



Issue Brief – No. 815
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Medicare Physician Payments and Spending

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OVERVIEW — *The Medicare program's physician payment method is intended to control spending while ensuring beneficiary access to physician services, but there are signs that it may not be working. The physician's role in the health care delivery system as the primary source of information and treatment options, together with growing demand for services and the imperfect state of knowledge about appropriate service use, challenge Medicare's ability to achieve these two goals. This issue brief describes the history of physician spending and the contribution of escalating service use and intensity of services to the rise in Medicare outlays, setting the stage for further discussion about the use of the Medicare payment system to control spending and ensure access.*

This issue brief is the first of two related papers on physician spending and Medicare's sustainable growth rate. Please look for the companion issue brief, due to be released October 2006.

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Medicare's physician payment approach may be broken. Medicare pays physicians based on a fee schedule, which is designed to promote the delivery of the appropriate volume and mix of services to beneficiaries. The fee schedule is combined with a spending target that is intended to moderate the increase in physician spending. Annual changes in the fees are tied to the difference between actual spending and the target. Since 2002, actual spending has exceeded the target, triggering reduction to physician fees. After fees were lowered in 2002, however, concerns about maintaining access to services led Congress to stop the fee reductions determined through this payment approach.

Growth in the volume and intensity of physician services has caused total Medicare physician spending to continue to rise. Physician groups, however, are increasingly dissatisfied with the payment approach and are calling for a system overhaul. Reform is expensive because the cumulative spending in excess of the targets must be "paid back." This payback requirement inflates the federal budget cost of changing Medicare's physician payment approach, making it more difficult for policymakers to enact a longer-term fix. As the rhetoric over physician spending intensifies, it is important to keep in mind certain fundamental concepts about the role of physicians in health care delivery and the possible unintended consequences of payment incentives on the delivery of services.

PHYSICIAN PAYMENTS

Medicare spent \$57.8 billion for physician services paid under the fee schedule in 2005, almost 7 percent more in total and over 9.5 percent more per beneficiary than the year before.¹ Medicare physician fees were increased by 1.5 percent between 2004 and 2005, but total spending went up faster because beneficiaries received more services and more intensive ones.² Physician services, which accounted for 16 percent of total Medicare spending, include office visits and consultations, termed evaluation and management services; imaging; major and minor surgeries and other procedures; and tests. Spending grew even faster for items and services that are typically associated with, or "incident to," physician office visits, such as diagnostic x-rays, laboratory and other tests, and certain drugs administered in physicians' offices that have historically been

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covered by Medicare.³ Physician services plus these related services accounted for 25 percent of the Medicare budget.

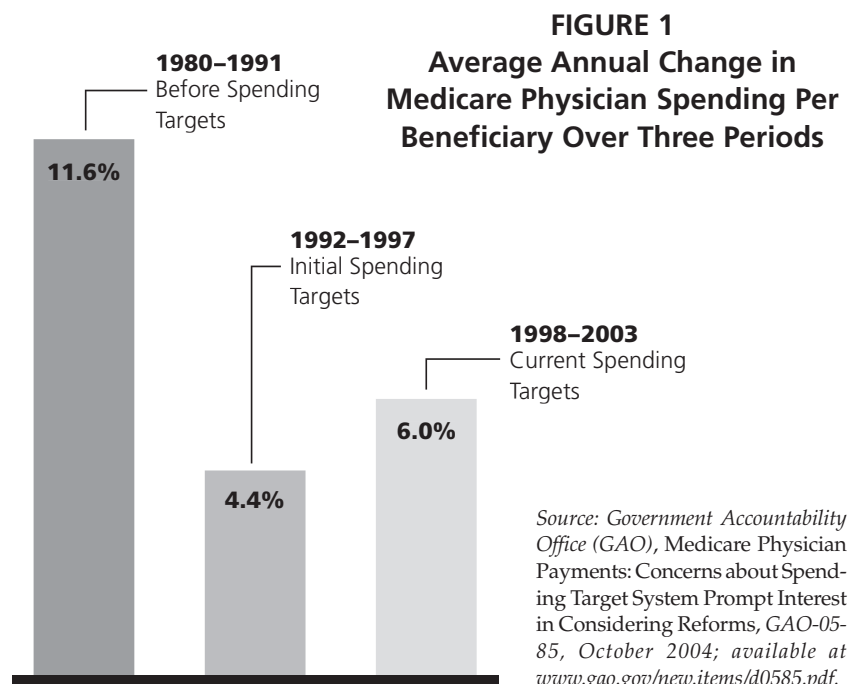
Rapid growth in physician spending in the late 1980s spurred Medicare to replace its charge-based payment system with a fee schedule starting in 1992.⁴ Fees are now based on the typical resources (professional time, equipment, supplies, etc.) required to provide each service, rather than physicians' historical charges. This change was intended to rationalize the payment for each service to reduce incentives for physicians to prefer one treatment over another for financial reasons.

In conjunction with the fee schedule, Congress mandated a spending target for physician services. The annual increase in physician fees depends on the relationship between actual spending on physician services and the target. The update is higher if spending is below the target and is lower if spending is above the target. This link between the update to the fees and the target was intended to dampen incentives inherent in a fee-for-service environment for physicians to provide more services and more intensive ones. Some believed that this would provide a collective incentive for physicians to control the volume and intensity of services delivered.⁵

GROWTH IN PHYSICIAN SPENDING

The growth in spending on physician services slowed after the implementation of the fee schedule and spending targets, but it has picked up in recent years. Prior to the spending targets, annual growth in physician services per beneficiary averaged over 11 percent for more than 10 years.⁶ With the initial version of the target, spending growth averaged 4.4 percent per beneficiary from 1992 through 1997 (Figure 1). Since then, physician spending growth has been higher in every successive year, except for 2002.

Growth in the volume and intensity of physician services has become more important in driving up physician spending than the update to fees. In 1998, the volume and intensity of physician and related services went up 1.6 percent. By 2004, volume and intensity had grown 8 percent and they grew another 7.5 percent by



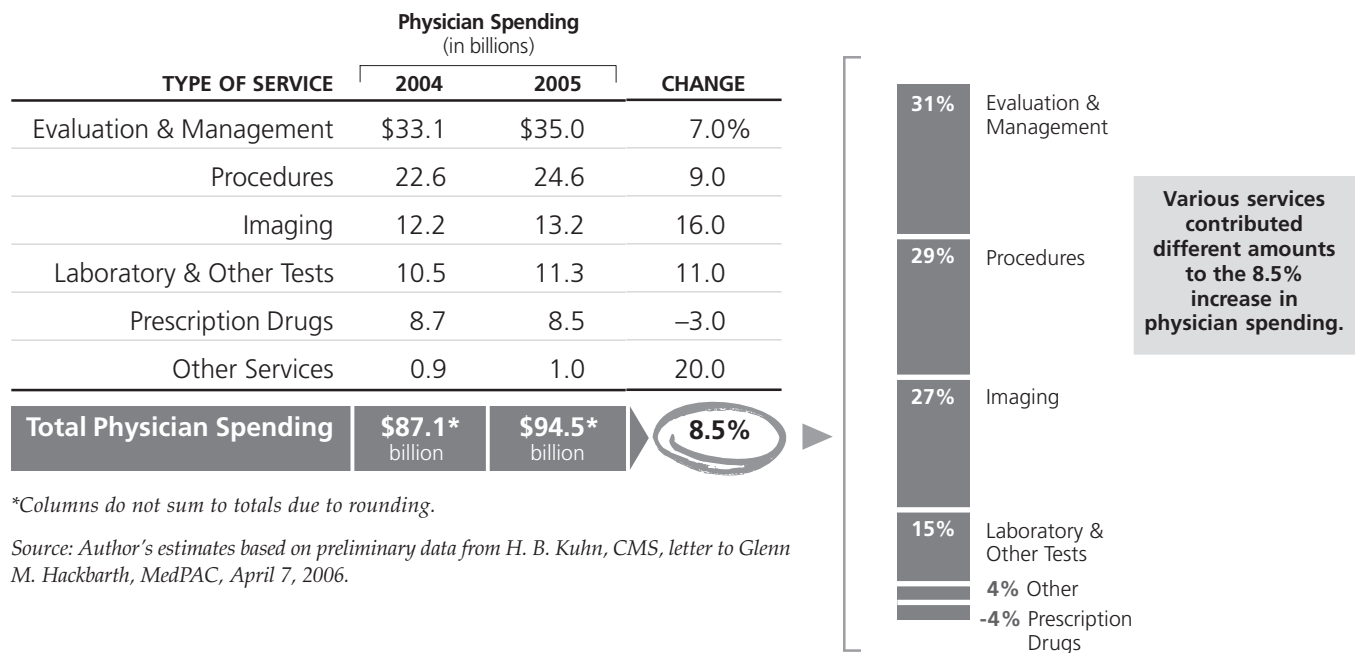
2005, contributing to an 8.5 percent increase in physician and related spending in that year.⁷

Spending for some physician services has grown faster than others (Figure 2).⁸ For example, between 2004 and 2005, spending for imaging services grew 16 percent.⁹ Spending for laboratory and other tests grew 11 percent. Both of these categories of services accounted for a relatively small share of total physician spending, yet, because they grew faster than the overall average, they contributed a disproportionate share to the total increase in spending. Imaging services were 14 percent of physician and related spending in 2005 but contributed 27 percent of the 8.5 percent total increase between 2004 and 2005. Laboratory and other tests were 11 percent of total spending and contributed 15 percent to total growth. This disproportionate contribution is particularly notable because these services may be more discretionary than others.

The difficulty in controlling Medicare spending by limiting the fees is illustrated by the experience with physician-administered drugs (Table 1, next page). Prices were reduced in 2004 for the small number of pharmaceuticals that have been covered by Medicare because they are administered in the physicians' office (such as chemotherapy agents). Congress acted to significantly reduce the prices paid by Medicare in response to analyses

Medicare physician spending is determined by the fees paid and the volume and intensity of services provided.

FIGURE 2
Change in Physician Spending, by Type of Service, 2004 to 2005



that indicated that Medicare’s payments for these drugs were often substantially higher than the cost of purchasing them, resulting in overpayments to physicians.¹⁰ The price cut was substantial, which contributed to a marked reduction in spending for these drugs. Volume and intensity continued to grow, however, and products shifted from less expensive to more expensive (or more intensive) ones. As a result, even though Medicare’s fees for these products were reduced by over 20 percent in 2005, drug spending only declined by 3 percent.

The rising use of imaging services has attracted particular attention. Imaging services have added significantly to physician spending growth because of increased volume and use of more sophisticated (and more expensive) services. The dramatic spending growth has raised concerns about the value and quality of these services. The Medicare Payment Advisory Commission (MedPAC) examined the growth of imaging services provided in physician offices. From 1999 to 2003, MedPAC documented a cumulative 45 percent rise in imaging services per beneficiary, compared to an increase of just over 20 percent for all physician services.¹¹ Spending on physician-provided imaging services rose 16 percent in both 2004 and 2005; during this time, more physicians were purchasing equipment to provide these services in their offices.¹²

This increase was due to the notable growth in service use as well as the shift from less intensive (standard) to more intensive (advanced, imaging procedure, and echography) imaging services from 2001 through 2005 (Figure 3). There has also been a shift in the types of physician visits over this period. Although the number of physician visits has gone up more slowly than other services, the increase in the more intensive visits has been faster than the rise in the less intensive ones.

A recent study of total health care costs of Medicare beneficiaries indicates that, between 1987 and 2002, most of the spending growth was due to the rise in the number of patients being treated for five or more conditions.¹³ Whether this reflects increased prevalence of disease, increased treatment,

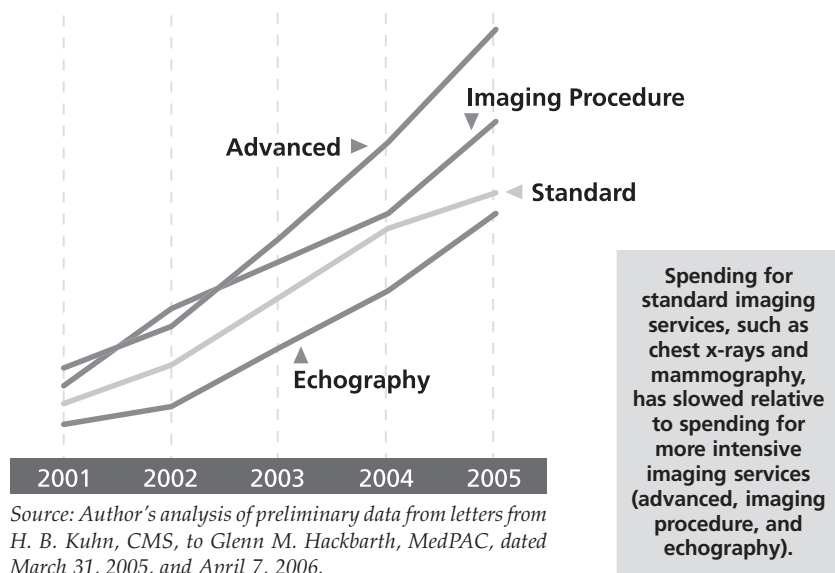
TABLE 1
Percentage Change in Price, Volume and Intensity, and Spending for Physician-Administered Drugs, 2003–2005

	2003	2004	2005
Price	1.9%	–11.7%	–21.1%
Volume and Intensity	18.8%	24.6%	22.7%
Spending Change*	24.2%	11.5%	–3.0%

* Other factors, such as change in beneficiaries, affect the change in total spending.

Source: H. B. Kuhn, Centers for Medicare & Medicaid Services (CMS), letter to Glenn M. Hackbarth, Medicare Payment Advisory Commission (MedPAC), April 7, 2006; available at www.cms.hhs.gov/SustainableGRatesConFact/Downloads/MedPAC_Letter_Estimated_2007.pdf.

FIGURE 3
Cumulative Growth in Medicare Physician Spending for Imaging Services, 2001–2005



Source: Author’s analysis of preliminary data from letters from H. B. Kuhn, CMS, to Glenn M. Hackbarth, MedPAC, dated March 31, 2005, and April 7, 2006.

or some combination is not clear. Technological advances have expanded treatment options and contributed to the rise in overall spending and physician spending in particular.¹⁴ These advances may include more effective care for certain conditions and services that improve the quality of life. Sometimes these advances make it feasible for certain services to be provided in the physician office, instead of settings like the hospital outpatient department. Although such a shift would not necessarily represent an absolute increase in services provided, it would contribute to higher physician spending.¹⁵

ACCESS TO PHYSICIAN SERVICES

Efforts to control physician spending in the Medicare program raise concerns about access to care. Reducing Medicare fees in accordance with the spending targets could affect physicians' willingness to care for Medicare beneficiaries. Indeed, physician groups have warned that projected physician fee cuts will lead to reduced access to services. As noted by a representative of the American Medical Association in testimony before Congress, "according to surveys by the American Medical Association (AMA) and Medical Group Management Association (MGMA), 45% of physicians and 40% of group practices will be forced to limit the number of new Medicare patients they can accept when the first cut of at least 5% goes into effect January 1, 2007."¹⁶ Likewise, the American College of Physicians stated that payment cuts will accelerate the trend of declining interest in specializing in primary care among medical students, which could reduce access to services.¹⁷

To date, there are no indications that access for Medicare beneficiaries has declined even though fees were reduced in 2002 and fees have not kept pace with inflation since then. According to a recent analysis by the Government Accountability Office (GAO), Medicare beneficiaries' use of physician services is rising.¹⁸ The proportion of beneficiaries receiving any physician service went from 41 percent in April 2000 to 45 percent in April 2005. For beneficiaries who received physician care, the average number of services rose by 14 percent over this period. These trends applied across all urban and most rural areas in all states. Even during 2002, the number of beneficiaries served and the number of services provided grew. GAO found that the proportion of beneficiaries who reported major physician access problems was small and constant from 2000 through 2004. Further, 99 percent of billed services were paid under assignment; that is, Medicare's fee was accepted as payment in full, and over 96 percent of physicians participated in Medicare.

MedPAC found that the percentage of beneficiaries reporting no problem getting an appointment for routine care or finding a new primary care physician remained steady between 2003 and 2005.¹⁹ Further, Medicare

Reducing Medicare fees could affect physicians' willingness to care for beneficiaries; however, use of physician services continues to rise.

beneficiaries indicated fewer problems getting a physician appointment than the privately insured. A 2004–2005 survey of physicians, conducted by the Center for Studying Health Systems Change, found that close to 72 percent of surveyed physicians said that they were accepting all new Medicare patients, a percentage that was virtually unchanged from four years earlier, and slightly higher than the percentage accepting all new privately insured patients.²⁰ Although 3.4 percent of surveyed physicians were not accepting new Medicare patients, this proportion had not changed and was similar to the percentage not accepting new privately insured patients. MedPAC also reported that the number of physicians delivering services to Medicare beneficiaries has more than kept up with increases in beneficiaries since 1999.²¹

Although MedPAC annually reviews a range of indicators of access to care and has not identified any systematic increase in access problems,²² there could be situations in which access might be a concern. Localized access problems or difficulties obtaining particular services or seeing particular types of physicians could be issues for Medicare beneficiaries. Access may be more challenging in areas where private payer fees are higher than Medicare's and where there are disproportionately more privately insured patients. Particular services or procedures may be affected if physicians do not invest in new technologies because of the lack of financial incentives or rewards. Access could also be limited if some services are less profitable to provide than others and physicians forego delivering the less profitable services and shift to delivering the more lucrative ones.

ISSUES IN PHYSICIAN SPENDING

A variety of factors affect the number and type of services provided to Medicare beneficiaries. There will be differences in treatment patterns across what appear to be similar patients, yet observed variations and patterns of growth in spending suggest that patient needs and preferences may not be the only determinants of the volume and intensity of services delivered. The imperfect science of medicine, fast-paced technological advances and changing health care needs of an aging population, combined with a culture that equates more with better, undoubtedly drives some use and spending growth. The central role of the physician as the health care decision maker creates a great potential for physicians to respond to financial incentives if they choose. All of these factors need to be recognized in cost control efforts that ultimately must balance the uncertainties of treatments with the realities of the federal budget.

The Physician as Advisor

The physician typically determines the number and type of health care services a patient will receive. Most Medicare beneficiaries are in the traditional fee-for-service program, in which the patient can choose which physicians or providers to consult. An important feature of this fee-for-service

Observed geographic variations in spending suggest that patient needs and also financial incentives help determine the services delivered.

environment is that physician income typically is directly correlated with the number and type of services provided. Certainly, treatment decisions predominantly reflect physician judgment, patient needs, preferences, and other clinical considerations, but particularly when appropriate care is uncertain or needs are ambiguous and the patient is covered by insurance, there are financial and cultural incentives to provide more services.

Congress has long been concerned about the role of financial conflicts of interest in contributing to increases in health care spending. A 1994 study demonstrated that physicians who had a financial interest in a laboratory ordered more tests from that laboratory for their patients than other physicians.²³ This and similar evidence contributed to the adoption of the so-called Stark anti-referral laws, which limit the ability of physicians to refer patients to facilities (such as a freestanding laboratory or an imaging center) in which they are part owners.²⁴ However, the limits do not apply to the services, procedures, pharmaceuticals, and laboratory tests physicians provide in their own offices. Delivering these services on the spot is convenient for the patient and may improve the continuity and timeliness of care. However, these are some of the very services that have shown the fastest growth.

Is More Better?

Substantial geographic variation in health care utilization has been well documented over many years.²⁵ For example, from 1999 to 2002, evaluation and management services per beneficiary varied over two-fold across the 50 largest metropolitan areas.²⁶ Imaging and tests each varied over three-fold. Geographic areas with higher use of health care services have not been shown to have higher quality of care. In fact, some evidence indicates the contrary. Quality of care, measured by use of some preventive measures and effective treatments, is lower in high-use areas. Appropriate service use did not always increase with increases in aggregate use.²⁷

Physician and hospital availability is related to the use of services. Areas with higher use of discretionary services tend to be those with a larger supply of physicians and hospital resources. Areas with higher spending tend to have a higher proportion of physician specialists and fewer primary care physicians. Unmeasured quality or need differences likely explain some of the differences in utilization. These factors, however, are unlikely to account for the full magnitude of the difference.

What Are the Best Practices?

The lack of agreed-upon standards for care may contribute to some of the observed variability as well as the growth in service use. A recent study by researchers at the Dartmouth Medical School found that the number of physician visits for similar patients with a terminal condition varied from an average of 50 visits during the last six months of life in one area

to less than 16 in another.²⁸ The researchers concluded that: “Evidence-based medicine plays virtually no role in governing the frequency of use of supply-sensitive services. Medical textbooks contain few evidence-based clinical guidelines concerning when to hospitalize, admit to intensive care, refer to medical specialists or, for most conditions, when to order diagnostic or imaging tests for patients at given stages in the progression of chronic illness.”²⁹

Although more health care is not necessarily better health care, underuse is also a problem. When there are protocols for treating particular conditions, they are not always followed.³⁰ Widespread failures to provide recommended care were documented in an analysis conducted by the RAND Corporation. For example, only 24 percent of patients with diabetes received the tests recommended to monitor this condition over a two-year period. Findings were similar for other chronic conditions, which indicates that more widespread adherence to guidelines may further increase service use.

The Connection Between Pricing and Volume

One issue widely discussed prior to the adoption of Medicare’s fee schedule was whether, or the extent to which, physicians create demand for their services to maintain or raise their income. The Congressional Budget Office and CMS, in estimating the budget impact of physician payment changes, included a “behavioral offset” based on evidence that at least some of the savings achieved by lowering fees would be offset by an increase in utilization. A 1998 CMS study of changes in fees for particular services and changes in the utilization of those services concluded that increased service intensity “is more frequently observed in physician practices that have had price reductions.”³¹

The profitability of individual services may affect their utilization.³² While Medicare fees are intended to reflect the relative resources required to provide each service so that no service is more profitable than another, the measurement of relative resources for the over 6000 different physician services is difficult. MedPAC posited that some overvalued services may be oversupplied because they are more profitable to provide than others. Undervalued services may also be oversupplied if providers seek to maintain their overall level of net revenues. Alternatively, physicians may stop delivering undervalued procedures altogether if the payments fall too far below the costs of delivery.³³

Medicare fees are intended to reflect the relative resources required to provide each service.

Singling Out Physicians

Physicians have direct financial incentives to provide more services in a fee-for-service environment. Those financial incentives are moderated somewhat for other categories of health care services because of two features of

payment and coverage. First, Medicare relies on physician monitoring and prescribing to control the amount and types of services provided in health care facilities. For a beneficiary to receive home health care, for example, a physician must approve a plan of care every 60 days, in part to ensure that home health care is actually needed. Similarly, physicians have to admit patients to and discharge them from hospitals. This reliance on a physician's professional judgment with respect to whether these services are needed is some check on utilization. The decision about the need for the service is not made by the provider that would directly benefit financially from delivering the service.

The second payment feature that moderates other providers' incentives for delivering more care is that payments for institutional providers generally are for a bundle of services, so the provider does not receive higher payments for providing more services. For home health care, Medicare pays the agency for providing 60 days of care, regardless of the actual number of visits provided.³⁴ Although the payment is adjusted based on characteristics of the patient and the treatment, it would be the same whether a patient received 10 visits from the home health agency or 15. Similarly, a hospital is paid for an entire stay, with the amount adjusted based on patient characteristics that are known to affect treatment costs. As a result, the hospital is financially rewarded for reducing its costs by controlling service use and lengths of stay. Home health agencies and hospitals still have strong incentives to seek additional patients; however those incentives are moderated by the requirement that a physician determine the need for admission.

CONCLUSION

Controlling spending on physician services is challenging. Advances in medical knowledge and technology continue to increase the number of patients who can benefit from the services and treatments available. Ensuring that Medicare beneficiaries have access to these medical advances requires appropriate and adequate physician payments. However, the ability and willingness of society to continue to sustain the level of physician spending growth seen over the last few years may be eroding.

The physician plays a key role in sorting through medical information and proposing patient treatment options. A variety of factors, such as clinical indicators, treatment protocols, patient preferences, and physician practices, influence the amount and type of physician services a patient receives. In many situations, there may be little consensus over appropriate service use or optimal treatments. This climate of uncertainty, particularly when physicians may financially benefit from one treatment choice over another, contributes to concerns about the value of at least some of the recent growth in the volume and intensity of physician services.

Medicare's spending on physician services is determined by numerous decisions made between physicians and their patients on the basis of clinical judgment, preferences, and particular circumstances. In these decisions,

the physician remains the key source of information, as even the best-informed patients and the Medicare program must rely on physician expertise in determining the appropriate treatment. Global assessments of the value to society of additional spending are extremely difficult because they may conflict with the individual decisions that contribute to spending. The debate will continue over how to ensure appropriate fees to maintain beneficiary access, the best approach for the Medicare program in controlling spending, and the role of the physician in achieving value.

ENDNOTES

1. This does not include beneficiary cost sharing. *2006 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, May 1, 2006, available at www.cms.hhs.gov/ReportsTrustFunds/downloads/tr2006.pdf; and *2005 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, March 23, 2005, available at www.cms.hhs.gov/ReportsTrustFunds/downloads/tr2005.pdf.
2. Intensity is the quantity and quality of the resources used to provide a service. Intensity increases, for example, when an MRI (magnetic resonance imaging test) is substituted for an x-ray.
3. In this paper, physician spending refers to the Medicare outlays for services paid for under the physician fee schedule. These are predominantly services provided by physicians but under certain circumstances may include services provided by other health professionals, such as therapists or nurse practitioners. The fee schedule is called the resource-based relative value scale, or RBRVS.
4. Under the charge-based systems, physicians were paid the lowest of what they billed for a service, the median of what they had billed for the service in the prior year, or a limit based on what physicians in the area had historically billed for the service.
5. For a discussion of Medicare's spending target, called the sustainable growth rate methodology, please see the forthcoming National Health Policy Forum Issue Brief, "Medicare's Sustainable Growth Rate for Physician Fees," scheduled for release in October 2006.
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Endnotes / continued ►

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14. See, for example, David M. Cutler and Mark McClellan, "Is Technological Change in Medicine Worth It?" *Health Affairs*, 20, no. 5 (September/October 2001), pp. 11–29; available at <http://content.healthaffairs.org/cgi/reprint/20/5/11?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=&author1=Cutler&andorexactfulltext=and&searchid=1&FIRSTINDEX=0&resourcetype=HWCIT>; and Jonathan S. Skinner, Douglas O. Staiger, and Elliott S. Fisher, "Is Technological Change in Medicine Always Worth It? The Case of Acute Myocardial Infarction" *Health Affairs* Web Exclusives, 25, no. 2 (February 7, 2006), pp. w34–w47.
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34. A per diem payment method is used if a patient receives fewer than five home health visits.



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