EXPLAINING DIFFERENCES BETWEEN THE TWO MEDPAC-SPONSORED ANALYSES OF PRIVATE INSURERS' PHYSICIAN FEES

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August 8, 2003

Executive Summary

In 2002, the Medicare Payment Advisory Commission (MedPAC) sponsored two studies comparing Medicare physician payment rates to those of private payers. Dyckman & Associates interviewed executives and technical staff of a large number of private plans operating in defined geographic markets, gathering information on those plans' physician payment methodology, fee determination process, and fee schedules for selected procedures (Dyckman & Associates, 2003). Direct Research, LLC undertook a study of typical private payment rates using claims data from two large nationwide private insurers (Direct Research, 2003). Both studies compared estimated average private rates to Medicare rates.

The two studies agreed that private rates exceed the Medicare level, but they disagreed modestly on the extent. The Direct Research (claims-based) study projected 2002 Medicare fees at about 77 percent of private rates. Initial estimates from the Dyckman & Associates study were slightly above this level, while the final estimates from the Dyckman & Associates study characterize Medicare rates as approximately 12 percent lower than private rates (that is, Medicare rates were about 88 percent of private rates).[1] Thus, there is an apparent discrepancy of about 11 percentage points between the two estimates.

This paper reconciles these two estimates. Mainly, the Dyckman study focused on plans' fee schedules, while the Direct Research study looked at amounts paid. Most of the difference between the two estimates can be traced to claims paid at rates above or below the base fee schedule amount. This analysis examines factors that affect either the fee schedule calculation, or result in claims being paid at rates other than the base fee schedule. Together, these identified factors plausibly account for most of the difference between the Dyckman & Associates and Direct Research findings.

In particular, the main systematic factors identified are the following:

- **Payment to non-participating providers**. The Dyckman study looked at plans' base or standard fee schedules, while the Direct Research study looked at average payment per service. Several factors may result in payments that are higher than (or lower than) the base fee schedule amount, including payments to non-participating providers, negotiated fees that selectively exceed the base fee schedule, and similar

[1] Mean Medicare health plan ratio for 68 fee schedules used by 33 health plans: 89%; median ratio: 87%.

factors. Based on a published study of one state (Maryland), payments to non-participating physicians may raise average private payment per service perhaps 4 to 5 percent above plans' base rates (MHCC 2003). This amount is captured in the Direct Research study but not the Dyckman & Associates study.

- **Medicare site-of-service differential.** The Direct Research study accounted for the Medicare site-of-service differential, while the Dyckman & Associates study did not for those plans that did not use a site-of-service fee differential (70% of the plans.) The site of service differential results in substantially lower payments for certain services when performed in facility-based rather than office-based settings. The site-of-service differential results in actual Medicare rates that average 4 percent below the level that would be estimated if the site-of-service differential were ignored. Thus, by not incorporating the site-of-service differential in either Medicare or private rates, the Dyckman & Associates study may have overstated average Medicare rates by about 4 percent, but overstated average private rates by only about 1 percent (30 percent of 4 percent). This could result in the Medicare-health plan fee differential being understated by approximately 3 percent.

- **Price index weighting by Medicare volume.** The Direct Research study calculated a volume-weighted price index, with the volume of Medicare services by CPT code as the weights. This directly answers the question "what would it have cost if Medicare had purchased its physician services mix, but at private payers' rates?". The Dyckman & Associates study, by contrast, used category of service weights (e.g., surgery, radiology, office visits) based on Medicare fees multiplied by volume (comparable to allowed charges) shares to compute an average ratio for all physician services. Based on the sample of codes used in each category, the Dyckman results put somewhat higher weight on services where Medicare pays better and lower weight on services where Medicare pays less well (compared to private rates). A spreadsheet calculation shows that this may have resulted in a roughly 2 percent differential between the two studies.

- **Underestimate of private fee inflation, 2001-2002.** The Direct Research study assumed 2 percent private fee inflation from 2001 to 2002, while the Dyckman & Associates study estimated actual private fee inflation at about 3.4 percent. Thus, the Direct Research estimate of Medicare-to-private rates is about 1 percentage point higher than it would have been if it had assumed the rate of private fee inflation as measured by the Dyckman & Associates study.

All together, these factors account for nearly all of the 11 percentage point difference between the results of the two studies. These factors suggest that the Direct Research study should show a Medicare-to-private fee differential that is 8 or 9 percentage points larger than the Dyckman & Associates study. This is accounted for by 4 to 5 percentage points for higher payments to nonparticipating providers, 3 percentage points for accounting for the site-of-service differential, perhaps 2 percentage points for the difference in weighting of categories of services, less 1 percentage point for a low estimate of private fee inflation from 2001 to 2002 in the Direct Research study.

Clearly, many non-quantifiable or random factors might also have influenced the two studies. The Dyckman & Associates study relies on a national sample of 33 plans willing to participate in the study. The plans appear to be well dispersed in terms of region and demographic characteristics. The Direct Research study relies on the claims of two large, nationwide insurance programs. Either study might have obtained a somewhat non-representative sample of private payers rates. There may also be other potentially quantifiable factors, not addressed here, that might contribute to the difference between the two studies.

Having said this, the systematic factors discussed above largely reconcile the results of the two studies. That is, of the roughly 11 percentage point differential between the two studies (the Direct Research estimate of Medicare at 77 percent of private rates and the Dyckman & Associates estimate of Medicare at 88 percent of private rates), 8 or 9 percentage points can plausibly be attributed to the systematic differences.

EXPLAINING DIFFERENCES BETWEEN THE TWO MEDPAC-SPONSORED ANALYSES OF PRIVATE INSURERS' PHYSICIAN FEES

1 Difference between base fee schedule and average payment per claim.

1.1 Payment to non-participating physicians.

Physicians not under contract to a health plan or not participating in a plan's provider network typically receive a higher total payment (combined health plan and consumer) for a given service than do participating physicians. Payments to such non-participating physicians will boost average private payment per service above the level of the private plan's base fee schedule. Health plan payment rates for non-participating physicians may or may not be higher than for participating physicians, depending on the particular benefit plan, state regulatory requirements regarding coverage for non-participating physician services and other factors.

In the Medicare program, almost all claims are paid under assignment. That is, the fee schedule amount is payment in full. For the few percent of claims dollars not paid on assignment, physicians are limited to total payment that amounts to 109.5 percent of the fee schedule amount. These non-assigned claims have a trivial impact on total payments for Medicare-covered physician services. In 2001, less than 2 percent of Medicare claims were not assigned. This means that total balance billing payments in Medicare are less than two-tenths of a percent of total physician payments for Medicare services (0.095*0.02 = 0.00185).

Among the privately insured, by contrast, a significantly higher proportion of claims are paid to non-contract or non-participating physicians, and there are seldom explicit legal limits on the total amount paid. In a recent study of private payers rates conducted for the State of Maryland (Maryland Health Care Commission 2003), private payments to non-participating providers (including enrollee coinsurance amounts) were shown to raise average payment levels by 3.5 percent (for HMO plans) to 5.5 percent (for non-HMO plans).

If the Maryland experience were typical, this suggests that total payment per service will exceed the typical private plan's base fee schedule amount by roughly 4 to 5 percent, due to additional payments made to non-contract or non-participating physicians. These amounts are reflected in the Direct Research figures, which are based on claims payment data, but are not reflected in the Dyckman & Associates study figures, which are based on health plan fee schedules.

1.2 The Medicare Site-of-Service Differential.

For procedures that are commonly performed either in physician offices or in medical facilities, the Medicare fee schedule lists two separate payment rates, called facility and non-facility rates. The higher, non-facility rate applies when a service is performed in a

physician's office or other non-facility setting. The lower, facility rate applies when the service is performed in a location where Medicare makes a separate facility payment, such as a hospital outpatient department or ambulatory surgical center. The lower, facility rate reflects lower Medicare payment to the physician for overhead costs.

The Direct Research study applied the site-of-service differential on a claim-by-claim basis, depending on where the service was performed. The Dyckman & Associates study, by contrast, used the higher, non-facility payment rate throughout.

For an individual procedure, the site-of-service differential is typically substantial. For the procedures subject to the differential, the (unweighted) average of the facility payments is 29 percent below the (unweighted) average of the non-facility payments. Weighting by total service volume and by place of service, ignoring the site-of-service differential overstates Medicare physician payments by 3.9 percent, based on analysis of the 2001 Medicare Procedure Summary file. (That is, total payments ignoring the site-of-service differential were 3.9 percent higher than total payments when the site-of-service differential was included.)

The conclusion is that, based on the mix of services and places of service in the Medicare claims, ignoring the site-of-service differential overstates average Medicare payment by about 4 percent. Thirty percent of the health plans in the Dyckman & Associates study used a site-of-service differential. Thus, we would expect an approximate 3 percent discrepancy between the rates estimated by Dyckman & Associates (ignoring site-of-service) and Direct Research LLC (including site of service).

1.3 Other factors that are more difficult to quantify.

1.3.1 Off-fee-schedule payments.

All Medicare payments are made at or below the Medicare fee schedule rates. Private payers, by contrast, will sometimes negotiate separate payment rates for valued providers, for example, for a large group practice that commands a large share of a particular market. To the extent that this occurs, the Direct Research analysis will show higher private payments tracking these above-fee-schedule amounts, but the Dyckman & Associates analysis will not.

Conversely, few Medicare claims are actually paid at billed amounts that are below the fee schedule amounts. For private payers, by contrast, a higher portion of claims may be paid at the billed charge when private fee screens are higher. The Direct Research estimate will reflect payment at billed charge when billed charge is below the private fee screen, but the Dyckman & Associates study will not.

1.3.2 Weights for major service categories.

The Direct Research analysis uses all procedures, and weights each procedure by the total (national) Medicare volume in that procedure. That is, it directly addresses the question

"what would it have cost, if Medicare had paid average private rates for all physician services". The method is a straightforward Laspeyres price index.

The Dyckman & Associates study, by contrast, used a sample of 104 CPT codes, grouped into six major categories of service. The ratio of Medicare to health plan fee for each sample CPT code was given equal weight within a service category,[2] implicitly assuming that the ratios are comparable for the sample and the non-sample codes. The six service categories were then weighted using the share of Medicare fee multiplied by volume attributable to the surveyed codes falling into each category.

Compare to the volume weights in the Direct Research study, the Dyckman & Associates study gives a higher weight to office visits, other evaluation and management services, and laboratory/pathology services, and a lower weight to assorted medical and diagnostic procedures, and radiology. Because Medicare pays best (relative to private payers) for office visits and other evaluation and management services, the Dyckman (payment weights) and Direct Research (volume weights) studies will differ in their estimate of the Medicare-to-private fee differential. A spreadsheet calculation shows that the difference in the weighting would narrow the estimated private-to-Medicare fee differential by about 2 percent in the Dyckman study compared to the Direct Research study.

2 Conclusion

The Direct Research study focuses on a comparison of actual Medicare and private health plan payment rates based on an analysis of national paid claims data for two major carriers. The Dyckman & Associates fee survey portion of their study focuses on a comparison between Medicare and private health plan fee schedules based on geographic market area fee schedule data submitted by 33 health plans. Both studies conclude that health plan fees are higher, on average, than Medicare fees. Actual differences in Medicare to private health plan fee ratios are about 11 percentage points between the two studies, prior to adjustment for known methodological differences between the studies. Virtually all of the difference in fee ratios between the two studies can be explained by differences in study methodology.

References:

Dyckman & Associates, Survey of Health Plans Concerning Physician Fees and Payment Methodology, Washington, DC, Dyckman & Associates, August, 2003.

Direct Research, LLC, *Medicare Physician Payment Rates compared to rates paid by the average Private Insurer, 1999 – 2001*, final report, Vienna, VA, Direct Research, LLC, August 2003.

Maryland Health Care Commission, *Practitioner Utilization: Trends within Privately Insured Patients*, 2000-2001, Baltimore, MD, MHCC, March 2003.

[2] The exception to this rule is the Office Visit category for which all CPT codes were included in the analysis.