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TALKING POINTS
SENATOR BOB DOLE
MEDICAL GROUP MANAGEMENT ASSOCIATION
57TH ANNUAL CONFERENCE
WASHINGTON HILTON HOTEL
OCTOBER 25, 1983

PHYSICIAN PAYMENT REFORM

O THE PHYSICIAN REIMBURSEMENT PROVISIONS CONTAINED IN THE ORIGINAL MEDICARE LEGISLATION WERE PATTERNED AFTER THE "USUAL, CUSTOMARY, AND REASONABLE" (UCR) PLANS DEVELOPED BY INSURANCE ORGANIZATIONS IN THE EARLY 1960S. UNDER THOSE PLANS A PHYSICIAN'S BILLED CHARGE WAS PAID IN FULL IF IT DID NOT EXCEED THE AMOUNT CUSTOMARILY BILLED FOR THE SERVICE BY OTHER PHYSICIANS IN THE AREA, AND IF IT WAS OTHERWISE REASONABLE.

O FOLLOWING THE IMPLEMENTATION OF MEDICARE, WE SAW DRAMATIC INCREASES IN PHYSICIANS' FEES. FROM 1966 TO 1971, PHYSICIAN FEES INCREASED 60 PERCENT FASTER THAN THE NON-MEDICAL ITEMS IN THE CONSUMER PRICE INDEX (CPI). IN RESPONSE, THE CONGRESS ACTED TO LIMIT THE PROGRAM'S RECOGNITION OF CHARGE INCREASES. AS A RESULT, MEDICARE'S PREVAILING CHARGE LEVELS ONLY INCREASE TO THE EXTENT JUSTIFIED BY AN ECONOMIC INDEX WHICH REFLECTS CHANGES IN PHYSICIANS' OPERATING EXPENSES AND EARNINGS LEVELS.

O UNDER THE CURRENT LIMITS, WHEN A PHYSICIAN'S BILLED CHARGE IS GREATER THAN THE CHARGE MEDICARE DETERMINES TO BE REASONABLE, A REASONABLE CHARGE REDUCTION IS MADE AND THE PHYSICIAN OR

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BENEFICIARY RECEIVES A REDUCED PAYMENT--THE PHYSICIAN IN THE CASE HE OR SHE ACCEPTS ASSIGNMENT, THE BENEFICIARY, WHEN THE PHYSICIAN REJECTS ASSIGNMENT.

- REASONABLE CHARGE REDUCTIONS, HOWEVER, HAVE LED PHYSICIANS TO REJECT ASSIGNMENT. IN FISCAL YEAR 1982, OVER FOUR-FIFTHS OF ALL ASSIGNED CLAIMS RESULTED IN REDUCED PAYMENTS FOR BILLED CHARGES. ON AVERAGE THE REDUCTION AMOUNTED TO $29.32 PER CLAIM.

- WHEN PHYSICIANS REJECT ASSIGNMENT, THEY MAKE THE BENEFICIARY LIABLE FOR THE DIFFERENCE BETWEEN THE PHYSICIAN'S CHARGE AND THE AMOUNT MEDICARE RECOGNIZES AS REASONABLE. IN FISCAL YEAR 1982 THIS LIABILITY AMOUNTED $28.10 PER PAID CLAIM.

- THEREIN LIES OUR PROBLEM. WE HAVE PUT OFF REFORMS IN THE AREA OF PHYSICIANS REIMBUSEMENT ON THE BASIS THAT THE CONSEQUENCES OF WHATEVER IS DONE WILL BE BORNE, NOT BY PHYSICIANS, BUT BY THEIR PATIENTS--THE MEDICARE BENEFICIARIES. WE NO LONGER CAN HOLD OFF THE FORCES CALLING FOR MANDATORY ASSIGNMENT UNLESS WE HAVE SOME OTHER REFORMS TO OFFER. IT IS TIME TO ACT, AND PHYSICIANS ARE IN THE SPOTLIGHT.

- THE ECONOMIC INDEX LIMITATIONS ADOPTED IN 1972 HAVE HAD SOME SUCCESS. THE RATE OF INCREASE IN PHYSICIANS' FEES RECOGNIZED

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BY MEDICARE BETWEEN 1967 AND 1981 WAS LESS THAN THE RATE OF INCREASE IN THE PHYSICIAN FEE COMPONENT OF THE CPI. BUT PRICE INCREASES ARE NOT THE ONLY PROBLEM. AS A RESULT OF INCREASED PHYSICIAN VISITS PER ENROLLEE, THE INCREASED USE OF SPECIALISTS, AND THE USE OF MORE EXPENSIVE TECHNIQUES, TOTAL RECOGNIZED CHARGES PER ENROLLEE HAVE INCREASED FASTER THAN THE CPI INCREASE IN PHYSICIAN FEES.

- BETWEEN 1975 AND 1981 THE PHYSICIAN FEE COMPONENT OF THE CPI INCREASED AT AN AVERAGE RATE OF 10.6 PERCENT WHILE RECOGNIZED CHARGES PER ENROLLEE INCREASED AT AN AVERAGE RATE OF 13.4 PERCENT. RECENTLY THE SUPPLEMENTARY MEDICAL INSURANCE (SMI) TRUST FUND ACTUARIES HAVE ESTIMATED THAT DOUBLE DIGIT RATES WILL CONTINUE FOR THE NEXT COUPLE OF YEARS.

- THE SMI TRUST-FUND IS ACTUARILY SOUND BUT ONLY BECAUSE MOST OF ITS COSTS ARE MET WITH INCOME PROVIDED DIRECTLY BY THE U.S. TREASURY. IN FISCAL YEAR 1983 THE TREASURY WILL CONTRIBUTE $13.7 BILLION TO THE TRUST FUND TO KEEP IT SOLVENT--ABOUT $3.30 FOR EACH PREMIUM DOLLAR RECEIVED FROM ENROLLEES.

- IN LIGHT OF CURRENT AND PROJECTED BUDGET DEFICITS THERE IS A PROBLEM. KEEPING THE SMI TRUST FUND SOLVENT PLACES AN INCREASING STRESS ON THE U.S. TREASURY, AND CONTRIBUTES TO GREATER DEFICITS.

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- LAST WEEK THE HOUSE WAYS AND MEANS COMMITTEE REPORTED THE TAX REFORM ACT OF 1983. UNDER ITS PROVISIONS EACH PHYSICIAN ON THE STAFF OF A PROVIDER HOSPITAL WOULD HAVE TO AGREE TO ACCEPT ASSIGNMENT FOR ANY MEDICARE BENEFICIARY THAT HE OR SHE TREATS AS AN INPATIENT OF THAT HOSPITAL. THE COMMITTEE INCLUDED THE MANDATORY ASSIGNMENT PROVISION BECAUSE OF CONCERN OVER THE POSSIBILITY THAT IN ITS ABSENCE BENEFICIARIES WOULD END UP BEARING AT LEAST SOME PART OF THE BURDEN OF THE COST SAVINGS OBTAINED FROM ANOTHER PROVISION WHICH FREEZES PREVAILING FEES FOR PHYSICIANS. WHILE I AGREE WITH THE INTENT OF THE COMMITTEE TO AVOID HAVING PHYSICIANS SIMPLY SHIFT THE BURDEN OF REFORM TO THE AGED, I BELIEVE THERE MAY BE BETTER WAYS TO ACHIEVE PHYSICIAN PAYMENT REFORM.

- THE FINANCE COMMITTEE HAS MADE AVAILABLE A COMMITTEE PRINT WHICH PROVIDES AN OVERVIEW OF PHYSICIAN REIMBURSEMENT PATTERNS UNDER MEDICARE. BESIDES PROVIDING DETAILS OF REASONABLE CHARGE DETERMINATIONS AND THEIR EFFECTS ON BOTH PHYSICIAN AND PATIENT, IT REVIEWS THE PAYMENT OPTIONS WHICH ARE CURRENTLY UNDER DISCUSSION. THE COMMITTEE WILL MOVE FORWARD WITH HEARINGS TO MORE FULLY EXPLORE THE PROBLEM AND THE SOLUTIONS.

- EARLIER THIS YEAR, THE SECRETARY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES WAS REQUIRED BY THE CONGRESS TO BEGIN THE COLLECTION OF DATA NECESSRY TO COMPUTE BY DIAGNOSIS RELATED

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GROUPS (DRGS) THE AMOUNT A PHYSICIAN CHARGES FOR SERVICES FURNISHED TO HOSPITAL INPATIENTS. IN 1985 THE SECRETARY IS REQUIRED TO MAKE RECOMMENDATIONS TO THE CONGRESS ON THE ADVISABILITY AND FEASIBILITY OF PROVIDING FOR A DRG TYPE PAYMENT SYSTEM FOR PHYSICIAN SERVICES.

- RECENTLY, THE FINANCE COMMITTEE ADOPTED A PROVISION WHICH WOULD DIRECT THE OFFICE OF TECHNOLOGY ASSESSEMENT TO REPORT TO THE CONGRESS AFTER CONSULTATIONS WITH PHYSICIANS ORGANIZATIONS ON WAYS TO MODIFY THE EXISTING SYSTEM FOR DETERMINING MEDICARE ALLOWANCES TO ELIMINATE INEQUITIES THAT EXIST BETWEEN REIMBURSEMENT LEVELS FOR MEDICAL PROCEDURES (E.G., SURGERY) AND COGNITIVE SERVICES (E.G., PHYSICAL EXAMINATIONS, COMPLETE HISTORIES, CONSULTATIONS, ETC.). THE STUDY WOULD ALSO INCLUDE SPECIFIC FINDINGS AND RECOMMENDATIONS ON CREATING A MEANS TO ADJUST ALLOWANCES TO PHYSICIANS, AS COSTS AND RISKS TO PHYSICIANS WHICH RESULT FROM NEW TECHNOLOGIES AND PROCEDURES, DECREASES OVER TIME.

- THE COMMITTEE EXPECTS TO MOVE AHEAD ON PHYSICIAN PAYMENT REFORM UTILIZING THE RESULTS OF THE REQUIRED STUDIES AND THE COMMITTEE'S HEARINGS. THROUGH THOSE HEARINGS I WOULD LIKE TO EXAMINE ALL OF THE SUGGESTED POSSIBLE MODIFICATIONS IN MEDICARE'S PHYSICIAN PAYMENT POLICIES.

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- I WOULD LIKE TO EXAMINE WHAT WE CAN DO TO REFORM THE PHYSICIAN REIMBURSEMENT SYSTEM IN WAYS THAT MAKE SENSE, ENSURE THE AVAILABILITY OF QUALITY CARE, AND PROVIDE POSITIVE RATHER THAN NEGATIVE INCENTIVES. I WOULD LIKE TO KNOW WHETHER PROSPECTIVE PAYMENT FOR PHYSICIAN SERVICES IS THE ONLY MECHANISM AVAILABLE WITH A REASONABLE CHANCE OF SUCCESS.

- RECENT DISCUSSIONS OF PHYSICIAN REIMBURSEMENT UNDER MEDICARE HAVE FOCUSED ON THREE MAIN ISSUES--THE IMPACT OF THE CURRENT PAYMENT METHOD ON BENEFICIARIES, THE APPROPRIATENESS OF REASONABLE CHARGE METHODOLOGY, AND PROGRAM COST INCREASES. IN RESPONSE TO THESE CONCERNS THERE IS INTEREST IN A NUMBER OF PROPOSALS.

- TO INCREASE PHYSICIAN ASSIGNMENT WE MIGHT CONSIDER THE "PARTICIPATING PHYSICIAN" CONCEPT, UNDER WHICH A PHYSICIAN WOULD VOLUNTARILY AND FORMALLY AGREE TO ACCEPT THE MEDICARE-DETERMINED CHARGE AS PAYMENT IN FULL FOR ALL COVERED SERVICES RENDERED TO HIS PATIENTS. THE ADVANTAGE OF SUCH AN ARRANGEMENT IS THAT BENEFICIARIES KNOWN IN ADVANCE THAT A PHYSICIAN TAKES ASSIGNMENT AND THEY WOULD THEREFORE NOT BE LIABLE FOR CHARGES IN EXCESS OF THOSE PAID BY THE PROGRAM. TO MAKE THE CONCEPT ATTRACTIVE TO PHYSICIANS A NUMBER OF INCENTIVES HAVE BEEN SUGGESTED INCLUDING SIMPLIFIED BILLINGS PAYMENT FOR ADMINISTRATIVE COSTS, COLLECTION OF COST SHARING

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BY THE PROGRAM INSTEAD OF THE PHYSICIAN, AND CREDITS FOR CONTINUING PROFESSIONAL EDUCATION.

- SUGGESTED CHANGES IN THE REASONABLE CHARGE METHODOLOGY INCLUDE THE LIBERALIZATION OF REASONABLE CHARGES TO INCREASE VOLUNTARY ASSIGNMENT, ELIMINATION OF SPECIALITY DIFFERENTIALS, AND ADOPTION OF STATEWIDE OR NATIONAL PREVAILING CHARGE SCREENS.

- ALTERNATIVE PAYMENT METHODOLOGIES HAVE BEEN SUGGESTED TO STEM INCREASES IN FEDERAL OUTLAYS. PROSPECTIVE PAYMENT IS ONE SUGGESTED ALTERNATIVE. I HAVE ALREADY MENTIONED THE PROSPECTIVE PAYMENT STUDY THE SECRETARY IS REQUIRED TO COMPLETE IN 1985. NEGOTIATED FIXED FEE SCHEDULES HAVE ALSO BEEN SUGGESTED AS BEING EASY TO UNDERSTAND AND ADMINISTER BUT LIKE A PROSPECTIVE PAYMENT SYSTEM BASED ON DRGS, A MECHANISM WOULD HAVE TO BE DEVELOPED TO ACCURATELY REFLECT THE RELATIVE VALUE OF THE SERVICES PROVIDED.

- SEVERAL APPROACHES HAVE BEEN OFFERED TO ENHANCE THE FORCE OF COMPETITION IN THE HEALTH CARE MARKETPLACE. IT HAS BEEN SUGGESTED THAT PHYSICIANS SHOULD BE PROVIDED A FINANCIAL STAKE IN WHAT SERVICES COST. PREFERRED PROVIDER ARRANGEMENTS ARE BUT ONE OF SEVERAL WAYS TO DO JUST THAT. IT IS ORGANIZATIONS SUCH AS YOURS THAT HAVE MUCH TO TELL US. GROUP PRACTICES HAVE HAD EXPERIENCE WITH CAPITATED PAYMENT PLANS

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AND VARIOUS OTHER PAYMENT METHODS WHICH WE WOULD BE INTERESTED IN HEARING ABOUT.

- IN CONSIDERING CHANGES IN PHYSICIAN REIMBURSEMENT UNDER MEDICARE, OUR DESIRE IS NOT TO SIMPLY CUT ANOTHER PROGRAM. IT IS RATHER TO PROTECT ONE OF THE MOST IMPORTANT PROGRAMS WE AS A NATION OFFER OUR CITIZENS.

MEDICARE COSTS

- RECENT ESTIMATES SHOW THE MEDICARE HOSPITAL TRUST FUND AS BEING DEPLETED AS EARLY AS 1990. THIS FINANCING PROBLEM IS MORE THAN ANYTHING ELSE, THE RESULT OF RAPIDLY GROWING HOSPITAL COSTS. SUCH COSTS ARE EXPECTED TO INCREASE AT AN AVERAGE ANNUAL RATE OF 10.5 PERCENT FROM NOW UNTIL 1995, WHILE THE BASIS FOR TRUST IS EXPECTED TO GROW AT AN ANNUAL RATE OF ONLY 7.0 PERCENT.

- THE HIGH COST OF HEALTH CAREIN THIS NATION, NOT JUST THE COST OF MEDICARE, IS A REAL PROBLEM. A PROBLEM FOR WHICH EVERYBODY HAS SOMEONE TO BLAME. WE HAVE HEARD THAT IT'S THE HOSPITALS, THE GROWING NUMBER OF ELDERLY, IMPROVED TECHNOLOGY, THE PHYSICIANS, THIRD PARTY COVERAGE, GOVERNMENT REGULATIONS, ETC. CLEARLY IT'S A PROBLEM IN WHICH ALL THESE THINGS SHARE SOME BLAME. BUT IT'S ALSO, MORE THAN ANYTHING ELSE, A PHYSICIAN PROBLEM.

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- IT IS THE PHYSICIAN WHO DRIVES THE HEALTH CARE SYSTEM. HE OR SHE ORDERS THE TESTS, ADMITS THE PATIENT, PERFORMS THE SURGERY, AND PRESCRIBES THE DRUGS. PERHAPS MORE IMPORTANTLY IT IS WHAT HE OR SHE DOES NOT DO THT SIGNIFICANTLY CONTRIBUTES TO THE PROBLEM. HE OR SHE DOES NOT, IN THE OPINION OF MANY, CONSIDER WHAT IT COSTS TO PROVIDE THE SERVICES HE PRESCRIBES.

- HOSPITALS HAVE BEEN IN THIS SITUATION WITH RESPECT TO MEDICARE. COST REIMBURSEMENT PROVIDED HOSPITALS WITH FINANCIAL INCENTIVES TO PROVIDE MORE SERVICES, EXTEND LENGTHS OF STAY, AND ADOPT NEW TECHNOLOGIES, WHETHER COST-EFFECTIVE OR NOT. THOSE DAYS ARE OVER. PROSPECTIVE PAYMENT WAS ADOPTED AS A WAY OF CHANGING INCENTIVES, REWARDING EFFICIENCY, AND CURBING COST GROWTH. BUT HOSPITAL PROSPECTIVE PAYMENT IS NOT THE ENTIRE SOLUTION.

- THERE ARE THOSE WHO HAVE ALREADY BEGUN TO PRESS FOR THE ESTABLISHMENT OF A NEW PRESIDENTIAL COMMISSION TO ADDRESS THESE ISSUES. I WOULD ARGUE THAT FIRST WE OUGHT TO ALLOW THE CONGRESS AN OPPORTUNITY TO DO WHAT IT IS HERE TO DO. IN MY VIEW, WE SHOULD REVIVE THE BIPARTISAN SPIRIT THAT MARKED THE SUCCESS OF THE SOCIAL SECURITY RESCUE PLAN.

- THE CUMULATIVE PROJECTED DEFICIT IN THE HI TRUST FUND IS SO LARGE--$300 TO $400 BILLION BY 1995--THAT TO MAINTAIN

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SOLVENCY WILL REQUIRE SUBSTANTIAL POLICY CHANGES. TO BRING THE HOSPITAL INSURANCE PROGRAM INTO CLOSE ACUTUARIAL BALANCE, EITHER OUTLAYS WILL HAVE TO BE REDUCED BY 30 PERCENT OR INCOME INCREASED BY 43 PERCENT.

O INCREASED BENEFICIARY COST SHARING, COST REDUCTIONS, AND HIGHER PAYROLL TAX RATES ARE BUT THREE OPTIONS LIKELY TO BE CONSIDERED BY THE CONGRESS TO CLOSE THE GAP BETWEEN REVENUES.

VALUE OF COST SHARING

O COST REDUCTIONS WITHOUT BENEFICIARY PARTICIPATION IS A GRAND IDEA. IT LEADS PEOPLE INTO THINKING THAT IN OUR EFFORTS TO CONTAIN BUDGET DEFICITS THEY WILL NOT BE HURT. BUT THAT IS A MISTAKEN NOTION. THEY WILL BE HURT, AS THE DEFICIT GROWS AND THE ABILITY OF THE TRUST FUND TO FINANCE NEEDED HEALTH CARE SHRINKS. BENEFICIARIES ARE CONCERNED. TAXPAYERS ARE CONCERNED. AND WE SHOULD BE CONCERNED ENOUGH TO REALIZE THAT INCLUDING BENEFICIARIES IN OUR COST REDUCTION PROPOSALS IS ESSENTIAL.

O MEDICARE BENEFICIARIES, ALONG WITH ANY OTHER PATIENTS, SHOULD BE MADE SENSITIVE TO THE HIGH COST OF CARE. PRICE SENSITIVITY MAKES SENSE WHERE THE BENEFICIARY'S DECISION TO SEEK MEDICAL CARE IS HIS OR HERS TO MAKE AND IT DOES NOT CAUSE NEEDLESS DELAY IN SEEKING NEEDED CARE. COST SHARING

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CAN BE USEFUL AND IS APPROPRIATE IN MANY INSTANCES. BUT WE MUST USE CAUTION.

- THE IDEA OF COST SHARING TO DETER UNNECESARY UTILIZATION AND DAMPEN SPIRALLING HEALTH CARE COSTS IS BY NO MEANS A RESOLVED ISSUE. THERE ARE THOSE WHO STRONGLY FAVOR IT, AS WELL AS THOSE WHO OPPOSE IT, BELIEVING THAT IT DEFEATS THE GOAL OF MAKING HEALTH CARE ACCESSIBLE.

- BOTH GROUPS (THOSE PRO AND CON) AGREE THAT COST SHARING DOES DETER USE, BUT DISAGREE ON THE EXTENT TO WHICH CONSUMERS ARE CAPABLE OF MAKING WISE CHOICES IN THAT AREA.

- ONE OTHER OPTION WE HAVE BEEN ASKED TO CONSIDER IN EXAMINING WAYS TO ALTER COST SHARING IS INCREASING THE PART B PREMIUM FOR THOSE ELDERLY INDIVIDUALS WITH RELATIVELY HIGH INCOMES. AS YOU RECALL, WE MADE CHANGES THIS YEAR WITH RESPECT TO THE SOCIAL SECURITY RETIREMENT PROGRAM THAT WOULD PROVIDE FOR TAXING THE BENEFITS OF WEALTHIER BENEFICIARIES. A CHANGE IN THE PART B PREMIUM COULD BE SEEN AS CONSISTENT WITH THIS MOVE.

SUMMARY

- PHYSICIANS, I BELIEVE, RECOGNIZE THE PROBLEM WE ARE FACING. I HAVE HEARD FROM VARIOUS PHYSICIAN GROUPS WHO ARE WILLING TO

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SPEND THE TIME AND EFFORT NECESSARY TO COME UP WITH WORKABLE SOLUTIONS. CERTAINLY THIS ORGANIZATION SHOULD BE INVOLVED IN THAT EFFORT. REFORM IS NEEDED NOW, NOT SOMETIME DOWN THE ROAD WHEN IT IS TOO LATE.

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Special 10-year averaging rules for lump sum distributions of pension plan benefit

- Distributions from qualified retirement plans receive special income tax treatment in recognition of the fact that the participant earned the retirement income over a period of several years.

- Generally, when the participant elects to receive his retirment income in a single payment (lump sum) he can spread the tax liability over a 10- year period.

- Since the tax benefits are so advantageous, they are limited to persons who meet certain requirements.

- While I do not suggest any changes in these rules currently, I would emphasize that the restrictions on the use of these rules are appropriate in certain circumstances.

- Therefore the women's pension bill that I introduced on October 19, S. 1978, does not allow use of this benefit for divorce distributions to the spouse of a participant.

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SPECIAL 10-YEAR AVERAGING RULES FOR LUMP SUM DISTRIBUTIONS OF PENSION PLAN BENEFIT

- AT RETIREMENT A PARTICIPANT IN A QUALIFIED RETIREMENT PLAN GENERALLY MAY ELECT TO RECEIVE HIS RETIREMENT FUNDS IN SEVERAL DIFFERENT FORMS. THE PARTICIPANT MAY ELECT A LUMP SUM (A SINGLE PAYMENT), A SINGLE LIFE ANNUITY (THE PAYMENT WILL CEASE WHEN THE PARTICIPANT DIES) OR OTHER PAYMENT FORMS.

- THE TAX TREATMENT OF A LUMP SUM DISTRIBUTION AND AN ANNUITY DIFFER. A LUMP SUM DISTRIBUTION RECEIVES SPECIAL 10-YEAR FORWARD AVERAGING RULES FOR THE ORDINARY INCOME PORTION OF THE DISTRIBUTION. IN ADDITION, LUMP SUM DISTRIBUTIONS ARE ELIGIBLE FOR THE LONG-TERM CAPITAL GAINS RATES AND THE UNREALIZED APPRECIATION IN EMPLOYER-SECURITIES IS NOT TAXED AT DISTRIBUTION.

- THE RECIPIENT OF A LUMP-SUM DISTRIBUTION MAY ELECT TO HAVE THE ORDINARY INCOME PORTION OF THE DISTRIBUTION TAXED UNDER SPECIAL TEN-YEAR AVERAGING RULES.

- THE TAX COMPUTED USING THE TEN-YEAR AVERAGING METHOD IS SEPARATE FROM AND IN ADDITION TO THE REGULAR INCOME TAX. THIS BENEFITS THOSE TAXPAYERS IN HIGH INCOME TAX BRACKETS, SINCE THE ADDITIONAL RETIREMENT INCOME DOES NOT INCREASE A TAXPAYER'S MARGINAL RATES.

- SINCE THIS BENEFIT IS SO ADVANTAGEOUS, IT IS LIMITED TO PERSONS WHO MEET CERTAIN REQUIREMENTS--THEY MUST HAVE 5 YEARS OF PLAN PARTICIPATION AND HAVE RECEIVED THE DISTRIBUTION UNDER CERTAIN CIRCUMSTANCES--DEATH, SEPARATION FROM SERVICE, RETIREMENT, OR ATTAINMENT OF 59 1/2.

- WHILE I DO NOT SUGGEST ANY CHANGES IN THESE RULES CURRENTLY, I WOULD EMPHASIZE THAT THE RESTRICTIONS ON THE USE OF THESE RULES ARE APPROPRIATE IN CERTAIN CIRCUMSTANCES.

- THEREFORE THE WOMEN'S PENSION BILL THAT I INTRODUCED ON OCTOBER 19. S. 1978, DOES NOT ALLOW USE OF THIS BENEFIT FOR DIVORCE DISTRIBUTIONS.

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United States Senate
COMMITTEE ON FINANCE
WASHINGTON, D.C. 20510

October 24, 1983

TO: SENATOR DOLE
FROM: SHEILA BURKE AND ED MIHALSKI
SUBJECT: SPEECH TO THE MEDICAL GROUP MANAGEMENT ASSOCIATION

Talking points for your speech before the Medical Group Management Association are attached.

The Medical Group Management Associaiton (MGMA) is a professional association which consists of approximately 4,400 individuals and member groups. The large majority of the members are administrators of both large and small medical group practices.

The most prevalent form of group practice today is the voluntary association of private physicians who form partnerships or professional corporations. In 1980 more than 88,000 physicians were in group practices. The largest number of groups was the single specialty type. Reimbursement to these groups for services varies from a fee-for-service to prepayment or a combination of the two.

You were invited to address the group by Mr. Ken Ackerman, Jr, President of the Association, who is from the Geisinger Medical Center, Danville, Pennsylvania, and by Larry E. Muff, President of the Kansas Association who is with the Salina Family Physicians.

The Association which is expecting an attendance of about 1,700, has asked you to speak generally on trends in physician reimbursement. They have also asked you to comment on the special 10-year lump-sum

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distribution of pension benefits. We have included a page containing background and comments on this subject.

The number of group practices are growing by leaps and bounds as more and more physicians find it advantageous to organize with others to provide services. Such advantages include the ability to share equipment, facilities, common records and the personnel involved in patient care and business management. From the patients point of view, such organizations offer improved accessibility and an emphasis on ambulatory care. Many of these groups are likely to be receptive to suggestions to move away from fee-for-service reimbursement to a more coordinated approach, for example DRG's.

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POSSIBLE REVENUE INCREASES

Fiscal Years	1984	1985	1986	1984-86
			(billions)	
Public property leasing	Ø.8	1.2	1.5	3.5
Income averaging - raise threshold to 130% and shorten base to 2 years	Ø.4	1.5	1.7	3.6
Compliance	*	Ø.1	Ø.2	Ø.3
FIRPTA withholding	Ø.1	*	*	Ø.1
6 month holding period and reduction of offset of capital losses against ordinary income	*	Ø.4	Ø.3	Ø.7
Stock option straddles		(to be supplied)		
Sport fishing equipment tax	*	*	*	*
Subtotal	1.3	3.2	3.7	8.2
Treat losses on trade or business property as capital losses	Ø.2	Ø.6	Ø.6	1.4
Limitations on dividends	Ø.3	Ø.5	Ø.6	1.4
Phaseout corporate graduated rates between $1 and $1.4 million of taxable income	Ø.1	Ø.2	Ø.2	Ø.5
Cap charitable deduction for nonitemizers at 25% of first $1ØØ of contributions	*	Ø.3	1.6	1.9
Revision of collapsible corporation rule (reverse Kelley case)	*	Ø.1	Ø.3	Ø.5
Repeal $1ØØ/2ØØ dividend exclusion	Ø.2	Ø.5	Ø.5	1.2

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Simplification of income tax credits	Ø.2	Ø.5	Ø.4	1.1
Estimated payments of alternative minimum tax	Ø.6	Ø.1	*	Ø.7
Repeal deduction for interest in excess of investment income ($2,ØØØ excluded, mortgage interest excluded, business excluded)	Ø.2	1.1	1.2	2.5
Revised real estate recapture rules		(to be supplied)		
<u>The following are effective after 1984:</u>				
Target deduction for two-earner couples	-	Ø.4	1.9	2.3
$3 bbl oil import fee and $1 bbl tax on domestic oil	-	6.6	8.9	15.5
Segmented Employer-paid health care cap equivalent to $25Ø (or) Statutory Fringe benefit exclusion cap at $26Ø	-	Ø.3	1.9	2.2
5% tax on corporate economic income		(to be supplied; at least $1Ø million for 1984-86)		
Increase in zero bracket amount to $2,4ØØ (3,6ØØ for joint returns) in 1985 and $2,5ØØ ($3,8ØØ) in 1986 and thereafter; increase in zero bracket amount for heads of households to $3,ØØØ in 1985 and $3,15Ø in 1986 and thereafter and adjustment of higher brackets for heads of households	-	(1.Ø)	(2.6)	(3.6)

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2-year delay in the following present law provisions:

Postpone 15% net interest exclusion to 1987	-	1.0	2.9	3.9
Delay foreign earned income exclusion increase from $85,000 to $90,000 until 1987	-	*	0.1	0.1
Delay 1984 and 1986 finance leasing rules until 1987	0.1	0.4	1.0	1.5
Delay increase in amount of used property eligible for investment tax credit until 1987	-	*	0.1	0.1
Sunset dividend re-investment plans at end of 1984	-	0.2	0.3	0.4
Subtotal	1.9	11.8	19.9	33.6
TOTAL	3.2	15.0	23.6	41.8

10
51.8

* Less than $50 million