schedules. For example, suppose that utilization rates rise by 3 percent in a year, resulting in higher expenditures than anticipated. One possible response is to lower the next year's fees for each service by this (or a lesser) amount so that over time payers have control over expenditure increases. Such strategies have received a great deal of publicity recently.[4]

West Germany has incorporated quantity responses into fee schedule negotiations for some time; more recently, several Canadian provinces have done likewise. In this article, we describe the systems that have developed, or are currently developing, in Canada. First, we provide a brief summary of the Canadian health care system and a history of the fee bargaining process. We then present the different approaches that provinces are using to control, simultaneously, physician price and quantity increases, and we discuss the impact of these approaches on utilization. We conclude with a discussion of the lessons the Canadian experience offers to others—particularly the United States—who may wish to adopt a similar system.

The Canadian Health Care System

There is no single Canadian health care system; rather, each of the ten provinces administers its own health insurance plan.[5] To receive federal contributions, however, provincial health plans must fulfill national eligibility and coverage standards including public administration, portability of comprehensive benefits across provinces, and universal coverage. It is therefore possible to make some generalizations about the country's health care system.

All Canadians are eligible for health insurance, which provides, at a

minimum, coverage for nearly all hospital and physician services.[6] Although financing varies from province to province, user charges are rarely levied. In popular (although *not* economic) terms, all Canadians receive "free" medical care.

In spite (or maybe because) of this universal coverage, Canada has managed to control expenditures for hospital and physician services to a much greater extent than has the United States. Before all of the provinces adopted comprehensive health insurance in 1971, Canada spent slightly more of its gross domestic product (GDP) on hospital and physician services than did the United States. By 1985, however, the United States spent more: 6.2 percent versus 4.8 percent. As a proportion of GDP, U.S. spending on hospital and physician care was about 30 percent higher.[7] There are many reasons given for Canada's recent success at controlling costs, but the most important appears to be provincial governments' monopoly over payments to providers: provincial governments are the sole source for nearly all payments to Canadian hospitals and physicians.[8] There is nowhere else for providers and hospitals to go if they are dissatisfied with government reimbursements.

Hospitals, with very rare exceptions, are not for profit and are run by community boards with ownership by charitable, municipal, or religious organizations. They are funded by global (that is, prospective) budgets from provincial governments. Physicians are rarely employed by hospitals and gain access to hospital facilities through the granting of privileges. Approximately 55 percent of Canada's physicians are general practitioners, not all of whom have hospital privileges.

As in the United States, physicians practice privately and are paid on a fee-for-service basis. Provincial fee schedules determine the price for each service, and physicians are not allowed to bill patients directly for charges above these prices (known in U.S. terms as "balance billing").[9] As described in detail below, updates in fee schedule rates are negotiated between provincial physician associations and the provincial governments.

The recent ban on billing patients for amounts over and above the fee schedule, coupled with rapid increases in physician supply in most of the provinces, has subjected physicians to increased financial pressures. With potentially fewer patients per physician, the provision of more services per patient has become an obvious way to increase or maintain income levels. The existence of some quantity increase, however, is not new in Canada. Between 1971 and 1985, utilization per capita rose by 68 percent, or at an annual rate of 3.8 percent.[10] Until recently, most of the provincial governments have been willing to accept this. However, the provinces feel increasingly strapped for funds. This, along with the recent pressure of

more significant quantity increases, has resulted in actions designed to contain future expenditure increases.

Currently, five of the ten Canadian provinces—British Columbia, Saskatchewan, Manitoba, Ontario, and Quebec, representing over 80 percent of the country's population—have incorporated some method of accounting for utilization increases in their fee schedule negotiations with their provincial medical associations. Before describing these approaches in detail, we present a history of fee negotiations in Canada.

The History Of Fee Negotiations In Canada

Quebec. The negotiation of fee schedules in the province of Quebec reflects a substantively different approach than that used elsewhere in Canada. The political culture and mobility-restricting language situation of physicians in that province have resulted in a different health care environment. Therefore, the following history is not applicable to Quebec, which is discussed separately.

Other provinces. The process of negotiating fee schedules in the rest of Canada is an example of the gradual formalization of the various means by which the government and medical profession have interacted since the introduction of national health insurance. At the outset, most provincial governments adopted the existing fee schedules of the provincial medical associations and paid amounts ranging from 85 percent to 100 percent of that value (to account for the fact that physicians would no longer have unpaid accounts). Thus, each medical association's schedule of fees became, on a prorated basis, the province's schedule of benefits. Over time, the process of arriving at the global increase to that schedule—the average percentage increase in dollar value across all fee items in the schedule—became more formalized, with annual increases determined by periodic negotiations (usually on a one-to-three-year basis).

In the beginning, provincial medical associations were content to bargain in this relatively informal fashion. However, as they became aware of the significant unilateral power that provincial governments could exercise, the desire emerged for a formal negotiating mechanism that equalized power. Unfortunately for the medical associations, an unanticipated formal mechanism was imposed by the introduction of wage and price controls for three years for the entire economy, starting in 1975. During this time, dissatisfaction grew among physicians; upon cessation of controls in 1978, the fee bargaining process, although more formal, had to incorporate three symptoms of that dissatisfaction.

First, there was an increase in the proportion of practitioners who were extra-billing, or balance billing. This was the profession's "safety valve"

for fee increases that were seen as unreasonably low. Second, some medical associations broke away from the governments' schedule of benefits and set their own fee schedules at (higher) levels, which they considered to be reasonable compensation. The difference between these two schedules was often the basis for the extra-billing levels imposed on patients. Third, the size of annual utilization increases became more significant as services per physician showed consistent annual increases of 1 to 2 percent. This latter factor had become important enough that a legislative committee in one province (Ontario) suggested as early as 1978 that fee increases should be contingent on guarantees of "flat utilization," and that future fee increases should be reduced if this turned out not to be the case.

Most attention, however, focused on the extra-billing issue. The result was a federal review in 1980 by Justice Emmett Hall. The banning of extra-billing was proposed, but only if it was combined with a binding arbitration mechanism to negotiate fees. This reflected the increasing formalization of provincial negotiation processes, which were becoming collective bargaining exercises.

The review precipitated prolonged consideration of what has become a major background issue in all fee negotiations in the 1980s: Are fees or incomes the subject of negotiation? For binding arbitration to work, there had to be some definition of what areas would be under arbitration. Provincial governments maintained that total outlays for physician services were of concern; therefore, they were interested in both the price of services (fees) and the quantity of services delivered. For their part, the medical profession maintained that they were only negotiating fees, and it was not their responsibility to be accountable for either the increased use of physician services by the population or, alternatively, the increased productivity of the average physician. The medical profession claimed that they would become "conscripted civil servants" if their income were the subject of negotiations.

The effective elimination of extra-billing in 1984 by the federal government through the *Canada Health Act*, and a legislative ban by each of the provinces by 1987, has been further cause for a focus on both negotiating processes and the validity of considering utilization. In two provinces (Saskatchewan and Manitoba), the ban on extra-billing was combined with the right to binding arbitration for fee settlements. Other provinces use nonbinding mediation, fact finding, or no formal dispute resolution mechanism. The exclusion of the right to extra-bill has, however, had repercussions for the rate of utilization increase: increasing utilization is the only mechanism left for physicians to increase income levels beyond the size of the fee increase.

In the two years following Ontario's ban on extra-billing (1986–1987 and 1987–1988), services per physician increased by nearly 2.5 percent each year; in the previous seven years, the average annual increase had been 1.2 percent. When these developments were combined with the effects of an economic downturn in western Canadian provinces after 1982—creating a revenue crisis for provincial governments—medical associations found themselves in negotiating sessions with provincial governments that were no longer willing (or fiscally able) to ignore the impact of utilization increases on provincial medical care expenditures. Steps were taken to introduce utilization control mechanisms in several provinces.[11]

Approaches To Controlling The Use Of Physician Services

There are two approaches used in Canada to control, or attempt to control, increases in utilization: the "threshold approach" and the "capping approach." Each has evolved from a different historical context and has employed different methods. The common principle in each approach, however, is the feedback of utilization growth on physician fees. In the threshold approach, no inviolable limit on expenditure is set; rather, some value is established above which only a preestablished or negotiated portion of the utilization increase feeds back onto the size of the fee increase. In the capping approach, a limit is set on annual expenditures that, by virtue of eventual complete feedback of utilization on fees, will not be exceeded. The approaches, with variations, are comparable to the concepts of "target" and "cap," respectively, in the United States.

The threshold approach. The approach used by most provinces was to establish the principle that they would no longer automatically be responsible for the entire cost of increases in the volume of services delivered. Utilization increases became subject to scrutiny to attribute financial responsibility to either the medical profession or the government. Beyond a threshold level, the cost of increases in the volume of services is at least partly the responsibility of the medical profession.

Four provinces have adopted the threshold approach—British Columbia, Manitoba, Saskatchewan, and Ontario. This approach noticeably respects the profession's concern that incomes *per se* will not be the subject of negotiations: the controls apply to aggregate government expenditures, not to expenditures at the level of individual physician income. The threshold level of utilization is set either at the previous year's volume (sometimes an average of a number of previous years) or at the previous year's volume plus some amount to account for factors such

as population increase, growth in the physician supply, natural disasters and public health epidemics, or new insured services/technologies.

The setting of the threshold is done either prospectively or retrospectively. Setting the threshold prospectively involves negotiations that define the causes of utilization increases that are allowable or the allowable size of the increase. This has been done in British Columbia, Saskatchewan, and Manitoba. In Ontario, the threshold is set in retrospective negotiations after the size of the utilization increase is known. In this case, there is no statement prior to the relevant benefit year that the upcoming year's utilization increase necessarily will be used to adjust the size of the next price increase. However, it is clearly the intent of the government to bring this principle to the bargaining table in each year's negotiations now that the precedent has been set. The retrospective application of utilization controls merely reflects that the judgments of "fact finders" (arbitrators) are now supporting the Ontario government's long-held contention that past quantity increases should receive some consideration when arriving at future fee increases. The intent is for the threshold eventually to be determined prospectively and explicitly.

The provincial governments use one of three ways to recoup expenditures on "excess" utilization above the threshold. Next year's fee increase is adjusted downward accordingly (as in Ontario and Manitoba), the profession temporarily works at reduced fees for a set period (as in British Columbia), or current fees are paid at a discounted rate to counteract the anticipated size of the utilization increase for the year (as proposed in Saskatchewan).

None of these approaches involves provincial governments in determining an individual physician's income; rather, they have an impact on the total funds available for distribution across the entire profession. This contrasts with the capping approach adopted by Quebec, in which the individual general practitioner's income is capped. These incomes, plus target income values for specialists, are aggregated to the total expenditure cap for Quebec.

Detailed descriptions of the different threshold and capping approaches follow. A summary is given in Exhibit 1.

British Columbia. Throughout the early 1980s, the provincial government tried unsuccessfully to incorporate concerns about increases in utilization into fee negotiations. In the 1985–1986 negotiations, however, they successfully incorporated a limit on their liability for utilization increases. There was no global fee increase for that year. In addition, a prospectively negotiated ceiling on utilization was implemented for one year. The ceiling allowed a 1.5 percent increase in utilization for population growth and a 2 percent increase for other factors. Any increases over

Exhibit 1
Approaches To Controlling Utilization In Canada

	Thresholds				Capping
	British Columbia	Manitoba	Saskatchewan	Ontario	Quebec
	1985–1986	1984–1985[a]	1987–1988	1987–1988	1976–1977
Threshold beyond which rules change?	Yes	Yes	Yes	No	Yes
Cap on individual incomes?	No	No	No	No	Yes
Type of rule setting	Prospective	Prospective	Prospective	Retrospective	Prospective
Focus of prospective rules	Agreed percent increase for population and technology	Grouping of justifiable and non-justifiable utilization	Average of previous five years' utilization	N/A	Quarterly income ceilings (GPs) and total cap for GPs and specialists
Justifiable utilization factors	Population growth, advances in medical services, natural disasters, epidemics, physician supply	Population growth, public health problems, new services, technology, physician supply	None	Population growth, physician supply	Physician supply
Method of recouping expenditures on excess utilization	Temporary reduction in size of fee payments	Reduction in global fee increase	Discounted fees in current year	Reduction in global fee increase	Reduction in specific and/or global fee increase
Dispute resolution mechanism	None	Binding arbitration	Binding arbitration	Fact finder[b]	None
Utilization committee	No	No	Yes	Yes	Yes[c]

[a] No longer in effect.
[b] As of 1989, the agreement establishing a mechanism for negotiating has been terminated and is to be renegotiated.
[c] The utilization committee in Quebec differs in function from utilization committees in other provinces. In Quebec, the committee meets to negotiate actual distribution of fee increases across individual procedures. In other provinces, the committees are analyzing the determinants of utilization in general. Furthermore, the Quebec committee is an ongoing project, whereas the committees in other provinces were originally established as one-time initiatives. However, it is possible that these committees will evolve into ongoing initiatives.

that would be the responsibility of the profession and would result in a retrospective fee adjustment. No adjustment was in fact required.

The 1986–1987 agreement (which was for a three-year period) allowed for a 3 percent increase in total utilization (1 percent for population increase and 2 percent for new medical services).[12] If utilization growth exceeded the threshold of 3 percent, monies would be withdrawn in

equal amounts from a Ministry reserve fund and the money budgeted for the fee increase to be awarded in the next year of the contract. If the threshold was exceeded by more than could be funded from these two sources, negotiations would be reopened for the subsequent years of the contract. The contract also stipulated that the government would fund any extraordinary utilization resulting from epidemics or natural disasters.

Under this arrangement, the medical profession has already had part of its second-year global fee increase temporarily reduced because of utilization increases that exceeded both thresholds. A 1 percent "excess" utilization in the first year was recouped with a 4 percent global fee decrease for three months of the second year of the contract.

Manitoba. An agreement was signed, beginning the 1984-1985 benefit year, which provided for binding arbitration for fee disputes and a 2 percent global fee increase. In addition, future fee increases would be adjusted for utilization increases above a threshold. Utilization increases would be classified into the "attributed" rise (increases in insured persons, increases in physicians, public health problems, shifts in health care delivery, and new insured medical services) and the "unattributed" (all other) increase. The percentage increase in future fees would be reduced by the amount of the unattributed utilization. Thus, the factors influencing utilization would be negotiated prospectively, but the actual size of the utilization feedback on future fees would not be known until the benefit year was complete and unattributed utilization calculated.

The 1986-1987 negotiations went to mediation (nonbinding, third-party mediator) and then to arbitration (binding, third-party board) almost immediately. Two issues were at the heart of the disagreement: the size of the global percentage increase in fees and the method of calculating unattributed utilization. The arbitration board was split on the issue, and, therefore, the decision was issued by the chairperson alone. It provided for a 5.7 percent global increase but noted a 1.9 percent increase in unattributed utilization, necessitating an increase of only 3.8 percent. Disagreement between the Manitoba Medical Association and the government over how this should be applied led to an informal, nonbinding reconvening of the board.[13] The chairperson's judgment supported the medical association's interpretation of how much downward adjustment in the fee increase should occur because of unattributed utilization growth.

The government eventually paid the award according to these terms but terminated the arbitration mechanism for future negotiations on the not completely accurate grounds that it "provided no controls on volume."[14] In the spring of 1988, the Manitoba Medical Association, with-

out a contract since April 1987, threatened to strike unless the government agreed to reestablish the binding arbitration mechanism.

After a surprise spring provincial election, a three-year agreement was signed with the new government containing a 3 percent increase in the first two years and an increase based on the national inflation index in the final year. This new contract contained no mechanism to account for utilization growth. It also reinstated binding arbitration. The previously established explicit feedback of utilization on fees is, therefore, no longer in place in Manitoba, although increased utilization no doubt will be at least an implicit part of the next round of fee negotiations in 1990.

Saskatchewan. In Saskatchewan, the issue of utilization controls became entangled in a court case. Using a mechanism that fell just short of being a cap, the government opened the 1987–1988 negotiations by proposing a threshold based on prior years' utilization increases. Negotiations quickly went to binding arbitration—the dispute resolution mechanism agreed to in 1985 when extra-billing was banned. The government wanted a 0 percent fee increase and a prospective threshold of a 0 percent increase in utilization; that is, the government did not want to fund *any* increase in utilization and did not want to provide any global increase in fees. The mechanism to be used to try to prevent funding of any utilization increase was discounting of fees for the entire year by the average of the previous five years' utilization increase—4.2 percent. Therefore, there was a presumption that utilization would increase by 4.2 percent, and prospective discounting of fees by that amount would prevent the flow of additional monies as long as the utilization increase was less than 4.2 percent.

This mechanism aims to keep total expenditures in the contract year at the same level as in the previous year. At the end of the contract year, if utilization actually increased by less than the anticipated 4.2 percent, then the profession would receive what was owing from the withheld discounted sums. However—and here is why the system cannot be considered a true capping approach—if utilization increased by more than 4.2 percent, the government would continue to pay out fees, and the profession would not give back the excess—they would keep the additional monies above the previous year's outlay.[15]

Disagreement by the Saskatchewan Medical Association with both the concept of a prospective threshold and this proposed utilization adjustment sent the matter to the arbitration board. The board ruled that the prospective threshold was legal, but that physicians should be financially responsible for only half of the anticipated increase in utilization. That is, fees should be discounted by only 2.1 percent.

Shortly thereafter, the Saskatchewan Medical Association took the arbitration decision to court on the grounds that the board exceeded its

jurisdiction in setting a fixed sum of money for insured services and by holding physicians responsible for even 50 percent of the anticipated increases in utilization. The court sided with the medical association and quashed the board's ruling. The government appealed the decision, and, in December 1988, the appeal court's judgment supported the government's right to set a threshold that took account of prior utilization. However, it confirmed that a true cap would be considered illegal by stating that payments to physicians must continue even after such a threshold value of total expenditure had been reached in a year.

Because of the delay occasioned by the court case, the 1987–1988 negotiations have not been completed, and physicians were paid at 1986 rates for 1987. Negotiations for 1988–1989 had not begun as of December 1988, but the government undoubtedly will be using the favorable court judgment to enshrine their threshold approach into future agreements. During the time of the court case, recognition of the somewhat arbitrary nature of the fifty-fifty attribution between the government and the profession for any utilization increase led to the formation of a joint committee to examine utilization issues.

Ontario. Utilization was discussed during both the 1981 and 1982 fee negotiations in Ontario, although utilization controls were not incorporated in any formal way into the contract. The five-year term of the 1982 contract did, however, establish a joint Ministry of Health and Ontario Medical Association committee to study utilization.

The subsequent 1987–1988 negotiations went to the "fact finder"—a nonbinding arbitrator—after two months. During the negotiations, utilization increases had been discussed as the basis for a retrospective component of the global fee increase, but no consensus was reached. The fact finder concluded that the gradual increase in utilization per physician contributed significantly to physicians' incomes, and financial responsibility therefore should be shared between the government and the profession. The fact finder chose a figure of 1.5 percent as the increase in utilization per physician for the previous year and recommended that the global fee increase for the current year be reduced by one-half of this increase, that is, by 0.75 percent. The fact finder arbitrarily chose this fifty-fifty split between the government and the profession "in the absence of more sophisticated analytical tools."[16] Both parties complied with the recommendation and also reestablished the joint government/Ontario Medical Association initiative to examine utilization. The previous committee had been disbanded after the medical association's withdrawal during a strike action over the banning of extra-billing.

The most recent round of negotiations in Ontario (1988–1989) also went to a fact finder, as the medical association and the government

disagreed over the amount of the global fee increase. The fact finder again recommended an adjustment to the overall fee increase based on the prior year's utilization growth. He estimated a 2.3 percent increase in utilization per physician after adjusting for population growth and, using the fifty-fifty split rule, recommended a reduction of 1.15 percent in the global fee increase. In June 1988, both sides studied the report, but the government, although not displeased with the continued acceptance of feedback of utilization growth on fees, rejected the recommendation in favor of their original (lower) offer of 1.75 percent for the global fee increase.

Informal talks took place with no resolution until December 1988, when the government unilaterally imposed the settlement of 1.75 percent on the Ontario Medical Association. In addition, the government gave notice that it was canceling the existing agreement governing the negotiating process and planned to establish an entirely new mechanism. The medical association recognizes that this new mechanism is being proposed "to try to impose utilization controls on the profession [and] . . . [w]e're going to want some sort of a mechanism whereby if we go to a third party to settle, it's going to be binding on both parties."[17] Therefore, the exact nature of the future mechanism for utilization feedback on fees in Ontario is still uncertain, but the fact of such a mechanism in the future is in little doubt.

The capping approach in Quebec. It is worth noting that while the Quebec approach to controlling utilization is interesting and worth recounting, it may well not be applicable either to other Canadian provinces or to the United States. Both the political culture in Quebec and the linguistic barriers to professionals seeking careers outside the province have allowed the government to adopt a more interventionist strategy with regard to physician payment than is politically feasible elsewhere in North America. Furthermore, the negotiating philosophy of the medical associations has been far more concerned with preventing regulatory interference with the medical practices of the profession than with protecting the entrepreneurial interests of individual high-earning members of the professional group. Indeed, individual income caps for general practitioners were introduced at the request of the profession, not imposed by government.

The capping approach, present for some time in Quebec, establishes individual income ceilings for general practitioners, as well as separate caps for overall expenditures on the services of general practitioners and specialists. The province discourages individual general practitioners from exceeding their income ceilings by discounting their fees severely once the ceiling has been reached. In addition, when the overall expendi-

ture cap for either general practitioners or specialists is exceeded in one year, the government recaptures funds by reducing fee increases for subsequent years. Therefore, although expenditures and individual income ceilings can exceed the cap in any particular year, the feedback mechanism prevents a cumulative departure from the series of caps because the overrun in previous years is, unlike the threshold approach, totally recaptured in subsequent years.

Fee negotiations in Quebec are between the government and two separate professional associations—*la Federation des medecins omnipracticiens* (general practitioners) and *la Federation des medecins specialistes* (specialists). Unlike in other Canadian provinces, negotiations are around the income level of physicians, which then becomes translated into a particular fee increase.

The history of fee negotiations in Quebec is quite different from that in the rest of Canada. From 1970 to 1975, physicians received no fee increase. In 1976, a large number of primarily English-speaking employers left Quebec after the election of a separatist government, thus reducing the province's tax base. Even though there was recognition that a fee increase was in order, the government was not in a position to grant physicians a large increase and offered only 1 percent. Simultaneously, expenditure controls for general practitioners were introduced by establishing individual income ceilings and a total expenditure cap. One year later, target incomes for each specialist group were introduced, although these were not applied at the individual level but used to calculate an overall expenditure cap for specialist services.

This method of controlling utilization differs from that used in other provinces. First, each round of annual fee negotiations sets a global fund calculated from the aggregated target incomes per physician and the expected number of physicians. Thus, increased physician supply does increase the size of the cap. For general practitioners, ceilings are calculated for a three-month period. Once the limit is reached within a period, the general practitioner is paid only 25 percent of the full fee for additional services. For specialists, the income target (which is not a ceiling leading to within-period fee discounting) is for a twelve-month period. The current annual income levels are (CAN)$120,298 for general practitioners and (CAN)$151,782 for specialists.[18]

Second, the average amount of gross billings is used to adjust fees the following year by bringing actual incomes in line with the targets. Because physician supply is relatively stable—Quebec is the only predominantly French-speaking province in Canada, *and* it has the most stringent licensing requirements—targets for physicians' gross incomes eventually translate into predicted limits on the total expenditures for physician

services. With the exception of a brief period in the early 1980s, this capping approach has been in place for over ten years and shows no signs of being disbanded.

The Impact Of Controls On Utilization

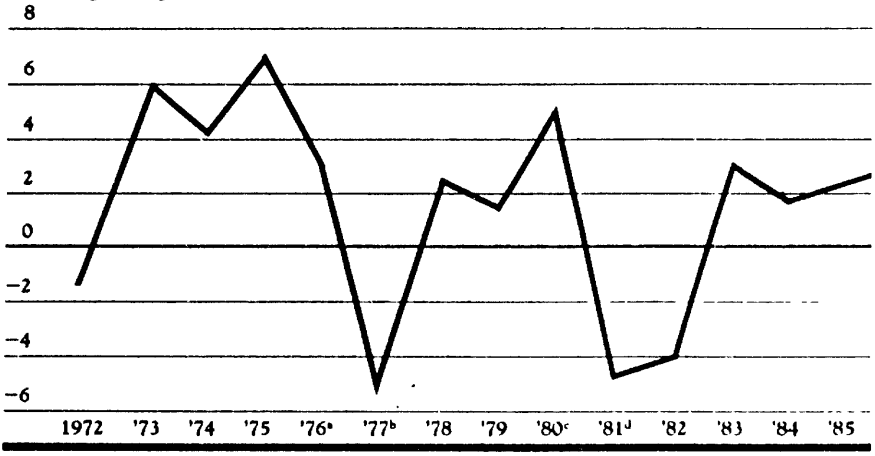
As Exhibit 1 indicates, controls on utilization are a relatively new concept in Canada. To date, controls either have been or are now in effect in five of the ten provinces. Of those five provinces, only Quebec and Manitoba have experience for more than three years. Thus, a comprehensive analysis of the effects of controls is premature; we are restricted, at this time, to reporting selective results.

We are reluctant to generalize the results from Quebec and Manitoba because both are somewhat atypical. Quebec has experienced some form of capping since 1976–1977. In Manitoba, although the threshold approach was introduced in 1984–1985, it was disbanded in the current contract for 1987–1990 and may not be reintroduced in future contracts. Nonetheless, the experiences of these provinces provide the only available evidence in Canada on the potential impact of utilization controls.

Exhibits 2 and 3 display the annual percentage changes in Quebec's fee-adjusted billings per physician, and the number of base services (consults, examinations, and surgery) and *actes complementaires* (minor diagnostic and therapeutic procedures, surgical assists, and anesthesia) per physician, for the five years preceding the cap and the eight years after.[19] During the initial postcap period, the rate of growth in fee-adjusted incomes (taking into account the revisions—bundling and unbundling—of the fee schedule) declined (Exhibit 2). But this decline is confounded by a repackaging of fee items in 1977 that severely reduced the number of billable procedures and the opportunities for procedural multiplication. Billings per physician gradually recovered after the fee schedule restructuring in 1977, only to decrease again in 1981 when the general practitioner cap was reinstated after a one-year lapse due to contract negotiation problems. It is interesting to note that billings grew by 5.18 percent in the year in which the general practitioner cap lapsed—the largest single-year growth of any postcap year.

In 1977 the restructuring of the fee schedule and the inception of the cap on total expenditures for specialist services (the general practitioner cap had already been in place for one year) decreased the volume of *actes complementaires* dramatically—by almost 40 percent in one year (Exhibit 3). The fact that base services were not affected to the same extent, and that the restructuring was targeted primarily at *actes complementaires* (which had increased 14 percent per capita from 1971 to 1976), suggests

Exhibit 2
Fee-Adjusted Billings Per Physician, Quebec, Annual Percentage Change, 1972–1985

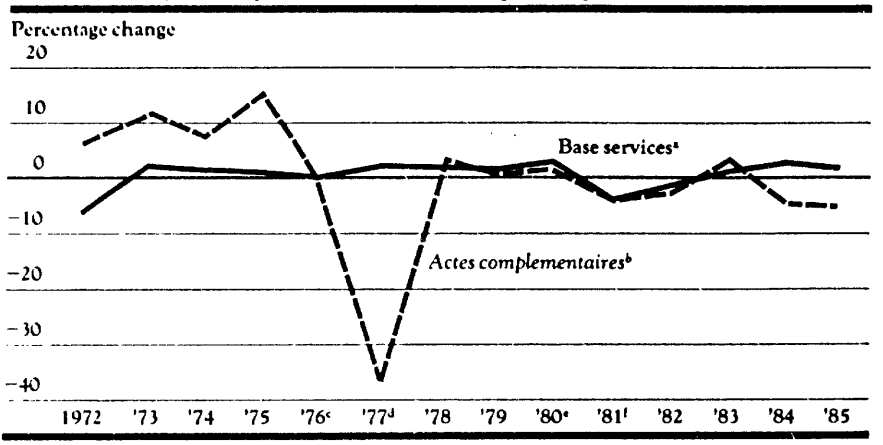


Source: M.L. Barer, R.G. Evans, and R. Labelle, "Fee Controls as Cost Control: Evidence From the Frozen North," *The Milbank Quarterly* 66, no. 1 (1988): 1–64.
[a]In 1976, fees for general practitioners (GPs) were capped.
[b]In 1977, a specialist ceiling was added to the GP ceiling and income cap.
[c]In 1980, the GP ceiling and income cap lapsed, but the specialist ceiling remained.
[d]In 1981, the GP ceiling and income cap was reintroduced.

that most of the dramatic impact on utilization can be attributed to fee schedule restructuring rather than to the expenditure cap. The natural experiment afforded by the lapse of general practitioners' caps in 1980 does suggest, however, that there is at least a short-run impact of the caps on utilization and income growth, although over time Quebec physicians are able to somewhat moderate the impact on billings by, presumably, shifting to more costly types of services. The Quebec experience with capping is, therefore, confounded by simultaneous introduction of fee schedule restructuring that appears to have been as effective as the caps, perhaps more so, in moderating utilization and expenditure growth.

Exhibit 4 displays evidence on average incomes per physician in Manitoba, adjusted to remove the contribution of negotiated fee increases to the income growth. The data are for the two years before the threshold, the three years after, and the first year of the new contract in which controls have been disbanded. The short time period makes interpretation difficult. These data are, however, consistent with an impact of utilization controls on the rates of growth in per physician expenditure, but could be in no way considered conclusive because of the low rate of growth in 1983–1984, when no controls were in place.

Exhibit 3
Services Per Physician, Quebec, Annual Percentage Change, 1972–1985



Source: M.L. Barer, R.G. Evans, and R. Labelle, "Fee Controls as Cost Control: Evidence From the Frozen North," *The Milbank Quarterly* 66, no. 1 (1988): 1–64.

[a] Base services include consultations, examinations, and surgery.

[b] *Actes complementaires* include minor diagnostic and therapeutic procedures, surgical assists, and anesthesia.

[c] In 1976, fees for general practitioners (GPs) were capped.

[d] In 1977, a specialist ceiling was added to the GP ceiling and income cap.

[e] In 1980, the GP ceiling and income cap lapsed, but the specialist ceiling remained.

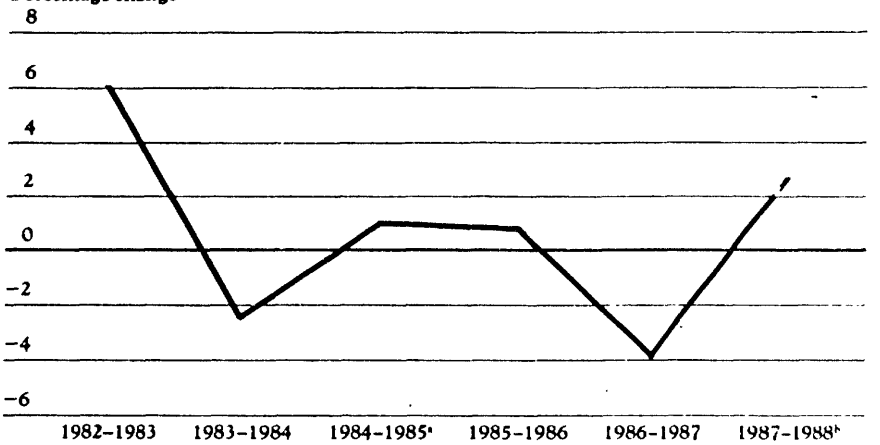
[f] In 1981, the GP ceiling and income cap was reintroduced.

Summary Of The Canadian Experience

The incorporation of controls on utilization into fee schedule negotiations in Canada has been an incremental process that, with the exception of Quebec, is only now becoming accepted as inevitable by the medical profession. Among the provinces excluded from this article, some are now starting to consider mechanisms for the feedback of utilization growth on fees, although even here it is mostly being preceded by careful consultation in the form of royal commissions (Nova Scotia) or utilization task forces (Alberta). In the four provinces that already have, or had, threshold approaches, the formalization of the approach was also generally preceded by many years of discussion of the concept, usually within the context of the fee negotiations themselves. Hence the title of the article—"Minding Our Ps and Qs"—which underlines the care that had to be taken by the provinces when dealing with the medical profession on the issue.

The major issue of concern for the medical profession has been the income control implied by simultaneous price and quantity limits in fee schedule contracts. The introduction of threshold approaches, rather

Exhibit 4
Fee-Adjusted Billings Per Physician, Manitoba, Annual Percentage Change



Source: Manitoba Health Services Commission and Health and Welfare Canada.
[a] In 1984, a new contract with the provincial government established a negotiated threshold.
[b] During 1987–1988, the threshold was absent because of a fee dispute.

than explicit caps, has been the political solution to the required compromise between the provinces and the profession. The threshold approach leaves individual income levels unregulated and only partially regulates the total funds available for physician services. Even with this solution, however, the medical profession has responded with legal challenges (Saskatchewan), political pressure leading to abandonment (Manitoba), or refusal to incorporate prospectively such controls into contracts (Ontario). Nevertheless, the concept has now become well enough established that within the next few years the majority (but not all) of Canadian provinces likely will have in place some mechanism for the feedback of utilization growth on fees.

The political difficulty of the process has, however, driven provinces to seek other avenues for controlling utilization as well. For instance, Ontario is aggressively promoting alternate remuneration systems to fee-for-service; British Columbia (unsuccessfully) attempted controls on the number of physicians allowed to bill the health insurance plan; and Quebec's capping approach was accompanied by a significant restructuring of the fee schedule.[20] This latter occurrence, in fact, confounds attempts to evaluate the impact of utilization controls on expenditures.

This, and the very recent inception of the threshold approaches in other provinces, leaves us in the unsatisfactory position of being unable to make any clear conclusions about the impact of combined price and quantity controls on overall expenditure growth for physician services. The initial indication is, however, that there is discernible but not dramatic impact. The simultaneous introduction of additional measures in other provinces may make such an analysis forever elusive.

Most of the lessons from the Canadian experience concern, therefore, the political considerations in smoothing the way for implementation of controls, rather than structural elements of a program to obtain maximum impact on expenditures. Combined price and quantity controls are too recently implemented and/or too confounded by other policies to allow for anything else. The intuitive appeal and implications of such utilization controls for expenditure growth have, therefore, to remain somewhat in the realm of "faith" or "hope" when considering the lessons outlined below.

The one exception to this is the implication of Canadian governments' monopsony powers (the power of one buyer) in health care. Elsewhere we have described how the exercise of this power may be one of the most important elements in the relatively better cost control experience of Canada compared to the United States—two countries whose health care systems are otherwise very similar structurally.[21] Controls on the quantity and price of physician services billed through provincial fee schedules in Canada are effectively controls on all sources of income for the physician.

This context for the Canadian experience helps to explain the strong resistance from the medical profession and, therefore, the relevance of the political lessons. But also it may be related to any eventual success claimed for such fee schedule price and quantity controls. In the United States, for example, unless Medicare has a highly potent symbolic value as a leader in health policy—a value that has not been in great evidence to date—the introduction of a fee schedule policy by the program may not be enough to control *total* societal expenditures on physician services. It may do little more than displace those burgeoning expenditures to other payers. It is in this vein that we offer the four lessons below.

Lessons From Canada

Introduce price and quantity controls at the outset. Payers who are introducing a fee schedule and wish to use it now or in the future to control expenditures should simultaneously introduce both the price and quantity controls at the outset. A major difficulty in Canada has been the

task of introducing the idea of quantity controls within fee negotiation processes that have existed for many years without any consideration of the topic or acceptance that it is even a legitimate item for negotiation. It is for this reason that Ontario has retrospectively established the rules for dealing with utilization increases, and that negotiations for all provinces except Quebec have avoided individual income or even total expenditure caps in the spirit of compromise.

The absence of quantity controls at the outset of government/profession fee negotiating in the early 1970s has led to a tenuous hold for the principle as it has emerged in the 1980s. In Manitoba, quantity controls have actually been put aside in the current contract. As long as there is no formalization of the rules that apply to utilization increases, each year's negotiation has to deal with the issue anew and set retrospective rules.

Set prospective rules. Rules must be set prospectively concerning (1) factors determining the size of the threshold or the cap; (2) the mechanism for payback or discounting if the threshold or cap is exceeded; (3) the determinants of a utilization increase that are justifiable; and (4) the bargaining and dispute resolution processes. The absence of any formal dispute resolution mechanism calls the credibility of the process into question. The Ontario government ignored the recommendations of its independent fact finder in the last round of negotiations; therefore, the medical profession in that province is now asking for a binding arbitration mechanism for dispute resolution. Neither British Columbia nor Quebec has a formal dispute resolution mechanism in place. The absence both of clear dispute resolution mechanisms and of prospective rules has contributed to the arbitrary nature of the methods for dealing with the degree of physician responsibility for utilization increases. This, in turn, has been a major line of attack by the medical profession, as well as a source of discomfort for provincial governments.

Underlying the policy of the government's recouping or not paying out for some or all of the utilization increase is an assumption that not all of this increase represents physicians meeting the legitimate medical care needs of the population. In the absence of specific service-level data to support this assumption, physicians have argued forcefully that patient demand, previously unmet needs, and technological change are driving utilization rates upward. For its part, the government has implied that induced demand by physicians is partly responsible. However, in the absence of data, they have generally taken recourse to justifications in public based on productivity gains by physicians that should, in a free and competitive market, partially flow back to the consumer (in this case, the taxpayer and the government) in the form of reduced prices (fees). The debate, however, has used the currency of assertion, claim, and

counterclaim in the absence of prospective rules that could be informed by careful scrutiny of specific areas of clinical practice where utilization increases have occurred.

Set up a payer/physician committee. A joint payer/physician committee should be established for ongoing scrutiny of specific clinical areas of utilization increase, to ascertain their impact on quality of care. This committee's findings should be incorporated into the fee-setting process. Three of the five provinces have established joint committees as part of, or separate from, the bargaining process to undertake microlevel reviews of areas of utilization increase. Evidence from these joint initiatives is expected to make the apportionment of fiscal responsibility for the utilization increases a more sophisticated and fair process.

Without such a committee, the initiative of quantity controls is bald cost containment untempered by concerns for the "quality of care" or real changes in the medical care needs of the population. Perhaps to counteract this claim, in Canada the factors that have been considered "justifiable" in the utilization increase have tended to favor the profession. The most notable case of this has been the use of calculations that rely on the utilization increase *per physician*, thus removing the impact of growth in the total supply of physicians on the overall utilization increase. One alternative, not currently used by any of the provinces, is to focus on utilization per capita, thus removing the impact of population growth on the utilization increase and also allowing adjustment for changes in the age/sex mix of the population—the increasing proportion of the elderly, for instance.

The task of joint committees on utilization could be to feed into the fee-setting process their best estimates of the relative contributions of factors such as population growth, medical/technological change, or previously unmet needs to both observed and projected utilization increases. It would not be unreasonable from a planning perspective if changes in the prevalence of disease amenable to medical care intervention were also one of the factors under consideration. However, political pragmatism may make such an inclusion less reasonable.

Include an all-payer system. Without an accompanying all-payer system, price and quantity controls likely will be ineffective in controlling total health care expenditures. Canadian experience does suggest the advisability of accompanying the introduction of a fee schedule with quantity controls, rather than trying to add on quantity controls later, and the initiative has obvious intuitive appeal. However, the absence of a single-source payer makes the exercise less likely to succeed, when the definition of success is control of total societal expenditures on physician services. The balloon may be squeezed within the physician services

sector by displacing the quantity response from one payer with controls to another without them.

One way to prevent this is to create an artificial single-source payer by generating local or regional coalitions of all-payers, as has already been done in some U.S. states or cities for hospital services. The hospital rate-setting commissions would have a parallel in fee-setting commissions that represented all insurers of care for the area. Thus, total quantities of medical care delivered in the area would be the subject of negotiation, not just the quantity attributable to one particularly concerned payer.

Such all-payer coalitions also facilitate the possibility of designing the cap in a more creative way than just total levels of service provision. Many of the factors justifying a utilization increase that we outlined earlier are likely to vary in their importance by region and/or by specialty. A centralized fee-setting exercise will not take account of these potentially important variations. In an all-payer system, the level of justifiable utilization increase could respect the local demographics and/or account for major changes in local specialty circumstances such as the introduction of new facilities in the local hospitals.[22]

Furthermore, by imposing the constraint at the level of the region and/or physician specialty, one problem of regulated utilization without individual income caps—the threshold approach or Quebec's approach for specialists—can potentially be ameliorated.[23] If there is a limit on the total pool of funds available for physician services, but no limits on the quantity of services billable by each physician, then the free rider who merely adjusts by increasing personal billings is left unpenalized. The "responsible" physician who carefully adjusts practice patterns in response to the overall cap will suffer some income loss in the current year, in addition to income loss in subsequent years if there is downward fee adjustment to recoup utilization increases generated by the free riders.

By localizing the cap on utilization to not only a specific community, but also a specialty, this perverse incentive is internalized to a small enough peer group that it might enable physician communities to identify their free riders and take their own action to overcome the problem. Thus the all-payer cap on local utilization might not only control the level of utilization increase, but also put incentives in place for physicians themselves to organize for the maintenance of local practice patterns commensurate with high-quality care. There is an assumption underlying this that physicians have a strong preference for, and a local ability to enforce, the provision of necessary before discretionary care. If this is true, then locally based control on the price and quantity of physician services through fee schedules has the potential of being a panacea by not only containing the cost of care, but also improving its quality.

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NOTES

1. Physician Payment Review Commission, *Annual Report to Congress* (Washington, D.C.: PPRC, 1987 and 1988); and W. Hsiao et al., "Estimating Physicians' Work for a Resource-Based Relative Value Scale," *The New England Journal of Medicine* 319 (1988): 835-841.
2. W.L. Roper, administrator, Health Care Financing Administration, testimony before the Ways and Means Subcommittee on Health, U.S. House of Representatives, 24 May 1988; and T. Rice, "Medicare: A Fixed Fee for Doctors," *The Washington Post*, 15 December 1987.
3. For a review of relevant studies through 1984, see J.R. Gabel and T. Rice, "Reducing Public Expenditures for Physician Services: The Price of Paying Less," *Journal of Health Politics, Policy and Law* (Winter 1985): 595-609. For more recent evidence from Canada, see M.L. Barer, R.G. Evans, and R. Labelle, "Fee Controls as Cost Control: Evidence from the Frozen North," *The Milbank Quarterly* 66, no. 1 (1988): 1-64.
4. PPRC, *Annual Report to Congress*, 1988.
5. For a more thorough description of the Canadian system, see E. Vayda and R. Deber, "The Canadian Health Care System: An Overview," *Social Science and Medicine* 3 (1984): 191-197; R.G. Evans et al., "Controlling Health Expenditures: The Canadian Reality," *The New England Journal of Medicine* (forthcoming); and Barer et al., "Fee Controls as Cost Control."
6. Universal coverage for hospital care was prompted by passage of the *Hospital Insurance and Diagnostic Services Act* of 1957, whereas coverage for physician care was brought about by the *Medical Care Insurance Act* of 1966. All provinces had instituted full coverage for hospital and physician services by 1971.
7. R.G. Evans, "Finding the Levers, Finding the Courage: Lessons from Cost Containment in North America," *Journal of Health Politics, Policy and Law* (1986, Tenth Anniversary Issue): 585-615.
8. For a discussion of the various reasons behind Canada's relative success in controlling costs, see Evans, "Finding the Levers, Finding the Courage;" Barer et al., "Fee Controls as Cost Control;" and Evans, "Controlling Health Expenditures."
9. This was the major purpose of the *Canada Health Act* of 1984. For a discussion of the political fights that preceded and followed passage, see M. Taylor, "The Canadian Health Care System, 1974-1984," in R.G. Evans and G.L. Stoddart, eds., *Medicare at Maturity* (Calgary, Alberta: University of Calgary Press, 1986), 3-39.
10. Barer et al., "Fee Controls as Cost Control."
11. Although we use the term "utilization" or "volume" throughout the following section, this is not strictly accurate. Most of the provinces base their calculations on expenditures, not on the actual number of services delivered. Their reasoning is that changes in the mix of services can, theoretically, reduce utilization (as measured by services) but still increase expenditures. Their concern is overall expenditure; therefore, they consider expenditure data a reasonable proxy for utilization.
12. There is provision in the agreement to adjust the 1 percent for population growth if actual growth exceeds this target.
13. $3.5 million or 1.9 percent of a potential $183.5 million was recommended as the

amount due to unattributable volume increase. The Manitoba Medical Association interpreted the ruling to mean an increase of $10.26 million to the fee schedule—5.7 percent of $180 million. The government interpreted it to mean an increase of $6.97 million—3.8 percent of $183.5 million.

14. M. Lloyd, "Physicians and Arbitration in Canada: The Alberta-Manitoba Experience," *Focus on Economics* 4 (Ottawa: Canadian Medical Association, 1987): 15.
15. Darrel Thomson, past official of Saskatchewan Health, personal communication, 7 November 1988.
16. J. Baillie, *Ontario Fact Finder's Report*, presented to J. Sloan, Ontario government, and H. Scully, Ontario Medical Association (Toronto: 19 June 1987), 48.
17. P. Rich, "OMA Promises to Be Vigorous in New Talks," *The Medical Post* (Toronto: 20 December 1988): 59.
18. M. Maychak, "Will Queen's Park Get Tough With Doctors?," *Toronto Star*, 13 June 1988.
19. Fee-adjusted billings are those that have been deflated to take out the effects of fee increases using the Quebec Physicians Fee Index. For details, see M.L. Barer, R.G. Evans, and R. Labelle, "The Frozen North: Controlling Physician Costs Through Controlling Fees—The Canadian Experience," monograph (Washington, D.C.: Office of Technology Assessment, 1985).
20. M.L. Barer, "Regulating Physician Supply: The Evolution of British Columbia's Bill 41," *Journal of Health Politics, Policy and Law* 13 (1988): 1–25.
21. Evans et al., "Controlling Health Expenditures."
22. A similar proposal for local "pools," capitalizing on Canada's single-source payer status, has been made for British Columbia in R.G. Evans, "Squaring the Circle: Reconciling Fee-for-service with Global Expenditure Control," working paper no. 5 (Vancouver: University of British Columbia, August 1988).
23. Individual income caps also are not without their problems. The payment of only 25 percent of the fee to general practitioners once they have reached their income ceiling in a quarter leads, according to anecdotal reports, to larger than average number of physicians taking vacations toward the end of each quarter. This has obvious implications for patients' access to physician services.

PREPARED STATEMENT OF JOHN M. EISENBERG

Mr. Chairman, I appreciate the opportunity to come before you and members of this Subcommittee to share the views of the Physician Payment Review Commission on the continued increase in Part B expenditures for physicians services. Today, I want to review with the Subcommittee the factors contributing to these increases, and the recommendations the Commission has made to address this problem.

As you know, Medicare outlays have been increasing rapidly throughout this decade, with Part B services growing faster than most of the rest of Medicare. Some of the growth in Part B is attributable to improvements in technology. There have also been increases in the intensity of services provided to beneficiaries that are more difficult to explain. These increases in Part B payment are becoming a very serious concern for beneficiaries, physicians, and taxpayers alike.

Physician services currently account for about 72 percent of Part B expenditures. Total Medicare outlays for Part B increased roughly 17 percent a year between 1980 and 1988, with expenditures for physician services increasing at nearly the same rate as total outlays. The growth in physician services per Medicare beneficiary (often referred to as the volume of services) was recently estimated to be about 7 percent annually for the years 1980 through 1987.[1] Since the introduction of Medicare's Prospective Payment System (PPS), the compounded annual growth rate for physician services has been more than twice as great as the rate of growth for inpatient hospital services.[2]

This year the growth in expenditures is somewhat below that of the last two years, but the pattern remains consistent with long term trends: the rate of increase continues to be far above what would be expected from general price inflation and growth in the number of elderly beneficiaries. Analysis of increases in Part B expenditures during the period 1983 to 1986 (a period largely covered by a fee freeze) found that almost three-fourths of increase in Medicare spending for physician services during this period was due to a growth in the volume of service per beneficiary and the substitution of more expensive for less expensive services.[3] Some of this increase is associated with the introduction of new technologies that enhance the quality of care available to beneficiaries. A number of other components to these rising expenditures for physician services have also been described in recent analyses. Shifts in the setting of some services have resulted in shifts in payments from Part A to Part B. At the same time, outpatient surgery increased in volume beyond what would have been expected from shifts in site of care related to PPS alone. Moreover, a more expensive mix of outpatient surgeries being performed has resulted in increased charges per service. The use of higher intensity visit codes with increasing frequency has further added to expenditures for physician services in recent years.

Analyses conducted by Janet Mitchell on changes in Medicare expenditures and volume of services show that Medicare physician expenditures per beneficiary increased by 29.5 percent over the four-year period from 1983 through 1986.[4] The rate of expenditure growth or service use, however, was not uniform for different categories of services, for specific services, or for services provided by physicians in an individual specialty. For example, three kinds of services grew at above-average rates: surgery, radiology and specialized tests. Increased spending for surgery was the single most important contributor to expenditure growth during the period. Even within surgery, some services declined in frequency while others, such as cataract surgery and coronary artery bypass surgery, increased substantially. The results of this analysis show the rapidity of change in the use of services and its effect on Medicare expenditures.

The development of policies to reduce the rate of expenditure growth is an important part of any reform strategy the Commission will consider. The Commission is concerned not just with how much Medicare spends but with the services on which Medicare dollars are spent.

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[1] This estimate is based on PPRC analysis using data from the Annual Report of the Board of Trustees of the Federal Supplementary Medical Insurance Trust Fund.

[2] Statement of William L. Roper, M.D. before the Committee on Ways and Means, U.S. Congress, House of Representatives, Washington, DC September 29, 1988.

[3] This research was based on pooled physicians claims for four states: (Alabama, Connecticut, Washington, and Wisconsin). J.B. Mitchell, G. Wedig, and J. Cromwell, "The Medicare Physician Fee Freeze," *Health Affairs* 8(1) 21-33, Spring 1989.

[4] Mitchell, Wedig and Cromwell, 1989.

FACTORS AFFECTING THE GROWTH IN EXPENDITURES

The job of designing sound policies to slow the growth in service use is complicated because many factors affect the trends we see. The number of medical services provided is ultimately the result of decisions made by beneficiaries or physicians acting on their behalf. Each responds to the information available on what care is indicated and to financial, legal, technological and other considerations about how to proceed.

In part, the increase in services comes from improvements in medical organization and technology and from a reduction in unmet need through deliberate changes in policy to improve access to care. Advances in medical technology also may add new services or lead to different applications that increase total services provided for a given medical problem. These services may significantly improve the outcomes of care, particularly in terms of quality of life for beneficiaries.

Incentives inherent in a fee-for-service payment system also may affect medical care decisions by physicians and beneficiaries. Physicians are clearly the primary decision makers about the use of medical services, including their own services. As agents of their patients, they are expected to either provide or arrange through referral all services that are of benefit. Since physicians are paid for each service they provide, the incentive is to provide or arrange for more services. It has been suggested that this incentive, inherent in any fee-for-service payment system, may be magnified when physicians face constraints on their fees or competition for patients.

For example, the substantial growth in physician supply, particularly in the past ten years, would have been expected to increase the number of services used as a result of making care more available. Some have argued, however, that physicians may have compensated for a decline in average patient load resulting from the rapid increase in their numbers by increasing the number of services they provide per patient. The potential for such a response is certainly there, with the financial incentive to add an extra service or test, the uncertainties in medicine about whether the extra care will benefit the patient, and concerns about professional liability.

Beneficiary demand for care also contributes to increased service use. Strong media interest in advances in medical care affects Medicare beneficiaries as well as the rest of the population. They have high expectations. Moreover, fee constraints and rising assignment rates, in conjunction with increases in supplementary coverage (Medigap), have reduced some financial barriers to seeking care.

While the primary goal of both physicians and beneficiaries is providing care that will benefit the patient, decisions about the use of any service that is perceived to have some potential benefit will be influenced by both the positive financial incentive for physicians to provide the service and the weak financial incentive for beneficiaries to restrict their use of services.

COMMISSION RECOMMENDATIONS FOR CONTROLLING THE VOLUME OF PHYSICIAN SERVICES

In its 1989 Report, the Commission has recommended that three policies be pursued:

(1) giving physicians collective incentives to contain costs through expenditure targets,

(2) increased research on effectiveness of care and development and dissemination of practice guidelines,

(3) improvements in utilization management by carriers and peer review organizations (PROs).

EXPENDITURE TARGETS

The Commission spent a great deal of time reviewing the evidence and considering options for controlling the rate of growth in Part B services. Some options, such as capitation, hold promise for the future, but do not currently provide means of addressing problems facing the Medicare program and program beneficiaries. Other approaches, such as fee freezes, do not address the more basic issues of assuring that beneficiaries receive appropriate high quality care.

The Commission concluded that the burden of expenditure increases on beneficiaries and on the Medicare budget has become so serious that a systematic and fair approach to controlling the volume of these services is an essential component of payment reform. The Commission has urged Congress to enact legislation this year to implement a package of payment reforms that includes a Medicare Fee Schedule based on resource costs, limits on balance billing, increased support for effectiveness research and practice guidelines, and expenditure targets.

The Commission has recommended that an expenditure target system for physicians' services under Part B be used to determine annual conversion factor updates

under the fee schedule. The target would reflect increases in practice costs, growth in the number of enrollees, and a decision concerning the appropriate rate of increase in volume of services per enrollee. The last would reflect tradeoffs between beneficiary needs, technological advances, and newly covered services on the one hand, and affordability on the other.

If actual expenditures during a year are equal to targeted expenditures, then the conversion factor update for the following year would be equal to the increase in practice costs. The update would be increased or decreased to reflect differences between actual and targeted expenditure increases.

As an example, assume that practice costs are increasing by 4 percent, enrollment is growing 2 percent, and volume of services is projected to increase by 7 percent per enrollee. This would lead to a 13 percent increase in expenditures. Now assume that a target of 11 percent is chosen, which would permit a volume increase of 5 percent. If actual expenditures rise 13 percent, then the conversion factor update for the following year would be 2 percent. That is, the 4 percent increase in practice costs would be offset by a 2 percent decrease to reflect the 2 percent volume increase above the 5 percent "allowed" increase. If actual expenditures rise only 9 percent, then the conversion factor update would be 6 percent (4 percent for practice costs, plus a bonus for staying below the target by 2 percent).

It is important to note that this expenditure target approach is not radically different from current practice. For years, the budget reconciliation process has resulted in various across-the-board as well as targeted cuts in Part B spending levels designed to keep spending within levels deemed acceptable for budgetary purposes. The key differences are that:

- Expenditure targets are determined prospectively and are explicitly based on factors directly linked to the need for and costs of care, and
- Expenditure targets are designed to provide the medical community with an opportunity to provide constructive input into the organization and management of physician services.

Expenditure targets would not alter the financial incentives for individual physicians and their patients. There is nothing in this policy that would prevent a physician from providing a beneficial service to a patient. The funds for providing Part B services cannot "run out." Medicare would pay for all covered services that are judged medically necessary and appropriate, just as it does now. The only negative repercussion for a physician is that if expenditures grow more rapidly than the targeted amount, fees would increase less in the following year. In fact, physicians would have the same incentives to provide more services that they have now since they will continue to receive payments for each additional service.

Under expenditure targets, the incentives to control volume would fall to the physician community, which could respond through education and support of the existing medical review systems. For example, the American Medical Association and national specialty societies could develop practice guidelines and disseminate them, and actively encourage their use. They could provide technical assistance to carriers and PROs in the development of review criteria and political support for sanctions of physicians who persisted in providing care that is inappropriate or does not meet standards of quality. To allow time for the necessary infrastructure to control costs to develop, the Commission has recommended that target rates of increase adopted this year and for the first few years not depart substantially from baseline rates of increase.

The Commission has recommended beginning with a single target at the national level, but anticipates that the policy will evolve to one with multiple targets. For example, targets could be established for states or carrier areas or for categories of services (for example, separate targets for surgery, nonsurgical procedures, and evaluation and management services). Broadening the target to include the rate of hospital admissions is another possible direction.[5]

For example, separate targets could be developed for each state or substate areas. The advantage of this approach is that state and local physician organizations could play a larger role in attempting to affect practice through education and peer review. Medicare has organized its infrastructure of carriers, intermediaries and PROs on a geographic basis that approximates state boundaries. With regional targets, physicians might feel that they could work through their local organizations to

[5] If the scope of expenditure targets extended beyond physicians' services, this would not imply that the prices for those services would be adjusted in response to the targets. Rather, the conversion factor update for the physicians' services would simply be based on a broader indicator of expenditure growth.

meet state or metropolitan targets, while national targets would encompass too many aspects of care beyond their control. The American College of Surgeons has proposed an expenditure target for surgical services. Separate targets for categories of services might also provide a basis for more structured physician response to expenditure targets. Separate targets could increase the participation of national specialty societies and give physicians more of a sense that they can respond to the incentives.

The Commission has been doing a great deal of work on the technical and administrative issues involved in alternative approaches and models for Medicare expenditure targets, and would be pleased to discuss our work with you in detail.

EFFECTIVENESS RESEARCH AND PRACTICE GUIDELINES

As I indicated earlier, there seem to be some very good reasons for the increase in Part B volume, but much remains that we cannot explain adequately. This is because there are basic gaps in our knowledge of the efficacy and effectiveness of medical care. There is increasing evidence that beneficiaries receive some services that are unnecessary and fail to receive some services that would benefit them. Over many years, a substantial research literature has documented unnecessary laboratory tests, radiological procedures, hospital admissions and days of care, surgical procedures, and drugs. Several recent studies of specific procedures have shown that as many as 10-30% of recipients were unlikely to benefit because the procedures were performed for inappropriate reasons.

These inappropriate procedures reduce the quality of care and increase cost. Inappropriate invasive procedures may involve substantial risks to the patient without accompanying benefit. The cost of these unnecessary services is also substantial. For instance, Medicare spends more than $300 million per year on physicians' charges for coronary artery bypass operations. If just ten percent of these are inappropriate, $30 million in physicians' charges and millions more for the associated hospital charges could be saved or spent for more beneficial services.

Incomplete knowledge of the risks and benefits of medical services and procedures also limits the effectiveness of utilization and quality review. Review criteria are not always based on sound evidence, with the result that much review is open to the criticism that it is arbitrary and inhibits good quality care. The Commission would like to see review of utilization and quality have a firmer base in knowledge of appropriate medical practice.

There are two ways to increase what we know about the risks and benefits of medical services: clinical research on effectiveness, and development of practice guidelines that draw on this research and on the clinical experience of practicing physicians.

The Commission has recommended a substantial increase in federal support for building our knowledge of the effectiveness and appropriateness of medical practices and getting that knowledge to practicing physicians and their patients. We need to know more about which of our diagnostic tools work, and which patients would benefit from particular therapy. This knowledge is essential if we are to reduce unnecessary and inappropriate services. The Commission applauds the Administration's request for additional funding to support research on the effectiveness of medical care. The legislation introduced by Senator Mitchell and others on this Subcommittee, and bills introduced by Congressmen Gradison and Waxman would take us a long way towards the goal of improving the effectiveness and quality of medical care.

We need more research to determine the medical outcomes and the costs of alternative medical practices and procedures, and to determine the best ways to organize and provide care. This work would include clinical trials, epidemiological studies of data generated by clinical practice, analyses of the cost-effectiveness of alternative ways to provide or organize care, and assessment of techniques used in managed care to influence physicians' clinical decisions.

The knowledge we have about effectiveness and appropriateness must be made available to physicians and their patients. Practice guidelines synthesize the best that we know from research and the judgments of practicing physicians into a form that can be readily used. The Commission has recommended that the federal government actively encourage the development and dissemination of practice guidelines so that they are incorporated into physicians' practices, made available to patients, and used as the basis for coverage and payment and for medical review criteria by hospital medical staffs, carriers, and PROs.

The Commission has also called for the federal government to support practice guidelines through funding, coordination and evaluation. Funds should be used to support and build on existing private sector activities by the medical profession and

others. Federal oversight should focus on insuring the integrity of the process, including the quality of the methods used and of the resulting guidelines, and facilitating efforts among those involved in developing the guidelines to share information, identify issues and set priorities.

The federal government also has a role as administrator of Medicare. The Health Care Financing Administration should reinforce the importance of basing medical review on sound criteria by assisting PROs and carriers in selecting and using review criteria that are consistent with practice guidelines.

UTILIZATION REVIEW

Improved utilization and quality review is essential to the success of expenditure targets. This reform involves more than devising a formula for fee updates. It must establish both a structure and incentives for physicians to assume greater responsibility for the effectiveness and efficiency of the care they provide. Expenditure targets are likely to have a positive effect on patient care as well as program costs only if physicians reimbursed by Medicare become more involved in the development and administration of the utilization and quality reviews, and more committed to making the reviews productive.

The Commission supports the current efforts by HCFA to move toward a more comprehensive approach to medical review and calls for further actions to strengthen the review process. The Medicare program will have to create a comprehensive medical review system that looks beyond individual services to complete episodes of care. This requires systematic integration of information drawn from claims data, analysis of practice variations and peer review of physician practice.

To take on these responsibilities, it is essential that carriers and PROs have additional resources and time to build the necessary capacity. It will also require more administrative flexibility and the cooperation of the medical community. The Commission has developed a set of specific recommendations to structure and focus the transition from the current system that has emphasized claims payment to one of comprehensive review. The key elements of these recommendations include:

- Requiring that HCFA, carriers and PROs to work together to delineate the future roles of PROs in reviewing care provided by physicians in different settings,
- Charging HCFA with responsibility for establishing procedures to involve both carriers and PROs in designing criteria used in utilization and quality review, in developing physician profiling activities, and investigating physicians suspected of providing inappropriate or substandard care or billing inappropriately,
- Ensuring that PROs and carriers consult with appropriate medical organizations when developing medical review criteria, and
- Designating a single entity to support research, demonstrations, evaluations, and technical assistance in quality and utilization review for carriers, intermediaries and PROs.

CONCLUSION

Between 1979 and 1989, Medicare spending on physician services per enrollee more than tripled, rising much more rapidly than inflation. Medicare is accounting for a growing proportion of the federal budget and the budgets of beneficiaries. There is a growing body of knowledge that suggests that many of the services provided to beneficiaries are of little or no value, while other appropriate and necessary services are not being provided.

The Commission believes that expenditure targets would provide a mechanism through which Medicare could control the growth of Medicare outlays. Expenditure targets would provide a collective financial incentive to the medical profession to slow expenditure growth by reducing services of little or no benefit to beneficiaries. While not providing direct incentives to individual practitioners, such a policy would encourage the leadership of medicine to become more active in the support of activities to better inform physicians of the medical benefits and risks of procedures, and to play a more active and constructive role in peer review activities.

The federal government's responsibility in such a policy goes beyond setting the targets and monitoring updates, however. The federal government must provide substantial support for activities that would increase knowledge on the effectiveness and appropriateness of medical care. It must also strengthen utilization and quality review activities by carriers, intermediaries and peer review organizations, encouraging these organizations to look to the medical profession for technical support on review criteria.

SUBMITTED BY SENATOR JOHN HEINZ

U.S. SENATE,
Washington, DC, April 3, 1989.

Hon. CHARLES A. BOWSHER,
Comptroller General of the United States,
General Accounting Office, Washington, DC.

Dear Mr. Bowsher: As Majority Leader, Chairman and Ranking Member of the Senate Special Committee on Aging, members of the Senate Committee on Finance, and Chairman of the Senate Committee on Governmental Affairs, we are writing to request that the General Accounting Office (GAO) conduct a study in a promising new area of health research that seeks to improve the quality and effectiveness of medical decision-making. We refer specifically to efforts to conduct research and develop clinical practice guidelines that can help direct practitioners toward the most effective and cost-efficient treatment options.

Growing public concern over the quality and rising costs of health care has driven the Congress, the Administration and the medical community to closely examine the true effectiveness of medical procedures used to diagnose or treat patients. Too often, we discover that certain tests and procedures used in the course of medical treatment have increased the costs of caring for patients while providing little to no benefit to the patient and exposing them unnecessarily to intrusive and possibly high risk interventions.

Knowing this, the Congress has supported research to improve our understanding of variations in physician practice patterns and the relative impact of alternative interventions on patient outcomes. The Department of Health and Human Services (the Department) has also launched an "Effectiveness Initiative" to expand the scope of this research to include studies that draw from existing administrative and newly developed clinical data in the Medicare database. At his confirmation hearing before the Senate Committee on Finance, Dr. Louis Sullivan reaffirmed the Department's commitment to this body of research and cited the need for better information on effective medical practices as one of his highest priorities as incoming Secretary.

This important area of research has the potential of both improving the quality of patient care and reducing unnecessary costs. If we are to be successful, we firmly believe that the methods and protocol for conducting outcomes research and developing practice guidelines must be scientifically valid and regarded as credible by the medical community, policy-makers, and the public.

Our concern is that the work being carried out in the public and private sectors is proceeding in the absence of any broad strategy or any clearly defined protocols for research and guideline development. We are also concerned by the limited discussion, at the outset, of how this research has been determined historically, what methods have been used, and their strengths and limitations. At the same time, we believe that the widespread support for this body of research presents a unique opportunity to draw on the resources and expertise available to the Congress and the Department in moving forward toward a common goal.

We are therefore requesting that the GAO undertake a study on what procedures and/or protocols should be followed in setting priorities for outcomes research, for determining the most appropriate) and cost-effective research strategy within a given priority area, and for developing practice guidelines.

Our intention is that the GAO compile information and recommend approaches to decision-making that will support the Department's efforts to proceed with outcomes research and guideline development in the most effective and scientifically sound manner possible. In conducting this study, we ask that the GAO build on the work already underway and the expertise available across the Department agencies and that the scope of the study include the full range of resources and programs under the Department's purview. We also ask that the GAO's study address the following questions.

(1) How is effectiveness defined by the different parties interested in medical practices and technologies (i.e. patients, physicians, insurers, and others)?

(2) What methods have been used and/or are being developed to determine the effectiveness of new or existing medical practices and technologies?

(3) What are the strengths and weaknesses of existing and emerging methods for determining effectiveness, including time and cost considerations?

(4) How should this information be integrated in planning future outcomes research and guideline development?

(5) What are this most successful approaches to disseminating information on research findings and practice guidelines to the medical community?

(6) Other questions as determined to be appropriate by the GAO.

Based on initial discussions with staff from the GAO's Program Evaluation and Methodology Division, we believe that this work can be done effectively and relatively promptly. While we welcome your recommendations on how such a study might best proceed, we believe it would be most useful if your work focused on specific medical procedures. This approach would not only provide a model for other types of diagnostic or treatment interventions, but would also provide information immediately relevant to current research on the procedures selected for study.

We look forward to your positive response and appreciate your attention to this important matter. Should you have any questions regarding our request, please do not hesitate to have your staff contact Nancy Smith of the Aging Committee minority staff at 224-1467.

Sincerely,

GEORGE J. MITCHELL,
Majority Leader.

DAVID PRYOR,
Chairman, Senate Committee on Aging.

JOHN HEINZ,
Ranking Member, Senate Committee on Aging.

JOHN GLENN,
Chairman, Senate Committee on Government Affairs.

PREPARED STATEMENT OF WALTER B. MAHER

Chrysler Corporation commends the work of the Physician Payment Review Commission in developing a comprehensive set of proposals to rationalize the pattern of payments to physicians by Medicare and to slow the rate of increase in Medicare costs.

As the private sector continues its struggle to bring under control the rising health costs which threaten the very fiber of our country's competitiveness, we welcome these efforts by America's largest health benefit plan, Medicare. Further, based on our company's experience, we believe it was most appropriate for the Commission to recommend at this time that Medicare address both the pricing and volume of services issues.

In mid-1981, as Chrysler was in the midst of a massive recovery effort, it established America's first Board of Directors'-level committee devoted exclusively to analyzing Chrysler's health care cost problem and searching for solutions. Since that time, a substantial number of cost management initiatives have been adopted by Chrysler, in cooperation with the UAW, and even more actions are planned. Some actions focused on price. Others, such as precertification programs, focused on volume, albeit in a piecemeal way. Despite these actions, Chrysler has seen its per capita cost of providing health coverage to employees and retirees increase at an average annual rate of 8.5 percent since 1981. While this was substantially better than the average business' experience, it nevertheless represented a rate of increase which exceeded both CPI and GNP growth. Worse, the last two years have seen double-digit rates of increase. In short, we and many other businesses have been running as fast as we can to combat the health care juggernaut, and we are falling farther and farther behind.

As a result, late last year we stepped back and asked ourselves: we have been analyzing and working on this issue for 8 years; what have we learned? This is what we have learned:

- U.S. health costs are the highest in the world by far.
- The high rate of expenditures is not yielding better health care for all Americans.
- There is a substantial amount of dissatisfaction with the system, both from payers and from 37 million uninsured Americans.
- A business adopting sound health cost management strategies can achieve significantly lower costs.
- Even the costs of a well-organized program are excessive and render U.S. business non-competitive in world markets.

In 1989, Americans will spend almost 50 percent more per capita on health care than the second most expensive country in the world (Canada); and we are well over

100 percent more expensive than Japan. These statistics would not necessarily be so frightening if we were getting our money's worth. America, however, ranks but 16th in life expectancy and 17th in infant mortality; there is virtually no health professional who does not readily admit to the existence of wastefulness in the delivery and consumption of health services; and despite all these expenditures, there are 37 million U.S. citizens without health coverage.

My company is concerned about the competitive damage inherent in the dramatic differences between health costs in the U.S. compared with other leading countries. We must compete with foreign automakers who have a $300 to $500 per car advantage over us due to health care costs alone. Coming off 1988, which saw business health costs in general increase a reported 22 percent, Hewitt Associates, a leading employee benefits consulting firm, is forecasting 1989 costs will increase another 21.5 percent. American business cannot continue funding such a health care system and succeed against international competitors. Put in its broadest, macroeconomic perspective, America's health care system creates a type of export tax since many significant exports from the U.S. are produced by its largest companies which traditionally offer good employee health benefit plans. Given this perspective, the system actually contributes to the U.S. trade deficit and impairs competition on many levels.

However, business pays only about 25 percent of America's health care bill. Federal, state, and local government programs pay 40 percent of the tab (using tax dollars, of course); and individuals pay 33 percent, the bulk of the balance, either through direct patient payments or private insurance premiums. This represents a painfully high, yet quite subtle, surtax on all Americans.

The causes of this problem are legion, but a factor undoubtedly contributing to most of them is that America's health system per se has never had to cope with any semblance of a resource limit. Further, health care has not appeared to be the type of good or service where purchasers, at least up to now, have been able to step in and regain overall control. As a result, based on analyses of both Medicare and private sector health benefit utilization, we have a system which encourages the provision of a high volume of unnecessary or questionable medical services, we observe significant variations in physician practice patterns with no difference in patient outcome, and new technology is substantially overused; (most of the above receives a powerful stimulus from the malpractice crisis that envelops medicine).

Our system also sees about 40 percent of the hospital beds in America empty. This excess capacity not only generates unnecessary system cost, but prompts hospitals to incur additional advertising and promotional expense as they seek to reach out to fill these beds or otherwise enhance their incomes. This contributes to an American phenomenon: the mass marketing of medicine, stimulating demand for services and creating a cultural appetite for health care.

If we examine the health systems other countries have adopted, we find two common denominators: they provide protection for all their citizens, and they have effectively established a process which provides some measure of control over how much of a country's resources its health system can consume. While the U.S. health care system has many, many wonderful attributes, these two features are missing. I submit we can embrace them without detracting from the good our system has to offer.

Recent recommendations to Congress by the Physician Payment Review Commission, a group established to advise Congress on reforms in Medicare policies for paying physicians, hold promise to start us on the road to recovery:

- To rationalize the current pattern of payments among physicians, which has overpriced and promoted an inappropriate volume of many surgical and technical procedures and undercompensated evaluation services, the Commission proposed to revise the Medicare fee schedule to base payments primarily on the resource costs incurred in efficient medical practice.
- To help assure the delivery of quality, effective health care, the Commission proposed funding should be provided to support effectiveness research and practice guidelines. The development of practice guidelines may not only serve to reduce unnecessary services, but may also provide protection from malpractice liability for physicians who follow them.
- To control year-over-year growth in spending for physicians' services annual expenditure targets are proposed and subsequent year's rate of fee increase would take into account overall compliance with the target. In the absence of effective practice guidelines, we believe this is a particularly appropriate recommendation.

If adopted by Congress, these initiatives could help pave the way for the private sector to incorporate similar principles into their plans. While not solving all the problems, they would represent: constructive first steps.

Clearly, however, business, labor, government, hospitals, physicians, and consumer groups must quickly and in a focused manner work together to resolve what is truly a national crisis. Health care costs pose a major competitive hurdle for American business and represent a substantial drain on the resources of all Americans. Neither business nor American citizens can afford such waste if we hope to preserve our economic status and standard of living.

PREPARED STATEMENT OF DAVID G. MURRAY

Mr. Chairman and members of the Committee, I am David G. Murray, MD, FACS, a member of the American College of surgeons' Board of Regents and of its Physician Reimbursement Committee. The College appreciates the opportunity to present its views on Medicare physician payment issues at this third hearing.

Mr. Chairman, the American College of surgeons believes that if serious steps are to be taken to moderate spending for Medicare services, including the services of surgeons, then some workable approach must be found to strike a better balance among fee considerations, increases in the volume and the intensity of services, and the financial protections afforded beneficiaries under the program. This, it seems to us, is far more important than focusing attention almost exclusively on how payments should be distributed among different categories of physicians.

If we are going to be realistic, Congress must recognize that spending for health care for the elderly probably will continue to rise, even if all payments to hospitals and physicians were to be frozen at today's price levels. After all, the total number of Medicare beneficiaries is increasing every year, and the average age of the older population in this country also is rising, so that the demand for medical services from the elderly should be expected to increase as well. Moreover, changing medical technologies, better diagnostic and surgical techniques, and improvements that enhance the quality of life for older patients also contribute to increased Medicare spending for health services. Few would suggest that the aged—but not the young—should forgo these benefits. The major policy problems for the Congress, as we see it, are to determine by how much spending growth can be moderated without serious consequences for aged patients and whether such costs can be made more predictable.

Up to now, only two general methods for moderating health spending have been discussed—either reducing the unit prices (or fees) of physicians' services or reducing the volume of those services.

The current volume of physicians' services obviously reflects judgments about medical necessity that are influenced by the state of medical knowledge, and also, in part, by the professional liability climate. We also believe that more physician-developed standards and guidelines are needed to define office and outpatient practice patterns relating to specific diseases, such as those that have been developed for a number of operations provided in inpatient settings. Criteria are needed to make reasonable judgments about the frequency, volume, and effectiveness of both procedural an non-procedural physician activities. Ultimately, if guidelines are to influence the volume issue, it will be necessary to directly link payment policies with professionally developed criteria concerning the appropriateness and the effectiveness of various medical and surgical treatments. The American College of surgeons is prepared to participate in these developmental and application efforts.

Those of us in surgery believe that it is impossible to effectively and efficiently address the volume issue across the entire spectrum of Medicare physicians' services. The practice of medicine is such a highly complex and diverse activity that no single approach for addressing volume questions, it seems to us, is likely to work. In most major hospitals, the responsibilities for quality assurance and volume issues are assigned to specific departments with the experience and competence to deal with these issues in the context of specific service categories. It is for this reason that we propose to address the issue of the changing volume of services within the broad scope of physician service categories, such as for surgery. In our view, Medicare will have greater success in dealing with the volume issue if the program follows the present examples within the medical profession for evaluating the appropriateness and quality of service.

Thus, we believe that major steps can be taken now to moderate the growth in Medicare spending, if the government and the surgical profession can join together to make such a plan work. Working with the government, we are prepared to develop criteria to determine the appropriateness of various surgical treatments and to assist, as appropriate, in applying such criteria to determine payments for those

services under Medicare. Furthermore, we are prepared to help identify unnecessary, outdated, or inappropriate services on a specialty by specialty basis.

We suggest another tool for moderating the expenditures for surgical services. Under this approach, the secretary of Health and Human services would calculate actual program expenditures for surgical services in a base year—perhaps 1989. From these amounts, the secretary would be directed to determine on a budget-neutral basis a surgery-specific conversion factor that would be applicable to Medicare surgical services, using a fee schedule for Medicare surgical procedures. Under the plan, this 1989 conversion factor would be updated for 1990 so as to remain budget neutral with respect to any expenditure goals for Medicare set forth by the Congress for that year. For 1991 and each year thereafter, the conversion factor would be increased to reflect changes in the cost of surgical practice, including professional liability costs, and changes in the general earnings levels of other comparable professionals.

The secretary would be required to determine a national expenditure target for surgical services subject to the surgical fee schedule. In estimating this expenditure target for 1991, the secretary, in consultation with representatives from beneficiary organizations and professional organizations of surgeons, would be required to take into account:

- population changes, including the total number of beneficiaries covered by Medicare, the age distribution of the enrolled population, and factors affecting morbidity;
- cost changes, including costs relating to the increased use of new technologies, and cost changes reflected in a market basket index of practice costs (e.g. expenses for professional liability insurance) relating to surgical services; and
- estimated changes in the expected demand for and volume of surgical services that are required by Medicare patients.

It is essential that these calculations be as objective as possible, so that there would be no room for bias or for use of the target plan solely to achieve predetermined budget reduction goals. Unless this process is seen to be reasonable by both the elderly and by surgeons, the target would have little, if any, advantage over the present ad hoc decisions now reached by the Congress as part of its short-term annual budget deliberations used to set the next year's rate of increase in allowed fees.

Under our plan, if the secretary finds that the estimated expenditure target for surgical services covered under the plan—taking into account the factors just described—would yield a significantly lower conversion factor than would result from the process used to update the fee schedule, he would be required to submit to Congress recommendations for adjusting future updates in scheduled payment amounts applicable in later years. In the event that the secretary makes such a finding, he would be required to consider the views of the Physician Payment Review Commission (PPRC), the surgical community, and beneficiary organizations in developing his recommendations. In any event, the proposal would be to adjust rates in a future year and not to cut off payments or to ration services when an expenditure target is reached. A cap which would require a cut-off or rationing would create intolerable hardships for patients. some have expressed concerns about the potential for expenditure targets to impair the access of beneficiaries to medically necessary physicians' services. Obviously, the American College of surgeons would not advocate an expenditure concept if it believed that access to medically necessary surgical care would be seriously impaired.

We believe that some time will be required before the first target expenditure goal can be set in order to develop the infrastructure and data base within the surgical community that would be required for an effective program of volume assessment and compliance with professional standards. We are prepared to make a commitment to develop the needed infrastructure within the surgical community to make this plan work. However, we believe that implementation of parts of a plan could begin almost at once if Congress believes it is necessary to begin phasing in a target expenditure program next year. The College is prepared to work with the government to that end.

Mr. Chairman, we were pleased to learn that the PPRC also supports the concept of expenditure targets. However, there is a significant difference between one of the approaches advocated by the PPRC and that recommended by the College. Whereas PPRC initially suggests a single target at the national level, the Commission seems to suggest that the setting of targets should eventually apply to smaller, geopolitical units—perhaps on a statewide basis. The College believes that separate expenditure targets should be established at a national level on a specialty-specific basis, including at a minimum a separate target for surgical services. This is because the prac-

tice guidelines must, of necessity, be related to specific categories of physicians' services and be developed and implemented on a specialty-specific basis. We believe this approach would be more acceptable to practicing physicians in the respective specialties, as well as being more easily administered.

We believe the best volume constraints are those that aim at reducing the volume of services that offer the least value, not those that would reduce the payments for all services equally. The use of incentives for constraints that seem obviously preferable requires that any penalty for failure be applied to the specialty responsible for the failure. We believe such an approach assigns responsibilities to the appropriate parties and is essential to a well-functioning plan.

While we would favor the establishment of specialty-specific expenditure targets, we have greater reservations about the establishment of geographic targets. First, there is no practical way to develop separate guidelines for different geographic areas. second, no practical way to establish appropriate geographic targets has been identified. If geographic expenditure targets were related to current or past experience, the targets would tend to freeze the differences that now exist among areas. This ought to be troublesome for elected officials and for their older constituents. The high volume, high cost areas would be benefited and the low use areas would not. We also believe it would be problematic to accurately adjust for high usage in an area that was due to patients from other regions using its resources.

In conclusion, the American College of surgeons supports a comprehensive set of proposals for dealing with a number of major physician payment reform questions, including the issue of expenditure control. Our plan specifically envisions an increased emphasis on the development, dissemination, and application of practice guidelines, coupled with the use of a national expenditure target for surgical services.

Thank you Mr. Chairman. I would be pleased to answer any questions that you or the Committee may have.

PREPARED STATEMENT OF MICHAEL SOPER

Good morning Chairman Rockefeller and members of the Subcommittee. My name is Michael Soper, and I am a physician. I am also Senior Vice President and National Medical Director of CIGNA Health Plan. CIGNA is the largest investor owned HMO, with nearly one and one-half million members and 30 health plans, both staff and IPA models, located throughout the United States. In the past, I have been the Medical Director of an SPA model HMO in Florida and a staff model HMO in Kansas City, Missouri.

Today, I represent the Group Health Association of America, the oldest and largest national association of HMO's. There are currently 614 HMO's nationwide with a total enrollment of more than 32 million people. I have been asked to comment on how HMO's manage the volume of services to our patients without sacrificing quality. CIGNA and the rest of the managed care industry, have discovered that the managed care approach has proven to contain costs while providing high quality health care. HMO participation in federal programs such as Medicare and the Federal Employees Health Benefits Program (FEHBP) provides an important alternative health care delivery option and often an enhanced benefit package. And, in the private sector, HMO's have achieved high consumer satisfaction while slowing the rate of employer costs for health care.

It has been well-documented that HMO's do achieve a lower utilization rate for certain costly medical services, particularly hospital inpatient care. It is also increasingly apparent that variations in medical practice patterns are normal. HMO's manage to contain the volume of medical services towards the lower end, but still well within, this broad range of acceptable medical practice.

This has been confirmed and reconfirmed by quality of care studies. However measured, including measures of health status outcomes, these studies consistently report that the quality of HMO care equals or exceeds that of the fee-for-service sector. HMO's have developed systems for measuring and managing quality. The systems vary on a plan by plan basis, but they are all aimed at assuring the appropriateness of care, including the access to all needed care. Some plans have process-oriented systems which track compliance with standards. Others have highly sophisticated systems using predetermined outcomes measures. Still other HMO's rely on external review agencies such as the National Committee for Quality Assurance (NCQA), the Joint Commission for Accreditation of Health Care Organizations (JCAHO), or the Accreditation Association for Ambulatory Health Care Inc.

(AAAHC). And, many HMO's do all of these. This systematic quality management of HMO's has no counterpart in the fee-for-service sector.

The inherent nature of an HMO, with its organized delivery system, relationship with physicians and application of medical management, lends itself to prudent and appropriate medical practices. Perhaps two features of this organized, managed approach are most noteworthy: The role of primary care physicians and the manner of physician compensation.

HMO's establish each member with a primary care physician who serves as the access point to the medical care delivery system. Most needs to most members are satisfied directly by the primary care physician. When necessary, this physician also manages and facilitates referrals to specialists or inpatient care. This structure assures continuity and coordination.

The HMO setting permits physicians to practice their profession free from considerations of the patient's ability to pay for a specific service. Such an arrangement is attractive to both physicians and patients, but it fuels the inflationary effect on volume that results from the piece work nature of fee-for-service compensation. Consequently, HMO's seek to compensate physicians in a manner other than fee-for-service. Salary is the most predominant form of physician compensation in staff model HMO's and capitation arrangements, which are equivalent to salary in many ways, predominate in IPA models, particularly for primary care physicians. Many observers credit this removal of fee-for-service incentives as a critical attribute of the success of HMO's in managing the volume of health services without compromise in quality.

Many HMO's have also developed physician payment incentives which provide opportunity for payments in addition to the basic salary or capitation rates. These incentives take many forms, such' as bonuses based on performance. In some cases, the incentive system is designed to demonstrate the well established principle of sharing risk among the physicians and the HMO. The most common incentive systems base the amount of the additional payment on the experience of a physician's entire patient panel, the aggregate results of a group of physicians, or the overall results of the HMO. Increasingly, measures of performance relating to quality and patient satisfaction are included in incentive arrangements.

Three years ago Congress adopted legislation prohibiting physician incentive payments by HMO's under Medicare.

We understand that this legislation was initiated by an incident in which a hospital established an incentive arrangement to share with the attending physician the savings realized by the hospital in any case in which the Medicare DRG payment to the hospital exceeded the cost of service to the patient. Such an arrangement, which rewards the physician to selectively admit to the hospital those patients least in need of hospital care, was clearly destructive to the intent of the Medicare prospective payment program. The practice was quickly and correctly prohibited by Act of Congress.

But HMO physician incentive payments are of an entirely different nature. The legislation wisely included an effective date of April 1, 1990 in order to determine the nature and impact of HMO incentives on the delivery of care, and whether or not corrective measures were needed. Studies recently released by the Physician Payment Review Commission (PPRC) and the Government Accounting Office (GAO) on physician incentive arrangements in HMO's did not find evidence that these financial arrangements have any adverse effect on quality of care.

The role of physician incentive payments in affecting physician performance must be viewed in the entire context of HMO organization and management practices. These arrangements demand data, and the data provides information and feedback to physicians that is helpful in comparing and sharpening the accuracy of their medical practice. Therefore, we would urge Congress to proceed very carefully if it chooses to address the issue of physician incentive arrangements in HMO's.

Finally, and to some most important, patient satisfaction remains at an all time high. Recent independent enrollment surveys put HMO enrollee satisfaction in the 90% range.

Mr. Chairman, neither we nor our systems are perfect. We constantly reevaluate the way in which we provide and pay for the health care of our members. We focus our management activities on quality and patient satisfaction as well as cost containment. We constantly look for improvement and are readily willing to try new ways. This ongoing evaluation process is similar to this committee hearing today. We congratulate you on your efforts and will cooperate with you to the fullest.

Thank you. I'd be happy to answer any questions.

PREPARED STATEMENT OF LOUIS W. SULLIVAN

Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today to discuss Medicare payments to physicians. Both the Administration and Congress have spent considerable time and other resources examining the issue of payment reform. Indeed, during the past two weeks, several of your colleagues in the House have been working on a reform package which the Administration supports at this time. Allow me to outline for you today the Administration's views on the matter.

A GENERALLY ACCEPTABLE FRAMEWORK FOR PHYSICIAN PAYMENT REFORM

The administration is favorably inclined toward a three-part framework for physician payment reform. The trilogy we envision includes a resource-based relative value scale (RBRVS) fee schedule, an expenditure target for Medicare physician services, and beneficiary protections. However, because the resource-based fee schedule alone does not control growth in the volume and intensity of physician services and, indeed, could exacerbate it, the Administration would oppose such a fee schedule if it is not linked to a volume control mechanism such as an expenditure target.

Further, because of the administrative complexity of the various components of a comprehensive reform package, and because the research necessary to assign relative values for many procedure codes has not been completed or fully analyzed, a gradual transition period over several years is necessary to implement a resource-based fee schedule and allow for mid-course corrections. Hasty implementation could have serious adverse budget effects and present beneficiary access problems. Finally, the RBRVS is sufficiently developed now to be useful in identifying and reducing Medicare payments for overpriced procedures. Also, let me re-emphasize my personal commitment to our citizens in rural America and to those who live in the inner cities, that they will have access to quality health care. In this regard, you can be sure that I will be personally vigilant concerning the potential effects of any new payment system on access to care in medically underserved areas.

A WORD OF CAUTION: PHYSICIAN PAYMENT IS MORE COMPLEX THAN HOSPITAL PAYMENT

At the outset, I must sound a note of caution and point out that implementation of a physician payment system will be an enormously complex undertaking. Physician payment is the most complicated payment system under Medicare. Implementation of a Medicare fee schedule will be much more complex than, for example, implementation of diagnosis related groups (DRGs) was for hospital payments. There are 7,000 physician payment codes compared with only 475 DRGs; there are 500,000 physicians in the United States compared with 7,000 hospitals; and about 400 million claims compared with 11 million inpatient hospital claims annually. Clearly, most comparisons between implementation of a resource-based fee schedule and the prospective payment system for hospitals fail to capture the administrative complexity of the physician payment system and the human reactions of those affected by the changes.

THE ELUSIVE PROBLEM: GROWTH IN THE VOLUME AND INTENSITY OF PHYSICIAN SERVICES

The rapid increases in part B program costs—due primarily to increases in volume and intensity of services—is the principal problem which must be faced "head on" as part of any major reform of physician payment. Allow me to share with you some insight into the magnitude of the volume-intensity problem.

In FY 1990, Medicare expenditures for physician services will exceed $31 billion. Over the next ten years, even without any program expansions, Medicare spending for physician services will likely triple. In part because of the rapid increase in physician spending, and if current trends continue, total Medicare spending is expected to exceed spending on Social Security by about the year 2005, making Medicare the nation's largest entitlement program.

Expenditures for physician services are the second largest component (after hospitals) of Medicare spending, and represent the third largest Federal domestic spending program. To underscore the magnitude of our national commitment to providing access to physician services for the aged and disabled, I would point out that the $31 billion we expect to spend on Medicare physician payments next year is considerably more than the proposed FY 1990 Federal contribution to farm price supports ($15.9 billion) protecting our natural resources and the environment ($14.4 billion) and the entire budget of the Department of Education ($20.9 billion). clearly, because the decision to spend more on physician services leaves less in our collective coffers to spend on other worthy public goods, we have a particular responsibility to

assure that our funds are well-spent. We must seize the opportunity, through the physician payment reform debate, to work toward this end.

Three primary factors contributed to the growth in Medicare physician spending over the past 10 years: an increase in the number and average age of Medicare beneficiaries (15 percent), increases in the prices of services (40 percent), and increases in the volume and intensity of services provided (45 percent). The latter concept, the so-called "residual" component (which excludes price and population changes, but includes new services and technology), has increased about 7 percent over the last year.

Between 1982 and 1987, total allowed charges for physician services grew from $15.1 billion to $26.6 billion, a dramatic 76 percent increase. Surgical related services (including anesthesia and assistants at surgery) accounted for 42 percent of this increase, and medical care (primarily physicians' visits) accounted for 27 percent. The remainder of the expenditure increase was accounted for by diagnostic radiology services (12 percent), laboratory services (11 percent), and consultations (6 percent).

Allowed charges for physician services in inpatient settings increased by 27 percent between 1982 and 1987. This increase in allowed charges is particularly striking because it occurred at a time when both the number of Medicare admissions and average length of stay declined markedly. Further, increases were even more rapid in other settings including outpatient hospital settings and physician offices. Importantly, while there have been particularly large increases in the volume of certain procedures, our data highlight across the board increases in the volume and intensity of all physician services. clearly, the volume problems is not isolated to a few select services.

FACTORS DRIVING THE GROWTH IN VOLUME AND INTENSITY

It is difficult to isolate the exact cause of the recent increases in Medicare payments to physicians because of the many changes occurring at the same time in both the public and private sectors, and the difficulty of measuring various factors.

For example, fee-for-service payment arrangements provide no incentives for physicians to control the number of services they provide. Indeed, because payment is received for each service rendered, physicians may be encouraged to perform services, some of which may be of marginal or no value. Also, because physicians have considerable discretion relating to billing practices, they may assign more remunerative codes to services for which they formerly assigned less remunerative codes ("upcoding"), or perhaps bill separately for services for which they formerly billed under a single code ("unbundling"). Finally, the current payment system is "sticky": it provides no incentives to encourage reductions in prices as the cost of performing a service decreases.

New medical technology has vastly improved the ability of physicians to provide the highest quality care in the world. This technological sophistication comes at a price, however, and the Medicare program feels its budget effects. And, despite promising research on the effectiveness of medical practice, at this time physicians often lack the information they need to make the most appropriate decisions regarding which treatment alternative is optimal for which patients.

There are so many other factors which could have affected physician spending over the past ten years, I am forced to simply enumerate them: Medicare physician fees were frozen at various times; the participating physician program was initiated; a direct billing requirement and fee schedule were implemented for laboratory services; the hospital PPS system was implemented following the TEFRA per admission limits; the PRO program was implemented; several billing changes, including the implementation of a common procedure coding system, occurred; the supply of physicians increased; market competition from health maintenance organizations (HMOs) and other alternative delivery systems grew; high rates (80 percent) of Medigap or Medicaid coverage minimized out-of-pocket costs for most beneficiaries; and, the malpractice crisis permeated the everyday practice of medicine, leading some physicians to practice so-called "defensive medicine" by ordering more services than they otherwise would.

Clearly, the factors which have given rise to the out-of-control expenditures for physician services now facing the Medicare program are many and inter-related. Together they present a profound challenge to policy makers charged with the task of taming their budget effects.

EFFORTS TO CONTROL MEDICARE PHYSICIAN SPENDING HAVE BEEN DWARFED BY INCREASES IN VOLUME AND INTENSITY

Efforts have been made to control physician spending without sacrificing service quality or imposing heavy financial burdens on beneficiaries. The Administration continues to strongly support vehicles to aggregate payments to physicians through the Private Health Plain Option (PHPO), Preferred Provider Organization (PPO) demonstration projects, and bundling of services for payment purposes. We continue to believe that managed care options hold significant long-term promise for controlling volume. Since this long-term strategy will not bear fruit for many years, however, we have pursued less systemic, yet beneficial, options for controlling volume.

Policies directed at influencing physician decision-making have been pursued vigorously. HCFA has increased spending for utilization review by carriers, and involved the medical community in the development of medical policies used in utilization review. Peer Review Organizations (PROs) play a critical role in detecting unnecessary utilization and assuring that services rendered are of high quality. Also, payments for some services have been adjusted (increasing payments for primary care services relative to other services, reducing payments for overpriced procedures, and outright fee freezes).

Most recently, the Department has cultivated an effectiveness initiative. The initiative is designed to provide better information to physicians on "what works" in the practice of medicine, thus encouraging the provision of only the most appropriate medical services. It is important to keep in mind, however, that this effort is not a panacea for controlling the volume of services provided to Medicare beneficiaries. Indeed, it is just as likely to increase the volume of some procedures as it reduces the volume of those proven to be less effective. Clearly, the intent of this effort is not to determine how much society *should* spend on health care, but rather to ensure that the money we *do* commit is wisely spent.

Using these tools, the Department and congress have attempted to hold the line on physician spending in a responsible fashion. While these mechanisms have been helpful to varying degrees, compound annual rates of growth of 16 percent over the past 10 years have dwarfed these efforts. During this period, we were quite successful in bringing hospital costs under control, but physician expenditures remain "out of control". Given this state of affairs, the Administration strongly supports the implementation of a volume adjustment to the periodic Medicare physician payment update.

EXPENDITURE TARGETS: VOLUME ADJUSTMENTS TO THE PHYSICIAN UPDATE—NOT RATIONING

The efforts to control physician spending described above have served the Medicare program well, and there is much to be gained by continuing to pursue them, regardless of possible implementation of a reform package. However, in order to enhance the effectiveness of these mechanisms, a system-wide approach to controlling volume, such as an expenditure target, is necessary.

An expenditure target sets in advance a socially acceptable rate of increase in physician spending. Under an expenditure target, a future physician fee update would be adjusted based on a comparison of the actual and target increases in outlays during a performance period. If outlays increased more rapidly than the target, the future update would be reduced proportionately. conversely, if actual outlays were below the target, some or all of the savings could be passed on to physicians in the form of a higher update. An expenditure target would make an adjustment to the physician payment update based on volume trends—similar to the way the MEI makes adjustments for earnings and practice cost trends.

Expenditure targets do not create a link between the patient care decisions of an individual physician and that physician's earnings. Rather, they depend on the collective response of many physicians. Because an expenditure target operates by merely adjusting payment updates, and not stopping payment, an expenditure target does not ration care or lead to other inappropriate denials of care. It should also be noted that expenditure targets represent a minimal change from the current system in which congress repeatedly has been forced to reduce the annual physician update because of the large increases in physician spending. Thus, in some respects, an expenditure target merely formalizes the current de facto policy. An expenditure target has an important advantage compared with this de facto policy. Ad hoc freezes and payment reductions do not create any incentive or framework to facilitate a constructive response to the volume issue within the medical community. In contrast, expenditure targets would create a collective incentive to encourage physicians to work with the Medicare program to identify and correct problems related to

unnecessary care. One response might be the development and dissemination of practice guidelines and other educational efforts. Another response would be greater involvement of local physicians with PRO and carrier activities.

The federal government would facilitate these efforts through increased support of research and education concerning effectiveness, and through a commitment to improve PRO and carrier systems. One new initiative would be to use the carrier data system to provide physicians with feedback on utilization profiles.

An expenditure target might also encourage the medical community to take a positive approach toward development of policies, such as bundling and managed care, which would have a more direct effect on utilization.

Finally, we believe that the Secretary should be authorized to allow for an "opt-out" for managed care organizations. Under such a policy, an organized physician group (such as a PPO or hospital medical staff) could opt-out of the general expenditure target, and receive a fee update based on the performance of the group in relation 'to the target rate. This option would provide incentives for physician groups to be organized to provide care in a cost-effective manner.

THE RBRVS-BASED FEE SCHEDULE: PAYMENT EQUITY IS NOT A SOLUTION TO THE VOLUME PROBLEM

An RBRVS is simply a set of numerical values which reflect the "value" of one service relative to others in terms of the resources required to perform the service. By itself, an RBRVS does not set payment levels. To convert an RBRVS into a fee schedule, the relative values must be multiplied by a monetary conversion factor and a geographic adjustor. The conversion factor may be adjusted to ensure that the fee schedule is either budget neutral or budget sensitive.

The development of the RBRVS grew out of the dissatisfaction expressed by some with regard to the present physician payment method. Since the Medicare program began, physicians have been paid using the "customary, prevailing, and reasonable" (CPR) method. While the fact that about 80 percent of physician services are rendered on an assignment basis indicates that CPR has purchased access to physician services for Medicare beneficiaries, concern has been expressed regarding the large disparities in charges among geographic areas and between cognitive versus procedural services.

Proponents of the RBRVS developed by Dr. Hsiao and his colleagues at Harvard University for HCFA believe that adoption of a resource-based fee schedule will promote payment equity among physicians; encourage the provision of a more appropriate mix of cognitive versus invasive services; and limit rising Medicare outlays for physician services. While a resource-based fee schedule would promote payment equity, it is still a fee-for-service system, and the volume problem which plagues the current system would haunt a resource-based fee schedule as well.

Indeed, we believe that implementation of a resource-based fee schedule without an accompanying volume-control mechanism could exacerbate the volume problem as physicians who face payment reductions under the fee schedule respond by providing more services to offset their losses. Such a reaction would lead to still higher rates of expenditure growth and signal a true failure of any reform.

In this light, implementation of a resource-based national fee schedule would be opposed by the Administration, unless it is linked to an expenditure target mechanism to control volume growth.

At this point, allow me to mention the geographic practice cost index (GPCI) being developed, as required by congress, by HCFA in consultation with outside experts. A GPCI would be used in conjunction with an RBRVS and the conversion factor to determine payment for a particular geographic area. Different GPCIs would have distinct redistributional effects across geographic areas, and concern for equity among physicians must be balanced with the need to assure access.

IMPLEMENTATION ISSUES

While initial results of the Harvard study are encouraging, the RBRVS is not yet ready for use as the exclusive basis for determining all Medicare payments.

Implementation of a national fee schedule would be a challenging task for HCFA and the 34 Medicare carriers. A number of complex tasks would need to be accomplished in a carefully sequenced manner if implementation is to have a predictable effect on payment levels and budget outlays and if the risk of a major system failure is to be minimized. Also, because of the lack of experience with such a system, the Secretary should have flexibility in implementing the fee schedule within the parameters established by legislation.

The Administration prefers that a resource-based fee schedule be phased in over several year period (for example, beginning January 1, 1993), perhaps using percentage blend between current charge based payments and resource-based payments. In each successive year, payments would move toward the fee schedule amount by a certain percentage, with fee schedule amounts fully in effect in the final year of implementation. This approach would help avert unintended consequences of the new payment system, minimize potential risks to access, provide physicians and beneficiaries with an opportunity to adapt to changes in payment, and allow mid-course corrections if serious problems were to develop. It also would provide private insurers an opportunity to implement a similar fee schedule, if they so desire. Wide-spread adoption of a RBRVS-based fee schedule would ensure that the price differences between Medicare and other forms of insurance would continue to be minimal, and thus help preserve access.

In addition, I hope that this Subcommittee will give serious consideration to adopting a full Geographic Practice cost Index (GPCI), one which takes into account overhead practice costs and physician income. We believe that this option minimizes the shift in payments across geographic areas, and therefore will contribute to a more orderly implementation.

Implementation of a national fee schedule also will require completion of several major tasks. Diverse coding and geographic localities must be conformed to a single uniform national policy. The constraint of budget neutrality or budget sensitivity further complicates the task. An additional factor is the status of the Harvard RBRVS itself. Even optimistically, a complete RBRVS will not be available until July 1990. Significant changes in currently available relative values are likely to result from a variety of ongoing revisions planned for the second phase of the Harvard study.

Finally, I would like to mention that implementation of a national fee schedule should not preclude out-year budget savings. Some have argued that an RBRVS-based fee schedule should be implemented in a budget-neutral manner. Budget neutral implementation implies that for every dollar of "over-pricing", there is another dollar of "under-pricing". The RBRVS study does not support this conclusion. And, regardless of possible implementation of a resource-based fee schedule, the RBRVS can be quite useful in identifying and reducing Medicare payments for over-priced procedures.

BENEFICIARY PROTECTIONS

A key issue in any Medicare physician payment policy is beneficiary access and financial protection. To assure that access is preserved under a new physician payment system, the Administration supports the continuation of the participating physician program, including payment differentials for participating physicians. We also support some limit on extra billing as a financial protection for beneficiaries. I am pleased to report that 40.7 percent of all physicians (who account for 60 percent of the total Medicare spending on physician services) have signed formal Medicare participation agreements for 1989. Importantly, bet veen January and March 1989, 80.1 percent of all physician services were rendered on an assignment-related basis—an all time high.

CONCLUSION

Clearly, Congress, the Administration, and the medical profession have before them a unique opportunity to moderate one of the most distressing trends in Medicare payments: consistent and large increases in the volume and intensity of physician services. A resource-based fee schedule alone does not confront this issue squarely, and therefore would not be supported by the Administration. The Administration supports implementation of an expenditure target for Medicare physician services, and finds a three part framework of an expenditure target, resource-based fee schedule, and beneficiary protections generally acceptable.

I would be pleased to answer any questions you may have.

PREPARED STATEMENT OF JAMES S. TODD

Mr. Chairman and Members of the Committee:

My name is James S. Todd. MD. I am Senior Deputy Executive Vice President of the American Medical Association. With me today is John Kelly, MD, Director of AMA's Office of Quality. Accompanying us is Bruce Blehart of the AMA's Department of Federal Legislation. The AMA appreciates this opportunity to discuss, with

this Committee, the issues of volume and quality of physicians' services to patients as we move toward major modifications in the methods for determining physician payments under the program.

There has been a great deal of speculation on the impact of physician payment reform on the delivery of services, especially as the Congress considers implementation of a Medicare reimbursement schedule based on a resource based relative value schedule (RBRVS). As you know, the AMA, like this Committee, has strongly supported the development of the RBRVS as a way of eliminating the anomalies caused by Medicare's current system of determining payments for physician services (the customary, prevailing and "reasonable" methodology).

In the early discussions on this issue, many looked to the RBRVS as a tool to solve utilization problems by changing demand for services through elimination of inappropriate economic incentives for over utilization of expensive procedures. We also heard a great deal of concern about potential increases in volume because of reduced reimbursement. The RBRVS, by itself, cannot be seen as a vehicle to direct utilization and control expenditures. The proper course to assure that the Medicare program is spending its money wisely and that our patients are receiving the highest possible quality of care is the use of physician developed practice parameters.

Let me add that it is still urgent that we not let-up on our efforts to bring the professional liability crisis under control so that defensive medicine can be addressed.

Today, I will discuss three issues regarding volume and quality under Medicare: expenditure targets; outcomes assessment research and practice parameters; and mandated assignment and fee controls.

EXPENDITURE TARGETS

The Physician Payment Review Commission (PPRC) has been before this Committee and has recommended substantial modifications to Medicare by calling for a system of explicit expenditure targets. The AMA believes that this proposal constitutes a radical departure from our nation's commitment in creating the Medicare program to provide the elderly with all necessary medical and other acute health care. Expenditure targets would require a complex system for implementation and operation, and they are an untried commodity that carries the potential of significant harm. It will replace our nation's commitment to the elderly with a system of economic incentives to withhold services to meet the expenditure target. In effect, it calls upon physicians to make the rationing decisions for society on a case-by-case, encounter-by-encounter basis.

The PPRC recommendation may appear to be a painless way—from the viewpoint of fiscal administrators to hold the line on program expenditures, but the bottom line of a decision to impose expenditure targets is the creation of an implicit system to ration health care. A national target that is tied arbitrarily to a formula based heavily on a political judgment about the appropriate rate of increase in volume of services per enrollee, rather than medical judgment about actual health care needs, provides the starkest possible proof of this point.

Questions about how expenditure targets would operate also should be examined thoroughly prior to any further consideration of this radical step—How would the target system be implemented and updated? Would physicians be insulated against potential liability problems arising from withholding care? Would collective action by physicians to constrain costs be viewed as restraint of trade by the Federal Trade Commission? Without any demonstration of an expenditure target system in the United States and without answers to these and other questions, acceptance of this recommendation would be very unwise.

In addition to our view that rationing is not an acceptable direction to reduce Medicare expenditures, the American people do not want rationing of health care for the elderly and disabled. *Public opinion surveys consistently find that the American people want to cover the health care needs of these populations:*

- In response to a 1986 poll conducted for NBC News and the Wall Street Journal, when asked: "To help reduce the federal budget deficit, would you favor reduced benefits for Medicare or not? . . ." 86% answered that they opposed reduced Medicare spending.
- In response to a 1987 poll conducted for ABC News and the Washington Post, when asked: "Should spending for (the Medicare program which helps reduce health care costs for the elderly) be increased, decreased or left about the same?". . . only 3% called for decreased spending, 22% called for spending to stay the same, and 74% called for increased spending.
- In response to a 1988 poll conducted for NBC News/Wall Street Journal, when asked: "Do you want to see the federal government spend more or less money .to

provide health care for the elderly?". . . only 5% called for less spending, and 83% called for more spending to meet the health care needs of the elderly.

Expenditure Target Experience

Establishing a nationwide or regional system of expenditure targets eventually would devolve into a system that would mirror many of the same problems evidenced in those Canadian provinces (British Columbia, Alberta and Quebec) that limit total expenditures for medical and health services. With their experience as a model as to what could happen in our country, there is mounting evidence that limiting program benefits through expenditure targets will result in medically unacceptable results.

As recently reported in the Canadian press, their health system is starting to deteriorate and rationing is now being openly discussed. According to the Canadian weekly newsmagazine Maclean's (February 13, 1989) patients have died after long waits for needed surgery. Other examples from these provinces that maintain an expenditure target system present a telling story:

- Montreal and Vancouver emergency departments often have no capacity to handle new patients.
- The wait in Vancouver for psychiatric, neurosurgical or routine orthopedic consultation is 1-3 months, 6-9 months for cataract extraction, 2-4 years for corneal transplantation, and 6-18 months for admission to a long term placement bed.
- Many waiting lists in the province of Quebec for angiograims are six months long.
- The wait in the province of Quebec for coronary artery bypass surgery is 8-9 months.
- In all of Canada, there are only 11 hospitals that are capable of performing open heart surgery (793 in the U.S.), 14 hospitals capable of performing organ transplants (319 in the U.S.), and only 12 hospitals have magnetic resonance imaging (MRI) equipment (there are no MRI facilities outside of hospitals in Canada). [Canadian figures are from 1988 and U.S. figures are from 1987.]

Based on this directly relevant Canadian experience, Congress should not experiment on our elderly population with this type of proposal. Such a system is unprecedented in the United States and holds very real risks for our elderly and disabled patients.

IMPROVING QUALITY AND OUTCOME ASSESSMENT

Rather than ration care, activities to assure quality, necessity, appropriateness and effectiveness should be accelerated. This goal can best be achieved through developing and funding of research into quality assessment so that clinically sound guidance can be provided to physicians for integration into their practices. The AMA supports the PPRC recommendation for increased funding in this area.

The Association believes that one potential and workable solution to help assure the provision of high quality care is the development of practice parameters. The AMA strongly supports the development of clinically relevant parameters that are designed to assure that patients receive appropriate medical care. Such parameters will allow the flexibility needed to maintain the individual nature of care that is essential in the patient/physician relationship. Through the AMA Office of Quality Assurance and Assessment, the AMA is taking a lead role in clinical appropriateness initiatives. Medicine does not require punitive expenditure targets to act effectively and responsibly to reduce inappropriate care.

To help ensure that outcomes assessment research is clinically relevant and that the results of an outcomes assessment study are interpreted properly, the research design and the results, in *all* cases, should be subject to development, review and evaluation by *practicing physicians before* policy decisions are made based on the studies. Moreover, the results of a study should be used as guides for physicians, not as absolute rules, so that physicians can continue to tailor medical care to meet the unique medical needs of each individual patient.

Practice guidelines, or practice parameters as we like to call them, are tools to assist physicians in the diagnosis and treatment of specific diseases or conditions. They are developed by synthesizing a broad array of medical information, including scientific studies, available data, and expert opinion, into the best information available based on sound medical principles. They are not like a cookbook, which provides a specified course of action. Instead, practice parameters outline the *range* of acceptable treatments and procedures for a given clinical situation. For example, for a patient with heart disease, the parameters would define the general range of appropriate treatment options. Through evaluation of the patient's medical condition, consideration of the patient's personal preferences, and through the use of the

practice parameters, the physician and patient could select the most appropriate treatment: medication, coronary angiography, coronary angioplasty, or a coronary artery bypass operation. Even with parameters, physicians remain responsible for tailoring treatment to what is most appropriate for the individual patient.

The primary purpose of practice parameters is to improve the quality of patient care by providing physicians with the best and most up-to-date educational information and alternatives about treatment options. An additional benefit of the parameters may be to control health care costs by reducing the provision of inappropriate or marginally beneficial care. However, it is premature to plan to use the guidelines to make payment denials. The use of guidelines for screening purposes and for potential payment denial should proceed cautiously and only with the advice of the medical profession.

The development of practice parameters requires considerable input from both practicing physicians and the research community. Input from practicing physicians is needed to make the practice parameters clinically relevant and to take into account the perspectives of the relevant medical specialty societies on the available options for treatment. The research community is needed to provide perspectives on the significance of specific studies and on the latest advances in medicine.

Practice parameters have already been developed by over twenty medical specialty societies. Some parameters have been completed in as little as a few months, while others have required considerably more time.

If practice parameters are developed correctly, and provide information that is clinically sound and useful, practicing physicians will use them. Activities such as the Maine Medical Assessment Program and the guidelines developed by the American Society of Anesthesiologists have shown that physicians will modify their practice patterns to optimize care when they are provided with relevant, well-documented scientific information concerning how to better treat patients.

Other benefits from the development of practice parameters may include a reduction in geographic variations in utilization of medical care services, greater assurance to third-party payors that medical services are appropriate, and an improvement in the professional liability climate. In fact, anesthesiologists in some states already have seen reductions in their professional liability premiums. There are some risks, however, to the development of practice parameters. If the parameters are developed incorrectly, patients might not be provided preferred treatment options, payment denials might occur for medically necessary services, medical innovation might be restricted, and professional liability exposure might be increased.

The federal government (and other third party payors) should not play a dominant role in the development of practice parameters. Practice guidelines developed by the federal government would not be agreeable to physicians, who, with historical justification, would be suspicious that cost savings, rather than quality, would be the government's overriding consideration. Moreover, the government lacks the expertise necessary to develop clinically relevant and scientifically sound parameters.

Instead, the federal government should oversee the development of guidelines by providing grants or contracts to physician organizations, including the AMA and academic centers, which then would actually develop the guidelines. Providing financial support to physician organizations would help ensure that clinically relevant and scientifically sound parameters are developed. This would also signal that the federal government is interested in the quality as well as the cost of health care.

Responsibility for overseeing any research and guideline development program should be assigned by legislation to the Office of the Assistant Secretary for Health, which has the necessary medical expertise. In addition, this would ensure that the research and guideline development process is separated from the HHS entity (the Health Care Financing Administration) that makes reimbursement decisions. Guidelines developed should be pilot tested in selected localities to demonstrate their appropriateness before they are disseminated or implemented on a national basis. Then they should be disseminated to physicians and other health care providers for educational purposes.

MANDATED ASSIGNMENT AND FEE CONTROLS

The AMA supports the PPRC's current decision not to recommend mandated assignment under the Medicare program. As you well know, mandated assignment would require physicians to accept the Medicare allowed amount as payment in full regardless of the excellence or unique nature of the services provided or the ability of the patient to pay the physician's regular charge for the service. However, we have strong concerns, both from a fairness and a volume concern, with a proposal of the Commission to impose permanent controls on physicians' fees. This is especially true within the context of this hearing since it is an economic fact of life that price

controls, which lower the real cost of services to consumers, increase the demand for those services. Studies on the effects of cost-sharing by the Rand Corporation and the Congressional Budget Office indicate that elimination of balance billing would cause an escalation in patient demand and could greatly increase Medicare expenditures.

Medicare already substantially discounts physicians' fees. The gap between Medicare allowed amounts and physicians' regular fees has grown from 10% in 1970 to the current approximate level of 27% (office visit). In other words, years of budget cuts and regulation have left Medicare paying only 73% of physicians' regular fees.

The record clearly demonstrates that physicians do care about their patients' economic circumstances and accept assignment a vast majority of the time. Physician acceptance of assignment has continued to increase to all-time record highs. 79.3% of charges being assigned in the last quarter of 1988 and new data indicate that 40.7% of physicians have agreed to be participating physicians in 1989 (an increase of 9.1%). This demonstrates the reality that physicians are responsive to their patients' situations.

The AMA encourages physicians to take their patients' economic status into account and data show that they do. An Urban Institute study summarized evidence that physicians are more likely to assign claims in low-income areas. The Physician Payment Review Commission's physician survey revealed that patients over age 75 were more likely to have claims assigned, and that claims are more likely to be assigned if the patient lacked supplementary insurance. Another PPRC analysis found that voluntary assignment rates were higher for poor patients than for better-off ones. Consider the following points from the PPRC surveys:

- For individuals with a regular source of care, the PPRC beneficiary survey reported that the voluntary assignment rate (excluding Medicaid) from the patient's regular physician was 56%, and 68% on the last visit with a specialist. The physician survey found that of non-participating physicians, 85% routinely accepted assignment for some of their patients, regardless of the service provided, and that 95% of these physicians consider the patient's financial status in this decision.
- When beneficiaries were asked whether they were actually balance billed on their most recent bill, only 17% indicated that they had been, with those over age 85 and those below 200% of the poverty level least likely to have received such a bill.
- A PPRC analysis of 1987 data from eight states found that 3% of patients had annual balance bills exceeding $500, that 52% had no balance billing liability and 30% had balance bills of $50 or less. Even among those patients with more than $5,000 in annual Medicare allowed charges, the majority had $50 or less in balance bills.

With a Medicare fee schedule, the problems of fee controls or mandatory assignment would be compounded because no fee schedule can adequately reflect differences in practice costs, illness severity, quality, amenities and other factors. Without the ability to balance bill, there will be no recognition of experience or other special abilities or amenities. The remuneration for a physician on his or her first day of practice for a service will be the same as for a highly skilled practitioner with decades of practice experience.

Finally, let me expand on the AMA's efforts in encouraging physicians to consider their patients' economic status in the assignment decision. There are currently 34 state medical society voluntary assignment programs either underway or in development. Additionally, there are numerous county programs in effect, many in areas without state programs.

CONCLUSION

Mr. Chairman, health care in this nation is approaching a crossroads and the choice of which road we pursue will fashion our health care system for the American people into the 21st century. We urge caution so that the decisions you make now do not take us down the wrong road—a road where Americans have to line up and wait for essential care as seen in the expenditure target provinces of Canada, or a road that denies services to citizens based on age as seen in Great Britain. While this point may seem too far off to be of concern, remember that those patients who today have limited access to care in Canada and Great Britain did not have a chance to express their views when action to limit total program payments were initiated years ago. We cannot emphasize strongly enough the need to exercise considerable caution before enacting uncertain proposals that might rapidly take us too far down the wrong road.

The choices you face are important ones, and we urge you to follow the directions that will assure our continued ability to care for our nation's elderly and disabled.

COMMUNICATIONS

STATEMENT OF THE AMERICAN ACADEMY OF ORTHOPAEDIC SURGEONS

EXPENDITURE TARGETS AND THE VOLUME OF SERVICES

The American Academy of Orthopaedic Surgeons appreciates the opportunity to comment on the volume of services issue as it relates to the cost of physician reimbursement under the Medicare program.

The Academy shares your concern about the rising cost of health care in America, and wants to actively participate in developing effective cost containment strategies. However, these strategies must be developed and implemented in a way which does not compromise the physician's ability to maintain the high standards of care available to elderly citizens.

We are aware that Congress is considering the Physician Payment Review Commission's (PPRC) recommendation that an expenditure target for physician services be set to control the overall cost of the Medicare program. The PPRC's rationale for expenditure targets is that they will force physicians collectively to reduce the volume of unnecessary and inappropriate services. Their recommended approach is based upon the presumption that the degree to which physicians collectively exceed the target reflects the degree to which they provided unnecessary and inappropriate services.

We believe that the expenditure target approach will have the unfortunate effect of reducing the volume of necessary and appropriate services, as well as those that are unnecessary and inappropriate. No one knows the potential impact of expenditure targets on the quality of patient care and access to care. There is simply not enough reliable data to implement this approach in a way which does not compromise the quality of our health care system.

Given that the PPRC's recommendation is predicated on the Canadian experience, we urge Congress to look at the impact of expenditure targets on that system. Our recent evaluation of that system causes us to be deeply concerned about the possibilities of:

- growing waits for necessary surgery;
- hospitals without the latest equipment to treat patients;
- hospital conditions that are degrading to the elderly patient; and premature deaths stemming from "queuing up" for treatment.

Our primary objection to a system of expenditure targets rests squarely on our concern for the health of America's elderly citizens. There are social and political consequences of the proposed expenditure target system which must be reckoned with. Its use will send a clear message to America's elderly that the Congress of the United States has decided that they are no longer entitled to the same high quality of care and assured access that the majority of Americans enjoy. Further, this inequity will fall more sharply on the shoulders of those Americans who, in addition to being elderly, are also poor or otherwise disadvantaged.

Arbitrarily established expenditure targets are a first step in a rationing system which will progressively proceed to reduce services available to the elderly—who have paid for it. Furthermore, expenditure targets place medicine in the position of denying care when the Medicare benefits package clearly identifies coverage.

We understand the interest of the Congress in examining volume of services as a possible means for containing Medicare costs. However, given the current state of our knowledge, it is not really possible to assess which, if any, of the services currently provided under Medicare are being provided unnecessarily or inappropriately.

Do we have anything better to offer? We believe we do. We believe Congress should focus its efforts on activities which will enhance our understanding of medi-

cal effectiveness and appropriateness as the primary method of controlling the volume of services and the cost of care. In this way, unnecessary services can be eliminated in a rational manner and needed services can be preserved.

To this end, we have been active in the development of practice guidelines for several orthopaedic diagnoses. We are active participants in the American Medical Association's Practice Parameter project, as well as the Joint Commission's Agenda for Change. We have every intention of expanding our role in these and similar projects, designed to help physician's tailor their practices to assure high quality, effective care. We openly admit that we are new at this endeavor, as is most of medicine. But we are refining our methods, and building up momentum. We are ready to make this commitment: if Congress will help us determine which orthopaedic services deserve highest priority in terms of their budgetary impact, we will meet any reasonable timetable for the development of practice guidelines to address those services.

We are also gratified by your recent interest in patient outcomes assessment research. The Board of Directors of this Academy has designated outcome studies as the area of top priority within the field of quality care. We have submitted a grant proposal to the National Center for Health Services Research, through which we hope to be funded to study outcomes of total hip replacements. We will have two representatives on the Institute of Medicine's Effectiveness Panel on Hip Fracture, meeting on July 12.

We also believe that the methodology of small area variation analysis holds promise as a means for identifying and moderating differences in practice patterns through voluntary physician initiative.

In summary, we believe that government support for private sector activities in the areas of practice guideline development, outcome research, and small area variation studies represents a more effective and equitable means for reducing unnecessary services than expenditure targets.

The crisis of cost containment within the Medicare program has affected all of us. Doctors have seen the practice of medicine undergo confusing changes and unprecedented levels of outside scrutiny. Politicians and economists have had to grapple with the tensions between fiscal responsibility and constituent expectations. But the group most vulnerable to the implications of this crisis are, without question, the elderly ill citizens of this country. Their health, their well-being, and even their lives hang in the balance. Expenditure targets are a crude, short-sighted way to deal with a complicated and delicate problem. We urge you to give us the chance to test other, more direct ways of addressing unnecessary and inappropriate services through the development of practice guidelines and the pursuit of basic knowledge through outcome studies. We are confident that through these measures, we can work together to cut costs, improve quality and continue to guarantee patient access to care under the Medicare program.

STATEMENT OF THE AMERICAN COLLEGE OF NUCLEAR PHYSICIANS AND THE SOCIETY OF NUCLEAR MEDICINE

Hon. LLOYD BENTSEN,
Chairman, Senate Finance Committee,
Washington, DC, June 16, 1989.

Dear Mr. Chairman:

On behalf of the American College of Nuclear Physicians and the Society of Nuclear Medicine, we are pleased to submit the enclosed statement and fact sheet for the record for the Senate Finance Committee's June 16 hearing on physician payment reform.

Our statement focuses primarily on the recently-implemented Radiology RVS payment system which has resulted in inequitable payment reductions of 20-40 percent for Nuclear Medicine specialists, while the cuts for radiology as a whole are less than half that magnitude. Since the law creating the radiology RVS called for only a 3 percent overall reduction for radiologic payments (which includes Nuclear Medicine) we believe the new fee schedule unjustly harms the less than 3,000 Nuclear Medicine specialists in this country.

Because of these inequities, the College and Society are seeking language in the budget reconciliation bill that will remove full-time Nuclear Medicine specialists from the Radiology RVS. These physicians would be paid under their 1988 usual, customary and reasonable fees until a national Medicare fee schedule for all physicians is adopted. The budget impact should be minimal.

Additionally, we oppose across-the-board cuts for radiology, since Nuclear Medicine services are included within Radiology in the CPT code. Because of the significant cuts our specialists have already sustained under the Radiology RVS, an additional 8 percent cut would be disastrous for this small group of physicians. Since most Nuclear Medicine specialists are NOT radiologists by training, we would urge Congress to treat the two specialties separately.

Thank you for your consideration of our views. If you have any questions, please call Randy Fenninger at 371-8090 or Melissa Brown at 429-5120.

Sincerely,

E. WILLIAM ALLEN, M.D.,
President, American College of Nuclear Physicians.
BARBARA Y. CROFT, PH.D.,
President, Society of Nuclear Medicine.

Enclosures.

STATEMENT

Mr. Chairman and Members of the Committee:

The American College of Nuclear Physicians and the Society of Nuclear Medicine are pleased to submit this statement concerning physician payment reform, and in particular, the new Radiology Relative Value Scale (RVS) payment system that went into effect on April 1, 1989. The College and Society together represent roughly 4,000 physicians involved in the clinical practice of Nuclear Medicine, most of whom practice full-time in this specialty.

The College and Society recognize that the present method of paying physicians under the Medicare program is in need of reform. Although we support reform that is equitable for both physicians and patients, we are opposed to short-term, untested and unsubstantiated changes in the payment system for a select group of physicians or specialties merely to achieve budgetary savings, especially if one group is unduly penalized in relation to others.

Full-time Nuclear Medicine physicians (the roughly 3,000 doctors who spend 50 percent or more of their time in Nuclear Medicine only) are deeply concerned that the new Radiology RVS payment system does not meet the test for equitable, long-term, proven reform for physicians. The College and Society are currently surveying our members to determine the national impact of the Radiology RVS on our specialty. Although the survey is now being analyzed, reports across the country reveal that these full-time Nuclear Medicine physicians are facing cuts of 20 to 40 percent, while cuts for Radiology as a whole are less than half that magnitude. If these substantial cuts continue, then Nuclear Medicine physicians will be forced to choose between two unacceptable alternatives: (1) continue to take Medicare patients and place their practices in fiscal jeopardy; or (2) exclude Medicare patients from their practices. Since neither of these options is acceptable, other alternatives must be created.

NUCLEAR MEDICINE IS DIFFERENT FROM RADIOLOGY

Nuclear Medicine is a distinct, separate specialty in which radioactive materials are administered to patients to diagnose and sometimes treat disease. An estimated 120 million Nuclear Medicine procedures are performed yearly in the United States; roughly one out of every three patients admitted to a hospital will receive a Nuclear Medicine study during his/her stay.

Nuclear Medicine physicians are primarily concerned with how organs function (physiology) in contrast to conventional Radiology which focuses on what structures look like (anatomy). Our physicians provide critical diagnostic information about heart disease, cancer, stroke, Alzheimer's disease, dementia, epilepsy, bone diseases and sports injuries, thyroid disease, lung diseases, AIDS, infectious diseases of unknown origin and pediatric diseases. For example, First Lady Barbara Bush recently was treated with radioiodine in a Nuclear Medicine procedure for her Grave's disease.

The specialty of Nuclear Medicine has its own medical certification board (American Board of Nuclear Medicine), its own residency training programs, and in many hospitals and clinics its own separate department. Nuclear Medicine specialists have four to eight times more Nuclear Medicine training (24 months) than general radiologists who receive their Nuclear Medicine training in three to six months. Our specialty is recognized as distinct and independent by both the American Board of Medical Specialties and by the American Medical Association. Additionally, Har-

vard Professor William Hsiao and his team on the Resource-Based Relative Value Scale study recognized Nuclear Medicine as a distinct specialty when they decided not to include Nuclear Medicine as part of Radiology in the Harvard study. Nuclear Medicine is now being studied separately in the second phase of this study.

Although some radiologists do perform some Nuclear Medicine procedures, we believe full-time Nuclear Medicine specialists (most of whom are not radiologists by training), generally provide a more physician-intensive and complex service, including more interaction with patients, taking histories, conducting limited physical examinations of the organs to be imaged, extensive interaction with the technologists, and providing an interactive consulting report to the referring physicians. Additionally, Nuclear Medicine physicians have significant daily involvement in quality control activities, above and beyond those mandated by the Nuclear Regulatory Commission.

NUCLEAR MEDICINE DID NOT SUPPORT THE RADIOLOGY RVS

During deliberations over OBRA-87, the College and Society expressed concerns about the Radiology RVS as proposed by the American College of Radiology. With very few details of the proposal and strong concerns about the negative impact on our specialty, we opposed the Radiology RVS provision in the reconciliation bill, and we opposed the inclusion of Nuclear Medicine in the Radiology RVS.

The Radiology RVS was developed by the American College of Radiology and accepted by HCFA. Neither ACR nor HCFA substantially consulted with our groups or other groups during the development or application of the Radiology RVS. ACR first surveyed *its own* members for charges for all radiologic procedures and then created a charge-based RVS from that survey. None of these practices surveyed, by definition, were solely Nuclear Medicine practices, and therefore, the full-time Nuclear Medicine practitioner was not adequately represented in ACR's sample. Using additional magnitude estimation data and their own experience, each of the ACR's six consensus panels (of which Nuclear Medicine was one), created an experience-based RVS for the CPT codes in their category. A final steering Committee combined the values of each consensus panel, with some adjustments, into one comprehensive RVS for all radiologic CPT codes.

RADIOLOGY RVS IS NOT EQUITABLE FOR NUCLEAR MEDICINE

The Radiology RVS, as implemented by HCFA using sometimes erroneous conversion factors, has been disastrous for Nuclear Medicine, with cuts ranging from 20-40 percent, which are greater than those for any other area of Radiology. The College and Society recently commissioned their own study, which revealed that the charge data collected by ACR was *not* reflective of full-time Nuclear Medicine practices and therefore was unrealistically low for Nuclear Medicine procedures. Full-time Nuclear Medicine specialists tend to have higher charges than radiologists performing these procedures because, we believe, of the higher physician involvement, more complex technology, more extensive Nuclear Medicine training, and extensive quality control activities. Because the ACR survey data did not reflect this type of intensive service, it created a systematic downward bias for Nuclear Medicine procedures.

The Radiology RVS payment system is further affected by erroneous conversion factors calculated by several Medicare carriers across the country. Although ACR is investigating "suspect" carriers to identify incorrect conversion factors, this is an extremely time-consuming and expensive process. The College and Society do not have the resources to send investigatory teams to "police" Medicare carriers, nor do we feel that medical specialty societies should be forced into this role. The entire Radiology RVS payment system has revealed numerous database problems with the carriers, which does not bode well for the adoption of conversion factors for the national Resource-Based RVS system in the coming years.

The College and Society are gravely concerned about the severe negative impact of the new Radiology RVS on the field of Nuclear Medicine. Since Nuclear Medicine represents the only large group of physicians who rely on one form of imaging for essentially their entire income, it seems inequitable that our specialty is facing greater decreases. Moreover, physicians who derive their income solely from Nuclear Medicine cannot balance off these decreases with increases in other areas such as interventional Radiology or general diagnostic radiology since they do not and cannot perform these procedures. Severe reductions in Nuclear Medicine payments will not only harm current practitioners, but will threaten the longevity and future of the field.

NUCLEAR MEDICINE PROBLEMS REQUIRE A LEGISLATIVE SOLUTION

The College and Society have shared our data and held discussions with both ACR and HCFA. ACR will not reopen the RVS to make adjustments for Nuclear Medicine, and HCFA believes that it can make very few changes for Nuclear Medicine without the consent of Congress.

We respectfully request that Congress recognize Nuclear Medicine as the distinct specialty that it is, and exempt full-time Nuclear Medicine physicians from the Radiology RVS. Instead, these physicians (less than 3,000) should be paid under their usual, customary and reasonable fees until Medicare adopts a national across-the-board fee schedule. Under this exemption, we would define full-time Nuclear Medicine physicians as those who are certified or eligible to be certified by the American Board of Nuclear Medicine or the American Board of Radiology with Special Competency in Nuclear Medicine, or those physicians for whom Nuclear Medicine services (78000-79000 in the CPT codes) account for at least 50 percent of the total amount of charges made by the physician for Medicare Part B services. Our physicians are ready to accept an equitable percentage reduction (such as the 3 percent mandated by Congress) in these UCR payments so that exempting Nuclear Medicine from the Radiology RVS will not have a significant budgetary impact.

The College and Society are continuing to gather data to support our exemption from the Radiology RVS, and will share it with the Subcommittee when it becomes available. We urge your consideration of our concerns and hope you will support our exemption for full-time Nuclear Medicine physicians from this inequitable payment system. We stand ready to assist this Subcommittee in this regard.

FACT SHEET

NUCLEAR MEDICINE CONCERNS WITH RADIOLOGY RVS

What is nuclear medicine?

Nuclear Medicine (NM) is a highly sophisticated medical specialty in which radioactive materials are administered to patients to diagnose and sometimes treat diseases. An estimated 120 million NM procedures are performed yearly in the United States.

NM physicians provide critical diagnostic information about heart disease, stroke, Alzheimer's disease, dementia, epilepsy, cancer, bone diseases and sports injuries, thyroid disease, AIDS, lung diseases and disorders, infectious diseases of unknown origin, and pediatric diseases. First Lady Barbara Bush recently was treated with a NM procedure for her Grave's disease.

How is nuclear medicine different from radiology?

Radiologists focus primarily on anatomy (how structures look), whereas Nuclear Medicine physicians focus on physiology (how organs work) Nuclear Medicine is a separate specialty with its own medical certification board and its own residency training programs. It is recognized as a separate specialty by the American Board of Medical Specialties and the American Medical Association. It is being studied separately in the Harvard Resource-Based RVS study. Some radiologists do perform some NM procedures, but full-time Nuclear Medicine specialists (most of whom are *not* radiologists) generally do not perform other radiologic procedures.

Why is nuclear medicine so concerned about the new radiology RVS?

The radiology RVS was created by the American College of Radiology. ACR surveyed its members, who are *not* representative of full-time Nuclear Medicine physicians. The Nuclear Medicine panel of the ACR project was dealing with inaccurate data to begin with, as shown in a recently-conducted study by Abt Associates for ACNP and SNM.

Nuclear Medicine did not support the provision in OBRA-87 mandating the radiology RVS, arguing that it would cause economic harm to the specialty. Indeed, since the radiology fee schedule went into effect on April 1, Nuclear Medicine physicians appear to be taking cuts of 20-40%, while the cuts for Radiology as a whole are less than half that magnitude.

HCFA acknowledges that NM may have a special problem, but cannot make significant changes in the RVS under the current law. We have shared our data and concerns with ACR, but they are unwilling to reopen the RVS.

What can Congress do to help nuclear medicine?

Congress should recognize NM as the distinct specialty that it is, and exempt full-time NM physicians (less than 3,000) from the radiology RVS. Instead, these physi-

cians would be paid their usual customary and reasonable fees until Medicare adopts a national across-the-board fee schedule.

STATEMENT OF THE NATIONAL ASSOCIATION OF REHABILITATION FACILITIES

Dear Mr. Chairman:

This statement is submitted on behalf of the National Association of Rehabilitation Facilities (NARF). NARF is the principle national membership organization of community-based medical and vocational rehabilitation facilities. A substantial number of NARF members are freestanding rehabilitation hospitals and rehabilitation units in general hospitals. These members are facilities that are excluded from the Medicare prospective payment system (PPS). They are reimbursed under the Medicare program on the basis of cost reimbursement limited by ceilings known as TEFRA target rate ceilings. We welcome this opportunity to submit comments for the record on the effect of the PPS on excluded facilities and hospital payments under the Medicare program for fiscal year 1990.

I. FY 1990 UPDATE

The Omnibus Budget Reconciliation Act of 1987 (OBRA '87) recognized the need for a separate annual update factor for all facilities excluded from the PPS. The Secretary of the Department of Health and Human Services (HHS) is required by law to set this update for excluded facilities for FY 1990 and subsequent fiscal years at the level of the market basket mix of hospital goods and services. The market basket reflects the increase in inflation for inpatient hospital goods and services.

NARF recommends that the excluded rehabilitation hospitals and units receive the full market basket as the update for fiscal year 1990, corrected for previous forecasting errors. As you will note in the report of the Prospective Payment Assessment Commission (ProPAC) ProPAC historically has supported a separate update factor for such excluded facilities. ProPAC recommends that the update for FY 1990 be the full market basket plus a correction for market basket forecast errors from previous years. This figure is 6.2%. NARF supports this recommendation.

In the NPRM of May 8, HCFA recommended the full market basket of 5.8% as provided by law. Excluded rehabilitation facilities should receive the full market basket for several reasons. First, such hospitals and units receive no other adjustment under the PPS on an annual basis. The only possible increase for payments for these facilities is the increase in the annual target rate per discharge. PPS hospitals, however have other adjustments available to them, such as changes in coding. If excluded facilities' costs exceed their target ceiling limitation; they do not receive additional reimbursement under Medicare, unless they file for an exception or adjustment to the limitation and the Health Care Financing Administration (HCFA) grants such relief. The process for applying and obtaining such relief is retrospective in application only and lengthy in terms of the time it takes to obtain relief.

Second, a separate update for excluded facilities continues to be required because the labor costs and the impact of the PPS on such facilities are considerably different from those of the PPS hospitals. Currently the labor costs of excluded rehabilitation hospitals and units exceeds 64%. Equally as important, the PPS has resulted in patients being admitted to excluded rehabilitation hospitals and units sicker and quicker. A recent National Rehabilitation Hospital, Washington, D.C., study showed increased acuity of patients admitted for rehabilitation since the start of the PPS. Approximately two-thirds of the respondents in that study reported increased nursing hours per patient day, reduced functional status measures, increased therapy, reduced time from onset to admission and similar indicators.

These factors suggest serious examination of a separate market basket specifically for rehabilitation. NARF currently is surveying its members to determine current labor costs as a percentage of total expenses and the rate at which the cost of services, particularly nursing and therapy costs are increasing. Those rates of change seem to be in excess of similar costs in PPS hospitals. This discrepancy should be recognized in a separate market basket for rehabilitation providers.

As noted, personnel costs in rehabilitation hospitals and units currently exceeds 64% of their total costs. This compares with an average of slightly less than 57% for PPS hospitals. Preliminary analyses of the first set of NARF survey respondents shows that rehabilitation hospitals and units continue to have a similar level of labor costs (salaries, wages and fringe benefits) if not several percentage points higher than that found in previous surveys.

This higher percentage of facility costs associated with personnel is also significant in looking at salary trends for the types of personnel related to rehabilitation specifically physical therapists, occupational therapists, and rehabilitation nurses. These specialists are in short supply. consequently, there is considerable competition to recruit and retain these personnel, resulting in higher salaries and recruitment costs. A NARF 1986 sample of 18 rehabilitation hospitals reported that for the then two most recently completed fiscal years ('85 to '86), the cost for physical therapy services increased by over 7.1%; occupational therapy by 6.6%; and rehabilitation nursing by 5%. These figures were higher than other national data compiled by the University of Texas which shows the mean maximum rate of change from '85 to '86 for maximum salary rates for registered nurses to be 5.46%; for physical therapists to be 4.46%; and for occupational therapists to be 5.66%. As mentioned, NARF is in the process of calculating data for earlier and later years.

A second area showing an increase in costs for rehabilitation facilities is in medical supplies. The same 1986 NARF survey referenced above indicated an increase of 27.4% in the cost of medical supplies for the '85 to '86 time period. This is probably a function of earlier patient transfers to rehabilitation facilities, partly because of the incentives in the PPS to discharge patients earlier. Data from a small sample of hospitals that have applied to HCFA for exception and adjustment relief have shown that the time for patient referral from a PPS hospital; to rehabilitation from onset of the disability has dropped dramatically. An earlier referral, while beneficial to the clinical needs of patients and their rehabilitation potential, usually means a sicker patient.

Finally, NARF recommends that there be no reductions to the market basket along the lines of policy target adjustment factors (PTAFs) as utilized previously by HHS. Excluded rehabilitation hospitals and units in the past were subject to reductions in the market basket for these PTAFs for factors that had absolutely no bearing upon excluded rehabilitation hospitals and units. These PTAFs included, for example, changes in practice patterns, site substitution, changes in case mix, productivity and the like.

Rehabilitation hospitals and units are experiencing substantially higher per discharge costs because of the sooner and sicker phenomenon as noted above. To the extent that changes in practice patterns affect per discharge costs the changes that resulted from the PPS tend to increase them. Excluded rehabilitation hospitals and units are the site to which the PPS patient has been substituted. Additionally, case mix changes that have occurred generally show increased, not decreased, severity. An early unpublished study done by ProPAc showed a considerably increase in case mix. The TEFRA system does not acknowledge changes in case mix on a positive or negative basis. Thus, excluded hospitals are not able to increase revenues by upgrading their case mix through coding, commonly known as "DRG creep."

II. STREAMLINING THE EXCEPTION AND ADJUSTMENT PROCESS

Currently, the only relief available to a rehabilitation facility which has exceeded its target ceiling limitation, for legitimate reasons related to patient care, is the administrative exceptions and adjustment process. The regulations governing this process were published pursuant to the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) and have not been amended since.

To summarize the process, once a provider has completed a cost reporting period and its Medicare costs exceed its TEFRA target rate, the facility can apply for exception or adjustment relief. It sends an application with supporting material to its fiscal intermediary (FI). The FI verifies the information and sends it to HCFA in Baltimore. Once HCFA receives a complete file, it has 180 days to analyze the application and come to a decision. This time period can take longer if the file is incomplete or additional information is required from the provider.

We estimate that currently, it takes a minimum of 12-14 months *after* the cost report is completed, not even audited by the FI, to analyze, draft and process an application for relief. This is particularly rough on rehabilitation hospitals and units, especially those which have had an increase in the severity of the cases they are serving resulting in longer lengths of stay, e.g., more severe strokes. Also costs may increase above the limits if the facilities serve increased numbers of certain types of severe cases with longer lengths of stay, e.g., more head injuries, spinal cord injuries and strokes, etc.

In the Family Support Act of 1988, the Conference report expressed interest in this process and its impact on these hospitals with long lengths of stay. It stated "the conferences expect the Secretary, in granting exemptions . . ., will take into account the increases in length of stay in PPS exempt hospitals." We recommend that the Committee reiterate its interest in this area.

NARF has been holding a series of discussions with HCFA and has provided recommendations on how the current relief process can be accelerated to the benefit of all involved. These recommendations include placing timeliness on FI actions and allowing FIs to make certain determinations on applications subject to very clear guidelines. Application would also continue to be reviewed at the HCFA national office. To date these recommendations have been well received by HCFA and we will continue to pursue them.

This statement addresses only issues assuring that excluded hospitals obtain the maximum update as allowed by law and accelerating the exceptions and adjustment relief process. The TEFRA system itself has significant defects, with serious consequences for excluded rehabilitation hospitals and units. Most of these defects pertain to the lack of the system's ability to recognize changes in case mix, severity of higher costs associated with longer lengths of stay and/or more intense care. These are issues which we will address to the Committee in a separate paper.