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MEDICARE VOLUME PERFORMANCE STANDARDS

HEARING

BEFORE THE

SUBCOMMITTEE ON
MEDICARE AND LONG-TERM CARE

OF THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ONE HUNDRED FIRST CONGRESS

SECOND SESSION

MAY 18, 1990

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MEDICARE VOLUME PERFORMANCE STANDARDS

FRIDAY, MAY 18, 1990

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

The hearing was convened, pursuant to notice, at 9:37 a.m., in room SD-215, Dirksen Senate Office Building, Hon. John D. Rockefeller, IV (chairman of the subcommittee) presiding.

Also present: Senator Durenberger.

[The press release announcing the hearing follows:]

[Press Release No. H-31, May 8, 1990]

FINANCE SUBCOMMITTEE TO HOLD HEARING ON MEDICARE PHYSICIAN PAYMENTS; RECOMMENDATIONS FOR MEDICARE VOLUME PERFORMANCE STANDARDS TO BE CONSIDERED

WASHINGTON, DC—Senator John D. Rockefeller IV, (D., West Virginia), Chairman of the Senate Finance Subcommittee on Medicare and Long-Term Care, announced Tuesday that the Subcommittee will hold a hearing on recommendations for the Medicare Volume Performance Standards (MVPS) for fiscal year 1991.

The hearing is scheduled for *Friday, May 18, 1990 at 9:30 a.m.* in Room SD-215 of the Dirksen Senate Office Building.

"Last year, Congress enacted historic legislation to rationalize Medicare physician payments. A key component of that legislation, MVPS, will encourage more efficient medical behavior and closer physician involvement in Medicare program policy," Rockefeller said.

"This hearing on the fiscal year 1991 MVPS sets us on a better course for planning and evaluating payment policies," Rockefeller said.

Recently enacted physician payment reform legislation directs the Secretary of Health and Human Services and the Physician Payment Review Commission to recommend to Congress a rate of growth for payments for physician services for the coming fiscal year. Congress considers this advice and then sets the MVPS, which is the rate of growth in spending for physician services reimbursed by the Medicare program.

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

Senator ROCKEFELLER. Good morning. There is a wonderful old saying: Be careful what you wish for or you may get it. That is what Senator Durenberger and I, and our colleagues on this committee and others wished for very hard and worked for very hard, and worked for with House Members for a better Medicare payment system for doctors and we got it, or we shall see.

Today, we face the considerable task of getting this new program up and running. We want to hear testimony on the fiscal year 1991

MVPS, a key component of the payment reform legislation last year, established this performance system as a better and more thoughtful way for Congress to update physician payment each year. The premise is relatively simple: Each year, we set a goal after the rate of growth in spending for physician services.

Then we evaluate this goal, and our decision on the update will be based on how well the program and physicians perform relative to that goal.

Last year, because of the short time, we directed the Secretary to set the goal for fiscal 1990, and he has done so. It is 9.1 percent. That means that during the fiscal year we are now in, we expect physicians, on a collective basis, to hold down the rate of growth in spending for their services to 9.1 percent.

Next year, we will look back to see how they did and then set the MEI update for fiscal 1992. From now on, however, Congress will set the goals. That is the point. That was the point of the legislation and beginning with this coming fiscal year. We will do so advised by the Secretary and the Physician Pay Review Commission, and importantly, and David and I made sure of this, by physicians themselves. They are mandated into the process.

We expect to set reasonable goals based on the factors outlined in the law: Inflation, enrollment growth and aging, changes in medical technology, evidence of access problems, if there are any, and inappropriate utilization of physician services, if there are any.

To say the least, this is a complicated process, especially as we strive to implement the new RBRBS fee schedule and to improve Medicare's data system, still 2 years off, and I expect that we will start carefully in setting our program goals.

"Doctor Durenberger," do you have a statement?

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

Senator DURENBERGER. Mr. Chairman, thank you very much. Let me just associate myself with your remarks. Let me also compliment not only you, but the witnesses today and the associations and organizations they represent, because without the folks out there, the process here in Congress would not have accomplished last November what it did accomplish.

Let me say that those of you who are getting to know the Chair of the subcommittee better know that he comes with these very long memos that Karen has prepared for him, and with at least three colors of highlighters. I haven't figured out the code yet, but I haven't been able to get past——

Senator ROCKEFELLER. Yellow and orange.

Senator DURENBERGER [continuing]. Yellow at this stage, but he has got yellow, orange, and green. Some day, somebody will write a story about how he made public policy by color as well as intuition.

Let me also say something else, because these subjects are complicated, maybe two other thoughts that occur to me. One is that to the degree that we are trying to make changes, substantial changes in the way we acquire and deliver health care in America by changing the way we finance that system, and I don't know that that is the best way to go about it, but that is the one we clearly

have been doing, it makes a big difference who is chairing the Finance Committee, as well, because as we all are learning in the budget process, the reconciliation process, the "do not watch my lips" or "do watch my lips process," that it always comes back to this committee, the Finance Committee, to make the decisions about whether we are going to concentrate only on the deficit, only on the revenues, or we are going to do some public policy.

So I just want to make sure that since there is only two of us here, the Chair and the ranking member of the Health Subcommittee, that we all realize that in—particularly in the time when we are concentrating only on the deficit, that somebody will recognize that without the Chair of this committee continually pushing us in the direction of using this process to make good, better albeit, incremental health policy, that we wouldn't be able to do it.

And also to say that the President and this Administration, while its focus seems to be on lips, is more substantially, all of the time, moving in the direction of facilitating progress in sensible health policy, and Dr. Wilensky is not only the latest, but probably the best example that we have of that.

So having said that, let me say I am looking forward to where the two designees, the DHHS and PPRC, are with regard to this major challenge that we have all agreed to lay out for ourselves. Then to conclude with one final observation, and that is just listening to, if I may just say, Gail and Karen, without being official about it, listening to them converse over here, the really good thing for me, having been at this now for eleven or twelve years, is not just watching people come closer together from what once appeared to be disparate points of view, but to watch the consistency with which thoughtful people continued to deal with intractable problems.

I think as long as we have people like Dr. Wilensky, who are willing to take on the impossible challenge of HCFA at this particular point in time, and as long as people like Dr. Davis are willing to continue to try to work as hard as they can to make this whole system work, regardless of the politics, regardless of all of the rest of this sort of thing, I think Jay and I and Lloyd Bentsen and Bob Packwood and everybody else who usually sits around here are very, very fortunate to have all of you out there on whom we can continually rely on to help us with these efforts.

Obviously, we can extend that to the staff and the representatives of all the associations. The staff of PPRC, of course, is very important, and the medical associations, in this case, are probably more important, because this whole system is not going to work unless the physicians in this country want it to work and help us make it work, and that is the message that I think we will keep rearticulating during the course of these hearings.

Senator ROCKEFELLER. Thank you, Senator, Durenberger.

Dr. Wilensky, I share his views about you, as you know, and you have indicated to me that you, in previous testimony, you are going to be very aggressive in implementing all of this, and you have been. It really is a stunning process. It is a fascinating process. It is all mixed up. As we do this, pretending that the medical world exists in a vacuum, of course it does not. It is subject, Medicare, to the budget summit. It gets its cuts. So that is one world, and then

this formula is another world, and judgment calls have been made by HCFA and by PPRC.

It is a fascinating process, because some of the numbers and the indexes aren't in yet. We can't measure some of the things that we are required to. So it is a fascinating and complex process and extraordinarily important, and we embark on it now with your testimony.

STATEMENT OF GAIL R. WILENSKY, PH.D., ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Dr. WILENSKY. Thank you. Thank you, Mr. Chairman, and members of the Subcommittee. I am happy to be here this morning to discuss the Administration's Medicare Volume Performance Standard recommendation for fiscal year 1991.

As we begin discussions of an appropriate MVPS for fiscal year 1991, we should remember that Medicare expenditures for physician services continue to grow at unacceptably high rates. Between 1984 and 1990, Medicare physician spending increased at an average annual rate of 12 percent per year.

For fiscal year 1991, the HCFA Actuary currently projects a 13.2 percent rate of growth in Medicare physician payments. This growth rate is more than twice the current rate of inflation. It is also much higher than the growth rate of other social programs such as Social Security and Medicare part A. In this time of large Federal budget deficits, we cannot continue to ask American taxpayers to subsidize such large increases in physician spending.

As you know, the Secretary is required to recommend, on April 15th of each year, a Medicare Volume Performance Standard for the following fiscal year. The Physician Payment Review Commission then comments on the Secretary's recommendation by May 15th of each year. If Congress does not act on the Secretary's recommendation, the MVPS rates of increase will be established through a default mechanism set forth in the law.

In making an MVPS recommendation, the Secretary is required by statute to consider inflation, changes in the number of enrollees, the aging of enrollees, technology, evidence of lack of access to Medicare physician services, evidence of inappropriate utilization of services and other factors that the Secretary considers appropriate.

After considering these factors, we are recommending for fiscal year 1991 an MVPS of 8.7 percent for surgery and 10.5 percent for non-surgery. We recommend an overall MVPS of 9.9 percent.

My written statement describes in detail the factors we considered in making our fiscal year 1991 MVPS recommendation. I will outline them only briefly for you.

As I describe the components of our recommendation, it may be helpful for you to refer to Table 1 attached to my full statement.

We estimate that the effect of inflation for fiscal year 1991 will be 3.6 percentage points. The increasing number of Medicare beneficiaries adds 1.2. percentage points, and the aging of the Medicare population adds 1.2 percentage points. In addition, as you have indicated, we recommend allowing 3.7 percentage points for other

factors, such as new growth in technology, access and utilization. This is one-half of the 7.4 percent estimated annual growth in expenditures for the period 1986 to 1990, in excess of that attributable to inflation, enrollment and aging.

While we cannot measure the precise effects of these factors individually, we believe that a 3.7-percentage point allowance for them is generous. Let me spend a moment discussing why we believe that 3.7 percent is an appropriate level for these factors.

In developing this recommendation, we examined growth and spending for physician services for the total U.S. population. We found that national per capita expenditures for all physician services increased at an average rate of 3.3 percent above price increases from 1984 to 1988. This 3.3 percent is very comparable to our recommended increase of 3.7 percent. If we look at technology, access and utilization as separate factors, the generosity of our 3.7 percent recommendation becomes clear.

A quantitative factor for technology has not been identified separately because the definitive data that are currently available would not allow us to quantify the effects of technology on total expenditures for physician services.

In terms of access, we have no evidence of a general access problem for Medicare beneficiaries. Medicare physician participation rates and assignment rates are at an all-time high. So at this point, we have no reason to believe that we have to increase the MVPS to ease any current general access problems. Of course, we will continue to examine the issue of access to physician services for Medicare beneficiaries.

Finally, we know that some portion of historical growth and volume and intensity of physician services is attributable to inappropriate utilization. The exact amount attributable to inappropriate utilization cannot be determined at this time, but several studies over the years have indicated that between 5 percent and as much as 30 percent of services performed may be inappropriate. We have not adjusted our recommendation downward, however, to account for this.

Thus, while one could argue that no factor at all should be allowed for future increases in technology, access and utilization, our recommendation allows for 3.7 percentage points.

In recommending the fiscal year 1991 MVPS, we considered only one additional factor: The impact of legislative changes enacted in OBRA in 1989. The actuary estimates that OBRA 1989 will result in increases in fiscal year 1991 of 1.9 percentage points for non-surgical services and 0.1 percentage points for surgical services.

In recommending the fiscal year 1991 MVPS, we made an adjustment for the effects of OBRA 1989 and surgery versus non-surgery, since the legislation affects these two types of services differently.

We also recommend adjusting the fiscal year 1991 standard to account for legislation which may be enacted later this year. Such an adjustment is necessary. Changes in law that affect Medicare benefits or the prices paid for Medicare services will raise or lower the baseline rate of increase in Medicare physician spending.

If an adjustment is not made, the MVPS would be established and measured relative to a baseline rate of increase that is no longer applicable. We believe that physicians should be held ac-

countable for their actions, and not for program changes which are enacted by Congress.

I would also like to point out that on May 3, 1990, we published a notice in the Federal Register specifying the definition of surgical services for purposes of the MVPS. We define surgical services as those services reported on the Medicare claims form as surgery performed by surgical specialists and services performed by assistants at surgery. Let me emphasize that we do not intend to introduce specialty payment differentials into the fee schedule.

Before concluding my statement, Mr. Chairman, let me say just a few words about our budget proposals.

The Administration's fiscal year 1991 savings proposals can be grouped into three broad categories: A proposal to provide the full MEI update for primary care services only; proposals to ensure that over-valuations are not built into the reform base; and other proposals that represent what we believe are solid health policy, independent of the fee schedule. Our proposals would slow the rate of growth in physician expenditures from 13.2 percent to a more appropriate 8 percent.

In concluding my remarks, I would like to mention that implementation of physician payment reform is proceeding well. The implementation process is extremely complex, and the time frames imposed by the law are extremely challenging. I look forward to keeping you informed of our progress in implementing this legislation over the coming years.

I will be pleased to answer any questions that you may have.

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

Senator ROCKEFELLER. Thank you, Dr. Wilensky.

I am trying to calculate here. If the Administration's part B budget were enacted, it would reduce projected rate of spending growth from 13.2 percent to 8 percent in fiscal 1991. You have got, let me see, a 13.2 baseline just generally on part B. If you take off 9.9, you get down to 3.3 percent. Then you note that we should assume that your volume performance recommendation should be modified to take into account the legislative changes in which you include budget cuts.

Dr. WILENSKY. The MVPS which we have proposed for 1991 is based on current law only. It is not based on any changes that may occur. We have indicated that in calculating the 1991 MVPS, we included the anticipated effects of OBRA 1989 as they relate to fiscal year 1991 because there were some benefit expansions that would increase spending that we didn't think ought to be held against the physicians. So we wanted to take account of them, but we don't have any law that may be passed later this year in the MVPS calculation.

Senator ROCKEFELLER. That is interesting. Let me clear this up. You are not disagreeing with me that budget cuts should be included?

Dr. WILENSKY. We think any changes in current law, in laws that are actually enacted that would impact in the relevant period, ought to be included if they either increase or decrease spending, so that we don't look at observed spending and pick up changes

that have to do with an expansion or reduction in benefits and attribute them to physician behavior.

Senator ROCKEFELLER. Then if you follow that logic out, does that mean that if the Congress were to enact the President's Medicare budget, which, of course, involve cuts——

Dr. WILENSKY. Right.

Senator ROCKEFELLER [continuing]. Which takes you then from, if you calculate 8 percent minus 3.3 percent, down to 4.7 percent, does that mean that the Secretary's Performance Standard Recommendation would drop to 4.7 percent?

Dr. WILENSKY. That is correct, if all of the changes were enacted. The reason is because the baseline rate of increase would be dropping significantly. Again, the point is——

Senator ROCKEFELLER. See, that brings up this really important matter of: What are we considering this as two separate worlds or one world? In other words, are we looking at the physician payment and the discipline behavior modification, our behavior modification, et cetera? As we were doing that last year, I am not sure we were thinking about the budget process, programs, quite as much, but now clearly, with the budget cuts, these two worlds begin to merge, and so the logic of the 4.7 is correct. That is a fairly severe judgment, nevertheless, logical, mathematically necessary because you represent the Administration and potentially somewhat severe.

Dr. WILENSKY. We think any changes in law, including benefit expansions that could occur as they occurred in OBRA 1989, need to be taken into account.

We, in fact, have said, as I have said in this testimony, that an adjustment needs to be made before the 1991 MVPS is firmly set to take account of any later economic information we have. We are using the MEI and other inflation figures that we know as of today, but which may not be accurate in September. But more importantly, if there are any changes in law in either direction, they need to be reflected or we will be hitting the doctors for actions that are outside their control. That is really the point. We have included the OBRA 1989 benefit expansions in mental health and Pap smears because we don't want to have the increased spending that would be associated with that for the medical specialists to count against them. So we raised the MVPS for nonsurgeons over what it would have been for the surgeons, because that is where the benefit expansion is.

So it is not our proposed cuts that we are including; it is any change in law that would reflect in the baseline spending that needs to be accounted for, increases or decreases in that law.

Senator ROCKEFELLER. I understand that. I think, as I indicated at the beginning, one of the issues here is a judgment call, so you have math on the one hand and judgment on the other hand, and the point is, I think, how much can doctors reasonably be expected to control the growth in the volume intensity, those things which they do control?

Dr. WILENSKY. Right.

Senator ROCKEFELLER. Not those things which they don't control, but those things which they do control. All of the witnesses which follow you will say that your judgments have been too harsh. So for the record, other than what you cite for volume control in the gen-

eral health care system, how can you expand on your recommendation of a 3.7-percent growth rate for volume and intensity?

Dr. WILENSKY. Since this was my idea, let me try and do that for you.

While I don't want to make light of the differences, I think it is important to put them in some perspective. We are recommending 3.7 percent as the residual factor, and PPRC is proposing 2 percent. So while it may suggest there are enormous differences, we don't want to make light of that 1.7 percent differential, but to put it in perspective.

What we thought was important was to look at all of the measurable effects that we knew about: Inflationary changes; the changes in enrollment; the changes in the aging of the population, and to account for those changes as they impact spending and then look at what was left. What was left was 7.4 percent.

That represented what all of us, at least most of us in this room today, have said are excessively high rates of increase that have been occurring over a substantial period of time. These high rates of increase are in the existing base that we are now working on.

We know that there is a fair amount, although we don't know how much, of inappropriate utilization. There may be some underutilization, as well. Most of the findings thus far have indicated more in the way of overutilization.

That would suggest backing away from where we are to a negative factor as opposed to this positive factor.

The second issue which I mentioned is, there is no evidence, that I am aware of, in any overall sense, that access to physician services is any problem for the Medicare population. So I think that our attitude was that over a sustained period of time, we have had unacceptable rates of increase. If we could, after adjusting for all those things that we know about, reduce the residual, which is the volume intensity that has always escaped us when we go to try to target price increases by half; that was a reasonable thing to do.

Senator ROCKEFELLER. Everybody is at the budget summit. Everything is on the table. Will you be advising the President and Mr. Darman about the impact of severe Medicare cuts on the viability of the new MVPS process, which the Administration so desperately fought for last year?

Dr. WILENSKY. Well, we have been involved in the budget process that has occurred thus far. I assume to the extent that Medicare or any other programs that are under HHS's jurisdiction get involved in any additional discussions, that we will have input into that.

The question of whether what we have on the table thus far is likely to put in jeopardy the existing new system is something that I don't agree with. Whether or not something might come out of the budget summit——

Senator ROCKEFELLER. I didn't ask.

Dr. WILENSKY. That, I don't know. I assume that we would have input.

Senator ROCKEFELLER. Will you be giving them advice or reminding them of these Medicare cuts? Because again, these two worlds merge now all of a sudden, and you know, you fought very hard for this particular type of formula last year, and we got it, but they

are at the summit now, and the budget cuts on Medicare are a very substantial factor.

Dr. WILENSKY. Again, the proposals that are up there already, we have had as much input, probably, as we are going to have in the near term.

For additional discussions, again, I assume that we will be involved either in the reconciliation bill or in the budget on an ongoing basis, and I certainly intend to be.

Senator ROCKEFELLER. That is fair enough.

Do you have, at the present time, an estimate on the default performance standards for fiscal 1991? What would be the default performance standards for surgical and non-surgical services? Does this include a 2-percent sequestration cut under Gramm-Rudman, should that occur?

Dr. WILENSKY. The answer is yes. We have an estimate of what the default will be, and, as you know, the calculation of that is specified by statute. It depends on the Medicare fee increases, the enrollment increase, the average volume intensity over a 5-year period, and any changes in law and regulation that affect the baseline rate of increase.

The number that we have, the bottom line number that we are projecting, which would include a 2-percent sequestration, is 11.6 percent.

Senator ROCKEFELLER. 11.6 percent?

Dr. WILENSKY. That includes the 1-percentage point reduction that comes off of the baseline. We started with a 13.6.

Senator ROCKEFELLER. Because there is some ambiguity there, is there not, in the language of the law which has occurred to us? That is, some can say that if Congress defaults, there is only a single performance standard; others say that——

Dr. WILENSKY. We have not made a definitive decision about if there is a default, whether we would have surgery and non-surgery rates.

Senator ROCKEFELLER. Yes.

Dr. WILENSKY. Yes, as I have indicated, in the MVPS that we are recommending, we are setting the same rate for surgery and non-surgery. The only difference that we have allowed is to reflect the effects of OBRA 1989 benefit expansions, which are not the same for the two.

So that while our MVPS recommendation looks as though it is different for surgery and non-surgery, it actually is the same, because the only area of difference is the OBRA expansion.

The reason we have taken that position with regard to the MVPS as opposed to the default, which we have not quite gotten to yet, is that after reviewing data from 1986 to 1990, we found that there is no empirical justification for a differential. We are not saying that we would not be open to considering a differential at a later time, but based on the empirical evidence that we had, which was then supported by a second data set, we don't believe that there is empirical justification now to go ahead with a differential.

Senator ROCKEFELLER. I will yield to Senator Durenberger.

Senator DURENBERGER. Gail, would you mind slowly going back over the 13.6 and telling me what the 13.6 is?

Dr. WILENSKY. No, that would be fine.

Senator DURENBERGER. Slowly——

Dr. WILENSKY. Do you want me to go from 13——

Senator DURENBERGER. I didn't hear the question or the answer, and I apologize for that. I was thinking of something else. But when I heard 13.6——

Dr. WILENSKY. That got your attention.

Senator DURENBERGER. And it was generous. What does it mean?

Dr. WILENSKY. That is what you start from. What you actually end up in the default is either 11.6 or 12.6.

Senator DURENBERGER. What does 13.6 represent?

Dr. WILENSKY. It includes inflation of 3.6 percent; enrollment of 1.2 percent——

Senator DURENBERGER. 1.2?

Dr. WILENSKY. Yes. Volume and intensity of 7.5 percent and OBRA 1989 changes of 1.3 percent for a total of 13.6.

Even without sequestration, according to statute, you would have a statutory reduction of 1 percent.

Senator DURENBERGER. This is that SPSAF where we do 1 percent, that extra 1½ and then 2 percent?

Dr. WILENSKY. Yes. Now, the assumption is, if you get to the default, probably, there will be no reconciliation bill and we will be under sequestration. Then our estimate is that it would be 11.6 percent, and that reflects a 2-percent reduction including an estimate of the physician behavioral offset which would result in 11.6.

Senator DURENBERGER. Obviously, we are not at the summit, so there is a little deficiency here, probably, in understanding everything there is to understand about sequester, but does it make any difference to the average physician in America if the sequestration is of, say, a $60 billion sequestration versus $100 billion sequestration?

Dr. WILENSKY. It depends whether or not it is trying to affect physician services. Our estimate of what will be affected is the 2 percent as it is now scheduled.

Senator DURENBERGER. If you had a $34 billion sequester, which was what they originally predicted, now they have got it up to $60, it may go up to $100, let's say. In the average physician's reimbursement for next October, November and December, what is he going to see? Is he going to see an 11.6-percent increase in his payments, rather than a 13.6-increase?

Dr. WILENSKY. Well, there wouldn't be except for the statutory maximum deduction of 2 percent. The fact is normally, yes, there would be, but this will cap it.

Senator DURENBERGER. But the dollar volume is not going to be effected because of the 2-percent cap.

Dr. WILENSKY. So unless that changes, it is protected.

Senator DURENBERGER. That is what I want people to understand, I think, that that is——

Dr. WILENSKY. Otherwise, it obviously would be much greater.

Senator DURENBERGER. Let me ask another question that is sort of preliminary to exploring the issues that the chairman was exploring.

Both he and I, travel our very conservative charge states, and when we got home in November, we were told that we didn't move the system quickly enough; in other words, the two of us should

have gone for a 3-year implementation or immediate implementation, not 5-year implementation, but we apparently satisfied people that we also have to represent national interests and they would never even get what they wanted if we had not done a 5-year deal.

Now in the last few months, we have been hearing from principally—at least speaking for myself, from rural primary care physicians that the first year before we actually get into fiscal 1991, I think, before we ever get into the actual implementation, their fees are going to be reduced and that the promises that their Senator gave them that somehow, this was going to increase payments to family practitioners and primary care, is a lie and that as a matter of fact, their reimbursements are going down.

Do you understand that problem, and can you address it?

Dr. WILENSKY. Let me comment to both parts of your statement. I can't pass up this notion that we aren't moving quickly. Let me explain some of what has to happen before we start in 1992, because the notion that we are doing this in a slow manner performance is really——

Senator DURENBERGER. We are the ones that set this up, so that is not a problem. That is not the criticism.

Dr. WILENSKY. Also, the fact of the matter is, the notion that this could be done any quicker doesn't recognize the massive reform of a payment system that has to occur.

Senator DURENBERGER. We convinced them that there is massive reform necessary, that the brightest people in the world are working on it, and now they say, "But the first thing they have come up with is a cut at the level where you promised us it was going up."

Dr. WILENSKY. The problem that exists has to do with the earlier phase-in of the balance billing limitation relative to the other changes. Now, our understanding of the actual impact is that it is an extremely limited problem. The balance billing limitation of 125 percent phasing down from 150 percent is starting before some of the other changes.

So there is a brief window where it is possible, depending on previous charges, that cuts could happen.

Senator DURENBERGER. If, in fact, the two of us on behalf of about 70 percent of our colleagues can demonstrate that, that will be at least, as a minimum, a discouraging factor in the implementation. It might even be a costly factor. Do you suppose it might be possible for us to work together to try to find some way to overcome that temporary 1-year problem?

Dr. WILENSKY. I assume it is pretty straight-forward. It would require a legislative fix.

Senator DURENBERGER. But I mean that probably, we could find one, right?

Dr. WILENSKY. I think those two phase-in schedules could definitely be sequenced differently from what they are now.

Senator DURENBERGER. Thank you.

Dr. WILENSKY. I assume it was not intended to have this outcome; although it is very limited, it was not intended to have it occur at all.

Senator DURENBERGER. I realize that none of this is easy, and I suppose it is just a matter, as we are traveling, and we have an

opportunity, maybe others don't have, of discovering some of the problems. This one was hardly predictable.

Now let me make sure that I understand the areas in which you and the PPRC will differ, and I presume you know that. I could save myself some time by asking a general question, but first, I take it on the inflation issues you are not going to disagree much, right?

Dr. WILENSKY. We should not.

Senator DURENBERGER. And on the number of enrollees or on the aging of the enrollees?

Dr. WILENSKY. Right.

Senator DURENBERGER. Those sort of volume or fee level numbers don't differ?

Dr. WILENSKY. There are only two points I am aware of where we differ, and I will tell you what they are if you would like.

Senator DURENBERGER. Yes.

Dr. WILENSKY. The first has to do with how much of the historical volume and intensity to include, and their recommendation was, as best I can remember, and Karen may wish to give a different interpretation, a flat off-the-top 2-percent reduction. Ours was to take what we observed and to say 50 percent of that was tolerable for the future.

The second point has to do with the differential with regard to surgery and non-surgery. We believe it occurred because we added additional years of data in terms of what we were looking at historically with regard to changes in surgery versus non-surgery expenditures. We have recommended no differential between surgeons and non-surgeons except for the OBRA 1989 benefit changes, because in looking at 1986 through 1990 BMAD files, the physician expenditure files, we found no empirical justification for a differential. Looking at a second data set supported that. Our understanding is that PPRC looked at 1986 through 1988 data, in which there is a difference, and on that basis, recommended a 1-percent differential.

Senator DURENBERGER. Again, just to make sure—and thank you very much for that response, because it helps me a lot. I thought I heard you in your testimony say that the lack of access was not——

Dr. WILENSKY. Overall lack of access for the entire Medicare population does not appear to be a problem.

Senator DURENBERGER. Then you said that at least at this stage, you have not factored in evidence of inappropriate utilization.

Dr. WILENSKY. Which would have reduced it.

Senator DURENBERGER. Right.

Dr. WILENSKY. Right. We have not because most of our information is based on four or five studies of five procedures.

Senator DURENBERGER. Yes. So we are kind of down to the——

Dr. WILENSKY. What feels right?

Senator DURENBERGER. Yes. And as I recall your testimony again, I think you said you took an 1986 to 1990 time frame?

Dr. WILENSKY. In terms of surgeons versus non-surgeons, it was 1986 to 1990; the volume intensity 1984 to 1988; 1984 to 1988 for the overall economy; 1986 to 1989 for Medicare specific data.

Senator DURENBERGER. In there, I suppose the largest factor is technology, is it not that kind of thing? Could you identify a factor that might help us discuss with them the difference?

Dr. WILENSKY. That has been one of the great unknown challenges that keep health care economists in business, and has been for the last 20 years. This issue of what technology contributes to health care expenditures varies all over the map. Estimates have ranged from 10 percent to 40 percent when we try to answer the question. When we try to answer the question specifically, it is usually dumped in as a residual volume/intensity factor, and we cannot come up with anything else.

Some of HCFA estimates attribute national health expenditure increases of 25 or 30 percent to volume as well as intensity and technology.

The reason it is so hard is because usually we try to look at the impact of specific technologies, so we might want to look at ocular implants or MRI's or CT scans. In fact, we usually do not do a very good job on determining the overall impact, because we find that on a per-unit basis, the costs go down. If you do a lot of angioplasties rather than bypass surgery, the cost will go down from that technology, but since it is a lot less invasive and a lot less painful, people who might never have had bypass surgery are likely to have angioplasty, and some of them that do end up needing bypass surgery anyway. And so, trying to figure out the impact on a system when you look at it technology by technology gets very complicated. In trying to get all the technologies together, you just have people trying to tease out residuals in an economic fashion.

Senator DURENBERGER. My last question, if the chairman will indulge me?

Senator ROCKEFELLER. Sure, go ahead.

Senator DURENBERGER. As I think about this particular area we are talking about now, your 7.4 percent area, I tend to think about it largely from the standpoint of the way we practice medicine or the way we deliver health care, and I know it is much too early in this process for you to come up with a scientific way to measure that.

But the tendency is going to be at this stage, to look at the system as though it is several hundred thousand individuals out there practicing against this amount of inflation, this number of enrollees, this much technology, et cetera. Where the reality is that when we get down, I guess, when we get down to this particular large factor, the main difference between whether we continue at the rate we have been at or we reduce that rate is going to be the way medicine is practiced and health care is delivered in this country.

So my question is: Is it appropriate for us or for you to begin to look at groups of physicians, and I do not mean that in the organizational sense as much as I mean—or maybe I do. I mean, can we begin to look at the way, in certain areas, medicine is practiced differently, thus reducing, for whatever reason, utilization, appropriate use of technology, more efficiency—I do not know what it is—reducing that historic increase. Would that be at least an appropriate additional piece of evidence to look at so we do not end up in some debate where one group says, "Take off 2," and you say, "Cut

it by 50," and everybody says, Dick Darman is a bad guy, and we are not really dealing with reality.

Dr. WILENSKY. There is no question that it would be a whole lot better to have an idea about what we would like to do, and what we would like not to do. That is one of the justifications for the increased emphasis on effectiveness and outcomes research, to get away from doing things we ought not to be doing.

But the other point is the whole organizational structure of the health care delivery system. It is one of the reasons that I personally, and the Department, are very strong advocates of coordinated care strategies of all sorts. We think that the incentives are much better in terms of the practice style, in addition to providing better information about what services are available.

There is no question that the MVPS is a very crude mechanism. Next year, we will probably give you a number for technology, but it won't be based on much harder science than saying about what half of what we observed seems right, because the fact of the matter is, when all is said and done, we do not know it. We have not been able to figure it out for the last 50 years, and we probably won't next year, either. But if we can get a better estimate of the impact of different organizational forms, of being in these primary care networks, PPO arrangements or an HMO and decide that is the model we want to use, we can either try to push physicians or patients into those models or we can say, "We are going to reimburse on this kind of basis. You do what you want, but we are using that as our standard," and set up an incentive that way. When you decide what you want to do, there are all sorts of ways to get there.

But we are just taking about a few areas. It is not like we have not been looking for cost containment strategies for awhile except for effectiveness. That is quite recent.

Senator DURENBERGER. Thank you. Thank you very much.

Senator ROCKEFELLER. Dr. Wilensky, you have a 3.3 percent for volume growth in the general health care system. Number one, I would like to know if that is a credible figure, not Medicare, but just the general health care system. Is that a credible figure?

Dr. WILENSKY. It is the figure. I do not know if it is credible.

Senator ROCKEFELLER. Because it is interesting that volume and intensity, therefore, of Medicare services, what you are saying, has always outpaced the general population services by a factor of 2.

Dr. WILENSKY. That is not really so surprising. I have to say—and I do not know whether this is good to "fess up" or not—that particular piece of information came to me after the 3.7 as a corroborating piece of information to say this seemed like a reasonable number. After the general view, the 3.7 seemed like an appropriate number.

Now, the question as to why that might occur has several reasons: In the first place, Medicare beneficiaries are much better insured than the rest of the population, and we know that leads people to demand more and it leads physicians to initiate more services, and there is empirical evidence indicating that this occurs.

So it is not surprising that we would historically see more utilization. The Medicare population is much better insured. Everybody

has something, and 80 percent have a lot. The other point is that they are older and sicker and need more health care.

Senator ROCKEFELLER. I understand that, and I was questioning, trying to figure out if you take out those that do not have health insurance at all——

Dr. WILENSKY. That is reducing the 3.3.

Senator ROCKEFELLER [continuing]. In the general population.

Dr. WILENSKY. Right. The 3.3 picks up the fact that our 31 million uninsured are all in the under age 65 category.

Senator ROCKEFELLER. Are there some things—putting that aside for the moment—that the private side is doing with respect to volume control that Medicare is doing?

Dr. WILENSKY. The private system in the last 2 years has been a lot tougher than Medicare has been. There is a lot more use of deductibles and co-payments. The big movement in the 1980's on the part of business has been away from first dollar coverage, which is exactly what you get when you provide wrap-around coverage to Medicare.

In addition, there is selective contracting that sometimes goes on; there is pre-admission screening and review and a whole series of strategies; a lot more push from the private sector toward all managed care activities, where there are 30 million people in HMO's and PPO's. In Medicare, we have one 1¼ million beneficiaries in risk-based HMO contracts out of 33 million, which is not a whole lot.

Senator ROCKEFELLER. Exactly.

Dr. WILENSKY. So there are all kinds of things going on. The private sector is being much tougher about trying to impact the system than the public sector has been.

Senator ROCKEFELLER. That will be part of the interesting future, won't it, to see where that can be transmitted?

Dr. WILENSKY. I suspect that will continue, but it may mean that there are things that we have felt unable to do in the public sector that, when they become sufficiently accepted in the private sector, we can follow.

Senator ROCKEFELLER. Yes. Yes. I want to work my way towards linkage. Let us draw aside the proper rate of volume growth.

The Secretary has recommended a 10-percent increase for next year in the rate of spending. Compared to virtually anything else in government, that is a lot. If physicians meet the performance standards, can I then assume that the Secretary will recommend a full MEI update for 1993?

Dr. WILENSKY. I do not know. It depends on where we are in the whole budget process, I suspect. But I have no reason to believe otherwise.

Senator ROCKEFELLER. Okay. Because that sort of gets to it, in a way, because the whole point is that—and the Administration fought for this, and granted, you weren't part of that at that time, but the whole concept of linkage—and that is that you will warn physicians for what they do to control their own or modify their own behavior, control their own volume and intensity, and then so-called punish them, so to speak, if they do not, but in any sense, there is meant to be linkage. That is the incentive. It is the philosophy.

But in a sense, if, because of the budget summit or other things like the judgment factor, the linkage disappears, then can you really expect doctors to respect this process and to react to this process?

Dr. WILENSKY. Let me go back and review with you what is in the update factor. I think if we are comparing it, say, to what happened with prospective payment, there are components that you want to look at. Certainly, you will want to include an inflation factor, and you are going to want to give an adjustment for aging of the population and the additional enrollees.

The question you will still be left with is the one that Mr. Durenberger raised. There will be some amount of volume and intensity increase, and the question will be for us to recommend and for you to decide whether or not that increase represents either appropriate medical care or whether it represents a style of practice that we want to foster. But when we decide what that is, then I agree with you: We ought to give the full amount for it. But it doesn't mean it would necessarily be either the 3.7 or the 5 percent PPRC example, because that would assume that you think that either 3.7 or 5 percent of this residual intensity/volume is where we want to keep the system in the future, even though we may, by then, have evidence of 20 percent inappropriate utilization or inappropriate practice organization styles that are leading to excessive use.

You would want to give the full amount of whatever we think is right and not reduce it arbitrarily for any other reason. That is a part of this mechanism. It will be especially important because of the balance billing limitations that will become effective at the same time. That takes out a very important safety valve that we have had, and it means that while access is not a problem now, if a lot of gaming goes on in the pricing of medical care, it obviously could become sometime in the future, an issue that we want to be concerned about.

Senator ROCKEFELLER. All of which I understand and listen to with interest, but it doesn't get the, I think, the point of my question. In other words, the link is the philosophy of the discipline. That is really the most important aspect of it. Physician behavior, physician volume intensity control and update are just flat-out linked.

Now we are talking about the realities of the situation where they, in fact, may not be. Would you disagree with that statement?

Dr. WILENSKY. As I understand your concern, the purpose of having the Volume Performance Standard was, in fact, to link the update in the future year to the difference between what we set it at and what we got.

Senator ROCKEFELLER. Right.

Dr. WILENSKY. I assume if the Congress had wanted to have an automatic mechanism, you would have passed an expenditure target which would have locked into law exactly the relationship between what you got and what you wanted, and that the fact that you didn't indicates that you would like to have a little more discretion.

Senator ROCKEFELLER. Right.

Dr. WILENSKY. I do not know of any planned attempt to try to get around the intent of having a volume performance standard

provide an update factor. The fact is, once you start setting prices, which is what you are doing in a relative value scale, you got to figure out how you are going to update them, and how well you did compared to how well you wanted to do is certainly an important factor in terms of developing the update.

It might not be the only factor you want to use, because you also might think that there is still something amiss in the system. It is different to do it with background data than it is to do it on purely budgetary grounds, which is I think what you are really asking me. I do not know if we are going to do that.

Senator ROCKEFELLER. That is fair enough. Let me ask one final question. There has been a lot of concern expressed over the Secretary's definition of services covered under the surgical performance standard. Specifically, the concern focuses on the definition of that surgery includes all surgical services performed by surgeons. I recognize that the Secretary's notice specifies that this definition will not lead to payment differentials by physician specialty. I appreciate that, because clearly, that was the intention and the will of the Congress, so to speak.

But could you explain for me why your surgical MVPS will not produce a specialty differential in payments and why the Department chose this particular definition?

Dr. WILENSKY. The latter is easier. It is the only thing we can do right now with the data we have got. We agree that procedure-specific definitions, irrespective of who does them, are better than a procedure linked with who does them. So if we had our druthers, we would not include the "Who does it" as the primary classification. Right now, it is what is done and is it done by surgeons or assistants at surgery. We would rather have something that is strictly surgical procedures, irrespective of who does them, and we intend to have that in the future.

We have had 120 days to get to where we are now. We just do not have a data set that accommodates otherwise. There is nothing in the fee schedule that will lead to having differential payments. That is clearly contrary to the whole spirit of the reform.

To the extent that you get differential behavior and differential updates, there will be a short period in which it is the "Who is doing the activity?" that relates to the increase. But there is no question that we will alter the definition of surgery and non-surgery as soon as our data set will allow us to do it and that there will not be differential payments for doing a procedure if a medical specialist does it or a surgical specialist does it.

Senator ROCKERFELLER. Are you looking at about a two-year requirement for the data?

Dr. WILENSKY. Let me talk to my experts here.

The answer I got is, "We hope 2 years."

Senator ROCKEFELLER. Okay. Senator Durenberger, do you have any other questions?

Senator DURENBERGER. No, Mr. Chairman.

Senator ROCKEFELLER. Are you sure? [Laughter.]

Senator DURENBERGER. Yes.

Senator ROCKEFELLER. An unusual answer.

Senator DURENBERGER. I will conclude with an observation on Jay's question a little earlier about a deficit strategy, and just to

reinforce on this side of the aisle, I guess, the significance of the advice that has to be given to the Administration with regard to the budget summit and that is, I think we all know that in the rest of the developed countries of the world that have more of a national health care delivery system, they are moving the direction of rationing, as they tighten up their budgets, but they form up as queues, and principally, everybody is treated the same: You either get it or you do not get it. If you are wealthy enough to take the bridge from Norway to Great Britain or Canada to the United States, that is okay, but generally, there is a system in place by which people eventually get care.

In this country, every time we cut across-the-board on payment to providers, we are cutting people all over rural America and all over the core of our cities out of the system in one way or another, because they are not going into good health care or whatever the reason is. We just have to stop this across-the-board percentage reduction, because we now know from looking at RBRBS, that it does not hurt as much in Miami as it does in Montevideo, Minnesota, and it does not hurt as much in some other high-priced place or some other high-priced specialty as it does in the hills of West Virginia.

Every time we do a 2 percent or a 4 percent or a 7 percent or a whatever it is reduction, we are just hurting more in this than a lot of folks who do not have access to the system they need.

So I hope there is a strong feeling on the part of those in the know, who know how the system really works, that even though this is the fastest growing part of the budget, this is one that has to be off limits in this discussion that is going on.

Dr. WILENSKY. I think the problem that you have mentioned will be helped significantly when RVS starts being put in place. Part of what has happened is that these areas in West Virginia and rural parts of West Virginia and rural parts of Minnesota have had, historically, very low levels of payment. When you couple that with lower charges for primary care as well, changing the relative values or relative weights in payments will significantly help. It will be much less harmful if a percentage reduction occurs if you have things in the proper perspective relative to each other than where they are now, where we know there are historical inequities with regard to payments to rural physicians and historical inequities with regard to primary care.

I think honestly, when you are talking about the kinds of big dollars that you are talking about in the deficit reduction, there is no way you are going to have a program like Medicare be put off limits. It is just too big a part. That is my personal opinion.

Senator DURENBERGER. Jay's point earlier was that this is 1981 to the hospitals, you know? It didn't really hit until 1983.

Dr. WILENSKY. Right.

Senator DURENBERGER. Everybody in this room knows that beginning in 1985, we took this strategy that was supposed to be good for cost containment and we abused it with the budget cuts every year, and we said to the hospitals, "If you do good, you are going to get rewarded," and instead, you know what we did to them. Everybody out there knows that happened, and so here we sit in the 1981 of DRG's or the 1990 of the 1992 PPS, the RBRBS, and they are all

saying, "I can see it. You know, as long as George's lips do not move, they are going to destroy this great system they are talking about."

This whole system is designed to get voluntary participation, all the folks, everybody has to make some sacrifice in this whole system, and it is pretty hard to get volunteers when some guys are closeted at the top of the mountain some place doing deficit reduction while we are sitting here trying to explore the intricacies of human behavior and the impact of all of these systems.

That is just a way to grind an ax that both of us have the same handle on, I think.

Dr. WILENSKY. Presumably, nothing is going to happen unless the majority of you guys agree with it, also.

Senator ROCKEFELLER. Dr. Wilensky, I thank you very, very much. You are a superb witness and a superbly prepared and informed witness.

I would ask, as time goes along—you know, this is a process which we, those have argued for 3 years, and I think one House member has argued for 2 years for RBRVS, and we came out of it with a 5-year hope, and the predicate is we can make mistakes and we have got to leave time. Even Doctor Hsiao admitted that it was not necessarily perfect, so this whole process requires good judgment and fair judgment.

So as we go along on this, either privately to Senator Durenberger and myself or publicly, we welcome how you think we can refine this, make it work better, because we would welcome that, and I thank you very much.

Dr. WILENSKY. Good. That is a very important consideration, because, in fact, what we are doing is a demonstration involving 480,000 physicians, unlike PPS, which had been in the works for 10 years and tried out in New Jersey. We are going to be rolling out a payment system that will probably have values rolling off the printing press as we go forward with our fees; and have never tried it.

So I think the acknowledgment that there will be mistakes made and that it will require judgment and understanding on our parts will be very helpful.

Senator ROCKEFELLER. Which however, should not be interpreted by anybody who might be listening to either of us saying that, that this is just kind of an open system waiting for pressure to bend us. I mean, the good judgment factor, the tough judgment factor is important all along that line.

Dr. WILENSKY. We are planning to implement on time and as written in statute, by January 1992.

Senator ROCKEFELLER. Thank you very, very much.

Our next witness is Karen Davis, one of the commissioners of PPRC. Karen, we welcome you. You have been here many times. We look forward to what you have to say.

STATEMENT OF KAREN DAVIS, PH.D., COMMISSIONER, PHYSICIAN PAYMENT REVIEW COMMISSION, WASHINGTON, DC, ACCOMPANIED BY PAUL GINSBURG, M.D., EXECUTIVE DIRECTOR

Dr. DAVIS. Thank you, Mr. Chairman. It is a pleasure to be here. I am accompanied by Dr. Paul Ginsburg, executive director of the Physician Payment Review Commission.

We are delighted to be here to talk about the implementation of the Medicare Volume Performance Standard. What I plan to do today is to describe the commission's recommendations for the Medicare Volume Performance Standard, rates of increase for 1991, and discuss what must be done by the medical profession and the Federal Government to make this system a success, as all of us wish.

On May 15th, the commission did submit a report to Congress, as required by law, containing its full recommendations for the volume performance system rate of increase for 1991. For at least a decade, the growth of physician expenditures has placed increasing financial burdens on beneficiaries and has drawn on Federal resources that might more appropriately be devoted to other public needs. It is the commission's judgment, shared by the Congress, that growth in physician expenditures must be lowered to a more sustainable rate.

As you have heard from Dr. Wilensky, the Secretary recommended a volume performance standard rate of increase for fiscal year 1991, a total of 9.9 percent, with 8.7 percent for surgery and 10.5 percent for non-surgery. The Secretary made a full allowance for inflation, enrollment, changes in average age of beneficiaries, prior legislation, by providing an allowance for an increase in volume and intensity per enrollee of half of the historical trend.

The commission recommends a somewhat different volume performance standard rate of increase of 11.2 percent overall with 9.3 percent for surgery and 12.1 for non-surgical services. In addition, we recognize that these rates of increase would be adjusted when one is considering the update to take into account the effects of subsequent legislation on 1991 expenditures.

The commission—as did the Administration—considered the effects of factors spelled out in the legislation. We had the Medicare actuary give us information on inflation, growth and numbers and average age of Medicare enrollees, and concurred with the Administration's estimates in those areas.

However, the commission found no satisfactory way to estimate accurately the effects of new technology on expenditures. In looking at access, we felt that across the board, Medicare beneficiaries do not generally experience deficiencies in access, although there are certainly problems in certain rural or urban under-served areas. We felt those could be better addressed by other policies. There is also substantial information, as Dr. Wilensky noted, that a number of services are inappropriate and could be eliminated without any effect of quality. It might even improve quality.

Therefore, we, like the Administration, stress the importance of exercising considerable judgment. The commission's approach, however, was somewhat different from that of the Administration's. We began with a baseline projection of what Medicare spending

would be in 1991, in the absence of any legislation, and then we looked at how much you could slow that growth without having an adverse affect on access for beneficiaries or quality of care. It was our judgment that in the initial years, the ability of physicians to affect medical practice is the factor that limits the pace at which the growth rate can be slowed.

We took the Medicare actuary's projection of what would happen to Medicare physician expenditures in 1991 in the absence of new legislation, and that was 13.2 percent for fiscal year 1991. We, then, would reduce that by 2 percentage points to 11.2. So that is basically the way we came up with our Volume Performance Standard rate of increase. Take the baseline projection and subtract off of 2 percentage points.

We further recommended that the VPS rates of increase for surgical and non-surgical services be 1 percentage point further apart, and as Dr. Wilensky mentioned, that is another area in which we differed from the Administration. We base that on evidence that we have that the Medicare volume of surgical services has grown less rapidly in recent years, and we particularly note the flattening of the rate of cataract surgery that has been a major factor. So it was our judgment that having a 1 percentage point difference between surgery and non-surgical services would, in fact, yield an equal effort on the part of surgeons and non-surgeons to achieve the Volume Performance Standard.

We also noted that the recommended rates of increase will need to be adjusted for subsequent legislation affecting fiscal 1991. Again, I think it is a point that came up in the questions earlier. However, we made a distinction between legislation, budget-cutting legislation, if you want to call it that, that focuses on price of services under Medicare part B and that that focuses on curbing utilization, for example, changes in prior authorization of assistance at surgery or anything that would affect carrier and PRO activities. If there are budgetary changes that would affect the volume of services, we think that ought to be counted toward helping meet the target rather than having the target over and above all legislative changes.

I would stress that the commission views the 1991 Volume Performance Standard as the first step in a long-range plan to slow expenditure growth to sustainable levels, such as the trend and the rate of growth of the Gross National Product. We believe that this can be done over a 5-year period, so we are making it very clear that while we are talking about 2 percentage points in the first year, that we would see further tightening over time until we succeed in slowing growth something closer to the rate of growth of the economy as a whole.

We think this can be done over the next several years, while maintaining access and quality of care. However, I think the challenge will fall primarily to the medical profession, and it is important that the medical profession receive strong support from the Department of Health and Human Services, particularly two agencies within that Department, both the Health Care Financing Administration and the new Agency for Health Care Policy and Research. We are pleased that the Congress has established the new Agency for Health Care Policy and Research and given it funding.

We think that funding will need to expand further to support additional research on effectiveness.

The new agency must also be encouraged to disseminate the information that they obtain from studies and from the profession's efforts. They need to improve and test the methods used to develop guidelines and to evaluate their effects and actual practice. We also believe that the Health Care Financing Administration, in addition to administering and developing the new Medicare fee schedule, must improve both their review methods and the criteria used by PRO's and carriers.

We think it is particularly important that profiling methods be available to carriers and PRO's so they can target their direct review activities. It is also important that the Department make the information available to the medical profession, beneficiaries and the public about utilization, appropriateness and access to services. We think it is important that the Medicare carriers provide physicians with data comparing their own utilization patterns with those of their peers.

The main indication that one would be going too quickly would be any evidence on reductions in access to care. Therefore, we think it is particularly important for the current beneficiary survey to obtain information on access move forward under the guidance of the Health Care Finance Administration. Therefore, the commission urges Congress to support funding for the Agency for Health Care Policy and Research, and HCFA, to improve PRO and carrier review. We would also note that it is important that beneficiaries also be involved in this effort and that practice guidelines that can be used by beneficiaries be developed, as well.

The goals of the Volume Performance Standard cannot be reached overnight. Growth can be slowed within a 5-year period to a sustainable level. However, the commission feels that it will need to reassess the situation every year in light of more recent information on access to services, technological change, appropriateness of current practice and the ability to identify and reduce services of little or no benefit.

We recognize that we are moving into new territory. However, we would note that other societies have been able to hold expenditure growth in health care to levels they consider affordable. With these new policies and programs, we have an unprecedented opportunity, not only to bring the growth and expenditures to a sustainable level, but to maintain access and quality and to improve the value received for these expenditures. This will require prudent and thoughtful management of the Volume Performance Standards system of the Congress and strong support by the Federal Government for the medical profession.

Thank you.

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

Senator ROCKEFELLER. Thank you Karen. We will get away from the "Dr. Davis," "Dr. Ginsburg" stuff.

Senator Durenberger?

Senator DURENBERGER. Karen, why do we not just begin by asking you to characterize the Administration's response, and just so—at least on paper—the response will relate to a question. You recall that I went through with Dr. Wilensky the analysis of their

MVPS recommendation where she thought that inflation, enrollment, aging and those kinds of issues were treated basically the same and that the difference would come in the so-called factors other than inflation, enrollment and aging. Then we began to explore with each other what was contained in those factors. She indicated that from their standpoint, they took the historical data, gave it a percentage, divided it by two and at this stage, the main variable between your recommendations and the Administration's recommendations lie in that area.

Now, could you just help the two of us and others who will take the time to try to understand the decision that we have to take during the course of the next few years? What are some of those factors are that are in there; how, in the thoughtful way, thinking about the fact that maybe the first time we do this, we are not going to be perfect, but at least we ought to pointing our colleagues in some direction?

Should we, in effect, settle for a 2-percent off like you have recommended or a 7.4 divided by 2? Or should we, right here in the beginning, be looking more carefully at some of the "Factors other than inflation, enrollment and aging?"

Would it be safe this year to just adopt some kind of a percentage, but warning our colleagues that is not what we are going to do next year? When we come to this next year, we hope to have additional information about the way medicine is practiced, about technology, about some of these other factors.

Dr. DAVIS. Yes, I would be happy to contrast what we have done with what the Administration has done. As I have indicated, we have used the Medicare actuary's estimates about increases in inflation, enrollment and aging of the population, as well as the effect of the 1989 OBRA legislative changes. So where we do differ is with regard to a factor for volume, intensity, technology, access, and services. What the Administration did was to figure out what would happen in 1991 in the absence of legislative changes. They took the historical trend for 5 years in volume intensity and projected that forward. That gave you an overall increase of 13.6. It gave you a 7.4 projected increase in volume, and they took half of that. So that is how they came to their bottom line number of 9.9.

We did something a little bit differently in getting the baseline for 1991. We didn't take the 5-year average of volume intensity and project it forward. We took the actuary for Medicare's best estimate of what will be Medicare physician outlays in 1991 over 1990, given more recent trends. So it is not just taking a 5-year average and extrapolating forward. It is a more refined methodology that the Medicare actuary uses. We took as our starting point 13.2 for what will be happening next year if we do not do anything. HCFA took 13.6, which is the equivalent to default mechanism in the law that takes a 5-year average of volume growth. So having gotten the 13.2, we reached a judgment of how much the medical community could be expected to adopt, change their practices, change their trends, ferret out some inappropriate utilization and reached a judgment that you could come down 2 percentage points from that 13.2. So that is how we get the 11.2 overall figure.

In terms of what we should be doing in another year, we certainly hope to have additional information on technology trends. We,

in fact, took an informal survey of all of the specialty organizations to tell us about new technologies that they thought were effective, and their implications for volume and intensity. We put together quite a bit of information on access. We reviewed all of the literature that exists to date on inappropriate use of services. We looked at PRO and super PRO review decisions. So we did have a substantial amount of information available to us. But we would certainly hope in another year to have far more information and fine-tuned information on trends and technology, access to care, extent of inappropriate services. Also, as soon as the new agency gets going, we hope that new research will be forthcoming over time.

But it is certainly our judgment that there is quite a bit of inappropriate utilization in the base and that there are not major problems with access to care as a whole for Medicare beneficiaries, and that one can certainly slow the growth in utilization. We would see, over time, while we would reach a judgment, year-by-year, that could, in fact, begin to slow the Medicare Part B physician outlays to something like the rate of growth in the gross national product. So we do not just see 2 percent as being overly stringent and therefore being maintained over a 5-year period, but as we learn more and as physicians are able to modify the practice, that we could go tighter than that over time.

Senator DURENBERGER. Without suggesting any criticism at all of the approach that they took at HCFA, I take it none of this gets done in a vacuum. You know, you are not sitting on one side of the world, and they are sitting on the other side of the world. I mean, you understand the way they are headed in the last—I mean, you all were involved in the legislation, so you have all followed this progress.

What it looks like to me is that one side chose to use historic data and the other side used historic data; actuaries cannot operate without historical data either, but they did more projecting based on what was happening from the middle eighties or the early eighties on towards the nineties.

Dr. DAVIS. That is correct.

Senator DURENBERGER. So it is kind of an honestly different way to begin with process. The end result is not overly larger. I mean, it is like yours would be, what, 1.2 or 3 percent greater?

Dr. DAVIS. We certainly do work closely with HCFA and had the HCFA staff and the actuary appeared before our meeting at the end of April, so certainly, we cannot take full credit for the method we have taken. We have certainly drawn on their expertise and information.

I wonder if Dr. Ginsburg would like to comment.

Dr. GINSBURG. One thing that was fortunate was that this difference in approach between the actuary's best projection versus the historical average did not turn out to give an end result that was very different as far as what we started to work from.

But that was fortuitous, because there were two differences that mostly canceled each other out. One of the differences we have been over, but the other one was that the legislation, in specifying the default mechanism, directs the Secretary to add up the different components; in other words, take inflation and enrollment and the 5-year average of volume and intensity, add those components

up. If you talk to an actuary or economist, they will say, "Well, it probably shouldn't have been written that way. The components should have been come compounded," and the actuary's projection of 13.2 percent is actually compounded.

So in the sense the actuary made a judgment that the volume and intensity, which historically grew at 7.4 percent, would more likely be growing at 6.6 percent in 1991. So in a sense, that is a 0.8 percentage point difference. Then when the difference between compounding and adding was brought in, the final difference between 13.6 and 13.2 was smaller. So it was fortunate that this difference in approach didn't make a large difference in the starting point and that the main difference between the commission and the Department is the judgment as to how far below that baseline to go this year.

Senator DURENBERGER. Now let me ask you: Given the realities that we have been discussing in terms of budget deficits and budget reconciliations and so forth, to the degree that we move downward from even the Administration's recommendations here in adopting a congressional MVPS or whatever it is called, where will the adverse impact be felt first and most deeply out there other than just the discouragement on the part of the people who believe? On whom will the adverse impact fall, or can you tell, as you are projecting, where it will fall most obviously?

Dr. DAVIS. We have to keep remembering that we are talking about slowing the rate of increase. We talk about budget cuts. Somehow we get a vision that we are going below what we are doing now. When we look at the CPI for physician fees, we see that it is going up faster than for the CPI overall. We are talking about slowing the rate of increase in the price that physicians are paid for services to something a little more comparable with what is true in the economy as a whole.

It is certainly our judgment that there will not be an adverse impact on beneficiaries, that beneficiaries will have access to care; they will have physicians willing to take care of them; that they will have quality services. Obviously, there is an impact on the physician community, but again, we estimate that in 1991, that fewer than 1 percent of physicians would have more than a 5-percent change in their revenue coming from care for Medicare beneficiaries, so again, relatively modest impacts even on the flow of revenues to physicians.

Now, again, that varies across specialty and across geographic areas with the kinds of recommendations we have made over time. Certainly, there is going to be more constraint as we move to a Medicare fee schedule, on surgical and high-tech services as opposed to increasing compensation rates for the provision of primary care services.

Senator DURENBERGER. You have left me at least with the impression that somewhere between the 13.2-percent recommendation from PPRC and the current rate of growth in the general economy is a direction we ought to be headed. That is a fairly substantial piece, I take it, to get from here to there, unless I misunderstood your response. How feasible is it, and who has to, in effect, give us the most in the system if you are going to move from your current

estimate of growth at 13.2 percent to the rate of growth in the general economy, which I assume is at least half of that or less?

Dr. DAVIS. I think if you look, again, focusing on this volume performance, volume intensity component type of VPS, again, while we project 13.2 to be baseline, we are recommending holding that to 11.2. That implies a 4.7 percent allowance for renewed volume and renewed intensity as contrasted with the HCFA allowance of 3.7. So we are saying that there should continue to be a 4.7-percent annual increase in new services.

Now, the question is: What kind of limitation would coming down to that involve? We think certainly, there is room to take out of the base certain inappropriate services that are currently being rendered. We also think that there is some evidence that one could have economies, for example, in the use of assistance at surgery. So there are certainly ways in which one would control or slow down the rate of increase in volume and the numbers of services, particularly expensive services, that could be achieved without in any way cutting into necessary care or the quality of care for Medicare beneficiaries.

Senator DURENBERGER. Just one last question on that point. For those of us on the Pepper Commission who found areas to agree on rather than disagree on, I think one of the areas was the restructuring of the financial access into this system. Since you have pointed to the appropriateness of the utilization of certain kinds of services as a place of opportunity, I would guess that some of us—I know I am—are thinking about the need to restructure that whole Medicare benefit.

Since we are talking about Medicare here, has the commission discussed—as we move into this era in which we are going to try to bring down the percentage growth through these Volume Performance Standards, have you discussed at all what you might recommend to us by way of needs to restructure the current Medicare insurance program so that there might be more appropriate incentives in that system for the Medicare beneficiaries to work with the providers to achieve some of these ends that we are thinking about trying to achieve? We are all on this "MEDIGAP" bill that is floating around, but that really isn't Medicare restructuring; that is sort of trying to send signals to a market that maybe should not even exist if we had an appropriate Medicare insurance program.

What is the commission doing in this area?

Dr. DAVIS. Certainly, the commission is familiar with the recommendations of the Pepper Commission. We are particularly interested in some of the recommendations that would have given a roll to the PPRC to look more broadly at the need for health system.

Congress has asked us to look at the Medicaid physician payment system, and we have a study under way, and we will be making a report to Congress in another year on that aspect. We also know that we are in the business of health policy and not in budget-cutting policy and that what we view our responsibility as a commission is to make recommendations that, in fact, make quality health care accessible to all Americans, and so we also discuss the importance of looking at this not as a deficit reduction approach, but the need to reallocate resources within the governmental spending on health care toward higher priority areas, whether it is child health

or health care for the uninsured or improving the Medicaid program, both with regard to covered people, but also benefits and the payment rates that are in that program.

So as we think about trying to slow Medicare part B outlays, we do so because we think there are high priority uses of that money to improve access to health care for all Americans, not just Medicare beneficiaries.

I think your question, though, was good, specifically its emphasis on possible restructuring of the Medicare program.

In addition to our looking at issues of physician payment under a fee schedule, we are certainly looking at managed care. We are looking at health maintenance organizations. Dr. Wilensky mentioned that only, I think she said, 1½ million Medicare beneficiaries were in risk contracts for the Medicare program. We are looking at ways of improving the method by which Medicare pays health maintenance organizations. The current methodology of setting the average annual adjusted per capita cost payment rate for HMOs could use some improvement, and certainly, we are looking at those kinds of options, as well as improving the basic Medicare physician payment.

Senator DURENBERGER. Last question, if the chairman will indulge me, but it is related.

Obviously, and to some degree, unlike the DRG's for hospitals, what we are undertaking here in physician payment reform is probably, if done appropriately, going to be adopted to all physician payment reform. In other words, it will not just be Medicare payments to hospitals like DRG's were, where everybody else can still buy their hospital services differently, the other third-party payers. This particular reform is the one that is most likely to become the way in which medical services are paid for in this country by all third party payers.

To what degree at this stage of the game, you said you worked with Medicare actuaries in coming up with this particular figure, is the commission looking in its own projections of inflation and utilization and volume and technology and all the rest of these factors? Are you looking at the general population and the impact that all of these factors are going to have on the general population, knowing that these same physicians are going to be practicing with the elderly, with those of our age and with the kids and so forth?

Dr. DAVIS. We do regard this as an important issue. It is not one that the commission currently has a mandate to do extensive study on, but we would be very concerned about potential impact on access by Medicare beneficiaries if, for some reason, there is generated a large divergence between what Medicare was paying physicians and what the private insurance or employer plans were compensated.

It would be useful to look at that and monitor that and perhaps, speaking individually and not on behalf of the commission, perhaps do some studies in that area.

I would like to comment on Dr. Wilensky pointing out that the real growth in utilizations in the whole health system for physician services was 3.3 percent, which suggested that there was a slower growth in volume on the private side than the Medicare side. We

think those figures are somewhat non-comparable, and I want to stress that.

When that 3.3 figure was calculated, what was basically done was to take the increase in total physician expenditures per capita and deflate that by the increase in the CPI for physician fees. The CPI reflects billed charges, not necessarily collected charges, not necessarily price discounts for PPO's, et cetera.

To calculate the volume increase in Medicare, one takes growth in Medicare physician expenditures per beneficiary and basically, deflate it by the growth in Medicare actual allowed charges. Allowed charges under Medicare are rising more slowly than the CPI for physician fees. So you are not really dividing by the same thing. By dividing total health system expenditures by something that is rising very rapidly, it makes volume increases look small, whereas dividing Medicare expenditures by something that is highly constrained in its growth makes the volume increase look larger. So I do not think those are quite comparable.

Senator DURENBERGER. I had never thought of that, but I agree with the appropriateness of making that comparison.

Dr. DAVIS. Anyway, your general point about the importance of looking at Medicare, not in isolation, but as part of a whole health system and in terms of physicians who are providing care to not just Medicare patients, but Medicaid patients, privately insured or non-insured patients is an important one. The point is an important one and one of the recommendations of the Pepper Commission to look at that more generally. Personally speaking, I think it would be useful.

Senator ROCKEFELLER. Thank you, Dave. I just would make a comment at this point. In listening to you, Dave Durenberger ask questions and ponder and think through, it reminds me, again, that you just have such long, deep, good experience in this and that you are thoughtful and that you are just groping to find a better way to do things, and that it is an incredible privilege for me to work with you and learn from you.

Senator DURENBERGER. Thank you, Mr. Chairman.

Senator ROCKEFELLER. Karen, you said something interesting earlier. You said that—you have got to remember, we were talking about slowing the rate of increase. That just triggered a thought to me on the whole question of how we deal with physicians and the psychology of dealing with them. There is a need to level with them and yet with the hostile camp of the Congress on the one hand and physicians on the other. Actually, I will not say government on the one hand and physicians on the other. However that sentiment has such a long and deep root, that there is just an instinct that whenever Congress suggests something that you better tear it to pieces before it gets going because it is probably bad. I think what Dave and I are trying to do is to get away from that.

That reminds me of something that Dave and I talked about when we were negotiating the physician payment reform with the AMA last year. I always knew my appointments were going to be kept because every time that Dr. Sammons came to see me, there was a full page ad in the Washington Post with a very sad-faced woman looking out of the window saying, "I've been made into to an expenditure target." [Laughter.]

Then I knew he would be there. [Laughter.]

At one point, we were, just on the psychology of doctors, the assumption was that somehow Congress was trying to make Medicare into Medicaid and that Congress was trying to savage physician's salaries. That whole question of the decrease in the rate of growth was something that became psychologically—politically, so to speak—important to make in the physician payment reform. So we just stuck in the phrase that once the fee schedule is, in fact, implemented by 1996, that no physician shall make less than he or she did the year before. That, of course is a totally unextraordinary statement, because we are talking about a rate of increase, and it says nothing, but the psychological effect of it was to somehow say, "No, we are not trying to savage you, and we are trying to look at this thing holistically and sensibly."

Let me go from that to, really, the same point: During your deliberations, the PPRC's deliberations, you had at least one commissioner who really said that the performance standards ought to have no increase in volume and intensity at all for fiscal 1991. The rationale was what we have been talking about previously with Gail, and also so-called truth-in-law. This commissioner's rationale was that the Federal budget situation is so bad and that our national health care cost crisis is so bad that, in fact, you really shouldn't have any allowance for volume growth. A very tight MVPS should be put in as an urgent message, really, to doctors to catch the attention of doctors so they will take the problem seriously. With rising health care costs coupled with this terrible budget crisis this commissioner said, "Let us just be tough about it," and kind of, "There is a shock value there, but it is useful. Doctors really have to understand how serious this problem is," and that is what he advocated. I would be interested in your comments.

Dr. DAVIS. When reasonable people get together, there are always an array of views, as one tries to reach a consensus on the issue. The chairman is certainly right that there was a point of view expressed that this country spends 40 percent more on health care than any other country; that health care costs have gone up at a very rapid rate for decades. It is undermining the Federal budget; it is undermining international competitiveness of our industry. We are in a serious situation, and instead of just saying we are at 11 percent of GNP, we are going to go and slow down and try to hold it to 12 or 13 percent instead of going to 15 percent, why do not we aim for 8? So I think that all of us recognize that that is a legitimate point of view that, in fact, we would all sometimes get frustrated and like to do more faster.

On the other hand, the point you started with was the psychology of dealing with physicians, and I think that point, in the end, was a major factor in the commission's recommendation to set a long-range goal, but to take this a step at a time rather than a Draconian, "Let us get there at once" sort of approach.

Certainly, I think when the Administration proposed cutting in half in 1 year the historical trend in volume, there was a reaction that this is severe; this is hard for us to change our practice that rapidly; the research on effectiveness has not been done; the guidelines have not been developed and implemented, and I think certainly, there was a psychological reaction on the part of the physi-

cian community that we heard from groups that presented views to us as a commission that they thought, "Well, this is just impossible. This is arbitrary. It is impossible."

So we took was what is a reasonable step toward this; what could be accommodated with the kind of research we now have, the evidence on inappropriate utilization, the trends and what could be done and came up with a 2 percentage point slowing in the rate of increase.

However, we thought it was also important to explain to the physician community what the problem is from a taxpayer or a congressional point of view; mainly, that you have a budget deficit; you are trying to slow an increase in governmental outlays to 5 percent, maybe, a year; and to have one component going up 13, even 11, is really not doable. It robs an opportunity to both reduce the deficit, but also to reallocate those funds toward care of children and others in this country who are also deserving of public support.

So we thought it was important that we communicate that to physicians. We are not just saying, "You are wasteful, you are inefficient. You are doing too much. You are draining the system." It is that there are other competing demands on the public purse that must be weighed against spending money in this area. Therefore, we are going to have a long-range goal of tightening that would try to bring the overall growth more in line with the growth of the overall Federal budget, of the overall economy as reflected by the gross national product.

The PPRC has listened extensively to physician groups; we have a very open process. We solicit the views of the AMA and all the specialty organizations, and we seriously consider those. In addition, the commission is a balanced group with a wide range of views, and we genuinely listen to each other as commissioners and have been able to reach recommendations through a consensus process and in nearly all cases, unanimous support behind them.

We do that to maintain or improve relations between the payer community and the provider community. It is important not only that provides better understand the problem that Congress faces as it deals with the budget, but it also gets to this issue of honoring the update if they meet the Volume Performance Standards. So I would also say that that is part of the psychology of not just feeling that we can not just trust them. They ask you to do this, you do it and then they say well——

Senator ROCKEFELLER. Do you think that the physician community, as a whole, in fact, chooses to understand or does understand the depth of the crisis that we are in financially? Let me expand that.

In other words, one can understand something and then as it begins to apply to one's own life, one's own life's circumstances become much more important. So one understands it but rejects the lessons that might emanate from it simply because of one's own considerations, one's own circumstances, one's own habits and views. And then there is another kind of consideration, where you look at the crisis, the various, the financial crises in the country, and then you say, this really is very severe. I see this hurting in the future. I think the health insurance community right now, at

least some substantial part of it, even more specifically, maybe 12 of the 14 major health insurance companies that belong to HIAA are, at this point, fairly responsive to the Pepper Commission's recommendations about a private insurance reform. They figure this is really their last shot, and if the system does not work this time, we are going to have what, in fact, half of the congressional members of the Pepper Commission voted for, which was national health insurance and right now.

So the insurance companies see, they modify their behavior, or we hope they will, because they see the real relationship between what is happening economically in this country and what might, therefore, be the impact, and so they do adjust, that is, if they do.

Are doctors more in that second phase at this time or do you think they are more in the first because it is still kind of remote and everybody always talks about budget crises and behavior modification has to really be enforced by the formulas that we have in this and other approaches? It is a philosophical question.

Dr. DAVIS. Education is very important. For a physician in practice, there is a tendency to think about this patient and doing the best for this patient and not missing anything and being very concerned about the ability to do the best that they can for that patient.

So I think it is very important that the PPRC, the Congress and others do an educational job to explain the kinds of trade-offs and challenges that are faced as we try to make these kinds of changes. I think it is important to stress not only the overall budget situation, which they certainly hear about, but the need to reallocate resources, to reduce the number of uninsured in this country, to cover more people, to improve care for children; that we are not just talking about slowing Medicare physician fees to save the budget, but it is also important because we need to have those funds available for improvements in other areas.

So I do not think one can either just assume that they understand this new system or understand the rationale behind it and would view it as a target program. Dr. Ginsburg would like to add to that.

Dr. GINSBURG. Yes. The observation that I have is that I see that much of the leadership of medicine, particularly many of the specialty societies, seem to be working quite enthusiastically to develop practice guidelines, I think understanding the need to constrain costs long-term, and they have been constructive.

But I am not sure how much has gotten down to the rank and file physician. I do not think that the leadership has done much of a job in communicating it to them.

One thing that has irked me in particular is some of the public relations work that the AMA has done with its membership, particularly on this issue of expenditure targets and Volume Performance Standards. I have recently seen advertising where the point of it was that the AMA defeated expenditure targets and it is business as usual. Such messages are going to reduce the chance that this program can be successful, because there was a clear agreement that there be a linkage between increases in expenditures and increases in fees, and the more the AMA tells its general membership that the agreement on linkage didn't happen, it defers the

point when the broad membership of medicine gets behind these efforts.

Senator ROCKEFELLER. Enough for philosophy.

The question of patient demand arises, and there will be comment on that in the next panel. The argument goes that as assignment rates rise and balanced billing declines and patients face lower costs that therefore, they may demand for care. Efficiencies of the system, lower costs encourage people wanting more care, patients demand, and that is a very significant factor in contributing to the growth in Medicare spending.

Two questions that I have from this: First, do you know of any definitive studies or measures of this phenomenon of patient demand and its impact on Medicare costs? Second, as Medicare seeks to control utilization through MVPS, should we try to distinguish between medically unnecessary services that are demanded by patients and those that are provided for other reasons?

Dr. DAVIS. Well, in terms of your issue about is the cost problem primarily one of patient-driven demand, I think in the case of Medicare beneficiaries, that is not the driving force behind the rising costs. I think first of all, if you will look at Medicare beneficiaries, the great proportion of the money is going for the care of patients who are very ill. They are having multiple hospitalizations, chronic health problems, perhaps in terminal illness. They are at a stage where they are feeling very vulnerable, very dependent upon physicians and others to make decisions with regard to what they get. So, we are not talking about frivolous care. There is a deductible, but, in fact, the bulk of Medicare expenditures are going for people who are just very seriously ill, very chronically ill. There have been studies that have shown that cost sharing has an effect on patient demand. Certainly, the Rand Health Insurance experiment documented that as patients pay more out of pocket, they use less care. There are also studies based on the Rand data that show that cost sharing is not a very good mechanism for differentiating medically appropriate care from medically inappropriate care.

Senator ROCKEFELLER. From the reaction of the consumer, it does not necessarily follow?

Dr. DAVIS. That is right. I am thinking about one specific study that looked at the Rand data for hospitalization utilization for patients that had free care versus patients that were assigned an insurance plan where they had to pay 20 percent or 50 percent out of pocket. Clinicians evaluated the hospital charts and rated it blind about whether this was a necessary admission—not a necessary admission, could have been cared for on an outpatient basis if such care was available, and while the patients that paid out of pocket used less hospital care, it reduced both appropriate and inappropriate utilization equally. In other words, it was not that it weeded out the appropriate care.

So there is certainly evidence that when patients pay more out of pocket, they use less care or equivalently, when they pay less out of pocket, they use more care. But whether that has a big effect that would affect the very dramatic increases in Medicare outlays that we have seen over time and whether that would be a major factor, I think, remains to be seen.

In terms of differentiating between patient-induced demand and physician-induced demand, again, that is very difficult to do. The studies that have tried to sort it out look at, say, the first visit to a physician for a given condition, and then a subsequent visit or going to the hospital or using a lab test would be a decision by the physician. But it is, again, very hard to sort out how much they are influenced by physician behavior. Maybe Dr. Ginsburg would like to add to that.

Dr. GINSBURG. Yes. I agree with all you said about how difficult it is to separate out what part of the increase in volume intensity was, in a sense, demanded by patients, versus suggested by physicians, that these decisions are made in the office. They are usually made jointly by the physician and patient. We hear anecdotes about patients coming in and demanding a CAT scan, but I doubt that it occurs routinely. It also may not absolve the physician of the responsibility for saying, "You do not need a CAT scan."

I am sure one of the reasons you asked the question was the advertisement in the Washington Post about the study on understanding the recent growth in Medicare physician expenditures. My staff and I have reviewed this the study in great detail. We do not think that the data used in the study or the particular econometric models used are really up to the task of drawing conclusions of that sort. It is just not the right data or method to be able to examine what components of growth of services over time is due to the assignment rate or the Medicare fee freeze or the prospective payment system.

So we feel strongly that many of the conclusions in that study are unwarranted.

Senator ROCKEFELLER. Thank you. Karen, another approach. You want to get, over 5 years, volume and intensity growth down to the rate of GNP growth. Would you comment, therefore, on the Secretary's finding that the growth and intensity of medical services in the general population has been 3.3 percent annually, which is impressive. On the other hand it was nearly 7.4 percent on volume intensity in the Medicare program?

Couldn't one say, therefore, that volume growth in the general population is at least as an appropriate target as is getting it down to the rate of GNP?

Dr. DAVIS. I think the first thing I would underscore about that, I am not quite sure that those numbers are comparable, the 3.3-percent growth in total physician expenditures per capita in real terms versus the 7.4 percent in Medicare. As I was explaining to Senator Durenberger, there is really a different methodology used in the two, and the deflation for price increases is quite different. But I think the commission would welcome an opportunity to really look into that issue and in trying to at least make its own best estimate about the real growth in volume is in the non-Medicare patient area versus the Medicare, and that would be a useful thing to look at.

In terms of our long-range goal, we have said that we think we ought to be aiming to hold the curve in Medicare physician outlays to something like the growth in GNP. Some of that would go for inflation; some of it would go for aging of the population and the growth in the number of beneficiaries. So it might be apply some-

thing like only 1 percentage point allowance for new technology, new services volume. So it certainly is starting with what is implicit it in our VPS of a 4.7-percent annual rate in increase in volume to we are moving to more like a 1 percentage point of rate of increase in volume.

So certainly, we would be going down, and we would be assessing year by year what is the trend in the private sector; what is happening there; what is a reasonable change to make. Maybe Dr. Ginsburg wants to comment.

Dr. GINSBURG. I do not have anything to add.

Senator ROCKEFELLER. Let me just ask one final question. I looked at the clock and grew alarmed.

You find that surgical expenditures have been rising less rapidly than non-surgical expenditures. We are also going to hear some testimony after you from surgeons on this. As I read their statement, they commend PPRC for acknowledging this lower growth rate, but they urge that surgeons not be "penalized" for it with a lower performance standard. That is interesting, because I want you to comment on that, and how can we avoid penalizing doctors for achieving, in fact, the goals that we set out for them to achieve?

Dr. DAVIS. The reason we recommended the differential VPS for surgery is that we looked at data for the period from 1986 to 1988, and we saw, looking at both volume trends, that there was about a 1.7 percentage point differential in the growth of volume for non-surgical services as compared with surgery. In other words, the surgery was going up 1.7 percent less than other services.

But if you took cataracts out of that data, you would find something close to a 4 percent slower rate of increase in volume for surgery relative to others. We have information from the Food and Drug Administration that tracks the sales of lenses in cataract, and that has now flattened out. So cataract is a big component of the overall surgical expenditures under Medicare. What we see is that there is a slowing, a flattening out, and particularly in the cataract area, and that that slows down the overall trend in volume on surgery.

Now, why is that happening? Is that happening as a result of the fact that the surgical community has been tightening up, identifying inappropriate use, et cetera? We do not see evidence of that. We see this flattening out being more that one has kind of reached the upper band on cataract surgery. As someone said, "We have run out of eyes," but just the basic trend in the technology itself is affecting that. It is not an effort to identify inappropriate utilization or curb abuses that are reflective of that. So when we were setting our target, we felt there ought to be equal effort on the part of surgeons and non-surgeons to achieve a slower rate of growth and volume, and that what one must take is our best estimate of what would happen in the absence of that effort, just because of changes in technology, and then say, "Let us come down relative to that."

So that is why we have a 1-percent differential. It is basically our own judgment that the baseline would have a 1-percent lower growth in the absence of any effort, and so we are asking for an equal effort on the part of both groups, not that we are penalizing surgeons, but maybe Dr. Ginsburg would like to comment.

Dr. GINSBURG. If we meet 4 years from now to talk about the Volume Performance Standards for 1995, we probably would not be able to use such an analysis. We would not be able to look at what happened between 1990 and 1991 and use that because then that issue that the surgeons raised might be relevant, in part. It is our judgment that the differential trends in surgery and non-surgery during this period in the late 1980's before anyone heard about volume performance standards and developing practice guidelines was, for the most part, changes in medical technology that were happening not because of collective efforts of physicians, but because of just the nature of technological change and the normal workings of the medical care system.

So we feel fairly confident, about this differential. Our goal is to say we want, in the sense, to pose to the surgeons and non-surgeons in 1991, that if they have equal success in reducing growth in volume compared to what it would have been otherwise, that then they would get equal updates. For this to happen, it was incumbent upon us to try to project what would happen in the absence of their efforts, so that we do not confuse the effects of their efforts with what would have happened otherwise.

Senator ROCKEFELLER. I thank you both very much. Senator Durenberger said he does not have any other questions. I wasn't aware that we had gone on so long, but frankly, I think Dave and I are both enjoying this so much because it is out of the world of the Pepper Commission and back into the saddle of the real hard stuff that we have got to get worked out.

Karen and Paul, thank you enormously. You are, as always, superb.

Dr. DAVIS. Thank you.

Senator ROCKERFELLER. Our only other panel is Dr. John Ring, chairman of the board of trustees, the American Medical Association; Dr. Robert Graham, executive vice president of the American Academy of Family Physicians, and Dr. Jerome Goldstein, who is a governor of the American College of Surgeons.

Senator ROCKEFELLER. Dr. Ring, we will start with you.

STATEMENT JOHN J. RING, M.D., CHAIRMAN OF THE BOARD OF TRUSTEES, THE AMERICAN MEDICAL ASSOCIATION

Dr. RING. Thank you, Mr. Chairman. My name is John J. Ring. I am a physician and I practice family medicine in Mundelein, IL. I am also chairman of the board of trustees of the American Medical Association.

With me today is Mark Segal of AMA's Department of Health Care Financing. The AMA is genuinely pleased to have this opportunity to discuss the volume of part B services provided to Medicare patients and the Medicare Volume Performance Standards.

While we are all concerned that part B of Medicare continues to grow, in reality, this growth has come about because of the many successes we have seen in medical care, including our ability to provide a level of care far beyond that imagined when the program began. The average Medicare beneficiary today is both healthier and older than the counterpart of 25 years ago. It is the very suc-

cess of the program that has brought us to the point where its very size and projected growth are the subject of close scrutiny.

Mr. Chairman, we are pleased to be able to thank you for taking the lead in last year's physician payment reform legislation. One major element of this program was the creation of the MVPS as a tool for Congress to use in monitoring the growth of part B Medicare. We also believe that other elements of last year's Budget Reconciliation Act, the creation of the Agency for Health Care Policy and Research, carrier-targeted review and annual monitoring of changes in utilization of and access to services will better assure that the Medicare program meets its promise of coverage for necessary medical care.

Congress has ordered HHS to make a recommendation for the MVPS each year, taking into account several factors: Inflation, enrollment changes, beneficiary population aging, changes in technology, evidence of inappropriate utilization, access and such other factors as are considered appropriate by the Secretary.

However, the HHS analysis accompanying the MVPS announcement demonstrates that the Administration ignored reality in some instances and failed to comply altogether in fulfilling some of its responsibilities. For three of the key factors identified by Congress to be considered; technology, utilization and access, HHS essentially threw up its hands, indicating that accurate estimates of these elements are just not possible now. Instead, HHS just simply advised lawmakers on a policy basis to arbitrarily halve the recent growth rate attributed to volume and intensity and allow volume to rise only 3.7 percent in 1991, and set the MVPS at 9.9 percent.

Mr. Chairman, the Administration has, in effect, abrogated its responsibility to you and to over 30 million Medicare patients. While research needed for making precise judgments about the contribution of these key factors to volume and intensity growth is limited, this does not justify the capricious determination that volume growth simply must be cut in half, without any basis for judging whether recent growth has been excessive or inadequate on these criteria or for forecasting how these factors might change in the near future.

There is simply no legitimate basis for recommending that volume growth should change from recent levels. As a starting point, it is time to recognize that together, we are holding the line against increases in Federal expenditures for medical care provided for Medicare patients. The bottom line is that the rate of increase in payments by Medicare care for medical care has substantially moderated.

From just a few years ago, when the annual growth rate in Medicare part B outlays was in the neighborhood of 20 percent, we have seen some amazing results. Last year, part B growth was less than half of that figure. A federally funded study recently released by the Urban Institute found that some of the major factors in Medicare part B increases were due to an increase in incomes for the elderly, the increase and diffusion of new medical technologies, and the increase in Medicare assignment rates.

These findings, which are consistent with work completed by researchers at the AMA, should cast a new light on the Medicare volume issue. Explaining part B physician expenditure increases

attributed to volume and intensity does not require acceptance of simplistic and unproven charges that physicians game the system and spur volume increases to maintain their incomes. Rather, Medicare expenditures have grown because of the increased access to safe and effective medical care enjoyed by Medicare beneficiaries. As a result of their growing income, reductions in out-of-pocket costs and major advances in health care technology have reduced risk and enabled many of them to enjoy a far better quality of life.

Medical advances, in addition to alleviating pain and suffering, do carry a dollar cost. Finally, we wanted to leave you with a message that the Medicare program cannot continue to bear a disproportionate share of the reconciliation-driven budget savings. In OBRA 1987 and OBRA 1989, Medicare provided, respectively, 49.7 and 34.8 percent of the total dollar savings.

Thank you, Mr. Chairman.

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

Senator ROCKEFELLER. Dr. Goldstein, would you like to go next?

STATEMENT OF JEROME C. GOLDSTEIN, M.D., FACS GOVERNOR OF THE AMERICAN COLLEGE OF SURGEONS

Dr. GOLDSTEIN. Thank you.

Mr. Chairman, Senator Durenberger, I am Dr. Jerry Goldstein, a fellow of the American College of Surgeons. The College appreciates the opportunity to share its views about Secretary Sullivan's recommendations on the MVPS rates of increase for fiscal year 1991. As you know, the American College of Surgeons was an active participant in this committee's work last year as it developed the physician payment reform legislation that Congress approved in the fall.

Last April, we presented to this committee the elements of a physician payment reform plan that, among other things, suggested ways to moderate the rate of spending growth under Medicare and to make program costs more predictable. Included in our plan was a proposal to establish a national expenditure target for surgical services, which is similar to the MVPS concept that was supported by this committee.

In expressing our support for the MVPS concept, the college has emphasized repeatedly that a single, unfocused standard for all physicians' services will provide no incentive for specialty groups to review the quality of practice within their respective areas of expertise. In our view, the Medicare program will have greater success in dealing with such issues by asking surgeons themselves to take responsibility for evaluating the appropriateness and quality of surgical services that are provided to beneficiaries. We also strongly believe that the definition of surgical services will have a major bearing on the success of the MVPS concept.

We are pleased with the definition that was published by the Secretary on May 3. Of the options considered by the Secretary, the published definition is the one that is most consistent with the College's views.

I hope it is clear that the College is committed to work with the Secretary and HCFA to refine the definition and to make the MVPS concept viable. In making this commitment, however, we

assume that data collection and analysis by the Department will broaden in content and be more rapidly processed so that a current, on-line assessment of the MVPS can be accomplished.

It also should be understood that the College is a voluntary professional organization, and while we can and will educate our fellowship with regard to physician payment issues and keep them informed concerning our activities, our ability to influence their behavior is limited. Thus, we will have to work with the Department in order to obtain the desired outcome.

The College believes that the MVPS rates proposed by the Secretary are far too low and could seriously undermine our ability to develop the processes needed to make the MVPS concept viable. In a letter to Secretary Sullivan, the College expressed serious concerns about his intention to recognize only one-half of the estimated historical growth rate in expenditures relating to the combined effects of technology, access and intensity.

We believe that this unrealistically low rate departs far too quickly from the trend line in the demand for surgical services and is inappropriate, given the very limited experience we have had thus far with the MVPS concept.

Dr. Sullivan has noted that the Department is not yet able to quantify the impact of changing surgical technologies, emerging diagnostic techniques, or other developments that could alter the utilization of current services. To assist in this effort, the College is working with the surgical specialty societies to initiate a process whereby the surgical community will provide the Secretary with an annual assessment of the expected impact of changing technologies on the use of and expenditures for surgical services.

While we have not seen specific recommendations from PPRC or the underlying analysis that supports their proposals, we understand that the commission's numbers are not quite as low as those from the Secretary. However, the commission seems to recommend an unusually large difference in the rates of increase for each MVPS category of service. The College believes that this differential is not warranted, especially given the very shaky information upon which the lower rate for the surgical MVPS seems to be premised.

I appreciated, Mr. Chairman, your last question to Dr. Davis and that you have read my written statement. Yes, we are pleased that the commission recognizes that surgical volumes are rising less rapidly than other physician services, but we hope that the PPRC's proposed differential is not intended to penalize those of us who are trying to cooperate with you to make this plan work. Again, we appreciate the opportunity to present our views to you today, and we will be happy to answer any questions you may have.

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

Senator ROCKEFELLER. Thank you, Doctor.

Dr. Graham?

STATEMENT OF ROBERT GRAHAM, M.D., EXECUTIVE VICE PRESIDENT OF THE AMERICAN ACADEMY OF FAMILY PHYSICIANS

Dr. GRAHAM. Mr. Chairman, thank you very much.

I am Dr. Robert Graham, the executive vice president of the American Academy of Family Physicians, which represents some 69,000 family physicians, residents and students. This morning, I would like to comment on two specific areas: One, the text of my prepared remarks, which you already have before you, and then two other items which have come up in your in your commentary with previous witnesses.

First, in terms of the two issues before you this morning, we do support the establishment of separate targets for surgical services, but we are concerned in the manner that the Secretary has proposed to go about this. The proposal in the Federal Register would establish the basis or the data base for these targets as being only services provided by surgeons.

Now, Dr. Wilensky has made it clear that the data from the experience of those services would be applied across the board to surgical services, an approach with which we would agree. But the fact that the entire data would be derived from a potentially unrepresentative and self-selected sample seems to us not to make sense.

It seems not to follow basic statistics 101. If you are going to do something with a full universe, you try to draw your sample so that it is representative of that universe, and this would not necessarily be so.

We recognize that HCFA does have data problems. We recognize that they are moving to correct them, and we support that, but in the interim, it does not seem sensible to us to begin the process with what could be a seriously flawed system of developing data about what physician performance is within this category of services.

Secondly, we have concerns about how HCFA is proposing to describe surgical services. They have specifically left out endoscopies and cardiac catheterizations. Having followed the debates within this body and in the House in the development of RVS, it is clear that the growth in services in those two areas was of particular concern in the Congress, and now to exclude them from a surgical MVPS would, again, seem not to be logical. It may fail the Darman test: If it looks like a duck and it walks like a duck—these to us, are surgical services. If you go to current procedural technology, CPT codes, and look for where they are listed, they are listed under surgical services.

We believe these should be part of the surgical services MVPS and that the omission of the Secretary in that proposal was a significant one.

In commenting on the two targets for MVPS updates that have been discussed already at length by Dr. Wilensky and Dr. Davis, we find the target and the derivation by PPRC to be the more acceptable. We acknowledge that there are difficulties in the area of determining what the appropriate component of volume and intensity is. Both Dr. Wilensky and Dr. Davis explained how their respective groups have tried to grapple with that. We suspect that there is no true right figure, but it seems to us that the mechanism by which PPRC has derived it, using a current actuarial estimate of what the actual growth will be in the specific index year and then making a policy determination as to what desirable and

achievable deflection from that growth might be without distorting the rest of the program, is as reasonable a way to go about it and, indeed, is more reasonable than what the Secretary has recommended.

I do need to acknowledge that if you find our arguments about including endoscopies and cardiac catheterizations compelling and are inclined to try to see them included in the surgical MVPS, then you would need to acknowledge that the MVPS developed by PPRC for surgery would need to be revised, because it is our understanding that those current figures do not reflect those procedures.

Now, if I could comment on two items which have come up in the discussion this morning. First, Senator Durenberger asked a question, I believe, of Dr. Wilensky about the problems that you are hearing about from some of your constituency in terms of the apparent charges that will be available for family physicians and other primary care physicians in rural areas. This is a problem. Dr. Wilensky indicated that it was her understanding that the problem might be of a relatively small magnitude. We get very mixed readings from that. We have worked very closely with the staff of this Committee, the staff of the Committee in the House, and with PPRC to get a better understanding of what the impact will be.

It appears to have been an unintended consequence in the drafting of the legislation. It is a limitation of fees for physicians to 125 percent of the prevailing charge or the MAAC limit, whichever is lower. But in some particularly rural areas where the prevailing has been very low historically, physicians are reporting that their fees for some of the services could drop by as much as 25 to 30 percent from their current acceptable MAC charges.

If this is something which across the board affects a few people, perhaps it will not develop into a major issue. Unfortunately, our impression is that as better data is developed among the family practice and internal medicine communities, that data suggests that it is a greater problem in magnitude and extent than was originally appreciated, and we would enlist the effort of you and your staff in finding a way that is consistent with the intent of the original RVS legislation to resolve this issue this year so that it does not become something that tends to unravel the whole approach.

The second comment I would make in closing is Dr. Wilensky referred several times to their data not suggesting any access problem. I can understand, as the HCFA staff might look across the board at all Medicare beneficiaries with all specialties in all areas that there would not be any terrible access problems being indicated. But again, anecdotally from our members, who practice in some of the most underserved and, in some cases, remote communities, we feel that we see a continuing problem in terms of access to Medicare beneficiaries. This is in part because of the unavailability of numbers of family physicians and other primary care physicians, and in part, because a number of the legislative and regulatory changes that have taken place in Medicare have added so much to the hassle factor that some physicians are seriously questioning whether or not they can continue to serve Medicare patients. They are already providing services at substantially discounted rates. They are now being told by the government that they have to

submit all bills themselves. They are now faced with a 400-page regulation talking about how they will change their clinical labs, and unfortunately, many of our physicians are talking about how much longer, even though RVS holds out real promise for improvement, how much longer they can be involved as providers in this program.

So I believe that the access issue is not an inconsequential issue which faces us and faces HCFA.

I thank you very much for the opportunity to present these comments.

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

Senator ROCKEFELLER. Doctor, you do remember that the flip side of the 100-percent billing is that hopefully, as you get geared up, that a bill that is submitted to HCFA on Thursday will be reimbursed on Friday morning.

Dr. GRAHAM. I understand that, and what I am reflecting, and also in the context of my comments to Senator Durenberger, is a number of our people understand what we are telling them are the better days to come, but we have to tell them that these days may be 2 and 3 and 4 years in the future. In the meantime, not only do they feel that they see an increased regulatory burden; then something like this comes up where it looks like their fees are actually going to take a cut this year, and they say, "Do you guys know what's going on? You promised us a better day, and it looks like it is getting worse." So some of our credibility is being questioned now.

Senator ROCKEFELLER. I would like to ask this of Dr. Ring and Dr. Goldstein.

Dr. Graham has testified that as far as the family physicians are concerned, they prefer PPRC's approach. You have expressed displeasure with both, and therefore, I would assume it would be incumbent upon you at formal testimony before the Finance Committee to state what your proposal is.

Dr. Ring?

Dr. RING. Thank you.

Our proposal would be that the Congress should establish the facts with regard to such items as technology, which neither PPRC nor HCFA could establish; access, utilization, and until then, go very, very carefully with regard to setting the MVPS. What we heard this morning from Dr. Wilensky and Dr. Davis was that they really didn't have the data to make a reasonable recommendation, so that their recommendations were arbitrary. The AMA believes that we should get the information that we need and then proceed on it.

Senator ROCKEFELLER. Dr. Ring, you know perfectly well, as I know perfectly well, that when you were helping us work out this program very recently that data limitations were going to be part of our limitations. You understood that; I understood that; the world understood that; the AMA supported the proposal understanding that. Now you come and say, "Well, it is not sufficient." You decline to say what the rate should be. You say, "Well, until sufficient data is available, we should sort of stay where we were."

I would like you to say for the record whether or not AMA is now in support of MVPS and Physician Payment Reform, as indeed you were last year, or whether you now do not support this program.

Dr. RING. AMA is unequivocally in support of MVPS, and we certainly support Physician Payment Reform. A false step on MVPS at this time could jeopardize Physician Payment Reform, and that is the basis of my answer to you. I suppose if we absolutely had to make a choice between PPRC and HCFA, we would choose PPRC.

Senator ROCKEFELLER. And that is your answer, then, as to what your proposal is? You take or do accept, so to speak, the PPRC proposal?

Dr. RING. If we had to choose, we would prefer PPRC to the HCFA proposal, but we would certainly much prefer that Congress act on full information, which it does not have at this time.

Senator ROCKEFELLER. Which you understood last year when we were doing this, so therefore your answer is, that formally you have no proposal, in fact, except criticism of PPRC and HCFA?

Dr. RING. Would you repeat that, please?

Senator ROCKEFELLER. Knowing full well last year, that we were not going to have the data, information that you have referred to, your official position, then, is that you have no proposal except to say that if you did, it would be PPRC over HCFA?

Dr. RING. That is correct.

Senator ROCKEFELLER. That is your formal medical proposal?

Dr. RING. That is my formal economic proposal. My medical proposal and my logical proposal is that we need more information before we can act.

Senator ROCKEFELLER. We all understand that. We all understand that, as did you last year, did you not, that we were not going to have it this year?

Dr. RING. We did not.

Senator ROCKEFELLER. You understand that? Of course you did, Doctor.

Dr. RING. No, we did not.

Senator ROCKEFELLER. Yes, you did.

Dr. RING. If you say so, Senator.

Senator ROCKEFELLER. Dr. Goldstein, what is your response?

Dr. GOLDSTEIN. The College basically supports the PPRC figures, as you clearly read and pointed out. Our one concern is that extra 1 percent knick under surgery. Without that 1 percent, the 10.3 percent for surgery, we think, is a very fair number, one that we could live with.

It is interesting to me, as I went over the figures as I understood them, that their average of 11.2 percent is basically the same whether they use the 10.3 for surgery or the 9.3 because of the less than equal distribution between surgery and non-surgery. So the College favors the 10.3 and finds that livable and acceptable.

Senator ROCKEFELLER. And the AMA does not?

Dr. RING. The AMA prefers to act on full information if we can possibly get it, Senator.

Senator ROCKEFELLER. Okay.

Dr. RING. If it is available.

Senator ROCKEFELLER. Of course it is gettable, but not by this year. Which some of you understood. If you did not, I will guarantee you that Jim Sammons understood it.

Dr. Ring, one further question from me, and this is on the question of patient demand, which I referred to earlier. I agree that patients need to have a financial stake in their health care, and if they do not, they do not become prudent consumers, although some interesting points were made by Karen Davis on that.

Dave Durenberger and I, in the Pepper Commission, insisted on that, and it was 75 percent deductible, 20 percent co-insurance, all balanced billing charges, which go as high as 25 percent in the first year, and in the meantime, of course, seniors are paying higher and higher premiums for both Medicare and Medigap. All that notwithstanding, I also acknowledge patients may demand care that is not really medically necessary. But they can not get it if a doctor declines to provide it, and the doctor is the arbiter.

So my question is: In the end, should not it be our goal to find a way to educate doctors and to help doctors educate their patients on the need to reduce the volume of unnecessary procedures about which doctors will be more informed on an earlier basis than will patients be? Isn't that, in fact, what MVPS is supposed to help us accomplish?

Dr. RING. The answer to that is yes, and the American Medical Association is prepared to assist the Congress in this effort. We have taken the lead in the development of practice parameters and brought together a number of specialty societies. We are attempting to define what constitutes appropriate medical care. We think that our diagnostic and therapeutic technology assessment (DATTA) program, which is a program for the evaluation of new technology, makes a positive contribution.

The average practicing doctor out there in the community really does know that there is a problem. I continue to practice, and believe me, every major decision I make with with regard to a patient is questioned by somebody else. There is somebody on the telephone; I get a letter, "Do you really want this patient in the hospital this extra day? Do you really think she needs the surgery?"

The average doctor knows that there is a serious crisis with regard to Federal health care expenditures. I think the AMA is prepared to work with you and prepared to provide leadership in the education of doctors. Doctors have an ethical obligation not to provide care that is not necessary. A patient walks into my office and says, "I want my gall bladder removed," and the question is, "Is there something wrong with your gall bladder?"

I am obliged to say, "No, I am not going to remove your gall bladder or recommend to the surgeon to remove your gall bladder if there is no gall bladder disease present."

Senator ROCKEFELLER. Let me stop you there and ask: Supposing there are two women who are pregnant, two young women who are pregnant and supposing one belongs to an HMO and the other belongs to another kind of a plan. One pregnant woman walks in for a check-up to the HMO and the HMO says, "Well, look, you are healthy and I do not see any reason that we should have to do a sonagram."

The other, who does not belong to the HMO, goes into or that other office and says nothing, and the doctor has a sonagram machine there, and the doctor says, "Well, I think we ought to do that." Now, HMO's did not, the other one did. You get to the ethical matter that you raised, necessary care/unnecessary care. Do you have a comment?

Dr. RING. A doctor's ethical obligation, is to the patient, not to the source of payment. If, in his medical judgment, he feels that patient needs a sonogram, it is incumbent on him to recommend that the patient have it regardless of whether it is going to be paid for by the HMO or not.

Senator ROCKEFELLER. Okay. Senator Durenberger?

Senator DURENBERGER. I guess you were all here for all of the other questions when we were asking them. I was going to express a view that sort of reacts to what has happened in the last 5 or 6 months since we have put this together.

I think the work that has been done by HCFA and the work that has been done by the Physician Payment Reform Commission is good work. I do not know whether to agree or disagree with the percentages they came up with, but I think at least it is a good place to get started.

I certainly got the impression that they do not have all of the answers; that by next year, there is going to be a different kind of an approach and maybe new factors will be involved and that by the year after that there will be something different. Yet, if I were a physician, particularly if I were a Minnesota physician, I would be deeply concerned about this whole concept of the MVPS's, because it is only the latter day version of the ET.

I want to restate on behalf of those of us who come from low-charge, high-quality states that our medical care will be destroyed by an inappropriate application of ET's or MVPS's or call it anything else you want; that we are going to be the first to go under because we are the low-charge folks and the same thing is true of primary care and so forth. I do not think that is going to happen on the East and West Coast. I do not think it is going to happen to plastic surgeons, and I do not think it is going to happen at that level, but I know it is going to happen in rural Minnesota, as hard as they try.

So I am really apprehensive about how we do this, but I am comforted by what I have heard this morning from the two professional organizations that they are not budgetary driven. Outside this room, there are a lot of folks that may well be. So I just want to say, principally to John Ring, that I think that both the Chair and I fell off our seats when we saw the AMA ad in the newspapers, because it was like business as usual. We can not do business as usual. The rest of the people who aren't here are ready to hang you out to dry with with a budget cut, and we are the only folks here who spend 3½, almost 4 hours trying to understand what is going on. I will tell you, that kind of an approach is counter-productive.

We have not discussed this ahead of time. His reaction, talking about the little old lady and all the rest of that sort of thing, we thought, I think, that that was out the window. I do not know what provoked it, and I am not trying to raise it as a big issue. I am just trying to turn to the positive side on this hearing, and that is, that

if we are going to be able to resist using the budget deficit or an MVPS to just arbitrarily cut payments for Medicare, we are going to have to have the help of a lot of physicians in this country.

I think they are going to have to be motivated more by doing what is right than just reacting against politicians and things like that. How that all gets put together, I am really not very sure, but an instinct tells me that an advertising campaign like that isn't the most appropriate way to do it. If it is, then maybe we ought to talk about it ahead of time, if it does happen to be the most appropriate way to shore up the troops. I could see us on the Floor at some point in time; it probably will not be before the election, but it may be right after the election, after we have taken the sequestration for October, November and December. Then you are going to be sitting there debating these issues—was it 1985 when we did the vote on trying to give Medicare the same protection as Social Security? In effect, we ended up splitting the difference. But you know where most of the votes were then. They were against giving to doctors and hospitals; that is the way they look at Medicare, an out.

If you think we marshalled enough votes then, we will not make it this time. There is no way we are going to make it this time around. I am suggesting, by going through this process, that we really are going to have to put some emphasis on the learning curve here on doing the MVPS the right way and being patient. We are also going to have to wait until next year, and we are going to have to plead with our colleagues, "We know this is not perfect. I know that percentage point looks awful high. I am sorry we have not done anything yet." But we are going to have to work and use the example of DRG's and the inappropriateness of using DRG's to cut budgets, and it is going to be a tough battle.

I am just using my little time here not to necessarily ask questions, but to try to urge the physician groups, all of them, not just the three that are here, but all of them to try to help us in the next few months think of positive ways that we can reinforce the RBRVS.

Dr. RING. I can appreciate your concern in Minnesota, and that is one of the motivations for the AMA's position with regard to extreme caution on the part of this committee with regard to the initial MVPS decision. I would like to ask Mark Segal to outline for you the steps that the AMA is taking with regard to MVPS. We are not opposed to MVPS.

Senator DURENBERGER. I believe I understand that.

Dr. RING. We are prepared to take action with our members. I would ask Mark Segal to explain in detail the AMA perspective and activities relating to the MVPS.

Dr. SEGAL. Thank you, Senator Durenberger.

The keystone of our support for MVPS has been the process, the information that was to be generated on utilization and volume, and the clear expression of congressional views about where expenditures should go. In general, we had much less of a feeling that the specific MVPS number should be viewed as an ironclad limit on what should be spent; rather, the AMA has viewed the MVPS as a benchmark and an information source for physicians.

In that context, the efforts that the AMA has engaged in to address volume and intensity of services which are on an accelerating growth curve are what we believe is how we will get to where the Congress wants us to be. These efforts include development of practice parameters and practice guidelines; evaluation of technology; a new medical review initiative to develop new, more innovative and less intrusive approaches to utilization review; and working with HCFA to try to do better PRO and carrier review.

I would also like to emphasize in the context of Senator Rockefeller's question about which number we would prefer that, given the considerations outlined in the legislation, we had not seen enough data and analysis to feel comfortable with generating a number. At the same time, we do not want to be put in a position of having to choose between an HHS number and a PPRC number. Given the analyses presented by HCFA and the PPRC and in the context of their recommendations and of the congressional action last year, it seems clear to the AMA that a number closer to the default would be preferable to either the HHS or the PPRC number. This is not to say that the AMA wants the default process itself to take effect because we fully support and expect the Congress to act. But the default MVPS for fiscal year 1991 of a 1-percent reduction from the projected growth rate, which is an expression of congressional caution and prudence as you enacted this process, seems to us to be a minimum and a safer kind of terrain than that set out by either the PPRC or HHS.

Senator DURENBERGER. I need to conclude and leave, but relooking the advertisement, I just want to leave you with this comment and a repontification of what I said. Whatever we come up with as far as an MVPS is concerned, that is going to be your salvation. Because when it really gets down to the tough budget time, we are going to have to say, "Everybody agrees that this is the most appropriate formula," so we all have a stake in coming up with a very, very good base for this MVPS.

This advertisement is confusing, not in the sense that it attacks that, but in effect says that we have a study that proves that doctors do not game the system and that the problem is really medical technology.

If you had a study that proved that the problem was medical technology, then I would say run the ad, but do not run an ad that says that doctor do not game the system, because it takes a lot more than one urban institute study to prove that that does not happen in America and that it is happening in America. You just heard Paul Ginsburg say that he does not agree with some of the information they come up with. That isn't necessarily real life.

We do need more information about the cost of medical technology. You heard that one of the first questions I raised with Gail Wilensky was, "Tell us about this medical technology factor," because I agree with that. Doctors do not want to game the system. They do not do it on purpose unless something forces them in one way or another to do it.

I do agree that medical technology is the major contributor. My only point is: What does this open letter to Congress, in effect, do to help facilitate the job that we have here of trying to lay some foundation under the MVPS? So where you have positive informa-

tion like new technology is a major contributor, I would say put that in there. Where you have the other kind, I am just not sure it does a lot of good.

Senator ROCKEFELLER. Could I just close, also, Dave, on sort of reinforcing that and saying to all four of you that we are, in fact, exploring the billing issues and possible solutions for recognizing the problems, some unanticipated, perhaps, but obviously, the goal of it was and is to protect seniors from high balance billing amounts.

So understand that where we see problems, we will try to adjust those problems. We are not going to compromise the goal on the balance billing. There may be other ways. I do not know exactly how that is, but I have got to say if we are even exploring that, and I guess I direct this more, Dr. Ring, at you through the American Medical Association this traditional attitude of, "We had better clobber this fast, because it might come to pass," something that Congress says, or, "We better attack or send the troops in."

I mean, for many, many, many years that, in my judgment, has been the way the American Medical Association has gone after things; attack and savage, search and destroy. It sort of generally is a safer policy because that means that whatever comes from Congress is likely to have less impact, and to the extent that we can search out and destroy, then we have helped our folks.

What I am saying, is what Dave was saying: We really have entered a new era now. Dave and I and others of us on this committee now are not in the business of searching out and destroying physicians' reimbursement, either financially or psychologically, in a sense of professional satisfaction. We are trying to enhance an entire process which has come under severe crisis and to make it work.

I honestly do believe, as evidently a lot of insurance companies, big insurance companies who do health insurance also believe, that if we do not, all of us, make the system work within a relatively few short years, that we are going to have ourselves a whole other kind of system in this country. I do not think that would be a system that you would prefer, any of you. Therefore, when we talk about dialogue and cooperating and working with each other in ways that we have not before, that I really mean that, and that I really think that is important for you, for physicians in general, for health care in general, and I say this again specifically to the American Medical Association. I do not have habits. I do not have ideological baggage. I do not have memories. I do not have history. I have only an adamant, passionate desire to save and to make better our health system and make sure that it gets, in fact, to lots of people who do not have it, which has something to do with uncompensated and charity care which affects not only hospitals, obviously, but also doctors.

So I work in earnest. I work in sincerity; so does Senator Durenberger. Most importantly, so does Senator Lloyd Bentsen, who chairs this committee. We just do not have time for games and for sparring, which is anything other than constructive and is based upon substantive differences. Upon that, spar we should and resolve we must. But on the traditional patterns of behavior, we have

run out of time for that or else we are just going to have another kind of system, and you folks aren't going to like it.

Dr. RING. The American Medical Association, Senator, is involved in probably its biggest internal change in the last 20 years. The most common comment I hear at AMA board meetings is that, "We need a kinder and gentler AMA." I am going to take your message back to the AMA board. I know that you work from a basis of sincerity and so does the AMA.

The AMA's primary interest is in providing high quality of medical care for patients, and we are ready to work with you, and I think that you will see a lot less search and destroy and a lot more cooperation on the part of the AMA in the future.

Senator ROCKEFELLER. Since there can be no higher note on which to end a hearing, we are adjourned.

Dr. RING. Thank you, Mr. Chairman.

[Whereupon, at 12:37 p.m., the subcommittee was recessed, subject to the call of the Chair.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED

PREPARED STATEMENT OF KAREN DAVIS

Mr. Chairman, I am pleased to be here on behalf of the Physician Payment Review Commission to discuss the implementation of Medicare Volume Performance Standards (VPS). I will describe the Commission's recommendations for VPS rates of increase for 1991, and discuss what will have to be done by the medical profession and the Federal Government to make the VPS system a success. On May 15, the Commission submitted a report to the Congress containing its full recommendations on the VPS rate of increase for 1991.[1] Commission staff would be pleased to provide you with additional information about that report.

For at least a decade, the rapid growth of physician expenditures has placed increasing financial burdens on beneficiaries and has drawn on Federal resources that might more appropriately be devoted to other public needs. It is the Commission's judgment—shared by the Congress—that growth in physician expenditures must be slowed to a lower, sustainable rate. The Commission proposed the concept of expenditure targets as a means to slow the growth of Medicare expenditures for physician services. Congress adopted that concept and established a system of Volume Performance Standards as part of the physician payment reform in the Omnibus Budget Reconciliation Act of 1989 (OBRA89).

The Volume Performance Standard system provides a collective incentive to the physician community to slow the growth of expenditures to Medicare beneficiaries. It is intended that this be accomplished by reducing services that provide little or no benefit to patients rather than by holding down physician fees. Physicians through their professional organizations should work to identity and reduce such services through their own educational programs and by working with Medicare's Peer Review Organizations (PROs) and carriers.

VOLUME PERFORMANCE STANDARD RECOMMENDATIONS

On April 15 of each year, the Secretary of Health and Human Services recommends a performance standard rate of increase for the following year. The Commission then comments on the Secretary's recommendation and offers its own recommendation to Congress by May 15. On April 16, 1990, the Secretary recommended a VPS rate of increase for fiscal year 1991 of 8.7 percent for surgery, 10.5 percent for nonsurgical services, and 9.9 percent for all services together. The Secretary made full allowances for expenditure growth due to inflation, increases in enrollment, increases the average age of beneficiaries, and the effects of prior legislation, while providing an allowance for an increase in volume and intensity per enrollee of one-half of the recent trend.[2]

At its recent meeting on April 26-27, 1990, the Commission examined the Secretary's recommendations and the rationale provided for them. The Commission then chose to recommend an alternative VPS rate of increase based on reasoning somewhat different from the Secretary's. The Commission recommends a VPS rate of in-

[1] "Medicare Volume Performance Standard Rate of Increase for Fiscal Year 1991," Physician Payment Review Commission, May 15, 1990.

[2] Letter from Louis Sullivan, M.D., Secretary of Health and Human Services, to J. Danforth Quayle, April 16, 1989. More precisely, the Department's allowance for an increase in volume and intensity is equal to one-half their estimate of the annual growth of expenditures from fiscal year 1986 to fiscal year 1990 in excess of that attributable to inflation, enrollment, and aging.

crease of 11.2 percent overall, with a rate of increase for surgical services of 9.3 percent and for nonsurgical services of 12.1 percent. These rates of increase would be adjusted for the effects of subsequent legislation on 1991 expenditures.

In developing its recommendation, the Commission considered the effects of factors specified in the legislation on projected expenditure growth and considered what rate of increase of expenditures each would justify. The factors are inflation, increases in the numbers and average age of Medicare enrollees, changes in technology, any problems with access, appropriateness of the services that Medicare beneficiaries receive, and any other relevant factors such as the effects of legislative changes on expenditure growth.

The Medicare Actuary provided to the Commission his projections of expenditure growth for fiscal year 1991 due to inflation, increases in the number and average age of Medicare beneficiaries, and the effects of prior legislation. The Commission reviewed the evidence provided and used the Actuary's estimates in developing its own recommendations. The Commission also reviewed evidence on effects of three factors that are difficult to quantify: new and changing medical technology, any limitations on beneficiary access, and the amount of inappropriate services provided to Medicare beneficiaries. The Commission found no satisfactory way to estimate accurately the effects of new technology on expenditures. The available evidence on access to services suggests that Medicare beneficiaries do not generally experience deficiencies in access. Also, available information indicates that on balance a substantial volume of services could be eliminated without any reduction in quality of care. Indeed, eliminating unnecessary and inappropriate services should improve the quality of care. Because the evidence on access and appropriateness is relatively sparse, one must exercise considerable judgment in reaching these conclusions.[3]

Because it is not possible to develop accurate projections of the effects that new technology, access, and appropriateness would have on expenditures, the Commission used an alternative approach to develop its recommendations. The Commission began with the baseline projection of the Medicare Actuary for the rate of growth of expenditures incorporated in the VPS. It then decided what reduction in this rate of growth could be achieved without threatening loss of access or quality of care for Medicare beneficiaries. This approach is particularly appropriate for the initial years under the VPS system, during which the ability of physicians to affect medical practice is the factor that limits the pace at which the growth rate can be slowed.

The Medicare Actuary projected a rate of growth of expenditures included in the VPS of 13.2 percent for 1991.[4] The Commission judged that the rate of expenditure growth for 1991 could be reduced by 2 percentage points to 11.2 percent by eliminating services that would have provided little or no benefit to beneficiaries. In effect, the Commission allowed full increases in expenditures for inflation, increases in the number and average age of beneficiaries, and prior legislative changes, but judged that the medical profession can achieve a 2 percentage point reduction in the overall growth rate by reducing the growth of volume and intensity of services without compromising access or quality of care. This would still provide a 4.6 percent allowance for increased volume and intensity of services per beneficiary.

The Commission's VPS rate of increase of 11.2 percent is higher than the Secretary's proposed rate of increase of 9.9 percent. The difference between the two is primarily due to a lower allowance by the Secretary for growth of volume and intensity per beneficiary.[5] The Secretary's recommended VPS rate of increase includes an allowance for increased volume and intensity equal to one-half the rate of increase for 1986–1990 because, as noted in his April 16 letter to the Congress, "we cannot justify a growth rate of 7.4 percent in these factors" (page 8). However, the Secretary's recommendation may be unrealistic in light of what can be achieved by the medical profession.

OBRA89 called for the Secretary and the Commission to recommend a separate VPS for surgical and nonsurgical services. The Secretary recommended VPS rates

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[3] There is some evidence of deficiencies in access for beneficiaries in some rural and urban underserved areas, and poor beneficiaries may generally experience lower access than others. However, this does not imply a general loss of access that should be remedied through a higher volume performance standard. These specific problems with access are better addressed through focused measures such as the bonus payments to physicians practicing in underserved areas that were enacted in OBRA89.

[4] The Commission is awaiting confirmation of the data and methods used by the Actuary.

[5] Comparisons between the Commission's VPS rate of increase and that proposed by the Secretary are somewhat complex because of differences in approach. However, differences in projections in the increase in volume and intensity per beneficiary are the largest factor, as explained in the Commission's May 15 report to Congress.

of increase of 8.7 percent for surgery and 10.5 percent for other services, but the difference is accounted for entirely by the effects of changes in pricing and expansion of benefits resulting from prior legislation.[6] The Secretary provided the same allowance for increased volume and intensity per beneficiary for surgical and nonsurgical services.

The Commission recommends VPS rates of increase for surgical and nonsurgical services that are one percentage point farther apart than those recommended by the Secretary. This reflects the Commission's baseline projection that surgical services will increase less rapidly than nonsurgical services in 1991. This projection is based on evidence that the Medicare volume of surgical services has grown less rapidly in recent years than that of nonsurgical services. In fact, the Commission found that the rate of increase of surgical services has recently fallen below historical levels and that the rate of growth of cataract surgery—the single largest surgical procedure for Medicare--has slowed. This one percentage point difference plus the projected differences due to prior legislation leads to Commission recommendations of a VPS rate of growth of 9.3 percent for surgical services and 12.1 percent for nonsurgical services.

These recommended rates of increase should be adjusted to account for effects of subsequent legislation on 1991 expenditures. For example, legislative measures to change coverage or to constrain allowed charges through a reduction in the update for prevailing charges would affect fiscal year 1991 outlays, and the Commission's recommendations should be revised to reflect them. However, legislative measures intended to slow expenditure growth by reducing utilization should not lead automatically to a lower VPS rate of increase. The medical profession is expected to meet the volume performance standard by reducing inappropriate utilization through practice guidelines and peer review mechanisms. It would seem that reductions expected to result from carrier and PRO activities that are directed by legislation, such as prior authorization of assistants at surgery, should not be offset by lowering the VPS rate of increase.

THE CHALLENGE OF VOLUME PERFORMANCE STANDARDS

I would like to place the Commission's recommendation in a larger context and discuss the responsibilities of the medical profession, the Department of Health and Human Services, and Congress for the success of the Volume Performance Standard system.

The Commission views the 1991 VPS as the next step in a long range plan to slow expenditure growth to a sustainable level, such as the trend in the rate of growth of the Gross National Product. The Commission believes that this can be accomplished within five years. The VPS for 1990, set according to the specifications in OBRA89, took the initial step. Each year, more resources would be available for physician services, but eventually the increase would accommodate only inflation, increases in the number and aging of beneficiaries, and a small allowance for new technology or to remedy any identified shortfalls in access. The Commission recognizes that Medicare enrollees should receive the benefits of new technology that is effective, but believes that increases in the volume of new services can be offset by reductions in services now provided that would be of little or no benefit.

It is the Commission's judgment that the rate of growth of expenditures can be reduced over the next several years while maintaining access and quality of care. This challenge and the work required to meet it will fall primarily to the medical profession, for they must take the lead in identifying and reducing services of little or no benefit. Recent efforts of medical organizations to begin or to accelerate the development and use of practice guidelines shows that the medical profession is already at work. To build on these initial efforts, the medical profession must receive strong support from the Department of Health and Human Services, particularly the new Agency for Health Care Policy and Research (AHCPR) and the Health Care Financing Administration (HCFA), and cooperation from others in the health care community.

AHCPR has been given the primary responsibility for supporting the development of more information and better tools needed to improve the quality of care and to reduce unnecessary services. AHCPR already supports much of the research that

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[6] Prior legislation increased benefits primarily for nonsurgical services (e.g., coverage was extended to Pap smears) and changed the prices Medicare will pay in 1991 for some services. These legislative measures are projected to add 1.9 percentage points to expenditure growth for nonsurgical services and 0.1 percentage points to expenditure growth for surgery. To achieve an average rate of growth of expenditures of 9.9 percent, the surgical performance standard was decreased to 8.7 percent and the nonsurgical performance standard increased to 10.5 percent.

enables physicians and their patients to know which services are effective and which are not and which services will improve patients' outcomes. The Agency is now funding several Patient Outcome Research Teams as well as a number of effectiveness research projects. Both should be expanded as rapidly as possible. In order to do this, the AHCPR will also need to expand its funding for the training of physicians and others to carry out effectiveness and outcomes research.

The Agency must effectively disseminate the information generated by research studies and support the profession's efforts to develop guidelines and to apply them in practice. The Agency should also support work to improve and test the methods used to develop guidelines and to evaluate their effects in actual practice.

The Commission suggests that the Agency use each of the mechanisms specified in OBR89 to produce guidelines, including grants and contracts with organizations outside the government. It should consider direct support for professional organizations so that the medical profession is fully involved and invested in the process, particularly since the medical profession will be held responsible for changing clinical practices. Of course, these organizations would be fully accountable for the integrity and scientific validity of the methods and processes used to develop the guidelines.

The Commission would like to note the need for speedy appointment of a permanent director of the Agency so that this work can proceed as quickly as possible.

The Health Care Financing Administration (HCFA) and its contractors must improve both their review methods and the criteria used so that review reinforces appropriate practice and is less intrusive. PROs and carriers need review methods that are more accurate than many they now use. For example, profiling methods can target direct review to those most likely to have inappropriate utilization patterns and increase the chance that aberrant patterns will be detected. These methods also avoid unnecessary intrusion into the clinical practices of most physicians.

The Department is also charged to provide the medical profession, the beneficiary community, and the public with information on utilization, appropriateness, and access to services. This will help to focus the work to eliminate unnecessary services and to ensure that beneficial services are provided to those who need them. Medicare carriers are to provide physicians with data comparing their own utilization patterns to those of their peers. The success of the Maine Medical Assessment Program suggests that this information will lead physicians to examine and modify their practices.

It is important to underscore the importance of better information on beneficiary access to appropriate care. Reductions in access would be the most important indicator that efforts to slow expenditure growth may be too vigorous. Without reliable information about access, it is difficult to move forward rapidly with confidence that access is not threatened. The Current Beneficiary Survey and other means of obtaining information on access assume increased importance under the VPS system.

The Congress must provide the funding that the Department needs to carry out its new and expanded tasks under the payment reform legislation. Congress provided the new Agency with substantial initial funding for 1990. The Commission urges the Congress to increase the funding for the Agency over the next several years to enable it to fully support rapid growth in the programs that provide the information base for improving clinical practice. HCFA and its contractors will need adequate funding to improve PRO and carrier review and to develop and disseminate information on access, appropriateness, and utilization of services.

Finally, success in containing costs through the VPS system will depend on Medicare beneficiaries' willingness to forgo services that can be expected to provide them with little or no benefit. Beneficiary organizations should disseminate information to their members about which services are effective and which can be eliminated without loss of benefit. OBRA89 directs AHCPR to develop practice guidelines that can be used by beneficiaries as well as guidelines for use by physicians. The Commission believes that beneficiaries can provide a needed perspective and should be involved in the development of the practice guidelines that will be used by them and by their physicians.

The task given the medical profession is a difficult one. The willingness we have seen from the medical profession to take up this challenge is very encouraging. The American Medical Association, the Council of Medical Specialty Societies, and many specialty societies have undertaken promising projects in this area. The American College of Physicians, which pioneered the development of guidelines, has begun to focus its attention on how to get physicians to use good guidelines. The American College of Cardiology developed several effective guidelines during the 1980s including guidelines for pacemakers that are credited with reducing and improving the use of that procedure. The American Urological Association (AUA) has committed

to an outcomes research project to determine the effectiveness of a major urological procedure and to develop practice guidelines for it. Recent research had raised questions about how this procedure would most appropriately be used. The AUA's decision to resolve this uncertainty through scientific investigation should be applauded.

CONCLUSION

The goals of the VPS system cannot be reached overnight. The growth of expenditures must be reduced at a prudent pace. The Commission expects that expenditure growth can be slowed within five years to a sustainable level. However, the uncertainty inherent in these predictions requires that these expectations be reassessed each year in light of more recent information on access to services, technological change, appropriateness of current practice, and the ability to identify and reduce services of little or no benefit. The annual recommendation of a VPS and, beginning next year, the update in fees, will provide an opportunity for the Secretary, the Commission, and the Congress to revisit these questions each year.

Volume Performance Standards and the programs to support the medical community's response to them are taking us into new territory. While other societies have been able to hold expenditure growth in health care to levels they consider affordable, none has done so within a system as fragmented and pluralistic as ours. And no society has resolved to develop the base of information needed to determine how best to spend their health care resources, as we seek to do through research on effectiveness and the determinants of outcomes.

With these new policies and programs, we have an unprecedented opportunity not only to bring the growth in expenditures to a sustainable level, but to maintain access and quality and to improve the value received for these expenditures. This will require prudent and thoughtful management of the Volume Performance Standard system by the Congress and strong support by the Federal Government for the medical profession.

PREPARED STATEMENT OF JEROME C. GOLDSTEIN

Mr. Chairman and members of the subcommittee, I am Jerome C. Goldstein, MD, FACS, a Fellow of the American College of Surgeons, on whose behalf I appear before you today. I also am a member of the College's Board of Governors and its Advisory Council for Otorhinolaryngology. In addition, I am the Executive Vice President of the American Academy of Otolaryngology—Head and Neck Surgery, Inc. The College appreciates this opportunity to share its views about Secretary Sullivan's recommendations on the Medicare volume performance standard (MVPS) rates of increase for fiscal year (FY) 1991.

As you know, Mr. Chairman, the American College of Surgeons was an active participant in this committee's work last year as it developed the physician payment reform legislation that Congress approved in the fall. We were especially pleased to work with the Committee on Finance and its staff to develop the MVPS concept and the establishment of a separate standard for surgical services. The College remains committed to work with you, and with Secretary Sullivan, to develop and implement this program in the most reasonable manner possible.

In April of last year, representatives from the College appeared before you to outline the elements of a physician payment reform plan that dealt with a number of concerns, including ways to moderate the rate of spending growth under Medicare and to make program costs more predictable. Included in our plan was a proposal to establish a national expenditure target for surgical services that would take into account expected changes in the number of Medicare enrollees, the increased aging of the population, changes in the costs of the practice of surgery, and anticipated changes in the frequency of surgical procedures. We felt that this would be a far more rational approach to preparing the Medicare budget than the often unpredictable steps that have been taken in recent years to establish Medicare spending policies.

We also believed that the MVPS-like concept could begin to provide incentives for the surgical community to address the all-important volume issues relating to the determinants of spending for physicians' services. The College believes that it is virtually impossible to effectively and efficiently address considerations regarding the volume of services across the entire spectrum of medicine. The practice of medicine is simply too complex and diverse to deal with volume concerns in an across-the-board manner. In most hospitals, for example, the responsibility for quality assurance and volume issues is assigned to specific departments with the experience and competence to deal with these issues in the context of specific service categories.

Thus, in expressing our support for the MVPS concept, the College has repeatedly emphasized that a single, unfocused standard for all physicians' services will provide no incentives for specialty groups to review the quality of practice within their respective areas of expertise. The College believes that the Medicare program will have greater success in dealing with such issues by asking surgeons themselves to take responsibility for evaluating the appropriateness and quality of surgical services that are provided to beneficiaries. We believe that the statutory provision that establishes a separate target for surgical services, and such other categories as the Secretary may determine, greatly improves the chances for success in dealing with increases in Medicare expenditures.

As a corollary, the College strongly believes that the definition of surgical services will have a major bearing on the success or failure of the MVPS concept. We are pleased with the definition that was published by the Secretary on May 3. Of the options considered by the Secretary, the published definition is the one that is most consistent with the College's views.

We recognize that other ways eventually may be used to define surgical services in a more precise manner, and we have met with representatives from the Health Care Financing Administration (HCFA) to discuss this issue. HCFA is working to improve Medicare's data and claims reporting systems in order to refine the target setting process and to set more precise MVPS rates for future fiscal years. We believe that, among other things, the improvements in Medicare's data systems will permit each surgeon to be monitored in terms of frequency, practice changes, use of an assistant at surgery, total cost per code, and so on, regardless of his or her specialty or the payment locality in which the service is performed. In addition, we recognize that fee differences could occur between surgeons and nonsurgeons who perform similar services due to a difference in yearly updates. However, we believe such differences could be addressed by the Secretary on a year-to-year basis to ensure that the same fee schedule amount is paid per procedure in each locality.

I hope it is clear that the College is committed to work with the Secretary and HCFA to refine the definition and to make the MVPS concept viable. In making this commitment, however, we assume the data collection and analysis by the Department will broaden in content and be more rapidly processed so that a current, on-line assessment of the MVPS can be accomplished. It also should be understood that the College is a voluntary, professional organization; and while we can educate our Fellowship with regard to physician payment issues and keep them informed concerning our activities, our ability to influence their behavior is limited. Thus, we would have to work with the Department in order to obtain the desired outcome.

Mr. Chairman, as the committee members know, on April 16, 1990, the Secretary recommended the same FY 1991 MVPS rates of increase for surgical services and for all other physicians' services—namely, 8.6 percent. This recommended increase takes into account inflation, changes in the number of enrollees, aging of the population, changes in technology, evidence of lack of access, and other factors. The rate then was adjusted to reflect certain benefit changes (mental health benefit improvements and coverage of Pap smears) that Congress included as part of the 1989 budget legislation, yielding the final MVPS rates of increase for surgical and nonsurgical services.

The American College of Surgeons believes that the MVPS rates proposed by the Secretary are far too low and could seriously undermine our ability to develop the processes needed to make the MVPS concept a viable one. In an April 19, 1990 letter to Dr. Sullivan, the College expressed serious concerns about his intention to recognize only one-half of the estimated historical growth rate in expenditures relating to the combined effects of technology improvements in medicine, access to quality surgical services, and intensity. We believe that this unrealistically low rate departs far too quickly from the trend line in the demand for surgical services and is inappropriate given the very limited experience we have had thus far with the MVPS concept. The law's default provision, if allowed to go into effect, requires that the MVPS calculations be reduced by a statutory performance standard adjustment factor of one percentage point for FY 1991. Further reductions that are made now could easily defeat the entire MVPS concept before it is even tested.

In his letter to Congress on the MVPS, Dr. Sullivan noted that the Department is not yet able to quantify the impact of changing surgical technologies, emerging diagnostic techniques, or other developments that could alter the utilization of current services. We recognize and agree that this is a major task that must be undertaken in a more thorough manner before reasonable judgments about the expected use of surgical and other physicians' services can be made. We are committed to work with the Secretary and his staff during this year to improve the estimating process and to provide Congress with a better understanding of the effects of setting

various target rates for surgical services. To that end, the College is working with the surgical specialty societies to initiate a process through which the surgical community will provide the Secretary with an annual assessment of the expected impact of changing technologies on the use of and expenditures for surgical services. Thus, we caution against setting the 1991 rates too low on the basis of incomplete information so early in the implementation of the MVPS concept.

While we have not seen the specific recommendations from the Physician Payment Review Commission (PPRC), or the underlying analysis that supports their proposals, we understand that the Commission's numbers are not quite as low as those from the Secretary. However, the Commission seems to recommend an unusually large difference in rates of increase for each MVPS category of services. The College believes that this differential is not warranted, especially given the very shaky information upon which the lower rate for the surgical MVPS seems to be premised. We are pleased that the Commission finally recognizes that surgical volumes are rising less rapidly than other physicians' services, but we hope that the PPRC's proposed differential is not intended to penalize those of us who are trying to cooperate with you to make this plan work. We believe that any differential between the rate for surgical services and the rate for other services should be no greater than that assumed by the Secretary to reflect the benefit changes that were included in the Omnibus Budget Reconciliation Act of 1989.

Mr. Chairman, we appreciate this opportunity to present the College's views on this important issue.

PREPARED STATEMENT OF ROBERT GRAHAM

I am Robert Graham, M.D., Executive Vice President of the American Academy of Family Physicians, the national medical specialty society representing over 69,000 family doctors, residents in family practice, and medical students. Thank you for the opportunity to meet with you today to discuss implementation of a key provision of Medicare physician payment reform the determination of volume performance standards for physician services.

During consideration of Medicare physician payment reform last summer the Academy emphasized to this committee its recognition of Congressional responsibility to define sound budget policy and to equitably allocate available financial resources among pressing public needs. We specified several principles which we believed should be incorporated into any proposal for expenditure targets, including the allowance of differentiation by categories or classes of services, consideration of changes in the aging of the population, medical technology, program enrollment, and access to services. The Medicare Volume Performance Standard provision of payment reform incorporates these elements and, if implemented as intended by Congress, we believe has the potential to provide incentives for more appropriate volume of services under Medicare.

DEFINITION OF SURGICAL SERVICES

The first issue I will address today concerns the implementation of the volume performance standard rates of increase for surgical services. OBRA 1989 provides for separate MVPS for different categories of physician services. The setting of separate standards for different categories of services acknowledges several practical realities: (1) the per beneficiary volume of different services has grown at dissimilar rates, in some cases at a rate faster than can be adequately explained and in other cases not at all despite evidence of a shortfall in access; (2) the degree of certainty of current knowledge regarding the appropriate indications for different services varies considerably; and (3) it is commonly accepted that the current volume of some services is inappropriately high and should be reduced while the current volume of other services is lower than might be appropriately expected.

Pursuant to section 6102 of OBRA 1989, on May 3, 1990, the Health Gaze Financing Administration published a notice of the definition of surgical services to be used for the purpose of setting the MVPS for 1991. According to HCFA, "surgical services means those services that are both performed by a surgical specialist and are currently classified by carriers in the surgery category in the Medicare payment record." As the notice makes clear, current data limitations restrict the definition of surgical services to two options, one based on classification by carriers in the surgery category in the Medicare payment record or one based on a combination of procedure code and the self-designated specialty of the physician performing the service. We believe HCFA's selection of the latter option to be undesirable from a policy perspective. As the Physician Payment Review Commission notes in its 1990 Report

to Congress, ". . . OBRA89 does not generally recognize physician specialty as a valid basis for payment differentials. Since differential fee updates would eventually lead to different rates of payment, a MVPS based on specialty per se would lead to specialty differentials . . ." HCFA's disclaimer that the definition would not lead to payment differential notwithstanding, we believe that the policy precedent elucidated in the definition of surgery by specialty is completely inappropriate given Congressional action in regard to specialty differentials. In addition, HCFAs approach would result in the volume of services by one group of specialists determining the update for another group of specialists providing that same service.

The main effect of defining surgical services by both carrier classification and physician specialty is to exclude endoscopies and cardiac catheterizations from the surgical MVPS. The rationale for excluding these services from the definition of surgery appears to be that HCFA does not believe them to be true surgical services and because surgical specialty societies feel they would have little influence over the providers of these services, most of whom are not designated as surgeons. The Academy questions these explanations.

Contrary to HCFAs assertions, endoscopies and cardiac catheterizations fall clearly within the definition of surgery. HCFA's instruction to carriers for typing surgical services references the surgical section of the AMA's Current Procedural Terminology (which includes codes for endoscopies and cardiac catheterizations) and makes no reference to the designated specialty of the physician. The newly proposed definition marks a significant departure from HCFA's current definition. There is no intrinsic reason to exclude endoscopies and cardiac catheterizations from the surgical MVPS. These services are among those that have experienced the fastest rate of Medicare volume growth and for which the indications are most uncertain. The fact that they are usually provided by physicians who are not designated surgeons makes them no less important to the Medicare program. Furthermore, keeping endoscopies and cardiac catheterizations under the surgical performance standard will emphasize the urgency of developing clinical guidelines for their use.

Specialty societies do not have any means to directly impact the volume of services provided by their members. Moreover, because physicians self designate their specialty, it is not clear that physicians designated as surgeons on the payment record possess the credentials required by the surgical specialty societies, or, if they do, that they are actually members. Presumably, specialty societies will be intimately involved in the development of clinical guidelines, and it is through the dissemination and use of guidelines that medical services will be provided in a more appropriate fashion. The dissemination and use of clinical guidelines is dependent on neither surgical designation nor specialty society membership.

We are aware that the planned implementation of the Common Working File in 1991 will eliminate the need to use specialty designation in the definition of any type of service and take note of HCFA's recognition of the legislative prohibition of specialty specific updates. However, we see no need to employ specialty designations at any point in the MVPS setting process. To the contrary, the use of procedure specific definitions of service type without reference to specialty designations would preserve Congressional intent as expressed in last year's adoption of Medicare physician payment reform.

RECOMMENDATION OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

Next I will address HHS recommendations to Congress on FY 1991 Volume Performance Standards. As required in the legislation the Secretary of Health and Human Services submitted to Congress a recommendation on the Volume Performance Standard (MVPS) target increase for FY 1991. In making the recommendation on the rates of increase the Secretary is to consider inflation, changes in number of enrollees, changes in the age composition of enrollees, changes in technology, evidence of inappropriate utilization of services, evidence of lack of access to necessary physicians' services and such other factors as the Secretary considers appropriate. The Secretary's recommendation is an important first step in the process. The second step is the Physician Payment Review Commission's review and recommendation to Congress by May 15. These recommendations must be credible and carefully developed so that the recommendations will lead to Congressional action.

The April 16th HHS Secretary's recommendation allows a 9.9 percent increase for all services. This includes an 8.7 percent target increase for surgical services and 10.5 percent increase for non-surgery. The components leading to the total amount include an inflation factor of 3.6 percent, an enrollment adjustment of 1.2 percent, an aging factor of .1 percent, OBRA 1989 changes containing increased mental health and preventive health benefits of 1.9 for non-surgery and .1 for surgery, and factors other than inflation, enrollment and aging of 3.7. The "other factors" catego-

ry includes changes in technology, inappropriate utilization and access. The HHS recommendation explains that a quantitative factor for technology has not been separately identified because no definitive data or studies are currently available to quantify the effects of technology. Likewise inappropriate utilization and access are indeterminable at this time according to HHS. In spite of the lack of information, HHS recommends a major budget reduction in the factors other than inflation, enrollment and aging. They recommend an adjustment of 3.7 percentage points for these combined factors, noting that they contribute to the growth in volume and intensity. The 3.7 is half of the 7.4 estimated annual growth in these expenditures for the period FY 1986 to FY 1990. HHS believes the continuing growth rate of 7.4 percent is unacceptable and therefore proposes the across-the-board reduction.

We believe this means of constraining the rate of increase in spending is not based on a thoughtful assessment of the factors outlined in the legislation nor consideration of congressional intent. The result is to establish a target that is much lower than is realistic and to position the MVPS program for failure. Considering the lack of data capability and analysis, and the untested MVPS methodology we believe it is ill-advised to make arbitrary decisions to reduce spending. In carefully crafting the total reform package Congress provided the tools to reduce volume and intensity. Outcomes and effectiveness research provide a sound basis for reducing inappropriate services. We believe Congress intended to provide physicians and payers with the information they need to make better choices act appropriate medical care through practice guidelines.

Another flaw in the HHS recommendation is that it fails to recognize that the volume of some services should appropriately be increased, such as primary care services. The reform package provides incentives to provide primary care services by increasing reimbursement for these services. We believe increased volume in these services to be an indication of improved access, rather than overutilization.

RECOMMENDATION OF THE PHYSICIAN PAYMENT REVIEW COMMISSION

A preferable target rate of increase is proposed by the Physician Payment Review Commission (PPRC). The PPRC recommends a MVPS rate of increase of 11.2 percent overall, with a rate of increase for surgical services of 9.3 percent and for nonsurgical services of 12.1 percent. An alternative approach, based on the Medicare Actuary's projections, was used by PPRC to develop its recommendations. The commission began with the baseline projection rate of growth of expenditures of 13.2 percent for FY 1991 and then considered what reduction in this rate of growth could be achieved without threatening loss of access or quality. They decided upon a 2 percent reduction in the rate of growth. We believe this approach is more realistic and preferable to the lower allowance for volume and intensity growth proposed by the HHS Secretary.

The AAFP also supports the PPRC utilization of a separate factor to account for increased volume and intensity per beneficiary for surgical and nonsurgical services. PPRC's projection that surgical services will increase less rapidly than nonsurgical services in 1991 is based on evidence that surgical services have grown less rapidly in recent years than nonsurgical services. The result is that the difference between the nonsurgical and surgical targets is greater in the PPRC recommendation than the HHS Secretary's. This is consistent with the provision in the law to provide for separate targets by category of physician service. The AAFP supported this provision, recognizing that actual performance may vary by type of service.

The underlying rationale of MVPSs is to present all physicians with a collective incentive to provide Medicare beneficiaries with only those services that are necessary and appropriate. The responsibility for determining necessity and appropriateness ultimately lies with the medical profession. While the informed patient should be maximally involved in all care decisions, the appropriate continuation of care remains a matter of professional judgment. MVPSs are intended to influence physicians' decisions about the appropriate continuation of care. Within the limitations of medical knowledge and the available resources, we accept the responsibility of working with our colleagues to provide appropriate medical services to Medicare beneficiaries.

PREPARED STATEMENT OF JOHN J. RING

Mr. Chairman and Members of the Committee:

My name is John J. Ring, MD. I am a physician in the practice of family medicine in Mundelein, Illinois, and I am also the Chairman of the Board of Trustees of the American Medical Association. With me today is Janet Horan of the AMA's Division of Legislative Activities. The AMA is pleased to have this opportunity to discuss the volume of Part B services provided to Medicare patients and the Medicare Volume Performance Standard (MVPS).

Growth in Expenditures for Part B of Medicare

At the outset, I want to set aside some of the myths that have been created about the growth in Part B of Medicare. While we are all concerned that this program continues to grow, in reality this growth has come about, by and large, because of the many successes we have seen in medical care, including our ability to provide a level of care far beyond that imagined when the program began. The average Medicare beneficiary today is both healthier and older than the counterpart of twenty-five years ago. The very success of the Medicare program has brought us to the point today where the program's very size and projected growth are the subject of close scrutiny.

Mr. Chairman, we are pleased to be able to thank you for taking a lead role in last year's activity which culminated in the creation of the MVPS as a tool for Congress to use in monitoring the growth of Part B of Medicare. We also believe that other elements of last year's Budget Reconciliation Act, the creation of the Agency for Health Care Policy and Research, carrier targeted review, and annual monitoring of changes in utilization of and access to services, will better assure that the Medicare program meets its promise of providing coverage for necessary medical care.

Before setting forth our concerns over the activity to date by the Department of Health and Human Services (HHS) and the Physician Payment Review Commission (PPRC) in establishing the MVPS for Fiscal Year 1991, I

want to focus on the growth in Medicare Part B expenditures and to assure you that America's physicians share your concern over this growth.

As a starting point, it is time to recognize that, together, we are holding the line against unreasonable increases in federal expenditures for medical care provided for Medicare patients. The bottom line is that the rate of increase in payments by Medicare for medical care has substantially moderated. From just a few years ago when the annual growth rate in Medicare Part B outlays was in the neighborhood of 20%, we have seen amazing results. Last year, Part B growth was at 9.5% and the growth rate for physician services was below 8%. (See Attachment I)

The American Medical Association continues to explore every aspect of this vitally important health issue, which has become a part of the annual budget debate. One federally funded study, recently released by the Urban Institute, draws the following conclusions about the underlying factors in the increases in Medicare Part B expenditures.

> The major factors behind the increases in Medicare Part B expenditures between 1983 and 1985 (a period of much faster growth in expenditures than today) were the increase in the incomes of the elderly and the increase and diffusion of new medical technologies (especially in the areas of cardiology, ophthalmology, gastroenterology and urology).
>
> The sharp increase in Medicare assignment rates, due in large part to an increase in the number of Medicare "participating" physicians, accelerated growth in Part B expenditures for physician services. The study suggests that the reduced out-of-pocket costs encouraged greater use of medical services.

These findings, which are consistent with work completed by researchers at the AMA, should shed new light on the Medicare volume issue. Our related research carefully analyzed factors in the 7.1% average annual per capita volume/intensity growth from 1983 to 1987 (a technical document setting forth this analysis is contained in Attachment II), and is summarized as follows:

0.1% due to aging of the average Part B enrollee

- 3.6% due to an increase in the share of enrollees served each year, because of a decline in the deductible in real (inflation-adjusted) terms
- 2.0% due to an increase in demand resulting from higher real after-tax household incomes of the elderly

- 0.1% due to reduction in real charges above the Medicare allowed charge resulting from increased assignment rates and restrictions on balance bills associated with the Medicare fee freeze and MAACs
- 1.0% due to the effect of Medigap coverage

This breakdown refutes the simplistic and unproven charges that physicians "game the system" and spur volume increases in order to maintain income levels. Rather, Medicare expenditures have grown because of the increased access to safe and effective medical care enjoyed by Medicare beneficiaries as a result of their growing income, reductions in out-of-pocket costs, and major advances in health care technology that have reduced risk and enabled many to enjoy a far better quality of life. Medical advances, in addition to alleviating pain and suffering, carry a dollar cost.

Physicians are working to assure that only necessary care is provided, and recent Congressional actions in the Omnibus Budget Reconciliation Act of 1989, P.L. 101-239, to establish working practice parameters, targeted review and the Medicare Volume Performance Standard(s) should help assure that this continues well into the future.

Medicare Volume Performance Standard(s)

Mr. Chairman, the AMA is pleased that the Congress followed your lead and incorporated the MVPS into the Medicare physician payment reform legislation. As evidenced by the recent announcement by HHS of its proposed FY 91 MVPS, ample reasons have been demonstrated that point to the wisdom of creating an advisory standard as opposed to a rigid expenditure target. Just as the past Administration continually called for unrealistic zero level updates for hospitals under the Prospective Pricing System, there are unrealistic projections in the HHS MVPS recommendation, evidencing a general inability to comply with Congressional directions. (Attachment III to this statement sets forth the AMA's views on MVPS issues.)

Congress ordered HHS to make a recommendation for the MVPS each year, taking into account several factors: inflation, enrollment changes, beneficiary population aging, changes in technology, evidence of

inappropriate utilization, access, and other factors considered appropriate by the Secretary. However, the HHS analysis accompanying the MVPS announcement demonstrates that the Administration ignored reality in some instances and failed to comply altogether in fulfilling some of its responsibilities.

For example, the HHS analysts ignored reasonable economic factors such as increases in care associated with patient demand and may have underestimated enrollment growth (projected by HHS at 1.2% -- an amount inconsistent with the historical growth of around 1.7%). It is even more disturbing that for three of the key factors identified by Congress to be considered -- technology, utilization, and access -- HHS essentially threw up its hands, indicating that factoring amounts for these elements is just not possible now. Instead, HHS simply advised lawmakers on a "policy basis" to arbitrarily halve the recent growth rate attributed to volume/intensity and allow volume to rise only 3.7% in 1991 and set the MVPS at 9.9%. Mr. Chairman, the Administration has in effect abrogated its responsibility to you and to the over 30 million Medicare patients.

While research needed for making precise judgments about the contribution of these key factors to volume/intensity growth is limited, this does not justify the capricious determination that volume growth simply must be halved. Without any basis for judging whether recent growth has been excessive or inadequate on these criteria -- or for forecasting how these factors might change in the near future -- there is no legitimate basis for recommending that volume growth should change from recent levels.

The American Medical Association remains concerned that the important matter of volume increases directly associated with increased demand for care continues to be ignored. Furthermore, as actions are implemented that will have the result of further diminishing the real cost of medical care to beneficiaries, there is a real potential that demand for care again will increase. For example, new balance billing limits in 1991 will further reduce the cost of care for beneficiaries, and most probably, will promote higher volume as greater access to care will be promoted. Nevertheless, the MVPS includes no recognition of this higher volume.

Mr. Chairman, if the MVPS is to fulfill its function to influence the future rate of growth, it is essential that it be based on complete knowledge and that the information and knowledge gained in developing the standard be disseminated. Reasonable information on evidence of inappropriate utilization, the impact of technology and evidence of lack of access would be highly beneficial to physicians and the public. Yet such information was not factored into the FY 91 MVPS. As this type of information becomes available, as other information used in setting the MVPS is updated, and as information about such other factors as the effects of demand and new billing limits are considered, they should be factored in on an ongoing basis and provided to the Congress and the public.

It is important to keep in mind that the 1991 MVPS default process set by Congress (1% below the projected growth rate) reflected assurances that Congress would have realistic information upon which to base the MVPS. However, with the paucity of analysis and the problems exhibited by HHS and the PPRC in making projections for a single year, we urge extreme caution in using an imperfectly estimated MVPS in establishing the conversion factor updates. (As the PPRC MVPS recommendations to Congress have been submitted just this week, we will provide the Committee with a follow-up response on their recommendations.) The MVPS could be a useful benchmark, but it is <u>not</u> an ironclad projection of appropriate growth in physician services.

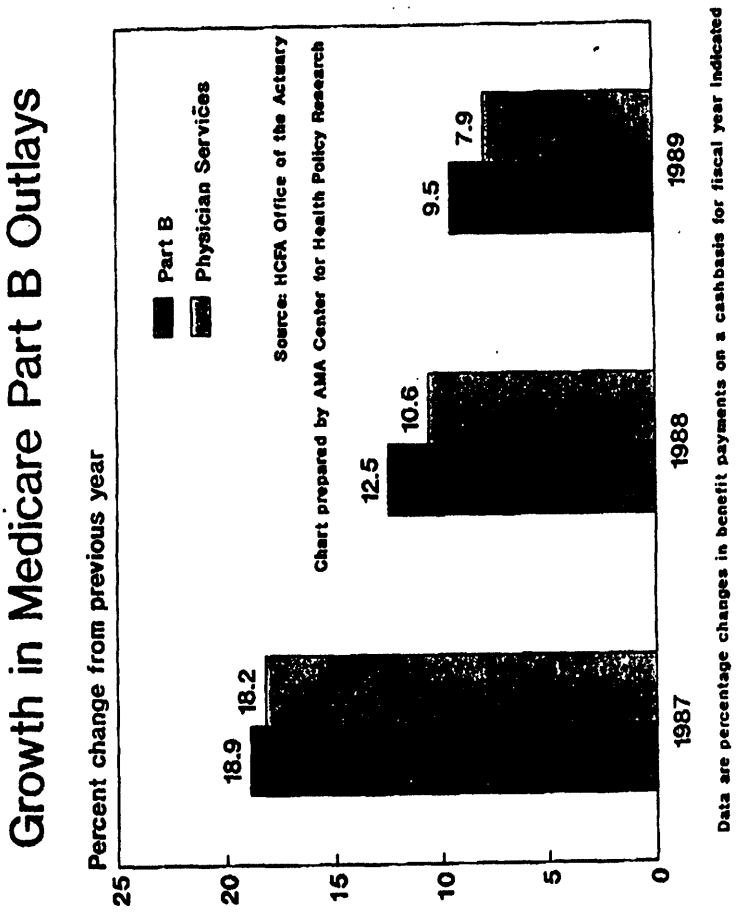
<u>Conclusion</u>

In conclusion, better knowledge of the underlying causes of growth than HCFA or the PPRC are currently providing is necessary to make intelligent decisions about the MVPS. The AMA is not taking lightly the issue of analyzing factors contributing to expenditure growth. We are studying, for example, the impact of technological change.

Finally, we want to leave you with the message that the Medicare program cannot continue to bear a disproportionate share of the reconciliation driven budget savings. In OBRA-87 and OBRA-89, Medicare provided, respectively, 49.7% and 34.8% of the total dollar savings (according to CBO estimates as set forth in Attachment IV).

As you continue to examine the Medicare program, we urge you to consider the benefits that are being purchased for millions of people in need of medical and other health care. Actions aimed at further dollar savings from this vital program or at artificially holding down legitimate program growth, especially with the major reforms now scheduled for implementation, may have unintended results and should not be taken without thoughtful deliberation and careful consideration of the consequences.

ATTACHMENT I



ATTACHMENT II

Expenditures on Medicare Physician Services: Accounting for Growth Components

This analysis focuses on explaining the 12.5% average annual growth rate in Medicare physician expenditures covering the period from 1983 to 1987. The choice of 1983 as the beginning point was made because it immediately predates implementation by Medicare of a series of measures that have limited fee increases and caused a divergence in the sources of expenditure growth between the Medicare and non-Medicare populations. The 1987 endpoint was chosen because it is the most recent year for which complete information is available on expenditures for physician services.

Expenditures are equal to price times quantity, leading to a commonly used decomposition of growth in expenditures. In particular, expenditure growth rates can be expressed as the sum of:

- population growth (1.8%);
- changes in the price or fee paid per service (3.3%);
- increases in the volume of services per capita (7.1%); and
- interactions of the growth rates of fees, population and volume per capita (0.4%).[1]

By itself, this breakdown does not explain growth rates; further explanation is required for each of the major components.

Population Growth[2]

Among the major components, population growth is the only factor determined completely independently from the physician services market. The aging of the overall population is causing the portion of the population that is elderly and covered by Medicare to increase over time.

Prices Paid per Service[3]

The portion of the fee covered by Medicare is based on 80% of the allowed charge. The rate of increase in allowed charges for most services is limited by the Medicare Economic Index (MEI). From 1983 to 1987, the MEI increased at an average annual rate of 3.3%. The 3.3% rate of increase of the MEI is used as an approximation of the rate of price increase in the Medicare program. This is probably a downward-biased estimate since some charges are not limited by the MEI.

Volume per Capita[4]

The 7.1% increase in Medicare volume is likely to be upwardly biased because of the downward bias in the rate of Medicare allowed charge increase used in its derivation.

The analysis that follows shows that ordinary demand sources fully explain the growth in volume per capita for Medicare beneficiaries. In other words, volume growth directly reflects the independent choices and value placed on physician services by beneficiaries, given their incomes, their out-of-pocket costs, their health, and the competing demands for their dollars.

Since the major point of this analysis is that increased demand can be explained independently from supply considerations, a detailed discussion of the demand sources of volume increases for the Medicare population follows.

Medicare Volume Increases[5]

The contribution of different factors to the recent 7.1% annual increase in the volume of services among Medicare Part B enrollees is summarized in Table 1. As noted earlier, the 7.1% growth rate in volume is likely to be an overestimate of the actual volume increase. This upward bias is probably more than sufficient to explain the discrepancy between the sum of individual demand effects and the 7.1% total in Table 1. Discussion of the individual effects follows.

Aging of Medicare Enrollees. Table 2 shows the age distribution of Medicare enrollees and Medicare reimbursements per enrollee by age group in 1977 and 1986. The data show that the share of Medicare population increased in older age groups from 1977 to 1986. They also indicate an increase in average reimbursement with age.

If the average reimbursement per enrollee within each age group had been the same in 1986 as in 1977, so that any increase in average reimbursement was solely due to the shift in the age distribution towards older age groups, then the average reimbursement would have been $768 in 1986. This implies that Medicare costs increased from $759 per enrollee in 1977 at an annual rate of 0.1% due to the aging of the Medicare population.

Enrollees Receiving Reimbursements. Since 1981, the Part B deductible has been held constant at $75. In inflation-adjusted terms, the deductible has declined. This has made it possible for an increasing number of enrollees to exceed the deductible and qualify for benefits in each successive year. The percentage of enrollees receiving Part B reimbursements for physician services increased from 65.3% in 1983 to 72.6% in 1986, or at an annual rate of 3.6% (U.S. Social Security Administration, 1988, Tables 7B2, 4 and 5).

Income. The average after-tax household income of the elderly in constant 1986 dollars increased from $15,560 in 1982 to $16,811 in 1986, or at an annual rate of 2.0% (U.S. Department of Commerce, 1989, Table 716). Using the estimate that the demand for physician services increases by 1.0% for every 1.0% increase in income, this translates into a 2.0% increase in demand.

Balance Bills. From 1983 to 1987, bills in excess of the amount Medicare covers on unassigned claims (balance bills) for physician services declined from $1.94 billion to $1.86 billion (U.S. Social Security Administration, 1988, Table 7.B1 and 11). This reflects the effect of the increasing share of services for which assignment was accepted and the limits placed on the size of balance bills by the Medicare fee freeze and maximum allowable actual charge (MAACs). The decline in balance bills reduced the rate of increase in out-of-pocket payments facing Medicare beneficiaries by over one percentage point. In turn, this precipitated an increase in volume per enrollee of over 0.1%.

Real Coinsurance. From 1983 to 1987, the rate of general inflation was virtually the same as the estimated increase in average allowed charges based on the MEI. Since the coinsurance rate on allowed charges is fixed at 20%, the change in real coinsurance payments per service was negligible and had no significant effect on volume.

Medigap Coverage. Medigap insurance is held by 72% of Medicare beneficiaries. Estimates indicate that those with Medigap use 24% more physician services (Christensen, et al., 1987). This implies that Medigap is responsible for magnifying the impact of increases in volume from other sources by 17.3% (24% x 72%). The increased utilization generated by Medigap derives from its common feature of covering all patient deductibles and coinsurance, and thereby reducing out-of-pocket costs for most covered Medicare enrollees to zero. This implies that without Medigap, the estimated total increase in volume per enrollee would have been 6.1% instead of 7.1%, so one percentage point of increased volume is attributable to Medigap coverage.

Conclusions

These results do not deny an important role for supply factors in determining volume growth. Indeed, there must be equal growth in the volume of services supplied and demanded for actual volume growth to be realized. The importance of the results is that they show that demand is determined independently from supply. Demand factors, therefore, have equal standing with supply, rather than supply having a disproportionate share of responsibility, in explaining the growth in the volume of physician services.

NOTES

1. The total quantity (Q) is equal to population (p) times volume per capita (v). If f represents the fee or price per service, then total expenditures are initially:

$$E = fQ = fpv$$

If expenditures grow at a total rate g, fees grow at rate g_f, population grows at rate g_p and volume per capital grows at rate g_v, then expenditures in the second period are:

$$E(1+g) = E(1+g_f)p(1+g_p)v(1+g_v)$$

$$\text{so} \qquad g = g_f + g_p + g_v + g_f g_p + g_f g_v + g_p g_v + g_f g_p g_v$$

The last four terms are the interactions of the growth rates of fees, population and volume per capita.

2. Medicare Part B enrollment data was from the Social Security Bulletin (1988), Tables 7.B 2, 4 and 5.

3. Medicare Economic Index information is reported in Committee on Ways and Means (1989), pp. 264 and 380.

4. Increases in volume per capita were derived from available data on total expenditures, beneficiary and fee increases by using the relationship linking expenditure growth to population, fee, and volume per capita growth rates given in note 1.

5. The estimates of volume increases associated with greater demand rely on estimates of the demand for physician services showing that volume increases by 1.0% for every 1.0% increase in real income and by 0.1% for every 1.0% increase in the out-of-pocket cost of physician services relative to other goods and services. These estimates are reported in a summary of health care demand studies in Feldstein (1988). The estimate of the percent by which volume demanded increases per percent increase in out-of-pocket costs used in this analysis is at the low end of the range of estimates reported by Feldstein. Insofar as possible, estimates of the sources of per capita utilization increases used in this analysis were based on comparisons of data between 1983 and 1987. When this was not possible, data for the most nearly comparable period were used.

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Table 1

Average Annual Percent Increase in Volume of Physician Services per Capita Among Medicare Enrollees, by Demand Source, 1983-1987

Source of Demand Effect	Average Annual Percent Increase
Aging of the average Medicare enrollee	+0.1%
Increase in the share of enrollees served each year	+3.6
Increase in real after-tax household income	+2.0
Change in real out-of-pocket price per service faced by Medicare enrollees	
Reduction in average real balance bills (charges in excess of the Medicare allowed charge on unassigned claims) per Medicare enrollee	+0.1
Increase in real coinsurance	0.0
Effect of Medigap coverage	+1.0
Total increase in volume	+7.1%

SOURCE: See text.

Table 2

Distribution of Medicare Enrollees and Reimbursement per Enrollee, by Age Group, 1977 and 1986

Age Group	Enrollment (in millions) 1977	1986	Percent of Enrollees 1977	1986	Reimbursement per Enrollee[a] 1977	1986
65-66	3.3	3.7	13.8%	13.1%	$573	$1,453
67-68	3.2	3.5	13.4	12.4	599	1,604
69-70	2.9	3.3	12.1	11.7	643	1,776
71-72	2.6	3.1	10.9	11.0	681	2,032
73-74	2.3	2.7	9.6	9.6	759	2,199
75-79	4.5	5.5	18.8	19.5	853	2,433
80-84	3.0	3.5	12.6	12.4	965	2,749
85 and over	2.1	2.9	8.8	10.3	1,068	2,946
TOTAL:	23.8	28.2	100.0%	100.0%	$759	$2,146

SOURCE: U.S. Public Health Service, (1988), Table 121, p. 175.

[a]Includes both Part A and Part B reimbursements.

ATTACHMENT III

Medicare Volume Performance Standards (MVPS)

The American Medical Association was pleased that Congress chose to enact Medicare Volume Performance Standards (MVPS) rather than expenditure targets (ETs). In choosing this direction, Congress clearly and unambiguously rejected the ET approach, most notably the full automatic link between expenditures and payment updates.

The MVPS legislation demonstrates Congressional intent to act every year to establish the MVPS and the payment update. It also requires that HHS and the PPRC recommend annual MVPS and payment updates. Of greater importance, these recommendations must be accompanied by detailed analyses of expenditures, utilization, and access; important factors that have yet to be completely understood.

Both HHS and the PPRC have critical roles in the annual MVPS and the conversion factor update. Many who supported ETs, including some within medicine, argued that since ETs would reflect all of the components underlying legitimate expenditure growth (i.e., inflation, growth in enrollees, technology, access, etc.), they would furnish a proper basis for payment updates. Indeed, the MVPS provisions detail such elements for consideration by the Secretary. Hopefully, precise estimates for each of these factors ultimately will be generated. However, the HHS and PPRC MVPS recommendations demonstrate that it not currently possible to develop acceptably precise estimates for each major component in a manner allowing their sensible combination in the formula underlying the MVPS. This is particularly true for elements such as technology change, access and unnecessary utilization where attempts to provide quantification have been quite controversial and unconvincing.

Clearly, Congress has identified an alternate path, the "default" mechanism used if it does not establish the MVPS. This default merely sums price and enrollee growth and the five year annual average of volume/intensity and reduces them by a fixed percentage, ultimately 2%. The promise of the finely honed MVPS may simply recede over time to this more prosaic and cautious default approach, and we should not pretend

that the default mechanism is anything more than this. In considering potential MVPS uses, Congress should be extremely sensitive to the current limitations in this measure.

In particular, the American Medical Association is concerned about tying physicians and their patients to attainment of any particular budget-driven MVPS. There is simply no reason to think, for example, that the volume/intensity growth in any year should be the "five year annual average of volume/intensity growth minus 2%." While this may be a reasonable policy goal on average, that may even be attainable over time, it has no real relevance to the true appropriate level of volume in any given year.

Specialty MVPS

Although some physician organizations have supported specialty ETs and volume standards, we believe that Medicare patients and all physicians stand to lose from such approaches. In particular, specialty and type-of-service standards and updates undermine the fundamental professional commonalities shared by physicians. They encourage clinical and socioeconomic fragmentation. They offer the illusion that only smaller more specialized groups can achieve the best outcomes for their patients and members. They undermine fundamental premises of effectiveness research and practice parameters by focusing on intra-specialty treatment decisions.

Specialty and type-of-service standards and updates place physicians in a narrow target at greater risk that their target will be exceeded as a result of unforeseen treatment advances or forecasting error. For example, between 1982 and 1987, surgery accounted for 42% of Medicare physician expenditure growth, with much of the growth concentrated in a few specialties and procedures. In a surgical MVPS, all surgeons, and only surgeons, would have borne the risk associated with these few services. Finally, such standards may stifle innovations in care by discouraging greater than anticipated growth in particular clinical modalities, "holding harmless" expenditures on services and specialties that exhibit little volume/intensity growth.

Moreover, specialty and type-of-service standards with differential payment updates would undermine the root premise underlying payment reform, basing payments on relative resource costs. Such updates raise the specter that the full cross-specialty resource-based relative value scale (RBRVS) can never be updated because relative payments will increasingly reflect non-resource factors as a matter of policy. A specialty-level MVPS could retain resource-based payments within a specialty. But the aim of the RBRVS was never simply to create within-specialty RBRVSs. That goal could have been satisfied at much lower cost to the federal government and the medical profession. Instead, physicians have been told that an RBRVS payment schedule was so essential that payment differentials not based in resource costs must be eliminated, even at the risk of potentially severe financial dislocations. It is inconceivable that this principle could now be casually discarded.

Also, a specialty MVPS, even without differential payment updates, poses many of the same obstacles that led the PPRC and many within the medical profession to avoid specialty differentials. For example, how do you identify a specialist or a specialty service? Who is a surgeon and what is surgery? These questions assume crucial importance if a specialty MVPS is intended to encourage peers to work together on utilization. Moreover, how can specialty differentials based on training be rejected as violating a principle of equal payment for the same service while allowing differentials based on performance against a "volume standard"?

How would a specialty or type-of-service MVPS be established and updated? As the PPRC carefully outlined in its recent report to the Congress, the many MVPS components which are very difficult to estimate will be even more elusive for specialty or type-of-service, especially in the stifling context of competition for shares of an overall MVPS.

Separate MVPS calculations would require profound and radical social judgements on the proper configuration of medical practice. Simply basing volume standards on past trends is equalling disturbing, consigning low growth services to a low growth allowance. Such an approach is especially questionable if payment reform is intended to alter incentives to provide certain services. In sum, specialty and type-of-service volume standards will prove woefully inflexible in the face of rapid changes across such artificial boundaries in patient demand, medical practice, and technology.

Geographic MVPS

The payment reform legislation clearly established the hard won principle that geographic payment differentials shall be based on resource cost differences and access considerations. At the same time, the Secretary must report to Congress by July 1, 1990 on the feasibility of geographic MVPS. We understand that there are substantial issues of data adequacy and geographic variability in utilization and its year-to-year growth. In addition, of course, are broader questions, like proper state-level rates of technology change. Our understanding is that the PPRC would deal with such issues through a variety of complex adjustments. Such attempts to moderate the effects of a geographic MVPS only serve to suggest that this is not the best route.

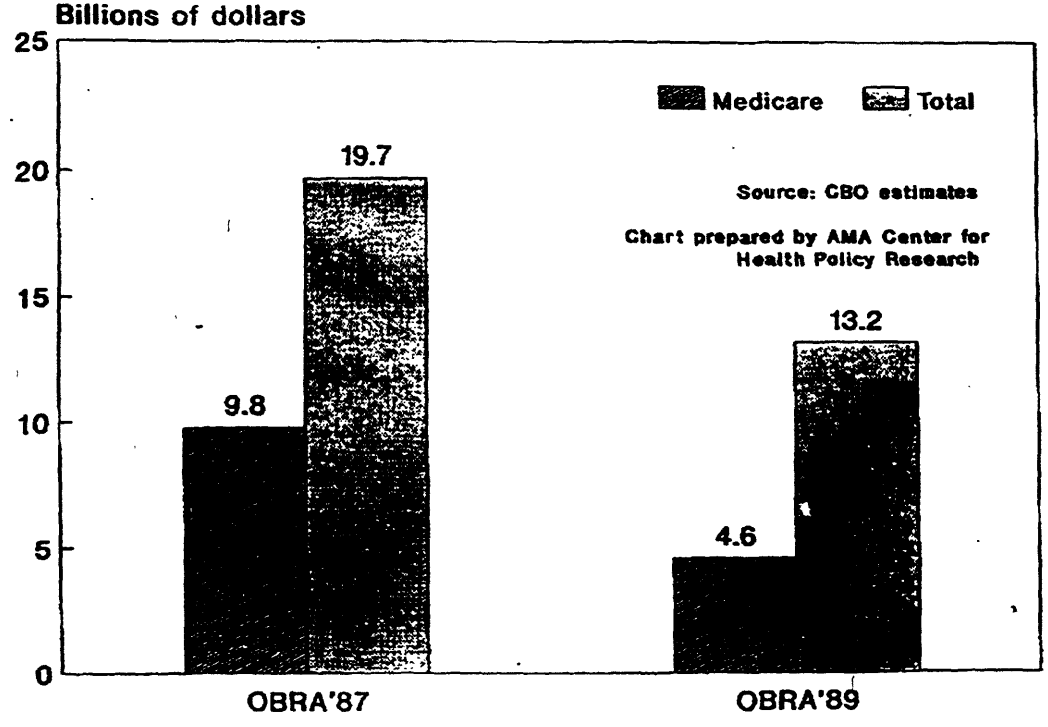
The state is still a large unit in which to influence physician behavior through MVPS. Incentives clearly will be diluted almost as much as at the national level. Indeed, a state MVPS would require adjustments that further diminish these incentives. At the same time, these adjustments would needlessly explode the complexity and administrative requirements of the new "simplified" payment system. What would a state MVPS really produce, and at what cost? At a minimum, experience certainly is needed with the national MVPS before considering such an untried step.

Group MVPS

The Secretary of HHS also has a Congressional mandate to study MVPS "carve-outs" for groups of physicians, and is to report on this by April 15, 1991. The PPRC must review and comment on this by May 15, 1991. Clearly many technical issues exist, and we eagerly await these reports. But analyses to date leave us very concerned. We especially challenge the logic of the underlying notion that "efficient physicians" should be removed from the general MVPS.

Even if a separate MVPS would only reward truly efficient practices, and not those with less ill patients, a carve-out will make those physicians least able to increase clinical "efficiency" most subject to the overall MVPS, which will be increasingly difficult to meet. It would discriminate against physicians for whom joining a group is neither feasible or appropriate. Finally, it might subject those Medicare patients that have chosen not to join an HMO or PPO to financial incentives that they have chosen to avoid. We are pleased that the PPRC opposed this approach in its recent report to Congress.

Budget Cuts Due to Reconciliation Acts



Figures are cumulative, multi-year effects due to budget act

PREPARED STATEMENT OF GAIL R. WILENSKY

Mr. Chairman and Members of the Subcommittee: The physician payment reform legislation enacted last year represents an important step towards achieving our mutual goals of containing Medicare physician spending, making Medicare payments to physicians more equitable, and protecting Medicare beneficiaries financially. The Medicare Volume Performance Standard (MVPS) rates of increase are an integral component of this legislation. I am happy to be here this morning to discuss the Administration's MVPS recommendation for FY 1991.

MEDICARE PHYSICIANS' SERVICES EXPENDITURE GROWTH

As we begin discussions of an appropriate MVPS for FY 1991, we should remember that Medicare expenditures for physicians' services continue to grow at unacceptably high rates. Between 1984 and 1990, Medicare physician payments increased at an average annual rate of 12.0 percent per year. It is rather sobering to consider that over the next 10 years, if present trends were to continue and even without any program expansions, Medicare spending for physicians' services would likely triple.

For FY 1991, the Health Care Financing Administration (HCFA) Actuary currently projects a 13.2 percent rate of growth in Medicare physician payments. Not only is this growth rate more than twice the rate of inflation, it is also much higher than the growth rates of other social programs. For example, Medicare payments to hospitals increased at an average annual rate of 6.7 percent between FY 1984 and FY 1989. Over the same period, Social Security payments increased at an average annual rate of 5.5 percent. Clearly, in this time of Federal budget deficits, we cannot continue to ask American taxpayers to subsidize such large increases in physician spending.

FY 1991 MVPS RECOMMENDATION

The Secretary is required to recommend an MVPS for the following fiscal year on April 15 of each year. The Physician Payment Review Commission (PPRC) comments on the Secretary's recommendation by May 15 of each year. If Congress does not act on the Secretary's recommendation, the MVPS rates of increase will be established through a default mechanism set forth in the law.

The MVPS system holds promise for moderating increases in Medicare physician expenditures. We believe that our recommendation defines an acceptable rate of growth for Medicare physician spending for FY 1991.

Our overall recommendation for the FY 1991 performance standard rates of increase is 9.9 percent for all services, with a rate of 8.7 percent for surgery and 10.5 percent for non-surgery (see Table 1). Note that our recommendation is based on current economic data, which could change later in the year. For example, our estimate of inflation could change between now and October when the Medicare Economic Index (MEI) is usually calculated.

Importantly, we recommend adjusting the standard to account for legislation enacted at a later date. If an adjustment is not made, the standard would be established and measured relative to a baseline rate of increase that is no longer applicable. Let me spend a moment explaining our rationale on this point.

In calculating the MVPS, it is important to distinguish between changes in Medicare outlays resulting from changes in the volume and intensity of physicians' services, and changes in Medicare outlays resulting from new legislation. Changes in law or regulation which affect Medicare benefits or the prices paid for Medicare services will raise or lower the baseline rate of increase in Medicare physician spending. We believe that physicians should be held accountable only for their own actions, not for program changes enacted by Congress.

RECOMMENDATION FOR SURGERY VERSUS NON-SURGERY

We are making the same recommendation for surgery and non-surgery, except that an adjustment was made for the different effects of the Omnibus Budget Reconciliation Act (OBRA) 1989 on surgery versus non-surgery. We do not believe that any other differential between surgery and non-surgery is justified at this time. Our analysis indicates no difference in growth trends between surgical and non-surgical services that would warrant an adjustment to the recommended MVPS for FY 1991.

On May 3, 1990, we published a notice in the Federal Register specifying the definition of surgical services for purposes of the MVPS. While the definition of surgical services we chose had no effect on the FY 1991 MVPS recommendation submitted to Congress by the Secretary, I would like to mention the definition we chose for the

record. We define surgical services as those services reported on the Medicare claims form as surgery performed by surgical specialists and services performed by assistants-at-surgery. Limitations of our current data systems prevent us from establishing a procedure-specific definition. We intend to implement such a definition as our data systems mature. In any event, we would not introduce specialty payment differentials into the fee schedule.

FY 1991 MVPS FACTORS

In making an MVPS recommendation, the Secretary is required by statute to consider:

- Inflation;
- Changes in the number of enrollees;
- Aging of enrollees;
- Technology;
- Evidence of lack of access to Medicare physicians' services;
- Evidence of inappropriate utilization of services; and,
- Other factors that the Secretary considers appropriate.

Allow me to detail for you these factors considered in the development of the Administration's recommended FY 1991 MVPS rates of increase.

Inflation

The MEI is the statutorily mandated measurement of allowable increases in prevailing charges for Medicare physicians' services. Since it is a longstanding and familiar index, we used the MEI as the primary measure of inflation for MVPS purposes. According to the most recent economic projections, the estimated MEI increase for CY 1991 will be 3.2 percent.

In addition to the 1991 MEI increase, four other factors will have an effect on the general level of physicians' fees in FY 1991:

- The differential 1990 MEI increases mandated by OBRA 1989;
- The annual update for laboratory services;
- The increasing numbers of physicians signing participation agreements, and thus receiving a 5 percent payment differential; and,
- The fact that actual and customary charges below prevailing charge levels increase at a faster rate than prevailing charges.

When all of these factors are considered, the "weighted composite inflationary effect" on physicians' fees is estimated to be 3.6 percent.

Changes in the Number of Enrollees

Average Medicare Part B enrollment in FY 1991 is estimated to be 32.732 million. Lowering that figure by the estimated enrollment in risk health maintenance organizations (HMOs) of 1.199 million results in a net figure of 31.533 million Part B enrollees excluding risk HMO enrollees in FY 1991. The corresponding figures for FY 1990 are 32.308 million, 1.134 million, and 31.174 million, respectively. These figures reflect an increase, exclusive of risk HMO enrollees, of 359,000, or 1.2 percent, for surgery and non-surgery.

Aging of Enrollees

The effects of the aging of the Medicare beneficiary population would add 0.1 percentage points in FY 1991.

Allowance for Other Factors: Technology, Access and Utilization

While we cannot measure their precise effects, for purposes of calculating the FY 1991 MVPS, we recommend allowing 3.7 percentage points for other factors such as new growth in technology, access, and utilization. This is one-half of the 7.4 percent estimated annual growth in expenditures for the period FY 1986 to FY 1990 in excess of that attributable to inflation, enrollment, and aging. In developing this recommendation, we examined the impact of factors other than inflation and enrollment on growth in physicians' services for the total population of the United States. National per capita expenditures for all physicians' services—Government programs, private insurers, and non-insured private payors—increased at an average rate of 3.3 percent above price increases for the period 1984 to 1988. This 3.3 percent is quite comparable to our recommended increase in factors other than inflation, enrollment and aging of 3.7 percent.

Technology.—A quantitative factor for technology has not been separately identified in the calculation of the FY 1991 MVPS because no definitive data or studies are currently available to the Department to quantify the effects of technology on

total expenditures for physicians' services. Even where the costs directly associated with a new technology can be measured, it is difficult to determine whether the ultimate impact of the technology (after medical improvements are taken into account) is to reduce or to increase total costs. For example, new imaging or diagnostic techniques, although more costly than an older technique, may reduce the need for other medical or surgical procedures. We will be working with the research and physician communities in trying to quantify the effects of technology in the future.

Evidence of Lack of Access to Medicare Physicians' Services.—Access to health care depends upon many variables, including the number and availability of hospitals and physicians and the mix of physician specialties in the area. One measure of access to care is the willingness of physicians to accept the Medicare allowance as payment in full. I would note that Medicare physician participation rates have climbed steadily since the inception of the participating physician program. Participation rates are currently at an all-time high, having increased from 28 percent of all physicians in 1985 to over 40 percent in 1989. The percentage of Medicare claims paid on an assignment-related basis has also increased—from 64 percent of all Medicare claims in 1985 to over 80 percent in 1989. We have no evidence of a general access problem for Medicare beneficiaries.

To help ensure access for Medicare beneficiaries in rural and inner city areas, Congress passed legislation in OBRA 1987 providing a 5 percent bonus payment for physicians' services provided in areas designated as health manpower shortage areas by the Public Health Service. In OBRA 1989, Congress increased this bonus to 10 percent, and expanded the areas covered by the bonus, effective January 1, 1991.

We are continuing to examine the issue of access to physicians' services for Medicare beneficiaries. A 5-year contract has just been awarded to conduct a survey of current Medicare beneficiaries. The Current Beneficiary Survey (CBS) is scheduled to begin in 1991. One of the purposes of this survey is to assess the effects of physician payment reform, including access to services, on Medicare beneficiaries. Also, OBRA 1989 requires the Secretary to monitor access and utilization of services and to report to Congress each year beginning in 1991 on the effect of physician payment reform on access and utilization. This report and the CBS survey will help us to assess the effect of physician payment reform on access and utilization in setting future MVPS rates of increase.

Evidence of Inappropriate Utilization of Services.—Over the years, several studies have indicated that between 5 and 30 percent of services performed may be inappropriate. Many reasons have been advanced for this situation, including lack of knowledge among physicians concerning the effectiveness of medical services. We also know that the availability of physicians and hospital beds, how physicians are paid, practice patterns that vary by specialty and/or geography, "upcoding" and unbundling affect utilization of health services. However, while we know that some portion of historical growth in volume and intensity of physicians' services is attributable to *inappropriate* utilization, the exact amount attributable to inappropriate utilization cannot be determined at this time.

In order to begin assessing the effectiveness of medical practice, the Department is pursuing a Medical Treatment Effectiveness Initiative designed to highlight "what works" in the practice of medicine. The Agency for Health Care Policy and Research has initiated an ambitious research program in order to make judgments about the appropriateness and effectiveness of particular services. We look forward to knowing the results of this effort.

OBRA 1989

In recommending the FY 1991 MVPS, we considered only one additional factor: the impact of legislative changes enacted in OBRA 1989. The Actuary estimates that OBRA 1989 will result in increases in FY 1991 of 1.9 percentage points for non-surgical services and 0.1 percentage points for surgical services. This difference is primarily due to the expansion of mental health services and the coverage of screening pap smears, both of which have little or no effect on surgery.

FY 1991 LEGISLATIVE PROPOSALS

The Administration's FY 1991 budget proposes a number of legislative changes designed to prevent building into the new payment system the inequities of the current system. The proposals are consistent with the goals of the fee schedule, but many of them are designed to eliminate past excesses. Allow me to describe our FY 1991 physician proposals.

Our FY 1991 savings proposals can be grouped into three broad categories:

- A proposal to provide the full MEI update for primary care services only;

• Proposals to ensure that over-valuations are not built into the reform base; and,
• Other proposals which represent solid health policy, independent of fee schedule implementation.

Our savings proposals would slow the rate of growth in physician expenditures from 13.2 percent to 8.0 percent. Even under our plan, Medicare will spend almost $2 billion more for physicians' services in FY 1991 than in FY 1990.

Update for Primary Care Services Only

We propose providing the full MEI update in 1991 only for primary care services. In addition to helping control spending for physicians' services, this proposal helps increase the relative price of primary care services versus other medical services, consistent with what will occur under the resource-based fee schedule. Under the Administration's proposal, the cumulative difference in updates between primary care and other services for the years 1988–1991 would total 13.1 percentage points.

Overvaluations

Reduce Medicare Payments for Over-valued Procedures.—In OBRA 1989, Congress reduced payments for 245 overvalued procedures by one-third of the amount by which they were overvalued compared to an estimated resource-based fee schedule, up to a maximum reduction of 15 percent. For 1991, we are proposing to reduce payments for overvalued procedures by two-thirds of the remaining amounts by which they are overvalued, up to a maximum reduction of 25 percent.

There is widespread agreement that significant overvaluation remains in Medicare payment amounts: PPRC and the Harvard study have documented such evidence, and Congress has recognized it by enacting the OBRA 1989 provision reducing Medicare payments for overvalued procedures. In this time of budget deficits, such overvaluation must be removed from the Medicare payment system.

Reduce Global Fees for Surgeons.—We propose reducing Medicare global fees for surgeons by either 2 percent across the board or a procedure specific amount for the highest volume surgeries.

Surgical global fees cover payments for the surgery itself, as well as in-hospital and post-discharge visits by the physician. However, between 1981 and 1987, the average length of stay decreased by 0.9 days for Medicare surgical admissions. In addition, the average length of stay for many procedures commonly performed on Medicare beneficiaries has dropped considerably over this period (3.7 days for transurethral prostatectomies, 5.2 days for total hip replacements, and 6.6 days for total knee replacements). Further, HCFA-funded research found no offsetting change in the number of post-discharge visits reported by surgeons between 1982 and 1987. Thus, global fees currently are overstated because they implicitly contain amounts for inpatient visits which are no longer being provided.

Reduce Radiologist and Anesthesiologist Fees.—While OBRA 1989 reduced payments for radiologist and anesthesiologist fees, HCFA data show that these services remain overvalued by as much as 15 percent. Under our proposal, we would calculate the national average radiologist and anesthesiologist conversion factors, reduce them by 10 percent, and apply a geographic practice cost index (GPCI) to approximate what would occur under the new fee schedule. We propose reducing the actual conversion factor in a locality by the amount that it exceeds this estimated conversion factor. No conversion factor would be reduced by more than 25 percent. Thus, while these services are overvalued by about 15 percent, our proposal would reduce payment for them by only 10 percent.

Reduce Medicare Payments in Over-valued Localities.—In addition to reducing Medicare payments for overvalued procedures, we are proposing to reduce payments for certain procedures in localities where payments are overvalued relative to the national average. This proposal would help reduce the extreme variations in Medicare payments across geographic areas, and it is very compatible with the phase-in to the fee schedule.

Other Policies

Phase-in Medicare Fee Increases for New Physicians.—We propose to continue to expand the current policy of limiting Medicare payments to first and second year physicians by limiting payments to third and fourth year physicians as well, both under the current system and under the fee schedule. The proposal would limit first year physicians to 80 percent, second year physicians to 85 percent, third year physicians to 90 percent, and fourth year physicians to 95 percent of the Medicare amount they would otherwise receive.

It is plain common sense to adopt a payment policy which takes into account the experience of the practitioner in determining payment amounts. The vast majority

of American workers earn more as they gain experience. Indeed, many health maintenance organizations (HMO's) have already recognized this fact. HCFA-funded research on HMO salaries revealed that HMOs pay less experienced physicians less than those with more experience.

Reform Payments for Assistants-at-Surgery.—We propose reforming Medicare payments for assistants-at-surgery by making the same payment for a surgery, regardless of whether or not a physician is used as an assistant-at-surgery. To accomplish this, the Medicare payment for the primary surgeon would be reduced by an amount equal to the Medicare payment for the assistant-at-surgery. Exceptions to this general rule would be allowed to adequately respond to difficult surgeries or patient conditions.

In FY 1991, Medicare payments for assistants-at-surgery will total about $500 million. However, evidence raises questions about the appropriateness of this level of expenditure. For example, a HCFA-funded study found that the use of assistants-at-surgery varies considerably by geographic region: in the Pacific and Mountain regions, assistants are billed for in 33 and 31 percent of inpatient surgeries, respectively. In contrast, assistants are billed for in only 10 percent of inpatient surgeries in the East South Central region, and 11 percent in the East North Central region. Such wide variation in practice styles should not be subsidized by the Medicare program. Furthermore, in 20 percent of surgeries involving assistants, the assistant is a physician other than a surgeon.

Median Cap on Technical Component of Diagnostic and Radiology Tests.—Technical components of diagnostic tests are frequently billed separately from professional components when there are large capital costs for equipment used in the tests (for example, electrocardiograms and stress tests). Currently, substantial geographic variation exists in Medicare prevailing charges and conversion factors for diagnostic technical components. We propose capping Medicare payment for technical components of diagnostic tests at 100 percent of the national median prevailing charge, and at 100 percent of the technical component of the radiologist fee schedule conversion factor for radiology tests. Leveling out payments for technical components across geographic areas has worked well for clinical diagnostic laboratory tests, and we believe that such an approach will be successful for diagnostic and radiology tests.

Limit on Anesthesia Payments to a Single Fee.—We propose making the same payment for anesthesia care, whether performed by an anesthesiologist or by a certified registered nurse anesthetist (CRNA) under the medical direction of an anesthesiologist. If a CRNA is used, the CRNA payment would be subtracted from the anesthesiologist's supervision fee. Amounts paid to CRNAs would not change. By paying a single fee for anesthesia services, the excessive payments for these services would be reduced, and anesthesiologists who do their own work, rather than medically directing others, would be treated more fairly.

Voluntary Hospital Physician Participation.—We will allow hospitals to voluntarily sign Medicare participation agreements on behalf of their hospital-based physicians, effective January 1, 1991. While the 5 percent payment differential given to participating physicians would not apply (unless individual physicians sign participation agreements), the marketplace benefits of participating would accrue to the hospital. We will carry out this proposal under current statutory authority.

Beneficiaries often do not have a choice of physicians when the services of a hospital based physician are required (radiology, anesthesiology, pathology, emergency services and consultations, for example). We believe that encouraging hospital medical staffs to participate in Medicare will help protect beneficiaries from balance billing when they have less opportunity to choose a physician. We also believe that hospitals should be given the opportunity to use their participation status as a marketing tool in the current competitive health care marketplace.

CONCLUSION

In concluding my remarks, I would like to mention that implementation of physician payment reform is proceeding well. The implementation process is extremely complex, and the timeframes imposed by the law are challenging. Of course, among the most critical pieces of information is the results of Phase II of the study being prepared by researchers at Harvard University. I personally met with Dr. Hsiao last week, at which time he assured me that he would deliver results from Phase II of the Harvard study to HCFA not later than September 30, 1990.

Implementation on January 1, 1992, will require our best efforts, but we can—and we will—meet the challenge. I look forward to keeping you informed of our progress in implementing this landmark legislation over the coming years.

I would be pleased to answer any questions you may have.

Table 1.—COMPONENTS OF FY 1991 MVPS RECOMMENDATION [1]

Factor	Estimated Effect		
	Surgery	Non-surgery	All Services
Inflation	3.6	3.6	3.6
Enrollment	1.2	1.2	1.2
Aging	0.1	0.1	0.1
Factors Other Than Inflation, Enrollment and Aging	3.7	3.7	3.7
OBRA 1989	0.1	1.9	1.3
Total	8.7	10.5	9.9

[1] Adjusted to account for changes in pricing and benefits resulting from legislation enacted this year affecting FY 1991 Medicare physician outlays.

COMMUNICATIONS

STATEMENT OF THE AMERICAN SOCIETY OF PLASTIC AND RECONSTRUCTIVE SURGEONS, INC.

Mr. Chairman, the American Society of Plastic and Reconstructive Surgeons (ASPRS) appreciates the opportunity to present testimony to your Subcommittee on Medicare and Long Term Care. We have worked closely with the American College of Surgeons and other surgical specialties on physician payment reform and now are particularly involved in efforts to refine the methodology for establishing Medicare volume Performance Standards (MVPS).

ASPRS has been strongly supportive of a separate target for surgery. We were enthusiastic about the Finance Committee's establishment of a surgical MVPS in last year's legislation and think that distinguishing between surgery and non-surgery will enhance your ability to address volume considerations now and in the future. Two indications that your judgment was correct have appeared recently. The report of the Secretary of Health and Human Services (HHS) recommended different MVPS for surgery and non-surgical services and noted that prior legislation was a key factor in this difference. Then, the report from the Physician Payment Review Commission (PPRC) also set different levels for the two standards, in this instance underscoring the rationale that the volume of surgical services in 1991 is predicted to increase at a slower rate than non-surgical services. It is noteworthy therefore that both HHS and PPRC set a different MVPS for the two standards and this reinforces the conclusion that surgery and non-surgery MVPSs should properly be separate. The scope of medicine is indeed too broad and complex to place volume concerns within a single homogeneous grouping. Future volume-related discussions must be addressed in terms of at least two distinct physician groups, surgeons and non-surgeons.

In assessing the methodology through which HHS and PPRC arrived at the targets for 1991, we believe more focus must be put on the historical growth rate in expenditures. The HHS and PPRC levels represent approximated data due to currently unavailable information. Reductions in the projected volume growth made by HHS, for example, were based on half of the average growth in volume and intensity over the past few years. Further, PPRC made a 2 percent reduction in the Medicare actuary projected rate of growth of expenditures to compensate for insufficient data.

The key here is to provide more precision in the factor that measures changes in technology. ASPRS is working with the American College of Surgeons to compile more complete information on new developments in plastic surgery and the frequency of their use for Medicare patients. By achieving greater precision here, ASPRS believes that this will bring more accuracy and stability to physician payment adjustments. Surgery hopes to provide you with this input in time for FY92 MVPS recommendations.

Development of practice guidelines and work with carriers and PROs will result, we expect, in decreases in volume growth through the reduction of inappropriate care. This does indeed contribute to the welfare of Medicare recipients by ensuring access to appropriate, high quality care. Yet, at the same time, we must give significant attention to developments, outcomes and the consequences of reducing Medicare outlays.

Again, ASPRS appreciates the courtesy of the Committee in considering its views.

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