



## Forum Session Meeting Announcement

**Friday, March 17, 2006**  
9:00am–9:30am — Breakfast  
9:30am–11:30am — Discussion

### Physician Spending Growth: Do We Get What We Pay For?

#### A Discussion Featuring:

**Mark Miller, PhD**  
*Executive Director*  
Medicare Payment Advisory Commission

**David Goodman, MD**  
*Professor of Pediatrics and Professor of Community and Family Medicine*  
Dartmouth Medical School  
*Chief of Allergy and Clinical Immunology*  
Dartmouth-Hitchcock Medical Center

**Samuel Nussbaum, MD**  
*Executive Vice President and Chief Medical Officer*  
Wellpoint, Inc.

**Paul Liss, MD**  
*Chief Medical Officer*  
Marshfield Clinic

#### Location

**Hyatt Regency on Capitol Hill**  
400 New Jersey Avenue, NW  
Yorktown Room

#### Registration Required

Space is limited. Please respond as soon as possible.

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# Physician Spending Growth: Do We Get What We Pay For?

## OVERVIEW

*Medicare fees for physician services in 2006 will be held to 2005 levels, yet Medicare physician spending is projected to rise by \$1.5 billion. Increases in the volume of physician services provided as well as their complexity have been driving up spending and are expected to continue to do so. This trend adds to concerns about the growing share of the federal budget devoted to health care and whether the added spending is improving health outcomes. This Forum session will examine recent trends in physician spending, the value of additional physician services, and public and private payers' efforts to get the most value out of the health care dollar.*

## SESSION

Each year Medicare consumes a larger share of the federal budget, fueled in part by physician spending increases that have averaged 10 percent annually in recent years.<sup>1</sup> This unrelenting growth contributed to the implementation of an annual update formula designed to help control outlays: for 2006, the formula called for a 4.4 percent reduction in physician fees. The Congress overrode this mandated reduction in response to physician concerns, keeping physician fees at 2005 levels. This temporary reprieve from the update formula will exacerbate spending growth<sup>2</sup> and only delay needed discussions about how to slow rising expenditures.

Increases in the volume of services beneficiaries receive as well as service intensity—that is, the complexity of the services provided—will cause Medicare physician spending to be higher in 2006 than it was in 2005. Health care cost increases that are greater than the growth in the overall economy have combined with concerns that the spending growth does not necessarily contribute to improved health outcomes. Together, they are fueling efforts to better understand the reasons for the increased service delivery and to tailor remedies to strategically cut this growth.<sup>3</sup>

The rise in volume and intensity of Medicare physician services has been attributed to several factors. One contributor is the additional services now covered under the Medicare benefit. Certain preventive services have been added that have directly increased the volume of physician services. Such expansions can also indirectly boost the amount of services provided when the newly covered services identify previously undetected health concerns that require treatment. Advances in medicine and technology have also

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added to the treatments and therapies that may be provided to beneficiaries, thus increasing physician service use and intensity. These advances may indeed improve treatments for certain conditions as well as the quality of life for some people. Technological advances sometimes make it feasible for certain services to be provided in the physician's office, instead of in settings like the hospital outpatient department. Such a shift in setting may make these services more convenient or more acceptable to patients, also contributing to their increased use.

The increased utilization may also be driven by other factors. The role of the physician as the gatekeeper to most health care services is said to contribute to the problem of unwarranted increases in spending. When physicians are paid on a fee-for-service basis, they are rewarded for providing more services. In fact, the use of discretionary services is higher in geographic areas where there are more physician and hospital resources.<sup>4</sup> As Arnold Relman, MD, once stated in the journal *Health Affairs*, "the fee-for-service physician is a supplier who is able to determine the demand for his own services."<sup>5</sup>

Some studies have shown a relationship between rising service use and the level of physician fees. The recent acceleration in physician spending could be partly a response to constraints on fees, by both Medicare and private payers, with physicians trying to maintain or increase income by billing for more services. An analysis of Medicare physician services by the Centers for Medicare & Medicaid Services concluded that the increase in intensity of services "...is more frequently observed in physician practices that have had price reductions."<sup>6</sup>

Policymakers will continue to be concerned about the impact of increased spending on the federal budget. Evidence on the substantial geographic variation in health care spending without commensurate differences in health outcomes suggests that it may be possible to both control spending and increase the value of the health care dollar.<sup>7</sup> At this Forum session, the speakers will lay out the extent of physician spending increases, discuss various incremental approaches to slow spending, and address how certain changes may maintain or even improve outcomes.

## KEY QUESTIONS

- How have changes in the practice of medicine affected utilization trends of particular services? How have payment policies affected these trends?
- How can the value of physician services be evaluated? What approaches can public and private payers adopt to minimize the use of services of questionable value?
- How extensive is the arsenal of current treatment guidelines and protocols? How can guidelines and protocols be used to influence physician services most effectively?

- What methods have private payers and plans used to control service volume and intensity? How successful have these efforts been in constraining costs? Improving outcomes?
- What are the barriers to implementing effective programs to control spending? What payment factors affect their success? What physician practice characteristics affect their success?
- How can efforts to contain physician service use and intensity be adapted to the Medicare fee-for-service program? What special challenges must be overcome?

## SPEAKERS

**Mark Miller, PhD**, executive director of the Medicare Payment Advisory Commission (MedPAC), will begin this Forum session with a presentation on MedPAC's recent work on the growth in the volume and intensity of physician services and how this has affected Medicare spending. Dr. Miller will be followed by **David Goodman, MD**, professor of pediatrics and of community and family medicine at Dartmouth Medical School and the chief of allergy and clinical immunology at the Dartmouth-Hitchcock Medical Center. Dr. Goodman will present evidence about the geographic variation in health care spending, the factors associated with this variation, and the value of higher spending with respect to health outcomes. **Samuel Nussbaum, MD**, executive vice president and chief medical officer of Wellpoint, Inc., will discuss the challenges faced by a large insurer in dealing with rising costs and the need to extract greater value from health care spending. **Paul Liss, MD**, chief medical officer of the Marshfield Clinic, will round out the panel by discussing initiatives undertaken by the large, multispecialty group practice to improve health outcomes.

## ENDNOTES

1. Medicare Payment Advisory Commission, *A Data Book: Healthcare Spending and the Medicare Program*, June 2005; [www.medpac.gov/publications/congressional\\_reports/Jun05DataBook\\_Entire\\_report.pdf](http://www.medpac.gov/publications/congressional_reports/Jun05DataBook_Entire_report.pdf).
2. Congressional Budget Office, "Cost Estimate, S.1932 Deficit Reduction Act of 2005, Conference Agreement, as amended and passed by the Senate on December 11, 2005," January 27, 2006; available at [www.cbo.gov/ftpdocs/70xx/doc7028/s1932conf.pdf](http://www.cbo.gov/ftpdocs/70xx/doc7028/s1932conf.pdf).
3. Christine Borger *et al.*, "Health Spending Projections Through 2015: Changes On the Horizon," *Health Affairs – Web Exclusive*, February 22, 2006, available at <http://content.healthaffairs.org/cgi/reprint/hlthaff.25.w61v1.pdf>; and Victor R. Fuchs, "More Variation in Use of Care, More Flat-of-the-Curve Medicine," *Health Affairs*, October 7, 2004, available at <http://content.healthaffairs.org/cgi/reprint/hlthaff.var.104v1.pdf>.

Endnotes / continued ►

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4. John E. Wennberg, Elliott S. Fisher, and Jonathan S. Skinner, "Geography and the Debate Over Medicare Reform," *Health Affairs – Web Exclusive*, February 13, 2002; available at <http://content.healthaffairs.org/cgi/reprint/hlthaff.w2.96v1.pdf>.
5. Arnold S. Relman, "The Future of Medical Practice," *Health Affairs*, vol. 2, no. 2 (Summer 1983): 5–19; available at <http://content.healthaffairs.org/cgi/reprint/2/2/5.pdf>.
6. Centers for Medicare & Medicaid Services, "Estimated Physician Volume and Intensity Response to a Price Change for Physicians' Services," memorandum from Volume-and-Intensity Response Team, Office of the Actuary, HCFA, to Richard S. Foster, Chief Actuary, August 13, 1998; available at <http://new.cms.hhs.gov/ActuarialStudies/downloads/PhysicianResponse.pdf>.
7. Elliott S. Fisher *et al.*, "The Implications of Regional Variations in Medicare Spending. Part 1: The Content, Quality, and Accessibility of Care," *Annals of Internal Medicine*, vol. 138, no. 4 (February 18, 2003): 273–287, available at [www.annals.org/cgi/reprint/138/4/273.pdf](http://www.annals.org/cgi/reprint/138/4/273.pdf); and Elliott S. Fisher *et al.*, "The Implications of Regional Variations in Medicare Spending. Part 2: Health Outcomes and Satisfaction with Care," *Annals of Internal Medicine*, vol. 138, no. 4 (February 18, 2003): 288–298, available at [www.annals.org/cgi/reprint/138/4/288.pdf](http://www.annals.org/cgi/reprint/138/4/288.pdf).



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