The New York Times
Economix
Explaining the Science of Everyday Life

DECEMBER 24, 2010, 6:00 AM

Fees, Volume and Spending at Medicare

By UWE E. REINHARDT

Uwe E. Reinhardt is an economics professor at Princeton. He has some financial interests in the health care field.

My post last week on Medicare's payment of physicians ended with the observation that from 2000 to 2009, Medicare raised physician fees only 7 percent (an average of 0.75 percent a year), while the Medicare Economic Index (or M.E.I.), which tracks costs incurred by medical practices, rose 34 percent (an average of 3.3 percent annually).

Even so, Medicare's spending on physician services per beneficiary rose 61 percent, an average annual compound rate of 5.4 percent a year.

The difference between the tiny increases in physician fees and the large increase in spending on physician services reflected, of course, a sizable increase in the volume of physician services per Medicare beneficiary. It grew by 46 percent over the period, at an average annual compound rate of 4.3 percent a year.

As is shown in the chart below, the growth in the volume of services varied considerably by type of service.

The volume of evaluation and management services (E&M in the chart), the bread and butter of primary care physicians, rose only modestly, by about 3 percent a year, as did major procedures such as surgery.

Small wonder, then, that, given the relatively low fees paid primary care physicians, their net practice incomes grew only modestly over the period. They remain low relative to those of physicians earning the bulk of their income from providing technical procedures (see Exhibits 2 and 3 here).

Diagnostic tests and imaging services (X-rays, ultrasonic scans, CT scans, M.R.I. scans, PET scans) rose at an overall average annual compound rate of about 7.1 percent from 2000 to 2009, although not evenly over the entire period. (Anything that grows at 7 percent a year doubles over a decade!)

As the chart shows, they have grown less rapidly since 2006, after Congress, in the Budget Deficit Reduction Act of 2005, capped the fees strictly for the use of the imaging equipment - separate from the fee paid physicians who interpret the images.

There can be no question that the capacity to look into the human body with imaging devices represents a major, high-value breakthrough in the history of medical technology. For many medical conditions and their treatments, it is apt to be hugely cost- and pain-saving, particularly in light of the alternative, exploratory surgery.

On the other hand, health policy analysts and policy makers have for some time wondered whether the very rapid annual increase in the volume of diagnostic tests and imaging has yielded commensurate clinical benefits.

A particularly controversial issue in connection with imaging has been the self-referral boom. For some years, this has been widely discussed in hearings and testimony of the Medicare Payment Advisory Commission, or Medpac, a body of stakeholders in health care that advises Congress on payment issues under Medicare (see also Chapter 4 here).

Self-referral describes any arrangement in which physicians who are not radiologists use imaging equipment installed in their own offices, or refer patients to imaging services in facilities in which they or their family members have an indirect ownership interest or with which they have compensation agreement rewarding them for such referrals.

Medpac has been interested in self-referrals in imaging, because research over the years has shown that, other things being equal, self-referring physicians with direct or indirect financial interests in imaging services tend to authorize far more imaging services (and the spending on them) than do colleagues without this apparent conflict of interests.

Under the Ethics in Patient Referrals Act of 1989, physicians with direct financial interests in a diagnostic laboratory service are prohibited by Medicare from referring a Medicare patient to such a facility. The act also prevents such a facility from billing Medicare for such services. Because the legislation was introduced by Representative Pete Stark, a California Democrat, it is known among health care providers as, simply, Stark I.

In 1993-94, Stark I was expanded to 10 designated health services, which include a wide range of imaging services. The expanded act is known as Stark II.

It is almost impossible to make such a law airtight in the face of the great variety of medical-practice settings in this country, and with legions of sharp consultants, investment advisers and accountants ready to help physicians circumnavigate it.

For one, ancillary services provided by physicians in their offices, including imaging services, are exempt from Stark II. For larger group practices, this exemption includes entire imaging centers, as long as a referring physician within the group does not get compensation as a direct function of referrals to the center.

Also excluded are certain clever leasing arrangements noted by Medpac and others. For example, a physician can lease a block of time in an imaging center owned by others, pay that center a "fee per click," then bill Medicare a higher fee for the service, booking as profit the difference between the fees. Use of that approach has been growing rapidly.

In testimony before Congress in 2005, Medpac officials alluded to even more sophisticated leasing arrangements, such as the one illustrated in the chart below.

Naturally, and understandably, organizations representing manufacturers of imaging equipment and of physicians and patients who look askance at any restrictions on the use of imaging vehemently object to Medpac's recommendations on the issue of self-referral. They argue, for example, that having imaging equipment in the physician's office serves the convenience of patients and allows more rapid diagnosis.

A fascinating narrative on how private health insurers and Medicare have both wrestled with physicians over the volume of imaging services is provided in a paper by Bruce Hillman and Jeff Goldsmith, "Imaging: The Self-Referral Boom and the Ongoing Search for Effective Policies to Contain It." It is one of a series of research papers on self-referrals in the current issue of the health policy journal Health Affairs (on whose editorial board I serve).

The issue of self-referral merely illustrates the great difficulty third-party payers face in general when they compensate physicians for procedures and products that are incidental to the referring physician's own services and do not require much or any of referring physician's time - but that yield the referring physician a profit.

The traditional working assumption had been that, in treating their patients, physicians are impervious to such financial incentives. Many, most likely, are. But a growing body of research has chipped away at the general validity of that assumption - hence the growing disillusionment with the hallowed fee-for-service method of compensating physicians.

At least for the next decade or so, we are stuck with fee-for-service and must wrestle with the problems it creates as best we can. For the longer term, I see two distinct approaches.

First, the existing Medicare program could gradually shift away from fee-for-service payment to bundled payments for all the care going into the treatment of defined episodes of illness - or to capitation for chronic care. This idea has been put forth by many policy analysts and by Medicare itself but would be a decade or more in the making.

An alternative is to sweep the entire problem under the rug by privatizing all of Medicare. This could be accomplished through the defined-contribution plan recently advocated by the economist Alice Rivlin of the Brookings Institution and Representative Paul Ryan, Republican of Wisconsin.

Under the Rivlin-Ryan plan, the problem of paying the providers of health care would no longer be visible and for government to solve. Instead, it would be the product of private and presumably secret deals between private health plans and the providers - and, indirectly, the elderly, who would be made to bear the risk of rising payments to providers.

Provided, of course, that elderly voters accept such a new deal.