April 15, 1997

The Honorable William V. Roth Jr.
United States Senate
Washington, DC 20510

Dear Senator Roth:

During the March 5 Finance Committee hearing on Medicare Reform, I promised to get back to you with my thoughts on your question on what policies may have helped or not helped in the dramatic reduction in the rate of increase in expenditures on physician services. As you know, the Congressional Budget Office (CBO) projects that Medicare expenditures on physician services will increase by less than 3 percent per year for the next decade, well below historical trends. No other major category of Medicare spending is projected to grow at such a slow rate. I think there are several reasons why this is occurring, only some of which can be directly or indirectly attributed to federal health policies. As explained below, policies such as resource-based Medicare payments may have contributed to lower expenditure growth. But much of the change is likely due to underlying shifts in practice patterns that would have occurred even in the absence of federal legislation. Specifically:

1. **There has been a major change in practice patterns over the past decade.** Using medical outcomes research, profiling of practice patterns, and cost-effectiveness analyses, physicians have found ways to manage and care for patients that are less costly than those used in the past. Specifically, conditions that in the past would have been treated in an inpatient setting, using surgical procedures and other invasive interventions, now often can be treated in the less expensive ambulatory setting using less invasive (and less costly) methods. As noted in our written testimony, many heart patients that in the past may have eventually required coronary bypass surgery can now be treated through medication and careful management by an internist of their diets and lifestyles, and when necessary, by a procedure called angioplasty that can clear blocked arteries without resorting to more invasive (and costly) bypass surgery. Similarly, the Physician Payment Review Commission, citing the Agency for Health Care Policy and Research, reported in 1994 that "Reductions in the volume of prostate-related procedures mostly reflect changes in treatment through increased use of drugs, less invasive surgical procedures, and watchful waiting" (PPRC, Fee Update and Medicare Volume Performance Standards for 1995, May 15, 1994).

2. **There has been a dramatic reduction in the "demand" for cataract surgeries and certain other procedures that were growing at double-digit rates in the 1980s.** In the same 1994 report from the PPRC that is cited above, the Commission noted that the demand for cataract surgery had decreased substantially in recent years as fewer patients were available who needed such treatments. As explained more fully in our written statement, the PPRC found that "The period of greatest growth in volume for a new medical procedure or technology is often the first few years following introduction, largely because it is during this period of diffusion that patients with existing indications are treated along with those newly identified. In the mid-1980s, the volume of new technologies such as cataract surgery was growing at double-digit rates, because there were tens of millions of patients who needed--and could benefit--from those treatments. As time has passed, however, the demand for such procedures has naturally declined."

3. **The shift to cost-effective medical management of conditions that in the past would have been treated more expensively has been encouraged by federal policies, particularly resource-based payments for physician services.** By enacting legislation in 1989 to mandate resource-based payments for physician services, Congress intended to reduce the incentives that rewarded physicians for ordering expensive surgical and other procedural services while financially penalizing them if they relied on cost-effective evaluation and management, or cognitive, services. Under the customary, prevailing and reasonable charge system that was then in effect, surgical procedures were paid far more for the work involved than...
evaluation and management services, such as office visits and consultations. The result was that physicians who provided a large volume of procedural services were paid more for their work than physicians who principally provided visits and consultations. This inequity was at odds with the goal of encouraging practice patterns that relied more on careful watching and non-invasive treatments of patients' conditions and less on surgical and other technological interventions. Resource-based payments, by paying the same amount for services that involve equivalent work, were intended to level the playing field. Despite flaws in the way that the RBRVS has been implemented, I believe that the RBRVS has helped equalize the incentives, and by doing so, has contributed toward the shift in practice patterns noted above.

The impact of Medicare volume performance standards (MVPSs) is more mixed. The MVPSs have contributed to slowing the growth in expenditures on physician services--not by encouraging physicians to be more efficient (as Congress intended), but because they triggered automatic reductions in Medicare payments whenever the MVPSs were exceeded. I am not aware of any evidence that suggests that the MVPSs have had any impact on decisions by individual physicians to lower volume in order to stay within the MVPSs. But they have led to lower updates for primary care services and other nonsurgical services in years when volume growth in those categories has exceeded the applicable MVPSs. Unfortunately, separate MVPSs and updates for surgical procedures, primary care services, and other nonsurgical services also re-created the distortions that resource-based payments were intended to correct, by resulting in higher conversion factor increases for surgical procedures than primary care services and other nonsurgical services that require the same amount of physician work.

Changes mandated by OBRA 94 in how the MVPSs are calculated will result in Medicare fee schedule payments declining by 21 percent over the next decade in constant 1996 dollars, according to Congressional Budget Office. Although these reductions are unquestionably contributing to lower expenditure growth, we are concerned that they may adversely affect access to care, particularly access to primary care services--a risk that will be even greater if further reductions are enacted this year. ASIM recommends replacing the separate MVPSs with single sustainable growth rate of at least per capita GDP plus two percent. We also recommend mandating a single conversion factor to replace the separate conversion factors for surgical procedures, primary care services and other nonsurgical services. Our testimony explains these recommendations in more detail.

In conclusion, I believe that changes in practice patterns that have occurred largely independent of federal health policies are principally responsible for the slowing of Medicare expenditures on physician services. Physicians deserve credit, I believe, for supporting outcomes-based research and changing their practice patterns based on such research. I also believe that Medicare resource-based payments have contributed to the change in practice patterns, by reducing the economic incentives to provide high cost invasive procedures.

Please let me know if you require further information.

Sincerely,

Alan Nelson, MD
Executive Vice President