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Survey of Health Plans Concerning Physician Fees and Payment Methodology

A study conducted by
Dyckman & Associates for the
Medicare Payment Advisory Commission

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Dyckman & Associates

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SURVEY OF HEALTH PLANS CONCERNING PHYSICIAN FEES AND PAYMENT METHODOLOGY

PREPARED FOR:

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EXECUTIVE SUMMARY

The Medicare Payment Advisory Commission (MedPAC) sponsored this survey of private health plans to obtain information regarding characteristics of physician payment methodologies and fee levels used by private health plans, and how these have been affected by recent Medicare physician fee changes. We surveyed health plans that operate in different geographic regions, and in environments with different demographics, competitive market conditions and managed care characteristics. Specifically, this report provides information obtained from private health plans on:

- Characteristics and recent changes in physician service markets
- Physician payment system characteristics
- Primary factors that influence changes in fee levels, particularly Medicare fee change decisions
- Payment methodology used for physician-administered drugs
- Fees used by health plans' primary benefit plans and how they compare to Medicare fees
- 2001-2002 health plan fee changes

The findings and conclusions included in this report are based on completed interviews with 33 health plans with a combined commercial enrollment of more than 45 million members, and analysis of physician fee schedules that are used for approximately 31 million members. The interviews were conducted from October through December 2002. Provided below is a summary of the report's primary findings based on the health plan interviews, supplementary data provided by the health plans and the physician fee survey.

Characteristics of Physician Service Markets

- Physician service markets vary in how physicians are organized. In the majority of markets, most physicians practice in small, single specialty groups. Other markets include many physicians in large, single specialty groups, multi-specialty groups and physicians consolidated in physician-hospital organizations (PHOs) and independent practice associations (IPAs).

- Large physician groups, sole area providers, PHOs and IPAs frequently seek to negotiate higher than standard fees; some health plans negotiate, others do not negotiate, but then risk provider withdrawals from their networks.

- Anesthesiologists, radiologists and other hospital-based physicians are the most aggressive specialists in terms of seeking higher fees; they typically have exclusive contracts with one or more hospitals and have substantial leverage in negotiating fees with health plans.

- There is increased physician consolidation in most markets, most commonly into large, single specialty groups and into more loosely structured organizations. Pressure from physicians to negotiate special fee arrangements has increased in most markets over the past two years.

- Most health plans report either stable or increasing physician network participation rates.

- Most health plans believe that the 2002 Medicare fee reduction and likely further fee reductions are increasing pressure on them for higher fees.[1] Other sources of fee pressure are rising malpractice rates and other practice expense increases. As discussed below, however, none of the plans reported that the Medicare reduction had a strong, direct impact on 2002 and 2003 fee decisions, other than for provider-specific contracts where fees are tied to Medicare fees.

- The median reported current health plan physician claims cost trend, inclusive of price, utilization, and mix changes, is 11.0%. The mean trend is 11.9%. The 2000-01 Medicare trend is 10.1%.

Physician Payment System Characteristics

- All of the health plans' fee schedules for their primary (largest enrollment) benefit plans have been influenced by resource-based relative value scale (RBRVS) methodology. The fee schedules fall into one of the following categories:

Fee Schedule Type	Number of Plans	Percent of Plans
1) RBRVS Fee Schedule – Use in a consistent fashion 2000-02 Medicare relative value units (RVUs) and 1-3 conversion factors (CFs)	13	39%
2) RBRVS Type Fee Schedule – Use 2000-02 Medicare RVUs, 4 or more CFs and/or make other fee adjustments for specific CPT codes or code ranges	7	21%
3) Fee Schedule Loosely Inspired by RBRVS Methodology – Use 1999 or earlier Medicare RVUs as a guide and/or move over time towards Medicare RBRVS relative fee values. Fee relationships vary considerably from RBRVS relative values.	13	39%

- Of 20 health plans that use RBRVS or RBRVS-type fee schedules, 13 use fees based on area Medicare fees and 7 based on national average Medicare fees; 10 use a site-of service differential and 10 pay for all services based on non-facility fees.

- Frequency of general fee schedule changes:
  Annually: 61% 1.5-3 years: 12% As needed: 27%

- Average health plan anesthesia conversion factors (CF) for base and 15 minute time units range from $31 to $52; mean and median CFs are both approximately $43, which is about 160% above the 2002 Medicare CF of $16.60.

[1] At the time of the health plan survey, 2003 Medicare fees were scheduled to decrease by 4.4 percent. Legislation enacted in February 2003 resulted in a fee increase of 1.6 percent instead of a fee reduction.

- Medicare pays physicians at 95% of "average wholesale price" (AWP) for physician-administered drugs. Most health plans set prices at either 95% or 100% of AWP; 22% pay 85-90% of AWP; 22% pay 101-115% of AWP. One third of health plans expect to move to more aggressive pricing in 2003.

Factors that Influence Physician Fee Decisions

When health plans were asked to identify the factors that they consider in making decisions regarding physician fee changes, the most important factors are:

1. Impact of fee changes on claims cost and premiums
2. Impact on plan's ability to maintain an adequate provider network
3. Parity/consistency with competitor fee levels

Desire to achieve specific proportionate relationship between plan fees and Medicare fees is not considered "very important" to any plan, but is "moderately important" to half the plans.

None of the plans indicated that 2002 or likely 2003 Medicare fee cuts has a strong or direct impact on their 2002 or 2003 fee decisions, other than in cases where provider fee contracts specify that fees are set at a specific percent of Medicare fees. However, approximately half the plans indicated that it has a moderate impact.

Physician Fee Survey

Physician fees for a sample of 104 common procedure codes were collected from 33 health plans. Fees for a total of 68 separate fee schedules were analyzed. These fee schedules include those used for PPO, HMO, POS and traditional/indemnity programs that cover approximately 31 million health plan members. The following table summarizes the fee survey findings.

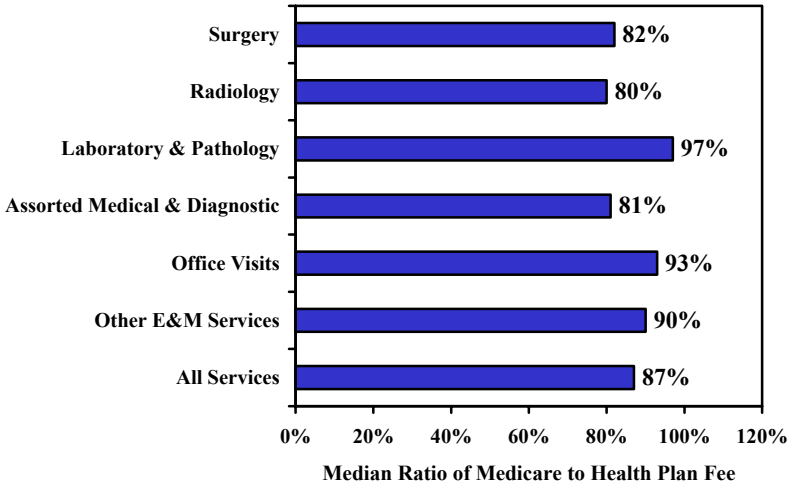
Comparison of 2002 Medicare to Health Plan Fees, and 2001-2002 Fee Changes, All Physician Services

	Median	Mean
	Medicare Percent of Health Plan	
2002 Medicare Carrier Compared to Health Plan Fees	87%	89%
2002 National Average Medicare Compared to Health Plan Fees	88%	90%
	2001-2002 Fee Change	
Percent Change in Fees, 2001-2002	3.4%	3.4%

There is considerable variation among type of service (TOS) categories in the ratio of Medicare to health plan fees. Median ratios of Medicare to health plan fees by TOS category are shown in the bar chart below. For Surgery, Radiology and Assorted Medical & Diagnostic procedures, Medicare fees are about 20 percent below health plan fees while the differential is 10 percent or

less for Laboratory & Pathology, Office Visits and Other Evaluation & Management (E&M) Services.

Comparison of 2002 Medicare Carrier to Health Plan Fees by Type of Service Category



The survey findings indicate that 2002 Medicare fees for all physician services combined are 10-15 percent lower than private health plan fees. The Medicare-health plan fee differential may be several percentage points larger than this, primarily because the sample of fee schedules for the study largely excluded small health plan and provider-specific negotiated fee schedules. Fees under these fee schedules tend to be somewhat higher than under those fee schedules examined in this study.

Additional findings from analysis of fee survey data relate to selected characteristics of the health plans and their service areas:

- The average ratio of Medicare to health plan fees is higher in the Northeast than in other geographic regions. Health plan fees are lower in the Northeast than in other regions.
- Health plan fees, on average, are higher in rural and small urban areas than in large metropolitan areas.
- There is a negative correlation between health plan fees used in specific geographic areas and the associated Medicare geographic adjustment factors used for physician services.

The Medicare geographic adjustment process for physician fees is intended to improve the equity of physician payment methodology, by adjusting fees to reflect geographic differences in physician practice input prices. Study findings of higher health plan fees in areas where Medicare geographic adjustment factors are lowest strongly suggest that factors other than physician practice input prices have a significant impact on market prices for physician services.

SURVEY OF HEALTH PLANS CONCERNING PHYSICIAN FEES AND PAYMENT METHODOLOGY

CHAPTER 1. PROJECT OBJECTIVES AND OVERVIEW OF METHODOLOGY

BACKGROUND AND PROJECT OBJECTIVES

Medicare is the largest single payer for physician services, accounting for 21 percent of the $286 billion spent for physician services in calendar year 2000.[i] However, private health insurers as a group account for a much larger share of physician expenditures, 48 percent[ii]. Both Medicare and private payers purchase physician services in the same physician service markets, which are largely local rather than national in character. As major purchasers, there is significant interdependence between Medicare and private health plans, with each likely influencing and being impacted by the other. The nature of these influences and impacts may differ depending on characteristics of local physician service markets.

The Medicare Payment Advisory Commission (MedPAC) sponsored this survey of private health plans to obtain information regarding characteristics of physician payment methodologies and fee levels used by private health plans, and how these have been affected by recent Medicare physician fee changes. We surveyed 34 health plans that operate in different geographic regions, and in environments with different demographics, competitive market conditions and managed care characteristics. Specifically, this survey provides information obtained from private health plans on:

- Characteristics and recent changes in physician service markets
- Physician payment system characteristics
- Primary factors that influence changes in fee levels, particularly Medicare fee change decisions
- Payment methodology used for physician-administered drugs
- Fees used by health plans' primary benefit plans and how they compare to Medicare fees
- 2001-2002 health plan fee changes

This information may provide MedPAC and the participating health plans with insights that can be helpful in developing recommendations for possible changes in physician fees and in the underlying physician payment methodology.

OVERVIEW OF STUDY METHODOLOGY

The study methodology included four primary tasks. These are each described briefly below.

Secure Health Plan Participation in Survey

Survey participation letters were sent out to 118 executives and senior staff at approximately 60 health plans, including Blue Cross Blue Shield plans and national managed care-health insurance companies. The health plans were assured of complete confidentiality of any information provided to us, and that even the names of participating plans would not be released. As an inducement to participate, we offered the plans a report of study findings with which they could compare their own experience and fees with summary data from other participating plans.

While we had projected that 10-12 health plans would participate in the study, 34 plans agreed to participate. For purposes of the study, each individual Blue Cross Blue Shield plan is considered a participant, even if it is part of a parent organization that operates several plans in different states. For national managed care companies, a company was asked to identify three different markets in which they have sizable enrollment for participation in the study, and each market is considered a separate health plan. A total of 34 health plans have provided information and/or fee data for the study; interviews have been completed with 33 plans and 33 plans submitted fee schedule data in response to the physician fee survey.

Exhibit 1 provides summary information regarding the participating study plans. The study health plans are well dispersed in terms of region and demographic environment. They serve the full range of environments, from largely rural areas to heavily urbanized areas, including most of the Nation's largest cities.

Exhibit 1. Distribution of Study Health Plans by Region and Largest Metropolitan Statistical Area (MSA)[iii] in Health Plan Service Area

Region	Health Plan: Largest Metropolitan Statistical Area Category				Total	Percent
	Less than .5 million	.5 to less than 1 million	1-3 million	Greater than 3 million		
Midwest	3	1	4	2	10	29%
Northeast	1	0	1	5	7	21%
South	0	2	2	5	9	26%
West	1	1	4	2	8	24%
Total	5	4	11	14	34	
Percent	15%	12%	32%	41%		

The participating study health plans offer a range of benefit plan types, including health maintenance organization (HMO), point of service (POS), preferred provider organization (PPO)

and traditional/indemnity plans. It is useful to understand that these benefit plan types are not defined in a consistent manner within the health care industry. For example, a POS plan may be categorized as an open-access HMO plan, a gatekeeper PPO plan, or its own distinct type of plan. Similarly, some may characterize a network-based plan that provides the same reimbursement for both in-network and out-of-network providers as a traditional/indemnity plan while others may characterize it as a PPO plan, because it provides full benefits for in-network providers and partial benefits (provider can balance bill above the allowance) for out-of-network providers. With these definitional caveats in mind, it is helpful prior to considering the study findings to compare the distribution of benefit plan types among participating study health plans with the distribution within the universe of health plans.

We obtained estimated enrollment of the participating study health plans by benefit plan type. For 24 of 33 plans interviewed in this study, the plan type with the largest share of enrollment is a PPO plan. For seven plans, the largest share of enrollment is in an HMO type plan and for two it is in a traditional/indemnity plan. Exhibit 2 provides more detail regarding the enrollment distribution by benefit plan type for the study health plans compared to data obtained through a national employer survey. The 2002 survey was conducted by the Kaiser Family Foundation and the Health Research and Educational Trust (Kaiser-HRET). [iv]

Exhibit 2. Distribution of Health Plan Enrollment by Benefit Plan Type, 2002

Benefit Plan Type	Distribution of Study Plan Enrollment (45 million)	Kaiser-HRET Distribution of Health Plan Enrollment
HMO	28%	35%
PPO	60%	61%
Traditional/Indemnity	12%	5%
Total	100%	100%

A number of study plans include POS enrollment with their HMO enrollment, others include POS enrollment with their PPO enrollment, while still others report POS as its own plan enrollment category. For both the study plans and the Kaiser-HRET survey data in Exhibit 2, one half of the separately reported POS enrollment is allotted to the HMO category and one half to the PPO category.

The data on enrollment by benefit plan type in Exhibit 2 indicates a similar distribution of enrollment between the study plan data set and the Kaiser-HRET employer survey. While the traditional/indemnity enrollment percentage is greater for the study plans than for the Kaiser-HRET survey, the latter may include only "pure indemnity" plans (those without a contracted provider network) in this category. This study includes many Blue Cross Blue Shield plans that tend to use a broader definition of traditional and indemnity plans. This could account for the larger proportion of traditional/indemnity plans in the study sample of plans than in the Kaiser-HRET survey data.

Survey Health Plans Regarding Physician Service Market Characteristics and Physician Payment Methodology

We scheduled and conducted structured phone interviews with executives and senior staff of each participating health plan. An interview overview was e-mailed to the primary plan representative for the study prior to the interview so that individuals with relevant expertise would participate (i.e., knowledge of health insurance market characteristics, physician market characteristics, provider relations and physician reimbursement). The interview overview is provided as Attachment A. A more detailed and structured interview guide was used to conduct the interviews.

The interviews were generally completed in 90-120 minutes. Typically, 2-3 individuals participated in the interview and, combined, were knowledgeable in the areas of health insurance and physician service market conditions, provider relations, and physician reimbursement. In some cases, as many as ten health plan staff participated in the interview. Interview participants ranged from mid-level managers to senior plan executives. Where local health plans were part of national managed care companies, interviews were conducted at both the corporate and individual market health plan levels.

Conduct Physician Fee Survey

We prepared a list of commonly performed physician services that included current procedural terminology (CPT) codes within each of the primary categories of physician services. The list of 104 sample codes, including diagnostic tests with professional and technical components, was finalized after review by MedPAC staff. The list of 104 codes is provided as Attachment B.

A fee data entry electronic worksheet was prepared which facilitated convenient data entry for 2001 and current 2002 fees for up to four fee schedules per health plan. The fee data could represent fees used in different locations within the health plan's service area or fees used for different type benefit plans. As a guide, health plans were asked to provide fee data for those plans with the greatest enrollment. The fee data entry worksheet was e-mailed to the participating health plans on October 25, 2002, with instructions to return the completed survey by November 8, 2002. Thirty-three of the health plans that volunteered to participate in the study returned completed fee surveys.

The fee data submissions were reviewed for completeness, internal data consistency, and possible errors. Most of the fee data submissions were complete, covering all or almost all of the sample codes, and with few if any errors. Follow-up contacts were made to check on suspect data and to provide clarifications and additional information as required.

Analyze Findings

The health plan interview findings were summarized and compiled into a health plan information matrix. This facilitated the determination of patterns across the findings from the individual health plan interviews and the development of the findings and conclusions that appear in the body of this report. Findings related to physician market characteristics are provided in Chapter

2 and characteristics of physician payment systems and factors that influence physician fee change decisions are discussed in Chapter 3.

National average Medicare fees and area-specific Medicare fees were compared to health plan fees on an individual code level, by major type of service category, and for all physician services combined. In addition, we computed fee changes between Fall 2001 and Fall 2002 for the same categories of services. The results of this analysis are provided in Chapter 4.

Possible Sample Biases

The fee data analyzed in this study comes from a large, geographically dispersed sample of health plans. The fee database includes fees from all benefit plan types (indemnity, PPO, and HMO) and from markets with different demographic characteristics. However, the sample of fee schedules is not a random sample of fee schedules used for private sector health insurance coverage. The sample of fee schedules:

1. Is somewhat over-representative of Blue Cross and Blue Shield plans
2. Does not include third party administrator (TPA) and small commercial (non-Blue Cross) health plans
3. Is very under-representative of provider-specific fee schedules (only a few included in the sample)

Relative to the average of all fees used under private health insurance arrangements, Issue 1, noted above, could result in a very small bias in either direction. Issue 2, considered by itself, probably results in the study health plan fees being slightly lower than true fees. Issue 3, considered by itself, almost certainly results in study plan fees being lower than true fees as provider-specific fee schedules are almost always higher than the health plan's standard fee schedules.

An additional factor that may result in some bias in the Medicare-health plan fee comparison relates to Medicare using a facility/non-facility fee differential for some procedure codes while only about one third of the health plans use this type of fee differential. We conducted a fee comparison using only non-facility fees. This may result in our overstating Medicare fees by 2-3 percent relative to health plan fees.

Considering all known possible sources of sample bias, the Medicare-health plan fee differential may be understated by several percentage points in the fee survey findings reported in Chapter 4.

CHAPTER 2. OVERVIEW OF PHYSICIAN MARKET CHARACTERISTICS

It is important for major purchasers of a product or service to have a good understanding of the characteristics of the market in which the product or service is sold. This information would include product characteristics, supply and demand conditions, transaction prices, major sellers and purchasers in the market, and factors that may interfere with competitive pricing, either causing prices to be higher or lower than expected under true competitive market conditions. In the market for physician services, which may be considered to include multiple sub-markets for different specialty services, if the price is too high over a sustained period, it could result in wasteful expenditures and may induce a misallocation of resources, i.e., an oversupply of the particular service and an undersupply of other services. If the price is too low, it could result in an inadequate supply of the physician service (e.g., enrollee access problems) and poor quality care. It is also important to note that physician service markets, while impacted by regional and national factors, are largely local, and differences in prices, provider organization, and supply-demand imbalances may exist even in nearby markets.

This study is intended to provide MedPAC and the participating health plans with current information regarding physician market characteristics and recent changes in those characteristics. All of the study health plans are active participants and major purchasers in their respective markets. As shown in Exhibit 3 below, all of the study health plans have a self-reported market share of at least 10 percent and most have a market share of at least 25 percent. The study health plans have a combined commercial (non-government program) enrollment of more than 45 million.

Exhibit 3. Distribution of Study Health Plans by Region and Market Share

	Health Plan Commercial Enrollment Market Share*					
Region	**10-24%**	**25-49%**	**50% & higher**	**Not Provided**	**Total**	**Percent**
Midwest	1	4	4	1	10	29%
Northeast	1	2	4	0	7	21%
South	1	6	1	1	9	26%
West	2	5	1	0	8	24%
Total	5	16	10	2	34	
Percent	15%	50%	29%	6%		

* Market share is defined as health plan commercial market (non-government plan) enrollment divided by total private health insurance enrollment.

Supply – Demand Conditions

The existence of shortages or excess supply of physicians has obvious implications for access, but also has implications for cost, as there may be additional fee pressure for physician services where shortages exist. We asked the health plans to discuss the overall supply-demand conditions for physician services, and whether shortages exist for specific specialties and in specific portions of their service area. For this topic, we focused on the availability of physicians in the community, not availability within the health plan's networks. Surprisingly, none of the surveyed health plans indicated that they are experiencing an overall shortage of physicians, even those operating in rural states with relatively low physician population ratios. Typical comments for plans that serve rural areas were that "our members understand they have to drive awhile to see a specialist" and "we are used to driving to the city to see a specialist." A number of those interviewed indicated that there was a maldistribution of physicians within their service area, with adequate or oversupply in the cities and selective shortages in rural areas.

Several plans identified specific specialties for which they believed there was an inadequate supply of physicians. Those specialties that were mentioned in three or more interviews are listed in Exhibit 4. For obstetrics/gynecology, the shortage is primarily for obstetrics, as some physicians have stopped doing deliveries because of very high malpractice insurance rates. Several additional plans indicated that they are not yet experiencing a shortage for obstetrics, but that they have significant concerns about an upcoming shortage.

Exhibit 4. Specialties Identified as Having an Inadequate Supply

Specialty	Number of Plans Indicating Shortage
Neurosurgery	5
Anesthesiology	4
Gastroenterology	4
Orthopedics	3
Obstetrics/gynecology	3

Physician Affiliation and Physician Consolidation

There is some anecdotal evidence as well as findings from recent studies that physicians have become more aggressive in dealing with health plans over fee and other payment issues.[v] According to some sources, this has been manifest in more network disruption, greater pressure on health plans for higher fees and more provider-friendly payment policies, and physician class action law suits against health plans. In this health plan survey, we focused on developments in the physician services market that may affect changes in physician fees.

We asked the health plans to describe how physicians are organized, what trends they are seeing in terms of physician consolidation and the extent to which there is now more or less health plan negotiation of fees with specific physician groups, instead of physicians accepting standard area-wide fee schedules. We also asked whether some physician specialties are more aggressive in

terms of seeking higher than standard fee schedule fees than others. Survey findings regarding physician market characteristics, patterns and trends are summarized below:

- Substantial variation exists among markets in how physicians are organized. In the majority of locations, most physicians practice in small, single specialty groups. In other areas, many physicians practice in large multi-specialty groups and large, single specialty groups. In some markets, where academic medical centers exist, there are large faculty practices that may be organized into single specialty groups, multi-specialty groups or physician-hospital organizations (PHOs).

- In most markets, there are independent practice associations (IPAs) and PHOs that were established in large part to negotiate with payers for risk and fee-for-service contracts. However, these organizations are not always very active. While IPAs and PHOs are increasingly involved in fee negotiations in some markets, they are less involved than several years ago in some others. Several health plans report declines in activity of IPAs and/or PHOs at the same time as physician groups become larger and more active in fee negotiations. Other plans report little change in IPA and PHO activity.

- Small, single specialty groups that are not part of active IPAs or PHOs almost always accept standard health plan fee schedules, unless they are sole area providers in rural locations, when they may demand and successfully negotiate higher than standard fees.

- Large single and multi-specialty groups increasingly seek to negotiate higher than standard fees. Examples were provided of single specialty groups of 50 to more than 100 anesthesiologists, emergency room physicians, cardiologists, gastroenterologists, oncologists, orthopedists, radiologists and other specialists who have market shares of 50 percent or greater. In some markets, the study health plans negotiate separate fee agreements with large groups, while in other markets they do not.

- Approximately two thirds of the health plans report increased provider consolidation and increased pressure to negotiate higher than standard fees. The consolidation is most commonly in the form of mergers and acquisitions resulting in large, single specialty groups and, to a lesser extent, in multi-specialty groups.

- In several markets, health plans report single specialty physician groups affiliating, primarily for fee negotiation purposes, with management services organizations. In other markets, a business manager for a radiology or anesthesiology group has sought to negotiate fees for several groups within the same specialty.

- Hospital-based physicians (radiologists, anesthesiologists, pathologists, emergency room physicians and sometimes neonatologists) are considered by most health plans as the most aggressive specialties in terms of seeking higher fees. Physician groups in these specialties typically have exclusive contracts with one and sometimes multiple hospitals in an area and, according to the health plans, have substantial leverage or "monopoly power" in the market for their services. Among hospital-based physicians,

anesthesiologists and radiologists are seen by the health plans as the most aggressive in terms of seeking higher fees.

To summarize these findings, most health plans report increased physician consolidation, sometimes primarily for the purpose of improving their leverage in fee negotiations. Some plans have succumbed to pressures from specific provider groups to negotiate higher than standard fees. In some cases, plans have increased fees for all providers in the market for the specific services at issue rather than agree to provider-specific fee schedules. Other plans have held firm and have not agreed to higher fees, accepting the risk of the groups terminating their health plan network agreements.

We asked the health plans what proportion of physician payments is made based on standard benefit plan fee schedules and what proportion is made based on negotiated or "exception" fee schedules. The health plan responses are provided in Exhibit 5. A quarter of the health plans report at least 25 percent of payments are based on exception fee schedules.

Exhibit 5. Percent of Payments Based on "Exception" Fee Schedules

	0-4%	5-9%	10-24%	25-49%	50% & above	Health Plans Responding
Number of Plans	11	4	8	6	2	31
Percent of Plans	35%	13%	26%	19%	7%	100%

Network Participation

Health plans were asked to provide their physician network participation (PAR) rates for their primary benefit plans. The PAR rate is the proportion of practicing physicians in the plan's service area that are in the plan's provider network. Some health plans have a single PAR network for all of their products (traditional, PPO, POS and HMO), while others may have two or more distinct networks. Shown below in Exhibit 6 are health plan PAR rates by percentage category for the health plans' product with the largest enrollment. For most plans, this is a PPO, but for several it is a traditional, so called indemnity product, and for others it is an HMO. Approximately half of the plans have PAR rates of 90 percent or higher. Almost all of the health plans either experienced an increase in physician PAR rates or no decline over the past two years. Several plans indicated that, because of the growing preference among customers for open access programs and wide choice of providers, it is increasingly important to have a large physician network.

Exhibit 6. Physician Network PAR Rate for Health Plan Product with Largest Enrollment

	60-69%	70-79%	80-89%	90-99%	Health Plans Responding
Number of Plans	3	9	5	16	33
Percent of Plans	9%	27%	15%	49%	100%

The health plans were asked whether any particular specialties were problematic regarding retention in the health plan's networks. Of the 20 plans that mentioned specific specialty categories, more than half noted that anesthesiologists and/or radiologists presented problems, by either terminating their PAR provider agreements or threatening to terminate as part of the negotiation process to obtain higher fees.

Impact of Medicare Fee Reduction on Physician Fee Demands

A primary focus of this study is an assessment of the impact of Medicare fee reductions on private health plan fees. One of the questions asked during the interviews was whether Medicare fee cuts, with specific reference to the 2002 Medicare fee reduction, result in more or less physician pressure on the health plan for higher fees. Approximately two thirds of the health plans indicated that the Medicare fee cuts added to fee pressures, while the remaining third either were uncertain or thought that Medicare fee cuts may have reduced pressure for higher fees. There were several distinct themes that emerged based on responses to this question.

- Some physicians are very explicit that they need higher fees from health plans to make up for the 2002 Medicare fee cuts.

- Some physicians do not distinguish between Medicare relative value unit (RVU) reductions and a reduction in the 2002 conversion factor (CF); all they know is that their Medicare fees are lower and they need fee relief from private payers.

- Some physicians are upset about loss of income from several sources, including Medicare fee cuts, Medicaid fee cuts, malpractice premium increases, nurses' wage increases, higher health insurance premiums and other practice expense increases, and are looking to the health plans to help them maintain their income.

- Some physicians are more aggressive in their fee demands when Medicare fees are increasing, demanding that private payers match Medicare fee increases, while others put more pressure on health plans for increased fees when Medicare fees are reduced.

A number of health plan interviewees noted that, in response to Medicare fee cuts, some physicians are no longer accepting new Medicare patients or even dropping current Medicare patients. According to several of the interviewees, this physician reaction is particularly evident in rural areas, where many physicians have a large combined Medicare and Medicaid caseload.

CHAPTER 3. PHYSICIAN PAYMENT SYSTEM CHARACTERISTICS AND FACTORS THAT INFLUENCE PHYSICIAN FEE CHANGE DECISIONS

Much of the discussion during the health plan interviews concerned physician payment methodology. A related topic is the factors that are most important in determining the timing and magnitude of health plan fee changes. In order to provide context for the discussion of physician payment methodology, we start this chapter by providing data on physician claims cost trends experienced by the study plans.

PHYSICIAN CLAIMS COST TREND

The study health plans were asked to provide their most current per member per year (PMPY) physician claims cost trend. This figure is inclusive of change in price, utilization and mix of services. Some of the plans provided cost trend data for all professional services, which is a broader category than physician services. The data reflect either the 2000-2001 trend or more current experience. Summary statistics reflecting PMPY physician claims cost trend data for 31 health plans as well as for Medicare are provided in Exhibit 7. Eighteen of the health plans provided the cost trend data to the nearest tenth of a percent, strongly suggesting that internal cost trend reports were consulted. Most of the remaining 13 plans that provided cost trend data provided figures to the nearest percentage point while several provided a range estimate (e.g., 10-12 percent). For those plans that provided range estimates, we used the midpoint in the range as the trend data point.

Exhibit 7. PMPY Physician Claims Cost Trend
(2000-2001 trend or more current experience)

Medicare[vi]	Low	25th percentile	50th percentile	75th percentile	High	Mean
10.1%	6.1%	8.8%	11.0%	14.0%	25.0%	11.9%

PHYSICIAN PAYMENT SYSTEM CHARACTERISTICS

We obtained descriptions of the physician payment methodology used by the health plans for their major benefit plans. For 24 of 33 plans interviewed in this study, the plan type with the largest share of enrollment is a PPO plan. For seven plans, the largest share of enrollment is in an HMO type plan and for two it is in a traditional/indemnity plan.

Almost all of the health plans have some enrollment in a traditional/indemnity plan. Generally, these type plans use a contracted provider network for which the provider agrees not to balance bill the member for amounts above the fee schedule amount. Sometimes the health plan uses the same provider network and fee schedule for its traditional/indemnity plan as for its PPO plan.

Extent of Adoption of RBRVS Methodology

The following information regarding physician payment methodology is for the plan type (e.g. PPO, HMO, POS) with the largest enrollment for the health plan, although the same payment methodology is often used for more than one plan type. For all 33 health plans interviewed, the physician payment methodology used is at least somewhat influenced by Medicare resource-based relative value scale (RBRVS) methodology. While a number of plans use fee schedules that were historically based on usual, customary and reasonable (UCR) charges, all of the fee schedules have been modified over time so that relative fee values are closer to RBRVS relative fee values than in the past.

For descriptive and evaluative purposes, we have classified the physician payment methodology used by the study health plans into one of three categories:

1. RBRVS fee schedules – Use in a consistent fashion 2000-2002 Medicare RVUs and 1 to 3 conversion factors.

2. RBRVS type fee schedules – Use 2000-2002 Medicare RVUs, 4 or more conversion factors and/or make other adjustments to fees for specific CPT codes or code ranges.

3. Fee schedules loosely inspired by RBRVS methodology – Use 1999 or earlier Medicare RVUs as a guide and/or reflect some movement over time towards Medicare RBRVS relative fee values. Fee relationships vary considerably from RBRVS relative values.

Shown below in Exhibit 8 is the distribution of the 33 study health plans into these three payment methodology categories. Several of the health plans in Category 3 indicated that they expect to move more closely to full RBRVS methodology in 2003.

Exhibit 8. Distribution of Health Plans by Physician Payment Methodology Category

	1. RBRVS Fee Schedule	2. RBRVS Type Fee Schedule	3. Fee Schedule Loosely Inspired by RBRVS	Number of Study Plans
Number of Plans	13	7	13	33
Percent of Plans	39%	21%	39%	100%

Use of Current RVUs

Of the 20 study health plans that use RBRVS or RBRVS type fee schedules, 14 use 2002 RVUs, five use 2001 RVUs and one uses 2000 RVUs. Several health plans indicate that they prefer to change the RVUs every two or three years to avoid more frequent fee reductions for some physicians based on changing RVUs.

Use of Geographic Practice Cost Indices (GPCIs)

Medicare uses geographic practice cost indices (GPCIs) to adjust fees in different geographic areas for variation in physician practice expenses. Thirty-four states are assigned a single statewide GPCI by Medicare while the remaining 16 states have two or more GPCIs that cover specific regions of the state.[vii] Of the 20 plans that use RBRVS or RBRVS type fee schedules, 13 use GPCI-adjusted RVUs to set their fees. Seven use national RVUs that are not GPCI-adjusted. Among those plans that use geographic-adjusted RVUs, several use geographic definitions that are different than Medicare's GPCI definitions. For example, a plan may use the Medicare GPCI for a specific metropolitan area and apply it to the entire state, rather than use the multiple sets of GPCIs used by Medicare for the state.

Site-of-Service Differentials

For physician services that are performed by physicians in both the physician office and hospital or other facility setting, Medicare uses different fees to pay for the physician service, a facility fee and a generally higher non-facility fee. The higher non-facility fee is intended to compensate physicians for additional overhead and supply expenses that they experience in their office, that the facility experiences (and is reimbursed for) when the service is performed in the facility setting. Historically, most private health plans used Medicare non-facility fees as a basis for setting their own fees and used those fees regardless of where the services were performed. Within the past few years, more health plans have adopted the Medicare site-of-service differential, paying a lower fee when the service is performed in a facility setting.[viii]

Of the 20 health plans that use RBRVS or RBRVS type fee schedules, fifty percent use a site-of-service fee differential that is the same or similar to that used under the Medicare program. Three health plans provided data on claims cost savings resulting from use of the site-of-service differential. Savings will vary based on relative value of physician services in the office or facility setting. Two plans indicated that savings approximated 2 percent, while one plan, operating in a market with several large academic faculty practices in which more services are done in the hospital setting, estimated savings of 3.6 percent.

Physician Payment Methodology Used for Medicare Managed Care Programs

Almost half of the 33 health plans interviewed operate Medicare+Choice or Medicare Cost programs. We asked these plans to describe the physician payment methodology used for these programs. Information was obtained from 13 health plans:

- Four plans use the same fee schedule as under their commercial HMO program
- Two plans use a percentage reduction from their commercial HMO or PPO fee schedule
- Four plans use the Medicare fee schedule for the area
- Three plans use a Medicare-based fee schedule, either fees based on older RVUs or a fixed percentage above Medicare fees.

2002 Fee Changes

We asked each of the study health plans to provide us with the average percentage change in fees during 2002. Some plans provided fee change data for "Physician Services," while other plans provided data for "Professional Services," for which the largest component is physician services. The range among 27 plans that provided fee change data is from -2 percent to 8.7 percent. The mean and median fee changes are 3.4 percent and 3.0 percent, respectively. Summary fee change data are provided in Exhibit 9 below.

Exhibit 9. Health Plan Average Fee Change

	-2% to 0%	.1 to 1.9%	2.0 to 3.9%	4.0 to 5.9%	6.0 to 8.9%	Health Plans Responding
Number of Plans	2	7	7	8	4	28
Percent of Plans	7%	25%	25%	29%	14%	100%

Frequency of Fee Changes

Health plans were asked how frequently they generally changed their fee schedule. The question focused on a systemic or general change in fees for most codes, rather than updating CPT codes or RVUs, or modifying fees for only a relatively small number of codes. The pattern of fee changes is shown in Exhibit 10.

Exhibit 10. Distribution of Health Plans by Frequency of General Fee Changes

	Annually	1.5 to 3 years	As Needed	Health Plans Responding
Number of Plans	20	4	9	33
Percent of Plans	61%	12%	27%	100%

A number of the health plans that now annually change their fees indicated that this practice began only within the past few years. The last category of plans, "As Needed", includes several plans that have not significantly changed their fee schedule for four years or more and also includes several plans that do change their fees from time to time, but only when they believe that provider network and member access concerns require it. When the health plans change their fees, most do not use a consistent fee change percentage to adjust all fees, but focus the fee changes for those specialties and categories of service that they feel require fee increases or for which they believe fee reductions are appropriate.

Specialty and Type of Service Categories for which Pressure is Greatest to Increase Fees

The health plans were asked whether there were specific specialty or type of service categories, such as office visits, surgery or consultations for which they are experiencing more intense pressure to increase fees. Twenty-nine of the 33 health plans interviewed mentioned one or more specialties or categories of service for which they are experiencing considerable pressure to increase fees. Provided in Exhibit 11 is a listing of the specialties and categories of service that were each mentioned by three or more plans for which they are experiencing the greatest pressure to increase fees.

Exhibit 11. Specialties and Categories of Service for which Pressure to Increase Fees is Greatest

Specialties and Categories of Service*	Number of Plans Mentioning	Specific Comments
Obstetrics	11	Sharply rising malpractice costs; concern about maintaining adequate supply
Anesthesiology	10	Tremendous leverage in bargaining, "monopoly power," need to maintain in network to prevent unknowing patient from being balance billed
Orthopedics	10	Sharply rising malpractice costs, leverage in bargaining
Neurosurgery	9	Sharply rising malpractice costs, physician shortages
Hospital-Based Physicians	8	See Anesthesiology comments
Radiology	7	See Anesthesiology comments
Cardiology/Cardiovascular Surgery	5	Leverage, sole area providers
Evaluation & Management (E&M) Services	5	Fees below Medicare; need to increase
Pediatrics/Pediatric Subspecialties	4	Need to assure access; market leverage, sole area provider (for subspecialties)
Emergency Room Physicians	3	See Anesthesiology comments
Gastroenterology	3	Decreased Medicare RVUs and fees (if implement site-of-service differential)
Pathology	3	See Anesthesiology comments

* Note some duplication in the case of some broad specialty categories including other specialties that were also mentioned on several occasions by the plans.

Use of Provider Financial Incentive Programs

A number of health plans have, within the past year, announced plans to introduce provider payment incentives related to quality, service, member satisfaction and cost-effectiveness. We asked the study plans whether they are currently using financial incentives that could have a

significant impact (e.g., 5 percent or more) on physician revenue. For purposes of this study, we are not considering HMO capitation and risk sharing programs as incentive programs.

Several plans use financial incentives for performance in their HMO programs. However, in only a few cases, does the amount of the incentive payment equal more than one or two percent of total HMO physician payments.

With one exception, no plan is currently using financial incentives under its PPO or traditional/indemnity type programs, other than on a small pilot project basis. For the one plan that has an operational quality and member satisfaction incentive program for its PPO physicians, incentive payments account for approximately 5 percent of total PPO physician payments. Several plans did indicate that they believe in the value of "pay for performance programs," and expect to introduce or expand existing pilot projects for these type programs.

Anesthesiology Fees

Medicare and many private health plans pay for anesthesiology services based on the current American Society of Anesthesiologists (ASA) Relative Value Guide. The Relative Value Guide includes base and time units for different types of services, where the time unit is defined as 15 minutes. A dollar conversion factor is applied to the number of base and time units to arrive at a fee for a specific anesthesiology service. We compared health plans average or typical conversion factor to the $16.60 national Medicare conversion factor.

Health plans may differ with Medicare and among themselves in terms of their use of physical status and other modifiers, which can increase anesthesiology fees. We have not sought to adjust fees for these or other differences in anesthesia payment methodology. Several plans use 10 minute instead of 15 minute time units. In order to standardize for the impact of this time unit difference, we have adjusted the conversion factor for the plans reporting 10 minute time units by an arbitrary and possibly conservative 15 percent.[2]

Shown below in Exhibit 12 are mean, 25th, 50th and 75th percentile values of average health plan anesthesia conversion factors, as well as percent differences from the 2002 $16.60 Medicare conversion factor. The median health plan conversion factor is $42.90, which is 158 percent greater than the Medicare conversion factor. The range among plans of average health plan anesthesia conversion factors is $31 to $52.

Exhibit 12. Anesthesia Conversion Factors

	25th percentile	50th percentile	75th percentile	Mean
Health Plan Conversion Factor (CF)	$39.75	$42.90	$46.00	$42.65
Percent Difference from Medicare CF	139%	158%	177%	157%

[2] Fifteen percent is used instead of 50 percent because the base units are the same for both the 10 and 15 minute time units. One plan reported using a 12 minute time unit.

Prices for Physician-Administered Drugs

Medicare uses a pricing formula for physician-administered drugs, under which the price is set at 95 percent of "average wholesale price" (AWP). These are drugs that are administered using various infusion techniques in the home, physician office or facility settings to oncology patients and to other patients with serious medical conditions. Medicare pricing for physician-administered drugs has gained increasing focus within the past year in light of information that AWP prices are often higher than actual transaction prices for these drugs[ix].

Exhibit 13 provides information on the pricing formula used by the study health plans for physician-administered drugs. All of the plans use a percentage of AWP formula, although some use another pricing approach for some types of drugs (e.g., immunizations) and/or for some providers. As seen in Exhibit 13, most plans use an AWP pricing formula that is in the range of 90 to 100 percent of AWP. The average percent of AWP used by the plans is 98 percent. Approximately one-third of the health plans indicated that they are either planning to or are seriously considering moving to a more aggressive pricing approach for physician-administered drugs in 2003. A number of these plans recognize that fees for the drug administration procedure codes may be too low and fees may be increased if drug prices are lowered.

Exhibit 13. Distribution of Health Plan Administered Drug Pricing by AWP Formula

	85-90% of AWP	95% of AWP	100% of AWP	101-109% of AWP	110-115% of AWP	Health Plans Responding
Number of Plans	7	8	10	5	2	32
Percent of Plans	22%	25%	31%	16%	6%	100%

FACTORS THAT INFLUENCE FEE CHANGE DECISIONS

An important objective of this study is to identify and assess the importance of specific factors that influence private payer decisions regarding fee changes. We are particularly interested in the role that Medicare fee and payment system changes play in the decision making process of private health plans.

We asked the health plan interviewees to identify the factors that they consider in making decisions regarding physician fee changes. In order to be able to compare and analyze the responses for the many health plans being interviewed, we identified six possible factors and asked them to rate each of the factors as being 1) very important, 2) moderately important or 3) not important in the process of considering what fee changes, if any, to make. The interviewees were encouraged to identify additional factors that are important in their fee determination process.

The results of this exercise are summarized in Exhibit 14. Almost all of the 27 respondents[3] think that controlling claims cost and premiums is a very important factor in the fee change decision process. Several health plans noted that they are experiencing greater pressure from providers to increase payment rates and at the same time being pressured by their customers to limit premium increases.

Maintaining an adequate provider network is also very important in decisions about fee changes. Twenty-two of twenty-seven health plans rated this factor as very important and none indicated that it was not important. The factor rated next most important is maintaining parity or consistency with competitor fee levels. Most plans do not want to pay much more or much less than their primary competition.

The desire to achieve or maintain a specific proportionate relationship between plan fees and Medicare fees is considered as moderately important by approximately half the health plans, but is not considered very important by any of the plans. It ranked fifth among the six factors identified.

Exhibit 14. Ranked Responses Regarding Factors that are Important to Health Plans in Fee Change Decisions

Factor		Very Important (1)	Moderately Important (1.5-2.5)			Not Important (3)	Average
1.	Impact of fee changes on claims cost & premiums	25	0	1	0	1	**1.1**
2.	Impact on plan's ability to maintain an adequate provider network that meets customers' access requirements	22	0	5	0	0	**1.2**
3.	Parity/Consistency with competitor fee levels	8	1	14	1	3	**1.8**
4.	Consistency with inflation or medical cost indices	0	0	17	1	9	**2.4**
5.	Desire to achieve specific proportionate relationship between plan fees & Medicare fees	0	0	11	5	11	**2.5**
6.	Need to honor commitments made to network physicians, regulatory authorities or other parties*	0	0	4	1	22	**2.8**

* The extent to which such type commitments are important in the fee determination / evaluation process.

[3] Thirty-three interviews were conducted. We did not structure the question by asking the health plans to rank specific factors until the 7th interview. However, the results would have been essentially similar to those shown in Exhibit 13 as most of the initial six interviewees identified Factors 1 and 2 as important and failed to mention Factors 4, 5 and 6.

In addition to the six factors ranked, health plans were asked if there were other factors that are important to them in evaluating and setting fees. Other factors mentioned by one or two plans include:

- Administrative overhead/simplicity – a lot of custom fee schedules (e.g., about 60 in one market), trying to have fewer fee schedules.
- Comparison to fee levels in nearby states / Physicians notify plan about nearby states' fees.
- In future, want to pay for performance.
- Look at changes in utilization of services (for example, physical therapy) and if large increase, limit fee increases.
- Maintain continuity with physician's income. Do not want specific specialties to experience a significant decline.
- Malpractice premium inflation.
- Other internal political factors, legislative influences.
- Overall cost trend.
- Overall performance and financial needs of plan.
- Payment based on performance.
- Physician expense increases, related to malpractice premiums, nursing salaries, etc.
- Plan takes into consideration how rural physicians are affected by changes as it is a mission of the plan to ensure that healthcare services be available in rural communities.

Impact of Medicare Fee Changes on Health Plan Fee Decisions

The health plans were asked several questions regarding the impact of Medicare fee changes on their fee changes, with specific reference to the 2002 Medicare fee reduction of 5.4 percent, the expected 2003 fee reduction of approximately 4 percent, and, should Congress take action in early 2003, a possible 2003 fee increase of 2 percent.[4] The health plans were asked if Medicare fee changes:

1. Have a direct or strong impact on their fee change decisions

2. Have moderate impact or some impact on their fee decisions

3. Have little or no impact on their fee decisions

None of the health plans indicated that the 2002 Medicare fee reduction had a direct, strong impact on its 2002 fee decisions for its primary fee schedules. Approximately half of the plans indicated that Medicare fee decisions had a moderate impact and half indicated that it had little or no impact. The health plan responses are summarized in Exhibit 15 below.

Most plans do not believe Medicare has had much of an impact on their 2002 fee decisions. However, there are concerns that further Medicare cuts will increase fee pressure on them. Several plans commented that physicians are facing economic pressures from multiple sources, including Medicare and Medicaid fee cuts, sharp malpractice cost increases, rising nursing costs and other practice expense increases. This could lead to a combination of physician withdrawal from their least profitable practice activities and cost shifting to private payers in multiple ways,

[4] Legislation was enacted in February 2003 to provide a 1.6 percent increase in Medicare physician fees.

including seeking higher fees, increasing utilization, more aggressive billing and engaging in more entrepreneurial activities such as opening diagnostic centers and specialty hospitals. The latter is a particular concern to some plans because they believe it will be disruptive to the medical community and will increase utilization and costs.

Exhibit 15. Summary of Health Plan Responses to Questions on Impact of Medicare Fee Changes on Fee Decisions

Responses for those health plans that indicated moderate impact	Responses for those health plans that indicated little or no impact
1. Use Medicare fees as a benchmark; one of several factors that impact on their fee decisions 2. Some provider contracts are tied to Medicare fees; several plans reduced fees as a result of reduced 2002 CF; others retained existing fees so as not to upset providers 3. The Medicare reduction in procedure RVUs and increase in E&M RVUs caused some plans to increase E&M fees to remain at or above Medicare fees; it caused others to continue use of 2000 or 2001 RVUs, so as not to sharply reduce some fees 4. 2002 Medicare fee cut had little or no impact on their 2002 fee decision; but doctors have experienced revenue impact and, if further cuts in 2003, plan will feel increased pressure for higher 2003 and 2004 fees 5. Plan has major concern if Medicare cuts continue in 2003 and beyond; physicians more aggressive regarding fees, more confrontational; end result: network disruption and higher fees 6. Doctors faced with Medicare cuts will cost shift, increase utilization to avoid loss of revenue	1. Decisions for 2002 and 2003 made prior to Medicare fee change announcements 2. Respond to forces in their market, not to what Medicare does 3. Physicians seek higher fees regardless of what Medicare does; if fees go up – pressure to match fee increase; if fees go down, pressure to make up the difference 4. Some who believe Medicare fee actions had no impact on their 2002 or 2003 fee decisions do have concerns about continuation of Medicare fee reductions; will probably cause larger fee increases in future years

CHAPTER 4. PHYSICIAN FEE SURVEY

An important component of this study is a survey of fees used by health plans for their commercial (non-government) health benefit plans. This data is of interest to MedPAC and others with responsibility for Medicare fee policy. Information is provided in this chapter on:

- Medicare physician fees compared to fees paid by other major payers in physician service markets
- Health plan physician fee variation across markets
- Health plan physician fee changes in 2002, which is of particular interest given the 2002 Medicare fee reduction of approximately 5 percent
- Relationship between health plan fees and Medicare geographic adjustment factors (GAFs)

The data represent fees obtained from more than thirty health plans in diverse and geographically dispersed market areas, and reflect physician payments made on behalf of approximately 31 million members. Findings are provided for a sample of 104 commonly used CPT codes, by code ranges that represent major type of service (TOS) categories and for all physician services combined.

DESCRIPTION OF FEE SURVEY METHODOLOGY

Selection of Sample Fees

We prepared a list of commonly performed physician services that included CPT procedure codes within each of the primary categories of physician services. The list of 104 sample codes, including diagnostic tests with professional and technical components, was finalized after review by MedPAC staff. The list of 104 codes along with procedure descriptions is provided in Attachment B. The sample of procedure codes was selected to include codes that represent:

- services within each major type of service category
- a sizable portion of Medicare high dollar volume codes based on review of 2000 Medicare claims data
- significant charges to private payers, but not necessarily to Medicare (e.g., maternity and preventive visit codes)

Fee Survey Worksheet

A fee data entry electronic worksheet was prepared that facilitated convenient data entry for 2001 and current 2002 fees for up to four fee schedules per health plan. Instructions were provided to health plans for completing the fee survey. The fee data could represent fees used in different locations within the health plan's service area or fees used for different type benefit plans. As a guide, health plans were asked to provide fee data for those plans with the greatest enrollment. For each fee schedule provided, health plans were asked to provide the product type, geographic market area, and the commercial enrollment the fee schedule covered.

Fee Data Submitted by Health Plans

Thirty-three of the health plans that volunteered to participate in the study returned completed fee surveys. The fee data submissions were reviewed for completeness, internal data consistency, and possible errors. Most of the fee data submissions were complete, covering all or almost all of the sample codes, and contained few if any errors. Follow-up contacts were made to check on suspect data and to provide clarifications and additional information as required.

Health plans provided anywhere from one to four fee schedules. Fee schedules were excluded if enrollment was less than 10,000, if the schedules were not used for a very large percentage of the plan's enrollment, or the schedule did not relate to a specific defined population (e.g., if it was used for out-of-network providers). Data for 68 fee schedules were used in the fee analysis. Fee data were provided for traditional/indemnity, PPO, HMO, and POS plans. In numerous instances, one fee schedule applied to one or more of these product types. For 64 of the 68 fee schedules, both 2002 and 2001 fees were provided.

Each fee schedule was assigned to a regional Medicare carrier using the geographic market description provided with the fee schedule. Medicare and clinical laboratory fees and supporting information were downloaded from the Centers for Medicare and Medicaid Services (CMS) website.[x]

Fee Analyses

For each health plan, we computed the ratio of the Medicare fee to health plan fee and the 2001-2002 percent change in fee for each CPT code. We then computed a simple average of these ratios and percent changes by TOS category, where the TOS category is defined by CPT code range.[5] In order to develop Medicare-health plan fee ratios and 2001-2002 fee changes for all physician services, we calculated and applied TOS category weights based on a review of Medicare's 2001 claims experience.[6] The TOS weights are shown below. They differ from

[5] This was done for all TOS categories except office visits. Because of the very heavy claims volume of a few office visit codes, we assigned a weight to each office visit code based on a review of 2001 Medicare claims experience for the office visit codes.

[6] TOS category weights were calculated applying 2002 national average Medicare fees to 2001 Part B Medicare Annual Data (BMAD) procedure summary file data on volume of services for each CPT code within each TOS

typical private health plan weights in that Medicare weights for Surgery and Office Visits are somewhat lower and weights for Other Evaluation & Management (E&M) Services are somewhat higher than private health plan experience.

Type of Service Category Description	Code Range	Weight for Calculating Average
Surgery	10000-69999	23.9%
Radiology	70000-79999	12.1%
Laboratory & Pathology	80000-89999	7.2%
Assorted Medical & Diagnostic	90000-99199	13.3%
Office Visits	99201-99215	20.7%
Other E&M Services	99217-99499	22.8%

Ratios of Medicare to health plan fees are computed for both Medicare carrier area fees and for national average Medicare fees. The health plan fees are for a specific geographic defined service area. In most cases, the health plan service area is included within a single Medicare physician fee area and in some cases is part of two or more Medicare fee areas. For the latter situations, the Medicare fees used in the fee ratio are for the Medicare fee area that is most representative of the health plan enrollment based on the information provided during the interviews.

FEE SURVEY FINDINGS

Medicare – Health Plan Fee Comparisons

Exhibit 16 provides data by TOS category for the ratio of Medicare fees to health plan fees for the geographic service area. Comparable data for the 104 individual CPT codes included in the survey sample are provided in Attachment C. The first data column shows the ratio of Medicare fee to health plan fee for the benefit plan with the lowest ratio. This lowest plan ratio varies among the TOS categories from 33 percent for Surgery to 64 percent for Office Visits. These ratios of health plan fees are for one or more traditional/indemnity plans. The next three columns show the 25th, 50th (median) and 75th percentile ratios. The last two columns in Exhibit 16 show, respectively, the highest ratio among the 68 benefit plans and the mean ratio. The ratios in the High column of Exhibit 16 range from 119 percent for Surgery to 231 percent for Laboratory and Pathology. The different statistical measures shown indicate the variability among health plans in relationship of Medicare fees to private fees.

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category. The TOS category weights are the sum of the products of fee and volume within each TOS category divided by the sum of the products of fee and volume for all TOS categories combined. Select data was excluded before summary including assistance at surgery, anesthesia, and some others that reflect less-than-full service provision.

For All Physician Services combined, the median and mean ratio of area Medicare fees to health plan fees are, respectively, 87 percent and 89 percent. These ratios clearly indicate that health plan fees are above Medicare fees.

Exhibit 16. Ratio of 2002 Medicare Carrier Fee to Health Plan Current (2002) Fee by Type of Service Category

Type of Service Category	CPT Code Range	Low	Percentile			High	Mean
			25th	50th	75th		
Surgery	10000-69999	33%	72%	82%	92%	119%	82%
Radiology	70000-79999	44%	72%	80%	96%	168%	84%
Laboratory & Pathology	80000-89999	36%	86%	97%	110%	231%	104%
Assorted Medical & Diagnostic	90000-99199	45%	72%	81%	93%	143%	82%
Office Visits	99201-99215	64%	83%	93%	101%	153%	96%
Other E&M Services	99217-99499	55%	83%	90%	98%	141%	92%
All Physician Services	10000-99499	49%	79%	87%	98%	130%	89%

The ratios shown in Exhibit 16 for the different TOS category show an expected pattern. The ratios are lower for Surgery and other procedure-oriented TOS categories than for Office Visits and Other E&M Services. This is consistent with many plans using higher conversion factors for Surgery and other procedure-oriented services than for E&M Services.

Exhibit 17 differs from Exhibit 16 in that it provides statistics on the ratio of national average Medicare fees, rather than GPCI-adjusted fees, to health plan fees.[7] Comparable data for individual CPT codes is provided in Attachment D. For All Physician Services combined, the median and mean ratios of national average Medicare fees to health plan fees are, respectively, 88 percent and 90 percent.

[7] The national average Medicare fee for a service was calculated as total relative value units for that service, from the physician fee schedule, multiplied by the 2002 conversion factor of $36.1992. In this calculation, the relative value units were not adjusted with geographic practice cost indices. Use of this calculation to estimate national average Medicare fees assumes that all Medicare payment localities have approximately the same mix of services.

Exhibit 17. Ratio of 2002 National Average Medicare Fee to Health Plan Current (2002) Fee by Type of Service Category

Type of Service Category	CPT Code Range	Low	Percentile			High	Mean
			25th	50th	75th		
Surgery	10000-69999	30%	75%	82%	91%	123%	83%
Radiology	70000-79999	40%	75%	83%	91%	130%	84%
Laboratory & Pathology	80000-89999	34%	90%	99%	112%	239%	106%
Assorted Medical & Diagnostic	90000-99199	41%	74%	82%	89%	132%	83%
Office Visits	99201-99215	68%	86%	94%	104%	158%	96%
Other E&M Services	99217-99499	52%	83%	90%	99%	133%	92%
All Physician Services	10000-99499	46%	82%	88%	95%	134%	90%

National average Medicare fees are considerably lower than health plan fees for Surgery, Radiology and Assorted Medical and Diagnostic procedures, while national average Medicare fees are somewhat higher than health plan fees on average for Laboratory and Pathology services. National average Medicare fees are lower than health plan fees for Office Visits and Other E&M Services, but the fee differential is less than for procedure-oriented services.

Fee Comparisons by Health Plan Characteristics

In addition to Medicare-health plan fee comparisons for all study plans combined, we analyzed comparative Medicare and health plan fees by selected characteristics of the health plans and their service areas. These characteristics are:

- Metropolitan area size
- Medicare geographic adjustment factor (GAF)
- Health plan fee schedule type
- Geographic region

Summary tables are included in the text below. More detailed tables are provided in Attachment F.

Metropolitan Area Size

Medicare fees tend to be higher in large metropolitan areas than in smaller metropolitan and rural areas, because physician practice expenses and other prices on which Medicare GPCIs are based are typically higher in large metropolitan areas. Exhibit 18 shows ratios of Medicare carrier fees and national average Medicare fees to health plan fees for the 68 study fee schedules by health plan metropolitan area size category. These three categories are defined as health plan service areas that include as its largest metropolitan statistical area (MSA):

- An MSA of less than 1 million population
- An MSA of 1-3 million population
- An MSA of greater than 3 million population[xi]

Exhibit 18. Ratio of 2002 Medicare Fees to Health Plan Fees by MSA Size Category for All Physician Services

Medicare Ratio	Less than 1 Million (n=22)		1-3 Million (n=23)		Greater than 3 Million (n=23)	
	Median	Mean	Median	Mean	Median	Mean
Ratio of Medicare Carrier Fee to Health Plan Fee	75%	77%	87%	91%	98%	99%
Ratio of National Average Medicare Fee to Health Plan Fee	81%	82%	91%	94%	92%	92%

As shown in the first data row of Exhibit 18, there is a very clear pattern of Medicare carrier fees being lower than health plan fees in rural-small MSA markets than in mid-size and large MSA markets. Focusing on median fee ratios, Medicare fees are 25 percent below health plan fees in rural-small MSA markets, 13 percent below health plan fees in moderate size markets and only 2 percent below health plan fees in large MSA markets. A similar pattern, although less pronounced, is also evident in the National average Medicare-health plan fee comparison data in Exhibit 18. National Medicare fees are almost 20 percent below health plan fees in rural-small MSA markets and less than 10 percent lower in moderate size and large MSA markets. There is a clear pattern of health plan fees being lower in more rural areas than in moderate size and large metropolitan areas.

Medicare Geographic Adjustment Factor

Medicare and private health plan use of GPCIs was discussed briefly in the previous chapter. The Medicare GAF for a specific geographic area reflects the application of the GPCIs for that area, for the average of all Medicare covered physician services. If the GAF for area A is .95 and the GAF for area B is 1.15, Medicare fees, on average, are approximately 21 percent higher in area B than in area A. Among the study health plan geographic service areas, the GAF varies from a low of .89 to a high of 1.22.[xii]

Variation in Medicare GAFs among geographic areas is intended to reflect differences in input prices for physician services and not variation among those areas in market prices for physician services. However, there may be an expectation of a positive correlation between GAF values and average health plan physician fee levels (i.e., health plan fees are higher where the GAF is higher, and lower where the GAF is lower).

We tested the hypothesis of a positive correlation between health plan fees (all services) and area GAF values by performing linear regression analysis, with the observations being health plan-Medicare fee ratios and associated area GAFs for 45 health plan geographic service areas. The health plan fee data used are for the health plan's primary (largest enrollment) type of plan for each health plan geographic service area. We used the health plan to Medicare fee ratio in the regression equations rather than the Medicare to health plan fee ratio, as was used elsewhere in

this chapter, because the regression equations focus on how health plan fees, rather than Medicare fees, are related to GAF values.

Two regression equations were estimated:

> Regression 1. Dependent variable: All physician services, average ratio of health plan fee to Medicare carrier fee (HP/MC). Independent variable: 2002 area GAF
>
> Regression 2. Dependent variable: All physician services, average ratio of health plan fee to national average Medicare fee (HP/NM). Independent variable: 2002 area GAF

Results of the regression analysis are summarized in Exhibit 19 below.

Exhibit 19. Results of Linear Regression Analysis

Dependent Variable	Number of Observations	Coefficient of GAF	Standard Error	T Statistic; Level of Significance	R Square
1. HP/MC	45	-2.02	.31	-6.48 p<.01	.49
2. HP/NM	45	-.83	.30	-2.78 p<.05	.15

Before commenting on the regression findings, it is acknowledged that there are numerous factors that may help explain variation in health plan fees across markets. However, these simple one variable regressions can lead to some interesting findings regarding Medicare fees relative to health plan fees.

Regression 1 shows a clear and strong pattern that the higher the GAF, the lower the ratio of health plan fees to area Medicare fees. For every 1 percentage point increase in the GAF, health plan fees as a percent of area Medicare fees decline by 2 percentage points.

Findings from regression 2 show that, not only are health plan fees not positively correlated with the GAF, there is strong evidence of a negative correlation. While as indicated by the R square, changes in GAF explain only a small proportion (15 percent) of the variation across geographic areas in the ratio of health plan fees to national average Medicare fees, the negative coefficient of GAF is statistically significant at the .95 level. Simply put, the higher the GAF, the lower are average health plan fees.

Health Plan Fee Schedule Type

In the previous chapter, we described the study health plans' physician payment methodology and categorized the fee schedules used for their primary benefit plans as being one of three types:

1. RBRVS fee schedules – Use in a consistent fashion 2000-2002 Medicare RVUs and 1 to 3 conversion factors.

2. RBRVS type fee schedules – Use 2000-2002 Medicare RVUs, 4 or more conversion factors and/or make other adjustments to fees for specific CPT codes or code ranges.

3. Fee schedules loosely inspired by RBRVS methodology – Use 1999 or earlier Medicare RVUs as a guide and/or reflect some movement over time towards Medicare RBRVS relative fee values. Fee relationships vary considerably from RBRVS relative values.

It is of interest to observe how health plan fees compare for each of the fee schedule types. Medicare carrier to health plan fee ratios by TOS category are shown in Exhibit 20, for each of the three fee schedule categories. Fee comparison data are shown for the primary (highest enrollment) type benefit plans in 42 geographic markets in which the study plans operate. For All Physician Services combined, Medicare fees are considerably lower than health plan fees for those plans that use RBRVS Fee Schedules than the other type fee schedules. The disparity among fee schedule types is particularly large for Office Visits, for which Medicare fees are substantially below fees for health plans using RBRVS Fee Schedules, while Medicare fees approximate or are above fees for health plans with other type fee schedules.

Exhibit 20. Ratio of 2002 Medicare Carrier Fees to Health Plan Fees by RBRVS Type

	1. RBRVS Fee Schedule (n=16)		2. RBRVS Type Fee Schedule (n=7)		3. Loosely Inspired by RBRVS (n=19)	
Type of Service Category	**Median**	**Mean**	**Median**	**Mean**	**Median**	**Mean**
Surgery	79%	80%	95%	88%	75%	79%
Radiology	80%	80%	99%	100%	78%	80%
Laboratory & Pathology	96%	94%	180%	145%	94%	98%
Assorted Medical & Diag.	82%	80%	96%	88%	78%	79%
Office Visits	85%	86%	103%	104%	94%	100%
Other E&M Services	85%	86%	101%	102%	90%	94%
All Physician Services	83%	84%	104%	100%	87%	88%

Geographic Region

Exhibit 21 provides data on ratios of Medicare carrier and national average Medicare fees to health plan fees, for All Physician Services combined for the 68 study fee schedules, categorized into four geographic regions: Northeast, South, Midwest and West. A clear pattern is evident. Both the Medicare carrier and national average Medicare to health plan fee ratios are considerably higher for health plans in the Northeast than in the other regions. While Medicare carrier and national average Medicare fees are substantially below both health plan fees in the South, Midwest and West, depending on the specific statistic examined, Medicare fees exceed or approximate health plan fees in the Northeast region.

Exhibit 21. Ratio of 2002 Medicare Fees to Health Plan Fees by Region for All Physician Services

	Northeast (n=11)		South (n=21)		Midwest (n=22)		West (n=14)	
	Median	Mean	Median	Mean	Median	Mean	Median	Mean
Ratio of Medicare Carrier Fee to Health Plan Fee	100%	105%	84%	84%	86%	87%	87%	86%
Ratio of National Average Medicare Fee to Health Plan Fee	94%	98%	86%	87%	89%	90%	89%	86%

2001 – 2002 Health Plan Fee Changes

Exhibit 22 shows percent change in the study health plan fees between 2001 and 2002. Attachment E provides comparable fee change data for individual CPT codes. Fee increases were greater for Office Visits and for Laboratory & Pathology services than for other services. However, fee increases for just a few pathology codes are responsible for the large fee increase for the Laboratory & Pathology category.

Exhibit 22. Percent Change: Health Plan Fall 2001 Fee to Health Plan Current (2002) Fee by Type of Service Category

Type of Service Category	CPT Code Range	Low	Percentile			High	Mean
			25th	50th	75th		
Surgery	10000-69999	-7.0%	0.0%	1.6%	6.0%	14.9%	2.7%
Radiology	70000-79999	-6.6%	0.0%	3.1%	9.0%	29.3%	4.8%
Laboratory & Pathology	80000-89999	-11.8%	0.0%	8.3%	14.1%	55.4%	9.6%
Assorted Medical & Diagnostic	90000-99199	-16.3%	-1.9%	0.0%	2.7%	11.5%	-0.6%
Office Visits	99201-99215	-15.8%	0.0%	7.2%	12.0%	36.4%	7.6%
Other E&M Services	99217-99499	-15.7%	0.0%	2.1%	5.9%	20.0%	2.4%
All Physician Services	10000-99499	-1.3%	0.3%	3.4%	5.9%	10.2%	3.4%

For All Physician Services combined, median and mean fee increases are 3.4 percent. These percentages approximate the fee changes obtained from the health plan interviews and reported in the previous chapter: 3.4 percent and 3.0 percent, respectively. It should be noted that the fee change data provided during the interviews usually covered a broader spectrum of services than included in the fee survey. The fee changes provided during the interviews include anesthesiology fees, and may also include fees for other professional services, home health, and other services. Based on our fee survey findings, it is reasonable to conclude that health plan fees increased by 3-3.5 percent between Fall 2001 and Fall 2002.

CONCLUSIONS

There has been much debate as to whether private health plan fees are, on average, higher or lower than Medicare fees. Some studies, relying on fee data sources that are generally not representative of total private health insurance experience, have come to different conclusions. This study, which uses a large, broadly representative sample of health plan fee schedules, presents clear evidence that, on average, 2002 Medicare fees are lower than health plan fees. This evidence is summarized below in Exhibit 23.

Exhibit 23. Medicare and Health Plan Fee Comparison, All Physician Services

	Median	Mean
2002 Medicare Carrier Compared to Health Plan	87%	89%
2002 National Average Medicare Compared to Health Plan	88%	90%
Percent Change in Health Plan Fees 2001-2002	3.4%	3.4%

The survey findings indicate that 2002 Medicare fees are approximately 10-15 percent lower than private health plan fees. The Medicare-health plan fee differential may be slightly larger than this, perhaps up to several percent larger, because the sample of fee schedules for the study largely excluded small health plan and provider-specific negotiated fee schedules. Fees under these fee schedules tend to be somewhat higher than under those fee schedules examined in this study.

The fee differential is less for Office Visits and greater for Surgery and most other categories of service. In 2002, health plan fees increased by approximately 3-3.5 percent, while Medicare fees declined by about 5 percent.

REFERENCES

[i] Levit K., Smith C., Cowan C., et al. Inflation Spurs Health Spending in 2000, Exhibit 4. Health Affairs, January/February 2002.

[ii] Ibid.

[iii] Metropolitan statistical areas (MSAs) and primary metropolitan statistical areas (PMSAs) were used, consolidated metropolitan statistical areas (CMSAs) were not used. Metropolitan Area Population Estimates: 1998 to 1999, U.S. Census Bureau. (http://eire.census.gov/popest/data/metro.php).

[iv] Employer Health Benefits Annual Survey, The Kaiser Family Foundation and Health Research and Educational Trust Report, Exhibit 5.2-Health Plan Enrollment, by Firm Size, Region, and Industry, 2002, p. 70, 2002.

[v] For example, see Short A., Mays C., and Lake T., Provider Network Instability: Implications for Choice, Costs and Continuity of Care, Issue Brief, Center for Health System Change, June 2001.

[vi] The Medicare 2000-2001 figure was provided by MedPAC.

[vii] Federal Register, Addendum D, November 1, 2001.

[viii] Information on private health plan use of site-of-service differentials is based on the primary author's experience in evaluating and designing physician payment systems.

[ix] United States General Accounting Office Report to Congressional Committees. Medicare: Payments for Covered Outpatient Drugs Exceed Providers' Cost, GAO-01-1118, September 2001.

[x] 2002 National Physician Fee Schedule Relative Value Files revised October 2002, RVU02_D.ZIP (http://www.cms.gov/providers/pufdownload/default.asp#rvu). 2002 Clinical Diagnostic Laboratory Fee Schedule, Revised December 5, 2001, 02CLAB.ZIP (http://www.cms.gov/providers/pufdownload/default.asp#rvu).

[xi] Metropolitan Area Population Estimates, U.S. Census Bureau (http://eire.census.gov/popest/archives/metro/ma99-02.txt; http://eire.census.gov/popest/archives/metro/ma99-04.txt), October 20, 2000. PMSAs and MSAs were considered, but CMSAs were not used.

[xii] Federal Register, Vol. 65, No. 212. Addendum F. Proposed 2002 Versus 1999 Geographic Adjustment Factors (GAF), p. 65588, November 1, 2000.

ATTACHMENTS

Attachment A: Overview of Interviews for Health Plans Participating in the MedPAC Study

October 15, 2002

There are three primary areas for which we are seeking information from each of the participating health plans in the study. We want to obtain an overview of the health insurance environment in which the Plan operates, a description of the physician services environment, and a description of the physician payment system used by the Plan, particularly how fee decisions are affected by changes in Medicare fees. Our focus is on physician fee rather than capitation arrangements. For Plans that operate in more than one primary geographic market, we would like information for the markets with greatest enrollment.

Typically, we would expect to interview two or more individuals with expertise in one or more of these areas. We prefer a single phone interview with multiple participants that should last about 90-120 minutes. Alternatively, 2 or 3 separate interviews can be scheduled, each lasting 30-60 minutes (the physician fee-payment discussion will likely require the most time.) It is again emphasized that all information provided will be kept strictly confidential. Provided below is a summary of the subjects we expect to cover within each of the three interview areas:

1) Overview of Health Insurance Environment
    - Geographic dimensions of your market(s)
    - Enrollment and market share for primary products
    - Recent changes in market characteristics and competitive conditions
    - Customer concerns about claims cost and, specifically, about physician fees

2) Characteristics of Physician Services Environment
    - Supply and demand conditions, predominant physician group sizes and affiliations
    - Recent changes in physician group size or affiliations that may affect fee negotiations or fee levels
    - Recent changes in provider networks and in provider relations
    - Recent changes in physician fee negotiating posture
    - All of the above by specialty category

3) Characteristics of Physician Payment Systems
    - Characteristics of physician payment system for primary products
    - If RBRVS system, how does it differ from Medicare Fee Schedule?
    - Extent of use of provider-specific fee schedules
    - Primary factors in fee update decisions
    - Fee changes in 2002 from 2001; expected fee changes in 2003
    - Impact of Medicare 2002 fee reductions on Plan fees; expected impact of possible 2003 fee changes (up or down)
    - Fee methodology used for physician administered drugs

Please contact Zach Dyckman by e-mail or phone (202-833-8877 ext. 15) if you have any questions.

Thank you in advance for your participation!

Attachment B: Fee Survey Codes

#	CPT Code	Description	Type of Service Category
1	11721	Debridement of nails, six or more	Surgery
2	17000	Destroy lesion, all benign or premalignant; first lesion	Surgery
3	17304	Chemosurgery of skin lesion; first stage, up to 5 specimens	Surgery
4	20610	Arthrocentesis, major joint or bursa	Surgery
5	27130	Arthroplasty, total hip replacement	Surgery
6	27244	Open treatment of femoral fracture	Surgery
7	27447	Arthroplasty, total knee replacement	Surgery
8	29881	Knee arthroscopy/surgery with meniscectomy	Surgery
9	33533	Coronary artery bypass, single arterial graft	Surgery
10	35301	Thromboendarterectomy, by neck incision	Surgery
11	36415*	Routine venipuncture	Surgery
12	36533	Insertion of implantable venous access device	Surgery
13	43239	Upper gastrointestinal endoscopy; diagnostic, with biopsy	Surgery
14	44140	Partial removal of colon/ Partial colectomy	Surgery
15	45380	Colonoscopy, diagnostic, with biopsy	Surgery
16	45385	Colonoscopy, diagnostic, lesion removal	Surgery
17	50590	Lithotripsy, fragmenting of kidney stone	Surgery
18	52000	Cystourethroscopy	Surgery
19	52601	Transurethral eletcrosurgical resection of prostate, complete	Surgery
20	58150	Total abdominal hysterectomy	Surgery
21	59400	Total vaginal delivery	Surgery
22	59510	Cesarean delivery	Surgery
23	62311	Injection, single of diagnostic or therapeutic substances; l/s	Surgery
24	66821	Laser surgery, incision	Surgery
25	66984	Extracapsular cataracts removal, with lens insertion	Surgery
26	67038	Vitrectomy, with epiretinal membrane stripping	Surgery
27	67210	Destruction of localized lesion of retina, photcoagulation	Surgery
28	70553	MRI, brain, without and with contrast	Radiology
29	70553 26	MRI, brain, without and with contrast	Radiology
30	70553 TC	MRI, brain, without and with contrast	Radiology
31	71020	Chest X-ray, 2 views, frontal and lateral	Radiology
32	71020 26	Chest X-ray, 2 views, frontal and lateral	Radiology
33	71020 TC	Chest X-ray, 2 views, frontal and lateral	Radiology
34	74160	CT Abdomen, with contrast materials	Radiology
35	74160 26	CT Abdomen, with contrast materials	Radiology
36	74160 TC	CT Abdomen, with contrast materials	Radiology
37	76092	Mammogram, screening, bilateral	Radiology
38	76092 26	Mammogram, screening, bilateral	Radiology
39	76092 TC	Mammogram, screening, bilateral	Radiology
40	77427	Radiation therapy, 5 treatments	Radiology
41	78465	Myocardial imaging, tomographic (nuclear scan of heart muscle)	Radiology
42	78465 26	Myocardial imaging, tomographic (nuclear scan of heart muscle)	Radiology
43	78465 TC	Myocardial imaging, tomographic (nuclear scan of heart muscle)	Radiology
44	80053	Comprehensive metabolic panel	Laboratory & Pathology

#	CPT Code	Description	Type of Service Category
45	80061	Lipid panel	Laboratory & Pathology
46	84443	Assay thyroid stimulating hormone	Laboratory & Pathology
47	85025	Hemogram & platelet count, automated	Laboratory & Pathology
48	88142	Pap smear, automated thin layer preparation	Laboratory & Pathology
49	88164	Pap smear, (the Bethesda System) manual screening	Laboratory & Pathology
50	88305	Level 4, surgical pathology, gross and microscopic examination	Laboratory & Pathology
51	88305 26	Level 4, surgical pathology, gross and microscopic examination	Laboratory & Pathology
52	88305 TC	Level 4, surgical pathology, gross & microscopic examination	Laboratory & Pathology
53	90806	Individual psychotherapy 45 - 50 minutes	Assorted Med. & Diag.
54	90862	Medication management	Assorted Med. & Diag.
55	90921	ESRD related services, month, for patients 20+	Assorted Med. & Diag.
56	92012	Eye exam; intermediate, established patient	Assorted Med. & Diag.
57	92014	Eye exam, established patient, one or more visits	Assorted Med. & Diag.
58	92980	Insert intracoronary stent, single vessel	Assorted Med. & Diag.
59	93000	Electrocardiogram	Assorted Med. & Diag.
60	93307	Echocardiography, heart	Assorted Med. & Diag.
61	93307 26	Echocardiography, heart	Assorted Med. & Diag.
62	93307 TC	Echocardiography, heart	Assorted Med. & Diag.
63	93320	Doppler echocardiography, heart	Assorted Med. & Diag.
64	93320 26	Doppler echocardiography, heart	Assorted Med. & Diag.
65	93320 TC	Doppler echocardiography, heart	Assorted Med. & Diag.
66	93510	Left heart catheterization	Assorted Med. & Diag.
67	93510 26	Left heart catheterization	Assorted Med. & Diag.
68	93510 TC	Left heart catheterization	Assorted Med. & Diag.
69	96410	Chemotherapy administration, infusion, up to 1 hour	Assorted Med. & Diag.
70	96412	Chemotherapy administration, infusion, 1-8 hours, add-on	Assorted Med. & Diag.
71	97110	Therapeutic procedure, one or more areas, 15 minutes	Assorted Med. & Diag.
72	99201	Office/outpatient visit, new patient (Level 1)	Office Visits
73	99202	Office/outpatient visit, new patient (Level 2)	Office Visits
74	99203	Office/outpatient visit, new patient (Level 3)	Office Visits
75	99204	Office/outpatient visit, new patient (Level 4)	Office Visits
76	99205	Office/outpatient visit, new patient (Level 5)	Office Visits
77	99211	Office/outpatient visit, established patient (Level 1)	Office Visits
78	99212	Office/outpatient visit, established patient (Level 2)	Office Visits
79	99213	Office/outpatient visit, established patient (Level 3)	Office Visits
80	99214	Office/outpatient visit, established patient (Level 4)	Office Visits
81	99215	Office/outpatient visit, established patient (Level 5)	Office Visits
82	99222	Initial hospital care (Level 2)	Other E&M
83	99223	Initial hospital care (Level 3)	Other E&M
84	99231	Subsequent hospital care (Level 1)	Other E&M
85	99232	Subsequent hospital care (Level 2)	Other E&M
86	99233	Subsequent hospital care (Level 3)	Other E&M
87	99238	Hospital discharge day, 30 minutes or less	Other E&M
88	99243	Office consultation (Level 3)	Other E&M
89	99244	Office consultation (Level 4)	Other E&M
90	99245	Office consultation (Level 5)	Other E&M

#	CPT Code	Description	Type of Service Category
91	99253	Initial inpatient consultation (Level 3)	Other E&M
92	99254	Initial inpatient consultation (Level 4)	Other E&M
93	99255	Initial inpatient consultation (Level 5)	Other E&M
94	99282	Emergency department visit (Level 2)	Other E&M
95	99283	Emergency department visit (Level 3)	Other E&M
96	99284	Emergency department visit (Level 4)	Other E&M
97	99285	Emergency department visit (Level 5)	Other E&M
98	99291	Critical care services, first 30-74 minutes	Other E&M
99	99311	Subsequent nursing facility care (Level 1)	Other E&M
100	99312	Subsequent nursing facility care (Level 2)	Other E&M
101	99313	Subsequent nursing facility care (Level 3)	Other E&M
102	99382	Initial comprehensive preventive visit, age 1-4 years	Other E&M
103	99386	Initial comprehensive preventive visit, age 40-64 years	Other E&M
104	99397	Comprehensive preventive visit, established patient, age 65+	Other E&M

* HCPCS code G0001

Attachment C. Ratio of 2002 Medicare Carrier Fee to Health Plan Current (2002) Fee

Description	CPT Code	Low	25th Percentile	50th Percentile	75th Percentile	High	Mean	n
Debridement of nails, six or more	11721	29%	68%	76%	90%	154%	79%	68
Destroy lesion, all benign or premalignant; first lesion	17000	61%	82%	97%	113%	275%	105%	68
Chemosurgery of skin lesion; first stage, up to 5 specimens	17304	56%	78%	91%	105%	167%	92%	68
Arthrocentesis, major joint or bursa	20610	42%	69%	81%	97%	167%	84%	68
Arthroplasty, total hip replacement	27130	22%	59%	75%	90%	202%	75%	68
Open treatment of femoral fracture	27244	30%	68%	77%	90%	117%	78%	68
Arthroplasty, total knee replacement	27447	21%	60%	75%	90%	115%	73%	68
Knee arthroscopy/surgery with meniscectomy	29881	21%	65%	75%	91%	121%	76%	68
Coronary artery bypass, single arterial graft	33533	22%	59%	75%	90%	115%	73%	68
Thromboendarterectomy, by neck incision	35301	25%	61%	73%	87%	115%	73%	68
Routine venipuncture	36415*	15%	50%	60%	82%	102%	64%	57
Insertion of implantable venous access device	36533	24%	65%	80%	90%	115%	76%	67
Upper gastrointestinal endoscopy; diagnostic, with biopsy	43239	42%	81%	94%	116%	173%	99%	68
Partial removal of colon/ Partial colectomy	44140	34%	71%	80%	94%	115%	81%	68
Colonoscopy, diagnostic, with biopsy	45380	37%	82%	95%	109%	167%	99%	68
Colonoscopy, diagnostic, lesion removal	45385	42%	79%	90%	105%	145%	92%	68
Lithotripsy, fragmenting of kidney stone	50590	21%	69%	80%	94%	152%	80%	68
Cystourethroscopy	52000	44%	81%	97%	105%	184%	97%	68
Transurethral eletcrosurgical resection of prostate, complete	52601	25%	63%	76%	91%	137%	77%	68
Total abdominal hysterectomy	58150	24%	65%	74%	93%	115%	76%	68
Total vaginal delivery	59400	50%	73%	79%	86%	117%	79%	66
Cesarean delivery	59510	49%	74%	83%	92%	124%	84%	66
Injection, single of diagnostic or therapeutic substances; l/s	62311	30%	74%	84%	98%	265%	95%	68
Laser surgery, incision	66821	21%	68%	77%	95%	130%	79%	68
Extracapsular cataracts removal, with lens insertion	66984	25%	56%	73%	89%	115%	72%	67

Description	CPT Code	Low	25th Percentile	50th Percentile	75th Percentile	High	Mean	n
Vitrectomy, with epiretinal membrane stripping	67038	25%	58%	74%	89%	115%	73%	68
Destruction of localized lesion of retina, photocoagulation	67210	38%	67%	77%	92%	116%	78%	68
MRI, brain, without and with contrast	70553	44%	69%	82%	98%	363%	94%	67
MRI, brain, without and with contrast	70553 26	20%	68%	80%	91%	125%	80%	68
MRI, brain, without and with contrast	70553 TC	44%	70%	83%	97%	465%	100%	67
Chest X-ray, 2 views, frontal and lateral	71020	37%	67%	79%	90%	133%	78%	68
Chest X-ray, 2 views, frontal and lateral	71020 26	33%	67%	77%	88%	132%	77%	68
Chest X-ray, 2 views, frontal and lateral	71020 TC	37%	69%	80%	90%	133%	79%	68
CT Abdomen, with contrast materials	74160	38%	67%	77%	92%	130%	79%	67
CT Abdomen, with contrast materials	74160 26	33%	67%	77%	90%	568%	85%	67
CT Abdomen, with contrast materials	74160 TC	38%	67%	77%	91%	131%	79%	67
Mammogram, screening, bilateral	76092	44%	73%	86%	101%	157%	90%	68
Mammogram, screening, bilateral	76092 26	44%	74%	90%	106%	167%	95%	68
Mammogram, screening, bilateral	76092 TC	44%	70%	84%	103%	159%	89%	68
Radiation therapy, 5 treatments	77427	17%	71%	80%	92%	115%	80%	64
Myocardial imaging, tomographic (nuclear scan of heart muscle)	78465	40%	67%	76%	92%	130%	79%	68
Myocardial imaging, tomographic (nuclear scan of heart muscle)	78465 26	31%	66%	77%	90%	130%	77%	68
Myocardial imaging, tomographic (nuclear scan of heart muscle)	78465 TC	41%	68%	76%	92%	139%	80%	68
Comprehensive metabolic panel	80053	24%	73%	100%	102%	464%	123%	61
Lipid panel	80061	26%	75%	97%	111%	309%	111%	62
Assay thyroid stimulating hormone	84443	26%	75%	100%	101%	273%	110%	62
Hemogram & platelet count, automated	85025	28%	72%	98%	100%	358%	108%	63
Pap smear, automated thin layer preparation	88142	43%	85%	100%	100%	147%	97%	62
Pap smear, (the Bethesda System) manual screening	88164	37%	89%	100%	124%	255%	116%	63
Level 4, surgical pathology, gross and microscopic examination	88305	42%	80%	95%	101%	200%	94%	66
Level 4, surgical pathology, gross and microscopic examination	88305 26	29%	65%	77%	90%	197%	78%	66
Level 4, surgical pathology, gross & microscopic examination	88305 TC	53%	86%	100%	132%	287%	118%	65
Individual psychotherapy 45 - 50 minutes	90806	58%	80%	90%	101%	217%	94%	67

Description	CPT Code	Low	25th Percentile	50th Percentile	75th Percentile	High	Mean	n
Medication management	90862	58%	80%	90%	98%	119%	89%	67
ESRD related services, month, for patients 20+	90921	58%	80%	86%	100%	146%	90%	68
Eye exam; intermediate, established patient	92012	60%	82%	95%	108%	215%	100%	68
Eye exam, established patient, one or more visits	92014	62%	83%	97%	115%	202%	104%	68
Insert intracoronary stent, single vessel	92980	18%	53%	71%	84%	118%	69%	68
Electrocardiogram	93000	35%	64%	74%	89%	116%	76%	68
Echocardiography, heart	93307	42%	66%	74%	88%	118%	76%	68
Echocardiography, heart	93307 26	20%	56%	73%	85%	117%	70%	68
Echocardiography, heart	93307 TC	43%	69%	79%	89%	126%	79%	68
Doppler echocardiography, heart	93320	30%	66%	73%	90%	118%	76%	68
Doppler echocardiography, heart	93320 26	26%	52%	71%	85%	115%	68%	68
Doppler echocardiography, heart	93320 TC	31%	69%	79%	89%	139%	79%	68
Left heart catheterization	93510	44%	71%	79%	91%	341%	84%	50
Left heart catheterization	93510 26	19%	55%	74%	89%	105%	73%	66
Left heart catheterization	93510 TC	44%	70%	81%	90%	560%	88%	53
Chemotherapy administration, infusion, up to 1 hour	96410	24%	70%	80%	89%	114%	79%	68
Chemotherapy administration, infusion, 1-8 hours, add-on	96412	24%	70%	81%	90%	114%	79%	68
Therapeutic procedure, one or more areas, 15 minutes	97110	57%	84%	95%	106%	171%	97%	67
Office/outpatient visit, new patient (Level 1)	99201	52%	80%	88%	96%	153%	88%	68
Office/outpatient visit, new patient (Level 2)	99202	64%	83%	93%	99%	143%	92%	68
Office/outpatient visit, new patient (Level 3)	99203	64%	84%	93%	101%	148%	95%	68
Office/outpatient visit, new patient (Level 4)	99204	64%	83%	93%	100%	167%	96%	68
Office/outpatient visit, new patient (Level 5)	99205	64%	83%	93%	100%	195%	97%	68
Office/outpatient visit, established patient (Level 1)	99211	55%	83%	93%	98%	231%	94%	68
Office/outpatient visit, established patient (Level 2)	99212	64%	84%	94%	99%	162%	94%	68
Office/outpatient visit, established patient (Level 3)	99213	64%	83%	93%	101%	155%	95%	68
Office/outpatient visit, established patient (Level 4)	99214	64%	84%	94%	101%	164%	98%	68
Office/outpatient visit, established patient (Level 5)	99215	64%	83%	93%	100%	178%	98%	68

Description	CPT Code	Low	25th Percentile	50th Percentile	75th Percentile	High	Mean	n
Initial hospital care (Level 2)	99222	53%	80%	85%	95%	132%	86%	68
Initial hospital care (Level 3)	99223	53%	80%	88%	97%	147%	90%	68
Subsequent hospital care (Level 1)	99231	32%	76%	84%	94%	118%	84%	68
Subsequent hospital care (Level 2)	99232	38%	80%	86%	96%	132%	87%	68
Subsequent hospital care (Level 3)	99233	40%	81%	89%	97%	147%	90%	68
Hospital discharge day, 30 minutes or less	99238	56%	82%	90%	98%	161%	92%	68
Office consultation (Level 3)	99243	63%	82%	92%	98%	145%	93%	68
Office consultation (Level 4)	99244	64%	82%	92%	99%	164%	94%	68
Office consultation (Level 5)	99245	64%	82%	91%	98%	171%	94%	68
Initial inpatient consultation (Level 3)	99253	45%	78%	84%	95%	123%	86%	68
Initial inpatient consultation (Level 4)	99254	53%	79%	87%	96%	159%	89%	68
Initial inpatient consultation (Level 5)	99255	58%	80%	88%	97%	199%	92%	68
Emergency department visit (Level 2)	99282	24%	65%	76%	87%	118%	76%	68
Emergency department visit (Level 3)	99283	30%	74%	83%	92%	142%	83%	68
Emergency department visit (Level 4)	99284	30%	74%	84%	93%	149%	85%	68
Emergency department visit (Level 5)	99285	30%	74%	84%	94%	210%	88%	68
Critical care services, first 30-74 minutes	99291	51%	81%	91%	97%	136%	90%	67
Subsequent nursing facility care (Level 1)	99311	63%	88%	97%	106%	142%	98%	68
Subsequent nursing facility care (Level 2)	99312	64%	89%	97%	106%	164%	99%	68
Subsequent nursing facility care (Level 3)	99313	64%	88%	96%	106%	163%	99%	68
Initial comprehensive preventive visit, age 1-4 years	99382	64%	84%	93%	115%	246%	108%	68
Initial comprehensive preventive visit, age 40-64 years	99386	64%	83%	92%	108%	205%	103%	68
Comprehensive preventive visit, established patient, age 65+	99397	57%	80%	90%	104%	332%	103%	68

* HCPCS code G0001

Attachment D. Ratio of 2002 National Average Medicare Fee to Health Plan Current (2002) Fee

Description	CPT Code	2002 National Medicare Fee **	Low	25th Percentile	50th Percentile	75th Percentile	High	Mean	n
Debridement of nails, six or more	11721	$ 36.92	26%	70%	78%	87%	159%	80%	68
Destroy lesion, all benign or premalignant; first lesion	17000	$ 62.62	63%	84%	97%	118%	241%	105%	68
Chemosurgery of skin lesion; first stage, up to 5 specimens	17304	$ 567.24	52%	82%	90%	102%	173%	93%	68
Arthrocentesis, major joint or bursa	20610	$ 66.24	41%	73%	84%	96%	174%	84%	68
Arthroplasty, total hip replacement	27130	$ 1,452.31	20%	63%	76%	88%	184%	75%	68
Open treatment of femoral fracture	27244	$ 1,137.38	27%	68%	81%	90%	114%	79%	68
Arthroplasty, total knee replacement	27447	$ 1,514.21	19%	64%	75%	88%	112%	74%	68
Knee arthroscopy/surgery with meniscectomy	29881	$ 629.14	19%	66%	78%	88%	117%	76%	68
Coronary artery bypass, single arterial graft	33533	$ 1,827.34	20%	63%	76%	87%	105%	74%	68
Thromboendarterectomy, by neck incision	35301	$ 1,061.36	23%	63%	75%	84%	106%	73%	68
Routine venipuncture	36415*	$ 3.00	15%	50%	60%	82%	102%	64%	57
Insertion of implantable venous access device	36533	$ 379.37	22%	70%	81%	89%	104%	76%	67
Upper gastrointestinal endoscopy; diagnostic, with biopsy	43239	$ 354.75	41%	83%	95%	113%	181%	100%	68
Partial removal of colon/ Partial colectomy	44140	$ 1,171.41	31%	74%	84%	92%	111%	82%	68
Colonoscopy, diagnostic, with biopsy	45380	$ 504.25	34%	83%	97%	113%	175%	100%	68
Colonoscopy, diagnostic, lesion removal	45385	$ 571.22	39%	82%	89%	103%	151%	93%	68
Lithotripsy, fragmenting of kidney stone	50590	$ 738.83	19%	71%	80%	90%	147%	80%	68
Cystourethroscopy	52000	$ 201.99	40%	84%	94%	108%	192%	97%	68
Transurethral eletcrosurgical resection of prostate, complete	52601	$ 769.96	23%	66%	76%	88%	138%	77%	68
Total abdominal hysterectomy	58150	$ 893.03	22%	68%	77%	89%	111%	77%	68
Total vaginal delivery	59400	$ 1,542.45	44%	74%	81%	89%	114%	81%	66
Cesarean delivery	59510	$ 1,756.75	44%	76%	85%	94%	121%	86%	66
Injection, single of diagnostic or therapeutic substances; l/s	62311	$ 211.77	28%	77%	85%	97%	225%	95%	68
Laser surgery, incision	66821	$ 229.50	19%	69%	81%	92%	125%	79%	68
Extracapsular cataracts removal, with lens insertion	66984	$ 669.32	23%	58%	74%	87%	110%	72%	67

Description	CPT Code	2002 National Medicare Fee **	Low	25th Percentile	50th Percentile	75th Percentile	High	Mean	n
Vitrectomy, with epiretinal membrane stripping	67038	$ 1,378.83	24%	61%	74%	87%	110%	73%	68
Destruction of localized lesion of retina, photocoagulation	67210	$ 603.08	35%	69%	76%	88%	113%	79%	68
MRI, brain, without and with contrast	70553	$ 1,014.30	48%	73%	83%	98%	270%	93%	67
MRI, brain, without and with contrast	70553 26	$ 119.10	19%	70%	79%	93%	124%	80%	68
MRI, brain, without and with contrast	70553 TC	$ 895.21	48%	73%	83%	98%	341%	98%	67
Chest X-ray, 2 views, frontal and lateral	71020	$ 33.67	34%	68%	77%	87%	112%	79%	68
Chest X-ray, 2 views, frontal and lateral	71020 26	$ 11.22	35%	69%	76%	87%	115%	77%	68
Chest X-ray, 2 views, frontal and lateral	71020 TC	$ 22.44	33%	69%	79%	86%	112%	80%	68
CT Abdomen, with contrast materials	74160	$ 310.23	34%	70%	79%	88%	112%	79%	67
CT Abdomen, with contrast materials	74160 26	$ 64.07	36%	70%	76%	85%	582%	85%	67
CT Abdomen, with contrast materials	74160 TC	$ 246.15	34%	70%	78%	88%	111%	79%	67
Mammogram, screening, bilateral	76092	$ 81.81	50%	77%	89%	100%	164%	90%	68
Mammogram, screening, bilateral	76092 26	$ 35.48	48%	76%	91%	106%	163%	95%	68
Mammogram, screening, bilateral	76092 TC	$ 46.33	50%	74%	87%	100%	168%	89%	68
Radiation therapy, 5 treatments	77427	$ 167.96	16%	74%	81%	92%	108%	80%	64
Myocardial imaging, tomographic (nuclear scan of heart muscle)	78465	$ 498.82	37%	71%	78%	91%	114%	79%	68
Myocardial imaging, tomographic (nuclear scan of heart muscle)	78465 26	$ 74.93	31%	69%	75%	87%	114%	77%	68
Myocardial imaging, tomographic (nuclear scan of heart muscle)	78465 TC	$ 423.89	37%	71%	78%	93%	126%	80%	68
Comprehensive metabolic panel	80053	$ 14.61	24%	73%	100%	123%	464%	126%	61
Lipid panel	80061	$ 18.14	26%	76%	95%	112%	302%	111%	62
Assay thyroid stimulating hormone	84443	$ 23.21	26%	75%	100%	101%	273%	110%	62
Hemogram & platelet count, automated	85025	$ 10.74	28%	75%	98%	119%	358%	112%	63
Pap smear, automated thin layer preparation	88142	$ 28.00	43%	92%	100%	129%	147%	107%	62
Pap smear, (the Bethesda System) manual screening	88164	$ 14.60	37%	89%	100%	124%	255%	116%	63
Level 4, surgical pathology, gross and microscopic examination	88305	$ 93.39	39%	83%	92%	104%	209%	95%	66
Level 4, surgical pathology, gross and microscopic examination	88305 26	$ 40.54	27%	68%	79%	88%	202%	79%	66
Level 4, surgical pathology, gross & microscopic examination	88305 TC	$ 52.85	59%	85%	105%	132%	294%	118%	65
Individual psychotherapy 45 - 50 minutes	90806	$ 95.93	64%	81%	89%	104%	187%	94%	67

Description	CPT Code	2002 National Medicare Fee **	Low	25th Percentile	50th Percentile	75th Percentile	High	Mean	n
Medication management	90862	$ 51.04	57%	81%	90%	97%	117%	90%	67
ESRD related services, month, for patients 20+	90921	$ 273.30	55%	81%	88%	100%	151%	90%	68
Eye exam; intermediate, established patient	92012	$ 61.18	66%	84%	92%	108%	223%	100%	68
Eye exam, established patient, one or more visits	92014	$ 91.22	68%	84%	96%	118%	204%	104%	68
Insert intracoronary stent, single vessel	92980	$ 790.59	17%	52%	71%	85%	108%	69%	68
Electrocardiogram	93000	$ 25.34	32%	65%	77%	85%	120%	77%	68
Echocardiography, heart	93307	$ 187.51	38%	66%	78%	86%	106%	77%	68
Echocardiography, heart	93307 26	$ 48.14	19%	56%	73%	85%	107%	71%	68
Echocardiography, heart	93307 TC	$ 139.37	48%	70%	81%	90%	113%	80%	68
Doppler echocardiography, heart	93320	$ 82.53	26%	64%	78%	86%	106%	76%	68
Doppler echocardiography, heart	93320 26	$ 19.91	24%	54%	69%	86%	105%	69%	68
Doppler echocardiography, heart	93320 TC	$ 62.62	27%	69%	82%	91%	125%	80%	68
Left heart catheterization	93510	$ 1,564.89	51%	73%	80%	88%	310%	84%	50
Left heart catheterization	93510 26	$ 230.59	18%	59%	75%	85%	103%	73%	66
Left heart catheterization	93510 TC	$ 1,334.30	51%	73%	80%	91%	505%	88%	53
Chemotherapy administration, infusion, up to 1 hour	96410	$ 55.75	22%	73%	80%	86%	122%	80%	68
Chemotherapy administration, infusion, 1-8 hours, add-on	96412	$ 41.63	21%	74%	80%	87%	122%	80%	68
Therapeutic procedure, one or more areas, 15 minutes	97110	$ 26.43	53%	86%	94%	106%	176%	98%	67
Office/outpatient visit, new patient (Level 1)	99201	$ 34.03	49%	80%	87%	95%	158%	89%	68
Office/outpatient visit, new patient (Level 2)	99202	$ 61.54	65%	85%	91%	100%	147%	93%	68
Office/outpatient visit, new patient (Level 3)	99203	$ 91.95	68%	86%	94%	102%	146%	96%	68
Office/outpatient visit, new patient (Level 4)	99204	$ 130.68	68%	85%	93%	101%	150%	96%	68
Office/outpatient visit, new patient (Level 5)	99205	$ 166.15	68%	86%	94%	103%	177%	97%	68
Office/outpatient visit, established patient (Level 1)	99211	$ 20.27	51%	84%	92%	99%	241%	95%	68
Office/outpatient visit, established patient (Level 2)	99212	$ 36.20	61%	85%	93%	102%	168%	95%	68
Office/outpatient visit, established patient (Level 3)	99213	$ 50.32	67%	86%	94%	104%	161%	95%	68
Office/outpatient visit, established patient (Level 4)	99214	$ 78.91	68%	86%	95%	104%	155%	98%	68
Office/outpatient visit, established patient (Level 5)	99215	$ 115.84	66%	86%	95%	100%	168%	98%	68

Description	CPT Code	2002 National Medicare Fee **	Low	25th Percentile	50th Percentile	75th Percentile	High	Mean	n
Initial hospital care (Level 2)	99222	$ 108.24	49%	79%	87%	93%	126%	87%	68
Initial hospital care (Level 3)	99223	$ 150.95	50%	82%	89%	96%	140%	90%	68
Subsequent hospital care (Level 1)	99231	$ 32.58	30%	78%	86%	93%	112%	85%	68
Subsequent hospital care (Level 2)	99232	$ 53.57	36%	80%	89%	95%	126%	88%	68
Subsequent hospital care (Level 3)	99233	$ 76.38	38%	82%	89%	97%	140%	90%	68
Hospital discharge day, 30 minutes or less	99238	$ 66.24	53%	84%	90%	98%	147%	92%	68
Office consultation (Level 3)	99243	$ 115.84	58%	84%	92%	99%	140%	93%	68
Office consultation (Level 4)	99244	$ 164.34	61%	85%	92%	100%	154%	94%	68
Office consultation (Level 5)	99245	$ 212.85	61%	84%	92%	99%	162%	95%	68
Initial inpatient consultation (Level 3)	99253	$ 95.20	42%	79%	87%	95%	117%	87%	68
Initial inpatient consultation (Level 4)	99254	$ 136.83	50%	79%	88%	95%	146%	90%	68
Initial inpatient consultation (Level 5)	99255	$ 188.60	54%	81%	89%	97%	183%	93%	68
Emergency department visit (Level 2)	99282	$ 26.43	23%	69%	78%	87%	103%	76%	68
Emergency department visit (Level 3)	99283	$ 59.37	31%	77%	85%	91%	135%	83%	68
Emergency department visit (Level 4)	99284	$ 92.67	31%	77%	85%	91%	138%	86%	68
Emergency department visit (Level 5)	99285	$ 144.80	31%	77%	85%	91%	196%	88%	68
Critical care services, first 30-74 minutes	99291	$ 208.87	48%	83%	91%	97%	130%	91%	67
Subsequent nursing facility care (Level 1)	99311	$ 40.18	59%	87%	97%	107%	137%	98%	68
Subsequent nursing facility care (Level 2)	99312	$ 61.90	68%	89%	95%	107%	155%	100%	68
Subsequent nursing facility care (Level 3)	99313	$ 84.34	67%	90%	96%	106%	154%	100%	68
Initial comprehensive preventive visit, age 1-4 years	99382	$ 106.43	68%	85%	93%	108%	231%	109%	68
Initial comprehensive preventive visit, age 40-64 years	99386	$ 133.21	68%	85%	91%	105%	212%	104%	68
Comprehensive preventive visit, established patient, age 65+	99397	$ 113.30	60%	81%	89%	103%	343%	103%	68

* HCPCS code G0001

** The National Medicare Fee is the product of total relative value units for the procedure and the 2002 conversion factor of $36.1992, without any geographic adjustment.

Attachment E. Percent Change: Health Plan Fall 2001 Fee to Health Plan Current (Fall 2002) Fee

Description	CPT Code	Low	25th Percentile	50th Percentile	75th Percentile	High	Mean	n
Debridement of nails, six or more	11721	-28.4%	-8.2%	-0.1%	0.0%	27.8%	-3.8%	64
Destroy lesion, all benign or premalignant; first lesion	17000	-18.8%	0.0%	9.7%	22.6%	42.9%	11.8%	64
Chemosurgery of skin lesion; first stage, up to 5 specimens	17304	-12.3%	0.0%	3.7%	10.6%	23.7%	6.6%	64
Arthrocentesis, major joint or bursa	20610	-33.8%	-7.0%	0.0%	8.7%	106.7%	5.4%	64
Arthroplasty, total hip replacement	27130	-23.1%	-6.2%	0.0%	0.0%	28.8%	-2.8%	64
Open treatment of femoral fracture	27244	-28.0%	-4.2%	0.0%	0.3%	4.7%	-2.5%	64
Arthroplasty, total knee replacement	27447	-24.8%	-7.9%	-0.3%	0.0%	11.1%	-3.8%	64
Knee arthroscopy/surgery with meniscectomy	29881	-28.8%	-0.5%	0.0%	2.2%	16.5%	-0.5%	64
Coronary artery bypass, single arterial graft	33533	-25.4%	-6.1%	0.0%	0.0%	17.1%	-2.6%	64
Thromboendarterectomy, by neck incision	35301	-24.7%	-10.0%	-0.5%	0.0%	13.6%	-4.3%	64
Routine venipuncture	36415*	-71.5%	0.0%	0.0%	0.0%	147.5%	-0.1%	53
Insertion of implantable venous access device	36533	-11.3%	0.0%	1.3%	7.5%	176.5%	13.9%	63
Upper gastrointestinal endoscopy; diagnostic, with biopsy	43239	-22.5%	0.0%	3.5%	33.4%	55.0%	16.7%	64
Partial removal of colon/ Partial colectomy	44140	-17.7%	0.0%	0.0%	4.8%	12.7%	1.6%	64
Colonoscopy, diagnostic, with biopsy	45380	-8.0%	0.0%	6.4%	34.2%	53.8%	16.4%	64
Colonoscopy, diagnostic, lesion removal	45385	-7.8%	0.0%	3.8%	22.1%	31.2%	9.8%	64
Lithotripsy, fragmenting of kidney stone	50590	-26.2%	-0.3%	0.0%	3.2%	14.3%	0.0%	64
Cystourethroscopy	52000	-0.2%	0.0%	11.4%	26.1%	69.1%	15.0%	64
Transurethral eletcrosurgical resection of prostate, complete	52601	-26.2%	-9.2%	-1.4%	0.0%	4.0%	-4.7%	64
Total abdominal hysterectomy	58150	-19.2%	-3.5%	0.0%	1.9%	10.0%	-1.1%	64
Total vaginal delivery	59400	-12.5%	0.0%	0.0%	5.0%	15.0%	1.8%	62
Cesarean delivery	59510	-9.3%	0.0%	0.0%	4.7%	21.0%	2.5%	62
Injection, single of diagnostic or therapeutic substances; l/s	62311	-37.9%	0.0%	3.0%	9.6%	47.0%	4.3%	64
Laser surgery, incision	66821	-39.1%	0.0%	2.3%	11.1%	38.6%	4.3%	64
Extracapsular cataracts removal, with lens insertion	66984	-27.1%	-9.9%	-1.8%	0.0%	15.9%	-4.7%	63

Description	CPT Code	Low	25th Percentile	50th Percentile	75th Percentile	High	Mean	n
Vitrectomy, with epiretinal membrane stripping	67038	-27.0%	-8.3%	-2.3%	0.0%	9.3%	-4.7%	64
Destruction of localized lesion of retina, photocoagulation	67210	-42.5%	-6.2%	0.0%	0.0%	13.5%	-3.4%	64
MRI, brain, without and with contrast	70553	-29.7%	-2.1%	0.0%	2.2%	74.3%	4.2%	60
MRI, brain, without and with contrast	70553 26	-31.8%	-3.5%	0.0%	1.3%	40.8%	-1.5%	61
MRI, brain, without and with contrast	70553 TC	-32.3%	-2.3%	0.0%	2.6%	81.0%	5.2%	58
Chest X-ray, 2 views, frontal and lateral	71020	-98.9%	-2.3%	0.0%	0.5%	11.4%	-2.0%	64
Chest X-ray, 2 views, frontal and lateral	71020 26	-31.2%	-1.0%	0.0%	1.6%	18.8%	-1.4%	64
Chest X-ray, 2 views, frontal and lateral	71020 TC	-8.0%	-1.3%	0.0%	3.7%	23.8%	1.1%	63
CT Abdomen, with contrast materials	74160	-8.8%	-0.8%	0.0%	2.7%	58.0%	3.7%	63
CT Abdomen, with contrast materials	74160 26	-89.9%	-3.2%	0.0%	0.6%	15.6%	-3.7%	63
CT Abdomen, with contrast materials	74160 TC	-8.2%	-0.6%	0.0%	3.9%	112.6%	7.8%	61
Mammogram, screening, bilateral	76092	-11.9%	0.0%	9.0%	35.8%	89.3%	19.8%	64
Mammogram, screening, bilateral	76092 26	-0.2%	0.0%	23.7%	54.0%	118.8%	32.1%	62
Mammogram, screening, bilateral	76092 TC	-13.1%	0.0%	3.0%	23.9%	112.7%	14.9%	59
Radiation therapy, 5 treatments	77427	-17.9%	0.0%	1.0%	4.9%	24.6%	2.9%	60
Myocardial imaging, tomographic (nuclear scan of heart muscle)	78465	-18.4%	-2.7%	0.0%	0.0%	40.2%	-0.6%	64
Myocardial imaging, tomographic (nuclear scan of heart muscle)	78465 26	-73.5%	-2.8%	0.0%	0.5%	13.6%	-5.4%	64
Myocardial imaging, tomographic (nuclear scan of heart muscle)	78465 TC	-13.8%	-3.7%	0.0%	0.0%	31.4%	-0.6%	63
Comprehensive metabolic panel	80053	-40.0%	0.0%	0.0%	2.0%	32.8%	0.9%	57
Lipid panel	80061	-52.9%	0.0%	0.0%	1.3%	32.2%	-0.5%	59
Assay thyroid stimulating hormone	84443	-45.5%	0.0%	0.0%	2.4%	28.9%	1.4%	59
Hemogram & platelet count, automated	85025	-48.5%	0.0%	0.0%	2.2%	100.0%	3.8%	60
Pap smear, automated thin layer preparation	88142	-17.9%	0.0%	0.0%	10.0%	280.0%	13.3%	59
Pap smear, (the Bethesda System) manual screening	88164	-16.7%	0.0%	0.0%	6.4%	200.0%	13.4%	60
Level 4, surgical pathology, gross and microscopic examination	88305	-8.2%	0.0%	12.0%	24.3%	58.3%	14.0%	62
Level 4, surgical pathology, gross and microscopic examination	88305 26	-39.1%	-7.8%	-0.5%	0.0%	19.0%	-3.7%	62
Level 4, surgical pathology, gross & microscopic examination	88305 TC	-8.2%	0.0%	32.5%	74.7%	144.1%	42.7%	61
Individual psychotherapy 45 - 50 minutes	90806	-11.1%	0.0%	1.2%	4.0%	14.6%	2.4%	62

Description	CPT Code	Low	25th Percentile	50th Percentile	75th Percentile	High	Mean	n
Medication management	90862	-16.7%	0.0%	0.0%	4.0%	12.3%	1.4%	62
ESRD related services, month, for patients 20+	90921	-8.0%	0.0%	3.6%	7.0%	18.1%	4.2%	64
Eye exam; intermediate, established patient	92012	-12.6%	0.0%	6.3%	12.3%	37.7%	7.5%	64
Eye exam, established patient, one or more visits	92014	-8.6%	0.0%	8.5%	20.1%	58.9%	11.9%	64
Insert intracoronary stent, single vessel	92980	-38.1%	-17.2%	-4.9%	0.0%	17.0%	-8.6%	64
Electrocardiogram	93000	-40.9%	-7.7%	-0.1%	0.0%	34.5%	-4.2%	64
Echocardiography, heart	93307	-21.5%	-5.8%	0.0%	0.0%	43.3%	-2.3%	64
Echocardiography, heart	93307 26	-52.6%	-17.5%	-0.1%	0.0%	5.6%	-10.3%	64
Echocardiography, heart	93307 TC	-30.4%	-2.4%	0.0%	3.2%	21.8%	0.0%	63
Doppler echocardiography, heart	93320	-28.5%	-5.9%	0.0%	0.0%	13.5%	-3.4%	64
Doppler echocardiography, heart	93320 26	-67.0%	-19.6%	-1.8%	0.0%	5.7%	-11.7%	64
Doppler echocardiography, heart	93320 TC	-30.4%	-2.7%	0.0%	2.9%	22.4%	0.0%	63
Left heart catheterization	93510	-22.0%	-6.0%	-2.1%	0.0%	54.9%	-0.6%	44
Left heart catheterization	93510 26	-25.9%	-9.1%	0.0%	0.0%	43.2%	-2.7%	60
Left heart catheterization	93510 TC	-20.2%	-3.6%	0.0%	0.0%	43.8%	-0.7%	46
Chemotherapy administration, infusion, up to 1 hour	96410	-25.6%	-5.2%	0.0%	0.0%	25.0%	-1.5%	64
Chemotherapy administration, infusion, 1-8 hours, add-on	96412	-26.8%	-3.4%	0.0%	3.1%	78.9%	1.5%	64
Therapeutic procedure, one or more areas, 15 minutes	97110	-46.4%	0.0%	3.0%	13.2%	19.8%	4.9%	63
Office/outpatient visit, new patient (Level 1)	99201	-17.4%	-4.1%	0.0%	3.7%	20.0%	-0.2%	64
Office/outpatient visit, new patient (Level 2)	99202	-7.1%	0.0%	4.4%	9.2%	28.5%	5.2%	64
Office/outpatient visit, new patient (Level 3)	99203	-20.4%	0.0%	6.1%	11.9%	38.4%	7.1%	64
Office/outpatient visit, new patient (Level 4)	99204	-38.7%	0.0%	5.0%	9.3%	31.9%	5.3%	64
Office/outpatient visit, new patient (Level 5)	99205	-46.3%	0.0%	5.6%	11.1%	33.5%	5.9%	64
Office/outpatient visit, established patient (Level 1)	99211	-5.7%	0.0%	6.7%	12.4%	43.8%	9.4%	64
Office/outpatient visit, established patient (Level 2)	99212	-2.9%	0.0%	7.2%	12.0%	38.3%	8.1%	64
Office/outpatient visit, established patient (Level 3)	99213	-9.4%	0.0%	7.3%	12.1%	36.4%	7.7%	64
Office/outpatient visit, established patient (Level 4)	99214	-30.9%	0.0%	6.9%	14.2%	38.3%	8.1%	64
Office/outpatient visit, established patient (Level 5)	99215	-33.3%	0.0%	5.9%	10.8%	28.7%	6.3%	64

Description	CPT Code	Low	25th Percentile	50th Percentile	75th Percentile	High	Mean	n
Initial hospital care (Level 2)	99222	-17.8%	-3.3%	0.0%	0.1%	20.0%	-0.9%	63
Initial hospital care (Level 3)	99223	-19.0%	-0.6%	0.0%	3.8%	20.0%	0.8%	64
Subsequent hospital care (Level 1)	99231	-22.4%	-5.5%	-0.7%	0.0%	21.1%	-2.0%	63
Subsequent hospital care (Level 2)	99232	-13.9%	-1.6%	0.0%	1.8%	27.1%	0.8%	64
Subsequent hospital care (Level 3)	99233	-22.1%	-0.9%	0.0%	3.5%	20.0%	0.6%	64
Hospital discharge day, 30 minutes or less	99238	-38.4%	0.0%	0.8%	5.0%	20.0%	1.1%	64
Office consultation (Level 3)	99243	-15.5%	0.0%	2.7%	7.6%	20.0%	3.7%	64
Office consultation (Level 4)	99244	-15.7%	0.0%	3.9%	8.6%	20.6%	4.4%	64
Office consultation (Level 5)	99245	-17.7%	0.0%	2.9%	7.5%	20.0%	3.6%	64
Initial inpatient consultation (Level 3)	99253	-24.1%	-3.2%	-0.2%	0.0%	20.0%	-1.6%	64
Initial inpatient consultation (Level 4)	99254	-39.7%	-1.5%	0.0%	1.1%	20.0%	-1.1%	63
Initial inpatient consultation (Level 5)	99255	-51.6%	-1.0%	0.0%	2.2%	20.0%	-0.9%	64
Emergency department visit (Level 2)	99282	-31.1%	-10.8%	0.0%	0.0%	50.0%	-2.9%	63
Emergency department visit (Level 3)	99283	-15.9%	-3.1%	0.0%	5.5%	50.4%	2.0%	64
Emergency department visit (Level 4)	99284	-36.8%	-2.7%	0.0%	6.4%	50.0%	1.7%	64
Emergency department visit (Level 5)	99285	-55.7%	-3.0%	0.0%	6.8%	50.2%	0.9%	64
Critical care services, first 30-74 minutes	99291	-7.0%	0.0%	4.0%	9.4%	24.2%	5.1%	63
Subsequent nursing facility care (Level 1)	99311	-22.2%	0.0%	3.8%	23.9%	37.0%	9.8%	64
Subsequent nursing facility care (Level 2)	99312	-13.8%	0.0%	5.9%	21.9%	30.6%	9.5%	64
Subsequent nursing facility care (Level 3)	99313	-7.9%	0.0%	8.8%	20.4%	27.5%	9.9%	64
Initial comprehensive preventive visit, age 1-4 years	99382	-42.7%	0.0%	1.4%	9.0%	77.8%	4.5%	64
Initial comprehensive preventive visit, age 40-64 years	99386	-6.9%	0.0%	0.0%	4.9%	49.0%	3.2%	64
Comprehensive preventive visit, established patient, age 65+	99397	-12.9%	-1.6%	0.0%	2.8%	45.0%	2.0%	64

* HCPCS code G0001

Attachment F: Fee Comparisons by Health Plan Characteristics

Metropolitan Area Size

Exhibit F-1. Ratio of 2002 Medicare Carrier Fees to Health Plan Fees by MSA Category

	Less than 1 Million (n=22)		1-3 Million (n=23)		Greater than 3 Million (n=23)	
Type of Service Category	Median	Mean	Median	Mean	Median	Mean
Surgery	72%	71%	84%	84%	92%	90%
Radiology	72%	69%	79%	83%	99%	99%
Laboratory & Pathology	77%	81%	98%	116%	111%	116%
Assorted Medical & Diag.	71%	71%	81%	83%	93%	93%
Office Visits	81%	84%	96%	98%	99%	105%
Other E&M Services	83%	82%	90%	93%	97%	99%
All Physician Services	75%	77%	87%	91%	98%	99%
Enrollment	6,317,000		5,752,000		18,963,000	

Exhibit F-2. Ratio of 2002 National Average Medicare Fees to Health Plan Fees by MSA Category

	Less than 1 Million (n=22)		1-3 Million (n=23)		Greater than 3 Million (n=23)	
Type of Service Category	Median	Mean	Median	Mean	Median	Mean
Surgery	77%	77%	85%	87%	83%	83%
Radiology	75%	75%	83%	86%	88%	90%
Laboratory & Pathology	85%	85%	103%	120%	112%	113%
Assorted Medical & Diag.	76%	77%	86%	86%	85%	86%
Office Visits	88%	90%	100%	101%	95%	97%
Other E&M Services	88%	88%	92%	96%	89%	93%
All Physician Services	81%	82%	91%	94%	92%	92%
Enrollment	6,317,000		5,752,000		18,963,000	

Health Plan Fee Schedule Type

Exhibit F-3. Ratio of 2002 Medicare Carrier Fees to Health Plan Fees by RBRVS Type

	1. RBRVS Fee Schedule (n=16)		2. RBRVS Type Fee Schedule (n=7)		3. Loosely Inspired by RBRVS (n=19)	
Type of Service Category	Median	Mean	Median	Mean	Median	Mean
Surgery	79%	80%	95%	88%	75%	79%
Radiology	80%	80%	99%	100%	78%	80%
Laboratory & Pathology	96%	94%	180%	145%	94%	98%
Assorted Medical & Diag.	82%	80%	96%	88%	78%	79%
Office Visits	85%	86%	103%	104%	94%	100%
Other E&M Services	85%	86%	101%	102%	90%	94%
All Physician Services	83%	84%	104%	100%	87%	88%
Enrollment	9,878,000		3,119,000		11,333,000	

Exhibit F-4. Ratio of 2002 National Average Medicare Fees to Health Plan Fees by RBRVS Type

	1. RBRVS Fee Schedule (n=16)		2. RBRVS Type Fee Schedule (n=7)		3. Loosely Inspired by RBRVS (n=19)	
Type of Service Category	Median	Mean	Median	Mean	Median	Mean
Surgery	82%	80%	94%	87%	79%	79%
Radiology	81%	80%	100%	97%	79%	81%
Laboratory & Pathology	97%	96%	171%	145%	97%	99%
Assorted Medical & Diag.	81%	81%	96%	87%	76%	79%
Office Visits	86%	87%	103%	103%	99%	101%
Other E&M Services	88%	87%	100%	101%	91%	95%
All Physician Services	85%	84%	104%	99%	86%	89%
Enrollment	9,878,000		3,119,000		11,333,000	

Geographic Region

Exhibit F-5. Ratio of 2002 Medicare Carrier Fees to Health Plan Fees by Region

	Northeast (n=11)		South (n=21)		Midwest (n=22)		West (n=14)	
Type of Service Category	Median	Mean	Median	Mean	Median	Mean	Median	Mean
Surgery	92%	96%	75%	76%	81%	79%	85%	84%
Radiology	105%	107%	76%	79%	82%	80%	80%	80%
Laboratory & Pathology	116%	123%	94%	95%	89%	108%	101%	99%
Assorted Medical & Diag.	100%	100%	78%	78%	80%	79%	81%	80%
Office Visits	97%	109%	92%	92%	93%	94%	94%	93%
Other E&M Services	97%	109%	85%	88%	92%	91%	84%	85%
All Physician Services	100%	105%	84%	84%	86%	87%	87%	86%
Enrollment	7,673,000		6,912,000		9,369,000		7,078,000	

Exhibit F-6. Ratio of 2002 National Average Medicare Fees to Health Plan Fees by Region

	Northeast (n=11)		South (n=21)		Midwest (n=22)		West (n=14)	
Type of Service Category	Median	Mean	Median	Mean	Median	Mean	Median	Mean
Surgery	89%	88%	77%	79%	83%	82%	86%	84%
Radiology	90%	96%	80%	81%	83%	83%	82%	80%
Laboratory & Pathology	112%	120%	98%	98%	94%	112%	108%	101%
Assorted Medical & Diag.	87%	91%	79%	80%	82%	83%	80%	80%
Office Visits	96%	101%	93%	95%	94%	98%	95%	92%
Other E&M Services	92%	102%	89%	90%	92%	94%	88%	85%
All Physician Services	94%	98%	86%	87%	89%	90%	89%	86%
Enrollment	7,673,000		6,912,000		9,369,000		7,078,000	