Analysis, Advice, and Congressional Leadership: The Physician Payment Review Commission and the Politics of Medicare

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Abstract In 1985, Congress established the Physician Payment Review Commission (PPRC) to help formulate changes in the system used by Medicare to pay for physician services. The recommendations of the PPRC and subsequent legislative action led to fundamental reform. As a new type of advisory body, the PPRC enabled Congress to establish an agenda for physician payment reform and set it into law despite initial resistance from the executive branch. Four key factors contributed to the influence of the commission: (1) an institutional design that enhanced and integrated congressional policy formulation; (2) the quality of the information generated for legislative deliberation; (3) the open, consensual process the commission used to translate that information into policy recommendations; and (4) the strategic packaging of the proposals for reform. In the process leading to enactment of the new payment system, the commission skillfully bridged the traditionally segmented roles of neutral analyst and political advisor for legislators pursuing Medicare reform. Implementation of physician payment reform has been largely an administrative responsibility, in which the PPRC has played a minimal role. The complexity and ambiguity of some of the legislative provisions have left room for administrative officials and interest groups to maneuver according to their priorities. Thus, despite congressional efforts to design a tightly controlled system, a considerable amount of work remains to assure its technical and political success.

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A New System for Paying the Doctor

Beginning in the middle 1980s, Congress enacted a series of changes in the policies governing physician payment under the Medicare program. Early on, legislators established the Physician Payment Review Commission (PPRC) to advise them on ways to adapt or replace the system used to pay for physician services. The recommendations of the PPRC and subsequent deliberations in Congress and the Reagan and Bush administrations led to legislation authorizing fundamental reform of Medicare's physician payment system in November 1989.[1]

The PPRC is not the principal agent of physician payment reform, for the need for a new system was evident and initial steps in that direction were taken by Congress before the commission held its first meeting. The analysis and advice of the PPRC have been instrumental, however, in the scope and pace of reform since the commission issued its first report in March 1987.

The outstanding achievement of the PPRC has been to facilitate broad and lasting changes in physician payment policies in response to congressional directives. It responded to a variety of problems in the Medicare program by developing a set of recommendations that were acceptable to the interests of beneficiaries, physicians, and representatives of the taxpaying public. Since the passage of the major reform package in 1989, the PPRC has assisted congressional oversight of implementation as the new policies are worked out by the Health Care Financing Administration (HCFA), the private insurance carriers for the Medicare program, and the medical community.

The purposes of my article are to describe the broad aims and specific elements of physician payment reform in the Medicare program, analyze the process that culminated in congressional enactment of the 1989 legislation, and assess the technical and political challenges inherent in implementing a policy of this scope and complexity.

Initially, I recount the context for reform—the rapid rise in governmental spending for physician services; unjustified differences in payments by procedure, by specialty, and by geographic location; and the increasing financial burden on elderly beneficiaries caused by premium increases and physician fees not covered by Medicare.

1. The main package of reforms was included in the Omnibus Budget Reconciliation Act of 1989 (Publ. L. No. 101-239), enacted by Congress on 22 November and signed by President Bush on 19 December 1989.

I then review the congressional decisions leading to comprehensive reform in 1989 and the sequence of reform Congress has authorized through 1996. I attempt to explain the legislative history of physician payment reform in light of theories of policy change, tracing the process of problem definition, policy formulation, and political negotiation.

Next, I discuss in some detail the role and contributions of the PPRC in the legislative process. In the course of policy-making, the commission performed a variety of functions and exerted a substantial influence over physician payment policies in the nation's health care system. As a new type of advisory body, the PPRC helped Congress establish an agenda for physician payment reform and set it into law despite initial resistance from the executive branch. There were four key factors that contributed to the influence of the commission: (1) an institutional design that enhanced and integrated congressional policy formulation; (2) the quality of the information generated for legislative deliberation; (3) the open, consensual process the commission used to translate that information into policy recommendations; and (4) the strategic packaging of the proposals for reform.

Finally, I consider the far more limited role the PPRC has played since legislative enactment of the new physician payment system. The complex and unfinished design of the policy shifts power from Congress to the executive branch and introduces considerable discretion into the process of implementation. I review the steps already taken and consider how implementation may proceed in the future. Based on the process to date, it appears that the ultimate character of the payment system and its substantive impact will depend a great deal on the value judgments inherent in technical analysis, the closed nature of bureaucratic decision making, and how individuals and organizations respond to the diverse rules and incentives established by the policy.

The Context of Physician Payment Reform

Medicare presently covers most of the costs of hospital and physician care and various other health services for 34 million elderly and disabled beneficiaries. The Medicare program was established in 1965 when Congress added Title XVIII to the Social Security Act. The program has two parts with separate benefits and sources of funding. Part A, the Hospital Insurance (HI) program, covers inpatient hospital services and provides limited coverage for skilled nursing care and home health services. It is financed by compulsory payroll taxes. Part B, the Supplementary Medical

Insurance (SMI) program, includes benefits for physician services as well as outpatient hospital care, outpatient laboratory tests, durable medical equipment, and certain other services.[2] Participation by Medicare beneficiaries in the Part B program is voluntary and the program is funded by premiums from beneficiaries, interest from the SMI trust fund, and general revenues from the federal government. The bulk of SMI funding, 75 percent of the total, comes out of general revenues (PPRC 1987: 10–13).[3]

At its inception, Medicare was a prototypical creation of what Theodore Lowi (1969) has termed "interest group liberalism." As a concession to the medical lobby, which strongly opposed Medicare, the 1965 legislation enunciated the principle that governmental policy was not to interfere with the practice of medicine. The system created to pay physicians reflects how the politics of the period overrode common economic sense:

> When the Medicare program was adopted in 1965, policymakers specified broadly how the program should pay physicians. The intent was to win physicians' cooperation and give Medicare beneficiaries access to mainstream medical care. Payment was to be based on reasonable charges, which were each physician's actual charges, as long as they did not exceed his or her customary charges or the prevailing charges of other doctors in the community. These guidelines provided the basis for CPR, the "customary, prevailing, and reasonable" method of paying physicians. (PPRC 1987: 4)

The charge-based payment system introduced incentives for physicians to regularly increase their fees. The effects of the new Medicare system were magnified in ways unintended by Congress (given its agreement not to alter medical practice in the private sector) as private insurers dropped fee schedules and service benefits in use at the time and adopted payment methods similar to the CPR scheme (CBO 1986: 26; Glaser 1989: 129). The inflationary tendency of the CPR payment system became evident soon after it was implemented and provoked a continuing stream of adjustments by policymakers. Beginning in the early 1970s, Congress gradually extended its purview over medical practice, primarily to slow the rise in costs that Medicare policies themselves helped stimulate. Yet incremental interventions proved unsatisfactory and generated a host of new problems. The system of CPR payments and accompanying rules that evolved

2. About three-quarters of the expenditures in the SMI program are for physician services (PPRC 1987: 13).

3. In addition to monthly premiums, Medicare beneficiaries must also pay an annual deductible and copayments of 20 percent for the services they receive under the SMI program.

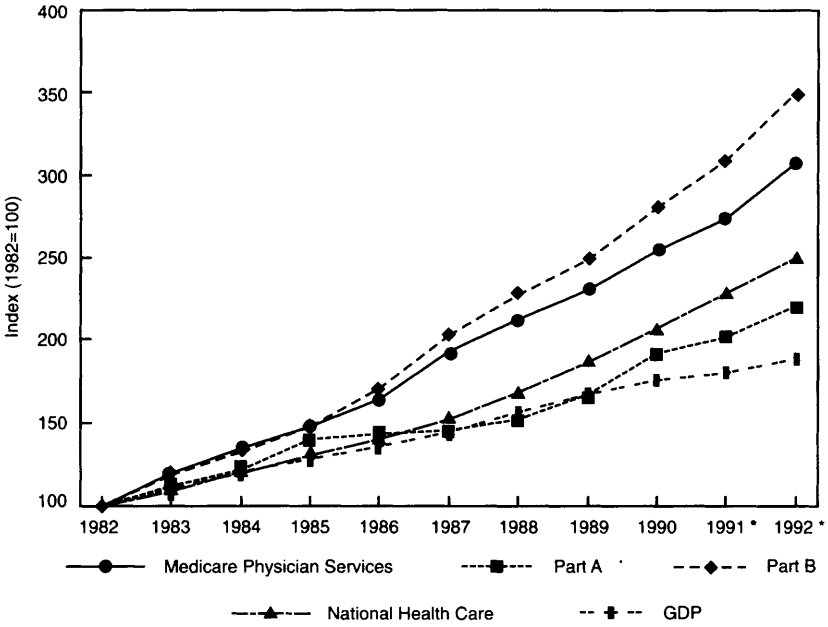

Figure 1 Trends in Gross Domestic Product and Expenditures for Medicare and National Health Care, 1982–1992

Note. * represents projections.

Gross domestic product is equal to gross national product less net property income from abroad.

Source. PPRC 1992: 5.

over two decades attracted criticism for its excessive costs, complexity, unpredictability, unfairness, and financial burden on many beneficiaries (Showstack et al. 1979; Langwell and Nelson 1986; Wilensky and Rossiter 1986; PPRC 1987).

By the late 1980s, a number of conditions in the charge-based system deteriorated and pushed government toward broad reform of the Medicare physician payment system.

First, expenditures for Medicare physician services were increasing at a faster rate than Medicare hospital expenditures or overall national health care expenditures, and they far outpaced the rates of increase in consumer prices and the gross domestic product (Figures 1 and 2). Medicare became a $100 billion program in 1990—the largest domestic program after Social Security—and from 1970 to 1989, Part B spending rose from 31 percent to 40 percent of total Medicare outlays (Table 1). Adjusted for inflation, Medicare physician payments per beneficiary more than doubled

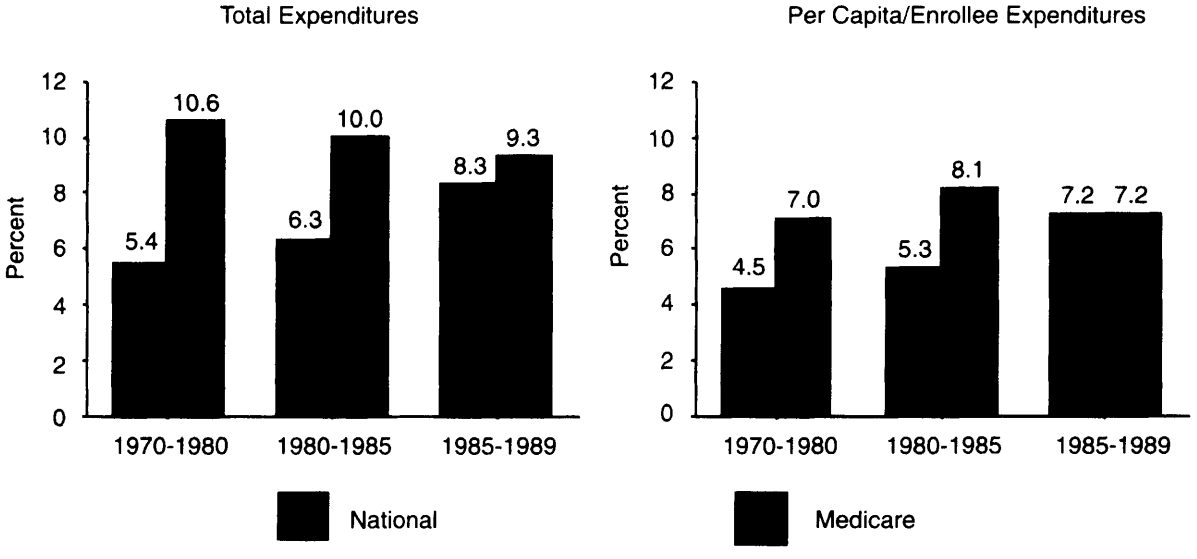

Figure 2 Average Annual Growth Rates of Real National and Medicare Expenditures for Physicians' Services, 1970–1989

Note. Real expenditures are in 1989 dollars, using the GNP fixed-weighted deflator.
Source. PPRC 1992: 17.

Table 1 Medicare Outlays, Fiscal Years 1967–1989

	Expenditures (millions of dollars)	
Fiscal Year	Part A Hospital Insurance	Part B Supplementary Medical Insurance
1967	$ 2,597	$ 799
1970	4,953	2,196
1975	10,612	4,170
1980	24,288	10,737
1985	48,654	22,730
1989	58,238	38,317

Source. Committee on Ways and Means 1990.

from $420 in fiscal year 1980 to $881 in fiscal year 1989—an average real increase of 8.6 percent per year compared to the 3.3 percent real annual growth in hospital payments per beneficiary during the same period (Committee on Ways and Means 1988).[4] These patterns of spending indicated that technological advances and financial incentives under the new Medicare Prospective Payment System (PPS) encouraged physicians to move many services that were previously provided inside hospitals to ambulatory settings (e.g., Sulvetta 1992).

Second, the CPR system created serious distortions in payments and inequities in physician incomes. Over time, it produced unjustified differences in payments by specialty and geographic location, penalizing physicians who provided primary care and resided in rural areas. The CPR system also tended to overvalue technical procedures and undervalue patient evaluation and management. The data in Table 2 show that, from 1986 to 1989, the annual increase in the volume of selected procedure groups was as high as 18 percent. Research suggested that financial incentives in the payment system could alter physicians' decisions regarding the type and volume of services they provided, their practice location, and choice of specialties.

Third, physicians became increasingly disillusioned with the administrative complexities of the CPR payment system. Their dissatisfaction intensified when Congress imposed a freeze on Medicare fee increases in 1984 and, two years later, restricted balance billing (the amount physicians

4. Real Medicare hospital expenditures per enrollee actually decreased by 0.6 percent per year from 1985 to 1989.

Table 2 Annualized Increase in Volume for Procedure Groups, 1986–1989

Procedure Group	Percentage
Medical Eye Services[a]	18.0
Other Medical Procedures[b]	17.0
Lab Services	16.4
Cardiac Services	13.4
Endoscopies[c]	11.4
Diagnostic Imaging	10.5
Surgery	7.4
Visits and Consultations	5.6

a. Medical eye services include visits and medical procedures for the eye. Cataract and lens replacement surgery is included in the surgery category.

b. Other medical procedures include gastroenterology, pulmonary, otolaryngology, immunization, and other services.

c. The endoscopies category excludes transurethral resection of the prostate (TURP).

Source. PPRC analysis of 1986–1989 BMAD I data (PPRC 1992: 4).

could charge patients above the fee paid by Medicare). By the late 1980s, the payment system bore little resemblance to the original scheme and its "mirage" of professional freedom and minimal governmental intrusion; official scrutiny and potential conflict now accompanied the submission of every bill to Medicare (Glaser 1989: 130).

Fourth, members of Congress had concerns that mandated increases in Medicare Part B premiums (required by law to cover 25 percent of the cost of the program) and balance billing were causing financial problems for beneficiaries. Increases in beneficiaries' out-of-pocket expenses for Part B surpassed increases in their Social Security cost-of-living adjustments from 1980 to 1990, as shown in Figure 3. Even with Medicare coverage, the elderly were spending more than one of every six dollars of after-tax income on health services (Figure 4). In addition, any hostile reaction by physicians to further cost controls might lower their participation in the Medicare program and threaten beneficiaries' access to care.

Fifth, the enactment of the Medicare Prospective Payment System for hospital services as part of the Social Security Amendments of 1983 (Publ. L. No. 98-21) demonstrated that health care cost containment was both technically feasible and politically feasible. It indicated that fiscal policy was ascendant and that "must pass" omnibus legislation such as Social Security reform and budget reconciliation was an instrument to curtail the power of medical interest groups (Oliver 1991a: 476; Hoadley 1991: 172). The pace of policy formulation in the omnibus bills made

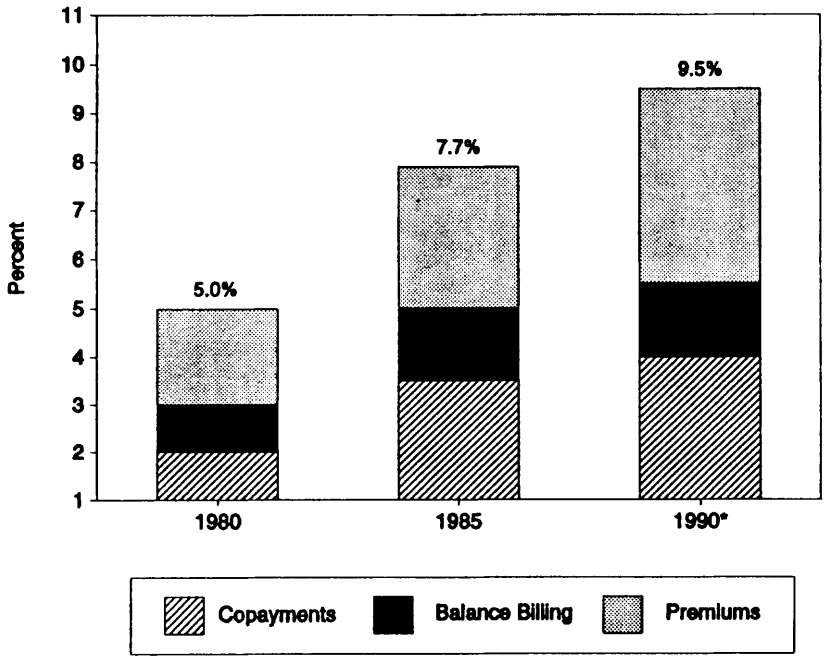

Figure 3 Annual Beneficiary Part B Liability as a Percentage of Social Security Benefits

Notes. Copayments include coinsurance and deductible. Social Security benefits are for full career worker born 1895–1925 who always earned the average wage.

*Projected

Source. PPRC 1991a: 17.

it difficult for lobbyists to keep up with the deliberations of legislators and their aides. The scope of the bills accentuated the power of committee decisions, because rules of debate severely restricted—or prevented altogether—amendments from the floor to mollify interest groups dissatisfied with specific provisions.

In sum, policymakers and others inside the health policy community concluded that the growth of physician payments for Medicare was producing unsustainable increases in federal outlays and in beneficiary premiums and copayments. From a societal perspective, physician services were consuming an increasing percentage of the gross national product and diverting resources from education, investment in the nation's economic infrastructure, and other health and social needs.

As the problems with Medicare physician payments mounted, Congress took a number of steps that eventually led to an overhaul of the

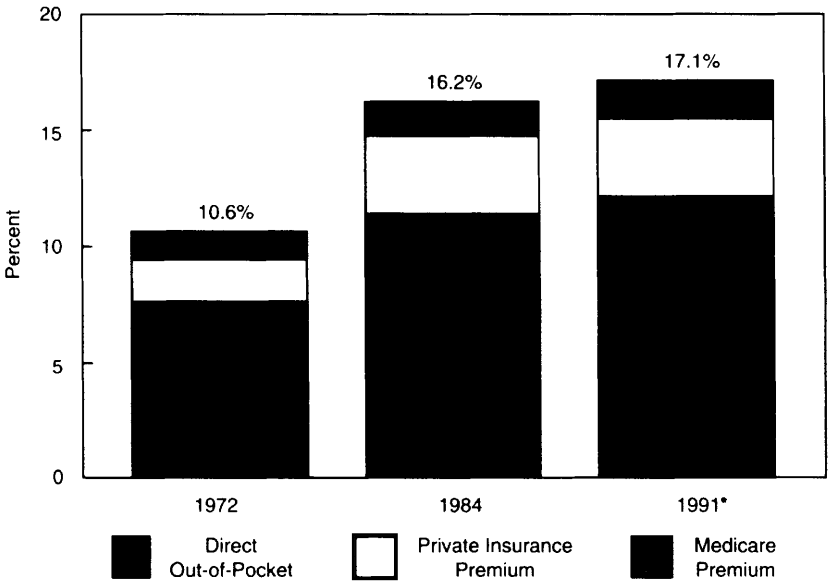

Figure 4 Elderly Family Out-of-Pocket Health Expenditures as a Percentage of After-Tax Income, Selected Years

Note. Expenditures are for households headed by someone age 65 or older.

Direct costs include deductible and coinsurance amounts for private insurance and Medicare Part A and Part B; balance bills; and costs of uncovered services such as nursing homes, prescription drugs, dental and eye-care services, laboratory tests, and medical supplies.

*1991 figures were estimated by Lewin/ICF.

Source. PPRC 1992: 10.

entire system. After the Reagan administration disregarded repeated congressional requests for reform proposals (Smith 1992: 157), legislators froze Medicare physician fees in 1984 and asked the Congressional Budget Office (CBO) and the Office of Technology Assessment (OTA) to conduct studies of alternative payment systems. In 1985, Congress created the PPRC to make recommendations each year regarding changes in payments and methods for determining payments, and directed the secretary of Health and Human Services to develop a relative value scale that could serve as a basis for payment for physician services.[5] In 1988,

5. The PPRC was established by Congress in 1985 under Section 9305 of Publ. L. No. 99-272, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA 85) to provide advice on physician payment reform in the Medicare program. The COBRA 85 legislation identified a number of specific areas for PPRC to address, including: the feasibility of reducing specialty and geographic differences in payments, increasing physician participation in the Participating Physician and Supplier Program (PAR), the feasibility of physician diagnostic-related groups (similar to those used in Medicare's prospective payment system for hospitals), and the appropri-

Congress charged the commission with the additional task of considering policies to moderate increases in the utilization of physician services and the resulting increases in Medicare expenditures. In the interim leading up to the major reforms in 1989, the PPRC adopted some broad principles for reform and recommended several specific changes, including proposals to reduce payments for what it deemed to be overvalued procedures. Congress adopted several of these measures to slow the increase in Medicare spending and to ease the transition to a new payment system. The following section describes the significant decisions that created the new physician payment system now being implemented in the Medicare program.

The Stages of Reform

Taken as a whole, physician payment reform is a considerable departure from previous policy and the most significant change to Part B of Medicare since the program was enacted in 1965. For the first time, the federal government placed limits on what physicians could charge Medicare beneficiaries over the amount paid by the government. The government moved from a modified fee-for-service payment system based on physician charges to a price schedule determined in advance by the federal government and intended to reflect more closely the actual economic costs of services. Finally, the government established a mechanism to set overall limits on Medicare outlays for physician services. Each of these actions dramatically revises the way the program has operated since its inception a quarter century ago.

Nonetheless, the reform is the product of a serial process in both its legislative history and administrative implementation (Ginsburg et al. 1990: 186; Smith 1992: 128). In its initial report, the PPRC acknowledged the necessity of an incremental approach to policy change even while pursuing comprehensive restructuring of the nation's system of physician payment. It recommended short-term steps intended to be consistent with the long-term direction of reform (PPRC 1987: xv). The stages in physician payment reform since 1984 are shown in Table 3, with the key provisions of each piece of legislation and administrative rule for program implementation.

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ate utilization of assistants-at-surgery. The legislation also required the PPRC to advise and make recommendations to the secretary of Health and Human Services regarding the development of a resource-based relative value scale for physician services (PPRC 1991a: 407).

Table 3 Stages in Physician Payment Reform, 1984–1996

1984

The Deficit Reduction Act of 1984 (Publ. L. No. 98-369) instituted a freeze on Medicare physician fee increases from July 1984 until October 1985 (Congress extended the fee freeze in 1985).

The legislation established the Medicare Participating Physician and Supplier (PAR) program to increase physician acceptance of assigned payments and reduce the financial liability of beneficiaries.[a]

Congress also mandated that the Office of Technology Assessment examine alternative methods of paying for physician services to guide reform of the Medicare system.

1985

The Consolidated Omnibus Budget Reconciliation Act of 1985 (Publ. L. No. 99-272) created the Physician Payment Review Commission (PPRC) to advise Congress on physician payment policies. The legislation also required that the PPRC advise and make recommendations to the Congress and the secretary of Health and Human Services regarding the development of a resource-based relative value scale for physician services.

COBRA 85 also directed the Health Care Financing Administration to undertake research and development of a resource-based relative value scale (RBRVS) for setting physician fees for the Medicare program.

Under COBRA 85, Congress extended the fee freeze to May 1986 for physicians who joined the Medicare PAR program, and to January 1987 for those who opted not to join the PAR program (PPRC 1991a: 4).

1986

The Office of Technology Assessment and the Congressional Budget Office sent Congress reports on physician payment systems and policy options for Medicare in early 1986.

The director of Office of Technology Assessment appointed the members of the PPRC in the spring of 1986. The chairman of the PPRC, Philip Lee, selected as executive director Paul Ginsburg, who had earlier served as the director of the health division of the Congressional Budget Office. The chairman submitted an appropriation request to Congress, which approved funding of the PPRC in the fall of 1986. After the initial appropriation, the PPRC hired the executive director and he proceeded quickly to hire the commission staff and begin work to meet the chairman's intent to submit a report to Congress by the end of March 1987. The PPRC held its first meeting in November 1986.

The Omnibus Budget Reconciliation Act of 1986 (Publ. L. No. 99-509) created further limits to balance billing by establishing "maximum allowable actual charges" (MAACs) for physicians not participating in the PAR program. OBRA 86 also

Table 3 Continued

directed the DHHS to use the concept of "inherent reasonableness" to reduce payments for cataract surgery and anesthesia during cataract surgery to achieve budget savings.

1987

The Omnibus Budget Reconciliation Act of 1987 (Publ. L. No. 100-203) reduced fees for 12 sets of "overvalued" procedures. The PPRC developed an approach to identify overvalued procedures to replace the administrative determination of the inherent reasonableness of charges called for under OBRA 86. The OBRA 86 provisions had proved cumbersome for the HCFA to implement (PPRC 1987: 53–56), and under OBRA 87, Congress established the new fee levels directly.

OBRA 87 allowed larger fee increases for primary care than other services and increased the fee differential between participating and nonparticipating physicians.

1988

The Technical and Miscellaneous Revenue Act of 1988 (Publ. L. No. 100-647) directed the PPRC to consider policies for moderating the rate of increase in physician expenditures and utilization of physician services.

1989

The Omnibus Budget Reconciliation Act of 1989 (Publ. L. No. 101-239) amended Title XVIII of the Social Security Act by adding Section 1848, Payment for Physician Services. OBRA 89 authorized four major changes:

- New limits were placed on the charges physicians may directly collect from patients above the amount paid by Medicare (balance billing).
- The Medicare program would replace its system of paying "customary, prevailing, and reasonable" physician charges with a new fee schedule. Payments under the new fee schedule would be set according to a new resource-based relative value scale measuring physician time and effort as well as historical charges for practice expenses and the costs of professional liability insurance.
- Congress would set a prospective Medicare volume performance standard (VPS) each year to determine the allowed rate of increase in aggregate physician payments under Medicare Part B (with separate standards for surgical and medical specialties). If actual expenditures fell above or below the target established by the VPS, Medicare would make retroactive adjustments to the annual fee update.
- The legislation created the Agency for Health Care Policy and Research (AHCPR) to conduct and sponsor research on the outcomes of medical treatments and provide technical assistance to medical groups undertaking the development of practice guidelines.

With the enactment of reform, OBRA 89 assigned responsibilities to the PPRC in three areas: (1) mandated studies of implementation issues, (2) review and comment

Table 3 Continued

on work performed by the DHHS, and (3) consultation with the secretary of Health and Human Services on implementation and revision of physician payment policies.

1990

The Omnibus Budget Reconciliation Act of 1990 (Publ. L. No. 101-508) made further reductions in fees for overvalued procedures.

OBRA 90 expanded the PPRC mandate to study issues for long-term reform, including the application of the RBRVS to Medicaid, medical malpractice reform, graduate medical education and physician supply issues, and options to constrain the costs of health insurance to employers.

The HCFA released a model fee schedule for Medicare based on the new RBRVS (1 September 1990).

Congress set the initial VPS for Medicare expenditures for physician services in 1991.

1991

The OBRA 89 limits to balance billing of Medicare patients became effective in January 1991. Balance billing of Medicare patients was restricted to 125 percent of the amount allowed nonparticipating physicians by Medicare.[b] Further limits were to be implemented in 1992 and 1993.

The HCFA announced its Notice of Proposed Rule Making (NPRM). The NPRM presented the proposed new Medicare fee schedule for public review and comment (5 June 1991).

The HCFA released its final rule on the Medicare fee schedule to be implemented January 1992 (25 November 1991).

1992

The HCFA began using the new Medicare fee schedule in January 1992. Fees for procedures that under the CPR system were less than 85 percent or over 115 percent of the new RBRVS fee schedule amount will rise or fall to the full fee schedule amount gradually over a five-year transition ending in January 1996, when all payments will be based solely on the fee schedule.

A fee schedule update for 1993 physician payments will incorporate adjustments to reflect actual expenditures for physician services relative to the VPS for 1991.

Balance billing of Medicare patients is restricted to 120 percent of the fee paid nonparticipating physicians by Medicare.

1993

Balance billing of Medicare patients will be restricted to 115 percent of the fee paid nonparticipating physicians by Medicare.

Table 3 Continued

Medicare physician payments will reflect for the first time the adjustments made to the fee schedule based on the difference between 1991 spending and the 1991 VPS for physician services.
1996
The transition to the full Medicare fee schedule will be complete in January 1996.

a. The PAR program offered higher payments to participating physicians who accepted assignment for all claims, thereby agreeing not to bill patients for amounts above the fees allowed by Medicare. The PAR program was the first time the government had restricted in any way the amounts physicians could collect directly from their patients (Hoadley 1991: 178).

b. OBRA 90 made a one-year exception for evaluation and management services, permitting physicians to bill patients up to 40 percent above the allowed payment by Medicare (PPRC 1992: 92).

Enactment: Designing a Feasible Package and Forging a Consensus for Reform

Those familiar with the customary operations of the American political system would concur with Jack Walker (1981: 90), who observed, "Public policies seldom result from a rational process in which problems are precisely identified and then carefully matched with optimal solutions. Most policies emerge, haltingly and piecemeal, from a complicated series of bargains and compromises that reflect the biases, goals, and enhancement needs of established agencies, professional communities, and ambitious political entrepreneurs."

This sort of process, characterized by defensive politics and incremental policy change, is how the federal government handled Medicare policies for physician payment until the late 1980s. Then, a number of factors altered the politics of health policy-making and enabled measures for broad reform to receive serious attention from Congress and officials in the executive branch.

Congress enacted the major reforms in Medicare physician payment in November 1989, just eight months after receiving the detailed recommendations of the PPRC. A combination of research and analysis, consensual policy formulation, and political balance created a formidable proposal, with no surprises for Congress and no late-developing opposition. The solid reasoning and political standing of the PPRC recommendations enabled key legislators to engineer adoption of the reform package in a year in which physician payment issues took a back seat to issues of more im-

mediate concern to the Congress at large. The following section attempts to explain the unusually strong actions Congress took in OBRA 89.

Policy-making and the Agenda for Medicare

Since most citizens and most elected officials are affected only at the margin by any given policy decision, they remain "rationally ignorant" (Olson 1990) and policies are formulated, adopted, and amended over time by a relatively small community of individuals and groups familiar with the issues at hand. Action leading to policy change most often occurs within a policy community composed of elected officials, legislative and administrative staffs, interest group leaders, researchers, and reporters whose knowledge and activities are devoted principally to a specialized policy area (Heclo 1978; Sabatier 1991).

The politics of an issue inside a policy community are determined in large part by the structure of the existing policy, that is, how it distributes the benefits it confers and the costs it imposes (Lowi 1969; Wilson 1973, 1983). Any proposed change in policy is, by definition, a threat to the existing distribution of benefits and costs, and groups with an identifiable stake in the outcome will organize themselves in the political system according to the pattern of changes being proposed. The simple but somewhat counterintuitive idea that policy determines politics implies that a policy with a long history will yield a fairly stable and predictable pattern of political competition within a policy community. In that case, the agenda for change and the shape of policy over time is dictated by the competition between "advocacy coalitions" whose members share particular beliefs, identify similar problems, advocate comparable solutions, and interact closely to influence the political system at large (Sabatier 1988).

The advocacy coalitions that contest each other in the development of Medicare physician payment policies correspond roughly to the three "structural interests" described by Robert Alford (1975) in his analysis of health care politics: (1) the "professional monopolizers," health care professionals and organizations who seek to maintain their traditional prerogatives in the delivery and financing of health services; (2) the "corporate rationalizers" in government, business, and research institutions who seek to impose greater political control, economic incentives, or both on a poorly organized and inflationary health care system; and (3) the "community population" of Medicare beneficiaries who seek more effective, accessible, and affordable health services.

Historically, Medicare has well served the interests of the "professional

monopolizers"—the providers of health services. The government has also looked after Medicare beneficiaries, the "community population," whose members were generally more concerned with the quality and accessibility of services than with costs, from which they were largely shielded. With the continuing rise in their premiums and out-of-pocket payments for physician services, however, beneficiaries have begun to rally around the cause of cost containment. A key group that articulates the interests of beneficiaries, the American Association of Retired Persons (AARP), is far more organized and influential than other citizen advocates in most health policy contests, due to the elevated electoral participation and activism of the elderly in American politics. Meanwhile, "corporate rationalizers" in government and business, as well as the general population of taxpayers under the age of sixty-five, have footed the bills but had little control over the particular services and aggregate outlays under the CPR payment system.

This is the peculiar but logical outcome of a political system in which concentrated interests systematically outweigh diffuse interests in policy-making. The logic suggests that taxpayers and other groups with individually small but cumulatively large stakes in a policy will be less active and, hence, less influential in the policy process. Changes that would impose costs on a concentrated group with individually large stakes are difficult to enact, therefore, and the result is a pattern of "organizational sclerosis" and political deadlock on collective actions that would produce large but diffuse benefits (Olson 1982).

Thus, as private and public expenditures for health services have accelerated without relief over the past two decades, the essential problem in health care politics has become how to impose costs on a concentrated group of health care providers in order to lessen the financial burden on the larger groups that receive and underwrite those services (Marmor et al. 1976).

The decision by Congress to establish a new Medicare payment system for physicians that included crucial restraints on individual fees and overall program outlays demonstrated the federal government's capacity and willingness to act in the supposedly conservative epoch of the 1980s (Brown 1990: 428; 1991: 40). To take the route they did, advocates of physician payment reform had to overcome not only the common interests of "professional monopolizers" but also the neoclassical economic ideology dominating policy analysis in the Reagan era, which viewed fee schedules as blunt and unwarranted governmental intrusion into voluntary markets of exchange (Glaser 1989: 130). Their success in reviving the acceptability

of pragmatic regulation was illustrated when the Bush administration's point person for implementing physician payment reform, Gail Wilensky, administrator of the Health Care Financing Administration, characterized the new policy as "government-administered price setting" in testimony before Congress (Iglehart 1991: 824).

What tipped the balance in health policy in favor of those who use and pay for physician services? The work of two leading theorists of public policy-making provides clues to answer the question. Paul Sabatier (1988) suggested that the balance among advocacy coalitions within a policy community can be disrupted and significant policy change can occur in two ways. The first is when large-scale economic, social, or political conditions press themselves on the policy community. The second is when the policy community itself learns from its experience with existing policies, new research and analysis of those policies and alternatives, and public discourse over proposals for change.[6] From the evidence presented below, it is clear that the reforms enacted in OBRA 89 were the result of growing budgetary pressures on all government programs *as well as* a wealth of experience and research demonstrating that incremental reforms could not control the volume and costs of physician services in the Medicare program.

Sabatier's theory provides an insight into the combination of external and internal pressures for policy change, but it does not fully explain the timing of physician payment reform or the makeup of the reform package adopted in 1989. Why did Congress adopt major changes in Medicare's physician payment system *at that time* and what dictated the *nature* of those changes? John Kingdon (1984) has argued that significant innovations in policy result from the coupling of three "streams" in the policy process: problems, politics, and proposals. Using this analytical framework, the regulatory character of the reform package and its rapid legislative passage can be attributed to how the issue of physician payment reform came to be defined, the political environment and process in which Congress handled the proposals for reform, and the way the PPRC crafted its legislative recommendations.

Problem Definition. Problems are conditions that people want to change. There are various ways in which problems become defined and move from the list of issues receiving attention to the agenda of issues that government

6. Sabatier's framework for policy change builds on the study by Heclo (1974) of social welfare policies in Britain and Sweden.

will take action on. Walker (1981: 88) suggested that problem definition and policy change are stimulated when a "performance gap" arises from a crisis, from forecasting, or from comparison with similar sectors or jurisdictions. The movement toward physician payment reform accelerated when expenditures for physician services became an issue *apart* from the rising costs of health insurance, hospital care, and other health services.

The performance gap occurred for three reasons. First, Medicare spending per beneficiary for physician services increased at an unprecedented rate during the first half of the 1980s and failed to slow dramatically even after the 1984 fee freeze (Figure 2). The aggregate indicators of expenses reflected a rapid increase in the volume and intensity of services provided each patient (Wilensky and Rossiter 1983; PPRC 1988; McMenamin et al. 1988; Mitchell et al. 1989).[7] Second, after the new Medicare Prospective Payment System (PPS) for hospitals went into effect in 1984, Medicare expenditures increased at a faster rate for physician services than for hospital services (Lee et al. 1990: 153; Brown 1991: 27–28). This happened in part because physicians moved many inpatient hospital services to ambulatory settings. Third, research and analysis demonstrated that there were significant distortions in the relative payments to physicians for different services (Hsiao, Braun, Becker, et al. 1988; Hsiao, Braun, Dunn, et al. 1988; Hsiao, Braun, Kelly, and Becker 1988), a substantial volume of procedural services were inappropriate or unnecessary (Chassin et al. 1986; Chassin et al. 1988), and wide, unexplained variations existed in medical practice patterns and expenditures (e.g., Wennberg and Gittelsohn 1982; Chassin et al. 1988). The research had direct and indirect effects on policy. The studies by William Hsiao and his colleagues at Harvard helped to design the resource-based relative values for the new Medicare fee schedule. The other studies, while not used directly, indicated the need for payment reform and for expanded research on the effectiveness and efficiency of medical services. Together, they eroded the legitimacy of the CPR payments as an economically rational system and the credibility of either market-oriented reforms or incremental regulation of the CPR payment system.

Policymakers must not only be aware of a problem but also define it in a way that makes government intervention appropriate (Walker 1981: 89). Hence, the failures of the "market" for physician payment and the limited or even counterproductive effects of incremental measures helped

7. The average volume of Part B services per beneficiary per year increased from 12 in 1975 to 24 in 1985, an annual rate of increase of 7 percent (PPRC 1988: 20–21).

pave the way for a more fundamental and more regulatory reform. By the late 1980s, policymakers believed that a government price schedule would establish a more rational supply of physician services and, more importantly, provide a lever for cost containment. Although the prevailing ideology among both policy analysts and policymakers weighed against strong governmental regulation, the performance gap was so evident and the failure of so-called market competition and other private sector remedies so demonstrable that regulatory solutions became identified with fiduciary responsibility to Medicare beneficiaries and to taxpayers. In the Technical and Miscellaneous Revenue Act of 1988, Congress specifically directed the PPRC to recommend mechanisms to control expenditures for physician services. In the eyes of both liberals and conservatives, the overriding concern was to produce a policy that could stem the flow of general revenues to the Part B program—even if it meant putting a cap on Medicare spending for physician services. William Roper, a former administrator of the HCFA and President Bush's deputy assistant for domestic policy when OBRA 89 was enacted, justified his support for PPRC recommendations that included expenditure targets:

> My conviction is that Part B is simply out of control. Annual growth of Part B has been 16 percent in recent years, outstripping by far the growth of any other major federal program. The incremental nibbling of recent years to restrain Part B has produced very little, next to nothing, in savings. The policies we pursue will have to be big time and serious; they may be arbitrary and even unfair, but we must pursue them. . . . I find expenditure targets distasteful philosophically, but the federal government has a responsibility to protect the public trust, and that seems to be the most responsive policy of restraint we could adopt over the short term. (Iglehart 1989: 1160)

Political Developments. Roper's comments underscore how frustrated policymakers came to define controls on Medicare spending for physician services not only as a matter for the health policy community to work out but also as a matter of fiscal policy for the government at large. Indeed, the problem of cost containment and a combination of external pressures, internal politics, and legislative maneuvers reversed the conventional politics of medical inflation and propelled the reforms that culminated in OBRA 89.

A potent contextual element in policy change was the antitax sentiment among American voters. The popular tax revolt and the resulting

evaporation of discretionary revenues for governmental operations in the 1980s spurred politicians to campaign as defenders of the public purse and take on the concentrated interests of the health care industry. In this respect, health care providers were vulnerable to the same political climate that produced major reforms in the transportation and telecommunications industries and in the federal tax code (Mucciaroni 1991). As in the other cases, Congress enacted physician payment reform despite the fact the issue itself was not highly visible to and was not demanded by the general public. The motive was budget containment, and the leadership came mainly from the health subcommittees of the congressional tax-writing committees, House Ways and Means and Senate Finance (Smith 1992: 128).

The specific provisions of OBRA 89 demonstrate Sabatier's point that external forces can powerfully shape the nature of change contemplated by members of a policy community. Most of the reports and options for a new system to replace CPR payments were on the table by 1986 and Congress and a number of physician groups had indicated strong interest in adopting a resource-based relative value scale (RBRVS) fee schedule to redistribute payments from generalists to specialists. Yet, Congress did not approve the new fee schedule until the PPRC proposed expenditure targets as a way to bring overall program costs under control. Representative Pete Stark, chairman of the House Ways and Means Subcommittee on Health, argued that a resource-based fee schedule "is taking the existing pie and cutting it up into different size slices. The question is [how] you get the size of the whole pie down" (Rovner 1989a: 391). The Ways and Means subcommittee took the heat from physicians by approving a bill with expenditure targets in June 1989, and soon afterward the Bush administration announced its support for the reform package (Hoadley 1991: 178; Smith 1992: 202–4).

The stakes for cost containment in the Medicare SMI program increased in 1989 following the political debacle over providing catastrophic health insurance for the elderly (Iglehart 1989: 1159). Senior citizens rejected the self-financing scheme Congress adopted in the Medicare Catastrophic Coverage Act of 1988 (Publ. L. No. 100-360), labeling it a tax without precedent in the nation's entitlement programs. That became the preeminent political issue when Congress reconvened in the fall of 1989, and it repealed most of the provisions in the legislation (Hoadley 1991: 179).

The package of proposals for physician payment reform that the PPRC sent to Congress in April 1989 also presented legislators with decisions about how much Medicare beneficiaries should contribute financially

toward their own health care. So, as members of Congress formulated a new physician payment system for Medicare late in the fall session, they were probably looking for positive action to take on behalf of beneficiaries. With the grass-roots effort that senior citizens mounted to repeal the catastrophic insurance program fresh in their memory, legislators on the House-Senate Budget Conference Committee chose to apply the strictest of the limits on balance billing proposed by the various health subcommittees (Iglehart 1991: 828). The OBRA 89 provisions established the same limits on balance billing for all physician services that they had previously established for overvalued procedures in OBRA 86 and OBRA 87 (PPRC 1989: 139).

The overall outline of the package accepted in November 1989, which included limits on balance billing and expenditure targets (relabeled *volume performance standards*) along with the RBRVS fee schedule, indicated that Medicare beneficiaries, not medical groups, were a political priority and that financial protection and cost containment were essential alongside any zero-sum revision of fees. Although Alford (1975) argued that the community population of individual patients and groups in need of better and more affordable health services is a "repressed" structural interest, the politics of OBRA 89 suggest a different pattern in Medicare. When collisions occurred over the distribution of costs and benefits in policy-making, 34 million Medicare beneficiaries from all socioeconomic and political categories constituted a formidable, "encompassing organization" (Olson 1982) to oppose the relatively exclusive group of 600,000 physicians. The PPRC acknowledged the influence of the senior citizen lobby from the outset, recommending in its initial report, "when tradeoffs must be made, access to care and financial protection for beneficiaries should not be sacrificed" (PPRC 1987: 3).

While physician payment reform represented responsible action for the collective good and a reaction to the momentary wrath of Medicare beneficiaries over the catastrophic health insurance program, it also manifested political and strategic lessons from the reform of the Medicare hospital payment system in the Social Security Amendments of 1983. Kingdon (1984: 200–204) noted how the enactment of one policy can establish new principles and alter the coalition structure in a policy community. An initial breakthrough can create spillover effects and open the political path to change in adjacent policies.

The new Medicare system for hospital payments provided a spillover to physician payment reform in a number of ways. Within a short period of time, the effect of PPS on Medicare spending for hospital services showed

policymakers that health care cost containment was technically feasible.[8] The rapid passage of PPS from experimentation to federal policy also indicated the waning political power of health care interests in the broad context of budgetary allocations (Oliver 1991a). Finally, PPS established the strategic precedent of enacting health care reforms in a broad legislative package, a maneuver Congress would follow throughout physician payment reform.

The linkage between the Medicare reforms for hospital and physician services was evident immediately. After approving the new payment system for hospitals, Senate majority leader Robert Dole and other congressional insiders predicted that 1984 would be "the year of the physician" (Brown 1991: 24; Hoadley 1991: 175). The prediction proved premature for comprehensive reform, but Congress served notice with the 1984 fee freeze that the problems demanded action and that major steps were on the way. The rapid legislative adoption of PPS got government back into the action in health care policy and set a pattern that continued through the decade: government was again an important player—indeed, the most important player—because of its expanding role as a purchaser of health services. By 1989, Medicare accounted for 23.4 percent of all payments for physician services in the U.S., up from 11.8 percent in 1970 (PPRC 1991a: 12). More significantly, Medicare payments amounted to 32 percent of all revenues for medical specialties that provided regular care to the elderly (Sunshine and Swartzman 1989). The enactment of the reforms in OBRA 89 indicated that the government was ready to use its substantial market share to purchase health services more wisely.

Even though the national mood on taxation and politics of Medicare dampened the historical power of provider interests, the federal government still had to concern itself with more than cost control alone. Payments set too low could endanger access to care for beneficiaries if a large number of providers refused to accept Medicare patients. It was also evident that the payment mechanisms and levels chosen for Medicare—which stood a good chance of being adopted by private insurers—would in the long run affect other important aspects of the nation's health care system, including the development of medical technologies and the overall supply of physicians, their geographic distribution, and choice of specialties. Furthermore, physicians and their allies in the health care system remained an influential political constituency because of their financial re-

8. A payment method based on diagnosis-related groups (DRGs) analogous to those used in PPS proved not to be acceptable for physician services, for reasons described in the next section.

sources and capabilities in political campaigns. Congress had to consider fairness towards physicians, therefore, as it sought ways to readjust their fees and relative incomes (Ginsburg and Lee 1991: 71–72).

Alternatives for Reform. Forces and actors outside of a policy community steer change in a general direction by defining problems and establishing the acceptable boundaries for governmental action. The actual movement of an issue onto the agenda for decisions, however, is nearly always determined by influential actors within the policy community who struggle to achieve consensus on a specific alternative for action. The advocacy coalitions within a policy community seldom arrive at a consensus on every element of a proposal, since political institutions by their nature handle only the problems that cannot be resolved through private transactions or negotiations. But there comes a point where political consensus, or as Nelson Polsby puts it, a "decision-making subculture," is formed and all actors agree on the problems at hand and the need to take action (Polsby 1984: 14).[9] This point is reached, it appears, when a technically *and* politically feasible blueprint for reform becomes available.

If this analysis is correct, then what allowed Congress to establish a new Medicare payment system for physicians in 1989 was the arrival of a usable method of payment in a politically acceptable package. The new Medicare fee schedule and the package of proposals in OBRA 89 were put together only after a number of years of development and detailed study by the PPRC and other participants in the health policy community.

As noted above, Medicare's hospital payment system showed that government price setting could encourage a more rational use of services and control outlays, so it was reasonable for policymakers to seek a similar solution for physician payments. A few members of Congress and the Executive Office of Management and Budget initially showed interest in a payment system for physicians based on diagnosis-related groups (DRGs), the same method Medicare adopted for hospital payments in 1983. A study team led by Janet Mitchell reported to the HCFA in 1984, however, that DRGs were at that time unsuitable for physician payments

9. There are three diminishing levels of "consensus" in the policy process: (1) consensus in society on the problems requiring attention (societal consensus), (2) consensus of policymakers on the intention to take political action (political consensus), and (3) consensus within a policy community on a specific alternative for reform (policy consensus). Only the first two levels of consensus are required for policy change to occur. A broad agreement on the means as well as the ends of a policy change—a policy consensus or "policy subculture" (Oliver 1991b: 170–73)—helps to sustain that change over a long period of time, however.

because it was difficult to specify the appropriate range of services, and hence, payment, for a given diagnosis (Mitchell et al. 1984). This conclusion led Congress, in COBRA 85, to seek advice on other payment methods from the OTA, the HCFA and the newly established PPRC.

In its early deliberations, the PPRC considered four forms of payment to physicians or medical groups: a refined CPR system, a fee schedule, specified service packages such as DRGs, and capitation. The commission found that service packages and capitation, while they helped control volume as well as prices for physician services, were not sufficiently developed to adopt on a widespread basis in the Medicare program. The imprecision of the methods and unpredictable consequences for providers and patients alike, including incentives for underprovision of services, led the PPRC to recommend the less radical option of a fee schedule. The commission stated that adoption of a fee schedule would not preclude the development of other payment methods to accompany or replace it in the future; it also noted that the fee schedule alone was an insufficient solution and acknowledged the "residual problem" of improving mechanisms to control the volume and total cost of services (PPRC 1987: 1–9, 32–33).

The commission reviewed alternative bases for developing a fee schedule and decided that payments should reflect resource costs. The Harvard team led by Hsiao began its studies to develop a resource-based relative value scale in 1986 and completed the first phase in 1988 (Hsiao, Braun, Becker, et al. 1988a). The PPRC and the HCFA conducted intensive reviews of the Phase I study. In its 1989 report to Congress, the commission concluded that the basic methodology used by Hsiao was sound and, after certain revisions, the results could be used to construct a fee schedule. This report gave Congress the signal that a workable basis for fundamental reform was finally at hand, nearly five years after it first initiated the reform process.

Once the commission pronounced that the RBRVS was sufficiently well developed to begin crafting a fee schedule, Congress was able to offer the new payment system to physicians as a quid pro quo for measures designed to meet the government's primary objective of cost containment. The combination of reforms undertaken in OBRA 89 addressed a number of economic and political trade-offs head-on and provided at least some benefits for all parties.

The medical community, led by the American Medical Association (AMA) and several important specialty groups, by and large favored the

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new fee schedule that provided greater equity through resource-based payments.[10] Opposition by surgeons and other procedure-oriented specialties that would suffer economic losses diminished when Congress offered a five-year transition to the fee schedule and retained historical measures of practice expenses in calculating relative values. Surgeons also received a separate volume performance standard (VPS) (beginning in 1991) that gave them more incentive to enforce controls over surgical volume in order to avoid fee reductions from exceeding the VPS. Although the VPS mechanism represented a regulatory limit on fee increases, the PPRC viewed it as a means to stimulate voluntary efforts by the medical profession to increase its knowledge of the effectiveness of services and to encourage more appropriate and economical patterns of medical care. Congress also created the Agency for Health Care Policy and Research (AHCPR) to develop information and tools to assist the voluntary efforts of physicians to control the volume and cost of services.

Beneficiaries gained financial protection through the effect of the VPS on overall payments and the progressive restrictions on balance billing by nonparticipating physicians. The reductions in balance billing represented a compromise between physicians who sought to maintain the right to charge more than the government's fee and patient advocates who wanted Congress to require physicians to accept Medicare fees as payment in full (mandatory assignment). Recent estimates by the PPRC indicated that in the aggregate, total coinsurance payments would decline by 6.5 percent and beneficiaries' liabilities for balance bills would fall by 74 percent under the new payment system (PPRC 1992: 89–91).

Advocates of prudent fiscal policy and taxpayers' interests endorsed the congressional decision to establish the VPS system and institute, for the first time, a limit on Medicare spending for physician services. Because the law gave Congress discretion in setting the VPS and fee updates (based on annual recommendations by PPRC and the secretary of Health and Human Services), physician groups felt it was less severe than using expenditure targets and fee updates calculated by the HCFA according to a mandated formula. OBRA 89 did establish a default formula for determining the VPS in the event Congress failed to act, however, and many legislators predicted the VPS would be virtually the same as expenditure targets in their impact.[11]

10. The AMA supported the development of the fee schedule in part because it maintained the fee-for-service basis of payment and represented a less drastic reform than capitation or diagnosis-related payments (Iglehart 1991: 824).

11. In fact, Congress in 1991 allowed the default formula established in OBRA 89 to deter-

Institutional Factors in Policy Formulation and Enactment

It is clear that throughout the latter part of the 1980s, Congress was in a mood to do something about physician payments and proceeded to do so in a systematic manner. The earlier, incremental steps such as instituting a fee freeze, promoting provider acceptance of assigned payments, restricting balance billing, and reducing overvalued procedures established the path toward more decisive measures.

As research by the Hsiao team at Harvard and information gathering and analysis by the PPRC advanced, momentum for reform continued to build within the Congress. In OBRA 1987, legislators directed the secretary of Health and Human Services to report on changes needed to implement a national fee schedule in 1990 or thereafter. In the spring of 1989, the full House Ways and Means Committee held a retreat in Savannah, Georgia, which included consideration of the fiscal implications of physician payment reform and its Subcommittee on Health held two separate retreats to better inform members of the issues and likely policy options. These retreats with representatives from the PPRC and other expert consultants supplemented the hearings convened by the Health Subcommittee to review the commission's annual reports and further hearings on specific issues.

Once a resource-based fee schedule proved to be technically feasible, it quickly became the centerpiece of reform. The provisions that accompanied it in OBRA 89 reflected policy learning by both analysts and decision makers about the extent and sources of increasing expenditures for physician services as well as potential methods for reversing the trend. Experience and analysis persuaded legislators that a comprehensive solution required a fair method of payment, brakes on the growing volume and intensity of physician services, and rules to ensure that the government's efforts to control its budget would not create greater financial hardships for Medicare patients.

Even though the PPRC provided Congress with each of the major elements of physician payment reform in its 1989 report, the enactment of the package in OBRA 89 is attributable more to institutional routines and determined leadership than to political rationality. For example, variations between congressional committees in emphasis and style had to be

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mine the VPS for 1992. It also allowed the default formula to determine the Medicare fee update for 1992, as recommended by both the secretary of Health and Human Services and the PPRC (PPRC 1992: 14).

reconciled (Hoadley 1991: 178–81; Glaser 1989: 140). The House Ways and Means Committee took the toughest stance in support of expenditure targets and automatic fee adjustments, following its historical role as guardian of the public purse (Fenno 1966; Manley 1970). Members of the House Energy and Commerce Committee were more reticent about the potential imposition of fee reductions on all physicians regardless of their individual volume of services, and chose to leave expenditure targets out of their plan in the face of intense lobbying from the AMA. The bipartisan approach of the Senate Finance Committee, led by Democrat Jay Rockefeller and Republican David Durenberger, found a pragmatic middle ground by replacing expenditure targets with volume performance standards, which would serve as an advisory guideline rather than an automatic trigger for fee reductions if aggregate expenditures exceeded the predetermined target. This compromise—described as a semantic change by Representative Willis Gradison, ranking Republican on the Health Subcommittee of the House Ways and Means Committee (Rovner 1989b: 3241)—was accepted in the final legislation and allowed advocates of payment reform to push ahead without sacrificing the key objective of cost containment.

The strategic choice to include physician payment reform in the annual budget reconciliation bill created both opportunities and obstacles. Earlier changes in Medicare payments were made through the budget process, and leaders were aware that a bill so technical and—because of the disputed cost containment provisions—controversial could only be passed in its entirety in an omnibus bill (Smith 1992: 205, 210). On the other hand, attaching it to OBRA 89 meant racing the clock and filling in critical, unfinished details without certainty as to their consequences. Further complications arose with the provision that government outlays under the new fee schedule would initially be budget-neutral compared to the CPR payment system, an agreement that was crucial in winning the acceptance of medical groups.[12] The Senate maintained a rule that excluded proposals with no fiscal impact from budget reconciliation; so the Finance Committee's version of physician payment reform was deleted from the bill that was approved on the Senate floor and sent to the House-Senate Conference Committee. The conferees, however, introduced an unofficial copy of the Senate provisions into their negotiations, and in this way the compromise necessary to secure agreement in both houses was reinstated in the budget bill (Hoadley 1991: 180).

12. Similarly, the provision that the new tax system be revenue-neutral was critical to the political success of federal income tax reform in 1986 (Mucciaroni 1991: 480).

Even so, the reinstatement of physician payment reform in OBRA 89 came at the last minute, after the leaders of the Conference Committee, House Ways and Means chairman Dan Rostenkowski and Senate Finance chairman Lloyd Bentsen, failed to reach agreement and declared it dead in the final days before congressional adjournment. Senator Rockefeller, the chairman of the Finance Committee's new Subcommittee on Medicare, who was deeply committed to the reform package, refused to accept this verdict and continued to work with Representative Stark and other House conferees, Roper, the president's chief representative on physician payment, and selected staff with health expertise. Tediously, they negotiated a package to insert in the conference report (Rovner 1989b: 3240).

According to congressional staff who participated in the negotiations, even this effort would not have succeeded without a last-minute disagreement on the main budget reconciliation package. This dispute gave the conferees an additional two days to reach consent on the Medicare reform proposals. At that point, Representative Rostenkowski took a strong position in support of the package, reconvened the conferees, among them Senator Bentsen and Representative Henry Waxman, chairman of the Subcommittee on Health and the Environment in the House Energy and Commerce Committee, and forged an agreement. The main sticking point was the calculation of the volume performance standards and updates of the fee schedule. The exhaustive negotiations, carried out over a stretch of four days, included meticulous decisions and hasty trade-offs, some that entailed swings of tens of billions of dollars for Medicare or physicians. Many important provisions, including the creation of the AHCPR and the separate fee schedules for radiologists and anesthesiologists, were accepted en bloc with almost no discussion (Smith 1992: 207–9).

The provisions on physician payment reform were among the last items incorporated into the final report of the Conference Committee, which concluded its work only hours before congressional adjournment in November 1989. Thus, the formulation reached by this small group of insiders was then on the "fast track" for final approval in the budget bill. As Congress headed home for the holiday season, few of its members, let alone lobbyists or administrative officials, knew the details of the new Medicare payment system. Jack Hoadley (1991: 172) has noted how the budget process alters the conventions of congressional policy-making:

> The use of budget reconciliation as the main way to pass health legislation has significant implications for policy making and the legislative process. It has quickened the pace of deliberations, moved much of it behind closed doors, imposed tight budget constraints on the set

of alternatives, curbed outside influence, and altered relationships between the executive and legislative branches.

The Contributions of the PPRC

The enactment of a new physician payment system for Medicare in 1989 was a product of responsive policy, budgetary politics, and timely leadership. It is notable that the leadership on this issue was by Congress rather than the president, and the vehicle for reform was fiscal policy rather than health policy per se. Although institutional and personal idiosyncrasies shaped the new system at the margin and made possible its acceptance in OBRA 89, the passage of physician payment reform can in large part be credited to key congressional leaders and to the PPRC, which laid a foundation for reform that remained solid through the legislative process. John Iglehart (1989: 1157) commented on the importance of the commission in building political momentum for comprehensive reform:

> Since 1984, efforts to alter Medicare's Part B policies have included a variety of policy actions calculated to generate savings but not intended to represent long-range reform. Perhaps the most important step taken by Congress in relation to Part B was the creation of a process through which new policies could be formulated. . . . [The PPRC] has evolved into much more than one might expect from a citizens' commission that meets about once a month for two days. Indeed, the PPRC has quickly become the most important influence on the direction that Congress pursues in changing Medicare's physician-payment policies.

While the problems associated with the Medicare physician payment system were evident and Congress had taken halfway measures to initiate reform, it was the PPRC that "coupled" (to use Kingdon's [1984] term) the problems, politics, and policy options necessary to dramatically restructure the system. Congress did not take strong action until the PPRC established itself and handled the key issues—rationality and equity in physician payments, overall costs, and financial security of beneficiaries—as parts of the same puzzle and linked their solutions together in a single, encompassing proposal.

The PPRC specified four roles for itself in its inaugural report to Congress in March 1987. The commission was to (1) serve as a source of independent expert advice to Congress and to the secretary of Health and Human Services; (2) provide opportunities for beneficiaries, physicians, and other interested parties to have their views considered in policy delib-

erations on physician payment issues (through nominating commissioners, formal oral and written testimony, and informal advice and comment to commissioners and staff); (3) conduct objective analyses to provide a basis for policy decisions to alter Medicare's method of paying physicians; and (4) perform the design work necessary to implement major changes in physician payment (PPRC 1987: 1).

In simplest terms, the experiment with PPRC proved valuable to Congress, because the commission skillfully bridged the traditionally segmented roles of neutral analyst and astute advisor throughout the policy process. It not only helped design the new payment system but also participated as a major partner in some of the most important and politically charged decisions (Smith 1992: 241).

The analysis and advice that the PPRC provided to Congress received wide acceptance because of the expertise and institutional design of the commission, the quality of information it generated, the process it established to translate that information into policy recommendations, and the political and strategic skill it demonstrated in packaging its proposal for reform.

Institutional Design. The PPRC was created as an arm of Congress, and from its inception it improved and integrated legislative policy-making. Weiss (1989: 428) observed the circumstances under which analysis from an internal body of experts such as the PPRC might be influential:

> Distrustful of the executive branch and the information it supplies, receptive to but wary of the information provided by interest groups, even occasionally skeptical of analysis from the congressional support agencies, committee staff are forced to figure out for themselves what is going on and what needs to be done. . . . With Congress engaged in writing 400-page bills and micromanaging details that used to be left to executive agencies to implement, the need for information is urgent.

The creation of a body such as the PPRC is a testament to the protracted partisan conflict that exists between the legislative and executive branches of the federal government, and represents an attempt by legislators to break the characteristic "deadlock and drift" in policy under those conditions (Burns 1963). This is extraordinarily difficult, however. The decentralized structure of the Congress and its patterns of behavior generally enable it to follow or respond to the president but not to take the lead. Because it is without the hierarchical, partisan control of the executive branch, James Sundquist (1981: 429) has suggested, "If the Congress

rejects the program of the president, the question is whether it can substitute a corresponding, equally well-integrated, program of its own. Can it establish the necessary centralized institutions that it has lacked, and endow them with authority? If it cannot, if its own decisions lack national perspective and consistency and coherence, the resurgence of Congress must lead to an inferior policy product."

Indeed, Congress devised the PPRC only after the executive branch did not come forth with proposals for a Part B counterpart to the new Medicare hospital payment system. Subsequently, the commission was able to develop a complex, long-term response to a number of pressing problems and saw all of the essential elements enacted into law. Under the circumstances, the development of physician payment policy represented "an extreme example of what Congress can do, with little help and some active opposition from the executive branch" (Smith 1992: 129).

A number of other agencies furnished Congress with pertinent data and analysis for policy formulation, but their missions did not include the range of work performed by the PPRC. Much of the current legislative bureaucracy dates back to the early 1970s, when a series of clashes with President Nixon moved Congress to strengthen its staff resources and institutional capacity in budgetary policy, foreign policy, and administrative oversight. It dramatically increased subcommittee staff, created the Office of Technology Assessment and the Congressional Budget Office, and expanded the Congressional Research Service and General Accounting Office. As a result, legislators had access to far more expertise and information to verify or contest positions taken by the executive branch.

Still, outside of budget preparation, legislators lacked an institutional mechanism to integrate policy and undertake major initiatives in lieu of presidential support. The ironic outcome of the expansion of staff resources was that Congress acted less as a collective institution and more as a collection of institutions, with subcommittees setting themselves up as the overseers of policy (Sundquist 1981: 411). When there was overlapping jurisdiction, as with the Medicare program, this dispersion of power and authority threatened the capacity of Congress to act as a whole. So, the tremendous financial pressures Medicare put on the federal budget, combined with the lack of presidential leadership, made physician payment policies a likely target for ad hoc instruments to formulate an integrated congressional policy. Under the circumstances, the PPRC became an important asset to legislators wishing to seize control of the agenda in this increasingly costly and prominent area of domestic policy.

What made the PPRC so instrumental to congressional leadership in

Medicare reform? First, it had independent expertise of a very high caliber. Though the commission itself was a congressional body, its members were appointed on a nonpartisan basis by the director of OTA and held full-time positions in private medical practice, universities, industry, or other independent organizations. This enabled the PPRC to draw upon a larger pool of individuals with strong credentials and experience than if it relied on individuals employed by the federal government. The diversity and quality of experts on the commission matched or exceeded the policy-making expertise in the executive branch, where domestic policy has languished and public service has been denigrated. And though the PPRC was created to assist legislators, the independence of the commissioners (including six physicians) increased their credibility with interests outside of Congress.

Second, the PPRC combined both analytical and advisory capabilities not integrated anywhere else in the legislative or executive branch. It had a relatively narrow focus; and unlike congressional agencies that performed objective analysis with no accompanying preferences or blueprint for action, the commission was geared toward recommending detailed legislation—a mission that required "a step-by-step melding of political strategy and technical rationality" (Smith 1992: 127). In the HCFA, by contrast, there was a sizable group engaged in research on physician payment but few staff actively pursuing alternatives for reform (Iglehart 1989: 1157).

Third, the ability of the PPRC commissioners and staff to collaborate with the three relevant legislative committees that were simultaneously working out a plan for reform was particularly vital to its influence. Within a short time, the PPRC emerged as a regular source of technical assistance for the House Committee on Ways and Means, House Committee on Energy and Commerce, and Senate Committee on Finance.[13] The commission was able to synthesize information, conduct independent research and analysis, and provide policymakers with relatively sophisticated options and a fairly good idea of the consequences of each option. The timely response of the PPRC to requests for advice and assistance, especially on budget issues, enhanced its relations with legislators and their staffs.[14]

13. Iglehart (1989: 1157) noted the frequent communication between the staffs of the congressional committees and their compatible views on reform: both generally supported an active government role and tended to favor regulatory rather than market instruments for allocating resources.

14. For example, the quick and persuasive assistance of the newly formed PPRC in deficit-reduction in 1986 enhanced its credibility with Congress, at the risk of offending physician groups. See Smith 1992: 223, n. 48.

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The central, yet independent, location enabled the PPRC to overcome a common problem for outside policy analysts, who are unable to reach all parts of the decentralized structure and often piecemeal process of policy-making in Congress. The commission was able to avoid the usual "dispersion of effort and duplication of work" (Weiss 1989: 416) and develop an integrated package of proposals because of its access to key members and staff of both parties on committees with diverse priorities and commitments. Even then, each committee formulated its own bill based on the PPRC recommendations; the differences were narrow enough, however, that the conference committee could broker a compromise rather than delay the reform for another year.

Finally, the PPRC was unusual in that Congress converted it into virtually a standing commission and assigned it progressive responsibilities. This allowed the leadership of both the PPRC and congressional committees to adopt a long-term approach and aim for systematic reform, while at the same time developing interim measures and solving short-term problems. Though the enactment of a long-term plan was never certain, the continuity of the relationship between the commission, interest groups, the Medicare program, and legislative committees facilitated the movement toward consensus on a comprehensive solution.

Information. Information and expertise are the handmaidens of power in the policy process. Walker (1981: 93) argued that "the great significance of the growing role of experts in democratic systems is not, as is often feared, their ability to manipulate elected representatives and gain irresponsible control over the routine operations of public bureaucracies, but rather their ability to provide the intellectual underpinnings of public policy." Carol Weiss, a longtime student of congressional policy-making, found that research and policy analysis are most often used to lend greater authority to positions policymakers have already taken on an issue. Other uses of information—warning, guidance, or enlightenment—are much less frequent (Weiss 1989).

It appears that in the course of physician payment reform, information provided by the PPRC and other sources primarily supported the intentions of Congress and periodically guided the detailed formulation of policy. Research and analysis established a severe critique of the CPR payment system, offered a promising method for eliminating many of the inherited distortions of that system, and provided a mechanism to slow the increase in Medicare outlays for physician services.

The information underpinning physician payment reform came from

many sources, and one of the principal contributions of the PPRC was to collect, analyze, and disseminate pertinent information to interest groups and policymakers. The work of the commission was influential because it provided information that was timely, independent, nonpartisan, and supported by relevant data. These features enhance "policy learning" and, by substituting evidence for rhetoric, defuse much of the conflict between advocacy coalitions over proposals for policy change (Sabatier 1988). The emphasis on objectivity was important and, perhaps, essential for securing physician acceptance and establishing mutual trust in the new regulatory system (Smith 1992: 4). Hsiao (1989) suggested that even though policy tends to be a political compromise negotiated by organized groups, objective information can narrow the divergent views and bring about quicker and better public decisions. In this light, the RBRVS was not a substitute for politics, but rather a starting point for discussion.

Due to the limited time and interest policymakers have to absorb sophisticated information on scientific issues, often the simplest function of research—documentation—is more useful than the analysis and prescription that follow (Brown 1991: 26–28). Ginsburg and Lee (1991: 91–92) asserted that the studies conducted by the PPRC that provided accurate measures of conditions or simulated the consequences of proposals were far more influential than research geared toward explaining conditions, behavior, or other outcomes. Some of the most useful information for physician payment reform came from statistical indicators and simple analysis that documented the magnitude and change in Part B spending for physician services; revealed overall increases in the volume and intensity of services per patient; and identified the shift from evaluation and management to procedural services, particularly in medical diagnosis (PPRC 1988). These data helped the commission refine the definition of the problem for policymakers and highlight the importance of controlling the volume as well as price of physician services.

As noted above, research also guided Congress's choice of payment methods for the new system. The work by Mitchell et al. (1984) convinced policymakers to steer away from DRGs for the time being, and the subsequent studies by Hsiao and his colleagues provided the data essential to calculating the physician work component of the fee schedule (Hsiao, Braun, Becker, et al. 1988; Hsiao et al. 1990). The PPRC made a significant contribution to the formulation of alternatives by proposing modifications to Hsiao's estimates of practice expenses and uniform sets of services to be covered in global fees for surgery (PPRC 1989; Smith 1992: 187). The revisions proposed by the commission and its recom-

mendation for a multiyear transition to the RBRVS fee schedule made the changes in payments more palatable to surgeons and other specialties anticipating a relative decline in their fees.

Finally, the idea for expenditure targets, which led to the volume performance standards enacted in OBRA 89, came from members of the commission. This aggressive approach to cost containment—a requisite component of the legislative package—was not considered by staffers of the PPRC or congressional committees until the commissioners themselves proposed the idea and agreed to pursue a place for it on the agenda of reform.

Members of the commission staff point out that, amid the overall success of the PPRC in policy development, a number of its proposals have been rejected and others have taken a long time to push through the political or administrative process. The fate of the commission's proposals are in fact tied largely to congressional interest on the issues. Without concerted interest from legislators, HCFA has been slow to adopt the global surgical fees recommended by the PPRC and has resisted the commission's call to revise the codes for physician visits. When HCFA set the conversion factor used to translate relative values in the new fee schedule into actual payments much lower than the one calculated by PPRC, Congress chose not to correct the administrative ruling through legislative action. Also, the PPRC unsuccessfully opposed the congressional decision that new physicians should be paid lower fees in their first few years of practice.

Process. By chartering a commission and directing it towards arcane methods of calculating physician payments, Congress shifted most of the overt politics from its chambers to the deliberations of the PPRC. Along with the great amount of energy that went into the technical design of the new Medicare physician payment system, the leap from the piecemeal adjustments in 1984 to the broad changes in 1989 reflected the efforts of the PPRC to build consensus and secure commitments to reform.

The initial challenge for the PPRC was to establish credibility with Congress and, by doing so, demonstrate to interest groups that cooperation with the commission was essential if they hoped to influence legislative deliberations on physician payment reform. The PPRC took a significant step toward credibility by completing its first report within four months of the initial meeting of the commission in November 1986.

The relationship of the PPRC to interest groups was important in defining issues and formulating policy alternatives. One role of the commission was to convene and organize the input of medical groups on payment

issues. It created a number of processes to help physicians agree on units of service and their relative values. The PPRC staff, for example, conducted a series of consensus panels to define uniform packages of services for global surgical fees and revise codes for evaluation and management services. They also used physician advisory panels to review relative values for physician work.

In addition, the commission's own research and analysis made it possible to test the empirical claims of the interest groups with greater rigor than congressional staff and even support agencies such as OTA and CBO are ordinarily capable of in such a specialized area. Throughout the process of reform, the credentials, experience, and expertise of the PPRC commissioners and staff diminished the informational power of lobbyists and strengthened the hand of those advocating a more rational and economical payment system.

As Congress acted on the commission's early recommendations and endowed it with greater resources and responsibilities, interest groups became more willing and cooperative participants in reform. The collaboration between legislators and the PPRC confirms the belief that, in a knowledge-based society, government is increasingly a major source of initiatives rather than a mere respondent and arbiter (Walker 1981: 78–79). Citing the hospital and physician payment reforms of the 1980s, Brown (1991: 41) endorsed the notion that government and the ideas it generates alter the balance of power among coalitions and push the political system toward greater innovation:

> Interest groups have learned that one cannot beat something with nothing, that the best defense may be a good offense. Once confident of their power to persuade policymakers that the status quo is the best of all possible worlds, these ex-veto groups now recognize that they must be "pro-active," must contribute "constructively" to the debate about change, must stay at the bargaining table "in good faith" on pain of being shut out. Like government, the groups have been drawn by the logic of public purchasing into a self-fueling dynamic of change in spite of themselves. . . . Today the group that cannot skillfully deploy its own arsenal of documentation, analysis, and prescription may not keep pace politically with government change agents secure in their command of the findings and recommendations of health services research and devoted to ideas whose time they want to hurry along.

Perhaps the most significant contribution of the PPRC in terms of process was the information it disseminated and the central point of access it offered to all participants across the policy community. The commis-

sion served as a nonpartisan forum for competing advocacy coalitions to exchange views and evidence and thereby advance policy learning (Sabatier 1988: 158–59). Rodwin (1989: 82) noted that the fact-finding and intellectual capital mustered by the PPRC enhanced its political influence: "As umpire and mediator, PPRC has revealed yet another example of American exceptionalism in health policy. PPRC is demonstrating—not inadvertently—that the process of inviting testimony from medical specialty societies, the AMA, and beneficiaries, and of subjecting each group to public cross-examinations, is a uniquely American method of conducting national negotiations between the federal government and the medical profession."

The PPRC, more than most governmental organizations, made its deliberations and recommendations in the open before representatives of medical interests, senior citizens, and the press (Iglehart 1989: 1157). A requirement that all materials presented to the PPRC had to be made public allowed for critical appraisal of the proposals presented by the various groups involved in the process. As Ginsburg and Lee (1989: 70) commented on the debate over a fee schedule, "Both organized medicine and beneficiary groups want the changes in relative payments to be based on the best data available rather than the outcome of arm wrestling in private among only some of the affected parties."

In contrast to the fragmentation and imbalance in lobbying that characterize conventional committee-based politics in the Congress, the central locus of activity in the PPRC meant that most interested groups, whether large or small, could present their views and receive a response from the commission. The emphasis the PPRC placed on openness had two notable effects. First, it established a relatively level playing field for all participants. An abundance of countervailing information from the competing coalitions prompted the commission to acknowledge interdependent issues and raise isolated concerns to a higher level of debate.[15]

A second aspect of the interplay between process and politics was that the accessibility and perceived fairness of the PPRC split the physician lobby. Given the opportunity to present their own views directly to the commission, a number of medical and surgical specialty groups defected from the AMA's intransigent position on expenditure targets and balance billing and accepted various elements of the PPRC plan for reform. The open process revealed divisions in organized medicine on a number of

15. E. E. Schattschneider (1960) referred to efforts to create a more open process and broader scope of debate as the "socialization of conflict."

issues: anesthesiologists and radiologists negotiated separate fee schedules with Congress, thus eliminating some of the strongest opposition to the general RBRVS fee schedule; the American College of Surgeons also challenged the Hsiao RBRVS and, in an unsuccessful attempt to get a separate surgical fee schedule, gave testimony supporting the adoption of expenditure targets; family physicians also accepted expenditure targets as preferable to more arbitrary limits on Medicare fee updates. The differences among physicians, particularly the surgeons' support for expenditure targets, left policymakers room to align themselves with broader constituencies and forced the AMA to focus its attention on the part of the PPRC package that threatened it most. It won the compromise replacing expenditure targets with volume performance standards but was unable to mount opposition to balance-billing restrictions (Hoadley 1991: 182–83).

One of the primary goals of the PPRC's chairman and commissioners was to forge a consensus on all issues before the body. With the outside medical community divided, the overall package proposed by the PPRC proved influential in legislative deliberations because the commission, with six physicians among its thirteen members, achieved consensus on all of its legislative recommendations save one. Four of the commissioners favored mandatory assignment of Medicare claims but, after voicing their position in a minority report, accepted a call for additional restrictions on balance billing.[16] On all other issues, the PPRC was able to bring together the approaches suggested by research and staff analysis with the advice and objections of interest groups and arrive at unanimous endorsement of the commission's position. It is likely that the PPRC's commitment to a consensual process of decision making strengthened its influence on congressional thinking and gave greater political weight to its blueprint for reform.

Strategy. A final factor that enhanced the feasibility of the PPRC recommendations was the strategic design of its proposals. The push for reform gained considerable momentum when the commission decided to link the basic problems and proposed solutions together in a single legislative package. Since different groups and coalitions focused on different issues, the commission recognized that, if left alone, each proposal could be vetoed by a powerful interest group concerned primarily with the con-

16. Glaser (1989: 137) suggested this controversy is not unique to the U.S.: "In every country, assignment of claims at some time becomes the most explosive issue between public authorities and the medical profession."

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sequences of that action. By the same token, the commission understood it needed to provide something positive to each constituency—beneficiaries, providers, and taxpayers. The package designed by the PPRC in its 1989 report to the Congress increased the viability of the individual components and made the overall thrust of reform more politically resilient.

Thus, the process the PPRC employed to build consensus on both the details and the major features of its 1989 recommendations and the political balance of the package made early passage possible. The openness of the commission's work and documentation of interest group positions meant that, after almost three years of hearings and policy design, Congress was well informed of all points of view before it began to actively consider the legislation. Members and their staffs knew the arguments and had independent analysis of those arguments. Not all groups supported the proposed reforms, but opponents of individual elements could not lobby against the whole package because it also contained things they wanted. As the legislative process unfolded and side bargains were struck, therefore, there remained no active opposition to the main provisions for physician payment reform. The absence of major controversy from the outside made it possible for committee leaders to work out internal differences in opinion and, under time pressure, push the new policy through in OBRA 89.

David Smith (1992: 211), who studied the roles of both the Prospective Payment Assessment Commission and the PPRC in Medicare reform, concluded that

> the PPRC supplied for Congress a coherent vision, the rationale for proposals, and the data and specifics for individual provisions, so that much of the [1989 annual report], with modifications, was adopted in the ultimate legislation. In this respect, the legislation itself stands as a recognition and testimonial to the vision that in 1984 and 1985 led to the creation of the Commission, to the political savvy of the Commission leadership, and to the quick and skillful job done by the Commission and the staff.

Implementation: Problem Solving and Institutionalizing Reform

Though the enactment of a new physician payment system for Medicare demanded skillful analysis and leadership, perhaps an even more difficult challenge for advocates of reform lies in policy implementation. Eugene

Bardach (1977: 3) articulated the lessons that might chasten even the most ardent supporters of a newborn program:

> It is hard enough to design public policies and programs that look good on paper. It is harder still to formulate them in words and slogans that resonate pleasingly in the ears of political leaders and the constituencies to which they are responsive. And it is excruciatingly hard to implement them in a way that pleases anyone at all, including the supposed beneficiaries or clients.

Since the passage of OBRA 89, the PPRC has worked with the HCFA and medical organizations to implement the various elements of the new physician payment system. Because it operates under legislative authority and its primary focus is policy development, the PPRC is playing a much smaller role in the implementation process than it did in helping set the congressional agenda and forging a feasible plan for reform. The commission has statutory responsibilities to advise Congress and comment on the annual Medicare volume performance standards recommended by the secretary of Health and Human Services. It is also charged with monitoring the effects of balance-billing limits on the financial liability of Medicare beneficiaries and their access to care. In other areas of the new policy, the PPRC has no specific authority but acts as an informal watchdog to safeguard legislative intentions in physician payment reform. The commission's institutional memory of policy development and its sensitivity to congressional concerns puts it in a position to study the decisions and actions of administrative officials and providers and, when necessary, offer alternative projections or interpretations that arise in the implementation process.

Although Congress used the reports and recommendations of the PPRC to draft a complicated and richly detailed statute, the implementation of OBRA 89 and related legislation involves a great deal of interpretation and fine-tuning as reform proceeds. For the commission and other parties watching to see how the new system performs, the challenges of policy implementation are both technical and political in nature.

Technical Challenges in Implementation

A daunting feature of physician payment reform for observers and participants alike is its sheer complexity. The package of multiple, interrelated goals and solutions needed for legislative approval set in motion a wide

array of activities designed to create a fairer and more efficient system of medical services. What will actually transpire, however, is not yet clear.

Despite its technical sophistication, the overall design of physician payment reform defies the cultural preference of Americans for "automatic solutions" to resolve political conflict and administer public policy (Morone 1990). The "econometric wizardry" of policy design (Glaser 1989) constrains the system only so much; real problem solving will depend on the interaction of the policy's rules and incentives with the uncertain behavior of individuals and organizations.[17] The effects of even the Medicare fee schedule—the most "automatic" of the changes in policy—depend on what services a half million physicians will choose to deliver and bill for among thousands of codes and amounts of payment.[18] The area with the greatest degree of interaction between public motives and private intentions and, therefore, the least predictable impact, is the development and implementation of medical practice guidelines.

In fact, each element of reform has its own institutional arrangement and time table for implementation, and each requires the coordination of numerous public and private actors to satisfactorily fulfill the goals of the policy. Bardach (1977: 5) had this type of policy in mind in his systematic diagnosis of implementation obstacles:

> A single governmental strategy may involve the complex and interrelated activities of several levels of governmental bureaus and agencies, private organizations, professional associations, interest groups, and clientele populations. How can this profusion of activities be controlled and directed? This question is at the heart of what has come to be known, among certain heretics, as the "implementation problem."

Because of this sort of complexity, Bardach likens implementation to a process for assembling a machine. For physician payment reform, much of the work needed to achieve the results intended by Congress remains to be done. The assembly of the "policy machine" includes the following elements and their schedules for implementation:

17. On the limitations of scientific and technical analysis in social problem solving, see Lindblom and Cohen 1979: 10–29.

18. The new payment system covers 7,000 procedural codes to be used by 500,000 physicians, who currently submit 450 million bills each year to over 50 carriers in the Medicare Part B program. By comparison, the hospital prospective payment system implemented in the Medicare Part A program in 1984 includes 475 diagnosis-related groups, 6,000 hospitals, and an annual volume of 11 million bills.

Balance-Billing Limits

- Beginning in 1991, physicians could not accept assigned payments or bill patients more than a specified proportion of the fee allowed by Medicare. In 1991, prior to the implementation of the fee schedule, the maximum charge was 125 percent of the average prevailing charge for a given service. In 1992, the maximum charge was 120 percent of the fee schedule amount. Beginning in 1993 and thereafter, nonparticipating physicians can only charge 115 percent of the amount in the fee schedule.[19]
- Beginning in 1992, physicians who accept assigned payments from Medicare are to be paid the lower of their actual charge or the amount allowed by the new fee schedule.

Medicare Fee Schedules

- In 1992 and in subsequent years, services with historical payments within 15 percent of the fee schedule (29 percent of all services) will be paid for at the full fee schedule amount.
- In 1992, services with historical payments more than 15 percent above or below the fee schedule (71 percent of all services) were paid for at the historical rate plus or minus 15 percent of the fee schedule amount. In 1993, payments will be 75 percent of the updated 1992 payment amount and 25 percent of the fee schedule amount; in 1994, 67 percent of the updated 1993 amount and 33 percent of the fee schedule amount; in 1995, 50 percent of the updated 1994 payment amount and 50 percent of the fee schedule amount; in 1996, 100 percent of the fee schedule amount.
- Over the five-year transition from 1991 to 1996, an estimated 20 percent of the total payment changes mandated in OBRA 89 and OBRA 90 should have been in place by 1991, 52 percent by 1992, 64 percent by 1993, 76 percent by 1994, 88 percent by 1995, and 100 percent by 1996.
- Relative values still have to be constructed for procedures representing about 15 percent of Medicare physician payments. Also, approximately one-third of all services currently covered by the new fee

19. The limits on extra billing of patients are actually more complicated in several ways. The actual amounts allowed are lower because nonparticipating physicians are paid only 95 percent of the allowed fee for participating physicians. In addition, the maximum allowable actual charges (MAACs) established under OBRA 86 still apply to some services, and limit balance billing based on an individual physician's historical charges (PPRC 1992: 92). Finally, some states have stricter limits on balance billing for Medicare services.

schedule need revised codes or relative work values to conform to other services in the fee schedule, according to the PPRC. OBRA 89 mandates that the codes and relative values for the entire fee schedule be reviewed and revised as needed every five years.

- Anesthesiology services are paid for according to a separate, specialty-specific fee schedule.[20]

Volume Performance Standards and Fee Updates

- Each year Congress updates the conversion factor for payments under the Medicare fee schedule. The update is to be based primarily on the difference between the actual increase in Part B physician spending in the previous year and the Medicare volume performance standard (VPS) set by Congress for that year. If expenditures exceed the VPS, the update is reduced accordingly; if expenditures fall below the VPS, the update is increased. Congress may set an annual VPS based on recommendations from the DHHS and the PPRC or allow the standard to be set by a default formula specified in OBRA 89. The VPS is supposed to reflect changes in the beneficiary population, inflation, appropriateness of care, access to care, and changes in technology. OBRA 89 set the first VPS for fiscal year 1990.
- A separate VPS is set for surgical and nonsurgical specialties.
- The VPS is currently a national standard but there continues to be interest in Congress and the HCFA for developing performance standards for states or voluntary groups of physicians.

Effectiveness Research and Development of Practice Guidelines

- OBRA 89 replaced the National Center for Health Services Research with the Agency for Health Care Policy and Research (AHCPR).
- The AHCPR is responsible for conducting, sponsoring, and disseminating research on the costs and outcomes of medical procedures. It also supports the development and implementation of practice guidelines. The AHCPR established a medical treatment effectiveness program with initial funding of $37.5 million in fiscal year 1990 and $62.6 million in fiscal year 1991, its first full year of operation.[21]

20. From April 1989 to January 1992, radiology services were paid under a separate fee schedule developed by the American College of Radiology. As of 1992, payment for radiology services will be made under the general Medicare fee schedule (CRS 1991: 9).

21. Funding for the AHCPR Medical Treatment Effectiveness Program amounted to $62.2 million in 1992 and President Bush's proposed budget called for $71.9 million in 1993 (AHSR 1992).

Each of these areas involves a different set of organizations responsible for implementation. Compliance with balance-billing limits rests initially with providers, since beneficiaries will not know the allowed charges and rules for every service. The Medicare carriers are responsible for informing physicians and beneficiaries of the law and regulations and, beginning in 1993, Medicare will notify beneficiaries of the charge limit for each claim. The carriers must also monitor and enforce the restrictions on balance billing, and the Office of the Inspector General in the HCFA may impose sanctions against a physician who "knowingly and willfully" has billed in excess of the allowed charge on a repeated basis. Under current law, however, neither the physicians nor carriers are required to issue refunds to patients who are overcharged (PPRC 1992: 91–98).[22]

The implementation of the new Medicare fee schedule is supervised by the HCFA. The services covered under the HCFA's Common Procedure Coding System are based heavily on the AMA's Current Procedural Terminology (CPT) and the changes in the coding system made annually by a group appointed by the AMA known as the CPT-4 editorial panel.[23] Each Medicare carrier and provider must interpret the codes to determine charges for individual patient services. The HCFA calculates the conversion factor and annual updates that translate the relative value for each code into actual payments under the fee schedule.

Congress determines the annual VPS and updates to the fee schedule based on the recommendation of the secretary of Health and Human Services and similar advice from the PPRC. If legislators elect not to choose the VPS, it is set by a default formula prescribed in OBRA 89.

There is a wide range of activities under way on outcomes research and practice guidelines in both the public and voluntary sectors. At present, more than fifty organizations are developing practice guidelines, including health care plans, medical societies, group medical practices, insurers, researchers, and consultants (Institute of Medicine 1992). The AHCPR conducts intramural research on the outcomes and effectiveness of medical services and has contracts and grants for extramural research and the

22. The sanctions include a monetary penalty of double the excess charges, civil penalties up to $2,000 per violation, and/or exclusion from the program for up to five years (PPRC 1992: 93). The PPRC recommended in its 1992 annual report that Congress pass legislation to mandate refunds to beneficiaries in cases of overpayment.

23. The American Medical Association CPT-4 editorial panel has twelve members representing the AMA and medical specialties, the Health Insurance Association of America, Blue Cross and Blue Shield, and HCFA. The panel meets four times each year to consider and approve changes in Current Procedural Terminology codes, and the approved changes are included in an annual update.

development of practice guidelines. The agency is currently sponsoring the development of sixteen practice guidelines and ultimately may add up to ten new guidelines each year (PPRC 1992: 222–24). In addition, public and private insurers and peer review organizations have initiated efforts to revise their utilization review activities to develop profiles of practice patterns and put less emphasis on case-by-case methods and interventions.

Thus, the new Medicare payment system has generated an enormously diverse and complicated set of endeavors. Some are mandated by legislation, while others are voluntary or efforts to preempt further governmental regulation. Little is fully in place, and the reform is very much a work in progress. The malleable character of the policy and the system it is trying to renovate means that there are still numerous challenges on the way to more orderly, effective, and efficient health services.

Political Challenges in Implementation

Seasoned observers of the American policy process understand that politics rarely ends when Congress enacts a law. Even when the technical assembly of a program is manageable, there are forces that can create a quite different "machine" than the one envisioned by protagonists in the legislative arena. The political forces and games in implementation tend to be more subtle than those at work in policy formulation and enactment, are usually hidden from public view, and exert their influence over a long period of time.

Fitting Actions to Intentions. With the enactment of OBRA 89, power over physician payment reform shifted from the legislative to the executive branch, especially to administrative officials at the HCFA and the DHHS. The source of much of this power lay in overall budget constraints and in the political nature of technical analysis.

Under the "customary, prevailing and reasonable" payment system, the HCFA was primarily what James Q. Wilson (1989) has termed a "procedural organization." It had clear standards for its activities but no particular responsibility for the outcomes of those activities; its charge screening system, for example, was not required to keep overall expenditures within a fixed budget or limit the aggregate financial liability of beneficiaries. Some of the provisions of OBRA 89 reinforced this orientation. The fee schedule and limits on balance billing, in particular, manifested the growing tendency of Congress to "micromanage" administration through elaborate rules or devices of its own design (Wilson 1989: 241–44).

Table 4 Volume Performance Standard Recommendations, Fiscal Years 1991 and 1992 (percent)

	All Services	Surgical Services	Nonsurgical Services
1991			
Secretary of Health and Human Services	9.9	8.7	10.5
Physician Payment Review Commission	11.2	9.3	12.1
Congressional Action	7.3	3.3	8.6
1992			
Secretary of Health and Human Services	6.2	4.1	7.1
Physician Payment Review Commission	8.6	6.6	9.6
Congressional Action	10.0	6.5	11.2

Note. Changes in the baseline between the time the recommendations were made and the time the Congress acted explain some of the discrepancies among the numbers.
Source. PPRC 1992: 33.

Other provisions of OBRA 89, however, transformed the nature of the HCFA's work to that of a "craft organization," where there is less regulation of daily operations but clear measures and expectations for outcomes. The implementation and enforcement of broad policy aims, especially achieving control over total Medicare spending on physician services, have revealed the discretionary nature and political priorities of administrative decision making.

One indication of how decisions can come out quite differently when there is no single, undisputed method of implementation can be seen in the variations in the annual volume performance standards recommended to Congress by the PPRC and by the secretary of Health and Human Services (Table 4). The recommended VPS must take into account growth and aging of the beneficiary population, inflation, appropriateness of care, access to care, and changes in technology, among other factors (PPRC 1992: 12–14).

Using its own method of calculation, the DHHS recommended for fiscal year 1991 a VPS of 8.7 percent for surgical services and 10.5 for nonsurgical services (9.9 percent overall). The PPRC, adopting a different method, suggested a surgical VPS of 9.3 percent and nonsurgical VPS of 12.1 percent (11.2 percent overall). Taking into account price cuts mandated in OBRA 90, Congress actually set a much lower VPS for each category. For fiscal year 1992, the DHHS recommended a surgical VPS of

4.1 percent and a nonsurgical VPS of 7.1 percent (6.2 overall), while the recommendations of the PPRC called for a VPS of 6.6 percent for surgical services and a 9.6 percent VPS for nonsurgical services (8.6 overall).

In each year, the DHHS has recommended a significantly lower increase in allowed spending than has the PPRC. On a budget of approximately $30 billion for 1992, in other words, the DHHS would allow physician payments to grow by about $720 million dollars less than allowed under the PPRC recommendation—close to $1,500 per physician in the country. Although the PPRC (1992: 13) has taken the position that by 1996, Medicare outlays for physician services should grow no faster than the nominal gross domestic product, its recommendations are in the short term more generous to the medical community.

The variations in the volume performance standards are relatively small when compared to the HCFA's dramatic departure from legislative expectations in calculating payments under the new Medicare fee schedule implemented in January 1992.

In September 1990, the HCFA released a model fee schedule to give a preliminary indication of how payments for specific physician services and specialty groups would fare under the new RBRVS compared to the existing system. The model fee schedule conformed closely to the results of simulations run prior to enactment of the law in 1989 and made available at that time to policymakers and interest groups.

Then in June 1991, the HCFA issued a Notice of Proposed Rule Making (NPRM) that would have reduced overall payments by close to 6 percent by the time the fee schedule was fully implemented. In just the period of transition until 1996, this would have lowered Medicare outlays by $6.9 billion (CRS 1991: 4). The PPRC noted that under the proposed schedule, "internists, who had expected payments to increase by 16 percent to 17 percent, will receive no increase; family physicians will have their expected increases cut substantially; and virtually all other physicians will have reductions much greater than those already anticipated. Reductions of this magnitude were not anticipated by the Commission, the Congress, or physicians" (Lee and Ginsburg 1991: 1563).

Physicians erupted in a "firestorm of protest" in response to the proposed fee schedule (PPRC 1992: 23). The congressional sponsors of the legislation held hearings over the summer of 1991 to question the HCFA's motivations and calculations.[24] The executive vice president of the AMA

24. The exchanges are found in the transcripts of hearings on the HCFA Notice of Proposed Rule Making on the Medicare fee schedule in the House Committee on Ways and Means,

argued that the NPRM was based on erroneous calculations and "unsubstantiated and demeaning assumptions about how physicians will respond to the new schedule," and he accused the HCFA and the Bush administration of "cynical and inappropriate" methods of implementation (Todd 1991).

The roots of the controversy were relatively simple. Under OBRA 89, the new payment system was supposed to be "budget-neutral." Yet the law provided that fees for services that were substantially undervalued (more than 15 percent below the fee calculated with the RBRVS) should increase toward the full fee schedule amount more rapidly than fees for overvalued services should be reduced; this imbalance or "asymmetry" in the transition period theoretically required *higher* payments under the new fee schedule and the HCFA felt compelled to find savings elsewhere to stay budget-neutral. In addition, physician groups and the HCFA's own model fee schedule assumed total spending would be the same under the new system as under the old all the way through implementation to 1996. In fact, the law only required budget neutrality in 1992, its first year of operation. The HCFA, under pressure from the Executive Office of Management and Budget to produce budget savings, crafted a complex approach that met both the 1992 neutrality test and budgetary demands.

The actuaries at the HCFA made four controversial calculations in the NPRM, which together reduced by more than 16 percent the conversion factor used to translate the relative value scale into actual dollar payments under the Medicare fee schedule (PPRC 1991b; Lee and Ginsburg 1991): (1) Since the increases in fees for undervalued specialties were more rapid and exceeded the savings from fee reductions for overvalued specialties, the HCFA deducted the net outlays for this asymmetry from overall payments by lowering the conversion factor by 6 percent; (2) the HCFA assumed that physicians would offset 50 percent of the reductions in payments by increasing their volume of services and, to compensate, the conversion factor was reduced by an additional 10.5 percent; this estimate did not consider that physicians whose fees increased under the new schedule might reduce their volume; (3) the HCFA projected that as physicians made the "crosswalk" from their old codes to the revised codes for evaluation and management services (which account for about 35 percent of all payments), their bills would be 13 percent higher than the amount

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Subcommittee on Health, on 25 June 1991; the House Committee on Energy and Commerce, Subcommittee on Health and the Environment, on 11 July 1991; and the Senate Committee on Finance, Subcommittee on Medicare and Long-Term Care, on 19 July 1991.

projected in simulations done by the PPRC (1991b: 12); and (4) the HCFA did not allow for the possibility that physicians might submit bills for services at rates below the fee schedule amount.

Eventually, the administration reversed course in the face of objections from Congress, the PPRC, and over 95,000 items of correspondence on the proposed fee schedule. In August 1991, the HCFA announced that it was redrafting the fee schedule with the approval of DHHS secretary Louis Sullivan and described the calculations in the NPRM as an unintentional side effect of technical language in the 1989 legislation (Rich 1991a). The "Final Rule" that the HCFA announced in November 1991 eliminated the $6.9 billion in "unintended savings" that the proposed rule had achieved during the transition period and set the baseline conversion factor for the new fee schedule 13.2 percent higher than under the proposed rule. The new design did not reduce the projected volume increase ("behavioral offset"), though, and thus real payments per service in 1996 were set at 6 percent below the baseline payments for the new system. The changes in fees for selected services under the two rules are shown in Table 5.

HCFA administrator Wilensky, who had defended the NPRM against a barrage of criticism without any support from President Bush or Secretary Sullivan (Iglehart 1991: 826), now defended the integrity of the Final Rule: "While we believe our proposed rule contained the most obvious interpretation of the statute, we also believe our new reading is consistent with the law" (Wilensky 1991: 6).

Interest Group Liberalism? The advice to Congress on volume performance standards and the revisions of the fee schedule illustrate that the methods and practices of actuaries, economists, and other technical analysts in government—like those of physicians—are highly variable and lack a firm, objective basis. A pertinent issue is who benefits from the ambiguity and discretion in the implementation of physician payment reform.

Theodore Lowi warned of policies that set forth broad mandates and leave important details for administrative officials to work out. He advocated a political process dominated by legislative bodies, institutions that have more visibility and more popular control than are found in the specialized agencies of the bureaucracy. His scheme for "juridical democracy" directed the federal government to focus on "those practices for which it is possible to develop a clear and authoritative rule of law, enacted democratically and implemented absolutely" (Lowi 1969: 271). For Congress

Table 5 Medicare Physician Fee Schedule: Fee Schedule Payments and 1991 Average Payments for Selected High-Volume Physician Services (in dollars)

Physician Service	1991 Average Payment	1992[a] Transition Payment	Full Fee[b] Schedule	NPRM[b] Full Fee Schedule
Office Visit, New, Level 1 of 5	27	26	26	23
Office Visit, New, Level 2 of 5	34	38	41	36
Office Visit, New, Level 3 of 5	40	47	55	48
Office Visit, New, Level 4 of 5	61	71	80	70
Office Visit, New, Level 5 of 5	67	80	100	88
Office Visit, Established, Level 1 of 5	13	13	13	11
Office Visit, Established, Level 2 of 5	20	22	22	20
Office Visit, Established, Level 3 of 5	26	30	31	27
Office Visit, Established, Level 4 of 5	39	45	47	42
Office Visit, Established, Level 5 of 5	57	66	73	65
Hospital Visit, Initial, Level 1 of 3	49	56	59	52
Hospital Visit, Initial, Level 2 of 3	77	88	94	83
Hospital Visit, Initial, Level 3 of 3	84	99	119	105
Hospital Visit, Subsequent, Level 1 of 3	28	31	31	27
Hospital Visit, Subsequent, Level 2 of 3	34	40	45	39
Hospital Visit, Subsequent, Level 3 of 3	47	55	60	52
Total Hip Joint Replacement (CPT: 27130)	2,105	1,772	1,697	1,513
Total Knee Replacement (CPT: 27447)	2,241	1,886	1,816	1,588
Insertion of Heart Pacemaker (CPT: 33207)	811	694	575	500
Coronary Arteries Bypass (CPT: 33512)	3,178	2,726	2,225	1,952
Upper GI Endoscopy, Diagnosis (CPT: 43235)	292	250	207	183

Table 5 Continued

Physician Service	1991 Average Payment	1992[a] Transition Payment	Full Fee[b] Schedule	NPRM[b] Full Fee Schedule
Sigmoidoscopy (CPT: 45330)	100	85	78	71
Diagnostic Colonoscopy (CPT: 45378)	337	286	263	223
Removal of Gallbladder (CPT: 47600)	743	626	599	535
Repair Inguinal Hernia (CPT: 49505)	445	379	335	297
Cystoscopy (CPT: 52000)	112	113	113	92
Prostatectomy (TURP) (CPT: 52601)	981	824	802	714
Total Hysterectomy (CPT: 58150)	834	805	805	603
Lasering, Secondary Cataract (CPT: 66821)	516	448	327	286
Remove Cataract, Insert Lens (CPT: 66984)	1,342	1,151	941	847
X-ray Exam of Chest (CPT: 71020-PC)	14	12	11	9
Contrast CAT Scans, Abdomen (CPT: 74170-PC)	91	77	69	58
Weekly Radiation Therapy (CPT: 77425-PC)	160	136	121	101
Surg. Path., Gross and Micro. (CPT: 88305-PC)	59	51	43	38

Key. CPT = current procedural terminology; GI = gastrointestinal; NPRM = notice of proposed rulemaking; TURP = transurethral resection of the prostate.

a. To determine the 1992 transition payment, the 1991 average payment is updated by the 1.9 percent update factor and reduced by 5.5 to reflect adjustment for the transition asymmetry.

b. Includes an annual update of 1.9 percent for 1992.

Source. HCFA 1991.

to delegate authority to administrators or private contractors was to give illicit sovereignty to narrow interests and judgments.

Lowi's concern was that administrative discretion served special interest groups to the detriment of the general public. The administration's compromise on the Medicare fee schedule under outside pressure does not provide a clear lesson, however, about winners and losers in the politics of implementation.

At first glance, the HCFA responded in its Final Rule to simple, if extraordinary, interest group pressure. The AMA and at least sixteen physician specialty groups launched a heated campaign to reverse the "cuts"—lower rates of increase, actually—in the fee schedule (Rich 1991b; Todd 1991).

Alternatively, the retreat by the HCFA was perhaps in response to Congress, which legitimated the complaints of the interest groups, rather than a reaction to the interest groups themselves. The committee hearings in June and July of 1991 generated a stream of grave remarks from the members of Congress responsible for Medicare policies, who also sent strong letters of objection to the DHHS. Their message was that the administration had clearly disregarded the intent of the law and, if necessary, legislators would repudiate the HCFA interpretation by enacting new statutory guidelines. Congressional leaders argued that the intent of the OBRA 89 package was to pursue cost containment through the VPS mechanism, not the fee schedule.

In the end, physicians got back nearly all of the funding projected in the congressional deliberations and the model fee schedule. Payments under the new Medicare fee schedule were expected to increase 11.7 percent annually, or 74 percent in all, from 1991 to 1996 (Wilensky 1991). Although some physicians suffered a *relative loss* compared to others under the resource-based fee schedule, in the five-year transition through 1996, the specialties with the most severe cuts under the relative value scale (anesthesiology and thoracic surgery) were still promised an *absolute increase* of 50 percent in their fees (Table 6). These projected increases, coming in a period when the rest of the U.S. economy was still in a prolonged recession, did not indicate that physicians were enduring any special hardship—if anything, they were staying ahead of other occupations. That an annual increase of 11.7 percent was considered economical is a remarkable indication of how uncontrolled expenditures on physician services have been in recent years.

The turnaround by the HCFA is not necessarily evidence of administrative responsiveness to interest group pressure or congressional authority, however. In fact, critics outside of the HCFA were in an unusually weak position to force a revision of the fee schedule. Despite its threats to do so, Congress was not inclined to overrule the HCFA through legislation because the budget agreement reached with the Bush administration in 1990 left the "scoring" of the budgetary impact of new legislation up to the Executive Office of Management and Budget. Once the HCFA set a conversion factor that the budget director determined to be "revenue-

Table 6 Impact of the Medicare Physician Fee Schedule, by Specialty (as percentage loss or gain)

Physician Specialty	1992		1996		5-Year Projected Increases for Physician Services	
	Payments per Service	Payments	Payments per Service	Payments	Average Annualized Payment	Cumulative Payment
All Specialties	−3	0	−6	0	12	74
Family Practice	15	16	28	30	18	125
General Practice	17	18	27	29	17	124
Cardiology	−9	−3	−17	−8	10	59
Dermatology	−1	0	0	2	12	77
Internal Medicine	0	1	5	7	13	85
Gastroenterology	−10	−4	−18	−9	10	58
Nephrology	−6	−2	−9	−5	11	66
Neurology	−4	−2	−4	−2	11	71

Psychiatry	−2	−1	3	5	13	82
Pulmonary	−3	−1	−2	0	12	74
Urology	−6	−2	−8	−4	11	67
Radiology	−10	−4	−22	−11	9	55
Anesthesiology	−11	−4	−27	−14	8	50
Pathology	−10	−4	−20	−10	9	57
General Surgery	−8	−3	−13	−7	10	62
Neurosurgery	−10	−4	−18	−9	10	58
Ophthalmology	−11	−4	−21	−11	9	55
Orthopedic Surgery	−8	−3	−11	−5	10	64
Otolaryngology	2	3	3	5	13	83
Plastic Surgery	−8	−3	−13	−6	10	63
Thoracic Surgery	−14	−5	−27	−14	8	50
Clinics	−1	0	−1	1	12	75
Optometry	20	21	41	43	20	148
Chiropractic	12	13	26	28	17	122
Podiatry	6	7	14	16	15	102

Source. HCFA 1991.

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neutral," legislators could not increase the conversion factor—and with it, physician payments—without taking funds from elsewhere in Medicare or another entitlement program to pay for the increase. The scoring rules severely limited new federal spending, and it was unlikely that Congress would attempt to increase payments to physicians at the same time it was unable to pass legislation extending unemployment benefits without the support of the president. In addition, legislators wanted to avoid reopening the physician payment system altogether and end up with a situation in which everything in the original reform package was up for grabs.

So the revision of the fee schedule may reflect bureaucratic responsiveness to presidential directives rather than to legislative intentions. One view was that the HCFA made its own judgments on the conversion factor but then relented to pressure from presidential aides worried about offending medical interests going into an election year. Other observers believed that the HCFA was impelled in the first place by the administration to take money out of the fee schedule and endure the predictable political explosion; this action would create distrust in the medical community over governmental management of health care and thereby curb growing support among physicians for national health insurance or other comprehensive reforms. During the summer hearings, in fact, members of Congress hinted openly that the dispute over implementation could be blamed on budget officials, not the HCFA administrators; and Wilensky protested that she was disturbed to see much of the goodwill she had worked to establish between the Medicare program and physicians "go down the drain."

Policy Performance: A Matter of Fixing Implementation or Finding Political Will?

Whatever the motivations of the various parties in implementing the fee schedule, the deal hammered together in OBRA 89 nearly came undone and a considerable amount of political capital was required to patch it back together. The solution reached in the HCFA Final Rule was not the product of an automatic formula prescribed in the original legislation; it was instead a negotiated package combining the views of the HCFA, legislative leaders, the PPRC, and organized medicine.

In terms of policy performance, the short-term results of implementation to date are not as important as the long-term lessons. First and foremost, the success of physician payment reform depends on long-term cooperation. Providers must regard payments as fair, beneficiaries must

have access to needed services, and costs must be brought under control. The sensitivity of the PPRC to provider interests in recommending the annual VPS and the concessions made by the HCFA in crafting the fee schedule suggest that, though the medical profession is more divided than a quarter century ago, its overall economic interests must still be accommodated for orderly program operation. Early disruptions threaten the interests of all parties close to the program.

Second, cost containment depends on a number of controls. The failure of the HCFA effort to reduce the initial fee levels indicates that concerted controls will have to come, as originally planned, through the annual VPS and fee updates determined by Congress. Attention is also necessary to ensure that future refinements and updates in the service codes and relative values that make up the fee schedule—areas in which organized medicine may exert a strong influence—reflect the principles of resource-based payment and do not become indirect means to inflate fees. The great unknown in cost containment is the generation and dissemination of information on medical care outcomes and the changes in physician practice patterns that may result.

Third, the complex analysis and adjustments made to the payment system are more likely to be understood and accepted if the process of implementation (calculation of the VPS, revision of codes and relative values, promulgation of practice guidelines and physician profiles, etc.) is conducted in public. As the HCFA revisions of the fee schedule showed, the closed nature of bureaucratic decision making promotes uncertainty and distrust and generally inhibits the cooperation necessary to sustain such a broad, evolutionary policy. A more open style closer to that of the PPRC and Congress in general may be more effective in instituting significant changes, particularly if the principles and methods of physician payment reform in Medicare are extended to state Medicaid programs and to private insurance.

Finally, the technical sophistication of the payment system does not eliminate the inherent politics of reform. William Glaser (1989, 1990), a strong critic of the resource-based fee schedule, argued that the "wizardry" of the Hsiao relative value scale and fine-tuning by the PPRC would be unnecessary in a political system where legislative and executive power was consolidated and narrow factions were less influential in policy deliberations. He contended that the RBRVS approach, though itself laden with value judgments, denies that physician payment is a struggle over relative incomes and reflects Americans' illusory devotion to formula systems of reimbursement and scientific design. Glaser commended physician pay-

ment systems in other nations, which generally have made the same adaptations (i.e., increasing the value of evaluation and management services and setting a cap on aggregate expenditures) through negotiations between physicians and government. Other systems make no pretense that politics can be replaced with automatic determinations of fees.

Thus, the intricacies of the RBRVS and volume performance standards may transform broad rhetoric into debate over mechanics, but the interests at stake remain the same. In each of the main areas of the policy—enforcing balance-billing limits, refining resource-based payment, and imposing cost controls—whoever is charged with fixing problems as they occur over time will require sustained political support. Perhaps the toughest task in implementation remains with Congress, which chose to forgo automatic expenditure caps in lieu of the advisory guidelines provided by the VPS. Now, on an annual basis, it must maintain discipline and set strict fee updates if it wishes to bring spending on physician services in line with growth in the rest of the economy, as the PPRC has consistently proposed. In implementation as in enactment, the success of physician payment reform will require the skills of technicians and politicians alike.

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