Physician Payment Reform in Germany and in the United States

Tsukasa Muramatsu

Abstract

With the recent strengthening of the physician expenditure cost control mechanisms in Germany called the "Gesundheitsstrukturgesetz" of 1993, Germany has again affirmed its belief in the need for and success of global budgeting for physician payments. In 1992 Medicare, the U. S. government-run health insurance program for the elderly first implemented the new Medicare Fee Schedule based on a point value system, known as the Resource-Based Relative Value Scale (RBRVS), which is very similar to the German "Einheitlichen Bewertungsmaßstab" (EBM). RBRVS uses a similar system for budgeting physician payments. Although this policy has only been taken in the United States for two years, many policy makers are considering expanding the payment mechanism to all payers, private and public, in an effort to control costs. This paper describes the historical and analytical framework of physician payment reform in the United States and provide some insights into its future direction. The first section focuses on the pressures during the 1980's that led to the new Medicare Fee Schedule based on RBRVS. Second the analytical methodology and budget considerations are discussed for implementing the Medicare Fee Schedule. Third, the potential affects of the reform on costs, quality, access and individual physician payment are analyzed. Lastly, the role of physician payment in the debate on U. S. health care reform is examined as well as the Medicare Fee Schedule's applicability to other payers.

Keywords : physician payment, Resource-Based Relative Value Scale, health care reform

I . Introduction

With the recent strengthening of the physician expenditure cost control mechanisms in Germany called the "Gesundheitsstrukturgesetz" of 1993, Germany has again affirmed its belief in the need for and success of global budgeting for physician payments. Unlike Germany, which has used global budgeting to control physician expenditures since 1978, the United States has only recently experimented with such measures, and primarily within Medicare, the government-run health insurance program for the elderly. In 1992, Medicare first implemented the new Medicare Fee Schedule based on a point value system known as the Resource-Based Relative Value Scale

Department of Nursing, College of Medical Technology, Hokkaido University

(RBRVS), similar to the German "Einheitlichen Bewertungsmaßstab" (EBM). Although this policy has only been in place in the United States for two years, many policy makers are considering expansion of the costs. Indeed in his election campaign, President Bill Clinton supported the establishment of "consistent rates applying to all payers" and "annual budget targets"[1]. While the current Clinton health care reform proposal does not mandate a fee schedule for physician payments, it allows the states to design a fee schedule to control health care costs.

II. The Need for Physician Payment Reform

In Germany the EBM was initially designed in 1977 to control health care costs which had increased from 5.6% of Gross Domestic Product to 7.8% in five years later. The causes of this explosion included the social reform policies enacted under Chancellor Brandt, the aging of population, and the growing medicalization of social problems, such as tobacco consumption, alcoholism and institutional care for the aged. Similarly, In Japan "the EBM" was designed in recently to control health care cost which had increased from 4.9% of GDP to 6.7% in two years later. Costs were also increasing for payments to physicians in part due to an oversupply of procedural services in relation to the less expensive evaluative and management services[2].

Likewise, the RBRVS for the basis of the new Medicare Fee Schedule was initially designed by Prof. Hsaio of the Harvard School of Public Health to correct a perceived imbalance in payment rates between physicians who performed more evaluative and management services, such as internists, family practitioners and pediatricians, and physicians who specialized in procedural services, such as surgeons[3]. He designed a scale which weighted the relative direct and indirect cost of performing such procedures, using empirical data social science techniques subject to changes based on widespread review.

Between 1981 and 1991, average annual incurred charges per Medicare enrollee nearly doubled in constant 1991 dollars from $ 658 to $ 1,205. The overall Medicare physician expenditures increased from $ 8 billion in 1981 to $ 26 billion in 1992. During the 1980's its growth rate in Medicare physician expenditures outpaced that of the Gross Domestic Product, national health expenditures and Medicare Part A. Much of this growth can be attributed to increases in volume and intensity, as prices have been constrained[4].

What factors led to the increase in volume and intensity of Medicare physician services? First, Medicare's implementation in 1983 of the Prospective Payment System for hospital costs shifted procedures from an in-patient to an out-patient basis. While Part A hospital costs had averaged between $ 54 billion and $ 56 billion (in 1980 dollars) during 1979-1984, after Prospective Payment System costs were redueced to between $ 43 billion and $ 47 billion. Part of this decrease can be attributed to an increase in Part B spending on out-patient physician services[5]. Second, demand for Part B services was also increasing due to improvements in out-patient

technology which reduced the time and psychic costs to the patient of out-patient surgery. Third, the monetary cost to the patient was aiso decreasing due to the freeze on Medicare feets, the increasing rate of physician participation, and to the prevalence of supplementaly insurance for the elderly. Fourth, greater public awareness of new technology increased the demand for out-patient surgery.

The fifth, and perhaps the most important reason for the high growth rates, resulted from supply side pressure from Medicare's Customary, Prevailing, and Reasonable (CPR) retrospective payment system which paid for physician services based on the most "reasonable" or the lowest charge between what the physician had "customarily" charged in the past, the "prevailing" charge of other physicians in the specialty and locality, or the physician's actual charge. This inflationary system was implemented for two reasons. One, when Medicare was created in 1965, it contracted with private insurance companies to handle physician reimbursements. These private companies paid physicians on a CPR basis, and thus so did Medicare. Second, in order to gain the support of the American Medical Association, which argued that physicians would not serve the elderly if the Medicare reimbursement rates were too low, the government agreed to pay whatever the physician charged. Thus, as a result of the CPR system, not only did physicians have incentives to increase their supply of services due to fee-for-service payment, but they had very little limit on how much they charged for those services. The CPR method resulted in not only fee inflation but also distortions in the relative payments for different types of services and geographic areas. In addition, CPR gave physicians inappropriate economic signals about how they should practice, what specialty to choose and where to practice.

Physician payment reform based on a RBRVS, as opposed to Customary, Prevailing and Reasonable payment method, was designed to achieve several goals which were sometimes conflicting as shall be discussed below. The first goal was to make the payment system equitable between specialties and regions. Second, it was to control the costs of physician services. Third, it was to ensure the elderly's continuing access to physician services. Lastly, it was to improve the quality of care by increasing the relative rate for preventative and maintenance care as well as by disseminating data on appropriateness of care.

Ⅲ. Methodology of Physician Payment Reform

In 1986, Congress created the Physician Payment Review Commission which took charge of recommending a mechanism to change the existing Medicare fee schedule based on CPR payment methodology. They contracted with Prof. W. Hsiao, who created the RBRVS at Harvard University (School of Public Health) to reflect the relative costs of efficiently-provided physician services in a perfectly competitive market. In 1989 Congress mandated the creation of a new Medicare Fee Schedule based on Hsaio's RBRVS.

A. Features of Physician Payment Reform

The Medicare Fee Schedule is calculated by multiplying the RBRVS relative point value of the procedure, based on Hsiao's work, by a Geographic Adjustment Factor and by a Conversion Factor which converts the weightings into dollar amounts for each of 7,000 procedures. The relative value scale, in turn, is a product of the work expended by the physician on the procedure, multiplied by the overhead costs necessary to supply the services, and multiplied by the malpractice costs associated with the service. The relative value scale ranks not only procedures within a specialty, but also between specialties.

In order to ensure access, control costs, and to maintain quality, Congress mandated the following features of physician payment reform. First, the Conversion Factor for 1992 was to be budget neutral, so that Medicare physician costs would be equal to the estimated level if the CPR methodology had been maintained. Second, due to pressure from specialists whose fees is reduced, the Medicare Fee Schedule is phased in over five years, starting in Jan. 1992. Federal legislation in 1989 also limited physicians' ability to charge patients an additional amount above the Medicare payment, a practice known as balance billing. Balance billing is limited to 20% above the Medicare charge in 1992, and to 15% for 1993 and beyond. Physicians can no longer balance bill Medicare patients who are also on Medicaid, the government-run health insurance program for the poor. Third, the legislation created the Agency for Health Care Policy Research (AHCPR) which supports health care research in the areas of quality, appropriateness, effectiveness and cost. It will also develop practice guidelines and clinical standards to help patients and their physicians make rational and economic choices about health care.

Lastly, while much of the physician payment reform legislation was designed to make the payment system more equitable, the Volume Performance Standard (VPS) was created to control the overall expenditure level. The VPS sets the rate of overall growth for physician services based on the change in the number of enrollees, in the age composition of the Medicare population, and in technology, evidence of inappropriate utilization, lack of access, and other factors. The Conversion Factor was determined two years laters by the difference between the actual growth in physician expenditures and the estimate of the VPS for that year. The Secretary of Health and Human Services and the Physician Payment Review Commission both recommend a VPS level to Congress, which can then set its own level or allow a default formula to determine the level.

Individual physicians will still have incentives to induce demand in order to increase their income due to the fee-for-service payment system. Collectively, however, their overall income level could be curtailed in the future, if the overall expenditure level is greater than expected. Thus, through the collective nature of the VPS, the Physician Payment Review Commission hopes to encourage the physician associations to become more involved in cost containment through the "development and dissemination of practice guidelines, provision of both technical and political

support to carriers and peer review organizations in their utilization review activities, and perhaps even altering their position on unrelated federal policy changes that would contain costs"[6].

B. Implementation of Physician Payment Reform

The Health Care Financing Authority (HCFA), charged with the implementation of Physician Payment Reform, has encountered much resistance from physicians both from specialists who disagree with the premise of the reform and from generalists who disagree with how the reform is being carried out. In 1992 this was due to HCFA's attempt to carry out Congress'dual restrictions of budget neutrality and the five year phase-in period. In 1993, it was due to the varying growth rates for the Conversion Factor between surgical and non-surgical practices.

The first problem, so-called asymmetric transition problem, appeared in 1992 resulted because undervalued fees increased faster than the decreasing rate of overvalued fees. This asymmetry would have resulted in a 2 % overall increase in expenditures for physician services. Because only a third of all fees were covered due to the phase-in and HCFA interpreted the budget neutrality language as applying only to fees covered under the new Medicare Fee Schedule, they leveraged the 2 % overall expenditure overrun onto just the Medicare Fee Schedule, resulting in a 6 % decrease to mitigate the effect of the asymmetric transition.

The second problem resulted from HCFA's estimate that physicians whose fees were reduced would increase their volume of services by 50 %. They estimated no change, however, in the volume of services provided by physicians whose fees had increased. HCFA's so-called behavioral offset led to a need to decrease overall fees by 3 % in order to maintain budget neutrality. The Physician Payment Review Commission, on the other hand, estimated that only 1 % volume adjustment was needed. Once again, HCFA leveraged up the 3 % by decreasing the Medicare Fee Schedule fees by 10.5 %.

As a result of the behavioral offset and the asymmetric transition, the fees that were set by the Medicare Fee Schedule were reduced by a total of 16.5 % from the estimated Customary, Prevailing and Reasonable level in 1996. Because many of the procedures initially covered under the Medicare Fee Schedule were performed by generalists, the decrease fell most heavily on those who should have been helped the most. After receiving over 95,000 letters of complaint, HCFA amended their proposal in the following ways. First, HCFA decided to maintain budget neutrality between the fully operational Medicare Fee Schedule in 1996 and its CPR predecessor in 1991, instead of buget neutrality between the only partially implemented Medicare Fee Schedule in 1992 and the 1991 CPR fee schedule. Thus they eliminated the problem of leveraging completely. Second, they eliminated the problem of excessive outlays during the transition years by reducing the historical base of fees, instead of adjusting the future rate increases. Reducing the historical basis also mitigated the problems of the asymmetric transition. With these changes , the Medicare Fee

Schedule was implemented in January 1992.

In 1993 Congress mandated that two Conversion Factors must be established, one for surgical and one for non-surgical specialties. The Secretary of Health and Human Services calculated the Conversion Factors based on the difference between the actual expenditure growth two years prior and the Volume Performance Standard, which had estimated the growth for that year. Surgical expenditures had grown 2.9 % in 1991, 0.4 % below their Volume Performance Standard. Non-surgical specialties, on the other hand, had increased by 10.5 %, 1.9 % above their Volume Performance Standard. Thus, the growth in the Conversion Factor for non-surgical specialties and for surgical specialties was reduced to 0.3 %, and the Conversion Factor was 2.9 %. As in 1992, the non-surgical specialists that were to be helped by the reform, were not pleased with the actual implementation of the reform. Although the resulting uproar did not influence Congress to modify the Secretary's recommendation, Congress may decide to return to one Conversion Facto in the future.

Ⅳ. The Effect of Physician Payment Reform

Because Medicare has only recently implemented Physician Payment Reform, it is difficult to predict whether it will reach its sometimes conflicting goals of equitable physician payment, increase access to care, cost containment and enhance quality. In addition, the adoption of this type of payment system by other payers, such as by state Medicaid programs, Blue Cross／Blue Shield and by private insurance companies, will substantially affect the goals. This section outlines the reform's potential effects on the goals.

A. Equitable Physician Payment

As a result of these reforms, the average payment per service will fall 6 % in 1996 in comparison with the level they would have been, had the Customary, Prevailing and Reasonable rates been maintained, according to the simulations by the HCFA[7]. Because of inflation and the expected Volume offset, the overall level of expenditures will not change at all to preserve budget neutrality. The specialists that will see payment per service increase the most are family practitioner, general practitioner, and the phisicians of internal medicine, psychiatry, otolaryngology and the limited license practitioners. Surgical specialties, radiology, anesthesiology and pathology will all see decreases in their payment per service. Although specialists will still be paid considerably more than general practitioners, the reform attempts to make payment more equitable by decreasing the difference in payment rates. The simulations also show that the geographic distribution of payment will change. Due to the Geographic Adjustment Factor and the preponderance of evaluative and management specialties which will see an increase in payment, rural localities will almost always see a greater increase in payment per service than corresponding urban areas in their states.

In response to the changes in relative fee levels, physicians are anticipated to change both their style of practice, as well as their professional relationships with one another and with hospitals. Because no other reform of this magnitude has occurred before, it is impossible to predict the degrees of change. The following discussion, however, outlines some of the possibilities. First, surgeons, anesthesiologists, radiologists, and pathologists, whose fees will be reduced the most, might ask for direct payment from hospitals for volunteer work or committee assignments. Conversely, the change in payment may return some clout and status to the primany care physician. Second, multispecialty practices might increase in number and composition as large groups of primary care physicians contract with various subspecialists to perform procedures which do not compate with those of the primary care physicians. Third, private physicians may shift older and more complicated cases to university-affiliated teaching hospitals with salaried staffs, as private physicians prefer more profitable patients.

Lastly, hospitals may seek to enter other business fields to compensate for their lost revenues. Additionally they might contract with subspecialists to provide services only to their patients only. This could lead to a change in the organizational structure of the hospital-physician relationship. No longer would physicians be independent of small business people who can contract with a number of hospitals, but rather salaried employees of one hospital.

B. Access

Two of the cost containment methods included in physician payment reform may reduce physicians' willingness to accept Medicare patients, leading to the "Medicaidization" of Medicare, in which physicians would not accept Medicare patients because of the low level of the fees as Medicaid. First in order to control costs, while volume and intensity are still growing, the Volume Performance Standard will inevitably restrict expenditure growth by capping the growth of fees, resulting in a growing differential between private fees and Medicare fees. Second, the restrictions on balance billing will reduce out-of-pocket expenditures for Medicare beneficiaries by an estimated 25 %, if physicians do not compensate with changes in the mix or volume of services[8]. Because budget neutrality calls for no increase in spending due to the new Medicare Fee Schedule, these costs will be born by the physician. Even if physicians do increase volume or intensity to offset the fee reductions, some income is likely to be lost. This decrease in income from Medicare patients may lead to a decrease in the elderly's access to health care.

C. Costs

While the Volume Performance Standard is responsible for containing Medicare costs, it may result in unintended consequences for prices and quantity of health care supplied or demanded. First, because Medicare accounts for only 13 % of the patient mix, hospitals and physicians may shift from Medicare to the private sector. This could result in savings to Medicare, but no change would be seen in the United States' overall health bill. Second, because these fees are not driven

by the market but by the resources expended in providing the procedure, an oversupply of some procedures and an undersupply of others may result to the price. Which will not necessarily equal the marginal cost for the service. Lastly, several studies have shown that when prices are restricted, physicians will induce demand to make up for reduced income[9]. HCFA anticipated that physicians whose fees were reduced would increase the volume of services by 50 %. The VPS attempts to correct for the anticipated oversupply by reducing the Conversion Factor two years hence if the actual expenditures are larger than that estimated by the VPS. This, however, dose not affect individual physicians' practice behavior which will continue to be influenced by the fee-for-service system.

In comparison to the Medicare Fee Schedule, the German "Einheitliche Bewertungsmaßstab" and the cost control regulations of the 1993 health reforms are more effective for serveral reasons. First, they can more accurately affect the income of those physicians or groups of physicians who are supplying services above a socially negotiated desirable level through economic monitoring and separate budgets for types of servicses. Second, in Germany the adjustment to unexpected increases in volume takes place in the year of the increase in volume, to increase the incentives to individual physicians not to oversupply. In the U. S., the adjustment takes place not untill two years later when the Conversion Factor is reduced if the actual volume was greater than the VPS.

D. Quality

One of the goals of physician Payment Reform was to improve the quality of medical care to for the elderly. The reformed payment system, however, rewards both high and low quality performance equally. To address this concern, the Congress created the Agency for Health Care Policy and Research to sponsor the development of clinical guidelines and to conduct research on medical outcomes to provide information for future guidelines. The guidelines on such clinical practices as acute pain management incorporate explicit statements of desired patient outcomes, appropriate clinical measures and targets to guide therapy, and the benefits, risks and costs of different approaches to care. In the future, these guidelines could also be used to improve quality of care not only through the provision of information to providers, but through assessing the competence of individual practitioners in evaluating and managing specific conditions. Monitoring practitioners' use of guidelines could also generate appropriate utilization rates to use as a norm in physician profiling.

How successful the use of these guidelines in conjunction with the reform of the payment system will be in improving quality is unclear. First, it may be more difficult to incorporate practice guidelines into actual clinical utilization than expected. Second, the sheer size of the task may impede its effective implementation. Unlike Medicare's hospital cost control mechanism known Diagnostic Related Groups (DRGs), which involve 11 M admissions, 7,000 hospitals and 475 DRG codes, the new Medicare Fee Schedule involves 350 M claims, 500,000 physicians and 7,000

procedural codes. Even the 7,000 codes may not be able to adequately describe all the care types. Third, the conflicting nature of the goals of cost control, equitable payment, and improved access will lead Congress to make difficult decisions which may affect the quality of the care offered. Congress may be forced to control expenditures by across-the-board cuts, or by targeting certain geographic regions or specialties. These decisions may be driven more by cost concerns than by concerns about the quality of the health care. Lastly, because Congress anticipated the difficulty in implementing the Medicare Fee Schedule, they restricted administrative and judicial review of the relative value scale and the conversion factor. Thus, they cannot be challenged in court. While this may speed the implementation, it limits the public's ability to affect the quality of care through litigation.

V. Future Directions for Physician Payment Reform

The current Medicare Fee Schedule is just the beginning of significant physician payment reform in the United States. Whether the reform will lead, in the long-term, to explicit expenditure targets, expenditure caps or some type of capitated payment is unclear. In the short-term, however, payment reform based on the RBRVS is being discussed by Blue Cross/Blue Shield, state Medicaid programs, private insurers, and by looking into several health care reform proposals. Many of the Blue Cross/Blue Shield plans take RBRVS as a method of reducing the difference between over-and under-valued services. The Blue Plans of Minnesota and Oregon have both already adopted the Medicare schedule, but with a substantially higher Conversion Factor in order to maintain the participation of their physicians. Twelve other Blues are also considering adopting the new system.

Likewise many states are interested in incorporating RBRVS into their current Medicaid fee schedules. Maine, Michigan, and Texas have done so already, and thirteen other states are considering doing so[10]. Hsaio's work included relative values for elderly services, such as obstetrics and pediatrics, which makes the transition between Medicare and Medicaid more easy.

Several recent health care reform proposals have included a uniform physician payment system. The American College of Physicians, one of the largest physicians associations, has called for national global budget to be divided among the states. Within each state, insurers and providers would agree on a Conversion Factor to be used with the RBRVS and Medicare's hospital cost containment policy, known as Diagnostic Related Group (DRG) system. If states exceeded their budget, fees in that state would be reduced in the following year.

The Clinton Health Security Act also includes a national health care budget to serve "as a backstop to the system of incentives and organized market power"[11]. Each regional alliance, which are health insurance purchasing cooperatives which most people will be mandated to join, will allow health care premiums in that region to grow by inflation and some other factor,

adjusted for demographic and socio-economic changes. Should the weighted-average premium requested by the regional health plans, now known as insurance companies, be greater than the per capita budget target, an assessment will be imposed on each health plan whose premium is greater than the weighted-average premium. The health plan will in turn impose an assessment on their providers, which will reduce provider fees. In order to ensure that health plans meet the budget target, states can set rates for health providers. While they would not be required to use the Resource-Based Relative Value Scale system that Medicare uses, it is likely that many states would.

Any wide-scale implementation of global budgeting for physician expenditures based on a Resource-Based Relative Value Scale will need to consider several obstacles. First, currently a wide discrepancy exists between rates paid by private and that paid by public payers as well as among private payers. For instance, the Physician Payment Review Commission estimated that if private insurers were to pay Medicare rates, the rates would be only 65% of what the private insurers currently pay. Conversely, Medicaid rates in 1989 averaged only 64% of Medicare's average allowed charge[12]. Equalizing the rates would be very costly to the government. One issue to be considered is how quickly to close the gap and what criterion should be used to maintain rate differentials.

Second, providers will not want the rate setting mechanism to be linked to the federal budget. For if it happens the fee setting process would be influenced by the federal deficit. An alternative arrangement would be the establishment of an appointed body of national recognized experts to either to set the fees themselves or to make recommendations to Congress on the appropriate levels. Third, the current Volume Performance Standard does not target individual physicians or even specialty or regional groups of physicians who provide more services than their peers. To tightly control costs, a mechanism must be in place to control both price and volume. Without volume controls, individual physicians, acting as free riders, will simply offset price reductions with volume increases to reach a target incomes.

Lastly, the creation of an all-payer rate setting mechanism should not eliminate competitive health plans, such as Health Maintenance organizations, which contract with physicians on a salaried or capitated basis. Instead, "qualified" competitive health plans that would have the option to use the all-payer rates could be established. All-payer rates should not also remove incentives for health organizations or for providers to compete based on price.

VI. Conclusion

The newly implemented Medicare Fee Schedule, based on a Resource-Based Relative Value Scale could function as the first step in the United States towards a system of global budgeting for all physician expenditures. The difficulties in implementing it and the conflicting nature of its goals foreshadow the problems the U. S. might face if it applied this system nationwide. On the

other hand, Germany's ability to control the level of Gross Domestic Product that is devoted to health care via controls on physician payment could provide lessons for the successful implementation of global budgeting in the United States.

Lastly, I consider that the methodology of Health Service Research in the United States and Germany will provide us some useful information in planning our future policy.

Ⅶ. References

1) Clinton B. The Health Care Plan. The New England Journal of Medicine, 327(11) : 804-806, 1992.
2) Henke KD, Ade C. Administrative Modernization : Health Care Reforms. Discussion Paper 178, Universitat Hannover. 1992.
3) Hasiao WC et al : A National Study of Resource-Based Relative Value Scales for Physician Services : Final Report. Boston : Harvard University, September 27, 1993.
4) Physicians Payment Review Commission. Annual Report 1992. March 1992.
5) Russell L, Manning C. The Effect of Prospective Payment on Medicare Expenditures. The New England Journal of Medicine, 320(7) : 439-444, 1989.
6) Ginsburg P, LeRoy L, Hammons G. Medicare PPR. Health Affairs, 9, 1 : 178-188, 1990.
7) Levy J, Borowitz M. The Medicare Fee Schedule Unveiled : An Account of Physicians Payment Reform. Health Policy, 22 : 263-286, 1992.
8) Blumenthal D, Epstein A. Physician-Payment Reform-Unfinished Business. The New England Journal of Medicine, 362(20) : 1330-1334, 1992.
9) Fahey D. Projected Responses to Changes in Phisician RBRVS Reimbursement : Induced-Demand Theory versus Contingency Theory. Medical Care Review, 49(1) : 67-91, 1992.
10) Iglehart J. The American Health Care System : Medicare. The New England Journal of Medicine, 327(20) : 1467-1472, 1992.
11) President Clinton's Health Care Reform Proposal and Health Security Act, October 27, 1993.
12) Ginsburg P, Thorpe K. Can All-Payer Rate Setting and the Competitive Strategy Coexist? Health Affairs, 11 : 73-85, 1992.