

How Should Medicare Pay Physicians?

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LARGE FEDERAL BUDGET DEFICITS AND THE PROJECTED Medicare trust fund crisis will continue to keep the pressure on Congress and the Health Care Financing Administration (HCFA) to reduce Medicare's costs. Following the adoption in 1983 of prospective payment for beneficiary *hospital care*, many observers believe that *physician services* will be the next Medicare cost-containment target.

With few exceptions, Medicare currently pays physicians on a fee-for-service basis. About 6,000 different services are coded; payment for each is determined by comparing the amount the physician charges with both physician- and area-specific ceilings for that service. Medicare updates the ceilings annually, basing new values on physician charges in the preceding year and the value of a national index of changes in incomes and physician-practice costs. Finally, on each claim physicians have the option of accepting or rejecting assignment of the benefit due. Accepting assignment limits how much the physician can charge the beneficiary to an amount determined by Medicare in exchange for a guarantee to pay part of the bill. Rejecting assignment permits the physician to charge the beneficiary more than the Medicare-determined fee, but Medicare does not guarantee collection of any portion of the billed amount.

Critics contend that this system is costly, inflationary, inefficient, inequitable, and confusing. In trying to address these specific problems, policy makers face two overriding and general questions: What should be the method of paying for physician services, and how should the assignment option be changed?

Although there are potentially many alternative payment methods, this paper focuses on the major differences, strengths, and weaknesses of three broad classes of approach: proposals to change physician-practice arrangements; proposals to change the unit of service Medicare pays for; and, proposals to change how Medicare sets fee levels. If Medicare changes its payment method and successfully limits its payments for physician services, physicians may compensate by refusing assignment and charging beneficiaries more. To keep this form of cost-shifting from undermining cost-control efforts, some have proposed a more stringent assignment option: eliminating the option altogether, or requiring physicians to choose (for some period of time) between accepting assignment either for all or for none of their care to Medicare beneficiaries. These proposals will be examined, along with other methods of increasing the proportion of services provided on assignment.

Criteria for Judging Alternative Proposals

Medicare seeks a physician payment system that, at the same time, reduces the rate of growth of payments, is easy to implement, is inexpensive to administer, is intelligible to physician and beneficiary, maintains quality and access, and influences physicians to provide an effective mix of services in an efficient manner.

Another important consideration may well be what Mark Pauly (1980) calls "fiscal neutrality." A payment method is fiscally neutral if, in deciding among alternative treatments, the physician's personal financial return is unaffected by his/her choice of a treatment. In other words, the payment system should not create a conflict between the physician's financial interests and the patient's medical and financial outcomes. Rather, it should reinforce the agency relationship, which is based on the expectation that the physician always acts in the best interest of the patient.

Is there any one payment system that satisfies these ideals? Realistically, the answer is no. If fiscal pressures dictate that Medicare spend less

for physician services, as it appears they do, then any changes made to meet that objective will result in reductions in either beneficiary access to care and/or the quality of that care. No system of paying physicians is likely to avoid the necessity of choosing among program spending, beneficiary spending, quality, and access. Given this reality, the question then becomes: Which payment system provides the best chance of making these necessary, albeit difficult, choices rationally and intelligently?

The answer, perhaps surprising in today's climate of enthusiasm for more "radical" reforms, may well lie within the fee-for-service system combined with a prospective fee schedule. Compared with other payment methods, fee-for-service with a predetermined fee schedule is better able to generate the information needed to monitor the quality of and access to care, has a better chance of attaining fiscal neutrality, is almost certainly easier to implement, is more readily understood, is probably not very costly to administer, and can better transmit financial signals for influencing the services physicians provide. Simply freezing existing fees will not create an ideal fee schedule, but this may be a reasonable starting point for making judgments about the relation between fees for a specific service and that service's cost of provision, its benefit to patients, and its effect on alternative services.

Regardless of what near-term political and administrative choices are made, two broader, system-wide trends are likely to reinforce efforts to contain Medicare's payments to physicians. One is the growth of programs and policies, both government-sponsored and privately initiated, to make the health care system more competitive. The other is the growth in the number of physicians relative to the population. As physicians become more plentiful—perhaps even in over-supply—blank spaces in their appointment books should encourage them to treat Medicare beneficiaries on terms more favorable to Medicare.

The Current Method of Paying Physicians

With few exceptions (Bovbjerg, Held, and Pauly 1982), Medicare uses the customary-prevailing-reasonable (CPR) charge method to determine how much it will pay for each service provided by a physician. In determining the CPR payment for a specific service provided, consideration is given to: the individual physician's *actual* billed charge;

the amount the physician *customarily* charges; and the *prevailing* charge in the community. Even though statute requires that payment be at the lowest amount among these, total CPR payments have not been restrained. Basing them on physicians' own charges, updated annually, has made them both relatively generous and relatively inflationary (Lee and Hadley 1979a; Huang 1977; Sloan, Cromwell, and Mitchell 1977).

The 1972 Social Security amendments included a provision to limit the growth in community-wide prevailing charges to a rate determined by an economic index that reflects national increases in incomes and physician-practice costs. In spite of this index, Medicare's payments for physician services have grown more rapidly than its payments for hospital services (table 1). The share of Medicare's total spending for personal health care going to physician services has increased from 21.4 percent in 1975 to 22.4 percent in 1982. Although much smaller than hospital care's 1982 share of 71.3 percent, payments for physician services are clearly large and still growing.

In addition to its being costly, the CPR method is also confusing to both physicians and beneficiaries. Most of the confusion stems from

TABLE 1
Medicare's Spending for Hospital Care and Physician Services: Amounts
and Rates of Growth, 1975-1982

Year	Annual Spending			
	Hospital Care		Physician Services	
	Dollars (billions)	Percent of total Medicare spending	Dollars (billions)	Percent of total Medicare spending
1982	36.3	71.3	11.4	22.4
1981	31.3	72.0	9.7	22.3
1980	26.0	72.8	7.8	21.8
1979	21.7	73.8	6.4	21.8
1975	11.6	74.4	3.3	21.4
Compound Rate of Growth (percent per year)				
	Hospital Care		Physician Services	
1979-82	17.2		19.2	
1975-82	16.3		17.7	

Sources: Gibson, Waldo, and Levit 1983, table 9; Gibson 1980, table 6.

two interrelated parts of the payment method—physician billing options and beneficiary cost-sharing. Typically, neither party knows in advance how much Medicare will allow. Beneficiaries do not know what their cost-sharing will be since, after a \$75 deductible, it is 20 percent of an unknown amount on *assigned* claims, plus the difference between that amount and the billed charge on *nonassigned* claims. Similarly, physicians don't know how much cost-sharing to bill beneficiaries on *assigned* claims, and they have trouble gauging the odds of being paid on *nonassigned* claims.

The current method is also problematic in that it creates inequities among physicians. Urban-rural and interregional variations in physician charges are preserved, regardless of how justifiable (or unjustifiable) those variations might be. But even within the same area, similar physicians who submit identical charges for the same service may receive different payments from Medicare if their "customary" profiles are different.

Another criticism of CPR is that it provides little incentive for physicians to be economical or efficient. This charge has several components. First, as a fee-for-service system it inherently encourages the provision of more, rather than fewer, services—the more services provided, the higher the physician's income. Second, CPR-determined fees are "sticky downwards," meaning that fees for procedures don't fall as the costs of providing those procedures decline over time (as physicians become more proficient in performing them or new technologies make them cheaper). Third, the CPR system is biased in favor of interventional procedures, high technology, and specialist services, and against the services more common to primary care. In other words, it overpays the former services and underpays the latter, contrary to what some believe to be the true or desirable relative values of these classes of services.

In sum, the principal complaints against Medicare's current method of paying physicians are that it is costly, inherently inflationary, confusing, inequitable, and inefficient.

Alternative Methods of Paying Physicians

There are many major options and minor modifications for changing how Medicare pays physicians. This paper examines the alternatives under three broad groups: proposals designed to change physician-

practice arrangements; proposals to change the unit of output Medicare pays for; and proposals to change how Medicare determines the price it will pay for each service. A fourth possible option, putting physicians on salary (Holahan 1980), as in the Veterans Administration or the British National Health Service, is not considered here because it is highly improbable. Salaried employment of physicians by group practices, clinics, and hospitals is indeed growing. But these organizations are typically reimbursed for the services of salaried physicians on the basis of capitation, fee-for-service, or reasonable cost.

Proposals to Change Practice Arrangements

This group encompasses a heterogeneous assortment of strategies, such as the health maintenance organization (HMO), the independent practice association (IPA), competitive bidding, the preferred provider organization (PPO), case management, health care brokers, and the primary care network. HMOs and IPAs are the most prevalent alternatives actually in existence, though they cover barely more than 5 percent of the nonelderly and an even smaller proportion of Medicare beneficiaries. The other alternatives are still experimental, with small-scale trials underway in a few places around the country. Another innovation—area-wide fiscal incentives—was recently proposed at the Conference on the Future of Medicare (Fox 1984).

These proposals are primarily a response to the argument that physicians bear no financial risk under the CPR version of fee-for-service reimbursement, since they get paid what they charge (or some fraction thereof) for each and every covered service they provide. Thus, to varying degrees and by varying methods, each plan addresses one or more of the following: the amount of financial risk the physician or physician organization bears; the methods of paying and/or managing physicians; and beneficiary freedom in selecting providers. Also, to varying degrees, these plans aim to change physician-practice arrangements, from independent fee-for-service practice to other organizational arrangements that increase physicians' incentives to monitor each other's behavior.

Except in the PPO (discussed below), bearing financial risk typically means that the physician receives a bonus for keeping utilization and expenditures below some target figure, but is penalized financially if that figure is exceeded. For HMOs and IPAs, the target is, in effect,

the premium or capitation income of the plan. For competitive bidding plans, it is the amount bid by the organization that wins the contract to provide care. If the economizing incentives are effective, the plan will have a surplus which it can distribute among the physicians. If expenditures exceed plan revenues, then all physicians may have to give up some income; overprescribing physicians may be disciplined if the plan is to continue operating. Such organizations, especially HMOs, can also pay physicians on a salaried basis which, relative to a fee-for-service payment basis, further reduces the incentive to provide care (Held and Reinhardt 1979). HMOs can also impose various types of management interventions/utilization controls to influence how much care physicians provide. The latter are especially important as group size increases (Held and Reinhardt 1979; Sloan 1974).

The other proposals address physician incentives on a more individual basis by setting up some kind of per-patient financial accounts against which the managing, brokering, or networking physician draws as services are used. Unlike IPAs and HMOs, which internalize to the group as much physician (and hospital) care as possible, these plans pit the physician responsible for the patient (and his/her account) against other physicians—typically specialists who depend on referrals for most of their patients. Again, financial risk is placed on the physician by rewarding or penalizing him/her according to some formula that compares actual expenditures to patients' accounts or target expenditures.

PPOs differ from these plans in that they do not generally rely on targets, bonuses, and penalties. They are really nothing more than discount-pricing schemes. In one version, a nonprovider organization (such as an insurer, employer, or union) negotiates fee discounts from physicians in exchange for the promise of more patients. Alternatively, physicians may form a PPO and market their lower fees to patient groups. Patients are directed to discounting physicians through advertising, exhortation, and financial incentives; it costs them more out of pocket if they go to a nonpreferred provider. Thus, PPOs are similar to the other plans in requiring a new organizational arrangement and in limiting beneficiary freedom in choosing providers, but are otherwise similar to fee-for-service, albeit with discounted fees.

The area-wide fiscal-incentive approach differs from the other strategies in this group by setting targets for Medicare spending for all services in a geographic area, comparing actual to target spending, and then penalizing or rewarding all physicians depending on whether the area

experienced a deficit (i.e., actual spending exceeded the target) or a surplus (i.e., spending was below the target). In effect, this proposal would place financial liability for managing all services in an area on physicians, and would leave the choice of methods up to them for achieving fiscal discipline. Unlike the other plans described, area-wide incentives would not directly limit beneficiary freedom in choosing providers, although there could be inter-area disincentives that would limit access directly (Hadley 1984).

Noting the differences among these proposals, should Medicare try to adopt one of them as its national system of paying physicians? Probably not. There are two reasons why none of these is reasonable as the singular Medicare method for paying physicians. First, physicians and beneficiaries would have to be forced to form or join such alternative systems; and organizing these new arrangements would present major problems of implementation. Second, estimates of cost-savings are usually projected from isolated experiments, most of which involve self-selected volunteers. These estimates would undoubtedly overstate aggregate cost-savings if the plan were compulsory for the system as a whole. Even if one-time savings were achievable by converting from fee-for-service to, say, a national Medicare HMO, it is less clear that the rate of increase in costs would be any lower compared with the existing system, without real reductions in quality or access.

None of these proposals offers a good mechanism for deciding how much Medicare should pay for care of a given level of quality and degree of access. In the short run, the pressure to cut costs might lead to an administrative decision irrespective of specific organizational arrangement, like "95 percent of what was paid last year." But over time, Medicare would still have to determine capitation rates, individual, or area budget targets. Medicare's inability to determine an appropriate capitation rate for enrolling beneficiaries in existing HMOs is a good example of the difficulties involved.

These plans are not designed to be fiscally neutral. On the contrary, one of their key features is that they create financial conflicts between providers and patients. Limiting how much can be spent, and tying physicians' remuneration to how much they stay below the limit, creates incentives not to accept for treatment beneficiaries who require more intensive care, and tilts the quality-cost and access-cost tradeoffs in favor of lower cost, quality, and access (i.e., to "cream-skim"). For those who believe that the current system favors too much quality

and too much access, the lack of fiscal neutrality may be viewed as a plus. It should be recognized, though, that this would be a fundamental shift away from the traditional physician-patient relationship based on trust and agency.

In spite of these flaws, however, Medicare should continue to encourage the development of new practice arrangements as competing alternatives to, although not a complete substitute for, fee-for-service practice. Both Medicare and private-sector alternatives—such as HMOs, PPOs, and IPAs—are likely to increase pressure on fee-for-service practice to restrain fee and expenditure growth. Even if no changes were made in the CPR system, competition-induced reductions in the growth of fees would save Medicare money. At the same time, competition among alternative provider systems would likely assure beneficiaries more protection against too little quality and access than would a government-sanctioned monopoly system (Bovbjerg, Held, and Pauly 1982).

One cautionary note: If alternative systems are successful in enrolling only relatively healthy (and less expensive) Medicare beneficiaries, while receiving rates based on average use of services by all (and more expensive) beneficiaries, then Medicare's spending could go up. Preventing cream-skimming and paying rates appropriate for the enrolled population would still be problems.

Proposals to Change What Medicare Pays for

The second group of plans focuses on the unit of output Medicare pays for. Rather than paying for individual *items* of service provided, these reforms would have Medicare pay for *packages* of services (Mitchell and Cromwell 1982). The ultimate package, of course, is the person-year, more commonly known as "full capitation" for physician services. Short of full capitation come other groupings of services. Riding the coattails of diagnosis-related payments for hospitals are proposals to pay for care received from physicians on a per diagnosis (or per episode of illness) basis. One proposal would combine payment for physician services to an inpatient with the payment to the hospital based on the patient's diagnosis-related group (DRG). Another would create separate diagnosis groupings appropriate for ambulatory care (Fetter 1980).

A final proposal would collapse sets of detailed procedures and

services into smaller but more comprehensive groups. For example, all types of office visits, regardless of duration or complexity, would be collapsed into a single procedure, all hospital visits into another procedure, all laboratory tests into a third, etc. These collapsed groups would still be billed and paid on a fee-for-service basis, but physicians could not increase billings by unbundling (i.e., disaggregating) services from the package.

With one important exception, there is no experience with paying physicians on a per diagnosis, per episode of illness, or per collapsed service-package basis. If nothing else, the lack of knowledge about or experience with defining, measuring, and constructing diagnosis-related groups or episodes of illness for ambulatory care and physician services make these strategies unattractive as short-run solutions to Medicare's cost problems.

The important exception is that a large number of well-defined, clearly delimited diagnoses and episodes of care are already incorporated in standard medical procedure coding terminologies (such as the American Medical Association's CPT-4). Many surgical procedures (e.g., cataract removal, hip replacement) include pre- and post-operative physician services, although usually not out-of-hospital laboratory and radiological services.

This exception is instructive on two counts. First, the start and end points of the episode of treatment are clearly defined; such demarcations make it feasible for the individual physician to estimate the cost in time and other resources to care for patients, and to set charges accordingly. Second, and even more important, paying for these procedures on a per diagnosis or per episode basis has not solved Medicare's problems of paying more than it wants, or of limiting the rate at which charges and expenditures for these services have been growing.

In using Medicare's new payment system for *hospitals* (DRG) as a model for a payment system for *physician services*, it is essential not to overlook why the former differs fundamentally from reasonable cost-reimbursement. It is not that Medicare pays hospitals fixed rates per DRG, but rather that payments are based on fixed rates set *in advance*. One would venture the guess that reasonable cost-reimbursement per DRG would be little different from the old reasonable-cost system in its results. Similarly, customary-prevailing-reasonable reimbursement

of ambulatory DRGs would be unlikely to provide very much fiscal relief for Medicare.

Finally, it should be noted that proposals merely to change the unit of payment from the individual service to some broader aggregation fail to accomplish two objectives: They are neither fiscally neutral, nor do they help to determine the right payment level. Changing the unit of payment from the individual service to some broader concept, such as the episode, diagnosis, time period, or service package (that is relatively independent of the specific number and quality of services actually provided) creates a strong incentive to under-provide care to all beneficiaries and to refuse care to those whose medical needs might outstrip the Medicare payment per unit. Paying per diagnosis or per episode does not make it any easier to determine the right payment level. If payment rates per diagnosis or per episode are set too high (relative to the fee-for-service equivalent), or if they increase at too high a rate, then Medicare's payments may be no lower than they would have been otherwise.

Proposals to Change How Medicare Determines Rates of Payment

The third set of payment options deals with fee schedules, which retain the essential practice characteristics of the fee-for-service system, but change how levels of the fee are determined. Fees would not be based—even in part, as under CPR—on each physician's *past* and *current* charges; rather, they would be determined *in advance* for each service. This prospective payment system for physician services still faces the critical issues of how, and at what values, fee levels should be set and, to a lesser degree, who receives the payment.

Setting fee schedules. The simplest way for Medicare to create a fee schedule would be to freeze existing customary and prevailing fees for every service in each area of the country. This would create area- and physician-specific fee schedules which would be known in advance and which would not be increased by a physician's own charges. However, such a fee schedule would also retain all of the current system's inter-physician payment inequities, as well as incentives for inefficiency. Some services will be overpriced relative to their costs and benefits, and others underpriced.

Inter-physician inequities could be eliminated simply by having fees apply to *all* physicians within a geographic area. The geographic areas could remain coterminous with Medicare carriers' boundaries; or a smaller number of areas could be created—for example, nine census divisions, *within* which differential rates for central city, other metropolitan, and nonmetropolitan areas might apply. Variations in rates *across* areas should reflect variations in the underlying nonphysician costs of providing services, such as rental for office space, utility rates, and wages for employees of physicians' practices.

The problem of correcting the current system's incentives for inefficiency is more difficult. Even if a procedure is produced efficiently, and priced economically, there is no inherent assurance that it is an *effective* procedure. The efficacy and effectiveness of procedures is a medical matter, and has to be continually monitored under conditions that go far beyond those available in the usual physician-practice setting. Once effectiveness of a procedure is established, however, efficiency demands that it be provided at a competitive cost relative to equally beneficial alternative services. With improvements in technology and accumulated experience, the costs of providing a given service may drop over time, and fee schedules should reflect this change.

In effect, Medicare would have to review the existing pattern of fees in order to identify those which it judges too high (or too low) relative to their costs, and to their benefits to patients. Neither individual physicians nor individual patients probably can make these evaluations, nor do they have much incentive to do so under the current system. Insurers, especially the large Medicare program, will have to make these determinations. Formulas like CPR cannot do it. Only by answering questions about relative values can Medicare, and indeed private insurers, discipline fees in the same way that informed consumers influence prices in conventional markets.

The goal of these adjustments would be a set of fiscally neutral fees for alternative services. The physician's profits from choosing one effective procedure over another should be approximately the same for both procedures. If they are, then the choice would be governed by what is better for the patient's medical and financial outcomes, not the physician's pocketbook.

An important point to note, however, is that the concept of profit

encompasses much more than the physician's rate of pay per unit of time required to perform a procedure. It also includes the financial return to the physician's investments in education, training, and capital equipment. In other words, simple comparisons between physicians' income per hour for office visits in the medical management of a cardiac patient and a coronary by-pass operation are meaningless. They must include adjustments both for other costs, including differences in training and support staff, and for benefit to the patient. This does not mean that such comparisons should not be made, only that they should be made intelligently.

Can such an ideal fee system be calculated or computed with existing data? Is this a simple technical problem that we can solve with our computers? Obviously, no. Just as the process of price determination in conventional markets is iterative and continuous, so it will be for Medicare. One of the virtues of the fee-for-service system is that it provides much of the information needed to make these adjustments.

Since changing relative fees over time requires judgment, simple formula adjustments to the entire schedule (such as Medicare's existing economic index, or one based on the rate of change in the GNP or consumer prices) would introduce new distortions over time. A more appropriate mechanism would be a "Commission on Relative Values for Physician Services," modeled after the new commission charged with recalibrating DRG-based payments to hospitals. Commissioners would represent the various interest groups affected by changes in relative fees (physicians, beneficiaries, Medicare), and technical experts. Its staff would conduct or commission the studies needed to gauge how the volume of specific services changed in response to changes in costs of provision and/or benefit to patients relative to fee levels. Periodically, the commission would recommend adjustments in relative fees.

Choosing the dollar multiplier that converts relative fees into absolute fees is another critical decision in constructing a fee schedule (Hadley et al. 1983). If set very low, Medicare will reduce its fiscal outlays, but physicians would be less willing to treat Medicare beneficiaries at existing levels of quality. If set very high, access, quality, physicians' incomes, and Medicare's payments would all go up. Balancing these competing pressures is fundamentally a political decision that should be left to the political process. Narrowing the debate from what each

and every fee should be to what the rate of increase in a single (or a few) dollar multipliers should be at least makes this a more manageable, if no less difficult, political issue.

A fee schedule would be very easy to implement and administer. As a preliminary, all providers of physician services would have to adopt a uniform procedure coding terminology for identifying services. Medicare would then make its payment schedule available to carriers, physicians, and beneficiaries. Physicians would identify the services provided on their bills and would be paid in accordance with the published rate. Carriers would no longer have to compute customary and prevailing profiles for every physician and service, nor would they have to compare actual charges with customary and prevailing profiles in order to determine Medicare's payment. Physicians and patients would know in advance how much Medicare would pay for a service.

Indemnity schedules. Although there are many variations on the fee schedule theme—e.g., schedule of maximum allowable fees and preferred provider organizations—that of an indemnity schedule is particularly appealing. Indemnity insurance, which reimburses the insured beneficiary a fixed amount for a covered service, regardless of the physician's fee, is by no means new in the health field. Nor is its recommendation as an alternative to the CPR method of fee determination (Gianfrancesco 1983; Pauly 1971).

Three reasons make the indemnity schedule an attractive approach:

1. It rewards Medicare patients for seeking care from lower priced physicians, since the beneficiary would keep the difference between the indemnity amount and the physician's charge.
2. It does not eliminate price competition among physicians in trying to attract Medicare patients.
3. It leaves physicians free to charge fees consistent with changes in their practice costs, in market conditions, and in technology.

Allowing physician charges to fluctuate is critical to monitoring the access and quality levels that the indemnity schedule buys. The differences between indemnity payments and physicians' average charges will be the barometer of how much access and what level of service beneficiaries are receiving for the Medicare payments. As the discrepancy between charges and the indemnity rates grows, Medicare beneficiaries will have increasing difficulty in finding physicians willing to treat

them under acceptable conditions; payments will have to be adjusted upward. Conversely, no increase will be called for as long as access and quality remain acceptable.

An indemnity schedule, like a fee schedule, can incorporate relative values to reflect Medicare's assessment of the relative costs and benefits of alternative services. Also, like a fee schedule, it would eliminate confusion over how much Medicare will pay. Physicians would be required to disclose both their fees and Medicare's indemnity amounts for the specific services they prescribe. Indemnity amounts could be varied to reflect regional and community variations in the cost of living, so that the real value of the indemnity to the beneficiary would be the same across the nation.

Billing arrangements could follow Medicare's existing or modified assignment options. Physicians who wish to attract patients would offer to accept assignment. Physicians who reject assignment would bill the patient but might face higher collection uncertainty.

What about Assignment?

The physician's option to accept assignment of Medicare payments has come to be viewed by some as a mechanism for protecting beneficiaries from physicians who charge in excess of what Medicare pays. In the last few years, the proportion of claims on which assignment has been accepted has increased slightly, even though Medicare's payments relative to charges have continued to fall (Fox 1984). One explanation of this paradox may be that in a more competitive medical market physicians may value the certainty of payment of lower amounts over the uncertainties of pursuing higher fees.

To other observers, the option to reject assignment is tantamount to license to overcharge. This fear has led to proposals requiring physicians to accept assignment on all claims (or to choose periodically between accepting assignment on all or none of their Medicare claims). To help gauge the consequences of such proposals, table 2 records the percentage distributions of Medicare services and physicians by rate of voluntary assignment. Over 50 percent of the physicians accepted assignment for less than 10 percent of their services to Medicare beneficiaries. Fewer than 15 percent accepted assignment for more than half of their Medicare services. Average Medicare practice sizes

TABLE 2
 Voluntary Assignment Rates of Medicare Services, California Physicians, 1978¹ (Services are measured in California relative value scale units)

Voluntary assignment rates	All Medicare services	Physicians ²	Total Medicare services per physician	Total nonelderly Medicaid services per physician
0-5%	32.2%	44.2%	5,919	1,617
5-10	16.4	12.9	9,799	2,039
10-30	32.1	24.4	10,190	2,277
30-50	6.8	7.0	7,527	2,693
50-90	7.9	7.4	8,190	4,653
90-100	4.7	6.2	5,805	4,493

¹ The voluntary assignment rate is computed by deleting claims for joint Medicare-Medicaid patients who must be treated on assignment, and taking the ratio of assigned services to total services (Medicare beneficiaries). Data are based on all claims submitted during the second calendar quarter of the year.

² 1,885 general practitioners, internists, and general surgeons who provided at least 250 relative value units of care to Medicare beneficiaries.

Source: Unpublished data from the Urban Institute.

were about the same at every level of assignment, so the distribution of Medicare services is similar to the distribution of physicians. However, physicians who accepted assignment at a high rate provided about twice as much care to nonelderly Medicaid patients as did those with low rates of assignment. This suggests that the former were likely to treat more near-poor Medicare beneficiaries than were other physicians.

If these distributions are representative of other specialties and other areas, they suggest that mandatory assignment would be a substantial disruption of many existing physician-patient relationships. For many physicians who currently accept assignment on relatively few claims, mandating assignment would induce them to drop out of the program entirely, making Medicare's physician coverage essentially worthless for patients who would choose to continue with them. Simulations based on national survey data suggest that the net effect of an all-or-none assignment system would be to lower the aggregate proportion of claims treated on assignment (Mitchell and Cromwell 1983). For other physicians, mandatory assignment would mean a sharp fee reduction, creating strong pressures to discriminate against Medicare beneficiaries in quality and access relative to private-pay patients.

The obvious advantage of the claim-by-claim, or perhaps person-by-person assignment option is that it permits beneficiaries to choose

between higher quality and better access, and lower costs. For many situations and services, beneficiaries may be perfectly willing, and have the opportunity, to seek physicians who accept assignment. In other situations, however, beneficiaries may have a strong preference for particular physicians, even if they do not accept assignment.

The assignment rate should be one of the key barometers of how Medicare's payments affect access to care. Mandating assignment would obviously eliminate this role. More importantly, although mandated assignment would preclude beneficiaries having to pay more out of pocket for their care if Medicare paid less, it would not preclude them from paying the costs of reduced quality and access.

Medicare could change incentives for physicians to accept assignment and beneficiaries to seek care from physicians who accept assignment while retaining the current system's claim-by-claim flexibility. Research has shown that physician willingness to accept assignment goes up with increases in Medicare's payment rate relative to his/her charges (Lee and Hadley 1979b; Paringer 1979). One way to pay more, and at the same time reward beneficiaries for seeking care from physicians who accept assignment, is to reduce beneficiary cost-sharing from 20 percent to, say, 15 or 10 percent of the Medicare fee. In effect, Medicare would guarantee a higher proportion of the fee, thereby reducing physicians' losses if they are unable to collect beneficiaries' cost-sharing.

To finance the reduction in cost-sharing for beneficiaries treated on assignment, Medicare could discount its payment for nonassigned claims. This would further increase the difference in beneficiary cost-sharing between assigned and nonassigned claims. Percentage reductions could be set so that the impact on taxpayers is neutral, with users of nonassigned services subsidizing reduced cost-sharing for users of assigned services.

Marginal changes in financial rewards and penalties would be much less disruptive than either the mandatory or all-or-none assignment proposals. Periodic adjustments could be made in percentage reductions in cost-sharing and fee amounts in order to meet assignment-rate goals. Physicians who do accept assignment typically charge less than physicians who do not (Holahan et al. 1979). Therefore, an important by-product of increasing beneficiary incentives to seek care from physicians who accept assignment is that it should contribute to moderating inflationary pressures on physician charges generally.

Concluding Observations

In reshaping the laws that govern the Medicare program, it would be prudent to remember one of the key laws of economics: You get what you pay for; and its corollary, If you pay less, you get less. Almost all of the proposals discussed, regardless of their structure or incentives, would save Medicare money, as long as Medicare paid less. However, physicians would view payment reductions for what they are and, in all likelihood, would cut back on quality of services provided and/or the number of Medicare patients they would be willing to see.

No system of paying physicians will eliminate the necessity of choosing among program spending, beneficiary spending, quality, and access. Given that choices must be made, the first and probably hardest question Congress must deal with is how much medical care it is willing to pay for on behalf of the elderly. If there were no return on the public investment in medical care, then the question would be much easier to answer; it would be clear that too much is being spent. But my own and other research suggest that there has been a positive correlation between the use of medical care and the length and quality of life (Hadley 1982; Rogers 1982).

Again, no payment system will magically provide the right answers to how much to spend. Nor will it be illuminating to debate the issue in terms of how many billions of dollars Medicare spends, the medical care sector's share of the GNP, or HCFA's share of the federal budget. There is nothing that is intrinsically right about health care making up 8 or 9 percent of the GNP, nor is there anything intrinsically wrong about 10 or 11 or 12 percent of the GNP.

At any percentage of the GNP, however, Medicare must pursue two goals: efficiency—getting the best value for its money—and equity—ensuring that everyone gets served according to needs and on an acceptable basis. In terms of promoting efficiency, our economic system has developed an unparalleled, highly decentralized method—the price system. In the market for physician services, this has taken the form of the fee-for-service system. Critics often contend that fee-for-service is a blank check for physicians, but that is to confuse the method of payment with the method of determination of fee levels. In instances in which governments have imposed fee schedules within a fee-for-service system, the level of payment can be very stingy indeed (Hadley, Holahan, and Scanlon 1979; Evans 1983).

Government does not make judgments about relative worth very easily. Although such questions are difficult, so too are those which would need to be addressed in order to design and implement any of the other proposals outlined in this paper. Relative to other choices, a fee schedule or, better yet, indemnity schedule offers several advantages. Its development from an initially frozen fee schedule could be phased in over the next few years. It would be least disruptive of existing practice arrangements and physician-patient relationships. It provides the best chance of developing a fiscally neutral payment system which does not discriminate against sicker or less healthy beneficiaries. It provides as a normal by-product of the billing and payment process most of the information required to monitor the system's performance and make needed changes, whether toward more fiscal restraint or greater quality and access. Lastly, it can be easily integrated with procompetitive policies, especially those which increase beneficiaries' cost-sharing or interprovider competition.

No payment system alone can both promote efficiency and assure equity of access. Other policy tools are needed. However, mandatory or all-or-none assignments are not very good choices. A much more flexible approach, which is easily integrated with a fee-schedule payment method, is to reward differentially physicians and beneficiaries for providing and seeking care on assignment and/or penalize them for transacting care on a nonassigned basis.

The pending Medicare trust fund crisis requires that difficult decisions be made. But crisis also brings opportunity—the opportunity to make substantial and beneficial changes in the structure of the Medicare program. Whatever changes are made in the next few years will probably be with us for many years to follow. The pressure for a short-run fiscal fix should not be allowed to overwhelm this opportunity.

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