Regulating Doctors’ Fees

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Review Article by
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This review article examines the issues raised by shifting from the "customary, prevailing, and reasonable" system of paying doctors under Medicare to a fee schedule based on construction of relative resource costs, in particular relative physician work effort. The volume edited by H.E. Frech III provides the basis to consider issues such as whether a relative surplus of specialist physicians exists and if so, whether changes in reimbursement will alleviate the maldistribution. Regulation of physician fees is likely to impact patient access, especially if balance billing is not allowed. Early research on the implementation of the new system indicates that fees have been set far below private insurance rates. Alternatives to price regulation are proposed. (JEL R97)

This book contains papers which were originally presented at an American Enterprise Institute-sponsored conference examining the desirability and probable consequences of shifting to a fee schedule for Medicare instead of its "customary, prevailing, and reasonable" (CPR) system. H. Frech and the other contributing authors examine the historical CPR system, the new Resource Based Relative Value Scale (RBRVS) system as well as other reimbursement methods. Such topics as balance billing, Medicare supplementary insurance, consumers' responsiveness to price, relative and absolute fees for various physician services, patients' access, effects on volume, and impact on quality are all addressed.

The volume by Frech and the chapter authors raise many important concerns about the RBRVS approach. It reasonably notes that instead of implementing price controls with all the familiar problems, consideration ought to be given to improving market forces and developing incentives for efficiency. Despite the numerous authors, the volume has a unified approach. The book makes a major contribution to the debate about health care by presenting new information and data and, especially, by formulating the issues in a straightforward and thought provoking manner.

The shift to the RBRVS system has occurred in the context of far more rapid increases in payments to physicians under Medicare than to hospitals (15 versus 6 percent since the 1984 implementation of the prospective payment system for hospitals) and a perceived excess in specialist physicians and a shortage of generalist physicians [Frech, pp. 36, 39]. Developed by Hsaio and his colleagues at Harvard, the RBRVS system became effective in 1992 and attempts to measure relative physician work effort. The RBRVS system is intended to help restrain physician expenditures under Medicare and to encourage entry into the generalist areas of medicine.

Understanding the conversion to a fee schedule for Medicare requires a brief analysis of the CPR system. Under the CPR fee for services payment system, the patient pays 20 percent of the doctor’s fee above the annual deductible and Medicare pays the remaining
80 percent. This fee is determined by the minimum of the physician's actual charge, his own individual customary charge, or the charge prevailing in the area. In addition, physicians have the option of balance billing, that is, collecting from the patient not only the deductible but also the balance of the bill above that reimbursed by Medicare. Physicians are under some pressure to balance bill to maintain their "usual fee" status. The CPR system thus reduces the incentive to compete by offering lower prices. Not surprisingly, the CPR fee system has been criticized for not restraining Medicare physician expenditures. However, volume of services is as important as price. In fact, the problem of excessive growth in Medicare physician payments has arisen largely because of increased services per patient, not because of increased prices [Frech, p. 4].

An additional complicating factor is the prevalence of insurance to cover the portion not paid by Medicare. Joseph Antos notes that Medicaid and Medicare-supplement or Medigap policies pay most of the physician charges not covered by Medicare. Thomas McGuire suggests that the Medigap-type policies increase Medicare volume by 5 to 10 percent. He proposes that Medigap, which undermines consumer price sensitivity, might be taxed so that consumers bear the real cost of their usage, thereby increasing social efficiency. McGuire notes the conflict between protecting the elderly from medical expenses versus increasing the uneconomic use of Medicare. However, one possible solution would be to cap out-of-pocket physician expenditures at a reasonable level. This would decrease the financial responsibility of the elderly and decrease the uneconomic demand for physician services. Given the lack of incentives for the economical use of physician services, it is not surprising that expenditures have increased so much.

A central issue under the CPR system is whether physician prices and earnings are distorted. Janet Mitchell includes pre- and post-operative care and still finds that surgery has been overpaid relative to office work. Mitchell also criticizes the CPR method because there is no mechanism to adjust payments downward. A procedure such as open-heart surgery or cataract surgery involving new technology may have a high initial cost and fee, but as the procedure becomes more commonplace, its cost (and difficulty) is often reduced [Pope and Schneider, 1992, p. 189] but its price does not decrease and may even increase. The RBRVS system could adjust the prices downward as effort decreases.

On the other hand, high relative surgical incomes could be an equilibrium result. William Marder and Richard Willke consider specialty training costs and note that ability, entry barriers, and disutility may help account for differential earnings. David Dranove and Mark Satterthwaite point out that if earnings differentials are compensating differentials, changes in fees may not be appropriate. Entry and exit should equalize the earnings of physicians in all communities and specialties after consideration of non-monetary factors like quality of life and stress. Indeed, substantial excess surgical capacity and full use of capacity in internal medicine may be consistent with equilibrium if surgery exhibits characteristics of monopolistic competition. In addition, Mark Satterthwaite notes that, since the causes of the income differences are unknown, changing fees may simply cause a long-run return to the previous situation with all the associated adjustment costs. Finis Welch adds the basic criticism that it is unacceptable to assume that only the explained portion of the variance in earnings is justified. Given inadequate information for the causes of the income differential, changing the fee structure may not solve the problem.

However, excess surgical capacity has persisted [Blackstone, 1974]. Jack Hadley mentions the experience of the airline industry during regulation. Prices were set at too