

Physician Cost Profiling

Increasing quality of care and controlling costs constitute a major objective of the Patient Protection and Affordable Care Act (ACA). Physician cost profiling, which refers to a system of rating individual physicians based on spending patterns, has emerged as a possible response to the ACA's cost control initiatives.¹ Each physician is assigned a single number, or cost profile, that places him or her on a relative scale of spending, generally broken down into high, average, or low classifications.² Cost profiles are calculated by determining: (1) the type of care to include in the profile; (2) the costs assigned to each unit of care; (3) the physician responsible for care; (4) peers to whom physicians should be compared; (5) the rubric for constructing the profiles; and, (6) the process for placing a physician in a low-cost or high-cost category.³ Purchasers can then use these cost profiles to determine high-cost physicians when making provider decisions.⁴ It is important to note, however, that physician cost profiling does not determine or address issues regarding physician competency, with licensing and credentialing entities overseeing these matters.⁵

Inherent in this new method of classification are issues related to the methodology, accuracy, and validity of the calculated rankings. The first issue stems from determining whether costs assigned to units of care should be issued according to each patient or by each episode of care.⁶ Additionally, issues arise when attempting to assign accountability for costs, as a patient's continuum of care often involves more than one physician.⁷ The reliability of the rankings and misclassification of physicians also raise concerns. In a recent study by RAND Health, analysts found that 22 percent of physicians were misclassified and 59 percent of physicians had profile scores with less than 70 percent reliability, which appear to indicate that the differences in scores did not actually reflect variations in physician spending.⁸ According to RAND, these substantial errors warrant delaying the use of physician cost profiling until these issues have been resolved.⁹

Although the debate persists as to whether any calculation method may provide an accurate rating of the relative costs of individual physicians, the cost-saving potential offered by profiling is attractive and is gaining momentum. Cost-profiling has been implemented in the ACA through Medicare, which will

provide physician profiles by 2012.¹⁰ Known as relative resource reports, the methodology of calculating these cost profiles has yet to be determined, but is part of the ACA's objective to lower the cost of Medicare claims.¹¹

Private insurers and employers also intend to implement use of physician cost profiles to incentivize beneficiaries to seek care from physicians with relatively lower spending patterns, by dividing physicians contracted within their health plan's network into tiers based on such factors as quality and cost.¹² For employees and other members of health plans utilizing this profiling method, patients may pay lower out-of-pocket charges if they visit physicians within the preferred ranking and higher out-of-pocket expenses for visiting physicians with a lower ranking.¹³ Some large employers have already implemented such tiered systems, and more are expected to do so as health care reform tightens government control of the insurance market.¹⁴

Generally, physicians have not responded favorably to physician cost profiling. In a letter addressed to 47 health plans around the country, the American Medical Association (AMA) and its partners stated that while they believe patient education about providers is important, inaccurate ratings from utilizing current methods of cost profiling will unnecessarily tarnish competent physicians' reputations and damage trusted physician-patient relationships.¹⁵ The letter cites numerous studies, including the study conducted by RAND, which illustrate the unreliability and inaccuracy of physician profiling.¹⁶ The AMA argues that these studies prove that using unscientific methods for creating tiered insurance plans is inadvisable.¹⁷ In concluding the letter, the AMA urged insurers to strongly reevaluate the systems through which they rate physicians and to demonstrate the systems' reliability and accuracy by scientific means before implementing them in their health plans.¹⁸

¹ "Is Physician Cost Profiling Ready for Prime Time?" By RAND Corporation, RAND Health (2010), p. 1.

² "Is Physician Cost Profiling Ready for Prime Time?" By RAND Corporation, RAND Health (2010), p. 1.

³ "Is Physician Cost Profiling Ready for Prime Time?" By RAND Corporation, RAND Health (2010), p. 2.

⁴ "Is Physician Cost Profiling Ready for Prime Time?" By RAND Corporation, RAND Health (2010), p. 1.

⁵ "Physician Profiling, Guiding Principles," By American Academy of Family Physicians, (2007),

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www.aafp.org/online/en/home/policy/policies/p/physicianprofiling.html. (Accessed 10/20/10).

6 “Is Physician Cost Profiling Ready for Prime Time?” By RAND Corporation, RAND Health (2010), p. 2.

7 “Is Physician Cost Profiling Ready for Prime Time?” By RAND Corporation, RAND Health (2010), p. 2.

8 “Physician Cost Profiling – Reliability and Risk of Misclassification” By John L. Adams, et al., The New England Journal of Medicine, Vol. 362, No. 11 (march 18, 2010), p.1014.

9 “Is Physician Cost Profiling Ready for Prime Time?” By RAND Corporation, RAND Health (2010), p. 1.

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12 “Doctors Slam Insurance Over Their Rankings,” By Anna Wilde Mathews, The Wall Street Journal (July 20, 2010).

13 “Doctors Slam Insurance Over Their Rankings,” By Anna Wilde Mathews, The Wall Street Journal (July 20, 2010).

14 “Doctors Slam Insurance Over Their Rankings,” By Anna Wilde Mathews, The Wall Street Journal (July 20, 2010).

15 “Letter addressed to CEO and Chief Medical Officer of 47 health plans around the country,” By AMA, et. al., (July 16, 2010), p. 2.

16 “Letter addressed to CEO and Chief Medical Officer of 47 health plans around the country,” By AMA, et. al., (July 16, 2010), p. 1.

17 “Letter addressed to CEO and Chief Medical Officer of 47 health plans around the country,” By AMA, et. al., (July 16, 2010), p. 1.

18 “Letter addressed to CEO and Chief Medical Officer of 47 health plans around the country,” By AMA, et. al., (July 16, 2010), p. 2.



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