

Issue Brief

Findings from HSC



GROWING PHYSICIAN ACCESS PROBLEMS COMPLICATE MEDICARE PAYMENT DEBATE

by Sally Trude and Paul B. Ginsburg

Projected cuts in Medicare physician payments raise serious concerns that Medicare beneficiaries will lose access to needed physician services. A study by the Center for Studying Health System Change (HSC) shows growing physician access problems among Medicare and privately insured patients. Patients have the most difficulties obtaining care from specialists and in certain communities. Proposals to increase Medicare fees across the board may prevent deterioration of access for Medicare beneficiaries but are unlikely to address system-wide access problems that vary by specialty and market.

Concerns About Access for Medicare Beneficiaries

The 5.4 percent cut in Medicare physician payments for 2002 and the expectation of additional cuts over the next few years have raised concerns that Medicare beneficiaries will face serious problems obtaining needed physician services. Congress is considering legislation to replace these scheduled reductions with modest increases until a new Medicare physician payment system is developed. These proposals may prevent significant deterioration in access to care for Medicare beneficiaries, but factors outside of Medicare have led to poorer access for all patients and may continue to do so even if future Medicare cuts are cancelled.

Three key measures of access are whether patients delayed or did not obtain needed care, whether patients could get a timely appointment with a physician and whether doctors are taking new patients. Based on these

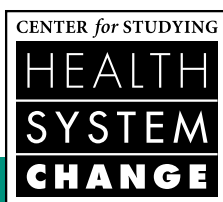
measures from HSC's Community Tracking Study Household and Physician Surveys (see Data Source, page 2), there is clear evidence that access problems are on the rise:

- The percentage of Medicare seniors reporting delaying or not getting needed care rose from 9.1 percent in 1997 to 11.0 in 2001 (see Table 1). Similarly, the percentage of privately insured people between the ages of 50 and 64 (near-elderly) who reported access problems increased from 15.2 percent to 18.4 percent over the same period.¹
- Both Medicare seniors and older privately insured people are also waiting longer for appointments with their physicians (see Table 2). By 2001, more than a third of Medicare seniors waited more than three weeks for a checkup. A

similar percentage waited a week or more for an appointment for a specific illness.

- The proportion of physicians accepting all new Medicare patients fell from 74.6 percent to 71.1 percent over the past four years (see Table 3). The proportion of physicians accepting all new privately insured patients also dropped. Moreover, the proportion of physicians who are not accepting any new patients—Medicare or privately insured—grew over the same period.

Physicians with the weakest connection to Medicare were most likely to refuse to accept new Medicare patients. In 2001, 16.3 percent of physicians whose Medicare practice was less than 10 percent of their practice revenue closed their practices to new Medicare patients. In contrast, less than 1 percent





Data Source

This Issue Brief presents findings from the HSC Community Tracking Study Physician and Household Surveys conducted in 1996-97, 1998-99 and 2000-01. They are both nationally representative telephone surveys. For discussion and presentation, we refer to a single calendar year of the survey (1997, 1999 and 2001).

The Physician Survey is of nonfederal, patient care physicians who spend at least 20 hours a week in direct patient care. Each round of the survey contains information on about 12,500 physicians, and the response rates ranged from 61 percent to 65 percent.

The Household Survey is of the civilian, noninstitutionalized population. Data were supplemented by in-person interviews of households without telephones to ensure proper representation. Each round of the survey contains information on about 60,000 people, and the response rates ranged from 60 percent to 65 percent.

Table 1
People Who Had Problems Obtaining Care, by Reason

	1997	1999	2001
DELAYED OR PUT OFF CARE, ANY REASON			
MEDICARE SENIORS	9.1%	9.8%	11.0%*
PRIVATELY INSURED NEAR-ELDERLY	15.2	17.6	18.4*
REASONS FOR DELAYING OR PUTTING OFF CARE			
COULDN'T GET APPOINTMENT SOON ENOUGH			
MEDICARE SENIORS	13.9	16.3	23.6*
PRIVATELY INSURED NEAR-ELDERLY	21.8	20.8	25.1*
COULDN'T GET THROUGH ON PHONE			
MEDICARE SENIORS	7.1	4.8	11.3*
PRIVATELY INSURED NEAR-ELDERLY	7.2	7.6	9.1

* Change from 1997 to 2001 is statistically significant at $p < .05$.

Source: Community Tracking Study Household Survey

Table 2
People Reporting Long Waits for Medical Checkups and Illness Visits, Comparison of Medicare Seniors and Privately Insured Near-Elderly

	1997	1999	2001
DELAY FOR CHECKUP APPOINTMENT EXCEEDS 3 WEEKS			
MEDICARE SENIORS	32.1%	35.0%	37.1%*
PRIVATELY INSURED NEAR-ELDERLY	25.8	28.7	33.1*
DELAY FOR ILLNESS APPOINTMENT EXCEEDS 1 WEEK			
MEDICARE SENIORS	34.6	41.3	40.3*
PRIVATELY INSURED NEAR-ELDERLY	29.9	35.2	36.3*

* Change from 1997 to 2001 is statistically significant at $p < .05$.

Source: Community Tracking Study Household Survey

of physicians with Medicare revenues making up more than half of their practice revenue closed their practices to new Medicare patients in 2001.

Access to Specialist Care Declines

The Balanced Budget Act of 1997 (BBA) made three substantial changes to Medicare payment for specialists. First, it replaced separate conversion factors for primary care, surgical services and other nonsurgical services with a single conversion factor (see box, page 4). Second, it increased the work relative value units for some services. And third, it began the transition to new practice

expense relative values. These changes reflected a return to the intended goal of Medicare physician payment policy to pay based on the amount of physician work required per service rather than the credentials or educational background of the physician. As a result of the BBA's changes, average payments for all physicians increased about 7 percent from 1998 to 2002, but payments fell 14 percent for cardiac surgeons and 10 percent for thoracic surgeons.²

During 1997-2001, surgeons' willingness to accept all new Medicare patients declined from 81.5 percent to 73.0 percent. At the same time, the proportion of medical specialists accepting all new Medicare patients grew slightly from 76.3 percent to 78.9 percent.

Table 3
Physicians Accepting New Medicare and Private Patients

	1997	1999	2001
ACCEPTING ALL NEW PATIENTS			
MEDICARE ¹	74.6%	72.5%	71.1%*
PRIVATE	70.8	70.5	68.2*
ACCEPTING NO NEW PATIENTS			
MEDICARE ¹	3.1	3.4	3.8*
PRIVATE	3.6	3.6	4.9*

¹ Excludes pediatricians.

* Change from 1997 to 2001 is statistically significant at p<.05.

Source: Community Tracking Study Physician Survey

Surgeons' acceptance of new privately insured patients showed similar declines, while medical specialists showed virtually no change.

Delays obtaining appointments with surgical and medical specialists have become particularly troublesome for Medicare seniors and older privately insured people. Roughly half of Medicare seniors must wait at least three weeks for a checkup with a specialist, and almost three in four must wait more than a week to see a specialist for a specific illness. Comparable percentages of older privately insured people also face delays in access to specialists. This inability to schedule appointments on a timely basis may be contributing to physicians' growing refusal to accept new patients.

Because both Medicare and privately insured patients are affected, current problems of access to specialists are likely unrelated to the BBA fee cuts. However, if payment differentials between private payers and Medicare increase in the future, that may limit beneficiaries' choice of specialists.

Many health plans use Medicare's fee schedule to benchmark their physician payments, which sometimes leads to turmoil. In Seattle, for example, about 150 specialists refused to renew their contracts with Regence Blue Shield, the largest insurer in Washington, when it revised its payments to conform to the new relative values in the Medicare fee schedule.³ To get the specialists to renew their contracts, Regence agreed to continue paying more for surgical services. In other communities, specialty differentials were maintained as specialty

practices and medical groups negotiated higher contract rates than those of primary care practices. As a result, Medicare beneficiaries may find their choices among specialists dwindling if payment differentials between Medicare and private payment grow. The differentials between Medicare and private payments vary by market, so access problems also vary by community.

Market Variation in Access and Relative Payment

The extent and type of access problems Medicare beneficiaries face depend on where people live. Moreover, the nature of access problems tends to be complex and cannot be captured with a single measure. For example, of the 12 nationally representative communities where HSC conducts site visits, Seattle has shown the steepest decline in physicians' willingness to accept new Medicare patients. In 1997, 71 percent of Seattle physicians were willing to accept all new Medicare patients, but in 2001, only 55 percent were willing. At the same time, the proportion of Seattle physicians willing to accept all new private patients fell from 71 percent to 62 percent. As a result, Seattle now ranks as the lowest of the 12 markets in physician willingness to accept all new Medicare patients.

Despite this drop, Seattle still ranks highest in other measures of access to care. For example, only 8 percent of Medicare beneficiaries in Seattle report putting off or delaying care, compared with 15 percent

to 16 percent in Cleveland, Indianapolis, Miami, Phoenix and Orange County, Calif.

Medicare beneficiaries in Seattle are also less likely to face appointment delays. About 24 percent of Medicare beneficiaries in Seattle face a delay obtaining a checkup, compared with 55 percent to 56 percent in Boston and Syracuse. And 55 percent of Seattle's Medicare beneficiaries must delay an appointment for a specific illness, compared with 70 percent in Boston. Ironically, Boston ranks among the highest of the 12 markets studied in physician willingness to accept all new Medicare patients but has some of the highest rates of appointment delays.

Monitoring Medicare access is complicated further by the wide variation in how health plans pay physicians relative to Medicare. In Northern New Jersey, private insurers use Medicare physician payments as a ceiling, while in Little Rock, private physician payment rates are much higher than what Medicare pays. Nor do plans mimic annual changes to Medicare's rates. In five of the 12 communities, health plans reported, on average, that private payments had fallen relative to Medicare payments. That is, when Medicare physician payment rates increased roughly 5 percent in 2000 and again in 2001, health plans did not follow suit with comparable increases.

Implications for Policy Makers

Medicare physician payment policy often has been driven by congressional efforts to reduce the federal budget deficit, constrained by concerns about access and physician representatives' pleas for fairness. In 1989, Congress created the Medicare fee schedule that included a formula linking annual changes in payment rates to changes in the number and type of physician services provided to Medicare patients. Lawmakers have revised this formula twice to achieve budget savings. A first cut in 1993 was followed by the 1997 BBA that sought more savings—\$5.3 billion from 1998 to 2002 and \$11.7 billion by 2007. The Congressional Budget Office estimated that payments to physicians over 1998-2002 would decline by 0.7 percent under the 1993 law and by 9.3 percent under the BBA.⁴

Policy makers
should not expect
to address
system-wide
access problems
through Medicare
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Web Exclusive

Supplementary data tables related to this Issue Brief are available online at www.hschange.org.



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Medicare Physician Payment in a Nutshell

Medicare physician payment is based on the principle that payments for different services should reflect differences in physician work. Physicians incur three types of costs to produce a service: work (their own time, energy and skill); practice expenses (medical equipment and space); and malpractice insurance. Medicare's fee schedule calculates a total relative value unit for each service based on these costs, and payments are determined by these relative values and a conversion factor that translates relative values into dollar amounts for each service.

When Medicare's fee schedule was first implemented in 1992, physicians were paid \$31 per relative value unit. A physician providing a service with 10 relative value units would have been paid \$310 for that service. A volume control mechanism links payment to growth in the number and mix of services physicians provide. The conversion factor is adjusted annually to hold Medicare spending for physician services to limits set by a formula specified by legislation. In 2001, the relative value unit was \$38.26. In 2002, it dropped to \$36.20.

Although previous payment changes have had little or no effect on Medicare beneficiaries' access to care, the prospect of unprecedented sharp declines in physician payment rates raises serious concerns. Unless Congress acts to change current law, Medicare physician fees are expected to drop again in 2003 and 2004.⁵ Lawmakers have proposed repealing the future cuts and providing modest increases over the next few years.

However, policy makers should not expect to address system-wide access problems through Medicare payment policy. The access declines witnessed in the four years preceding the Medicare payment cut may be temporary and may relate to such non-Medicare factors as patients' demand for physician services, changes in private insurance, the number and type of available physicians and local market conditions. Moreover, Medicare's national payment formula may be too blunt an instrument to address access problems that vary by specialty and market.

Finally, to accurately assess Medicare beneficiaries' access to care, policy makers should monitor access for the privately insured as well as avoid attributing system-wide problems to Medicare. For example, hotlines that collect complaints about Medicare patients' access problems will overlook similar problems of access occurring for the privately insured. ●

Notes

1. These analyses compare Medicare seniors to privately insured people 50 to 64 years of age because of the similarities in their medical resource use.
2. "New Data Specify Pay Cuts for 32 Specialties in 2002," *Part B News*, Vol. 15, No. 48 (Dec. 17, 2001).
3. Strunk, Bradley C., Kelly Devers and Robert E. Hurley, *Health Plan-Provider Showdowns on the Rise*, Issue Brief No. 40, Center for Studying Health System Change, Washington, D.C. (June 2001).
4. Congressional Budget Office, *Budgetary Implications of the Balanced Budget Act of 1997* (December 1997).
5. Office of the Actuary, Centers for Medicare and Medicaid Services, *Estimate Sustainable Growth Rate and Conversion Factor for Medicare Payments to Physicians in 2003*, N3-01-21 (March 1, 2002).