

Forecasting Trends in Physician Fees and Incomes and Effects on Access to Care for Medicare Beneficiaries In Traditional Medicare

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The issue: The Medicare Trustees in their 2016 report have expressed concern (p.3) about the impact of future trends in Medicare physician payment rates on beneficiary access to physician care and the willingness of a large proportion of physicians to accept Medicare patients. Since the rate of growth of physician payments in the short and long run is specified by the MACRA law and other rules, we want to determine whether anything can be said about projecting the other key determinants of physician access. The trustees placed primary emphasis on the trend in Medicare reimbursements relative to both practice costs and private sector reimbursements.

The objective. We infer from the discussion that the primary goal is to keep access to physicians (in terms of both volume of services and proportion/convenience of finding a physician who takes Medicare patients) should remain at about the current level, which is generally regarded as satisfactory.

Current access. Based on information from an annual survey that MEDPAC cited in their March 2016 report to Congress, access to physicians for Medicare beneficiaries in traditional Medicare remains good, with more than 90% of physicians treating some Medicare patients, (Can provide more detail.) The most negative finding was that, among Medicare patients searching for a new primary care physician, 15% reported serious problems in finding one and xx% reported moderate problems. (This is about the same rate as privately insured patients report.) But those beneficiaries who already have a regular physician find them continuing to accept Medicare patients.

Reasons for concern for the future. There are several reasons why the Trustees were concerned about preserving this level of access in the future. A general concern is that the projected payment updates specified in law do not take into account changing economic conditions (like economywide inflation). More specific concerns are that physician costs may rise more rapidly than payment rates, and that private insurer payment rates, already somewhat larger than Medicare rates, may rise further relative to those rates incentivizing physicians to switch to treating private patients.

Observations on developing the basis for some type of prediction or forecast.

- *General economic conditions.* The report does contain assumption about long term trends in price inflation for the economy as a whole. We are not sure these have been compared to projections of payment rates. More seriously, it seems impossible to forecast unexpected deviations from the approximately 2% assumed rate, and the payment system has no automatic adjuster. However, we have no good models of how a reduction in real fee levels if inflation spiked would affect access to Medicare beneficiaries; the lower overall real income might even make them more willing to take patients or at least increase volume. It does not seem that much can be done with this factor.

- *Practice costs increases for Medicare services* The Trustees fear that physician payment amounts in traditional Medicare “are not expected to keep pace with the average rate of physician cost increases” and that the cumulative gap could become large unless physicians are somehow able to increase productivity or lower their cost growth below historical trends. Definitionally this means that net revenue or profit margins on Medicare business would shrink which might lead to a reduction in supply. The goal seems to be to keep those margins constant per unit of care at current levels over future time periods.
- *Comparison to private health insurance.* The final concern is that, not only might there be an absolute decline in rewards for seeing Medicare patients but “the availability and quality of care received by beneficiaries would... fall over time compared to that received by those with private health insurance.” This sentence could be interpreted as setting a goal of maintaining the current ratio or relative access compared to private insurance. The most general problem here is that as far as I know we have little basis for forecasting access to care in private insurance. We do have household surveys on access that ask subjective judgments about how easy it is to get a physician appointment and the like, but have no definitive measure or measures of access nor ones that clearly distinguish access from use.

Some complex considerations. Here we provide a discussion of considerations in thinking about a measure that might project traditional Medicare beneficiary access. (We ignore here what might happened to access in Medicare Advantage programs although that would seem to be an important policy question as well.)

- *The role of volume or quantity.* One might conjecture that the willingness of physicians to accept Medicare patients may depend on their total net revenue from Medicare business, not just on unit prices or margin per unit. For example, if the physician has excess capacity (whatever that might mean) a lower margin per unit on Medicare patients might be offset by higher volume, either in total or relative to private volume. Some have conjectured as noted above that physicians might offset lower prices with higher induced volume. Whether or not this is true, demographic projections imply that over time there are likely to be fewer younger people with private insurance relative to Medicare beneficiaries, which would itself shift relative volume.
- *The role of narrow networks and private panels.* Another consideration is that almost all private plans now limit insureds to certain providers, paying nothing or paying at lower rates for out of network providers and requiring higher out of pocket payments. The patient may still find it easy to get an appointment with a network doctor (though not always or even usually, to judge from anecdotes) but clearly does not have access to the large range of physicians who take Medicare patients. Even if the payment rate to the network physicians are higher than those in Medicare, how is access to be affected and defined? A measure of the relative number of area physicians taking Medicare patients versus private patients and how that is forecasted to change over time would seem to be an important component of access.

- *The role of practice cost changes.* While there could be some differentiation, it is likely that physicians will experience the same trends in practice cost for their private patients as for their Medicare patients. In Medicare an increase in practice costs only affects the margin, and increasing payments to keep up with increasing practice costs would maintain the margin. However, economic theory suggests that the same story is not true for private prices. If the physician is modelled as having some private market power, an increase in practice costs will not usually lead to a matching change in prices. That is, a given percentage increase in marginal cost (which is only part of total cost) may lead to an increase in the monopoly price which is several multiples of the cost increase, depending on the firm level of demand. Hence for Medicare to try to chase private prices may be both difficult and illogical. The increase in private price for the monopolist will reduce volume and will still not offset the negative effect on net income, but the actual pattern is quite complex in theory and even more complex in practice if there is bargaining between providers and private insurers.

Possible ways to proceed. The most serious problems to producing useful information on this question are (1) we do not have a specification of access goals or measures and (2) we do not have a way to model private sector insurance behavior with regard to pricing and access (networks and panels) over time. As a first step I believe it would be useful to step back and see what we can say about modelling goals and private sector behavior in a more formal way than in these notes. That may tell us better what we want to measure and, if private sector behavior is to be included in that measure, how we might project that behavior.

Some data that might be helpful in the meantime would be (1) projections of physician practice costs relative to payment rates in current law, and (2) projections of the numbers of private and Medicare patients per physician (requires forecasting practicing physicians as well as demographic changes) to generate some idea of potential volumes per practice and how they may change over time.

On the private sector side it is much more daunting to think of what data might be needed and what might be available. The projection of fee levels and per unit margins over time might be obvious, but we also need some kind of projection of which proportion of physicians in areas are available on average to privately insureds.