The Heritage Foundation Backgrounder

No. 732 | The Heritage Foundation • 214 Massachusetts Avenue N.E. Washington, D.C. 20002 (202)546-4400

October 25, 1989

THE MEDICARE RELATIVE VALUE SCALE: COMPARABLE WORTH FOR DOCTORS

INTRODUCTION

Congress soon will take final action on legislation that would change sharply the way that Medicare pays for physicians' services and outpatient treatment for the elderly. The measure is contained in the fiscal 1990 Budget Reconciliation Bill as approved by the House of Representatives. The Senate, however, removed this and many other provisions from its version of the Reconciliation bill, and a conference committee is now working to resolve the differences. While these provisions so far have received surprisingly little attention, they have sweeping implications for government spending and for the medical profession.

Under the legislation, Congress would impose a new price-fixing system, known as the "resource-based relative value scale" or RVS, to determine the amount that Medicare will pay for each of several hundred different procedures performed by doctors. It also, starting next year, would set annual "expenditure targets" for the total amount that the federal government spends on Part B of Medicare, the segment of the program that reimburses physicians' services. In recent years, Part B spending has been spiraling at annual rates of more than 13 percent, and it is projected to continue escalating into the future. This alarming situation is forcing Congress to search for new ways to restrain Medicare payments.

Quantifying Variables. The RVS and expenditure target strategy is the product of a study conducted for the government by a team of social scientists at Harvard. The study sought to determine the appropriate fees for hundreds of medical procedures by estimating and calculating the "value" of a physician's work involved in performing different treatments. The social

scientists sought to quantify such variables as the time, intensity, mental and physical effort, skill, judgment, and stress that go into the job of providing each medical service.

In its basic concept, the RVS system is similar to the now widely discredited concept of "comparable worth," a scheme for ranking jobs on the basis of statistical measurements of education, levels of difficulty, and the time and skill necessary to perform a task.[1] Like comparable worth, RVS is based on the assumption that the market has failed. Both schemes attempt to compensate for this alleged market failure by imposing arbitrary values on work. And both exhume the long buried labor theory of value as the basis for determining compensation.

Debased Care. The RVS/expenditure target system is no answer to the problem of runaway health costs. In fact, it will make matters worse. The reason: Because the proposed system excludes the market forces of supply and demand in determining the value and price of medical services, it will distort medical care prices even further and create shortages of medical care. The result will be a debased quality of care to Medicare beneficiaries.

Instead of adopting the RVS/expenditure target system, Congress should restrain Medicare spending by increasing the annual Part B Medicare deductible from $75 to $250 and by requiring physicians to disclose their fees, in advance, to their patients. In addition, the federal government should make incremental changes in Part B fees in ways that induce the supply of services to match the demand – an approach very different from the spurious comparable worth RVS approach. Congress also should reform the tax treatment of private health insurance and medical expenses for all Americans so that consumer choice is the primary regulator of health care prices. In this regard, a key reform would be to end the tax-free status of company-based health plans and instead institute health care tax credits for families. Thus, Congress would help reduce health costs for all Americans, including the elderly, without shortages and distortions throughout the health care market.

THE PROBLEM OF RISING HEALTH CARE COSTS

For more than a decade, U.S. health policy has been driven by growing concern in both government and private industry over the rapidly escalating costs of medical care. Total national health expenditures have grown from roughly $250 billion in 1980 to about $540 billion last year, or from 9.1 percent of gross national product (GNP) to 11.2 percent. During the same period medical care prices have, on the average, increased twice as fast as general inflation.

1 For an analysis of comparable worth, see Robert Rector, "The Pseudo-Science of Comparable Worth: Phrenology for Modern Times," Heritage Foundation *Backgrounder* No. 635, February 29, 1988.

The problems in government health programs such as Medicare have been even worse than in the private sector. In 1980, Medicare cost $35 billion; last year, the program spent an estimated $87.6 billion. Even adjusted for general inflation, this is 73 percent real growth in the past eight years.

Medicare's Two Parts. The Medicare program is divided into two parts, Part A (Hospital Insurance or HI) and Part B (Supplemental Medical Insurance or SMI). Part A pays for most hospital care for the elderly, as well as for some skilled nursing and home health care. It is financed by a portion of the Social Security payroll tax imposed on workers.[2] All retirees automatically qualify for Part A Medicare coverage when they become eligible for Social Security. Nonelderly, disabled Americans become eligible for Medicare Part A after receiving Social Security disability payments for more than two years.

Part B of Medicare pays for a large share of outpatient physician services and related items for the elderly. Part B is a voluntary program available to all Part A beneficiaries. Those who choose to enroll in Part B pay a flat premium for coverage. Premium revenues fund 25 percent of the cost of Part B benefits; the remainder is funded out of general federal revenues. Over 95 percent of the elderly currently are enrolled in Part B.

In an effort to control Medicare spending, Congress in 1983 enacted the "prospective payment system" (PPS) as a price-fixing scheme for Medicare Part A, which pays for in-hospital services for the elderly. While PPS has slowed the growth in spending in Part A, the cost of Part B, which pays for physician and outpatient services, has continued to escalate at double digit rates.

Medicare Outlays, Fiscal Years 1983-1988

Fiscal Year	Part A		Part B	
	Dollars (in millions)	Percent increase (over prior year)	Dollars (in millions)	Percent increase (over prior year)
1983	38,624	10.8	18,311	17.7
1984	42,108	9.0	20,372	11.3
1985	48,654	15.5	22,730	11.6
1986	49,685	2.1	26,217	15.3
1987	50,803	2.3	30,837	17.6
1988	52,730	3.8	34,947	13.3

Source: 1987 Annual Report of the Board of Trustees: Federal Hospital Insurance Trust Fund and Supplementary Medical Insurance Trust Fund and CBO and HCFA, Office of Management and Budget projections for 1989 through 1994 under current law.

2 The current HI tax is 2.9 percent of all wages up to $48,000, with employees paying half directly and employers paying half.

Shift to Outpatient Services. Among the factors responsible for this growth in Medicare Part B spending are a larger volume of services, the growth in the size of the elderly population, and higher fees for some physicians. Also playing a major role are the introduction of new medical technologies and recent changes in hospital reimbursements. Recent technological developments make it possible to treat more conditions outside of hospitals: in doctors' offices, at surgical centers, or with prescription drugs. Both Medicare, in its reimbursement structure, and the private sector, through insurance, have encouraged patients to make greater use of these outpatient services. The result has been a shift in spending from hospital to outpatient physician services.

This has had unintended effects on spending for hospital care. More and more hospitals have established their own outpatient surgical centers, clinics, and laboratories, to take advantage of the preferential Medicare and private insurance reimbursement rates. In some cases, the cost of a hospital-based outpatient procedure now is greater than if it were performed either inpatient at the hospital or at a true outpatient center.

The proposed RVS and expenditure target system are an attempt by Congress to address these and other problems by extending to Medicare Part B the price control strategy imposed on Part A in 1983.

HOW MEDICARE PART B WORKS

Under Medicare Part B, beneficiaries must pay the first $75 of medical costs each year. After that, Medicare pays 80 percent of what it considers to be the "reasonable" or "approved" charges for the services the beneficiary receives. The beneficiary must pay the remaining 20 percent (called coinsurance), plus any additional amount the doctor charges. The amount that a doctor charges above the Medicare approved rate is known as "balanced billing." If a doctor accepts the Medicare-approved charge as payment in full for a service, it is known as accepting "assignment."

In 1984, Medicare established a program under which physicians can agree to accept assignment for all services provided to their Medicare patients. Doctors who enroll in this program are called "participating" physicians. The program can be attractive to doctors because Medicare provides somewhat higher reimbursements to participating physicians and advertises their availability to beneficiaries. Nonparticipating physicians can accept or refuse assignment on a claim-by-claim basis. In 1988, some 37.3 percent of doctors agreed to be participating physicians in Medicare, while doctors as a whole accepted assignment of the Medicare-approved charge for 76.3 percent of all claims billed to Medicare.[3]

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3 *Background Material and Data on Programs Within the Jurisdiction of the Committee on Ways and Means* (Committee on Ways and Means, U.S. House of Representatives) 1989 edition, March 15, 1989, pp. 393, 395.

HOW MEDICARE PAYS DOCTORS

Medicare pays for most physician services on a fee-for-service basis.[4] For each claim, the price that Medicare considers to be the reasonable or approved charge is the lowest of:

1) the physician's actual charge for the service,

2) the physician's customary charge for the service, or

3) the prevailing charge for the service in a particular locality.

This method of calculating physician payments is known as the customary, prevailing, reasonable charge system, or CPR. In practice, Medicare uses each doctor's customary charges and the local prevailing charges as benchmarks, or fee-screens, in determining whether the actual charge a doctor submits on an individual claim is reasonable. In 1975, Congress established a Medicare Economic Index (MEI) to measure overall changes in the operating expenses and earning levels of physicians. Congress then required Medicare to limit its annual increases in the prevailing rates to the MEI. Thus, if the MEI increased by 5 percent in a given year, Medicare could raise the prevailing rates for the following year by no more than 5 percent. Before 1984, Medicare updated the customary and prevailing fee-screens each July.

Congressional Tinkering. Since 1984 Congress on several occasions has enacted legislation to change the reimbursement formula. It has canceled or delayed, for instance, annual increases in Medicare's prevailing rates, increased the rates by arbitrary percentages, specified changes in the way the MEI is calculated (to give higher rate increases to certain categories of doctors), or placed percentage limits on the balanced billing amounts nonparticipating doctors can charge their patients.

THE DEVELOPMENT OF THE RESOURCE-BASED RELATIVE VALUE SCALE (RVS)

The basic CPR, or prevailing charge, system dates back to the 1930s and 1940s, when physicians helped design it as a way to obtain favorable reimbursement rates from insurers. In essence, CPR became a system in which doctors were paid whatever they charged as long as it was not too

4 Under a managed care system, such as a Health Maintenance Organization (HMO), the provider is paid a set, annual fee for providing all necessary medical care to the patient. In contrast, under a fee-for-service system the provider bills separately for each service or package of services provided to the patient. For example: a doctor could bill separately for an office visit and each of two tests, even though all three services were provided at the same time. Similarly, a surgeon could bill separately for each of the specific services he provides, or he could simply charge one price, sometimes called a global fee, for all the services included in performing a particular operation.

outrageous. Together with the cost-plus systems used until the 1980s to pay hospitals, CPR historically has been one of the main causes of escalating U.S. health care spending and costs. When Congress created Medicare and Medicaid in 1965, it simply replicated this flawed payment system in the new government programs.

Divorced from Real Market Prices. The changes made by Congress in Medicare's CPR system since 1975 have served mainly to increase paperwork and confusion for both doctors and patients, yet have done relatively little to restrain the growth in Medicare Part B spending. The result has been a payment system for doctors that is still inflationary, but it is also bureaucratic and largely divorced from any concept of real market prices for medical care.

Faced with rising Medicare costs, Congress in 1985 ordered the Department of Health and Human Services (HHS) to study Medicare physician reimbursements and develop a new "relative value scale" to use in setting physician fees. The study, completed in September 1988, was conducted by a team of social scientists under the direction of William C. Hsiao, Professor of Economics and Health Policy at Harvard University. The study attempts to determine the "true" value of over 400 medical procedures performed by doctors in eighteen different medical specialties.

Conference Committee Decision. Earlier this year, HHS sent the report to Congress, and this summer the House Ways and Means Committee approved the inclusion of RVS as a physician payment reform measure in its fiscal 1990 Budget Reconciliation package. The Senate, however, removed this and many other provisions from the Reconciliation Bill, and it is now up to a conference committee to decide what will be contained in the final version of the legislation. The Bush Administration supports the proposal.

As the proposal now stands, RVS would be phased in between 1991 and 1995. New physician fees based on RVS gradually would replace those set under the old CPR system. At the same time, the House bill proposes reducing the amounts doctors are allowed to charge in balanced billing, and introducing a new procedure for setting annual expenditure targets for the entire Medicare Part B program.

The Rationale for RVS

The central assumption of RVS advocates, as stated by Harvard's Hsiao, is that the market has not worked, and the rise in American health care costs is a result of this market failure. RVS advocates contend that consumers are ignorant and incapable of making intelligent choices about medical care.[5]

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5 William C. Hsiao *et al.*, "Estimating Physicans' Work for a Resourced-Based Relative-Value Scale," *New England Journal of Medicine*, September 29, 1988, p. 835. See also "Insider Interview, William C. Hsiao," *Health Week*, December 12, 1988, p. 26.

They cite as evidence for this view the performance by physicians of unnecessary or inappropriate tests and surgery, including procedures that too often are of questionable benefit or inadvisable given the patient's overall condition or that may even pose a health risk to the patient.[6]

Regulatory Nightmare. These critics further claim that failure of the market is compounded by the failure of federal health care policy. According to Professor Hsiao, the failure to curb rising Medicare costs is not due to a failure of federal regulation but to the wrong kind of regulation. Hsiao argues that it is the doctor who needs to be controlled, since he or she is the "key decision-maker" in the delivery of health care services. The difficulty with Hsiao's scheme is that, while regulating a relatively few hospitals is difficult enough, directly regulating America's one-half million physicians would be a nightmare. Rather than attempt this daunting task, Hsiao argues that the best means of regulating doctors is indirectly by regulating the prices they charge.

In addition to regulating the prices charged by doctors and ultimately controlling Medicare spending for outpatient services, RVS proponents have other objectives. They see RVS as a tool for achieving what they consider to be socially desirable policy goals. In their view, American medicine is too technology-oriented, and this is reflected in existing health care reimbursement systems that favor expensive technology and procedures over the less expensive techniques. Further, they believe the current reimbursement system has encouraged greedy doctors to gravitate toward lucrative specialties, while leaving general practitioners unfairly undercompensated for their simpler, though essential, primary care services. They see RVS as a way to divide the physician reimbursement pie more fairly.

HOW RVS WOULD WORK

According to RVS advocates, distortions in the medical market prevent prices from determining the value of medical service. For Hsiao and his Harvard colleagues, the "true value," or price, of a service is not based on the relationship between the supply of the service and the demand for it. Rather, the true value is based on the resource cost required to perform various kinds of physicians' services. The Harvard study attempts to determine these resource costs for over 400 physicians' services in eighteen different specialties.

Hsiao defines the relative value scale as "an index of the relative levels of resource input spent when physicians produce services or procedures."[7]

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6 William C. Hsiao, "Health Care Costs and Physician Payment Reform," *The DRI/McGraw Hill Economic Outlook Conference*, Washington, D.C., February 15, 1989.

7 William C. Hsiao, *et al.*, "Results and Policy Implications of the Resource-Based Relative-Value Study," *New England Journal of Medicine*, September 29, 1988, p. 881.

Reduced to a Formula. The index is nonmonetary. The resource inputs include the work actually performed, plus the costs of the physician's education and the overhead of running his practice. As social scientists, Hsiao and his colleagues have devised a formula for determining this resource cost in nonmonetary terms. It is:

Resource Based Relative Value = (Total Work) x (1 + Specialty Practice Costs) x (1 + Opportunity Costs of Specialty Training).

In this formula, the measurement of Total Work includes such variables as time, effort, professional judgment and level of skill involved in the procedure – before, during and after the treatment. The Practice Costs include all the overhead of operating a practice, including malpractice liability insurance. Specialty Training refers to the costs of the doctor's medical education.

What characterizes the RVS system is not its emphasis on production costs, for they simply reflect market prices of standard items such as equipment, supplies, office rent, and employee salaries. Rather it is the attempt to measure and quantify a doctor's labor. In fact, the value of work accounts for approximately half of the index used in calculating the relative value scale.[8]

Soft Elements. The Harvard study identifies four essential components of a physician's work: time; mental effort and judgment; technical skill and physical effort; and psychological stress. Although conceding that these soft elements are almost impossible to measure objectively, the study authors nonetheless attempt to measure them, using quantitative methodology from the field of social psychology. To obtain measurements of the skill and effort needed to perform specific treatments, the Harvard study relies on a survey of about 3,000 physicians in the specialties being measured. The doctors surveyed were asked to rate the comparative time and effort involved in performing different procedures. The authors then used statistical methods to further refine those ratings.[9]

To establish a relative ranking of different procedures or services according to their level of difficulty, the Harvard study identifies a common or standard procedure within each specialty and uses it as a reference point for determining the ratings for other procedures within the specialty. The

8 Lynn Etheredge and Allen Dobson Ph.D., "Review of the Resource-Based Relative Value Scale Study," prepared for the American Medical Association by the Consolidated Consulting Group. Washington, D.C., December 1988 (unpublished manuscript).

9 The body of services or procedures used for the survey ratings and subsequent statistical measurement and analysis was derived from the *Physicians Current Procedural Terminology* (4th edition) (Chicago: American Medical Association, 1986), referred to as the CPT-4.

common or standard service is assigned a numerical score of 100. For a service considered half as difficult, the score is 50, and for a service or procedure considered twice as difficult, the score is 200.

Example: For a doctor specializing in internal medicine, an office visit to treat a "sore throat, fever and fatigue in a 19 year old college student," who is an "established patient," is rated at 100.[10] A slightly more difficult service would be the treatment of a 55-year-old man on a follow-up visit to the office "for management of hypertension, mild fatigue on a beta blocker and thiazide regimen"; this wins an RVS score of 123.[11]

Having constructed in this manner a basic index of the relative values of different medical procedures, the authors of the Harvard Study then factor other variables (costs of operating a practice and education) into the final index. The finished product is a set of numerical values, one for each procedure, which can then be multiplied by a fixed dollar amount – called the conversion factor – to produce a set of prices for Medicare to use as its new fee schedule.

HOW EXPENDITURE TARGETS ARE STRUCTURED

While Medicare can use this new RVS system to redistribute payments among physicians, there are still two remaining problems that RVS does not address: how to control the volume of services delivered by doctors and how to control total Medicare spending. Doctors who receive lower reimbursements under RVS, for instance, might simply prescribe more services, thus maintaining their same total income, and hence, cost to Medicare.

It is to address these two problems that the concept of expenditure targets has been included in the proposal. Under the targets, beginning in 1992, the RVS conversion factor would be updated, according to annual expenditure targets for total Medicare Part B spending as set by Congress.[12] The index of relative values for all procedures covered by RVS would in the future be multiplied by the new conversion factor to establish Medicare's payment rates for the following year. According to, Philip R. Lee, M.D., the Chairman of the Physician Payment Review Commission, the system would work as follows:

> If actual expenditures during a year are equal to targeted expenditures, then the conversion factor

10 Hsiao *et al.*, "Estimating Physicians' Work for a Resource-Based Relative-Value Scale," *The New England Journal of Medicine*, September 29, 1988, p. 838. Specific values for the differing procedures are found in Table 1: "Physicians' Estimates of Intraservice Work and Time for Selected Services, According to Specialty."

11 *Ibid.*

12 Under the House version of the Reconciliation bill, while RVS would be phased in over a period of years, the expenditure target system would begin operating in 1990.

> update for the following year would be equal to the increase in [physician] practice costs. The update would be increased or decreased to reflect differences between actual and targeted expenditure increases.
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> As an example, assume that practice costs are increasing by 4 percent, enrollment is growing by 2 percent, and volume of services is projected to increase by 7 percent per enrollee. This would lead to a 13 percent increase in expenditures. Now assume that a target of 11 percent is chosen, which would permit a volume increase of 5 percent. If actual expenditures rise 13 percent, then the conversion factor update for the following year would be 2 percent (4 minus 2). If actual expenditures rise only 9 percent, then the conversion factor update would be 6 percent (4 plus 2).[13]

Thus if enough doctors increase the volume of their services to compensate for the new, lower reimbursement rates, causing Medicare spending to exceed that year's expenditure target, then all doctors will be penalized the following year by a further reduction in their reimbursement rates.

THE FLAWED PREMISE OF RVS

The central premise of RVS advocates is that the failure of the CPR prevailing charge reimbursement system to control costs indicates that the market does not work in health care. In reality, however, the current CPR reimbursement system is not a market system at all. For a true market to exist, it is necessary that the person demanding the service (the consumer) pay for the service. When this happens, the price reflects both the cost to the provider for producing the service and the value the consumer attaches to the service. If the cost for producing the service is higher than what the consumer feels it is worth, then the provider has to find a way to lower his costs if he wants to sell his service.

Patient Does Not Pay. If the consumer demanding the service is not paying for it, he will view it as "free" and demand more of it regardless of the actual costs of production or the degree of benefit derived. Since CPR is based on

13 See statement of Philip R. Lee, M.D., Chairman, the Physician Payment Review Commission, before the Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, March 21, 1989. Under the legislation, HHS would use the MEI or another index to calculate each year the basic update for the conversion factor.

some third party (government or an insurer) paying the consumer's health care bills, the reimbursement rates do not reflect true market prices. What they represent are how much some third party is willing to let the provider charge, and the provider has every incentive to press for as much as possible, knowing that the patient does not pay the bill.

The problem, then, is not that the market has failed in health care. Rather, the problem is that the market has not been tried – at least not in the more than 30 years that CPR has been used as the primary system for paying physicians. Hence the essential error of Hsiao and his Harvard colleagues is in assuming that, because markets are not currently working in health care, they never could work. Hsiao could come to this conclusion only if the market had been tried and failed. For a market to be tried requires active, powerful participation by the market's two key decision makers: the provider and the consumer. But because the consumer has been largely removed from the health care purchasing equation, the provider is left in a much stronger position to determine both the quantity and price of his services. Rather than recognizing this as undermining the market and devising ways to put the consumer back into the picture, Hsiao surprisingly simply accepts the current situation as inevitable, targets the provider as the sole key decision maker, and attempts to devise a new way to regulate him.

The Problem of Quality

Ignoring market mechanisms and the role of consumers leads to serious problems beyond just the question of how to determine true prices. In this regard, Hsiao concedes the limitations of his research, observing, for example, that RVS does not account for the severity of a patient's case within each procedure. This is the same problem that currently confronts Medicare's Prospective Payment System for setting hospital reimbursements. Both systems assume that doctors are treating the average case and reimburse accordingly. But, of course, doctors treat real people, and their individual cases may be more or less severe than the average. While in theory it might be assumed that doctors or hospitals will come out even in the end, in practice this does not necessarily happen. Instead, providers have an strong incentive to avoid, or limit their treatment of, patients with more severe cases if they stand to lose money.

The experience under Medicare's prospective payment system is that many hospitals have an incentive to avoid or even dump difficult cases. RVS likely will cause doctors to do the same. Despite continuing efforts to adjust hospital reimbursements to account for differences in patient cases, the

Inspector General of the Department of Health and Human Services last year estimated that there are over 540,000 cases annually of Medicare patients receiving poor quality hospital care.[14]

This raises an even more important issue: the fact that RVS does not take into account the quality of medical services. Yet, quality and benefit are among the consumer's most important considerations in selecting any service. With more time, research, and better methods, advocates of RVS claim the possibility of progress in the area of quality, postulating the development of a quality index for physicians' services.[15] Still, how subjective concepts of quality and benefit will be quantified in future social science research is unclear.

Failure of Price Regulation

The final flaw in RVS is the assumption that price setting is an effective regulatory tool. Even the proponents of RVS admit that doctors can compensate for reduced prices by increasing the volume of their services.[16] Given this tendency, the only real way to control total spending is to regulate directly the patient's access to medical services. This is most clearly done through the methods of rationing and waiting lists used in government-financed national health systems in other countries. To a lesser extent, it is also done in certain managed care systems used by the private sector in the U.S. The proposed Medicare reforms rely on neither of these approaches. Instead, the proposed reforms would aim to restrict volume by further price controls in the form of the expenditure target mechanism.

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14 Office of the Inspector General, Department of Health and Human Services, "National DRG Validation Study: Quality of Patient Care in Hospitals," July 1988. Based on a review and analysis of 7,050 cases selected through statistical sampling, the study found a 6.6 percent overall rate of poor quality care. This rate applied to the 8.28 million cases of disease during the period covered by the study yields an estimated 546,480 cases of poor quality care.

15 The limitations Hsiao describes are fundamentally technical, not conceptual; and he claims they can be overcome with time and further research. On the subject of quality, for example, he says that when the appropriate data become available, it will be possible to construct a quality index. But for the moment, quality is not encompassed within the RVS system: "The number of years of experience and certification by a specialty board have been suggested as crude proxies for quality. We had neither the time nor the budget to investigate these possibilities and thus omitted a quality adjustment from the RVS." Likewise: "We have argued elsewhere that current knowledge and data make it unfeasible to incorporate benefit systematically into any relative value. Nevertheless, a rational payment system should recognize social benefits in the relative value. Perhaps this topic should have a high priority in future research." Hsiao *et al.* "Results and Policy Implications of the Resource-Based Relative-Value Study," *New England Journal of Medicine*, September 29, 1988, p. 888.

16 As noted by Dr. William Roper, the former Administrator of the Health Care Financing Administration which administers Medicare, "A fee schedule based on a relative value scale, no matter how carefully constructed, cannot be expected to address the growth in the volume and intensity of services. Whatever their merits, fee-for-service systems do not provide physicians with incentives to control this growth." William L. Roper, M.D., "Perspectives on Physician-Payment Reform," *New England Journal of Medicine*, September 29, 1988 p. 866.

WHY RVS AND EXPENDITURE TARGETS WILL NOT WORK

Setting expenditure targets for total Medicare spending and then reducing physician reimbursement rates when spending exceeds the targets does nothing to change the behavior of individual physicians or patients. If a doctor increases the volume of his services, he alone will benefit from the increased revenue. If as a result of such actions, Medicare reduces its rates the following year, then all the other doctors in his specialty will share the penalty. Thus the physician who provides more services may still come out ahead, while his colleagues who play by the rules will lose. The more Medicare cuts its rates, the greater the incentives for doctors to increase the volume of their services.

The only other alternative would be for doctors to make up the difference by charging their patients higher amounts through balanced billing. But the reforms attempt to cut off this avenue as well by setting new, fixed percentage limits on balanced billing.

The reform package, in fact, offers only three, very weak solutions to the problem of controlling the volume of services:

1) Increasing research on identifying the most cost effective treatment methods and disseminating the results to doctors and patients in the form of practice guidelines.

While this could provide an excellent body of useful information, there is no requirement that doctors or patients act on the information. Because Medicare is paying the bills, consumers and doctors have an incentive to simply ignore the information. In and of itself, this proposal constitutes an almost wishful attempt to educate consumers and providers on how to responsibly spend someone else's money for their own benefit.

2) A more comprehensive medical review system to monitor the utilization and quality of services.

To be effective, this would mean ever greater direct regulation of physicians. It is precisely this kind of costly, heavily bureaucratic approach that the RVS price-fixing system is designed to avoid.

3) A study of the possibility of exempting HMOs and other managed care plans from the expenditure target system.

Such a move would mean that managed care plans, which contract with Medicare to provide beneficiaries with comprehensive care for a fixed annual fee, would receive better reimbursement rates in future years, while doctors in private practice would have their reimbursements cut. Over time, the combined effect would be to bully and bribe more physicians into managed care plans, where they are more easily regulated.

The real danger of the whole RVS/expenditure target system is that it will gradually lead physicians, particularly the better ones, to avoid treating Medicare patients at all. Short of conscripting doctors, there is nothing to

prevent an exodus of medical specialists into the purely private market, where fees are higher and returns on investment in modern medical technology are better. The result: fewer medical specialists treating the elderly – the very population that increasingly will need them.[17]

This leads to the ultimate danger that, based on arguments of fairness, RVS eventually will be imposed on the rest of the U.S. health care system. There is, historically, good reason to believe this will happen. Whenever prices are controlled, providers flee into segments of the market that are uncontrolled. The regulators then follow them. Government price control, once instituted in an industry, spreads wider and wider.

TRUE MARKET REFORMS

Congress will not be able to reduce the growth in Medicare Part B spending until genuine market prices for physicians' services are introduced. Only then will patients be the price controllers, applying a mixture of objective and subjective criteria that no social scientist or computer-generated formula can replicate. But genuine market prices for physicians' services will only be established when private sector consumers start to pay out-of-pocket for most of their routine medical care and to buy their own insurance to cover the costs of more serious illnesses. This is the essential, primary reform needed to address a range of problems in the American health care system, including those in Medicare.[18] Only this will make consumers consider value when they seek medical services.

Direct Tax Relief. This general reform can be achieved by giving consumers direct control over the money spent on their health care. The current tax exclusion for employer-provided insurance should be eliminated; instead, workers should receive the money their employers now spend on their health care as cash wages. To compensate for eliminating the tax exclusion for employer-provided insurance, Congress should provide all Americans with tax relief for their medical expenses directly through the personal income tax code.

Taxpayers could be provided with, say, a basic tax credit of 20 percent of the money spent on health insurance premiums and a 30 percent tax credit for all out-of-pocket medical expenses. Americans should be given more tax relief for purchasing medical care out-of-pocket than for buying it through insurance and receive additional assistance if they face heavy medical bills or high insurance costs because of their medical history. Under this

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17 Again, as Dr. Roper has noted, "Given that Medicare has a 21 percent share of the physician market, any fee schedule that differs markedly from current rates will increase the risk that physicians will provide fewer of certain services or procedures to Medicare patients, accept Medicare assignment less frequently, or both." *Ibid.*, p. 867.

18 For a more detailed explanation of these and related proposals, see: Stuart M. Butler and Edmund F. Haislmaier, eds., *A National Health System for America* (Washington, D.C.: The Heritage Foundation, 1989).

arrangement, patients would become more cost conscious, and individuals and families would be free to choose among competing insurance plans and select the one that best suits their particular needs. They could do so on their own, through their employer, or through some other group or association – but they would receive tax benefits directly, and all Americans would be eligible for this tax relief, regardless of where they worked.

Incentives for Consumers and Providers. These reforms would give consumers new incentives to become more prudent purchasers of insurance and medical services, since any money they saved on their health care could be used for other purposes, something they cannot now do under the employer provided health insurance system. Providers would, in turn, be given incentives to offer their customers better value for their money by finding ways to deliver quality care at reasonable prices. The final result would be a set of market prices, particularly for routine items, that Medicare could use as a guide in setting reimbursements.

These structural reforms in America's health care system, would introduce powerful market forces into health care. With a real market operating, Medicare would not have to invent one artificially. It could pay for services according to rates set by the market, not by social scientists.

While taking steps to introduce real market operation, however, Congress can initiate other actions to bring more consumer sensitivity to Medicare to help curb the escalating costs of Part B. Among them:

1) Increase the Medicare Part B deductible.

Congress should increase today's $75 annual Part B deductible to $250. This would save $3 billion to $4 billion now spent on routine services for the elderly. Congress should use part of these savings to expand Medicaid coverage for poor and near-poor retirees, so that they are not hurt by this reform. Congress could use the remaining savings to pay for some of the new benefits included in last year's catastrophic act, such as coverage for extended hospital stays or the cap on Part B beneficiary copayments and reducing future growth in Medicare spending. If, in future years, Congress were to index the Part B deductible to keep pace either with the growth in Medicare Part B costs or with the annual Social Security Cost of Living Adjustment (COLA), future Medicare savings would be considerable.

2) Require physicians to disclose their fees in advance to Medicare patients.

For all nonemergency services, Medicare should require physicians to tell their patients, in advance and in writing, how much treatment will cost. This statement should list all of the services to be provided and disclose the total costs, the amount Medicare will reimburse, and the amount the patient must pay in coinsurance and any balanced billing. For basic primary care services, physicians could have copies of this information available in their waiting rooms, listing their charges for a standard office visit and the most common diagnostic tests and procedures. In 1986 Congress mandated this type of

disclosure for elective surgeries costing more than $500. There is no reason why such disclosure could not be extended to other services. To the extent that patients are informed of the cost of their care in advance, they are more sensitive to price, yet free to choose a more expensive doctor and pay the difference out of their own pocket.

3) Adjust reimbursement rates to reflect the current supply and demand for services.

Until such time as private sector reforms generate a set of market prices for Medicare to use, the program still needs a mechanism for determining reimbursement rates. This should not be done by continuing to use the current CPR prevailing charge system or instituting the new RVS system. Both of these suffer from serious defects. They are costly and confusing and bureaucratic to administer. Further, they are arbitrary pricing systems, which ignore many of the factors that determine the supply and demand for services.

Congress simply should index Medicare rates according to future increases in the consumer price index. If Congress, by examining the quantity of services demanded and supplied finds that specific rates are too high or too low, it can adjust rates *ad hoc*. While such a system is in many ways as arbitrary as CPR or RVS, it has the advantage of being much simpler and less costly to administer. It also is more honest in that it avoids expending the vast amounts of time, effort, and money required to impose a flawed theory of value. And while the *ad hoc* system is not ideal, and fundamental reforms are needed, it does mean that Medicare will be reacting to outcomes in the health care market, rather than creating a reimbursement system that does not consider whether it will produce a shortage or an overabundance of services.

CONCLUSION

Congress should not be fooled into thinking that, by replacing one complex and bureaucratic physician payment system with another, it will solve the problem of Medicare cost escalation. Indeed, not only will the RVS/expenditure target proposal fail to achieve this goal, but it also is nearly certain, in the long run, to decrease the quality and availability of medical services for the elderly.

Market Forces At Work. What policy makers need to recognize is that, whether they like it or not, market forces are at work in the health care system. Chief among those forces is basic consumer demand, which drives the health care industry just as it does any other industry. As long as government policies, whether in Medicare or elsewhere, encourage consumers to think that health care is a "free" good, consumers will demand ever greater quantities of it. And as long as consumers are shielded from the true costs of their health care, providers will continue to offer a growing volume of services at whatever prices they can obtain. In the end, health care costs will continue to escalate.

Clear Choice. A government-imposed price structure, based on some theoretical calculation of the "true value" of medical services like RVS, will do nothing to change consumer demand for those services or improve the efficiency of their delivery. The most it can accomplish is to create artificial surpluses or shortages depending on the levels at which the prices are set. And it will accomplish even this undesirable result only through an enormous expenditure of time, effort and money.

In Medicare, as in the rest of the American health care system, the choice is simple and clear. If Congress is to solve the problem of escalating health care costs, it must do so either by rationing and regulating the consumer's access to medical services or by introducing genuine, free market reforms. Congress should choose free market reforms. Rationing should not become the guiding principle of American health care.

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