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New Study Compares Medicare-Commercial Payment Gaps by Specialty

An October 2021 study conducted by the Urban Institute assessed the gap between commercial insurance payments and Medicare payments for professional physician services to determine whether the payment gap between Medicare and commercial insurance differs by specialty. This Health Capital Topics article will discuss this latest research on the payment differences.

Utilizing data from FAIR Health, the Urban Institute reviewed commercial insurance claims across the U.S. (for approximately 60 insurers and third-party administrators covering over 150 million Americans under age 65) from March 2019 through February 2020.[1] In one of the first studies to look at the commercial-to-Medicare payment ratio on a specialty level, and across such a large number of procedure codes, the researchers reviewed the payment gap across 17 non-pediatric and non-geriatric specialties:

(1) Internal Medicine;
(2) Family Medicine;
(3) Urology;
(4) Obstetrics & Gynecology;
(5) Psychiatry;
(6) Dermatology;
(7) Gastroenterology ;
(8) Ophthalmology;
(9) General Surgery;
(10) Cardiology;
(11) Cardiovascular Surgery;
(12) Emergency & Critical Care;
(13) Surgical and Radiation Oncology;
(14) Radiology;
(15) Neurosurgery;
(16) Anesthesiology; and,
(17) Orthopedics.[2]

The researchers reviewed the top 20 Current Procedural Terminology (CPT) codes for each specialty based on: (1) the frequency of the procedures; and (2) the expenditure amount for the procedures.[3] In totality, these codes represented approximately 41% of all of the FAIR Health professional spending data.[4] While the Urban Institute largely used the expenditure amount procedures (termed the expenditure-weighted ratios) in their comparisons, the researchers noted that the trends were largely the same for the high-frequency procedures.

In determining the commercial-to-Medicare payment ratio for each procedure code, FAIR Health utilized rates from the 2020 Medicare physician fee schedule (MPFS) after adjustment for the geographic practice cost index (GPCI).[5] The researchers also constructed a weighted average among MPFS non-facility and facility rates for applicable procedures, to control for the fact that "Medicare pays physicians higher rates for certain physician services provided in an office-based setting."[6] FAIR Health then compared those MPFS rates for each code to the national and state-specific average *imputed allowed amounts* for the commercial claims.[7] Because FAIR Health does not share actual contracted rates (i.e., allowed amounts), so as to "protect the confidentiality of proprietary rates negotiated between individual payers and providers," it instead constructs imputed allowed amounts for each claim line by calculating the ratio of the actually allowed amount to the provider charge for each claim, then averages those ratios across claim lines and geographies; the average of those ratios is subsequently "applied to the actual charge on each claim line within the region and service group to calculate an imputed allowed amount for each claim line."[8] FAIR Health did confirm that the imputed allowed amounts and actual allowed amounts were very similar (with a correlation of approximately 0.9).[9]

In comparing the various specialties, the researchers found that family medicine, obstetrics and gynecology, dermatology, ophthalmology, and psychiatry had the lowest commercial-to-Medicare payment ratios[10] – 1.1 of Medicare or less.[11] Nine of the 17 specialties had ratios between 1.2 and 1.5, including gastroenterology, cardiology, general surgery, and orthopedics.[12] The specialties with the highest commercial-to-Medicare payment ratios were: radiology (1.8); neurosurgery (2.2); emergency department/critical care specialties (2.5); and anesthesia (3.3).[13] Across all codes and specialties, the average ratio was approximately 1.6.[14]

The researchers analyzed and compared the data in a couple of different ways. First, the procedure codes were classified into six broad service categories: (1) Procedures; (2) Evaluation & Management; (3) Tests; (4) Treatments; (5) Imaging; and, (6) Anesthesia.[15] When the national average ratios were compared across these service categories, the categories largely ranged between 1.4 and 1.6 with one exception – anesthesia (3.3).[16]

Second, the researchers compared the data across the 12 states to analyze geographic variation. Because the data sample only had data for all specialties for 12 states, those were the states analyzed. This comparison found that commercial-to-Medicare payment ratios varied fairly widely, from 1.2 in Pennsylvania to 2.6 in Wisconsin; as mentioned above, the U.S. average was 1.6.[17] Additionally, while researchers admitted that comparing data across both geographic location and type of service (i.e., physician price versus hospital prices) was difficult, they noted that "some evidence suggests wider

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geographic variation in physician prices than in hospital prices," based on their data as well as the findings of past studies.[18]

This study is not the first to review the payment gaps between Medicare and commercial payors.[19] In fact, the researchers reviewed a number of past studies to confirm the reasonableness of their commercial-to-Medicare payment ratios. A 2018 Congressional Budget Office (CBO) study reviewed 2012-2017 data for a single payor to construct average annual commercial and Medicare prices for 20 common services in each core-based statistical area in the U.S.[20] The author found that "average commercial prices were substantially higher than Medicare [fee-for-service] prices and were up to three times higher out of network than in network…[Further,] commercial prices varied widely among and within geographic areas."[21] Additionally a 2019 study utilized 2016 data from Truven's MarketScan database to estimate a national average commercial price for each service and compared it to MPFS rates; while this study is very similar to the October 2021 Urban Institute study (and had similar findings), the 2019 study did not adjust the Medicare comparison price for geography or place of service.[22]

The Urban Institute researchers discussed some potential policy implications for their findings. Notably, any physician payment reforms wherein commercial payment rates become tied to the Medicare rate or a Medicare benchmark (e.g., a rate no more than a certain percentage of Medicare) could result in large payment cuts – but only to a small number of physician specialties – resulting in large income losses for those providers.[23] However, the researchers noted that "many specialties receive more modest commercial markups over Medicare rates, around 130 to 150 percent...[t]hus, these specialties would see smaller payment reductions in the face of proposed policies."[24]

While reforming commercial insurance rates for physicians is not likely to be at the top of the federal government's priority list anytime soon, other governmental initiatives may serve to force the commercial insurance industry to change (i.e., reduce payment rates). For example, effective January 1, 2021, every U.S. hospital is required to "provide clear, accessible pricing information online about the items and services they provide."[25] The pricing information that must be publicly disclosed includes certain standard charges for hospital's services, such as commercial payor-specific negotiated charges.[26] Because approximately 40% of hospitals had yet to comply with the rule as of June 2021,[27] and the data posted by hospitals vary widely in quality and comprehensibility, "the data…hasn't delivered meaningful transparency, [but] it has raised awareness of the issue."[28] However, with some tweaks to the rule, as well as harsher penalties for noncompliant hospitals,[29] perhaps this new rule could serve to reduce commercial insurance payment rates for those specialties with the greatest markups to Medicare and help constrain healthcare costs.

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2 *Ibid*, p. 4.
3 *Ibid*, p. 3.
4 *Ibid*, p. 3-4.
5 *Ibid*, p. 5.
6 *Ibid.*
7 *Ibid*, p. 4-5.
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9 *Ibid.*
10 This term is also referred to as commercial insurance markups in other studies, i.e., a ratio of 1.1 means that the commercial payment is 110% of the Medicare payment.
11 McMorrow, Berenson, and Holahan, Urban Institute, October 2021, p. 1.
12 *Ibid*.
13 *Ibid*, p. 1-2.
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16 McMorrow, Berenson, and Holahan, Urban Institute, October 2021, p. 9.
17 *Ibid*.
18 *Ibid.*
19 For more information on past studies related to Medicare-commercial insurance payment gaps, see: "Gap Between Private Insurance and Medicare Hospital Payments Increased in 2018" Health Capital Topics, Vol. 13, Issue 9 (September 2020), https://www.healthcapital.com/hcc/newsletter/09_20/HTML/PAYMENT/convert_widening_payment_gap_9.22.20c.php (Accessed 10/20/21); "Widening Payment Gap between Medicare and Commercial Insurance" Health Capital Topics, Vol. 12, Issue 6 (June 2019), https://www.healthcapital.com/hcc/newsletter/06_19/HTML/MEDICARE/convert_hc_topics_medicare_comm_ins_pymt_gap_6.20.19.php (Accessed 10/20/21).
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23 McMorrow, Berenson, and Holahan, Urban Institute, October 2021, p. 11.
24 *Ibid.*
25 "Hospital Price Transparency" Centers for Medicare & Medicaid Services, https://www.cms.gov/hospital-price-transparency (Accessed 10/20/21).
26 "Requirements for making public hospital standard charges for all items and services." 45 C.F.R. § 180.50(b)(3).
27 "Hospital Price Transparency: June 2021 Update" By Austin Barrington, FSA, MAAA, et al., Milliman, https://us.milliman.com/-/media/milliman/pdfs/2021-articles/6-22-21-price_transparency.ashx (Accessed 10/20/21).
28 "Hospital price lists were supposed to improve transparency—they haven't" By Megan Leonhardt, Fortune, October 7, 2021, https://fortune.com/2021/10/07/law-hospital-prices-transparency-fail/ (Accessed 10/21/21).
29 Such changes were suggested in the 2022 Outpatient Prospective Payment System proposed rule. "CMS Includes Several Changes in CY 2022 OPPS Proposed Rule" Health Capital Topics, Vol. 14, Issue 7 (July 2021), https://www.healthcapital.com/hcc/newsletter/07_21/HTML/OPPS/convert_opps-proposed-rule-2022_7.27.21.php (Accessed 10/20/21).

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