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Report to Rep. John E. Moss, Chairman, House Committee on Interstate and Foreign Commerce: Oversight and Investigations Subcommittee; Rep. Anthony Moffett; by Elmer B. Staats, Comptroller General.

Issue Area: Health Programs: Reimbursement Policies and Utilization Controls (1208).
Contact: Human Resources Div.
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Organization Concerned: Department of Health, Education, and Welfare.
Congressional Relevance: House Committee on Interstate and Foreign Commerce: Oversight and Investigations Subcommittee. Rep. John E. Moss; Rep. Anthony Moffett.
Authority: Social Security Amendments of 1972 (P.L. 92-603; 42 U.S.C. 1395b). Medicare-Medicaid Anti-Fraud and Abuse Amendments (P.L. 95-142; 91 Stat. 1202). Social Security Act. S. 1470 (95th Cong.). H.R. 7079 (95th Cong.). H.R. 9916 (95th Cong.). H.R. 12244 (95th Cong.).

Under medicare, physicians have an option on each claim to accept assignment for charges to medicare patients. By accepting assignment, the physician agrees to accept as payment in full that amount which medicare determines to be reasonable. In response to congressional concern over the low medicare part B assignment rate in Connecticut, the following were reviewed: historical assignment rates in Connecticut and other New England States, studies concerning reasons why physicians do or do not accept assignment, a study of the potential effects of mandatory assignment, the effects of mandatory assignment under medicaid, pending legislative proposals, and other legislative options for increasing assignment rates. Nationwide, the general trend has been a decline in assignment rates. Two studies showed that physicians, in deciding whether to accept assignment, respond to economic incentives or disincentives. Factors affecting Connecticut's assignment rate included: the per capita income of the area, uncertainty as to what medicare's reasonable charges would be, and complicated claims mechanisms. Reasons cited for low participation rates in medicaid involved: lower reimbursement rates, lengthy claims processing time, and excessive paperwork. Three options which might have some positive effect on assignment rates are pending in the Congress. While it is difficult to determine the specific effect implementation of any option or combination of options would have, the logical step would be to carry out demonstration projects to test the results of various studies. (RRS)

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COMPTROLLER GENERAL OF THE UNITED STATES
WASHINGTON, D.C. 20548

B-164031(4)

May 31, 1978

RESTRICTED — Not to be released outside the General Accounting Office except on the basis of specific approval by the Office of Congressional Relations.

The Honorable John E. Moss, Chairman
The Honorable Anthony Moffett
Subcommittee on Oversight and
Investigations
Committee on Interstate and
Foreign Commerce
House of Representatives

In response to your September 30, 1977, request regarding the low Medicare part B assignment rate in Connecticut, we reviewed

--historical assignment rates in Connecticut and other New England States,

--studies concerning the reasons why physicians do or do not accept assignment,

--a Medical Economics study concerning the potential effects of mandatory assignment under Medicare,

--effects of mandatory assignment under Medicaid,

--pending legislative proposals designed to increase assignment rates, and

--other legislative options for increasing assignment rates.

Our enclosure summarizes our results. We have concluded that declining assignment rates have been studied over the years, and it appears that the next step would be to initiate demonstration projects to test those study results. We have drafted legislative language for your consideration which would give the Secretary of the Department of Health, Education, and Welfare specific authority to experiment with various alternatives for increasing assignment rates (see p. 14).

HRD-78-111
(106152)

We obtained the views of the Medicare Bureau of the Health Care Financing Administration on this report and have incorporated their comments where appropriate. The Medicare Bureau believes it already has legal authority to conduct demonstration projects. However, the Bureau also said, and we agree, that the proposed amendment would be a useful signal of congressional concern about the present assignment rate issue. Furthermore, our proposal adds a reporting provision which is not required under existing law.

It is our policy to release Congressional request reports within 30 days after their issue dates. However, because hearings may be held on matters relating to the report, we will restrict its distribution until that time, unless either of you publicly release its contents earlier. Should neither of these events occur within a reasonable time, we will be in touch with your offices to make arrangements for the report's distribution.

Comptroller General
of the United States

Enclosure

ENCLOSURE I

INFORMATION ON ASSIGNMENT

RATES UNDER MEDICARE

HOW ASSIGNMENT WORKS

Under Medicare, doctors have an option on each claim to "accept assignment" for charges to Medicare patients. By accepting assignment, the physician agrees to accept as payment in full that amount which Medicare determines to be "reasonable." 1/

The amount determined to be reasonable (less Medicare's 20-percent coinsurance and annual $60 deductible requirement) is paid directly to the physician by the Medicare part B carrier. In Connecticut, the carrier is the Connecticut General Life Insurance Company. To obtain the coinsurance and any portion of the deductible that may not have been met, the physician must collect these amounts from either the beneficiary or the beneficiary's complementary insurance company. The elderly can obtain other insurance to cover Medicare's coinsurance and deductible requirements. In Connecticut, this coverage is often provided by the Connecticut Medical Service (Blue Shield).

To illustrate how assignment works, assume that a physician agrees to accept assignment and submits to the Medicare carrier a claim for $100. Assume also that the reasonable charge for the service is $90 and that the beneficiary had previously incurred medical costs of $40.

The carrier notifies the physician that the reasonable charge is only $90, and furthermore, that the beneficiary has only satisfied $40 of his/her annual $60 deductible requirement. Consequently, the carrier reimburses the physician $56--80 percent of $70 ($90 less the $20 needed to satisfy the deductible requirement). The physician, in turn should bill the beneficiary $34--$20 for payment of the deductible and $14

1/ Reasonable charge determinations take into consideration what the physician has charged for a particular service in the past (customary charge) and also what other physicians in the same area have charged for the same service (prevailing charge). The reasonable charge is the lowest of the (1) actual charge, (2) customary charge, or (3) prevailing charge.

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for the coinsurance. The physician is not supposed to bill the beneficiary for the $10 difference between his/her charge of $100 and Medicare's reasonable charge of $90.

When the physician does not accept assignment, it is the beneficiary's responsibility to submit a claim to the Medicare carrier for reimbursement. Furthermore, using the above example, the beneficiary would be liable to the physician for the entire $100 billed but would only be reimbursed $56 from Medicare. The basic distinction from an assigned claim is that the beneficiary is also liable for the $10 difference between the physician's charge of $100 and Medicare's reasonable charge of $90.

The advantages of the assignment method for the beneficiary are basically twofold. First of all, the beneficiary is relieved of the paperwork needed to submit a Medicare claim. Secondly, the patient almost always pays less when a physician accepts assignment. Medicare reasonable charges are almost always less than what the physician actually charges because the reasonable charge determination is based on charge data which can be from 6 to 30 months old. 1/

For physicians, the advantage of accepting assignment is that they are guaranteed payment of most of the charge, assuming that the deductible requirement has been met. When the physician does not accept assignment and seeks payment directly from the beneficiary, the physician has no such guarantee. The beneficiary does not need to submit a paid bill--only an itemized bill--in order to be paid by Medicare. Consequently, the beneficiary can ignore the physician's bill without suffering any financial loss from Medicare.

The disadvantages that physicians encounter in taking assignment are that (1) they are more than likely going to be paid less than they charged and (2) they have more paperwork because they have to bill two parties to receive payment for their services.

1/ Under Medicare, physicians' customary charges (profiles) are to be updated every July based on charges during the preceeding calendar year. Thus, reasonable charges are based on data which is 6 to 18 months old at the beginning of the year and 18 to 30 months old at the end of the year.

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ASSIGNMENT RATES - A DECLINE AND WIDE VARIANCES

Nationwide, the general trend in assignment rates 1/ has been a decline. The national rate reached a peak of 64.4 percent in 1969, and since then, it has declined to 50.5 percent in 1977, a drop of 13.9 percent.

According to Medicare Bureau statistics, the trend for Connecticut has been as follows:

Calendar year	Assignment rate (percent)
1969	48.1
1970	45.7
1971	45.6
1972	42.3
1973	43.0
1974	41.1
1975	39.4
1976	40.0
1977	43.1

Within the New England area, the rates for 1977 varied from Connecticut's 43.1 percent to Rhode Island's 78.0 percent. On a national basis, one-third (22 of 65) of the States or portions of States covered by the various part B carriers had assignment rates less than the 40-percent rate in Connecticut in 1976. The chart on the following page shows the assignment rates for the New England States from 1969 to 1977. As evident Connecticut's assignment rate is much lower than the other States.

1/ The assignment rate represents the percentage of claims taken on assignment to the total number of claims processed, excluding those claims submitted by hospital based-physicians or claims submitted under a group practice prepayment plan, which by definition, are always assigned. This is commonly referred to as the "net" assignment rate. In calendar year 1976 about 44 million claims were taken on assignments.

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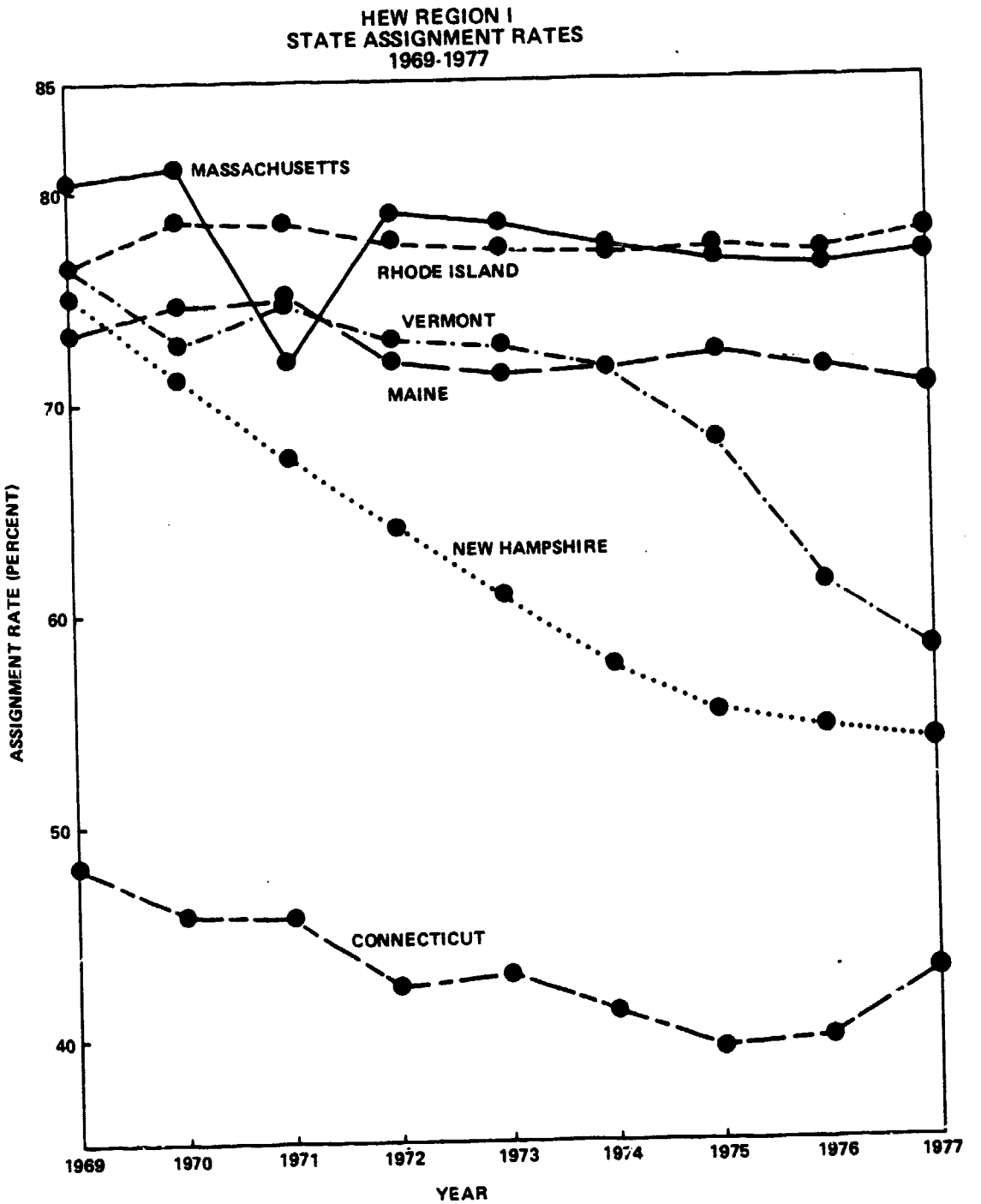
HEW REGION I
STATE ASSIGNMENT RATES
1969-1977
85
80
70
60
50
40
ASSIGNMENT RATE (PERCENT)
MASSACHUSETTS
RHODE ISLAND
VERMONT
MAINE
NEW HAMPSHIRE
CONNECTICUT
1969
1970
1971
1972
1973
1974
1975
1976
1977
YEAR

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The chart also shows that despite Connecticut's general decline over the years, the assignment rate rose about 3 percent in 1977. When Connecticut's 1977 assignment rate is analyzed by calendar year quarters, a steady increase is shown from the first quarter to the last quarter--41.3, 41.5, 43.3, and finally to 45.4.

REASONABLE CHARGE REDUCTIONS: ASSIGNED VS. UNASSIGNED CLAIMS

As discussed earlier, beneficiaries generally have to pay more when a physician does not accept assignment because he or she is liable for the difference between the physician's bill and the amount of Medicare's reasonable charge determination. Other measures of the financial impact on the beneficiary are the relative number of claims reduced and the amount of the reasonable charge reductions for unassigned claims in comparison with assigned claims. The chart below provides a comparison of reasonable charge reductions for the two types of claims.

Nationwide Reasonable Charge Reductions

	Assigned claims			Unassigned claims		
Calendar year	percent reduced no.	percent reduced amount	average amount reduced	percent reduced no.	percent reduced amount	average amount reduced
1973	55.6	11.9	$ 7.33	66.4	12.6	$ 9.66
1974	64.5	14.3	$ 9.42	72.7	14.7	$11.55
1975	70.8	17.8	$12.35	77.4	17.7	$14.51
1976	74.3	19.9	$14.74	78.9	19.8	$16.86
1977	72.8	19.4	$15.20	77.1	19.0	$16.54

The principal points with regard to the above chart are

--the percent of unassigned claims reduced has always exceeded that of assigned claims, although the variance has been steadily declining over the years;

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--the percent of the reasonable charge reduction for assigned claims and unassigned claims has remained about equal;

--the actual dollar amount that the average claim has been reduced has consistently been greater for unassigned claims, basically because unassigned claims tend to be larger than assigned claims.

In Connecticut, for 1976 the number and extent of reasonable charge reductions for assigned and unassigned claims generally has followed the national pattern. In the first two quarters of 1977, however, the percent of claims reduced as a result of the reasonable charge determinations was about the same for both assigned and unassigned claims.

Connecticut Reasonable Charge Reductions by Quarter 1976-1977

Year	Quarter	Assigned claims percent reduced		Unassigned claims percent reduced	
		no.	amount	no.	amount
1976	1	71.9	16.3	80.1	17.0
	2	74.7	17.4	83.1	18.8
	3	74.1	17.9	82.4	19.3
	a/ 4	69.2	15.6	78.5	17.4
1977	1	74.7	14.9	75.5	14.3
	2	76.6	16.1	77.6	16.0

a/ Does not include November 1976 data.

ASSIGNMENT STUDIES

Several studies have been made to determine the factors affecting assignment. Studies have been made by:

--The Health Insurance Benefits Advisory Council ("A Report on the Results of the Study of Methods of Reimbursement for Physicians' Services Under Medicare," July 1973).

--Medical Economics ("Will Doctors Tolerate Another Medicare Squeeze," Oct. 17, 1977).

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--The Connecticut State Medical Society ("Connecticut's Rate of Acceptance of Medicare B Benefits by Assignment," Aug. 1977).

In addition to these studies, a Committee for Better Assignment Rates in Connecticut was formed in February 1977 to identify ways to increase Connecticut's assignment rate. Finally, the Health Care Financing Administration has contracted for several studies to try to identify how assignment rates could be increased.

Health Insurance Benefits Advisory Council

Section 224(b) of the Social Security Amendments of 1972 (Public Law 92-603) required the Health Insurance Benefits Advisory Council 1/ to study the methods of reimbursement for physicians' services under Medicare. The study was released in July 1973 and covered, among other things, acceptance of assignment by physicians. In performing the study, the Council used two consulting firms--the Research Triangle Institute of North Carolina and Robert R. Nathan Associates of Washington, D.C.

The Research Triangle Institute studied the factors influencing the acceptance of assignment in six States--New York, Massachusetts, California, New Jersey, Florida, and Ohio. Questionnaires were sent to a sample of 559 physicians, 314 of which responded. The Institute categorized the factors influencing physician acceptance of assignments into two categories--patient-related factors and program-related factors.

For patient-related factors, the Institute found that the financial situation of the patient was extremely important. If a patient appeared able to pay, the physician generally would be inclined to refuse assignment and bill the patient directly. In addition if there were a close personal relationship between the patient and the physician or if a large bill was involved, the physician would tend to accept assignment.

Regarding program factors, the assurance of payment was always cited as a significant factor. On the other hand,

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1/ Section 1867(b) of the Social Security Act authorizes the Health Insurance Benefits Advisory Council to provide advice and recommendations for the Secretary's consideration on matters of general policy with respect to titles XVIII and XIX of the Social Security Act.

factors which influenced a physician not to accept assignment were (1) the complexity of the program, (2) the concern that Medicare's reasonable charge determination would be less than the physician's charge, and (3) the patient's lack of understanding of Medicare. In some cases a patient thinks that he/she no longer bears any financial liability when a physician accepts assignment. Thus, the patient becomes confused and upset when the physician attempts to collect the coinsurance and the deductible.

Nathan Associates investigated the factors or variables influencing the acceptance of assignment in 35 States, including Connecticut, Maine, Massachusetts, and Rhode Island. The data analyzed by Nathan Associates consisted primarily of statistics maintained by the Office of Research and Statistics of the Social Security Administration.

Socioeconomic variables (e.g., per capita income, urban versus rural settings) were found to be important explanatory variables. States with higher than average per capita incomes experienced lower assignment rates, other variables held constant. States with higher percentages of their elderly living in cities larger than 100,000 persons also had lower assignment rates. The Nathan model explained 60 percent of the total variation in the assignment rates, leaving 40 percent to be explained by other factors not included in the model.

Many Medicare enrollees who also had Medicaid coverage were also associated with a higher assignment rate. According to Nathan Associates, this was probably because under Medicaid, assignment is mandatory.

Both studies showed that physicians, in deciding whether to accept assignment, respond to economic incentives or disincentives. An example cited was the patient's ability to pay a fee higher than Medicare's reasonable charge.

Medical Economics study

In the October 17, 1977, issue of Medical Economics, the possibility of making assignments mandatory under Medicare was addressed in an article: "Will doctors tolerate another Medicare squeeze?" The Medical Economics staff surveyed a national cross section of office-based physicians in all fields of practice except pediatrics. Of the 1,000 physicians that were polled, 450 responded.

The doctors were asked, among other things, whether they took Medicare patients and accepted assignment, and if they would stop taking Medicare patients or reduce their Medicare

caseloads if compulsory assignment was required under Medicare. According to the study,

> "The responses made clear that if the option of collecting their full fee directly from Medicare patients is taken away, doctors may desert the program in droves."

Ninety-three percent of the respondents had Medicare patients, but only 16 percent accepted assignment in all cases; the rest accepted assignment on a case-by-case basis. Fifty-six percent said that they would either reduce or eliminate their Medicare cases should assignment be mandatory.

Although most of the physicians said that they were against mandatory assignment, the study pointed out that there were some doctors who felt a duty to their patients, therefore, ruling out abandonment of the Medicare program. Likewise, those physicians who relied heavily on Medicare patients for a source of income were not likely to stop seeing Medicare patients.

Connecticut State Medical Society

In August 1977 the Connecticut State Medical Society issued a statement concerning the acceptance of assignment under part B of Medicare. The Society's statement identified many factors affecting assignment rates and made many recommendations.

The factors listed that partly affected Connecticut's relatively low assignment rate included the (1) relatively high per capita income of the area, (2) uncertainty as to what Medicare's reasonable charges would be, and (3) complicated claims mechanism existing between Connecticut General and the Connecticut Medical Service.

Because of these factors, the Society made several recommendations. One was that Connecticut General and the Connecticut Medical Service develop a workable mechanism to assure that payment of all benefits due subscribers from both programs be made automatically and simultaneously. Physicians have to bill both insurance companies to receive payment for their services.

Committee for better assignment rates in Connecticut

In February 1977 the committee for better assignment rates in Connecticut was formed by William M. Ratchford, Commissioner, State of Connecticut commission on aging,

and Congressman Moffett. The committee's goal is to increase Connecticut's assignment rate.

As a first step towards achieving that goal, a program was started to educate Medicare beneficiaries on how assignment works and how they can benefit from it. In June 1977 the committee distributed leaflets discussing assignment rates to Medicare beneficiaries. The committee also sponsored workshops through the part B carrier to train some beneficiaries so that they can educate as many other beneficiaries, as possible, in Connecticut.

The committee also met with the Connecticut State Medical Society to discuss the Society's problems with assignments. As a result of these efforts, the Health Care Financing Administration, working with the carrier, has arranged to make available to both doctors and patients each physician's "fee profile" under which customary charges are established. Explanations of physicians' fees and Medicare reimbursements will also be made available under the program. This procedure will alert physicians to Medicare rates and allow patients to consider charges when selecting a physician. Since the first profiles were released in January 1978, it is too early to determine the experiment's impact.

Also, in response to the Society's work, the committee was instrumental in initiating the development of a joint system for filing claims between Connecticut General and the Connecticut Medical Service. Under the new system, if the physician accepts assignment, he/she will not have to file two claims--one for the Medicare portion and one for the complementary insurance. According to the Chairman of the Connecticut State Medical Society, the new system will be implemented in July 1978.

Health Care Financing Administration studies

The Health Care Financing Administration has several studies underway or planned which address physician assignment rates. Two such studies are:

1. The Urban Institute: "Physician Pricing Patterns in California 1972-1975."

2. The Center for Social Research, City University of New York: "Study of Physician Reimbursement under Medicare and Medicaid."

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The Urban Institute study (expected to be completed in May 1978) evaluates the effects of Medicare/Medicaid reimbursement on physicians. One preliminary result cited in an interim report was that physicians are much less inclined to accept assignment than is commonly assumed and may resist an attempt to increase voluntary assignment. The rationale for this position is that assignment rates, as currently reported, are somewhat inflated due to the inclusion of those claims falling under joint Medicare/Medicaid eligibility. If a patient is eligible for both Medicare and Medicaid coverage (dual beneficiaries), then assignment is mandatory because under Medicaid, physicians are not permitted to bill beneficiaries. Thus, because claims of dual beneficiaries are included in the calculation of assignment rates, the rates do not represent purely voluntary acceptance of Medicare assignment. 1/

The interim report indicated that in California, assignment rates were 60 percent for general practitioners, 56 percent for general surgeons, and 40 percent for internists. However, after eliminating joint Medicare/Medicaid claims, assignment rates fell to 33 percent for general practitioners, 37 percent for general surgeons, and 22 percent for internists.

As part of the same contract, the Urban Institute has been trying to determine why physicians would be willing to accept assignment if a fee reduction were involved. In an interim report, the Institute cites profit maximization as one reason why physicians accept a fee reduction. Accepting a reduction will increase a physician's profit if and only if:

--It attracts new patients.

--New, low-fee patients do not displace high-fee patients.

--The reasonable charge covers variable costs.

The Institute also found both direct and indirect evidence that charity concerns (e.g., financial strains on the patient) motivate some physicians to accept a fee reduction. Finally the Institute noted that the assignment rate depends

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1/This was also mentioned in our report: "Study of the Application of Reasonable Charge Provisions for Paying Physician's Fees Under Medicare" (Dec. 20, 1973) to the Senate Special Committee on Aging.

on the risk of noncollections. If this risk is high, then physicians would be inclined to accept assignment because they are guaranteed payment for most of the charge.

The Center For Social Research's "Study of Physician Reimbursement Under Medicare and Medicaid" partly identifies those factors that affect Medicare assignment rates. The study's methodology is based on the belief that physician acceptance of assignment is an economic decision. Carrier policies in processing and settling claims have economic implications for physicians, and therefore, carrier performance measures, such as denial rates, timeliness of payment, and reasonable charge levels, would influence assignment decisions. The study is expected to be completed in September 1978.

ASSIGNMENT UNDER MEDICAID

Assignment is mandatory under Medicaid. Also, in comparison with the Medicare program, few physicians actively participate in Medicaid. Of those who do, few receive the bulk of all payments.

To illustrate, in six major metropolitan areas throughout the Nation, about 40 percent of the physicians receive payments under Medicaid. Nine percent of all physicians in these areas, however, account for 75 percent of all Medicaid payments. In contrast to the 40-percent participation rate under Medicaid, the Medical Economics survey disclosed that 93 percent of their surveyed physicians had Medicare patients.

In the six areas, physicians cited reasons for low participation in Medicaid. These included the lower reimbursement rate which had to be accepted through assignment and, to a lesser extent, lengthy claims processing times and excessive paper work.

PENDING LEGISLATION

Four bills have been introduced during the first session of the 95th Congress which could increase assignment rates under Medicare--S. 1470, H.R. 7079, H.R. 9916, and H.R. 12244.

S. 1470 and H.R. 7079

On May 5, 1977, Senator Talmadge introduced S. 1470 which was subsequently referred to the Senate Committee on Finance.

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A companion bill--H.R. 7079--was introduced by Congressman Rogers on May 10, 1977, and was referred jointly to the House Committee on Ways and Means and the House Committee on Interstate and Foreign Commerce.

The bills, among other things, would change the administrative and reimbursement procedures currently used under the Medicare and Medicaid programs. With respect to assignment rates, the bills would amend title XVIII of the Social Security Act by adding a new section: "Agreements of Physicians to Accept Assignment."

Under the new section, the concept of "participating" physicians was introduced. A participating physician would be one who voluntarily and formally agrees to accept assignment for all Medicare patients. Those choosing not to participate could continue to elect to use the assignment method of billing on a claim-by-claim basis, as is the case under present law.

To encourage physician participation, the new section provides for expediting claims processing for participating physicians by having each physician submit his/her claims using one of several alternative simplified bases, including multiple billing listing of patients. Carriers would be required to process these claims expeditiously and, in addition, physicians would be paid $1 for each claim submitted in accordance with the simplified billing procedure.

H.R. 9916

Representative Holtzman introduced H.R. 9916 on November 2, 1977. The bill was referred jointly to the House Committee on Ways and Means and the House Committee on Interstate and Foreign Commerce.

Among other things, Representative Holtzman has said that the bill would require that Medicare's reasonable charge determinations be based on current charge data, rather than data that is 6 to 30 months old (see p. 2). Using current charge data would increase the amounts received by physicians taking assignment. It is anticipated that by using current data, the national decline in assignment rates will be reversed.

The bill would also require physicians to give patients advance estimates of the reimbursements they will receive for services rendered under the Medicare program. Such action would eliminate the uncertainty surrounding reasonable charge determinations.

H.R. 12244

Representative Moffett introduced H.R. 12244 on April 19, 1978. The bill was referred jointly to the Committee on Ways and Means and the Committee on Interstate and Foreign Commerce. Basically, the bill would amend the Social Security Act to require physicians to accept assignment under part B of the Medicare program with respect to services they furnish in Medicare-participating hospitals.

LEGISLATIVE OPTIONS

Several studies have identified many factors which influence or are believed to influence assignment rates. Some of the factors most frequently mentioned appear to be outside the scope of what administrators or legislators could reasonably address, for example, the financial situations of patients or the personal relationships between patients and their physicians. On the other hand, there seem to be various options available which might have some positive effect on assignment rates. Three such options are the specific legislative proposals introduced by Senator Talmadge, Congresswoman Holtzman, and Congressman Moffett.

It is difficult to gage the specific effect implementation of any option or combination of options would have on assignment rates. Accordingly, it would appear that a logical step at this time would be to carry out demonstration projects to test the results of the performed studies. Under a demonstration approach, various options or a combination of options could be tested in different locations throughout the Nation. Such demonstrations could range from increasing the economic incentives to making assignments mandatory.

If conducted properly, the demonstrations should provide the Congress and the Department of Health, Education, and Welfare (HEW) considerable insight as to the variables that have the greatest effect on assignments and the costs involved, both monetary and nonmonetary. With this information, the Congress and HEW would be able to make an informed decision on how to proceed nationally.

If such an approach is considered desirable, we recommend that the Congress amend the Social Security Act to provide the Secretary of HEW specific authority to implement pilot or demonstration projects to identify those factors or activities that would have the greatest effect in increasing assignment rates and the associated cost. The Secretary, in turn, should

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be required to report to the Congress the results of such projects and provide specific recommendations and alternatives for increasing assignment rates.

To accomplish this, title 42, section 1395b-1, subsection (a)(1) of the United States Code(Supp. V, 1975) should be amended. 1/ Specifically, a subparagraph (K) should be added which would read as follows:

> (K) to determine methods for increasing the rate of physician acceptance of assignment for health care and services under this subchapter; in addition, the Secretary should report to the Congress on the experiments and demonstration projects carried out under this subparagraph including alternatives and recommendations for increasing assignment rates.

The Medicare Bureau said that it believes it has authority under section 1395b-1(a)(1) to carry out such demonstrations. However, the Bureau also said, and we agree, that the proposed amendment would be a useful signal of congressional concern about the present assignment rate issue. Furthermore, the proposed subparagraph adds a reporting provision which is not required under section 1395b-1(a)(1).

1/ Section 222(b) of the Social Security Amendments of 1972, which appears as title 42, section 1395b-1, subsection (a)(1) of the United States Code(Supp. V, 1975), authorizes the Secretary of HEW to conduct demonstration programs for a variety of purposes. Subparagraph (J) was added to this section by section 17d of the Medicare-Medicaid Anti-Fraud and Abuse Amendments, Public Law No. 95-142, 91 Stat. 1202.