Medicare Spending on Physicians — No Easy Fix in Sight

Joseph P. Newhouse, Ph.D.

Medicare’s method of payment to physicians has been a thorny problem since the program began more than 40 years ago. Medicare’s initial method for setting fees mimicked the typical system used by the Blue Shield plans of the 1960s: payment for the lowest of usual, customary, or reasonable fees. Twenty-five years later, the resulting fee schedule made little sense; individual physicians were paid grossly different amounts for providing identical medical services, with large variations across different geographic areas. As a result, Medicare adopted the resource-based relative-value scale in an attempt to tie relative fees to the amount of work and practice expense involved in delivering specific services.

Henceforth, Congress would simply determine the dollar value of a unit on this scale; the Centers for Medicare and Medicaid Services would determine the relative value of each service. The resource-based relative-value scale was introduced amidst a widespread view that physicians who performed evaluation and management services were underpaid as compared with those who performed procedures, in part because physicians performing new procedures tended to become more adept at them over time, and therefore the cost per procedure decreased (alternatively, physicians could perform more such procedures in a day). A similar scenario was less plausible for evaluation and management services. Medicare fees, however, often did not decrease commensurately with any reduction in cost. As a result, many procedures were thought to have become highly remunerative and perhaps were performed too often as a result. Moreover, there was some concern that the underpayment for evaluation and management services was leading to a dearth of primary care physicians.

Perhaps surprisingly to those involved in the initial reform, the concerns about potential underpayment for evaluation and management services have persisted, along with concerns that this underpayment has contributed to a shortage of primary care physicians. In this issue of the Journal, Maxwell et al. examine how the distribution of payments under Medicare’s fee schedule changed over the decade from 1992, when it was introduced, through 2002. They show that, as the reformers intended, the relative values or fees for evaluation and management services increased 20%, whereas those for imaging, major procedures, and other procedures decreased 1 to 15%.

Despite the fee increase, Maxwell and colleagues report that in 2002 the share of Medicare spending on physicians for evaluation and management was exactly where it was in 1992 — 49.5%. How could this be, given the large increase in relative fees? Considering just the service codes that existed in 1992, the quantity of evaluation and management services grew 18% over the following decade, but the quantity of imaging services soared some 70% and the quantity of nonmajor procedures increased 21%. Thus, the disproportionate increase in the quantity of imaging services offset the relative increase in the fees for evaluation and management services. Moreover, Maxwell et al. show that almost a quarter (10.4% of 44.9%) of the growth in the total quantity of physicians’ services was attributable to the introduction of new codes, few of which were for evaluation and management services, since new codes are much more likely for imaging, procedures, and tests.

However, if the fee Medicare pays actually reflects the resources used in evaluation and management services — the intent of the resource-based relative-value scale method — why do so many primary care physicians feel shortchanged? Among the reasons is a formula that Congress has used since 1998 to limit the growth in spending on physicians’ services per Medicare beneficiary to approximately the rate of growth in the gross domestic product. Because of this limit, spending for evaluation and management services is reduced to accommodate the surges in imaging services and new codes. In fact, for the past 6 years, the formula has indicated that fees should be cut. Since 2003, Congress has ignored the formula, but it has either given below-inflation increases or simply frozen fees. The net result is that Medicare payments to physicians for evaluation and management services have not increased.

The data described by Maxwell et al. also point to a second explanation for why payments for evaluation and management services have not been higher. Although the resource-based relative-value scale may have better aligned fees with costs than
the old method based on the Blue Shield system, the cost of new procedures often decreases over time. In principle, any such decreases are to be accounted for by an annual review of relative fees and a more intensive 5-year review, but in practice this mechanism has been flawed. Initial errors should have been equally likely to have been high or low, so correcting them should have led to roughly equal numbers of fee increases and decreases. Since new procedures generally become less costly to perform as they become part of routine practice, on balance the reviews should have decreased more fees than they increased. Maxwell and colleagues, however, show that exactly the opposite happened. Relative fees are almost never reduced in the review process and are frequently increased; they rose fully 82% of the time in the first 5-year review. This increase probably stems from the “squeaky wheel syndrome” — services that are relatively undervalued are more likely to generate complaints and hence enter the review process than services that are overvalued. Although the overall spending limit prevents such asymmetric changes from generating increases in Medicare spending on physicians, the net result may well be a distorted relative-value scale.

Unfortunately, neither the spending limits nor the asymmetric review process is likely to disappear. The overall pressure on the federal budget and the large share of it that Medicare represents, 17% in 2007, will probably keep the increases in Medicare spending on physicians’ services modest. Many procedures that become less costly over time may well continue to fly under the radar of the review process. With no easy fix in sight, Medicare spending on physicians will probably remain a thorny issue.

Dr. Newhouse reports serving on the board of directors of and holding equity in Aetna. No other potential conflict of interest relevant to this article was reported.

From the Department of Health Care Policy, Harvard Medical School; the Department of Health Policy and Management, Harvard School of Public Health — both in Boston; and the Kennedy School of Government, Cambridge, MA.