APPENDIX E. MEDICARE REIMBURSEMENT TO PHYSICIANS

CONTENTS

PHYSICIAN PAYMENT REFORM

The Omnibus Budget Reconciliation Act of 1989 (OBRA 1989) provided for the implementation, beginning January 1, 1992, of a new payment system for physicians' services paid for by Medicare. This fee schedule payment system replaced the previous reasonable charge payment system. The new system was enacted in response to two principal concerns. The first was the rapid escalation in program payments. The second was that the use of the reasonable charge payment had led, in many cases, to payments which were not directly related to the resources used.

Under the current system, payments are made under a fee schedule which is based on a resource-based relative value scale (RBRVS). Annual updates to the payment amounts are based, in part, on a comparison of actual physician spending in a base period compared to an expenditure goal known as the Medicare volume performance standard (MVPS). Use of the MVPS was intended to moderate the rate of growth in physician expenditures. The law also places limits on amounts that physicians can bill in excess of Medicare's approved payment amount.

MEDICARE FEE SCHEDULE

The Secretary of DHHS is required to establish a fee schedule before January 1 of each year that sets payment amounts for all physicians' services furnished in all fee schedule areas for the year. The fee schedule amount for a service is equal to the product of:

—The relative value for the service;
—The geographic adjustment factor (GAF) for the service for the fee schedule area; and
—The national dollar conversion factor for the year.

Relative value unit

The relative value unit (RVU) for each service, the first factor used to calculate the fee schedule, has three components:

—The physician work component reflects physician time and intensity, including activities before and after patient contact;
—The practice expense or overhead component includes all categories of practice expenses (exclusive of malpractice liability insurance costs). Included are office rents, employee wages, physician compensation, and physician fringe benefits; and
—The malpractice expense component reflects costs of obtaining malpractice insurance.

The proportion that each component represents of the total RVU varies by service.

Geographic adjustment factor

The second factor used in calculation of the fee schedule is the geographic adjustment factor (GAF) for the fee schedule area. There are currently 211 fee schedule areas nationwide.

The GAF is designed to account for geographic variations in the costs of practicing medicine and obtaining malpractice insurance as well as a portion of the difference in physicians' incomes that is not attributable to these factors.

The GAF is the sum of three indices. Separate geographic practice cost indices (GPCIs) have been developed for each of the three components of the RVU, namely a work GPCI, a practice expense or overhead GPCI, and a malpractice GPCI. In effect, a separate geographic adjustment is made for each component. However, as required by law, only one-quarter of the geographic variation in physician work resource costs is taken into account in the formula. (Table E–24 at the end of this chapter shows the GAF values for each of the 211 fee schedule areas nationwide.)

The three GPCI-adjusted RVU values are summed to produce an indexed RVU for each locality.

Conversion factor

The conversion factor, which is the third fee schedule factor, is a dollar multiplier which converts the geographically adjusted relative value for a service to an actual payment amount for the service. The law initially required the establishment of a single conversion factor. Beginning in 1993, two conversion factors applied—one for surgical services and one for nonsurgical services. Beginning in 1994, there were three conversion factors—one for surgical, one for primary care, and one for nonsurgical services. The 1996 conver-

sion factors are $40.80 for surgical services, $35.42 for primary care services, and $34.63 for other nonsurgical services. Thus, the payment for a surgical service with an adjusted relative value of two is $81.60; the payment for a primary care service with an adjusted value of two is $70.84; the payment for a nonsurgical service with an adjusted relative value of two is $69.26. Anesthesiologists are paid under a separate fee schedule which uses base and time units. A separate conversion factor ($15.28 in 1996) applies.

Payment formula

The payment for each service is calculated as follows:

$$\text{Payment} = CF \times [(RVU_{work} \times GPCI_{work}) + (RVU_{practice\ expense} \times GPCI_{practice\ expense}) + (RVU_{malpractice} \times GPCI_{malpractice})]$$

Where:

CF = conversion factor;

RVU_{work} = physician work relative value units for the service;

$GPCI_{work}$ = geographic practice cost index value for physician work in the locality (the value reflects only one-quarter of the variation in physician work as required by law);

$RVU_{practice\ expense}$ = practice expense or overhead relative value units for the service;

$GPCI_{practice\ expense}$ = geographic practice cost index value for practice expense or overhead applicable in the locality;

$RVU_{malpractice}$ = malpractice relative value units for the service; and

$GPCI_{malpractice}$ = geographic practice cost index value for malpractice applicable in the locality.

MEDICARE VOLUME PERFORMANCE STANDARDS; CONVERSION FACTOR UPDATES

A key element of the fee schedule is the conversion factor. One consideration in establishing the annual update in the conversion factor is whether efforts to stem the annual rate of growth in physician payments have succeeded. This growth is measured by the Medicare volume performance standards (MVPSs).

MEDICARE VOLUME PERFORMANCE STANDARDS

The law requires the calculation of annual MVPSs, which are standards for the rate of expenditure growth. The purpose of these standards is to provide an incentive for physicians to get involved in efforts to stem expenditure increases. The relationship of actual expenditures to the MVPS is one factor used in determining the annual update in the conversion factor.

Implementation of the MVPS provision began in fiscal year 1990. As modified by subsequent legislation, there are three separate MVPS rates of increase—one for surgical care, one for primary care, and one for nonsurgical services.

The law contains a formula for calculating the annual update in the MVPS. However, Congress may modify the update that would otherwise apply. The Secretary of DHHS is required to make a recommendation to the Congress by April 15 each year. In making the

recommendation, the Secretary is to consider inflation, changes in the number of part B enrollees, changes in technology, appropriateness of care, and access to care. The Physician Payment Review Commission (PPRC), a Congressional advisory body, is required to review the Secretary's recommendation and submit its own recommendation by May 15.

The Congress may establish the standard rates of increase. If the Congress does not specify the MVPS, however, the rates of increase are determined based on the default formula. The default standard is the product of four factors reduced by a performance standard factor of four percentage points. The four factors are:

—The Secretary's estimate of the weighted average percentage increase in physicians' fees for services for the portions of the calendar years included in the fiscal year involved;

—The Secretary's estimate of the percentage change from the previous year in the number of part B enrollees;

—The Secretary's estimate of the average annual percentage growth in volume and intensity of physicians' services for the preceding 5 fiscal years; and

—The Secretary's estimate of the percentage change in physician expenditures in the fiscal year (not taken into account above) which will result from changes in law or regulations.

The MVPS for fiscal year 1996 is a decrease of 0.5 percent for surgical services and 0.6 percent for other nonsurgical services (see table E–1).

TABLE E–1.—MEDICARE VOLUME PERFORMANCE STANDARDS, 1990–96

Fiscal year	Surgical	Nonsurgical	Primary care	All
1990	([1])	([1])	([2])	9.1
1991	3.3	8.6	([2])	7.3
1992	6.5	11.2	([2])	10.0
1993	8.4	10.8	([2])	10.0
1994	9.1	9.2	10.5	9.4
1995	9.2	4.4	13.8	7.5
1996	−0.5	0.6	9.3	1.8

[1] Separate performance standards for surgical and nonsurgical services not required for fiscal year 1990.

[2] Separate performance standards for primary care services not required for fiscal years 1990–93.

Source: O'Sullivan (1996).

CONVERSION FACTOR UPDATES

Annual updates in payments under the fee schedule are made by updating the dollar conversion factor. The law contains a formula for calculating the annual updates. However, the Congress may modify the updates that would otherwise apply.

In April of each year (beginning in 1991), the Secretary of DHHS is required to recommend to the Congress the updates in the conversion factors for the following year. In making the update recommendations, the Secretary is required to consider a number of factors including the percentage change in actual expenditures in

the preceding fiscal year compared to the MVPS for that year, changes in volume and intensity of services, beneficiary access to care, and the increase in the Medicare economic index (MEI). The MEI is a percentage figure which is revised annually; it has been used in the program to limit annual increases in recognized fees. The MEI is generally intended to reflect annual increases in the costs of operating a medical practice; however, for several years the MEI percentage was set by the Congress. The PPRC is required to review the Secretary's update recommendation and submit its own recommendation to Congress by May 15 of each year.

The Congress either specifies the updates to the conversion factor or a default formula, specified in law, applies. The default fee update is equal to the Secretary's estimate of the MEI increased or decreased by the percentage difference between the increase in actual expenditures and the MVPS for the second preceding fiscal year. (Thus, the 1996 updates reflect actual fiscal year 1994 experience.) However, the law specifies a lower limit on the default update. The maximum downward adjustment in the update is 5.0 percentage points. There is no restriction on upward adjustments to the MEI.

Table E–2 shows the 1992–96 fee schedule updates. This table shows what the MEI was for each year, the impact of the MVPS calculation (i.e., the "performance adjustment"), legislative modification (if any), and the resulting update percentage. The table also shows the conversion factors for each year.

TABLE E–2.—CONVERSION FACTORS: CALCULATION OF UPDATES AND ANNUAL FACTORS, 1992–96

Calendar year	Calculation of update (in percent)				Conversion factor
	Medicare economic index	Performance adjustment	Legislative adjustment	Update	
Calendar year 1992:					
All services	3.2	−0.9	−0.4	1.9	$31.00
Calendar year 1993:					
Surgical	2.7	0.4	.....	3.1	31.96
Nonsurgical	2.7	−1.9	.....	0.8	31.25
Calendar year 1994:					
Surgical	2.3	11.3	−3.6	10.0	35.16
Primary care	2.3	5.6	0.0	7.9	33.72
Other nonsurgical	2.3	5.6	−2.6	5.3	32.90
Calendar 1995:					
Surgical	2.1	12.8	−2.7	12.2	39.45
Primary care	2.1	5.8	0.0	7.9	36.38
Other nonsurgical	2.1	5.8	−2.7	5.2	34.62
Calendar year 1996:					
Surgical	2.0	1.8	.....	3.8	40.80
Primary care	2.0	−4.3	.....	−2.3	35.42
Other nonsurgical	2.0	−1.6	.....	0.4	34.63

Source: O'Sullivan (1996).

Over time, implementation of the default formula update would have the effect of lowering the conversion factors. This is in part attributable to the fact that the default MVPS includes an automatic 4 percentage point reduction from the historical growth rate trend. CBO estimates that under current law, the primary care conversion factor would drop to $35.06 in 2002, the surgical conversion factor would drop to $35.73 and other nonsurgical services would decline to $30.39.

LIMITS ON BENEFICIARY LIABILITY

Medicare pays 80 percent of the fee schedule amount after the beneficiary has met the $100 deductible for the year. The beneficiary is responsible for the remaining 20 percent, known as coinsurance. If a physician does not accept assignment on a claim, the beneficiary may be liable for additional charges known as balance billing charges. However, the law places certain limits on these balance billing charges.

Assignment/participation

A physician is able to choose whether to accept assignment on a claim paid under the fee schedule. In the case of an assigned claim, the physician bills the program directly and is paid an amount equal to 80 percent of the fee schedule amount (less any unmet deductible). The physician may not charge the beneficiary more than the applicable deductible and coinsurance amounts. In the case of nonassigned claims, the physician still bills the program directly; however, Medicare payment is made to the beneficiary. In addition to the deductible and coinsurance amounts, the beneficiary is liable for the difference between the fee schedule amount and the physician's actual charge, subject to certain limits. This is known as the balance billed amount.

A physician may become a "participating physician" by voluntarily entering into an agreement with the Secretary of DHHS to accept assignment on all claims for the forthcoming year. Medicare patients of these physicians never face balance billing charges.

The law includes a number of incentives for physicians to become participating physicians, chief of which is higher recognized fee schedule amounts. The fee schedule amount for a nonparticipating physician is only 95 percent of the recognized amount for a participating physician.

The law specifies that physicians are required to accept assignment on all claims for persons who are dually eligible for Medicare and Medicaid. This includes "qualified Medicare beneficiaries" (QMBs); these are persons with incomes below poverty for whom Medicaid is required to pay Medicare premiums and cost-sharing charges.

Balance billing limits

Nonparticipating physicians may charge beneficiaries more than the fee schedule amount on nonassigned claims; these balance billing charges are subject to certain limits. The limit is 115 percent of the fee schedule amount for nonparticipating physicians. The nonparticipating physicians fee schedule payment level is 95 percent of the participating physicians level. Thus, the balance billing

limit is only 9.25 percent higher than the level recognized for participating physicians (95 percent × 115 percent).

MEDICAL CARE OUTCOMES AND EFFECTIVENESS RESEARCH

OBRA 1989 created a new agency, the Agency for Health Care Policy and Research, which replaced the then existing National Center for Health Services Research in the Public Health Service. The mission of the new agency was to enhance the quality, appropriateness and effectiveness of health care services and access to such services. These goals were to be accomplished by establishing a broad base of scientific research and promoting improvements in the clinical practice of medicine and the organization, financing, and delivery of health care services.

Specifically, the agency was directed to conduct and support research, demonstration projects, evaluations, training, guideline development, and the dissemination of information on health care services and delivery systems, including activities on: (1) the effectiveness, efficiency, and quality of health care services; (2) the outcomes of health care services and procedures; (3) clinical practice, including primary care and practice-oriented research; (4) health care technologies, facilities, and equipment; (5) health care costs, productivity, and market forces; (6) health promotion and disease prevention; (7) health statistics and epidemiology; and (8) medical liability.

IMPACT OF MEDICARE FEE SCHEDULE

The Medicare Fee Schedule was designed to remove many of the inequities of the previous payment system by shifting payment away from tests and procedures toward evaluation and management services. Because the fee schedule was intended to be implemented in a budget-neutral fashion, total outlays under the new system were expected to match the outlays that would have occurred under the previous payment system. In general, under the new payment system, primary care physicians were expected to receive higher payments per service, and specialty physicians were expected to receive lower payments per service. Payment levels in rural areas were also expected to increase relative to metropolitan areas.

The overall payment level under the Medicare Fee Schedule is established through the conversion factor. In effect, the conversion factor translates the relative value units for individual services into actual dollar payments. Increases or decreases in the overall level of payments are accomplished by adjusting the level of the conversion factor.

Using data from 1991, 1992, and 1993, PPRC examined the initial impact of the Medicare Fee Schedule on physicians. From 1991 to 1993, physicians' payments per service declined by 4 percent. Surgical specialties had about an 8-percent reduction in payment per service compared with the 2-percent increase for medical specialties. Specialties that predominantly provide evaluation and management services fared better. Payments to general and family practitioners increased by 17 percent over the 2-year period, while

those to internists rose by 2 percent. Pathologists and thoracic surgeons had the largest reduction of 16 percent, followed by gastroenterologists, radiologists, and cardiologists with reductions ranging from 10 to 12 percent.

The total Medicare payment a physician receives depends not only on the payment per service but also on changes in the number and intensity of services billed. Although physicians had about a 4-percent reduction in payment overall from 1991 to 1993, a 6-percent increase in the number and intensity of services per physician led to about a 4-percent increase in total Medicare payment per physician over the 2-year period.

PPRC analyzed Medicare claims data from the first 6 months of 1994 and 1995 to measure changes in physician payment patterns. Across all services, Medicare payment per service went up 3.8 percent, on average, between 1994 and 1995 (table E–3). This increase, combined with a 4.1-percent rise in volume and intensity of services per physician, drove up Medicare payment per physician by 8.0 percent. Medicare revenue per physician, consisting of Medicare payments on all claims and balance billing up to charge limits on unassigned claims, increased by 7.9 percent. Growth in revenue per physician was slightly lower than growth in payment per physician because of declines in balance billing.

There are marked differences in payment changes across service families and physician specialties. The 9.0-percent rise in payment per service for primary care was higher than the increase for all other types of services (table E–3). Payment levels for evaluation and management services other than primary care went up by 6.7 percent and those for surgical services increased by 5.0 percent, while payment rates for other nonsurgical services fell by 0.4 percent.

Changes in payment per service by specialty reflect the mix of services each specialty actually provided. For example, family and general practice physicians, who furnish a large share of primary care services, experienced one of the largest average service payment growth rates, at 7.5 percent (table E–3). Except for ophthalmologists, surgeons also received payment increases of 5.2 percent or more. Specialists, such as cardiologists and gastroenterologists, who provide a relatively large share of other nonsurgical services saw little growth in payment levels; in fact, average payment levels actually fell by 1.4 percent for cardiologists.

Payment levels grew faster in rural than in metropolitan areas (table E–3). They went up by 4.8 to 6.6 percent in rural areas, but only 3.5 to 3.8 percent in metropolitan areas. These patterns are consistent with the Medicare Fee Schedule's expected shift of payments toward rural areas.

Changes in volume and intensity do not appear to be highly correlated with those in payment levels, either by service type or physician specialty. Most specialties had increases in the volume and intensity of services per physician as well as in total payments and revenue per physician (table E–3). One exception was radiologists, among whom volume and intensity per physician decreased by 1.5 percent, mostly in the area of routine diagnostic radiology services. Gastroenterologists also had decreases in volume and intensity per physician, as well as in Medicare payments and revenue. This was

due largely to reductions in volume and intensity of colorectal endoscopy procedures like sigmoidoscopy.

TABLE E–3.—CHANGE IN MEDICARE PAYMENT AND VOLUME BY TYPE OF SERVICE, LOCATION, AND SPECIALTY, 1994–95

[Percentage change]

Type of service, location, and specialty	Medicare payment per service	Volume and intensity per physician	Medicare payment per physician [1]	Medicare revenue per physician [2]	Percentage of 1995 Medicare payments
All services	3.8	4.1	8.0	7.9	100.0
Evaluation and management services:					
Primary care	9.0	3.1	12.4	12.2	20.0
Other	6.7	0.3	6.9	6.9	16.5
Surgical services	5.0	4.5	9.7	9.6	23.2
Other nonsurgical services	−0.4	5.9	5.4	5.4	40.3
Location:					
Metropolitan areas:					
>1 million	3.5	2.8	6.4	6.4	53.0
<1 million	3.8	5.6	9.6	9.5	34.5
Rural counties:					
>25,000	4.8	7.1	12.2	12.1	10.1
<25,000	6.6	1.4	8.1	7.9	2.5
Specialty:					
Cardiology	−1.4	3.5	2.1	2.0	8.4
Family/general practice	7.5	−0.1	7.4	7.2	10.1
Gastroenterology	1.2	−2.6	−1.5	−1.6	2.9
Internal medicine	5.0	5.1	10.4	10.2	16.7
Other medical specialties	5.7	8.0	14.2	14.2	8.2
General surgery	6.1	7.5	14.1	14.0	5.6
Dermatology	7.8	4.2	12.3	12.1	2.1
Ophthalmology	1.1	2.2	3.4	3.3	9.0
Orthopedic surgery	5.7	3.8	9.7	9.5	4.8
Thoracic surgery	5.2	4.2	9.6	9.5	2.4
Urology	5.9	5.8	12.0	11.9	4.1
Other surgical	5.8	2.4	8.3	8.2	3.2
Radiology	1.6	−1.5	0.1	0.0	7.9
Pathology	−1.6	2.3	0.7	0.6	1.2
Other	2.5	4.8	7.4	7.5	13.4

[1] Medicare payments are allowed charges.
[2] Medicare revenue is allowed charges on assigned claims and submitted charges on unassigned claims not in excess of charge limits.

Source: Physician Payment Review Commission (1996).

The fact that primary care services had the highest payment growth may appear surprising, given that these services received a 7.9-percent conversion factor update in 1995, whereas surgical services got a 12.2-percent update. To analyze the effects of policy changes on Medicare payment per service, changes in payment rates were separated into those caused by changes in, respectively, relative value units, geographic adjustment factors (GAF), and conversion factors (table E–4). Changes not explained by these three policy elements are the result of the transition from historical to fee schedule payments, which is difficult to measure explicitly. Payment increases due to high conversion factor updates for surgical services were offset somewhat by the continued transition away from historical payment levels to fee schedule amounts. Primary care services, on the other hand, realized payment increases from both the conversion factor update and ongoing transition, and so had higher net growth than surgical services.

Predictably, 1995 conversion factor updates had the largest effects on payment per service for all services (table E–4). The updates ranged from a high of 12.2 percent for surgical services to 7.9 percent for primary care and 5.2 percent for other services.

Relative value unit changes dampened the effects of the conversion factor updates (table E–4). An across-the-board reduction of 1.1 percent was made to all RVUs to offset the effect of fee schedule and other payment policy changes on total expenditures. Practice expense RVU adjustments were also made, as required by the Omnibus Budget Reconciliation Act of 1993 (OBRA 1993). The RVU changes for 1995 ranged from −1.0 percent for primary care to −3.7 percent for surgical services.

Geographic adjustment factor changes were intended to be budget neutral overall and were, in fact, quite small (table E–4). These changes were primarily due to the use of more current information in computing the geographic practice cost indexes that make up the GAFs for Medicare payment localities, along with some technical improvements in the calculation of the GPCIs. The updates appear to have reduced rural area GAFs by 0.2 to 0.3 percent, on average. Similar-sized changes will occur in 1996 when the new GAFs are phased in completely.

Residual changes affecting Medicare payment per service varied from 2.5 percent for evaluation and management services other than primary care to −4.1 percent for other nonsurgical services (table E–4). These changes reflect the continued transition away from the customary, prevailing, and reasonable (CPR) charge system to fee schedule payments. The final year in which CPR policies affected payments was 1995. Starting in 1996, payments will be based entirely on the fee schedule. Compared with others, medical specialties generally experienced smaller transition effects in 1995. By contrast, the combination of transition effects and RVU changes, along with relatively low conversion factor updates, led to reductions in average payment per service for cardiologists and pathologists of 1.4 and 1.6 percent, respectively.

TABLE E–4.—EFFECT OF POLICY CHANGES ON FEE SCHEDULE PAYMENTS, 1994–95

[Percentage change]

Type of service, location, and specialty	Total change in Medicare payment per service	Change due to			
		Relative value unit changes	Geographic adjustment factor changes	Conversion factor updates	Transition to fee schedule
All services	3.8	−1.9	0.1	7.5	−1.9
Evaluation and management services:					
Primary care	9.0	−1.0	0.0	7.9	2.1
Other	6.7	−1.0	0.0	5.2	2.5
Surgical services	5.0	−3.7	0.0	12.2	−3.5
Other nonsurgical services	−0.4	−1.6	0.1	5.2	−4.1
Location:					
Metropolitan areas:					
>1 million	3.5	−1.8	0.1	7.4	−2.2
<1 million	3.8	−2.0	0.1	7.7	−2.0
Rural counties:					
>25,000	4.8	−1.9	−0.2	7.7	−0.8
<25,000	6.6	−1.4	−0.3	7.4	0.9
Specialty:					
Cardiology	−1.4	−2.6	0.0	5.7	−4.5
Family/general practice	7.5	−1.1	−0.1	7.2	1.5
Gastroenterology	1.2	−1.9	0.1	5.7	−2.7
Internal medicine	5.0	−1.1	0.1	6.4	−0.4
Other medical	5.7	−1.0	0.1	5.6	1.0
General surgery	6.1	−1.4	0.0	9.9	−2.4
Dermatology	7.8	−1.0	0.1	10.5	−1.8
Ophthalmology	1.1	−5.7	0.1	10.0	−3.3
Orthopedic surgery	5.7	−3.0	0.0	10.5	−1.8
Thoracic surgery	5.2	−1.4	0.0	11.2	−4.6
Urology	5.9	−1.2	0.1	10.1	−3.1
Other surgical	5.8	−2.0	0.1	10.0	−2.3
Radiology	1.6	−1.0	0.0	5.3	−4.8
Pathology	−1.6	−1.6	0.1	5.2	−5.3
Other	2.5	−0.8	0.1	7.3	−4.1

Note.—Changes due to the transition to fee-schedule-based payments are calculated as the difference between total payment changes and the sum of changes attributable to relative value changes, geographic adjustment factor changes, and conversion factor updates.

Source: Physician Payment Review Commission (1996).

SELECTED FEE SCHEDULE ISSUES

The Medicare Fee Schedule is based on a relative value scale (RVS) and a conversion factor. The RVS is composed of three components representing physician work, practice expense, and malpractice expense. The RVS is adjusted for differences in costs across geographic areas. The conversion factor translates the rel-

ative value units into payments for services. Issues arise in each of these aspects of the MFS.

CONVERSION FACTOR

There are three limitations in the methodology that determines the conversion factor. First, determining separate performance standards and updates for different categories of service leads to distortions in relative payments, which then no longer reflect the fee schedule's resource-based relative values. By applying different updates to each category, RVUs in different categories are not worth the same amount. This violates the basic principle underlying the resource-based relative value scale, namely that each RVU should be worth the same amount regardless of the patient or service to which the RVU is attached.

Second, the formula for the performance standard takes a fixed deduction of 4 percentage points from the historical trend in volume and intensity growth for the prior 5-year period. This approach will lead to unrealistic performance standards over time because no matter how much physicians restrain the number and intensity of services, they must achieve a further reduction of 4 percentage points each year or receive lower updates.

Finally, annual adjustments to the conversion factors are based on whether actual expenditure growth met the standards 2 years earlier. This approach fails to capture shortfalls and surpluses that occur during the intervening years and thus does not fully account for all Medicare spending for physician services.

RESOURCE-BASED PRACTICE EXPENSE AND MALPRACTICE RELATIVE VALUES

Although the Omnibus Budget Reconciliation Act of 1989 incorporated resource-based payment for physician work into the Medicare Fee Schedule, the practice expense and malpractice expense components of the relative value scale remained charge-based. As required by 1994 technical amendments to the Social Security Act, HCFA is taking steps to develop resource-based practice expense values to be implemented in 1998. The Secretary of Health and Human Services is required to devise a methodology that reflects the staff, equipment, and supplies necessary to provide medical and surgical services in various settings and report to the Congress by June 30, 1996.

In November 1994, HCFA released a request for proposals (RFP) to develop the database necessary to calculate resource-based practice expense relative values. According to the RFP, HCFA is interested in exploring a variety of approaches to creating relative values and thus asked for proposals to develop a comprehensive database. The agency expects to let additional contracts to support development of several approaches once the database is complete, originally scheduled for spring 1996. Although these steps should improve the practice expense component of the fee schedule, the malpractice relative values will remain charge based.

FIVE-YEAR REVIEW OF WORK RELATIVE VALUES

The Health Care Financing Administration is required to conduct a review of the entire relative value scale every 5 years. Because the Medicare Fee Schedule was first used in 1992, the initial revision must be completed by 1997. This revision is being confined to the work relative values because practice expense and malpractice expense relative values remain charge based.

The 5-year review process began in December 1994, when HCFA invited public comments on all work relative values. After reviewing the comments received, HCFA referred a subset of these work values to the American Medical Association/Specialty Society Relative Value Scale Update Committee (RUC) for evaluation.

The RUC met in August 1995 and February 1996, and made recommendations to HCFA on more than 1,100 current procedural terminology (CPT) codes. The committee recommended increases in the work relative values for some 300 codes, decreases for about 100, and no change for more than 650 codes. Recommendations to HCFA on a few codes, including the anesthesia work relative values, are still pending. Additionally, the RUC referred some codes to the CPT editorial panel for possible coding changes before their relative values were reviewed. The work relative value changes recommended by the committee seem to reflect both refinement of values believed to be assigned incorrectly at the inception of the relative value scale and corrections to accommodate changes in the work of individual services since that time.

HCFA is reviewing these recommendations with its carrier medical directors and will publish proposed values in a Notice of Proposed Rulemaking. After HCFA reviews comments from the public and makes final revisions, the new work relative values will be issued in the fall of 1996. They will be used for payment beginning in January 1997.

FEE SCHEDULE PAYMENT AREAS

The current fee schedule payment areas are based on the payment localities carriers established under the charge-based payment system that preceded introduction of the fee schedule. Carriers had established these localities for a variety of economic, political, and administrative reasons, with resulting area constructs that showed wide variation in size and population nationwide. While many States defined single statewide areas, one State had over 30 areas when the fee schedule was implemented.

As part of physician payment reform, Congress asked PPRC to study the geographic impact of the fee schedule, including the issue of defining payment areas. In its 1991 annual report, the Commission recommended that Congress redefine the areas. In particular, it recommended subdividing into substate areas only those States with a high degree of within-State price variation, leaving the rest of the States as statewide areas. In States with high price variation, payment areas would be defined according to Metropolitan Statistical Area (MSA) population categories, so that, for example, a State's MSAs with populations between 1 and 3 million defined one payment area.

More recently, HCFA contracted with Health Economics Research (HER) to analyze alternative definitions of payment areas. Among the options it explored, HER recommended retaining only those current payment areas with GAFs that exceed State averages by some threshold. The change would create more statewide areas and eliminate some payment areas in those States that continue to include some substate areas. According to HER, this option was recommended because it is based on current payment areas, reduces the number of areas, and does an acceptable job of tracking local price variation.

Metropolitan areas that cross State borders pose a particular problem with regard to defining payment areas. Although boundaries for payment areas do not cross State boundaries (except for the Washington, DC area), markets do cross those boundaries. The definition of Metropolitan Statistical Areas (MSA) is designed to encompass areas that function as integrated economic markets. To the extent that an MSA is indeed a single market (or a complicated network of indistinguishable, overlapping markets), then allowing a State line to create an arbitrary payment differential may disrupt physician and patient purchasing and care patterns. Additionally, some of the data used to develop the GPCIs are based on information collected at the MSA level, so dividing MSAs along State boundaries and averaging one State's portion with other areas of the State can result in geographic adjustment factors that differ within the MSA even though the underlying data cannot be used to identify price differences within the MSA. There are more than 30 border-crossing Metropolitan Statistical Areas containing nearly one-tenth of the Nation's population.

HISTORICAL DATA

ASSIGNMENT RATE EXPERIENCE

The total number of assigned claims as a percentage of total claims received by Medicare carriers for physicians and other medical services is known as the total assignment rate. Initially, the net assignment rate was computed in the same manner except that it omitted hospital-based physicians and group-practice prepayment plans which were considered assigned by definition (this distinction is no longer made). The net assignment rate declined until the mid-1970s when the rate leveled off at about 50 percent. Since 1985, the rate has increased significantly rising to 94.2 percent in 1995. This increase reflects both the impact of the participating physician program as well as the requirement that laboratory services must be paid on an assigned basis. Table E–5 shows the net assignment rates for fiscal years 1969–93.

The statistics included in table E–5 are programwide data. Assignment rates vary geographically. For example, the assignment rate (taken as a percent of dollars) for physician services in fiscal year 1995 ranged from a low of 67.0 percent in South Dakota to a high of 99.9 percent in Rhode Island. The national average assignment rate for physicians services during this period was 96.7 percent (see table E–6).

TABLE E–5.—NET ASSIGNMENT RATES,[1] 1969–95

[In percent]

Fiscal year	Claims	Covered charges
1969	61.0	NA
1970	61.2	NA
1971	60.1	NA
1972	56.4	NA
1973	53.4	49.0
1974	52.2	47.8
1975	51.9	47.7
1976	51.0	47.8
1977	50.5	47.9
1978	50.6	49.3
1979	51.1	50.4
1980	51.4	51.3
1981	52.2	52.9
1982	52.8	53.8
1983	53.5	55.3
1984	56.4	57.7
1985	67.7	67.4
1986	68.0	69.5
1987	71.7	73.7
1988	76.3	79.4
1989	79.3	82.6
1990	80.9	84.8
1991	82.5	87.6
1992	85.5	90.8
1993	89.2	94.0
1994	92.1	96.0
1995	94.2	97.1

[1] Both measures of assignment exclude claims from hospital-based physicians and group-practice prepayment plans that are considered assigned by definition.

NA—Not available.

Source: Health Care Financing Administration, Bureau of Program Operations.

PARTICIPATING PHYSICIAN PROGRAM DATA

Physician participation rates have increased significantly since the inception of the program (see tables E–7 and E–8). For the calendar year 1995 participation period, the physician participation rate (including limited licensed practitioners) had risen to 72.3 percent accounting for 92.6 percent of allowed charges for physician services during the period. The participation rate rose to 77.5 percent in 1996.

Table E–9 shows the percentage of participating physicians and limited licensed practitioners as a percentage of total physicians and limited licensed practitioners for each State. The national average of participating physicians and limited licensed practitioners continues to increase. By the calendar year 1995 participation period, this percentage had risen to 77.5.

TABLE E–6.—PHYSICIAN ASSIGNMENT RATES AS PERCENT OF ALLOWED CHARGES BY STATE, SELECTED YEARS 1985–95 [1]

[In percent]

Census division/State	Fiscal year								
	1985	1987 [2]	1989	1990	1991	1992	1993	1994	1995
National	65.5	70.8	80.6	83.0	86.1	89.4	93.2	95.6	96.8
New England:									
Maine	81.5	84.3	91.4	92.4	94.4	96.7	98.0	98.6	99.1
New Hampshire	56.5	58.3	67.8	69.9	80.8	89.4	93.9	95.6	96.9
Vermont	64.3	71.7	93.4	94.7	95.9	97.8	98.6	99.0	99.1
Massachusetts [3]	93.7	98.2	99.3	99.5	99.5	99.6	99.7	99.7	99.8
Rhode Island	94.0	95.1	97.1	98.7	99.7	99.7	99.8	99.8	99.9
Connecticut	57.6	62.8	80.4	84.7	87.7	91.7	94.7	96.6	97.6
Middle Atlantic:									
New York	70.3	73.9	81.1	81.9	84.4	87.7	90.7	93.2	95.6
New Jersey	62.3	63.8	70.4	73.0	76.3	80.5	85.4	89.7	92.6
Pennsylvania	88.1	91.0	94.9	95.7	98.5	99.1	99.4	99.6	99.6
East North Central:									
Ohio	50.8	58.8	77.8	82.6	87.3	92.5	97.7	99.5	99.7
Indiana	49.6	59.2	74.7	77.2	81.5	85.7	92.9	95.4	96.5
Illinois	51.7	59.9	72.4	75.9	78.8	83.2	89.2	93.6	98.6
Michigan	88.2	89.7	93.6	94.5	94.4	95.9	97.8	98.6	99.0
Wisconsin	51.7	54.6	65.6	68.2	71.7	78.2	86.8	91.2	94.2
West North Central:									
Minnesota	30.6	39.9	46.1	47.6	52.3	57.1	67.1	77.4	86.2
Iowa	46.9	53.2	67.5	69.8	73.4	78.8	85.6	89.9	99.2
Missouri [4]	50.1	61.2	72.3	74.9	78.5	83.7	91.6	95.1	96.7
North Dakota	30.5	36.3	50.3	55.0	67.1	72.1	74.9	87.6	92.9
South Dakota	18.7	26.7	38.7	39.2	40.2	43.3	50.2	57.3	67.0
Nebraska	47.3	43.4	59.6	64.9	70.3	76.8	83.8	87.7	89.6

Kansas [5]	72.7	78.7	87.2	88.8	91.9	94.5	96.2	96.8	97.1
South Atlantic:									
Delaware	81.8	81.9	88.1	90.5	92.9	95.2	96.8	97.5	97.8
Maryland [6]	81.6	84.6	91.6	91.4	92.8	94.3	96.7	97.5	98.1
District of Columbia [7]	78.1	80.5	86.5	87.5	89.4	92.1	94.1	95.7	96.6
Virginia [8]	66.4	73.4	85.1	87.3	89.6	92.5	95.7	97.4	98.4
West Virginia	66.7	76.9	90.3	93.2	95.5	97.2	98.4	98.8	99.1
North Carolina	60.3	66.2	79.2	80.8	83.9	88.8	93.7	95.5	96.7
South Carolina	64.9	75.4	85.8	87.1	88.9	91.6	94.4	95.9	97.0
Grorgia	63.9	69.1	80.5	83.5	96.6	90.3	94.0	96.3	97.4
Florida	62.2	68.6	80.3	84.1	87.6	91.0	95.0	97.3	98.4
East South Central:									
Kentucky	50.3	63.5	80.8	84.8	88.8	91.9	95.5	97.1	97.9
Tennessee	55.6	65.5	80.9	84.0	89.5	93.1	96.3	97.5	98.3
Alabama	74.6	91.7	90.1	92.3	94.9	96.6	98.0	98.6	98.9
Mississippi	63.5	73.5	85.4	88.1	90.6	93.1	95.6	97.1	97.8
West South Central:									
Arkansas	72.6	81.1	90.3	92.0	93.7	95.4	96.6	97.9	98.7
Louisiana	51.0	67.8	84.8	88.0	91.0	93.8	95.2	96.9	98.1
Oklahoma	39.0	48.6	66.0	68.2	72.8	77.8	85.0	90.6	94.2
Texas	63.0	67.2	78.0	79.9	83.0	87.4	91.6	94.7	96.6
Mountain:									
Montana	42.6	42.9	50.7	53.0	54.8	61.3	72.7	80.6	86.3
Idaho	25.2	26.4	33.7	36.1	40.2	40.1	54.1	64.5	71.7
Wyoming	33.8	30.4	40.2	43.9	48.9	57.5	69.0	78.2	81.8
Colorado	56.0	56.8	67.6	70.4	74.1	79.7	86.8	91.4	93.5
New Mexico	58.3	57.6	71.7	76.1	80.1	84.9	91.5	94.0	95.2
Arizona	52.8	57.1	72.0	76.2	80.3	84.4	89.6	91.7	92.8
Utah	63.1	69.4	79.9	80.4	83.1	88.4	92.8	95.2	96.6
Nevada	81.6	86.8	94.4	96.0	97.4	98.4	99.0	99.2	99.4
Pacific:									
Washington	45.5	46.6	50.8	54.8	60.8	69.2	74.3	87.5	93.4

TABLE E–6.—PHYSICIAN ASSIGNMENT RATES AS PERCENT OF ALLOWED CHARGES BY STATE, SELECTED YEARS 1985–95 [1]—Continued

[In percent]

Census division/State	Fiscal year								
	1985	1987 [2]	1989	1990	1991	1992	1993	1994	1995
Oregon	38.7	46.9	58.4	59.9	63.2	69.3	82.1	88.0	92.3
California	71.3	74.0	87.7	84.4	87.4	90.2	93.8	96.0	97.3
Alaska	54.4	64.3	78.5	79.6	83.2	89.1	93.9	95.4	96.2
Hawaii	61.2	72.0	80.7	82.9	85.8	93.1	96.1	92.8	98.7

[1] Rates reflect covered charges for physician claims processed during the period.

[2] The actual participation period was January 1987 through March 1988, and the participation agreements were in effect for that time.

[3] Massachusetts enacted a Medicare mandatory assignment provision, effective April 1986. The fact that the assignment rates shown here are not 100 percent may be explained by the inclusion in the data base of billings by practictioners other than allopathic and osteopathic physicians, which are included in the Medicare statutory definition of ''physician.''

[4] Starting with fiscal year 1993, includes data for all counties in Missouri plus two counties on the State border located in Kansas.

[5] Starting with fiscal year 1993, includes data for all counties in Kansas excluding two counties on the State border.

[6] Starting with fiscal year 1993, includes data for all counties in Maryland excluding two counties on the State border.

[7] Starting with fiscal year 1993, includes data for the District of Columbia plus two counties in Maryland located on the State border plus a few counties and cities located in Virginia, near the State border.

[8] Starting with fiscal year 1993, includes data for all counties in Virginia excluding a few counties and cities near the State border.

Source: Health Care Financing Administration, Bureau of Program Operations.

TABLE E–7.—MEDICARE PHYSICIAN PARTICIPATION RATES: PERCENT OF PHYSICIANS AND LIMITED LICENSED PRACTITIONERS WITH AGREEMENTS AND THEIR SHARE OF ALLOWED CHARGES, 1984–95

Participation period	Percent of physicians signing agreements	Participating physicians' covered charges as a percent of total [1]
October 1984–September 1985	30.4	36.0
October 1985–April 1986	28.4	36.3
April 1986–December 1986 [2]	28.3	38.7
January 1987–March 1988	30.6	48.1
April 1988–December 1988	37.3	57.9
January 1989–March 1990	40.2	62.0
April 1990–December 1990	45.5	67.2
January 1991–December 1991	47.6	72.3
January 1992–December 1992	52.2	78.8
January 1993–December 1993	59.8	85.5
January 1994–December 1994	64.8	89.4
January 1995–December 1995	72.3	92.6
January 1996–December 1996	77.5	NA

[1] Rates reflect covered charges for physician services processed during period.

[2] The actual participation period was May through December of 1986, and participation agreements were in effect for that time. However, charge data are generally collected by quarter; thus, the data for the last three quarters of 1986 are used as a proxy for the participation period.

NA—Not available.

Source: Health Care Financing Administration, Bureau of Program Operations.

Table E–10 shows the allowed charges of participating physicans as a percent of total allowed charges, by State, for several participation periods. This percentage increased substantially, rising from 36 percent in the October 1984 to September 1985 period to 92.6 percent in the calendar 1995 participation period.

PARTICIPATION, ASSIGNMENT, AND CHARGE REDUCTIONS

Historically the difference between the physician's billed charge and Medicare's approved or reasonable charge was referred to as the reasonable charge reduction. Beginning in 1992, with implementation of the fee schedule, the term reasonable charge reduction no longer applies. Instead, the term "charge reduction" refers to the difference between the physicians' billed charge and the fee schedule amount. Charge reductions were made on 83.9 percent of unassigned claims in fiscal year 1995. The average amount of the reduction was 15.6 percent of billed charges, or $13.01 per approved claim. Beneficiaries were liable for these reduction amounts, although it is not known how often physicians actually collected from beneficiaries. The total reduced on all unassigned claims was $425.4 million in fiscal year 1995.

TABLE E–8.—PARTICIPATION RATES AS PERCENTAGE OF PHYSICIANS BY SPECIALTY, FOR SELECTED PARTICIPATION PERIODS, 1985–96

Specialty	Oct. 1985–Apr. 1986	Jan. 1987–Mar. 1988	Jan. 1989–Mar. 1990	Apr. 1990–Dec. 1990	Jan. 1991–Dec. 1991	Jan. 1992–Dec. 1992	Jan. 1993–Dec. 1993	Jan. 1994–Dec. 1994	Jan. 1995–Dec. 1995	Jan. 1996–Dec. 1996
Physicians (M.D.s and D.O.s):										
General practice	27.3	25.6	35.8	39.7	44.0	48.0	55.1	59.1	59.9	66.3
General surgery	33.9	37.2	52.2	55.8	60.5	66.3	73.8	77.6	80.2	85.8
Otology, laryngology, rhinology	24.6	27.0	41.2	45.2	49.6	57.0	66.2	72.2	77.1	82.6
Anesthesiology	21.1	20.3	28.3	30.8	36.5	49.3	64.6	71.5	73.9	81.0
Cardiovascular disease	35.6	43.2	55.5	60.6	65.4	72.0	78.7	82.5	81.9	88.3
Dermatology	34.0	38.1	48.7	53.4	57.0	61.6	69.8	75.8	79.3	83.6
Family practice	25.5	27.1	39.7	47.2	50.8	57.7	66.1	71.3	74.5	81.4
Internal medicine	32.5	33.6	45.2	48.8	52.6	57.8	66.2	71.0	73.8	79.8
Neurology	34.8	39.2	49.2	53.1	56.1	63.8	71.8	76.4	78.9	84.1
Obstetrics-gynecology	29.1	31.5	44.2	48.8	52.6	58.0	65.7	69.9	72.5	71.3
Ophthalmology	27.3	35.1	50.5	55.6	60.0	66.1	73.2	78.3	81.2	86.2
Orthopedic surgery	29.0	32.6	49.2	53.7	58.4	65.5	74.9	79.2	82.6	86.8
Pathology	39.6	41.2	50.6	53.4	59.2	65.8	73.3	76.8	78.9	83.1
Psychiatry	30.0	28.6	37.8	41.6	44.1	48.8	53.5	57.8	58.7	64.6
Radiology	41.3	39.8	49.6	55.6	62.0	68.2	74.7	78.6	82.8	84.9
Urology	27.8	30.9	45.6	49.6	53.6	61.7	71.8	78.6	83.0	89.3
Nephrology	50.8	49.7	60.0	66.5	71.7	76.3	82.4	84.3	87.0	90.0
Clinic or other group practice—not GPPP	33.8	50.6	67.8	68.7	73.9	77.0	75.5	80.5	79.4	84.5
Limited license practitioners (LLP):										
Chiropractor	25.4	19.7	24.8	26.2	28.6	31.4	35.6	39.8	42.6	47.3
Podiatry-surgical chiropody	38.2	33.4	52.6	54.0	59.6	64.2	70.9	75.3	79.2	83.3
Optometrist	44.0	44.1	48.9	54.0	56.9	59.0	62.7	65.6	66.9	70.3

Source: Health Care Financing Administration.

TABLE E–9.—PHYSICIAN AND LIMITED LICENSED PRACTITIONER PARTICIPATION RATES AS PERCENTAGE OF PHYSICIANS AND LIMITED LICENSED PRACTITIONERS, BY STATE, FOR SELECTED PARTICIPATION PERIODS, 1985–96

State	Oct. 1985–Apr. 1986	Jan. 1987–Mar. 1988	Jan. 1989–Mar. 1990	Apr. 1990–Dec. 1990	Jan. 1991–Dec. 1991	Jan. 1992–Dec. 1992	Jan. 1993–Dec. 1993	Jan. 1994–Oct. 1994	Jan. 1995–Dec. 1995	Jan. 1996–Dec. 1996
Alabama	58.2	68.8	75.9	74.6	82.7	83.4	85.1	87.2	90.5	91.8
Alaska	10.4	27.1	38.8	48.0	53.8	55.1	60.4	66.3	77.1	73.5
Arizona	15.4	28.1	41.2	53.5	61.3	64.5	76.2	82.6	87.1	85.2
Arkansas	45.2	42.0	53.1	53.9	59.9	57.8	62.1	64.4	74.8	77.2
California	30.0	38.9	54.0	57.7	60.8	62.6	65.9	69.0	74.5	80.5
Colorado	28.1	19.5	28.1	33.9	35.3	48.0	55.7	58.5	65.2	79.5
Connecticut	22.2	17.4	29.3	32.8	40.8	48.1	55.4	57.8	61.8	84.3
Delaware	23.9	31.2	37.5	42.5	43.9	51.9	57.4	60.0	68.0	72.2
District of Columbia	30.5	28.0	34.4	37.9	39.8	45.9	50.6	52.8	63.0	65.3
Florida	25.7	24.9	32.8	34.4	36.5	41.5	55.6	62.2	68.0	70.9
Georgia	33.1	25.8	49.7	49.5	53.6	57.2	74.9	82.7	86.3	87.2
Hawaii	20.6	47.8	53.7	56.8	57.3	64.1	75.9	80.4	82.8	83.6
Idaho	11.0	10.4	16.0	17.3	19.5	22.9	37.1	49.7	54.7	60.1
Illinois	23.1	26.7	40.0	42.3	46.9	50.8	57.6	61.8	73.3	75.6
Indiana	18.2	26.9	40.0	42.6	45.1	49.3	55.8	61.3	72.8	75.7
Iowa	29.7	25.1	45.3	48.1	51.9	58.8	61.8	63.2	81.1	83.6
Kansas	45.4	51.4	61.6	57.1	62.6	70.3	73.2	78.7	84.4	91.1
Kentucky	24.3	34.2	50.5	56.4	59.5	64.0	73.6	69.1	83.4	85.8
Louisiana	18.8	18.1	32.6	34.6	42.9	44.6	44.0	46.7	57.4	61.0
Maine	35.4	34.2	51.2	48.7	50.3	51.6	52.0	53.6	68.9	72.2
Maryland	30.4	30.1	42.8	45.9	45.3	58.7	72.5	77.3	88.1	89.9
Massachusetts	48.1	43.8	46.9	50.5	50.8	50.0	50.2	48.9	64.7	74.9
Michigan	44.0	32.7	41.7	44.7	53.7	51.7	58.1	62.1	75.3	80.2
Minnesota	18.5	22.4	25.4	27.5	29.3	34.4	44.4	51.3	58.6	70.6
Mississippi	19.1	23.6	33.4	38.0	42.7	47.9	53.6	53.8	59.4	77.3
Missouri	35.2	24.5	39.6	45.7	49.0	51.8	67.5	81.8	87.6	86.7
Montana	24.3	17.0	21.5	23.4	24.8	23.7	54.7	58.7	70.1	77.4
Nebraska	20.0	25.7	42.5	49.2	56.5	61.1	70.6	75.9	82.5	86.3
Nevada	21.7	33.5	57.0	69.8	72.9	75.4	84.9	87.9	91.2	90.8

TABLE E–9.—PHYSICIAN AND LIMITED LICENSED PRACTITIONER PARTICIPATION RATES AS PERCENTAGE OF PHYSICIANS AND LIMITED LICENSED PRACTITIONERS, BY STATE, FOR SELECTED PARTICIPATION PERIODS, 1985–96—Continued

State	Oct. 1985–Apr. 1986	Jan. 1987–Mar. 1988	Jan. 1989–Mar. 1990	Apr. 1990–Dec. 1990	Jan. 1991–Dec. 1991	Jan. 1992–Dec. 1992	Jan. 1993–Dec. 1993	Jan. 1994–Oct. 1994	Jan. 1995–Dec. 1995	Jan. 1996–Dec. 1996
New Hampshire	26.9	25.9	28.0	30.9	32.7	38.5	43.0	48.0	60.4	77.0
New Jersey	18.0	22.7	26.0	27.6	29.6	36.5	42.6	45.9	54.9	60.6
New Mexico	17.7	30.8	36.3	45.6	49.7	53.6	66.8	74.2	78.1	80.7
New York	20.8	24.1	29.8	30.4	34.6	36.9	40.7	46.2	59.2	64.2
North Carolina	39.1	31.4	54.2	52.9	58.1	68.2	72.8	76.5	77.6	81.0
North Dakota	10.9	20.5	31.7	42.2	43.9	45.8	55.0	77.4	81.8	92.2
Ohio	21.7	28.9	46.8	50.8	52.5	57.3	76.6	83.3	90.5	91.8
Oklahoma	13.8	20.8	31.6	36.4	39.0	44.4	53.9	64.9	72.3	76.1
Oregon	18.5	26.1	36.9	41.7	46.7	51.7	59.2	66.5	79.7	82.1
Pennsylvania	50.8	32.1	39.0	42.1	45.9	53.0	59.7	61.1	67.3	69.3
Rhode Island	46.7	50.8	58.8	67.0	67.8	70.3	80.9	82.2	80.9	66.8
South Carolina	17.9	25.3	42.1	55.5	57.9	63.0	67.3	70.2	76.1	82.7
South Dakota	8.0	12.7	20.0	19.6	20.6	23.7	31.6	41.2	51.7	71.4
Tennessee	21.1	43.4	57.6	58.4	63.7	67.6	70.5	76.9	80.6	83.1
Texas	19.7	19.4	28.9	36.4	38.9	52.9	61.3	68.6	76.9	80.3
Utah	29.3	42.2	54.7	65.1	65.6	69.5	80.3	82.0	85.9	86.8
Vermont	41.5	34.1	40.5	43.8	45.4	54.2	56.5	58.8	68.8	76.1
Virginia	29.6	33.6	40.9	46.0	48.1	49.7	52.2	52.9	55.6	84.3
Washington	23.6	26.9	31.4	34.7	46.1	53.1	64.7	73.9	76.2	86.4
West Virginia	22.9	37.5	59.1	63.2	66.3	68.4	75.9	81.9	87.2	89.3
Wisconsin	31.0	35.1	40.0	46.5	46.8	55.5	66.8	73.7	81.2	83.9
Wyoming	18.3	20.3	19.3	34.6	39.1	50.2	53.3	63.0	66.4	81.2
National	28.4	30.6	40.7	44.1	47.6	52.2	59.8	64.8	72.3	77.5

Source: Health Care Financing Administration, Bureau of Program Operations.

TABLE E–10.—ALLOWED CHARGES OF PARTICIPATING PHYSICIANS AS A PERCENT OF TOTAL ALLOWED CHARGES BY STATE, FOR SELECTED PARTICIPATION PERIODS, 1984–95 [1]

[In percent]

Census division/State	Oct. 1984–Sept. 1985	Jan. 1987–Mar. 1988 [2]	Jan. 1989–Mar. 1990	Apr. 1990–Dec. 1990	Jan. 1991–Dec. 1991	Jan 1992–Dec. 1992	Jan. 1993–Dec. 1993	Jan. 1994–Dec. 1994	Jan. 1995–Dec. 1995
National	36.0	48.1	62.0	67.2	72.3	78.8	85.5	89.4	92.6
New England:									
Maine	50.9	64.8	79.4	80.5	84.2	89.9	92.4	93.6	96.2
New Hampshire	40.1	36.0	42.8	46.2	68.3	80.7	88.1	90.8	93.2
Vermont	37.3	46.8	81.4	85.9	90.2	93.4	94.8	95.6	96.9
Massachusetts	70.7	89.1	95.4	95.0	96.7	96.3	95.9	96.4	97.4
Rhode Island	68.7	85.8	88.8	95.2	97.6	98.5	98.9	99.1	99.4
Connecticut	30.7	45.3	65.9	67.9	76.2	82.4	87.9	92.2	94.1
Middle Atlantic:									
New York	31.5	40.8	51.7	58.0	63.7	72.2	77.7	82.5	87.5
New Jersey	21.5	32.8	42.3	49.6	55.2	61.8	72.6	80.1	84.6
Pennsylvania	71.4	75.1	81.6	87.9	92.3	95.4	98.0	98.6	98.7
East North Central:									
Ohio	24.9	41.5	61.9	70.9	79.1	86.3	94.6	97.0	97.8
Indiana	18.9	43.3	60.6	65.2	70.2	80.9	89.1	92.4	94.0
Illinois	29.4	42.0	58.1	61.8	66.1	72.2	82.2	87.9	90.7
Michigan	55.4	71.9	85.6	86.0	86.5	92.0	95.1	96.5	97.6
Wisconsin	31.3	31.7	42.7	48.9	45.6	61.5	76.9	84.0	91.1
West North Central:									
Minnesota	9.9	14.6	20.2	25.4	28.6	35.5	49.5	68.3	80.5
Iowa	28.5	41.0	54.2	57.8	61.9	71.0	80.8	85.2	90.4
Missouri [3]	26.7	37.5	41.8	40.1	40.4	45.3	67.7	86.9	93.4
North Dakota	6.9	16.0	32.3	45.5	53.2	61.2	65.8	68.1	89.3
South Dakota	3.2	10.4	19.5	21.2	21.1	24.6	36.0	42.6	59.2

TABLE E–10.—ALLOWED CHARGES OF PARTICIPATING PHYSICIANS AS A PERCENT OF TOTAL ALLOWED CHARGES BY STATE, FOR SELECTED PARTICIPATION PERIODS, 1984–95 [1]—Continued

[In percent]

Census division/State	Oct. 1984–Sept. 1985	Jan. 1987–Mar. 1988 [2]	Jan. 1989–Mar. 1990	Apr. 1990–Dec. 1990	Jan. 1991–Dec. 1991	Jan 1992–Dec. 1992	Jan. 1993–Dec. 1993	Jan. 1994–Dec. 1994	Jan. 1995–Dec. 1995
Nebraska	30.5	31.8	51.7	54.8	60.3	69.7	79.8	83.8	86.2
Kansas [4]	48.0	NA	82.5	82.3	86.8	91.3	94.6	94.8	95.3
South Atlantic:									
Delaware	57.0	58.5	70.8	76.6	81.7	87.2	93.5	94.6	95.3
Maryland [5]	57.8	67.4	80.4	83.3	85.6	86.4	87.1	87.4	92.9
District of Columbia [6]	60.3	66.6	73.9	76.8	80.8	85.4	90.1	92.4	93.8
Virginia [7]	31.0	53.0	69.5	71.2	78.4	84.1	90.9	94.1	96.3
West Virginia	34.5	59.3	77.5	80.6	85.2	90.0	93.4	95.3	96.3
North Carolina	34.4	44.9	55.2	63.9	68.3	82.4	87.1	90.7	92.7
South Carolina	29.9	55.2	68.5	67.6	71.6	79.3	86.6	90.4	62.7
Georgia	29.3	43.0	50.7	65.9	74.9	82.8	81.6	90.9	94.8
Florida	30.0	41.9	61.6	68.8	74.9	81.8	89.0	90.1	94.7
East South Central:									
Kentucky	22.3	44.7	64.3	72.6	76.9	84.3	90.7	93.4	94.6
Tennessee	25.1	41.3	57.4	68.5	76.8	86.8	91.8	94.3	95.6
Alabama	42.5	66.9	81.3	84.9	88.5	91.7	94.9	96.2	97.0
Mississippi	14.3	44.9	65.3	68.3	73.9	82.1	88.6	91.2	92.8
West South Central:									
Arkansas	47.9	68.3	81.0	84.5	86.5	90.0	93.4	95.2	96.4
Louisiana	16.2	48.2	71.0	76.7	81.2	86.6	89.4	91.3	92.2
Oklahoma	16.6	24.9	39.1	50.0	57.7	62.8	74.0	83.8	91.4
Texas	26.2	38.9	52.5	56.9	63.6	72.6	81.5	85.9	90.6

Mountain:									
Montana	25.6	23.8	29.9	29.7	34.1	42.7	58.9	67.4	.....
Idaho	8.6	9.3	13.2	17.5	21.1	23.5	41.2	54.0	61.6
Wyoming	15.7	14.1	19.7	25.8	31.9	44.1	61.0	72.1	75.6
Colorado	23.5	34.0	47.7	50.5	55.9	63.5	76.4	82.6	86.1
New Mexico	34.1	28.1	39.5	51.1	57.8	64.9	78.2	85.0	89.6
Arizona	32.7	38.3	49.8	60.2	67.8	75.2	83.7	88.9	90.6
Utah	43.8	58.4	68.9	65.1	75.1	81.8	83.1	91.3	94.7
Nevada	41.5	63.4	69.9	82.1	87.5	92.3	96.0	97.9	98.4
Pacific:									
Washington	17.5	20.2	26.9	31.8	37.9	45.2	50.7	82.3	90.5
Oregon	17.3	25.5	34.8	43.3	50.7	59.8	73.6	80.9	87.5
California	42.2	50.2	67.2	71.2	75.6	80.0	86.6	89.6	93.7
Alaska	17.2	34.3	50.0	49.3	58.0	70.9	81.3	84.4	85.4
Hawaii	39.7	53.5	58.6	70.1	74.3	84.7	90.6	94.7	97.2

[1] Rates reflect covered charges for physician claims processed during the period.

[2] The actual participation period is January 1987 through March 1988, and the participation agreements were in effect for that time.

[3] Starting with fiscal year 1993, includes data for all counties in Missouri plus two counties on the State border located in Kansas.

[4] Starting with fiscal year 1993, includes data for all counties in Kansas excluding two countries on the State borer.

[5] Starting with fiscal year 1993, includes data for all counties in Maryland excluding two countries on the State border.

[6] Starting with fiscal year 1993, includes data for the District of Columbia plus two counties in Maryland located on the State border plus a few counties and cities located in Virginia near the State border.

[7] Starting with fiscal year 1993, includes data for all counties in Virginia excluding a few counties and cities near the State border.

NA—Not available.

Source: Health Care Financing Administration, Bureau of Program Operations.

Through 1984, approximately the same proportions of assigned and unassigned claims were reduced (see table E–11), and were reduced by similar proportions and amounts. From 1984 to 1995, the proportions of assigned and unassigned claims reduced remained about the same, but the percentage and amounts of the reductions diverged. The percent and dollar reductions on assigned claims continued to increase while the percent and dollar reductions of unassigned claims decreased. This pattern was due to the imposition of limits on the actual charges of nonparticipating physicians, which limited the rate of increase in prices for unassigned services relative to the overall increase in charges. The substantial growth in the overall percentage of services billed on an assigned basis also may have contributed to this pattern.

As a result, total beneficiary liability for charge reductions on unassigned claims fell. Total liability peaked in 1986 at $2.813 billion, and declined to $425.4 million by 1995.

The impact of charge reductions on unassigned claims was spread unevenly across the population. Calendar 1995 data show a 15.4-percent national average reduction on unassigned claims (see table E–12). Beneficiary liability for these charge reductions ranged from a high of $34.5 million in New York to a low of $0.0 million in Rhode Island.

The changing pattern of charge reductions reflects, in part, overall changes in participation and assignment rates. As shown in table E–13, participating physicians accounted for a growing share of total physician charges. During the first participation period (fiscal year 1985), participating physicians (30.4 percent of all physicians) accounted for 36.0 percent of all physician charges. In 1995, the proportion of physicians participating grew to 72.3 percent, and accounted for 92.6 percent of all physician charges. Total covered charges represented by unassigned claims declined from 34.5 to 2.8 percent over the same period. The proportion of charges billed by participation and assignment status varies by State; these data are shown in table E–14.

DISTRIBUTION OF PHYSICIAN SERVICES

Tables E–15 to E–23 show the distribution of physicians' services for calendar year 1994. These tables provide data from the third year of the implementation of the Medicare Fee Schedule. As noted earlier, the fee schedule appears to be having its intended effect. The projected pattern of redistribution from the procedurally oriented specialties to the primary care specialties has begun taking place.

The 1994 data are tabulations from the 1994 National Claims History Procedure Summary, which is a summary of all claims filed with the Medicare carriers. The totals shown will differ from total SMI outlay figures for 1994 shown in the budget for several reasons:

The amounts shown in these tables are allowed amounts, rather than reimbursements—that is, they include both Medicare's and the enrollee's share of approved changes.

TABLE E–11.—CHARGE REDUCTIONS FOR MEDICARE PART B[1] FOR ASSIGNED AND NOT ASSIGNED CLAIMS, FISCAL YEARS 1975, 1980, AND 1985–95

Charge category and assignment status	Fiscal year												
	1975	1980	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995
Percentage of claims reduced:													
Assigned	68.3	80.0	81.7	82.5	83.0	85.5	86.3	87.6	86.7	87.0	[2] 88.2	88.1	86.4
Not assigned	75.6	83.7	84.6	84.9	82.5	85.7	89.2	89.2	90.7	85.4	[2] 85.5	86.7	83.9
Percentage reduction in charges for covered services:													
Assigned	16.4	22.5	27.0	28.4	27.9	29.3	30.9	32.6	35.2	39.2	42.1	42.5	41.8
Not assigned	16.6	22.3	25.6	26.6	25.5	24.7	25.2	25.3	24.0	19.7	16.9	16.4	15.6
Amount reduced per approved claim:													
Assigned	$11.13	$21.81	$33.19	$36.43	$36.98	$39.97	$43.72	$48.22	$54.20	$63.60	$79.49	$71.03	$72.31
Not assigned	$13.45	$21.96	$33.12	$33.15	$31.44	$29.47	$29.67	$28.97	$24.84	$18.95	$17.26	$13.45	$13.01
Amount reduced on claims not assigned (in millions)	$450.1	$1,454.0	$2,571.9	$2,812.5	$2,677.8	$2,312.6	$2,213.7	$2,198.0	$1,948.5	$1,317.0	$797.5	$572.4	$425.4

[1] Excludes claims from hospital-based physicians and group-practice prepayment plans.
[2] Figure may be slightly overstated due to the possibility of a claim being counted more than once because more than one type of reduction is applied.

Source: Health Care Financing Administration, Bureau of Program Operations.

TABLE E–12.—CHARGE REDUCTIONS FOR UNASSIGNED CLAIMS BY STATE,[1] JANUARY–DECEMBER 1995

[Dollar amounts in millions]

Census division/State	Covered charges[2]		Percent reduction in unassigned charges	Amount reduced, unassigned charges[2]
	Total	Unassigned		
National	$95,843.6	$2,543.2	15.4	$392.3
New England:				
Maine	389.8	2.6	12.8	0.3
New Hampshire	295.7	7.4	13.1	1.0
Vermont	138.7	1.2	11.9	0.1
Massachusetts[3]	2,518.5	4.1	8.4	0.3
Rhode Island	413.5	0.4	5.4	0.0
Connecticut	1,466.0	28.3	12.9	3.7
Middle Atlantic:				
New York	6,946.4	253.1	13.7	34.5
New Jersey	3,359.2	188.9	13.6	25.6
Pennsylvania	6,097.8	21.1	9.4	2.0
East North Central:				
Ohio	3,898.5	11.4	11.1	1.3
Indiana	1,690.4	59.1	17.0	10.0
Illinois	3,236.4	130.6	15.2	19.9
Michigan	3,563.5	40.2	18.9	7.6
Wisconsin	1,329.5	69.3	15.0	10.4
West North Central:				
Minnesota	859.4	110.5	14.5	16.1
Iowa	750.0	45.0	14.0	6.3
Missouri[4]	1,891.3	53.9	9.2	2.8
North Dakota	221.3	15.7	15.3	2.4
South Dakota	179.5	50.7	15.0	7.5
Nebraska	391.7	39.9	14.9	6.0
Kansas[5]	584.9	15.3	12.6	1.9
South Atlantic:				
Delaware	286.2	5.0	11.9	0.6
Maryland[6]	1,390.4	22.6	14.4	3.3
District of Columbia[7]	1,143.2	32.8	16.1	5.3
Virginia[8]	1,408.6	20.3	13.0	2.6
West Virginia	597.2	4.9	12.8	0.6
North Carolina	2,677.4	67.5	13.7	9.3
South Carolina	987.1	25.5	12.7	3.2
Georgia	2,167.7	44.8	12.9	5.8
Florida	7,791.8	107.9	23.2	25.0
East South Central:				
Kentucky	1,308.1	21.1	12.5	2.6
Tennessee	1,898.4	27.1	12.7	3.5
Alabama	1,563.2	15.8	15.0	2.4
Mississippi	760.7	13.6	13.2	1.8
West South Central:				
Arkansas	864.4	10.6	16.2	1.6
Louisiana	1,397.5	21.2	13.3	2.8
Oklahoma	840.5	36.3	13.7	5.0

TABLE E–12.—CHARGE REDUCTIONS FOR UNASSIGNED CLAIMS BY STATE,[1] JANUARY–DECEMBER 1995—Continued

[Dollar amounts in millions]

Census division/State	Covered charges[2]		Percent reduction in unassigned charges	Amount reduced, unassigned charges[2]
	Total	Unassigned		
Texas	4,903.3	134.3	14.5	19.5
Mountain:				
Montana	172.1	19.0	16.8	3.2
Wyoming	57.2	9.3	13.8	1.3
Idaho	178.8	44.1	15.3	6.7
Colorado	628.4	35.3	15.7	5.6
New Mexico	268.4	12.0	13.1	1.6
Arizona	1,044.6	66.7	13.5	9.0
Utah	284.2	8.3	13.7	1.1
Nevada	478.5	2.7	13.2	0.3
Pacific:				
Washington	1,113.2	60.2	14.6	8.8
Oregon	515.3	39.6	15.0	5.9
California	7,946.8	187.5	15.8	29.6
Alaska	56.7	1.9	15.0	0.3
Hawaii	240.8	2.6	16.2	0.5

[1] Rates reflect covered charges for physician claims processed during the period. National data exclude data for Puerto Rico, the Virgin Islands, the Railroad Retirement Board, and Parenteral and Enteral Claims. As a result of report changes effective April 1, 1992, charge reductions include: reasonable charge medical necessity and global fee/rebundling.

[2] Amounts in millions.

[3] Massachusetts enacted a Medicare mandatory assignment provision, effective April 1986. The fact that the assignment rates shown here are not 100 percent may be explained by the inclusion in the database of billings by practitioners other than allopathic and osteopathic physicians, which are included in the Medicare statutory definition of ''physician.''

[4] Starting with fiscal year 1993, includes data for all counties in Missouri plus two counties on the State border located in Kansas.

[5] Starting with fiscal year 1993, includes data for all counties in Kansas excluding two counties on the State border.

[6] Starting with fiscal year 1993, includes data for all counties in Maryland excluding two counties on the State border.

[7] Starting with fiscal year 1993, includes data for the District of Columbia plus two counties in Maryland located on the State border plus a few counties and cities located in Virginia, near the State border.

[8] Starting with fiscal year 1993, includes data for all counties in Virginia excluding a few counties and cities near the State border.

Source: Health Care Financing Administration, Bureau of Program Operations.

The amounts shown are for services rendered during calendar year 1994; budget figures are for payments made during the fiscal year regardless of when the services were rendered.

The amounts shown are only for services reimbursed by carriers under the fee schedule; hence, they do not include part B payments to hospital outpatient departments or to risk-based prepaid medical plans.

TABLE E–13.—DISTRIBUTION OF ALLOWED CHARGES FOR SERVICES BILLED BY PARTICIPATION STATUS OF PHYSICIAN AND ASSIGNMENT STATUS OF CLAIM, 1984–95 [1]

[In percent]

Time period	Total	Participants	Nonparticipants	
			Assigned	Unassigned
Oct. 1984–Sept. 1985	100.0	36.0	29.5	34.5
Oct. 1985–Mar. 1986	100.0	36.3	29.4	34.3
Apr. 1986–Dec. 1986 [2]	100.0	39.1	28.0	32.9
Jan. 1987–Mar. 1988 [3]	100.0	48.1	25.2	26.7
Apr. 1988–Dec. 1988	100.0	57.9	21.0	21.1
Jan. 1989–Mar. 1990	100.0	62.0	19.0	18.5
Apr. 1990–Dec. 1990	100.0	67.2	16.7	16.1
Jan. 1991–Dec. 1991	100.0	72.3	14.6	13.1
Jan. 1992–Dec. 1992	100.0	78.8	11.6	9.7
Jan. 1993–Dec. 1993	100.0	85.5	8.5	6.0
Jan. 1994–Dec. 1994	100.0	89.4	6.6	4.0
Jan. 1995–Dec. 1995	100.0	92.6	4.6	2.8

[1] Rates reflect covered charges for physician claims processed during the period.

[2] The actual participation period was May through December 1986, and the participation agreements were in effect for that time.

[3] The actual participation period is January 1987 through March 1988, and the participation agreements are in effect for that time.

Source: Health Care Financing Administration, Bureau of Program Operations.

Further, the amounts shown underestimate what they are supposed to represent by a small amount because some claims for services rendered in 1994 had not been processed by carriers at the time the 1994 files were submitted to HCFA, and because some claims recorded had to be eliminated due to recording errors.

Table E–15 illustrates that in 1994, 76.9 percent of allowed amounts under the fee schedule were for physicians' services, and another 3.1 percent were for the services of limited license practitioners—psychologists, podiatrists, optometrists, audiologists, chiropractors, dentists, and physical therapists. About 4.2 percent went to independent laboratories in 1994, while 15.8 percent went to suppliers of medical equipment, prosthetics, and ambulance services.

About 28 percent of all allowed amounts were for hospital inpatient services, and about 37 percent of allowed amounts for physicians' services were inpatient. The share of physicians' services that are inpatient has dropped in recent years, from nearly 64 percent in 1981.

TABLE E–14.—DISTRIBUTION OF ALLOWED CHARGES FOR SERVICES BILLED BY STATE, PARTICIPATION STATUS OF PHYSICIAN, AND ASSIGNMENT STATUS OF CLAIM, JANUARY–DECEMBER 1995 [1]

[In percent]

Census division/State	Total	Participating physician	Nonparticipating physician	
			Assigned	Unassigned
National	100.0	92.6	4.6	2.8
New England:				
Maine	100.0	96.2	3.1	0.7
New Hampshire	100.0	93.2	4.1	2.7
Vermont	100.0	96.9	2.3	0.8
Massachusetts	100.0	97.4	2.4	0.2
Rhode Island	100.0	99.4	0.5	0.1
Connecticut	100.0	94.1	3.6	2.3
Middle Atlantic:				
New York	100.0	87.5	8.7	3.8
New Jersey	100.0	84.6	8.6	6.8
Pennsylvania	100.0	98.7	1.0	0.4
East North Central:				
Ohio	100.0	97.8	1.9	0.3
Indiana	100.0	94.0	2.9	3.2
Illinois	100.0	90.7	5.2	4.1
Michigan	100.0	97.6	1.5	0.9
Wisconsin	100.0	91.1	3.9	5.0
West North Central:				
Minnesota	100.0	80.5	7.3	12.3
Iowa	100.0	90.4	3.8	5.8
Missouri [2]	100.0	93.4	3.6	3.0
North Dakota	100.0	89.3	3.7	7.0
South Dakota	100.0	59.2	10.5	30.3
Nebraska	100.0	86.2	3.8	10.0
Kansas [3]	100.0	95.3	1.9	2.8
South Atlantic:				
Delaware	100.0	95.3	2.7	2.0
Maryland [4]	100.0	92.9	5.3	1.8
District of Columbia [5]	100.0	93.8	3.0	3.2
Virginia [6]	100.0	96.3	2.2	1.5
West Virginia	100.0	96.3	2.9	0.9
North Carolina	100.0	92.7	4.2	3.1
South Carolina	100.0	92.7	4.5	2.8
Georgia	100.0	94.8	2.9	2.3
Florida	100.0	94.7	3.9	1.4
East South Central:				
Kentucky	100.0	94.6	3.5	1.9
Tennessee	100.0	95.6	2.8	1.5
Alabama	100.0	97.0	1.9	1.1
Mississippi	100.0	92.8	5.2	2.0
West South Central:				
Arkansas	100.0	96.4	2.4	1.2
Louisiana	100.0	92.2	6.1	1.7
Oklahoma	100.0	91.4	3.7	4.9

TABLE E–14.—DISTRIBUTION OF ALLOWED CHARGES FOR SERVICES BILLED BY STATE, PARTICIPATION STATUS OF PHYSICIAN, AND ASSIGNMENT STATUS OF CLAIM, JANUARY–DECEMBER 1995 [1]—Continued

[In percent]

Census division/State	Total	Participating physician	Nonparticipating physician	
			Assigned	Unassigned
Texas	100.0	90.6	6.4	3.1
Mountain:				
Montana	100.0	83.1	6.3	10.6
Wyoming	100.0	75.6	7.2	17.2
Idaho	100.0	61.6	11.7	26.7
Colorado	100.0	86.1	7.7	6.2
New Mexico	100.0	89.6	5.8	4.6
Arizona	100.0	90.6	2.1	7.3
Utah	100.0	94.7	2.3	3.0
Nevada	100.0	98.4	1.0	0.6
Pacific:				
Washington	100.0	90.5	3.8	5.7
Oregon	100.0	87.5	5.5	7.0
California	100.0	93.7	3.8	2.5
Alaska	100.0	85.4	11.0	3.6
Hawaii	100.0	97.2	1.7	1.1

[1] Rates reflect charges for physician claims processed during the period.
[2] For fiscal year 1993, includes data for all counties in Missouri plus two counties on the State border located in Kansas.
[3] Starting with fiscal year 1993, includes data for all counties in Kansas excluding two counties on the State border.
[4] Starting with fiscal year 1993, includes data for all counties in Maryland excluding two counties on the State border.
[5] Starting with fiscal year 1993, includes data for the District of Columbia plus two counties in Maryland located on the State border plus a few counties and cities located in Virginia, near the State border.
[6] Starting with fiscal year 1993, includes data for all counties in Virginia excluding a few counties and cities near the State border.

Source: Health Care Financing Administration, Bureau of Program Operations.

TABLE E–15.—ALLOWED AMOUNTS FOR CLAIMS BY TYPE OF PROVIDER, 1994

Type of provider	Allowed amounts (millions)	Percent of total	Percent inpatient
Physicians	$39,222.0	76.9	36.5
Limited license practitioners [1]	1,584.0	3.1	1.4
Laboratories	2,155.0	4.2	0.2
Medical suppliers [2]	8,033.0	15.8	0.7
All providers [3]	50,994.0	100.0	28.2

[1] Includes psychology, podiatry, optometry, audiology, chiropractic, dentistry, and physical therapy.
[2] Includes suppliers of medical equipment, prosthetics, and ambulance services.
[3] Total does not include charges for hospital outpatient department facility fees or for risk-based prepaid medical plans since these are not reimbursed under the CPR system.

Source: Health Care Financing Administration, Bureau of Data Management and Strategy.

Table E–16 shows the distribution of spending for physicians' services by specialty. (It excludes limited license practitioners, labs, and suppliers.) In 1994, generalists accounted for 26.4 percent of spending, nonsurgical specialists for 26.7 percent, and surgical specialists for 30.4 percent. Radiologists, anesthesiologists, and pathologists together accounted for 11.8 percent of allowed amounts. Radiation oncologists, osteopathic manipulative therapists, intensivists, emergency medicine physicians, and other physician specialties accounted for less than 5 percent of total allowed amounts for physicians' services.

The major physician specialties treating the Medicare population, in descending order of importance as measured by total allowed amounts, were general internists (13.7 percent of allowed amounts), ophthalmologists (9.8 percent), cardiologists (8.4 percent), radiologists (7.3 percent), and family practitioners (6.2 percent).

The share of services provided on an inpatient basis varied by specialty, generally increasing with specialization. About 32 percent of the services of generalists were inpatient in 1994. The inpatient share for nonsurgical specialists was 42 percent and 38 percent for surgical specialists.

TABLE E–16.—ALLOWED AMOUNTS FOR PHYSICIANS' SERVICES BY SPECIALTY, 1994

Specialty	Allowed charges (millions)	Percent of total	Percent inpatient
Generalists:			
General practice	1,163.0	3.0	17.8
Family practice	2,449.0	6.2	24.3
Internal medicine	5,380.0	13.7	36.9
Pediatrics	45.0	0.1	19.0
Clinics	1,321.0	3.4	37.5
All generalists	10,359.0	26.4	31.8
Nonsurgical specialists:			
Allergy/immunology	94.0	0.2	3.4
Cardiology	3,507.0	8.9	53.8
Dermatology	847.0	2.2	0.9
Gastroenterology	1,113.0	2.8	43.2
Neurology	596.0	1.5	44.2
Psychiatry	866.0	2.2	33.7
Physical medicine and rehabilitation	286.0	0.7	55.5
Pulmonary disease	801.0	2.0	66.0
Nuclear medicine	65.0	0.2	20.6
Geriatric medicine	72.0	0.2	29.8
Nephrology	648.0	1.7	50.3
Infectious disease	164.0	0.4	75.0
Endocrinology	160.0	0.4	34.1
Rheumatology	221.0	0.6	13.5
Peripheral vascular disease	25.0	0.1	58.2
Hematology/oncology	808.0	2.1	18.9

TABLE E–16.—ALLOWED AMOUNTS FOR PHYSICIANS' SERVICES BY SPECIALTY, 1994—Continued

Specialty	Allowed charges (millions)	Percent of total	Percent inpatient
Medical oncology	217.0	0.6	18.4
All nonsurgical specialists	10,490.0	26.7	41.9
Surgical specialists:			
General surgery	1,957.0	5.0	63.0
Otolaryngology	457.0	1.2	14.4
Neurosurgery	331.0	0.8	83.6
Gynecology/obstetrics	305.0	0.8	39.3
Ophthalmology	3,848.0	9.8	2.3
Orthopedic surgery	1,902.0	4.8	58.8
Plastic and reconstructive surgery	191.0	0.5	30.4
Colorectal surgery	79.0	0.2	33.8
Thoracic surgery	677.0	1.7	89.5
Urology	1,605.0	4.1	26.3
Hand surgery	24.0	0.1	18.7
Vascular surgery	244.0	0.6	72.4
Cardiac surgery	263.0	0.7	96.3
Surgical oncology	26.0	0.1	56.3
All surgical specialists	11,909.0	30.4	37.5
Radiology	2,872.0	7.3	28.9
Radiation oncology	420.0	1.1	5.1
Anesthesiology	1,227.0	3.1	67.8
Pathology	540.0	1.4	41.9
Manipulative therapy	19.0	.....	18.7
Critical care (intensivists)	52.0	0.1	78.7
Emergency medicine	592.0	1.5	4.0
Other physician specialties	743.0	1.9	23.1
Total—all physicians	39,222.0	100.0	36.5

Source: Health Care Financing Administration, Bureau of Data Management and Strategy.

Table E–17 shows the distribution of spending for physicians' services by type of service. About 39.3 percent of spending was for medical care (nonsurgical) in 1994. About 32.7 percent of spending was for surgical procedures in total, adding together the amounts for surgeons, assistant surgeons, and anesthesiologists. About 10.8 percent was for diagnostic laboratory tests, which would include not only blood chemistry analysis and urinalysis, but also tests such as EKGs. About 9.2 percent of spending was for radiology, and 5.1 percent was for consultations.

TABLE E–17.—ALLOWED AMOUNTS FOR PHYSICIANS' SERVICES BY TYPE OF SERVICE, 1994

Type of service	Allowed charges (millions)	Percent of total	Percent inpatient
Medical care	$15,427.0	39.3	32.3
Surgery	11,299.0	28.8	48.7
Assistance at surgery	232.0	0.6	93.2
Anesthesia	1,287.0	3.3	66.4
Diagnostic laboratory tests	4,218.0	10.8	20.1
Diagnostic radiology	2,898.0	7.4	23.7
Therapeutic radiology	689.0	1.8	4.8
Consultations [1]	1,990.0	5.1	58.9
Mammography	52.0	0.1	0.5
Pneumococcal vaccine	91.0	0.2	
Other [2]	1,038.0	2.6	0.3
All services	39,222.0	100.0	36.5

[1] Includes first and second opinions for surgery.
[2] Includes treatment for renal patients, pneumococcal vaccine, and medical supplies, among other things.

Source: Health Care Financing Administration, Bureau of Data Management and Strategy.

Table E–18 lists the top 20 individual services, ranked by total allowed amounts on claims submitted by selected physicians for 1994. The most important exclusion is amounts for the services of anesthesiologists, since there would typically be a charge for anesthesiology for the surgical procedures. The amounts for surgical procedures include claims by both the primary surgeon and any assistant surgeons, but not the amounts for anesthesiologists.

The top 20 services (out of more than 7,000) accounted for 37.6 percent of all spending for all physicians' services in 1994. Cataract extraction with implantation of an intraocular lens was the highest ranked surgical procedure, accounting by itself for 4.9 percent of total allowed amounts for physicians' services. Most of the services in the top 20 were evaluation and management services (that is, visits and consultations).

Table E–19 presents total allowed amounts for selected groups of generic services, and shows the percent of total allowed amounts for all physicians' services accounted for by each group. As in table E–18, certain physicians' services—most notably for anesthesiologists—are not included in the allowed amounts for each service group. No attempt was made to define and rank all possible service groups, so that there may be other important service groups that do not appear in the table. For example, diagnostic radiology accounts for 7.4 percent of allowed amounts for physicians' services (from table E–17), but radiological services do not appear in table E–19.

TABLE E–18.—TOP 20 SERVICES BILLED BY PHYSICIANS UNDER MEDICARE, 1994

Rank order	Service code	Description	Allowed charges (millions)	Percent of total
1.	99213	Office/outpatient visit, EST	$2,609.0	6.7
2.	66984	Remove cataract, insert lens	1,928.0	4.9
3.	99232	Subsequent hospital care	1,546.0	3.9
4.	99214	Office/outpatient visit, EST	1,472.0	3.8
5.	99231	Subsequent hospital care	930.0	2.4
6.	99233	Subsequent hospital care—comprehensive	720.0	1.8
7.	99212	Office/outpatient visit, EST	697.0	1.8
8.	99223	Initial hospital care	527.0	1.3
9.	99215	Office/outpatient visit, EST	502.0	1.3
10.	93307	Echo exam of heart	457.0	1.2
11.	99254	Initial inpatient consult	433.0	1.1
12.	90844	Psychotherapy 45–50 minutes	425.0	1.1
13.	99285	Emergency room visit	344.0	0.9
14.	66821	After cataract laser surgery	327.0	0.8
15.	92014	Eye, exam and treatment	327.0	0.8
16.	99238	Hospital discharge pay	324.0	0.8
17.	99255	Initial inpatient consult	307.0	0.8
18.	27447	Total knee replacement	300.0	0.8
19.	99222	Initial hospital care	299.0	0.8
20.	99244	Office consultation	291.0	0.7
		Total	$14,765.0	37.6

[1] Amounts for surgical procedures include fees for primary and assistant surgeons, but not for anesthesiologists.

Source: Health Care Financing Administration, Bureau of Data Management and Strategy.

The 21 service groups shown in table E–19 accounted for 44.3 percent of all allowed amounts for all physicians' services in 1994. The single most costly group was office visits (accounting for 15.5 percent of total allowed amounts for physicians' services), followed by hospital visits (11.2 percent). Cataract surgery of all types accounted for 5.0 percent of total allowed amounts for physicians' services. It should also be noted that the amount for hemodialysis includes only physician services and does not include the much larger amounts for the facility charges for hemodialysis that were not billed under the fee-for-service reimbursement system.

In recent years, there have been many changes in the delivery of health care services. Some of the more significant changes affecting Medicare services have been in the delivery of surgical services. First, there has been significant growth in the amount of surgical care provided by some specialties. Second, there has been a dramatic shift in the place of surgical care; that is, surgical care is now frequently provided in outpatient settings, whereas previously, most surgical care was provided in inpatient settings.

TABLE E–19.—ALLOWED AMOUNTS FOR SELECTED GROUPS OF PHYSICIANS' SERVICES, 1994

Service group	Allowed charges (millions) [1]	Percent of total
Hospital visits (99221–99238)	$4,388.0	11.2
Office visits (99201–99215)	6,082.0	15.5
Cataract surgery (66830–66985)	1,956.0	5.0
EKGs (93000–93018, 93015–26)	667.0	1.7
Transurethal surgery (52602)	131.0	0.3
Coronary artery bypass (33510–33516)	193.0	0.5
Hip arthroplasty (27130–27132)	157.0	0.4
Cardiac catheterization (93501–93553)	581.0	1.5
Colonoscopy (45378–45385, 44388–44393, 45355)	548.0	1.4
Hemodialysis/CAPD (90935–90947)	167.0	0.4
Thromboendarterectomy (35301–35381)	118.0	0.3
Knee arthroplasty (27446, 27447, 29881)	336.0	0.9
Pacemaker inplant/removal (33200–33214, 33233–33237)	101.0	0.3
Vein bypass (35501–35587)	75.0	0.2
Emergency room visits (99281–99285)	907.0	2.3
SNF visits (99301–99313)	675.0	1.7
Nursing home visits (99321–99333)	37.0	0.1
Home visits (99341–99353)	82.0	0.2
Prostatectomy (55801–55845)	59.0	0.2
EEGs (95816–95827, 95950, 95955)	43.0	0.1
Pacemaker tests (93731–93736)	81.0	0.2
Total	17,383.0	44.3

[1] Amounts for surgical procedures include fees for primary and assistant surgeons, but not for anesthesiologists.

Source: Health Care Financing Administration, Bureau of Data Management and Strategy.

As shown in table E–20, the most significant shift in site of surgical care between 1980 and 1994 was out of inpatient settings and into other settings. Outpatient hospital settings benefited most from this shift, growing from only 3.3 percent of all surgical charges in 1980 to 25.6 percent in 1994. The proportions of surgery taking place in a physician's office and in other nonhospital settings also grew somewhat. In 1994 the proportion of all surgical care provided in inpatient settings had dropped to 46.4 percent.

TABLE E–20.—CHARGES SUBMITTED TO MEDICARE FOR ALL PHYSICIAN SURGICAL SERVICES BY PLACE OF SERVICE, 1980, 1990 AND 1992–94

Year and place of service	Surgical charges [1]		
	Amount in millions	Percent of surgical charges	As percent of total settings charges
1980:			
Total	$3,828	100.0	31.8
Office	445	11.6	12.2
Outpatient hospital	129	3.3	29.5
Inpatient hospital	3,231	84.4	44.1
Other [2]	23	0.6	3.7
1990:			
Total	11,048	100.0	33.3
Office	2,004	18.1	16.2
Outpatient hospital [1]	2,867	26.0	54.3
Inpatient hospital	5,563	50.4	40.6
Ambulatory surgical center	488	4.4	51.2
Other [2]	127	1.1	14.5
1992:			
Total	10,958	100.0	31.3
Office	2,103	19.2	14.8
Outpatient hospital [1]	2,791	25.5	50.3
Inpatient hospital	5,249	47.9	39.2
Ambulatory surgical center	622	5.7	90.3
Other [2]	193	1.8	16.6
1993:			
Total	10,777	100.0	30.0
Office	2,128	19.7	14.1
Outpatient hospital [1]	2,731	25.3	48.4
Inpatient hospital	5,085	47.2	38.4
Ambulatory surgical center	697	6.5	90.5
Other [2]	136	1.3	11.1
1994:			
Total	11,904	100.0	29.5
Office	2,379	20.0	14.0
Outpatient hospital [1]	3,046	25.6	47.9
Inpatient hospital	5,518	46.4	38.5
Ambulatory surgical center	798	6.7	91.0
Other [2]	162	1.4	8.7

[1] May include some services rendered in an ambulatory surgical center.
[2] Includes homes, nursing homes, and other places of service.

Source: Health Care Financing Administration, Bureau of Data Management and Strategy.

Table E–21 shows the percent of total surgical charges by specialty in 1980 and 1994. In 1980, three specialties (ophthalmology, general surgery, and orthopedic surgery) accounted for nearly half of all Medicare surgical care. These same three specialties accounted for close to 44 percent of total surgical care in 1994. The shares among these specialties changed. While ophthalmologists accounted for only 13.6 percent in 1980, by 1994 their share had increased to 20.9 percent due primarily to the substantial growth in cataract surgery during the 1980s. For gastroenterologists, surgical care represented much larger proportions of their total Medicare practice in 1994 than in 1980. On the other hand, surgical charges for urologists represented much smaller proportions of their total Medicare practice in 1994 than in 1980.

TABLE E–21.—SUBMITTED SURGICAL CHARGES AS A SHARE OF TOTAL SURGICAL CHARGES AND AS A PERCENT OF TOTAL PRACTICE CHARGES BY MEDICAL SPECIALTY, 1980 AND 1994

Specialty	Percent distribution of surgical charges		Surgical charges as a percent of total practice charges	
	1980	1994	1980	1994
All physicians	100.0	100.0	31.8	29.5
Ophthalmology	13.6	20.9	62.1	64.8
General surgery	22.1	11.6	71.6	70.7
Orthopedic surgery	13.0	11.3	73.6	70.9
Urology	10.7	5.9	75.6	43.5
Thoracic surgery	8.0	4.7	82.2	81.9
Clinic and other group practice	4.7	2.4	25.8	21.9
Internal medicine	4.2	2.7	6.9	5.9
Cardiovascular disease	2.7	7.1	22.4	24.2
Podiatry	3.0	4.7	53.5	65.0
Gastroenterology	1.7	5.8	45.9	62.3
Dermatology	2.4	4.9	60.9	69.3
Neurological surgery	2.9	2.2	70.2	78.1
Othology, laryngology, rhinology	1.9	1.7	49.7	43.5
Plastic surgery	1.3	1.4	88.1	84.5
Other	8.4	12.7	.....	9.2

Source: Health Care Financing Administration, Bureau of Data Management and Strategy.

As shown in table E–22, many different medical specialties participated in the shift to outpatient surgery. In 1980, only two specialties (dermatology and podiatry) performed the majority of their surgical services in outpatient settings; in these cases, the care was generally provided in the physician's office. In 1994, eight specialties provided a majority of their surgical care in outpatient settings: ophthalmology, podiatry, gastroenterology, dermatology, ENT, internal medicine, plastic surgery, and urology. Podiatrists and dermatologists continued primarily to work in their offices; internists split their noninpatient work between office and outpatient settings, while most of the other specialties provided their surgical services in outpatient hospital and ambulatory surgical facilities.

Most surgical specialties, such as general, orthopedic, cardiovascular, neurological, and thoracic surgeons, remained closely tied to inpatient hospital settings.

In 1994, ophthalmologists provided most (41.8 percent) of the surgery done in outpatient hospital settings (see table E–23). The predominance of ophthalmologists in this setting is due to cataract surgery. Dermatologists accounted for the largest proportion of office surgical charges, 24.0 percent. However, ophthalmologists and podiatrists also represented significant percentages of office surgical charges, 21.1 and 16.5 percent respectively. In inpatient settings, the traditional surgical specialties—general surgery, orthopedic surgery, cardiovascular surgery, thoracic surgery, and urology accounted for 65.3 percent of all surgical charges.

Table E–24 summarizes the practice cost indices for geographical areas in 1996.

TABLE E–22.—SUBMITTED SURGICAL CHARGES UNDER MEDICARE BY MEDICAL SPECIALTY AND PLACE OF SERVICE, 1980 AND 1994

[In percent]

Medical specialty	1980					1994					
	All settings	Office	Inpatient hospital	Outpatient hospital	Other [1]	All settings	Office	Inpatient hospital	Outpatient hospital [2]	ASC [3]	Other [1]
All physicians	100.0	11.6	84.4	3.3	0.5	100.0	20.0	46.4	25.6	6.7	1.4
General surgery	100.0	4.4	92.6	2.9	0.1	100.0	5.3	70.9	22.1	1.4	0.2
Cardiovascular disease	100.0	1.7	97.9	0.4	([4])	100.0	2.0	82.9	14.0	0.1	1.0
Dermatology	100.0	94.6	4.0	0.9	0.6	100.0	97.2	0.2	1.9	0.4	0.3
Gastroenterology	100.0	12.0	75.6	12.3	0.1	100.0	7.4	36.2	48.8	7.5	0.1
Internal medicine	100.0	17.5	76.6	5.7	0.2	100.0	24.7	43.2	29.7	2.1	0.4
Neurological surgery	100.0	1.1	98.5	0.5	([4])	100.0	1.1	95.0	3.7	0.1	0.0
Obstetrics/gynecology	100.0					100.0	14.7	72.3	11.9	1.0	0.1
Otology, laryngology, rhinology	100.0	12.6	83.7	3.7	([4])	100.0	33.0	25.4	37.1	4.1	0.4
Ophthalmology	100.0	7.9	87.1	5.0	0.1	100.0	20.1	3.2	51.1	25.3	0.3
Orthopedic surgery	100.0	6.3	90.2	3.4	0.1	100.0	8.0	76.3	14.1	1.4	0.1
Plastic surgery	100.0	13.0	67.2	19.7	0.1	100.0	21.9	31.7	38.7	7.2	0.4
Thoracic surgery	100.0	0.8	98.7	0.5	([4])	100.0	0.7	96.3	2.8	0.1	0.0
Urology	100.0	8.0	90.6	1.4	0.1	100.0	26.1	49.8	22.2	1.8	0.2
Podiatry	100.0	71.3	13.5	0.9	14.3	100.0	69.4	1.3	4.9	1.6	22.8
Clinic and other group practice	100.0	10.1	85.3	4.5	0.1	100.0	11.8	60.3	25.1	2.6	0.2
Other	100.0					100.0	12.5	64.7	21.2	1.3	0.4

[1] Includes homes, nursing homes, and other places of service.
[2] May include some services rendered in an ASC.
[3] Ambulatory surgical center.
[4] Less than 0.05.

Source: Health Care Financing Administration, Bureau of Data Management and Strategy.

TABLE E–23.—PERCENT DISTRIBUTION OF ALLOWED SURGICAL CHARGES BY SELECTED SPECIALTIES AND SELECTED PLACE OF SERVICE, 1994

Place of service	Percent
Inpatient hospital:	
General surgery	17.8
Orthopedic surgery	18.7
Thoracic surgery	9.7
Urology	6.3
Cardiovascular disease	12.8
Clinic and other group practice	3.1
Gastroenterology	4.6
Internal medicine	2.5
Ophthalmology	1.4
Neurological surgery	4.5
Other medical and surgical specialties	18.6
Total	100.0
Office:	
Ophthalmology	21.1
Dermatology	24.0
Podiatry	16.5
Urology	7.7
Internal medicine	3.3
General surgery	3.1
Orthopedic surgery	4.6
Gastroenterology	2.2
Family Practice	3.5
Clinic and other group practice	1.4
Other medical and surgical specialties	12.6
Total	100.0
Outpatient hospital:	
Ophthalmology	41.8
Gastroenterology	11.1
General surgery	10.0
Orthopedic surgery	6.2
Internal medicine	3.1
Urology	5.1
Clinic and other group practice	2.3
Otology, larynology, rhinology	2.4
Plastic surgery	2.1
Other medical and surgical specialties	15.9
Total	100.0

Source: Health Care Financing Administration, Bureau of Data Management and Strategy.

TABLE E–24.—1996 GEOGRAPHIC PRACTICE COST INDICES BY MEDICARE CARRIER AND LOCALITY

Carrier number	Locality number	Locality name	Cost indices		
			Work	Practice expense	Mal-practice
00510	05	Birmingham, AL	0.994	0.912	0.927
00510	04	Mobile, AL	0.975	0.858	0.927
00510	02	North Central, Alabama	0.973	0.850	0.927
00510	01	Northwest, Alabama	0.990	0.873	0.927
00510	06	Rest of Alabama	0.964	0.818	0.927
00510	03	Southeast Alabama	0.970	0.858	0.927
01020	01	Alaska	1.064	1.155	1.617
01030	05	Flagstaff, AZ	0.971	0.936	1.321
01030	01	Phoenix, AZ	1.004	0.963	1.321
01030	07	Prescott, AZ	0.971	0.912	1.321
01030	99	Rest of Arizona	0.989	0.948	1.321
01030	02	Tucson, AZ	0.978	0.942	1.321
01030	08	Yuma, AZ	0.984	0.925	1.321
00520	13	Arkansas	0.954	0.853	0.427
02050	26	Anaheim/Santa Ana, CA	1.037	1.205	0.752
00542	14	Bakersfield, CA	1.023	0.992	0.686
00542	11	Fresno/Madera, CA	1.000	0.977	0.596
00542	13	Kings/Tulare, CA	0.987	0.954	0.596
02050	18	Los Angeles (1st of 8)	1.056	1.207	0.752
02050	19	Los Angeles (2nd of 8)	1.056	1.207	0.752
02050	20	Los Angeles (3rd of 8)	1.056	1.207	0.752
02050	21	Los Angeles (4th of 8)	1.056	1.207	0.752
02050	22	Los Angeles (5th of 8)	1.056	1.207	0.752
02050	23	Los Angeles (6th of 8)	1.056	1.207	0.752
02050	24	Los Angeles (7th of 8)	1.056	1.207	0.752
02050	25	Los Angeles (8th of 8)	1.056	1.207	0.752
00542	03	Marin/Napa/Solano, CA	1.015	1.180	0.596
00542	10	Merced/surrounding counties, California	1.002	0.988	0.596
00542	12	Monterey/Santa Cruz, CA	1.008	1.143	0.596
00542	01	Northeast coastal counties, California	1.003	1.090	0.596
00542	02	Northeast rural, California	0.982	0.953	0.596
00542	07	Oakland/Berkeley, CA	1.042	1.215	0.596
00542	27	Riverside, CA	1.011	1.059	0.667
00542	04	Sacramento/surrounding counties, California	1.020	1.069	0.596
00542	15	San Bernadino/east central counties	1.015	1.056	0.749
02050	28	San Diego/Imperial, CA	1.017	1.077	0.618
00542	05	San Francisco, CA	1.068	1.330	0.596
00542	06	San Mateo, CA	1.049	1.300	0.596
02050	16	Santa Barbara, CA	1.016	1.119	0.686
00542	09	Santa Clara, CA	1.064	1.289	0.596
00542	08	Stockton/surrounding counties, California	1.001	1.041	0.596
02050	17	Ventura, CA	1.028	1.192	0.686

TABLE E–24.—1996 GEOGRAPHIC PRACTICE COST INDICES BY MEDICARE CARRIER AND LOCALITY—Continued

Carrier number	Locality number	Locality name	Cost indices		
			Work	Practice expense	Mal-practice
00824	01	Colorado	0.989	0.951	0.827
10230	04	Eastern, Connecticut	1.033	1.132	1.001
10230	01	Northwest and north central Connecticut	1.049	1.159	1.001
10230	03	South central Connecticut	1.056	1.226	1.001
10230	02	Southwest Connecticut	1.055	1.275	1.001
00570	01	Delaware	1.021	1.032	0.792
00580	01	District of Columbia plus Maryland/Virginia suburbs	1.051	1.192	0.980
00590	03	Fort Lauderdale, FL	0.998	1.036	1.867
00590	04	Miami, FL	1.016	1.087	2.456
00590	02	North/north central Florida cities	0.978	0.952	1.417
00590	01	Rest of Florida	0.971	0.914	1.417
01040	01	Atlanta, GA	1.007	1.030	0.902
01040	04	Rest of Georgia	0.965	0.856	0.902
01040	02	Small Georgia cities 02	0.981	0.917	0.902
01040	03	Small Georgia cities 03	0.966	0.884	0.902
01120	01	Hawaii/Guam	0.999	1.220	0.921
05130	12	North Idaho	0.957	0.864	0.588
05130	11	South Idaho	0.963	0.887	0.588
00621	10	Champaign-Urbana, IL	0.952	0.884	1.008
00621	16	Chicago, IL	1.028	1.080	1.382
00621	03	De Kalb, IL	0.953	0.873	0.780
00621	11	Decatur, IL	0.962	0.864	0.880
00621	12	East St. Louis, IL	0.988	0.929	1.202
00621	06	Kankakee, IL	0.959	0.881	0.901
00621	08	Normal, IL	0.969	0.893	0.731
00621	01	Northwest, IL	0.951	0.842	0.731
00621	05	Peoria, IL	0.980	0.906	0.731
00621	07	Quincy, IL	0.946	0.824	0.731
00621	04	Rock Island, IL	0.972	0.858	0.731
00621	02	Rockford, IL	0.978	0.941	0.813
00621	13	Southeast Illinois	0.946	0.814	0.731
00621	14	Southern Illinois	0.946	0.822	0.822
00621	09	Springfield, IL	0.981	0.936	0.946
00621	15	Suburban Chicago, IL	1.007	1.093	1.159
00630	01	Metropolitan, Indiana	0.989	0.937	0.363
00630	03	Rest of Indiana	0.973	0.872	0.346
00630	02	Urban, Indiana	0.974	0.896	0.346
00640	00	Iowa	0.960	0.877	0.679
00740	05	Kansas City, KS	0.989	0.949	1.191
00650	01	Rest of Kansas	0.958	0.877	1.191
00740	04	Suburban Kansas City, KS	0.989	0.949	1.191
00660	01	Lexington and Louisville, KY	0.989	0.904	0.819
00660	03	Rest of Kentucky	0.957	0.821	0.819
00660	02	Small cities (city limits), Kentucky	0.960	0.850	0.819

TABLE E–24.—1996 GEOGRAPHIC PRACTICE COST INDICES BY MEDICARE CARRIER AND LOCALITY—Continued

Carrier number	Locality number	Locality name	Cost indices		
			Work	Practice expense	Mal-practice
00528	07	Alexandria, LA	0.958	0.864	0.911
00528	03	Baton Rouge, LA	0.984	0.894	0.911
00528	06	Lafayette, LA	0.971	0.857	0.911
00528	04	Lake Charles, LA	0.974	0.901	0.911
00528	05	Monroe, LA	0.958	0.867	0.911
00528	01	New Orleans, LA	0.999	0.946	0.997
00528	50	Rest of Louisiana	0.965	0.850	0.913
00528	02	Shreveport, LA	0.971	0.889	0.911
21200	02	Central Maine	0.961	0.929	0.759
21200	01	Northern Maine	0.964	0.920	0.759
21200	03	Southern Maine	0.980	1.034	0.759
00901	01	Baltimore/surrounding counties, Maryland	1.021	1.036	1.115
00901	03	South and Eastern Shore Maryland	0.985	0.972	0.862
00901	02	Western Maryland	0.982	0.930	0.862
00700	02	Massachusetts suburbs/rural cities	1.015	1.101	0.978
00700	01	Urban Maine	1.030	1.167	0.978
00623	01	Detroit, MI	1.043	1.038	3.051
00623	02	Michigan, not Detroit	0.998	0.935	1.844
00720	00	Minnesota (Blue Shield)	0.990	0.965	0.594
10240	00	Minnesota (Travelers)	0.990	0.965	0.594
10250	01	Rest of Mississippi	0.950	0.813	0.726
10250	02	Urban Mississippi	0.964	0.868	0.726
00740	03	Kansas City (Jackson County), MO	0.989	0.949	1.207
00740	02	North Kansas City (Clay/Platte), MO	0.989	0.949	1.204
11260	03	Rest of Missouri	0.944	0.810	1.159
00740	06	Rural north west counties, MO	0.950	0.835	1.159
11260	02	Small eastern cities, Missouri	0.940	0.809	1.159
00740	01	St. Joseph, MO	0.952	0.850	1.159
11260	01	St. Louis/large eastern cities, MO	0.983	0.921	1.193
00751	01	Montana	0.952	0.864	0.756
00655	00	Nebraska	0.951	0.872	0.444
01290	03	Elko and Ely (Cities), NV	0.984	0.986	0.887
01290	01	Las Vegas, et al. (Cities), NV	1.012	1.022	0.887
01290	02	Reno, et al. (Cities), NV	0.997	1.049	0.887
01290	99	Rest of Nevada	0.997	1.013	0.887
00780	40	New Hampshire	0.988	1.034	0.916
00860	02	Middle New Jersey	1.032	1.137	0.762
00860	01	Northern New Jersey	1.059	1.215	0.762
00860	03	Southern New Jersey	1.024	1.082	0.762
01360	05	New Mexico	0.975	0.903	0.792

TABLE E–24.—1996 GEOGRAPHIC PRACTICE COST INDICES BY MEDICARE CARRIER AND LOCALITY—Continued

Carrier number	Locality number	Locality name	Cost indices		
			Work	Practice expense	Mal-practice
00801	01	Buffalo/surrounding counties, New York	1.003	0.936	0.821
00803	01	Manhattan, NY	1.095	1.359	1.546
00801	03	North central cities, New York	1.005	0.967	0.821
00803	02	New York City suburbs/Long Island, NY	1.068	1.235	1.759
00803	03	Poughkeepsie/north New York City suburbs, NY	1.011	1.081	1.218
14330	04	Queens, NY	1.058	1.240	1.686
00801	04	Rest of New York	0.989	0.937	0.821
00801	02	Rochester/surrounding counties, NY	1.012	0.992	0.821
05535	00	North Carolina	0.971	0.918	0.435
00820	01	North Dakota	0.951	0.860	0.617
16360	00	Ohio	0.991	0.940	1.049
01370	00	Oklahoma	0.970	0.882	0.481
01380	02	Eugene, et al. (cities), Oregon	0.959	0.938	0.637
01380	01	Portland, et al. (cities), Oregon	0.997	1.000	0.637
01380	99	Rest of Oregon	0.962	0.907	0.637
01380	03	Salem, et al. (cities), Oregon	0.965	0.929	0.637
01380	12	Southwestern cities (city limits), Oregon	0.967	0.954	0.637
00865	02	Large Pennsylvania cities	1.006	1.002	0.936
00865	01	Philadelphia/Pittsburgh medical schools/hospitals, Pennsylvania	1.027	1.040	1.213
00865	04	Rest of Pennsylvania	0.973	0.899	0.719
00865	03	Small Pennsylvania cities	0.983	0.917	0.736
00973	20	Puerto Rico	0.883	0.739	0.268
00870	01	Rhode Island	1.019	1.074	1.569
00880	01	South Carolina	0.976	0.899	0.361
00820	02	South Dakota	0.936	0.856	0.443
05440	35	Tennessee	0.976	0.899	0.524
00900	29	Abilene, TX	0.960	0.851	0.827
00900	26	Amarillo, TX	0.975	0.883	0.827
00900	31	Austin, TX	0.987	0.986	0.827
00900	20	Beaumont, TX	0.993	0.893	1.428
00900	09	Brazonia, TX	0.993	0.966	1.428
00900	10	Brownsville, TX	0.955	0.848	0.827
00900	24	Corpus Christi, TX	0.983	0.898	0.827
00900	11	Dallas, TX	1.012	1.012	0.893
00900	12	Denton, TX	0.968	0.952	0.827
00900	14	El Paso, TX	0.973	0.893	0.893
00900	28	Fort Worth, TX	0.989	0.972	0.893
00900	15	Galveston, TX	0.989	0.966	1.428
00900	16	Grayson, TX	0.959	0.874	0.827
00900	18	Houston, TX	1.021	1.005	1.428

TABLE E–24.—1996 GEOGRAPHIC PRACTICE COST INDICES BY MEDICARE CARRIER AND LOCALITY—Continued

Carrier number	Locality number	Locality name	Cost indices		
			Work	Practice expense	Mal-practice
00900	33	Laredo, TX	0.957	0.851	0.827
00900	17	Longview, TX	0.973	0.863	0.827
00900	21	Lubbock, TX	0.955	0.894	0.827
00900	19	McAllen, TX	0.961	0.837	0.827
00900	23	Midland, TX	0.991	0.900	0.827
00900	02	Northeast rural, Texas	0.960	0.857	0.827
00900	13	Odessa, TX	0.991	0.900	0.827
00900	25	Orange, TX	0.993	0.893	0.827
00900	30	San Angelo, TX	0.948	0.844	0.827
00900	07	San Antonio, TX	0.978	0.926	0.827
00900	03	Southeast rural, Texas	0.963	0.872	0.889
00900	06	Temple, TX	0.968	0.884	0.827
00900	08	Texarkana, TX	0.955	0.872	0.827
00900	27	Tyler, TX	0.971	0.894	0.827
00900	32	Victoria, TX	0.983	0.868	0.827
00900	22	Waco, TX	0.966	0.877	0.827
00900	04	Western, TX	0.956	0.818	0.827
00900	34	Wichita Falls, TX	0.950	0.857	0.827
00910	09	Utah	0.978	0.891	0.644
00780	50	Vermont	0.974	0.988	0.452
00973	50	Virgin Islands	0.966	0.978	1.023
10490	04	Rest of Virginia	0.976	0.876	0.504
10490	01	Richmond and Charlottesville, VA	1.004	0.991	0.511
10490	03	Smalltown/industrial Virginia	0.974	0.897	0.517
10490	02	Tidewater and northern Virginia counties	0.990	0.965	0.530
01390	03	East central and northern Washington	0.985	0.943	0.748
01390	02	Seattle (King County), WA	1.006	1.077	0.748
01390	01	West and southeast Washington (excluding Seattle)	0.982	0.968	0.748
16510	16	Charleston, WV	0.980	0.881	1.004
16510	18	Eastern Valley, WV	0.960	0.899	1.004
16510	19	Ohio River Valley, WV	0.959	0.833	1.004
16510	20	Southern Valley, WV	0.952	0.815	1.004
16510	17	Wheeling, WV	0.957	0.840	1.004
00951	13	Central Wisconsin	0.959	0.849	1.160
00951	40	Green Bay (northeast), WI	0.976	0.894	1.160
00951	54	Janesville (south central), WI	0.966	0.895	1.160
00951	19	La Crosse (west central), WI	0.972	0.879	1.160
00951	15	Madison (Dane County), WI	0.990	1.000	1.160
00951	46	Milwaukee suburbs (southeast), WI	0.990	0.959	1.160
00951	04	Milwaukee, WI	1.001	0.978	1.160
00951	12	Northwest Wisconsin	0.961	0.850	1.160
00951	60	Oshkosh (east central), WI	0.973	0.886	1.160

TABLE E–24.—1996 GEOGRAPHIC PRACTICE COST INDICES BY MEDICARE CARRIER AND LOCALITY—Continued

Carrier number	Locality number	Locality name	Cost indices		
			Work	Practice expense	Mal-practice
00951	14	Southwest Wisconsin	0.959	0.850	1.160
00951	36	Wausau (north central), WI	0.962	0.866	1.160
00825	21	Wyoming	0.968	0.881	0.811

Note.—Work geographic practice cost index (GPCI) is the 1/4 work GPCI required by Section 1848(e)(1)(A)(iii) of the Social Security Act.

Source: Federal Register (1995).

REFERENCES

Federal Register. (1995, December 8). Medicare program; Physician fee schedule for calendar year 1996; Payment policies and relative value unit adjustments; Final rule and notice. *60*(236). pp. 63350–53.

O'Sullivan, J. (1996, August 5). *Medicare: Payments to physicians* (96–666 EPW). Washington, DC: Congressional Research Service.

Physician Payment Review Commission. (1996). *Annual report to Congress*. Washington, DC: Author.