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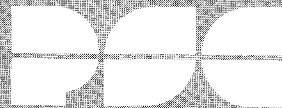

HEALTH POLICY BULLETIN

FOCUS: MEDICARE PHYSICIAN PAYMENT REFORM

The federal government once again is sharpening its cost-cutting scissors; the target is Medicare physician payments. The feds hope to reduce the rapid escalation of Medicare physician payments: Between 1980 and 1986, these payments increased 140 percent, compared to an increase in hospital payments of 99 percent.

Recent piecemeal attempts to reform physician payment—the most prominent being freezes on fees—have done little to control physician expenses, simplify complex billing procedures, or make the payment system predictable for government, physicians, and consumers. This is not surprising given the way Medicare currently pays physicians. Payment is the lowest of (1) the billed charge; (2) the customary charge (the median of individual charges for a given service in a year); or (3) the prevailing charge (currently determined by a complex procedure comparing the customary charges of physicians in a given geographical area). The American Medical Association (AMA) believes this system is inequitable for physicians and beneficiaries (who must pay some premiums and out-of-pocket expenses), in part because it does not reflect the true costs of physician services.

The federal government seems to agree. It wants a simpler, more predictable payment mechanism that curbs rapid increases in expenditures. The government thinks that a resource-based relative value scale (RBRVS) may be such a mechanism. An RBRVS is a list of all physician services ranked according to "value," that is, the resource costs—physician time and intensity, practice costs (including malpractice premiums), and amortized cost of specialty training—of providing the service. The more resource costs required to provide a service, the higher its relative value. The value for a procedure must then be multiplied by a dollar amount ("monetary conversion factor") to arrive at a payment.

In less than a month, the Harvard School of Public Health will release a detailed study of an RBRVS for 18 physician specialties. This much-anticipated study was commissioned by the U.S. Health Care Financing Administration (HCFA) after a directive from Congress in 1986. The AMA is a subcontractor, ensuring that the study reflects the perspectives of practicing physicians. Considerable review inside and outside government, with public hearings, will follow publication of the study.

There is much speculation about the contents of the Harvard study. An RBRVS likely would lower reimbursement for some procedural doctors—radiologists, pathologists, surgeons, and others—and increase payments to primary care physicians. This reflects the government's belief that some procedural doctors now charge disproportionately high fees for their services. Will this lead to divisiveness among the specialties? "It could, but it certainly doesn't have to," says Tom White, manager for Medical Economics and Health Care Delivery at the Michigan State Medical Society. "The effects of an RBRVS will vary from state to state. If the perception that Michigan physicians are underpaid by Medicare relative to the whole nation is true, it is possible that an RBRVS will boost payments for some specialties without cutting payments to others." White also notes that the AMA prefers an RBRVS to other proposed large-scale Medicare physician payment reforms. "An RBRVS is much better for physicians and patients than physicians' DRGs or capitation would be because it is much more likely to ensure that patients receive the medical care they need. All the financial incentives with DRGs and capitation are to use as few services as possible."

This raises what is likely to become a central problem for government: An RBRVS, unlike the Prospective Payment System for hospital payments, does nothing to discourage utilization. And it is increased utilization that many blame most for escalating health care costs. White offers another possible scenario: "To control costs, the federal government may just decide that it will not pay anymore than x billion dollars to physicians under Medicare and then work back from there to the fees it will pay for individual services."

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Some version of the RBRVS, with a monetary conversion factor selected by the government, will likely be the new method for paying physicians under Medicare. And physicians *will* argue—if not in Michigan, then in other states—about the fairness of the relative values; it is inevitable with such a potentially fundamental change in physicians' relative standing. Oddly enough the federal government may have unintentionally reduced resistance to reform by favoring the RBRVS over alternatives: It is a system that may divide physicians among themselves; a system that cuts all physicians' fees would be more likely to unite them against the feds.

FOCUS: RETIREE HEALTH BENEFITS LIABILITY

Rapidly rising health care costs have forced many businesses to pay more than they ever dreamed for the retiree health benefits they promised to employees years ago. This has spurred corporate scrutiny of retiree health expenditures with an eye toward limiting escalating health costs immediately as well as in the future. A new rule from the Financial Accounting Standards Bureau (FASB), which sets standards for accounting, may further invigorate restrictions on retiree health benefits. Later this month, FASB will release a draft rule calling for businesses to include future retiree health benefits as liabilities on their balance sheets. Six months of public hearings and revision of the rule will precede its adoption in 1989. It will go into effect in 1992, although smaller employers may have longer to comply.

At present, most companies do not set aside money for (and thus count as liabilities) the retiree health costs of current employees; they pay only for their retirees' premiums or bills as they incur them. "FASB is saying that if corporations made a promise to provide health benefits for their employees, they ought to count the cost of that obligation during the working lifetimes of their employees," explains Jim McCready, senior consultant in the actuarial, benefits, and compensation consulting division of Coopers and Lybrand in Detroit. Such labor-intensive industries as health care and those with large retiree populations will be hardest hit. The new rule also will have a large bearing on businesses' credit and, thus, their ability to borrow money.

Most companies have known for months about the proposed rule, and it has driven many businesses to quantify for the first time their future health care obligations. Nationwide, these obligations are estimated to total from $100 billion to $2 trillion. Individually the largest manufacturing corporations may face new liabilities of $1 billion or more. McCready, whose firm has contracted with a consortium of 26 major corporations to estimate their future retiree health care costs, says they face a difficult task: "Health care costs are difficult to predict; we're talking here about some workers who may not retire for thirty or more years. Still, a ballpark figure for the present value of future health benefits liability for a worker who retires at 65 is $14,000. For early retirees it is much higher: approximately $36,000 at age 55. These values vary, of course, depending on the benefits package a company has.

"Because the new rule will hurt businesses' bottom lines, many are even more likely than before to cut retiree health benefits. Quantifying future benefits for the new rule will accelerate businesses' realization that they cannot cover all health care for retiring workers, even with Medicare paying a good part of it," says McCready.

Businesses can restrict benefits to current retirees by raising copays and premium contributions. Cancellation of retiree benefits by a few companies has been met with staunch opposition and lawsuits. It is most likely that companies will limit benefits for future retirees (current workers) by tying the breadth of coverage to years of service, requiring employee cost sharing from the first day of work through retirement, or not offering retiree benefits at all.

The new FASB rule will eventually affect government as well. Although the Government Accounting Standards Board (GASB) will wait for the final FASB rule before embarking on its own review of retiree health benefits, historically, GASB rules have paralleled those of FASB.

OF INTEREST

To try to control skyrocketing health care costs for 8,000 employees, a fast-service food store chain in Arizona will not cover conditions brought on by "personal life-style decisions" in its health insurance policies. These include alcohol and other drug abuse, AIDS, and self-inflicted wounds. The company, Circle K Corp. of Phoenix, Arizona, is self-insured and therefore exempt from providing state-mandated employee benefits by the federal Employee Retirement Income Security Act of 1974.

— Peter Pratt, Consultant/Health Policy

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