CENTER for STUDYING HEALTH SYSTEM CHANGE

Issue Brief

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AN UPDATE ON MEDICARE BENEFICIARY ACCESS TO PHYSICIAN SERVICES

By Sally Trude and Paul B. Ginsburg

After declining markedly between 1997 and 2001, Medicare seniors' access to physician care stabilized between 2001 and 2003, according to a national study by the Center for Studying Health System Change (HSC). Access to care trends were parallel for Medicare seniors 65 and older and privately insured people between the ages of 55 and 64—the near-elderly—suggesting that health system developments were much more important influences on beneficiary access than any effects of Medicare's 2002 physician payment rate reduction. In addition, access to care for both Medicare seniors and privately insured near-elderly people was comparable in local health care markets where commercial insurance payment rates far exceed Medicare's. However, both Medicare seniors and older privately insured people waited longer for physician appointments.

Access to Physician Services Stabilizes for Medicare Seniors

After a significant decline between 1997 and 2001, access to physician services for Medicare beneficiaries 65 and older stabilized between 2001 and 2003, according to HSC's Community Tracking Study (CTS) 2003 Household Survey (see Data Source). About 9.9 percent of Medicare seniors reported delaying or not getting needed medical care in 2003 compared with 11.0 percent in 2001 (see Table 1).

Policy makers had worried that seniors' access to care would continue to decline in the face of a Medicare physician payment rate reduction of 5.4 percent in 2002 and the potential for further large annual reductions. When overall access to physician services declined in 2001 because of growing system-wide capacity constraints prior to the payment cuts, policy makers feared Medicare patients, in particular, would have trouble getting care as a growing proportion of physicians indicated an unwillingness to serve new Medicare patients.[1]

Access by the Numbers

Comparisons of trends for privately insured near-elderly people (ages 55-64) and Medicare seniors could indicate whether potential access problems are developing across the health system or—if exclusive to Medicare seniors—stem from Medicare policies.

Mirroring the trend for Medicare seniors, the proportion of privately insured near-elderly people that reported delaying or not getting care stabilized between 2001 and 2003. Similarly, the privately insured near-elderly population experienced a spike in access problems in 2001 comparable to Medicare seniors, indicating system-wide capacity constraints affected access to physician services before the Medicare payment reduction. Since then, access problems for both groups have moderated, indicating the Medicare payment rate reduction did not disrupt Medicare seniors' access to care in the short term.

For Medicare seniors reporting problems getting care in 2003, roughly one in five reported they couldn't get an appointment soon enough, up from 14 percent in 1997 (see Table 2).

The proportion of Medicare seniors seeing a doctor at least once in the previous

Table 1

Trends in Access to Care for Privately Insured Near-Elderly People and Elderly Medicare Beneficiaries, 1997-2003

	Reported Delaying or Not Getting Care When Needed			
	1997	1999	2001	2003
Privately Insured Near-Elderly (Age 55-64)	15.2%	17.6%*	18.4%	17.4%#
Medicare Seniors (Age ≥65)	9.1	9.8	11.0*	9.9

* Change from previous survey is statistically significant at p <.05.

Change from 1997 to 2003 is statistically significant at p <.05.

Source: HSC Community Tracking Study Household Survey

Although the proportion of Medicare seniors and privately insured near-elderly people with access problems did not grow, these patients waited longer to see physicians.

Table 2

Reasons for Problems for People Who Reported Delaying or Not Getting Needed Care, 1997-2003

	1997	1999	2001	2003
Couldn't Get Appointment Soon Enough				
Privately Insured Near-Elderly (Age 55-64)	22.0%	21.4%	25.4%*	24.3%
Medicare Seniors (Age ≥65)	14.0	16.9	24.6*	20.4#
Couldn't Get Through By Phone				
Privately Insured Near-Elderly (Age 55-64)	7.2	7.7	9.2	7.3
Medicare Seniors (Age ≥65)	7.2	5.0	11.8*	7.7*

* Change from previous survey is statistically significant at p <.05.

Change from 1997 to 2003 is statistically significant at p <.05.

Source: HSC Community Tracking Study Household Survey

Table 3

Access by How Much Commercial Sector Pays Physicians Above Medicare Rate

	Medicare to Private Payment Rate Gap		
	Low	Medium	High
Reported Delaying or Not Getting Care When Needed			
Privately Insured Near-Elderly (Age 55-64)	18.6%	14.5%	19.0%
Medicare Seniors (Age ≥65)	8.1	8.8	8.6

Note: Communities where private insurers' physician payment rates substantially exceeded Medicare's rates were categorized as high; communities with private rates that were comparable to or below Medicare's were classified as low; and those communities with private rates that fell in between were categorized as medium. Information is based on HSC site visit interviews. See *http://www.hschange.org/CONTENT/553/* for more information.

Source: HSC 2002-03 Community Site Visits and Community Tracking Study Household Survey, 2003

year continued to rise in 2003, with 92 percent reporting at least one visit to a doctor during the year, compared with 87 percent in 1997. Medicare seniors reported having 5.5 physician visits a year in 2003 on average, up from 5.2 visits in 1997.

Payment Differentials Across Local Communities

Across the country there are significant differences between Medicare physician payment rates and commercial insurance payment rates, according to findings from HSC's 2002-03 site visits.[2] In some health care markets, such as Indianapolis; Little Rock, Ark.; Seattle and Syracuse, N.Y.; many physicians were receiving commercial payment rates for privately insured patients that went as high as 125 percent to 200 percent of the Medicare fee schedule. With a wide gap in payment rates, Medicare seniors could potentially have more trouble getting medical care in these markets than in communities, such as Cleveland, Miami and Orange County, Calif., where Medicare payment rates were at least as favorable as commercial rates.

Despite differences in Medicare and commercial payment rates across the markets, the proportion of Medicare seniors reporting problems in markets with the widest payment rate gap did not vary significantly from Medicare seniors in markets with more favorable Medicare payment rates (see Table 3). In addition, pri-

vately insured near-elderly people did not appear to gain better access to care relative to Medicare seniors in markets with favorable commercial payment rates.

Physician Choice

In 2003, dissatisfaction with physician choice decreased for the privately insured but remained unchanged for Medicare seniors. As provider networks expanded and health plans loosened managed care restrictions, a smaller percentage of privately insured near-elderly people in 2003 reported dissatisfaction with their choice of primary care physician (PCP) or specialist compared with 1997.

Seniors in Medicare fee-for-service did not face the same shifts in managed care experienced by the privately insured. However, from 1997 to 2001, physicians' willingness to accept all new Medicare patients fell from about 75 percent to 71 percent.[3] In particular, surgeon's willingness to accept all new Medicare patients fell from about 82 percent to 73 percent. Despite this, the proportion of Medicare seniors reporting dissatisfaction with their choice of PCP and specialist remained unchanged (see Table 4).

Patients Waiting Longer

Although the proportion of Medicare seniors and privately insured near-elderly people with access problems did not grow, these patients waited longer to see physicians. Both groups experienced longer waiting times whether waiting for a checkup or an appointment for a specific illness (see Table 5).

Medicare seniors and privately insured near-elderly people waited longer for appointments to both primary care providers and specialists. For example, Medicare seniors waited on average about 12 days in 2003 to see their primary care provider for a checkup compared with 10 days in 1997. For privately insured near-elderly people, the average waiting time for a checkup with their primary care provider rose from 11 days to almost 14 days. Similar trends in average waiting times were experienced for Medicare seniors and near-elderly patients for appointments with specialists for a specific illness.

Table 4

Trends in Dissatisfaction with Choice of Physician, 1997-2003

	Dissatisfaction with Choice of Physician			
	1997	1999	2001	2003
Primary Care Physician				
Privately Insured Near-Elderly (Age 55-64)	6.9%	6.0%	6.9%*	5.8%*
Medicare Seniors (Age ≥65)	3.2	3.3	3.5	3.7
Specialist				
Privately Insured Near-Elderly (Age 55-64)	6.5	6.1	6.4	4.6*#
Medicare Seniors (Age ≥65)	4.1	4.0	3.7	3.3

* Change from previous survey is statistically significant at p <.05.

Change from 1997 to 2003 is statistically significant at p <.05.

Source: Community Tracking Study Household Survey

Table 5

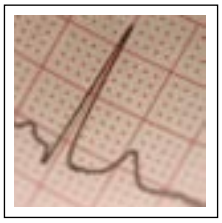
Average Waiting Time in Days for Checkup and Illness Appointments for All Physicians, PCPs and Specialists, 1997-2003

	1997	1999	2001	2003
All Physicians: Checkup				
Privately Insured Near-Elderly (Age 55-64)	12.4	13.2	14.2*	15.0#
Medicare Seniors (Age ≥65)	10.8	11.5	12.4*	12.4#
All Physicians: Visits for Specific Illness				
Privately Insured Near-Elderly (Age 55-64)	7.2	8.0*	8.5	8.7#
Medicare Seniors (Age ≥65)	7.6	9.6*	8.9	8.7#
PCP: Checkups				
Privately Insured Near-Elderly (Age 55-64)	11.0	11.6	12.7*	13.8#
Medicare Seniors (Age ≥65)	10.3	10.9	11.8	11.6#
PCP: Visits for Specific Illness				
Privately Insured Near-Elderly (Age 55-64)	4.3	5.1*	5.3	5.0
Medicare Seniors (Age ≥65)	6.1	8.0*	6.9*	6.2
Specialist: Checkups				
Privately Insured Near-Elderly (Age 55-64)	16.0	17.4	18.2	17.8
Medicare Seniors (Age ≥65)	12.2	14.2	15.2	14.8#
Specialist: Visits for Specific Illness				
Privately Insured Near-Elderly (Age 55-64)	12.1	12.6	13.7	14.5#
Medicare Seniors (Age ≥65)	10.1	12.1*	12.1	12.5#

* Change from previous survey is statistically significant at p <.05.

Change from 1997 to 2003 is statistically significant at p <.05.

Source: Community Tracking Study Household Survey



Data Source

This Issue Brief presents findings from the HSC Community Tracking Study Household Survey, a nationally representative telephone survey of the civilian, noninstitutionalized population conducted in 1996-97, 1998-99, 2000-01 and 2003. For discussion and presentation, we refer to a single calendar year of the first three surveys (1997, 1999 and 2001). Data were supplemented by in-person interviews of households without telephones to ensure proper representation. The first three rounds of the survey contain information on about 60,000 people, while the 2003 survey contains responses from about 47,000 people. Response rates ranged from 60 percent to 65 percent for the first three rounds and 57 percent in 2003.

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Significant increases in waiting times occurred in 2001 as well and were attributed to growing system-wide capacity constraints. Although waiting times have continued to rise, complaints about having to delay care did not show a comparable increase. Presumably, patients now expect longer waits for appointments and no longer consider these longer waits as delaying care.

Policy Implications

Historically, Medicare physician payment policy has sought to constrain total spending for physician services yet remain neutral to the care setting and type of care delivered. Medicare uses a formula linking annual changes to the payment rate for each unit of service to growth in the number and mix of services physicians provide. If the number and mix of services physicians provide per beneficiary exceeds the established budget, the payment rate is cut to bring spending back within budget.

Due to the growth in the number and intensity of physician services, the formula cut the 2002 payment rate by 5.4 percent and was expected to make further large annual reductions. Although the reduction held Medicare per capita spending growth for physician services to 2 percent, policy makers feared that additional payment reductions could threaten beneficiaries' access to care. In 2003, the formula reduced the physician payment rate by 4.4 percent, but subsequent legislation repealed the reduction and increased the physician payment rate 1.6 percent. For 2004 and 2005, Congress suspended the Medicare physician payment formula and increased the payment rate by 1.5 percent. From 2003 to 2004, Medicare spending per capita grew 7 percent.[4]

From an individual physician's perspective, the Medicare payment adjustment appears arbitrary, if not counterproductive. A cost-effective physician who provided fewer services per beneficiary would reduce his own Medicare revenue yet would not affect total Medicare physician spending. And at the end of the year, the cost-effective physician would face the same payment rate reductions as a physician who had dramatically increased the number and mix of services provided.

Although access to care for Medicare seniors has stabilized in the short term, access problems could grow over time, especially if a large cumulative payment rate reduction is enacted. Physician response to the 2002 reductions may have been tempered by an expectation that Congress would overturn the payment reductions. Also, making sharp changes in patient caseloads in the short term is impractical for physicians. Furthermore, some physicians can partially offset the effects of rate cuts on revenue by shortening visit times and increasing the number of patients they see, increasing the number of services offered, or changing the type and location of services offered. But ultimately, continued declines in payment rates are likely to reduce physicians' acceptance of Medicare patients.

Without a way to control the growth in the number and intensity of services physicians provide, Congress is stranded between a trade-off of uncontrolled spending and risking access problems for Medicare beneficiaries. Attempts to constrain costs will undoubtedly require a larger toolbox that encompasses a variety of approaches better targeted to reducing costs by focusing on high-cost patients and financial incentives for individual physicians.

Notes

1. Trude, Sally, and Paul B. Ginsburg, *Growing Physician Access Problems Complicate Medicare Payment Debate*, Issue Brief No. 55, Center for Studying Health System Change, Washington, D.C. (September 2002).
2. Letter from Paul B. Ginsburg to U.S. Sen. Max Baucus, April 10, 2003. Available at *http://www.hschange.org/CONTENT/553/*.
3. Trude and Ginsburg, 2002.
4. Medicare Payment Advisory Commission, *Report to Congress: Growth in the Volume of Physician Services* (December 2004).

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