

3
SECTION
B

Physician services

R E C O M M E N D A T I O N

The Congress should update payments for physician services by the projected change in input prices, less an adjustment for productivity growth of 0.9 percent, in 2005.

COMMISSIONER VOTES: YES 17 • NO 0 • NOT VOTING 0 • ABSENT 0

SECTION 3B

Section 3B: Physician services

In this section

- Are current Medicare payments for physician services adequate?
- How should Medicare payments for physician services change in 2005?
- Update recommendation

To assess the adequacy of Medicare payments for physician services, MedPAC considers several factors, including access to physician care, physician supply, private payment levels, and the volume of physician services. We also examine estimated 2005 input costs for physician services. Our analysis of payment adequacy finds that these indicators are generally positive or neutral. Thus, the Commission recommends that payments for physician services be updated by the projected change in input prices, less an adjustment for productivity growth. This increase in payments would maintain beneficiary access to care and maintain physician willingness and ability to furnish services to Medicare beneficiaries.

Background

Medicare pays for physician services according to a fee schedule. The fee schedule assigns each service relative weights intended to reflect the resources needed to furnish each physician service. These weights are adjusted for geographic differences in practice costs and multiplied by a dollar amount—the conversion factor—to determine payments. In general, Medicare updates payments for physician services by increasing or decreasing the conversion factor.

In 2004, Medicare's payments for physician services increased by a modest amount through a 1.5 percent increase in the conversion factor legislated by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). The Act mandates at least the same update in 2005. Over and above this increase, the MMA targeted additional payments to certain physicians—primarily, those who practice in rural areas (see text box).

Before the MMA was enacted, Medicare was slated to decrease 2004 payments for physician services by about 4.5 percent and 2005 payments by about 1.7 percent. These cuts would have resulted from the implementation

of the sustainable growth rate (SGR) formula required by statute, which ties physician payment updates to a number of factors including growth in the volume of physician services relative to growth in the national economy. MedPAC has discussed the problems associated with the SGR formula in previous reports and continues to follow a two-step approach for making update recommendations for physician services (consistent with the other provider sectors).¹ This approach first considers the adequacy of current payments and then assesses the factors that will affect efficient providers' costs in the coming year—2005.

Are current Medicare payments for physician services adequate?

A discussion of payment adequacy requires collecting and examining indicators related to physician care. First, we consider available information on beneficiary access to physician care, which includes a review of beneficiary and physician survey information and physician supply data. Second, we compare Medicare's reimbursement levels with those of the private sector. Third, we examine changes in the volume of physician services to assess trends that may be associated with payment levels.

The recent Medicare legislation includes several physician payment provisions

In addition to increasing the physician fee schedule's conversion factor by at least 1.5 percent in 2004 and 2005, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) includes provisions that will raise payments for services furnished by many fee-for-service physicians:

- A floor is established for the physician work component of the fee schedule's geographic practice cost index (GPCI). This floor will raise payments for services furnished in areas with below average physician work GPCIs, and will be in place from 2004 to 2006.
- Geographically adjusted payments for services provided in Alaska will increase to become 67 percent higher than the national average. That is, the work, practice expense, and medical malpractice

GPCIs will each be increased to 1.67. This increase will be in effect in 2004 and 2005.

- Services provided by physicians in newly established scarcity areas—determined separately for primary care physicians and specialists—will receive a 5 percent bonus in Medicare payments. This bonus will occur from 2005 to 2007.
- For the pre-existing 10 percent bonus payment to physicians practicing in designated health professional shortage areas, responsibility for identifying eligibility will shift from the individual physician to the Secretary of Health and Human Services. These automatic 10 percent bonus payments will start in 2005.

A service furnished in an area that qualifies for both the scarcity area bonus and the shortage area bonus can receive both incentive bonuses described above. ■

As with other sectors, MedPAC’s framework for assessing payment adequacy for physician services relies on indicators of beneficiary access to physicians and physician willingness to serve Medicare beneficiaries. Physicians are not required to report their costs to Medicare as are other providers—such as hospitals. Thus, we do not look at financial performance directly, and focus our payment adequacy assessment more intensely on monitoring trends in beneficiary access and physician availability. Indeed, as discussed in our March 2003 report, MedPAC assessed physician response to cuts in 2002 fee schedule payments through a physician survey. Results from this survey inform our current analysis of payment adequacy.

Our review of trends in access and payment adequacy do not reveal problems at the national level, but the Commission finds that it is important to understand and monitor variations among different markets and among different services and physician specialties. For example, the distribution of payments—among market areas, services, or specialties—may not be optimal even if the overall level of payments is adequate. Indeed, surveys sponsored by the Centers for Medicare & Medicaid Services (CMS) find geographic variation in beneficiary access to physician care.² MedPAC continues to examine these issues to inform future discussions, but the current update analysis is based primarily on information at the national level.

Beneficiary access to physician services

Physicians are often the most important link between Medicare beneficiaries and health care. Some 80 percent of noninstitutionalized beneficiaries report that a doctor’s office or a doctor’s clinic is their usual source of care (CMS 2003). Monitoring access to physicians, therefore, helps us evaluate beneficiaries’ access to health care.

To assess beneficiary access to physician services, this section examines results from surveys of beneficiaries and reviews data on physician supply and physicians’ willingness to serve Medicare patients. By design, many of the surveys’ questions rely on respondents’ own views. For example, respondents use their own judgment when determining if they are able to schedule timely appointments. Subjective responses can be useful measures for tracking beneficiary experience and perceptions, particularly over time.

Our analysis of access to physician services includes data collected in 2002, when the fee schedule’s conversion

factor decreased by 5.4 percent. Despite this decrease, most indicators do not imply a significant reduction in beneficiaries’ access to physician care during 2002. Further, in cases where we are able to analyze 2003 data, we find that, on a national level, access to physician care was good in 2003.

Beneficiary assessment of access to physicians

Results from several different surveys conducted between 2000 and 2003 show that beneficiary access to physicians appears to be good overall. The majority of beneficiaries report that they are able to find new doctors and schedule medical appointments in a reasonable amount of time. Small subsets of beneficiaries, however, report that they experience problems in this regard. Because most surveys do not compare access measures between Medicare beneficiaries and other privately insured people, it is difficult to determine the extent to which access problems, such as appointment delays, are unique to the Medicare population. Available research, which has compared these populations, has found an increase in access concerns for both populations between 1997 and 2001 (Trude and Ginsburg 2002).

A large and relatively new beneficiary survey—the Consumer Assessment of Health Plans Survey for Medicare fee-for-service (CAHPS-FFS)—provides useful information on access to physician care. This annual CMS-sponsored survey is conducted primarily through the mail; it samples between 100,000 and 120,000 beneficiaries each year, including community-dwelling, institutionalized, and disabled individuals. Chapters 1 and 2 of this report provide more detailed discussions of the CAHPS-FFS survey.

Results from the CAHPS-FFS survey indicate that beneficiaries usually consider physicians to be their main source of health care, and increasingly, these physicians are generalists rather than specialists. Among the 89 percent of beneficiaries who reported having a “personal” provider in 2002, 86 percent said that this provider was a generalist, and 12 percent said he or she was a specialist. Between 2000 and 2002, the share of beneficiaries who reported a generalist to be their regular provider increased by 3 percentage points, while the share of beneficiaries who reported a specialist to be their regular provider fell 3 percentage points.

This survey also asked about problems obtaining health care, seeing specialists, and scheduling medical

**TABLE
3B-1**

Most beneficiaries report good access to necessary, specialty, and routine care, 2000–2002

Survey question	2000	2001	2002
Within the past 6 months. . . .			
If you or your doctor believed you needed care (e.g., tests or treatment), how much of a problem, if any, was it to get this care?			
No problem or small problem	97.0%	97.5%	97.1%
Big problem	2.9	2.5	2.9
If you or your doctor thought you needed to see a specialist, how much of a problem, if any, was it to see a specialist?			
No problem or small problem	93.6	94.8	94.3*
Big problem	6.4	5.2	5.7*
If you made an appointment for regular or routine care, how often did you get an appointment as soon as you wanted?			
Always or usually	92.5	92.1	90.3*
Sometimes	6.4	6.7	7.9*
Never	1.2	1.2	1.8*

Note: *Indicates a statistically significant change between 2000 and 2002, at a 95% confidence level ($p < 0.05$). $N > 100,000$. Numbers may not add to 100 percent due to rounding.

Source: MedPAC analysis of 2000–2002 Consumer Assessment of Health Plans Survey (CAHPS) data for fee-for-service Medicare from CMS.

appointments. As discussed in Chapter 1, almost all beneficiaries (97 percent) in 2002 reported small or no problems receiving care that they or their doctor thought was necessary (Table 3B-1). Additionally, 94 percent of beneficiaries reported that they had small or no problems seeing a specialist when necessary. When asked specifically about the timeliness of scheduling an appointment for regular or routine care, 90 percent reported that they usually or always received care as soon as they wanted. This share dropped from 93 percent in 2000, suggesting that continued monitoring of this access indicator is important.³

In an effort to obtain more timely data on beneficiary access to physician services, MedPAC has begun sponsoring a telephone survey to Medicare beneficiaries age 65 and over (Berk and Schur 2003). Although this survey—interviewing about 1,000 beneficiaries per round—is much smaller in scope than the CAHPS-FFS

survey, it provides useful, more up-to-date information on trends in access to physician services.⁴ The initial round of the survey was conducted in the fall of 2003, and provides baseline information.

Results from this initial survey indicate that 93 percent of beneficiaries who were seeking a new physician reported that they encountered small or no problems; 5 percent reported big problems; and 2 percent reported being unable to find a new doctor. When asked about access to specialists, similarly, 93 percent of beneficiaries who tried to find a new specialist reported having small or no problems finding one; 3 percent reported a big problem; and 2 percent reported being unable to find a new specialist. (One percent responded that they did not know.)

This telephone survey also found that most beneficiaries did not typically encounter delays when trying to schedule doctor appointments for both routine and illness- or injury-related care. For routine care, 71 percent of the beneficiaries who tried to schedule an appointment reported that they never experienced delays; 21 percent reported that they sometimes experienced delays; 3 percent said they usually experienced delays; and 5 percent said that they always experienced delays. Compared to the CAHPS-FFS survey, a higher share of beneficiaries in this MedPAC survey sometimes encountered appointment delays and fewer never encountered delays.

As expected, for illness- or injury-related needs, beneficiaries' ability to schedule timely appointments was better. Specifically, 80 percent of the beneficiaries who tried to schedule an appointment for an illness or injury reported that they never experienced delays; 16 percent said they sometimes experienced delays; 3 percent said they usually experienced delays; and 1 percent said that they always experienced delays.

For our access analysis, we also examined surveys conducted between 1997 and 2001 by the Center for Studying Health System Change (HSC), which compared Medicare beneficiaries' access to care to that of privately insured people aged 50 to 64 (near elderly).⁵ In general, these results suggest that both populations encountered somewhat growing rates of access problems between 1997 and 2001. Medicare beneficiaries tended to fare somewhat better, though this difference may be closing (Trude and Ginsburg 2002). For example, in 1997, 16 percent of the Medicare beneficiaries who reported delaying or not obtaining care said that they could not get an appointment soon enough, compared with 21 percent of

the privately insured, near elderly respondents. By 2001, this share had grown to 24 percent for Medicare beneficiaries and 25 percent for the privately insured near elderly (Ginsburg 2002).

Changes in supply of physicians

The number of physicians furnishing services to Medicare beneficiaries has more than kept pace with the growth in the beneficiary population in recent years (Table 3B-2). From 1995 to 2002, the number of physicians billing traditional Medicare grew by 10 percent, but Medicare Part B enrollment grew by only 6.5 percent. This difference in growth rates led to an increase in the number of physicians per 1,000 beneficiaries, from 12.9 to 13.4. Note, however, that the number of physicians per Medicare beneficiary does not necessarily reflect the share of beneficiaries in physicians' patient caseloads; some physicians in this count may treat relatively few beneficiaries per year, while others may treat mostly Medicare beneficiaries.

When comparing 1991 with 2001, the General Accounting Office (GAO) also found increases in physician supply across the United States. GAO reports that during the study period, the number of physicians in the U.S. increased by 26 percent—twice the rate of total population

growth in the study period. The mix of generalists to specialists remained about the same—one-third generalists to two-thirds specialists (GAO 2003). The increase in physician supply compared to the total population parallels the increase in the number of physicians billing Medicare per beneficiary.

Assignment and participation rates

To supplement our data on the supply of physicians treating Medicare patients and patients' access to physician care, we examine assignment rates—the share of allowed charges for which physicians accept assignment—and physician participation rates—the share of physicians signing Medicare participation agreements. (The text box on p. 110 provides related definitions.) Based on claims data from 2002, 99 percent of allowed charges for physician services were assigned (Figure 3B-1). That is, for almost all allowed services, physicians agreed to accept the Medicare fee schedule amount as the service's full charge.

TABLE 3B-2

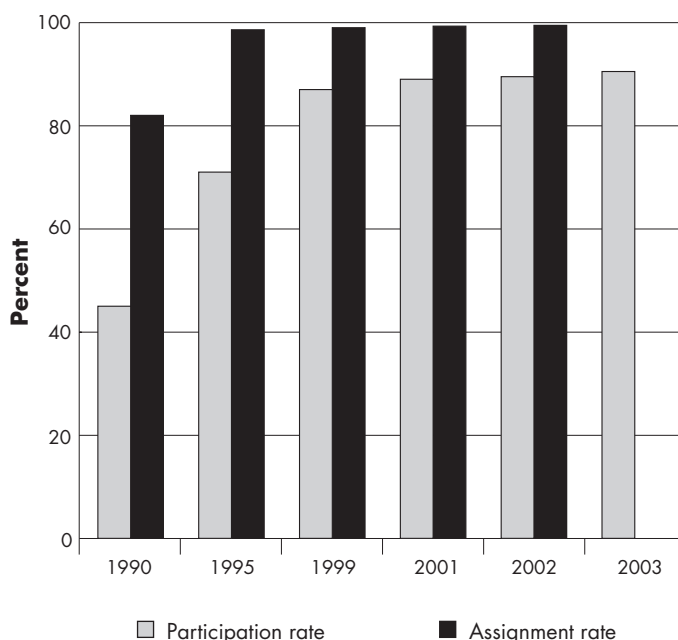
The number of physicians billing fee-for-service Medicare is increasing, 1995–2002

Year	Number of physicians	Part B enrollment (millions)	Number of physicians per 1,000 beneficiaries
1995	460,700	35.641	12.9
1996	469,915	36.104	13.0
1997	476,164	36.445	13.1
1998	478,123	36.756	13.0
1999	484,576	37.022	13.1
2000	489,067	37.315	13.1
2001	494,718	37.657	13.1
2002	506,594	37.946	13.4

Note: The number of physicians includes allopathic and osteopathic physicians and excludes nurse practitioners, physician assistants, psychologists, and other health care professionals. The denominator is the number of beneficiaries enrolled in Medicare Part B, including traditional Medicare and Medicare+Choice, on the assumption that physicians are providing services to both types of beneficiaries.

Source: MedPAC analysis of unpublished CMS data.

FIGURE 3B-1 Participation and assignment rates have grown to high levels



Note: Participation rate is the percent of physicians signing Medicare participation agreements. Assignment rate is the percent of allowed charges paid on assignment. The assignment rate for 2003 is not shown; it requires calculations from claims not yet available.

Source: Committee on Ways and Means' Green Book (2000), unpublished CMS data, and MedPAC analysis of 2002 claims for a 5 percent random sample of Medicare beneficiaries.

What it means when physicians accept assignment, participate, or balance bill

A **cept assignment**—A physician is able to choose whether or not to accept assignment on a claim paid under the fee schedule. When accepting an assigned claim, the physician bills the program directly and is typically paid an amount equal to 80 percent of the fee schedule amount. The physician may not charge the beneficiary more than the applicable deductible and coinsurance amounts. In the case of nonassigned claims, the physician still bills the program directly; however, Medicare reimburses the beneficiary, rather than the physician. Consequently, the beneficiary is liable for the physician's charges, which includes the difference between the fee schedule amount and the physician's actual charge—the balanced bill amount (described below).

Participate—A physician participates, or becomes a participating provider, by voluntarily signing an agreement with Medicare to accept assignment on all claims for the forthcoming year. There are a number of

incentives for physicians to become participating physicians, chief of which is higher fee schedule payments. Allowed charges for nonparticipating physicians are only 95 percent of the fee schedule amounts; participating physicians can receive the full fee schedule amount. Nonphysician practitioners who bill Medicare Part B may also sign Medicare participation agreements.

Balance bill—Balance billing occurs when a physician's charges exceed the fee schedule amount. Medicare limits the amount physicians may balance bill the patient. The total nonassigned charges for a service may not exceed the fee schedule amount by more than 9.25 percent.⁶ Given the limitations on balanced billing and the small share of charges at the unassigned amount, the average annual beneficiary liability for balance billing is quite small. The extent of balance billing, however, varies by physician location and specialty. ■

Further, while 95.6 percent of allowed charges were for services furnished by participating physicians, 3.6 percent were for services furnished by nonparticipating physicians who decided to accept assignment. Only 0.9 percent of allowed charges were for services furnished by nonparticipating physicians who did not accept assignment. For these nonassigned charges, physicians likely billed higher amounts, making the beneficiary liable for added coinsurance, a practice known as balance billing.

The high share of charges with accepted assignment is likely due in large part to the additional, valuable benefits physicians receive when accepting assignment and signing Medicare participation agreements. When physicians accept assignment, they can receive payments directly from Medicare (less the beneficiary cost-sharing portion) rather than collecting from the beneficiary. A high rate of assigned charges also reflects the high rate of physicians who agree to participate in Medicare—91 percent in 2003 (Figure 3B-1). Participating physicians agree to accept assignment on *all* allowed claims, in exchange for a 5 percent higher payment on allowed charges than nonparticipating physicians. Participating physicians receive other valuable benefits, including the listing of their name and contact information on Medicare's website,

and the ability to verify a patient's Medicare eligibility and Medigap status. Medicare's physician participation agreement does not place any requirements on physicians to take Medicare patients.

Physicians' willingness to accept new beneficiaries
A key indicator in examining physician supply is the degree to which physicians are accepting new Medicare patients into their practices. In general, the most recently available data indicate that most physicians practicing in the United States are willing to accept new Medicare beneficiaries, particularly those who have a practice with a relatively large proportion of Medicare patients already.

The smaller share of physicians who report reluctance to serve Medicare beneficiaries may be responding to a variety of factors other than, or in addition to, payment adequacy. These other factors may include the administrative burden of Medicare, local physician supply, demand for physician services, local market insurance conditions, dependence on referrals, size of Medicare patient caseload, and the amount of time physicians are willing to devote to patient care. Unfortunately, it is difficult to disentangle these other factors. Consequently, our discussion on physician willingness to serve Medicare

patients is limited to physician responses to simple questions on whether they provide care to Medicare patients. Where possible, we also compare physicians' willingness to accept Medicare patients with their willingness to accept all patients.

The most recent survey information on physicians' willingness to serve new Medicare beneficiaries comes from the National Ambulatory Medical Care Survey (NAMCS). This survey is conducted in 52 reporting periods during the year to ensure that responses are evenly spread throughout the year. Results from the 2002 NAMCS survey indicate that 95 percent of office-based physicians reported that they accepted any new patients and 93 percent of physicians with at least 10 percent of their practice revenue coming from Medicare accepted any new Medicare patients. These figures do not differ significantly from the percentage reported on the 2001 NAMCS (Burt 2003).

This finding is similar to results from a 2002 MedPAC-sponsored survey of physicians who spent at least 10 percent of their time with Medicare fee-for-service (FFS) patients. This study was started in April of 2002, after physicians had time to learn about and react to a fee schedule conversion factor cut of 5.4 percent. It found that among physicians who were accepting *any* new patients, 96 percent were accepting some or all new FFS Medicare patients. The percentage accepting *all* new Medicare patients, however, was lower, at about 70 percent. Further, physicians reported that they were more likely to accept Medicare patients than Medicaid, HMO, uninsured, self-pay, and charity care patients, but less likely to accept Medicare FFS patients than private FFS and preferred provider organization (PPO) patients (Schoenman and Feldman 2003).⁷

HSC surveys conducted between 1997 and 2001 also compare physicians' willingness to accept new Medicare patients with their willingness to accept new privately insured patients (Trude and Ginsburg 2002). The proportions in both cases fell at about the same rate. Specifically, the proportion of physicians accepting all new Medicare patients fell from 75 percent in 1997 to 71 percent in 2001; the proportion of physicians accepting all new privately insured patients fell from 71 to 68 percent. (Note that this rate does not include physicians who accept some but not all Medicare beneficiaries.)

Some local market analyses reveal that physician surveys and patient surveys produce seemingly contradictory

results. HSC found that in some local markets, patients' assessments of access to physician care do not necessarily track with physicians' willingness to accept patients. In Boston, for example, HSC found relatively high rates of appointment delays reported by Medicare and privately insured, near elderly patients, but relatively low rates of physician unwillingness to accept these patients. The reverse effects were reported in the Seattle area (Hargraves et al. 2003).

Private payer reimbursement for physician services

Medicare purchases many of the same types of physician services as private payers—traditional indemnity insurers, PPOs, HMOs—and Medicaid. Historically, Medicare's payment rates for physician services have been below private insurers' rates, on average (PPRC 1996). If Medicare's payment rates fall relative to the rates of other payers, some physicians may stop accepting Medicare patients and instead focus their practices on other patients. A widening of the gap between Medicare and private rates may not lead to access problems for beneficiaries, however. Multiple factors influence access to care, including the supply of physicians, supplemental insurance coverage, and the administrative burden for physicians of one payer relative to another.

To assess Medicare's position in the marketplace over time, MedPAC hired a contractor—Direct Research, LLC—to compare Medicare rates for physician services with those of private insurers (Hogan 2003). Using two large claims databases, the contractor analyzed trends in Medicare rates for physician services relative to private rates.⁸ Previous work by this contractor has shown that, through 2001, the difference between Medicare and private rates had decreased since the mid-1990s. Shifts in private plan enrollment from higher-paying indemnity plans to lower-paying PPOs and HMOs accounted for most of the decline. Medicare's rates were about 66 percent of private rates in 1994, but this percentage had risen to about 83 percent in 2001.

Analysis of 2002 data shows that the gap between Medicare and private rates widened (Hogan 2003). It is still much narrower than it was in the mid-1990s, however. The factors behind the change in 2002 were:

- Average private rates for physician services dropped slightly—1 percent. The main factor was a continued shift of private enrollment from plans with relatively

high payment rates, such as traditional indemnity insurance, to plans with lower payment rates, such as preferred provider organizations.

- Medicare’s payment rates dropped more than private rates in 2002, with a 5.4 percent decrease in the physician fee schedule’s conversion factor. This reduction was mitigated somewhat by the increases in payment rates for non-fee schedule services—laboratory services and Part B drugs—that are included in CMS’s definition of physician services.

The net effect was that overall Medicare rates for physician services, as a percentage of private rates, went from 83 percent, in 2001, to 81 percent, in 2002.

Changes in the volume of physician services used

Changes in the volume of services are another indicator of the adequacy of Medicare’s payments for services. If the overall volume of services provided to beneficiaries falls, it may mean that providers are offering fewer services because payments are inadequate. Conversely, large increases in volume growth may indicate that Medicare is overpaying for services. However, data on growth in the volume of physician services must be interpreted cautiously; some evidence suggests that volume goes up when payment rates go down, the so-called volume offset (Codespote et al. 1998). Such a volume offset, if it occurs, makes interpreting an increase in the volume of physician services very difficult.

Bearing this in mind, we analyzed growth in the volume of physician services using claims data for 1999 through 2002. We measured volume as per capita use of physician services by beneficiaries in fee-for-service Medicare. For this measure, units of service were weighted by each service’s relative weight from the physician fee schedule. The result is a measure of volume growth that accounts for changes in both the number of services and the complexity, or intensity, of those services.

Across all services, volume growth rates have increased:

- 5.6 percent, from 2001 to 2002,
- 5.4 percent, from 2000 to 2001, and
- 4.3 percent, from 1999 to 2000.^{9,10}

Among broad categories of services—major procedures, evaluation and management, other procedures, imaging, and tests—growth rates vary, but all are positive. Imaging and tests grew the most. From 2001 to 2002, the imaging growth rate is 9.4 percent, and the growth rate for tests is 11.1 percent.

Within these categories, some services grew much faster than others (Table 3B-3). From 2001 to 2002, we see the highest growth in volume—approaching 20 percent—of nuclear medicine, computed tomography, magnetic resonance imaging, laboratory tests, and minor procedures which include outpatient rehabilitation.

By contrast, some services show decreases in volume. Those services include coronary artery bypass graft (CABG), hip fracture repair, colectomy, and arthroscopy. No evidence suggests that these decreases are due to inadequate payments, however. Some of the decreases are small, in a range from 1.6 percent to 2.3 percent. The decrease in arthroscopy volume in 2002 follows relatively rapid growth in previous years and may not signal a change in access for Medicare beneficiaries. For example, research results published in 2002 raised questions about the efficacy of arthroscopy in the treatment of osteoarthritis of the knee, so the decline may be a response to medical knowledge (Moseley et al. 2002).

The decrease in CABG volume is larger than for other services, at 4.1 percent from 2001 to 2002. One likely explanation for this decrease is that it represents substitution of one service for another. Specifically, the CABG decrease is occurring at the same time that there is greater use of coronary angioplasty, which is a newer procedure for treating coronary artery disease.

How should Medicare payments for physician services change in 2005?

In addition to considering current payment adequacy, the MedPAC update framework also analyzes changes in costs projected for the coming year. For physicians, we examine two factors to forecast input costs: change in input prices and MedPAC’s policy goal for productivity growth. Input price change generally reflects inflationary growth and thereby increases expected physician expenses; productivity growth, on the other hand, reduces costs and thereby decreases expected physician expenses.

**TABLE
3B-3****Use of physician services in fee-for-service Medicare, for selected services, 1999–2002**

Type of service	Percent change in units of service per beneficiary		Percent change in volume per beneficiary		Percent of total volume
	Average annual 1999–2001	2001–2002	Average annual 1999–2001	2001–2002	
All services	3.8%	5.1%	4.9%	5.6%	100.0%
Evaluation and management					
Office visit—established patient	2.2	2.8	2.7	4.0	18.3
Hospital visit—subsequent	1.9	2.6	2.1	4.0	8.5
Consultation	4.6	4.2	5.8	6.0	5.9
Emergency room visit	4.1	2.8	6.9	6.6	2.7
Hospital visit—initial	0.3	1.1	0.4	1.8	2.2
Office visit—new patient	0.4	1.2	0.1	0.9	2.1
Nursing home visit	-0.8	1.2	0.3	3.5	1.8
Imaging					
Echography—heart	9.2	9.8	11.0	13.1	2.0
Standard—nuclear medicine	14.7	12.1	18.0	17.1	1.9
Advanced—CT: other	14.5	13.8	16.4	16.5	1.8
Advanced—MRI: other	18.5	15.3	22.3	17.4	1.5
Standard—musculoskeletal	3.5	3.7	5.5	6.5	1.2
Advanced—MRI: brain	19.2	12.3	16.1	13.8	1.0
Standard—chest	-0.4	1.9	-1.1	1.2	0.8
Advanced—CT: head	5.6	5.6	4.9	5.3	0.4
Imaging and procedure—heart, including cardiac catheterization	6.9	3.2	8.8	6.4	0.3
Major procedures					
Coronary artery bypass graft	0.0	-2.8	-1.8	-4.1	0.9
Knee replacement	9.0	10.4	8.2	9.5	0.7
Coronary angioplasty	9.9	5.7	8.8	5.1	0.5
Hip fracture repair	-1.4	-2.2	-1.2	-1.6	0.4
Hip replacement	7.7	3.7	7.4	3.1	0.4
Explore, decompress, or excise disc	10.3	5.6	11.7	5.5	0.4
Colectomy	0.6	-1.5	-0.6	-2.3	0.3
Other procedures					
Minor—other, including outpatient rehabilitation	18.6	20.1	16.2	18.3	3.4
Cataract removal and lens insertion	-0.3	3.4	-0.2	3.5	2.1
Colonoscopy	12.4	9.1	12.0	10.0	1.2
Upper gastrointestinal endoscopy	4.4	3.6	3.5	3.5	0.6
Cystoscopy	1.7	1.5	0.9	4.0	0.6
Arthroscopy	13.7	-4.4	13.4	-2.3	0.3
Tests					
Electrocardiogram	1.0	3.0	1.1	3.3	0.8
Cardiovascular stress test	9.1	8.7	10.4	12.0	0.5
Electrocardiogram monitoring	1.9	5.4	3.4	6.6	0.2
Lab test—other (physician fee schedule)	12.2	14.0	13.9	16.9	0.2

Note: CT (computed tomography). Volume is measured as units of service multiplied by each service's relative weight (relative value units) from the physician fee schedule. To put service use in each year on a common scale, we used the relative weights for 2002. For billing codes not used in 2002, we imputed relative weights based on the average change in weights for each type of service.

Source: MedPAC analysis of claims data for 100 percent of Medicare beneficiaries from all 12 months of each year.

**TABLE
3B-4**

Medicare Economic Index weights and forecasted input price changes for physician services for 2005

Input component	Category weight (percent)	Price changes for 2005 (percent)
Total	100.0%	3.5%
Physician work	52.5	3.4
Wages and salaries	42.7	3.3
Fringe benefits (nonwage compensation)	9.7	4.0
Physician practice expense	47.5	3.6
Nonphysician employee compensation	18.7	3.5
Wages and salaries	13.8	3.3
Fringe benefits (nonwage compensation)	4.8	4.1
Office expense	12.2	2.1
Professional liability insurance	3.9	9.4
Medical equipment	2.1	2.4
Drugs and supplies	4.3	2.7
Pharmaceuticals	2.3	3.1
Medical materials and supplies	2.0	2.0
Other professional expenses	6.4	2.5

Note: Forecasted price changes for individual components are calculated by multiplying the component's weight by its price proxy. Forecasted price changes are not adjusted for productivity. Numbers may not total exactly because of rounding.

Source: Unpublished, fourth-quarter 2005 estimates from CMS, dated December 12, 2003.

Input price inflation

To measure input price inflation for physician services, we use the Medicare Economic Index (MEI), which CMS constructs from various datasets on price information and survey data supplied by the American Medical Association (AMA). The MEI provides a weighted average of price changes for inputs used to furnish physician services. For 2005, the MEI forecasts that input prices for physician services will increase by 3.5 percent (Table 3B-4).

Within this aggregate estimate of input cost increases are individual input cost changes. CMS sorts the specified inputs into two major categories: physician work and physician practice expense. Physician work includes salaries and fringe benefits allotted for physicians. Physician practice expense includes nonphysician employee compensation, office expenses, professional liability insurance (PLI), drugs and supplies, and medical equipment.

To calculate the projected costs for these inputs, CMS first estimates the share—or weight—of physicians' practice revenues attributable to each input, based primarily on data supplied by the AMA. CMS attributes 52.5 percent of physician revenues to physician work and 47.5 percent to practice expense, which includes a PLI weight of 3.9 percent (CMS, 2003).¹¹

Compared with the data used to determine the input weights, the data used to forecast input price changes is more timely. CMS currently projects that from 2004 to 2005, input prices for physician work will increase 3.4 percent, based on increases of 3.3 percent in wages and salaries and 4.0 percent in nonwage compensation. Practice expenses are projected to increase by 3.6 percent. This projection includes a 9.4 percent increase in PLI, which continues to be the fastest growing input cost. As 2005 approaches, this figure may change to reflect updated premium information.

Some physicians—particularly those practicing in certain geographic areas and those whose specialty includes high-risk procedures—report PLI premium increases that are much higher, and thus make up a significantly higher percentage of their revenues than forecasted in the MEI. The MEI, however, is not designed to reflect price changes for individual physicians nor their patient caseloads, but is instead designed to account for an *average* price change for all physicians (see text box on p. 116).

Productivity growth

As discussed in the beginning section of this chapter, which outlines MedPAC's framework for analyzing payment adequacy, the Commission believes that efficient providers should be able to reduce the quantity of inputs required to produce a unit of service by at least a modest amount each year while maintaining service quality. MedPAC has adopted this policy standard, or goal, to encourage provider efficiency when making its update recommendation. MedPAC has determined that achievable productivity growth—based on a 10-year average of the Bureau of Labor Statistics' estimate of economy-wide, multifactor productivity growth—is currently 0.9 percent for 2005.¹² By considering both productivity growth and forecasted input price inflation, we expect the cost of producing physician services to increase by about 2.6 percent during the coming year.

Update recommendation

RECOMMENDATION 3 B

The Congress should update payments for physician services by the projected change in input prices, less an adjustment for productivity growth of 0.9 percent, in 2005.

RATIONALE 3 B

Our analysis finds that current Medicare payments for physician services are adequate. Currently, the projected change in input prices for 2005 is 3.5 percent and MedPAC's standard for 2005 productivity growth is 0.9 percent. Because the forecast of the MEI is updated quarterly, this recommendation assumes that the Congress would use the most recent MEI estimates.

Spending

- Our estimates indicate that implementing this recommendation would increase Medicare spending in 2005 by \$200–600 million, relative to current law.

Beneficiary and provider

- This recommendation would maintain current levels of beneficiary access to physician care. It would also help maintain physician willingness and ability to furnish services to Medicare beneficiaries. ■

Professional liability insurance (PLI) payments in Medicare

Medicare accounts for physicians' costs for professional liability insurance (PLI) in three ways. One way is through the Medicare economic index (MEI), which is used to adjust payments equally to account for PLI costs across all physicians serving Medicare beneficiaries. The other two ways are through the physician fee schedule, which assigns relative value units (RVUs) to services and geographic practice costs indexes (GPCIs) to areas of the country. These two components of the fee schedule allow Medicare payments to account for PLI differentially—by service and by geographic area—based on PLI premium differences (Figure 3B-2).

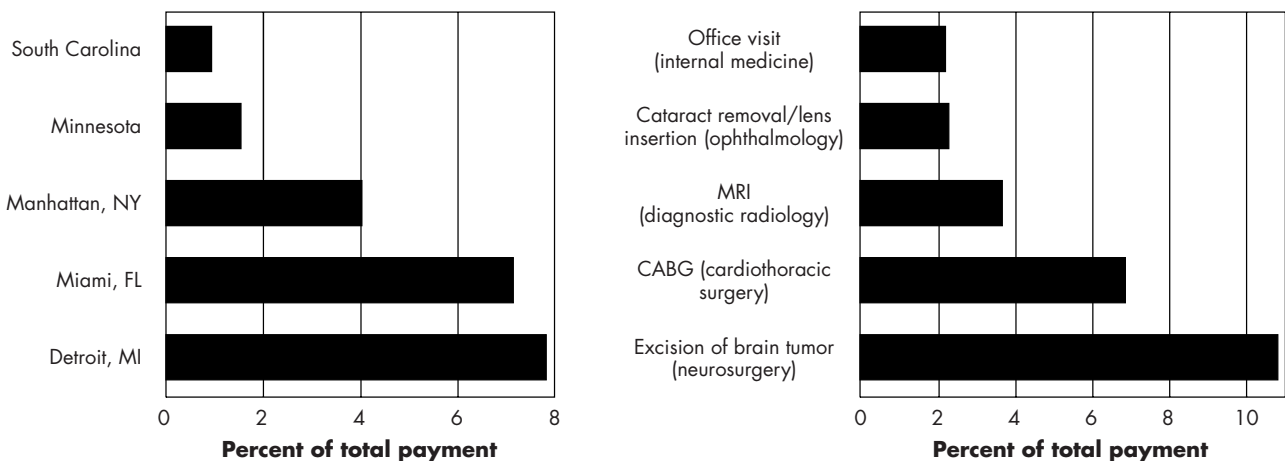
In contrast, the PLI weight in the MEI reflects the average circumstance of physicians who treat Medicare beneficiaries. Because the majority of services used by

Medicare beneficiaries are not major procedures (which usually lead to high PLI premiums), the MEI's PLI weight is less representative of specialists who furnish a large number of such procedures.

The fee schedule's RVUs, on the other hand, designate higher payments for services furnished by neurosurgeons and cardiothoracic surgeons, who bear higher PLI premiums. Similarly, the fee schedule's GPCIs adjust payments to physicians who practice in geographic areas with high PLI premiums, such as Detroit, Michigan. Given both of these factors, over 20 percent of Medicare's payments to a Detroit neurosurgeon under the fee schedule can be attributable to PLI, if a fairly high proportion of the neurosurgeon's practice consists of major procedures. ■

FIGURE 3B-2

PLI payments vary by locality and service, as a percentage of total payments under the Medicare fee schedule, 2002



Note: (PLI) professional liability insurance, (CABG) coronary artery bypass graft. PLI payments for services are national averages.

Source: MedPAC analysis of claims for 100 percent of Medicare beneficiaries in 2002.

Endnotes

- 1 For a detailed discussion of the SGR, see MedPAC's March 2002 report, p.74.
- 2 In particular, results from the Consumer Assessment of Health Plans Survey for Medicare fee-for-service (CAHPS-FFS) indicated geographic differences in access to primary care physicians and specialists.
- 3 Changes in the wording of this survey question between the years may have affected responses.
- 4 This survey was limited to beneficiaries age 65 and over, due to sample size limitations. Because this telephone survey is limited to a three-week period, its response rate is not comparable with those of government-sponsored surveys with field periods of several months. The reported results from this survey, however, are weighted to be nationally representative with respect to basic demographic variables.
- 5 In its Community Tracking Study, HSC surveys households, physicians, and employers in 12 communities across the country. These sites were selected to be nationally representative when analyzed collectively.
- 6 The 9.25 percent cap on balance billing is equal to 115 percent of the nonparticipating physicians' allowed charge (95 percent of the fee schedule amount).
- 7 For further details, the report on this survey is available on MedPAC's website. Unlike the NAMCS, this survey was able to distinguish Medicare FFS from Medicare managed care caseloads.
- 8 To compare Medicare and private payment rates, the contractor first calculated a price index for each type of private plan (health maintenance organization, point-of-service, preferred provider organization, and indemnity). Each price index was a weighted average of service-level price comparisons between Medicare and private payment rates, using Medicare's volume in each service as the weights. These plan-specific estimates were then weighted based on estimates of private enrollment in each type of plan.
- 9 These estimates include only services paid for under the physician fee schedule. The estimates would be higher if they included the volume of other services in CMS's definition of physician services, such as Medicare Part B drugs and laboratory services. Estimates of volume growth from CMS illustrate this point (Grissom 2003). According to these estimates, volume growth for 2001 to 2002 was 6 to 8 percent. The low end of this range is volume growth for services paid under the physician fee schedule, which is the definition of physician services used in this report. The high end of the range includes volume growth for the broader definition of physician services.
- 10 These growth rates are higher than reported in MedPAC's March 2003 Report to the Congress: Medicare payment policy. For instance, the all-services growth rate from 2001 to 2002 in that report was 4.3 percent, which is 1.3 percentage points below our current estimate for this growth rate. Reasons for the increase in MedPAC's estimates include: use of full-year data instead of data for the first six months of each year, and claims data for 100 percent of beneficiaries instead of data for a 5 percent sample of beneficiaries.
- 11 CMS recently updated its input category weights, based on 2000 survey data from AMA. Rebasings these weights resulted in a decrease in the share of revenues going towards physician work, and an increase in the share of revenues going towards practice expense, with an increase in the PLI share.
- 12 MedPAC's productivity standard is similar to CMS's estimate, which is also based on private, nonfarm multifactor economic data from the Bureau of Labor Statistics.

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