

The Primary Care–Specialty Income Gap: Why It Matters

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A large, widening gap exists between the incomes of primary care physicians and those of many specialists. This disparity is important because noncompetitive primary care incomes discourage medical school graduates from choosing primary care careers.

The Resource-Based Relative Value Scale, designed to reduce the inequality between fees for office visits and payment for procedures, failed to prevent the widening primary care–specialty income gap for 4 reasons: 1) The volume of diagnostic and imaging procedures has increased far more rapidly than the volume of office visits, which benefits specialists who perform those procedures; 2)

the process of updating fees every 5 years is heavily influenced by the Relative Value Scale Update Committee, which is composed mainly of specialists; 3) Medicare's formula for controlling physician payments penalizes primary care physicians; and 4) private insurers tend to pay for procedures, but not for office visits, at higher levels than those paid by Medicare. Payment reform is essential to guarantee a healthy primary care base to the U.S. health care system.

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Incomes of primary care physicians are well below those of many specialists, and the primary care–specialty income gap is widening.

According to surveys done by the Medical Group Management Association, median physician income for all primary care increased by 9.9% from 2000 to 2004, compared with a 15.8% increase for all non–primary care specialties. During those years, median income for family practice physicians increased 7.5% to \$156 000, median income for invasive cardiologists increased 16.9% to \$428 000, median income for hematologists and oncologists increased 35.6% to \$350 000, and median income for diagnostic radiologists increased 36.2% to \$407 000. **Table 1** shows trends in physician compensation.

Two other sources, *Medical Economics* and the Center for Studying Health System Change, confirm these trends (1–4). The income disparity is not explained by a difference in hours worked per week (5). Fifteen percent of full-time family practice physicians earned less than \$100 000 in 2004, whereas 20% of invasive cardiologists, 25% of neurosurgeons, and 14% of orthopedists had incomes of \$600 000 or more (1).

Does this income gap matter? Yes. Although incomes of primary care physicians are far higher than the earnings of most persons in the United States, and the public has little sympathy for physicians who cry poor, the lower income of primary care physicians is a major factor leading U.S. medical students to reject primary care careers (6, 7). The percentage of U.S. medical graduates choosing family medicine decreased from 14% in 2000 to 8% in 2005 (8). Seventy-five percent of internal medicine residents eventually become subspecialists or hospitalists rather than general internists (9). Because office visit fees are relatively low, primary care physicians schedule many short, rushed visits to keep afloat financially, which potentially compromises patient outcomes (10) and fosters the unsustainable physician work life that contributes to students' avoidance of primary care careers (11). With a median debt of \$120 000 for public and \$160 000 for private medical schools, medical students are further discouraged from choosing careers

in primary care because of the noncompetitive income (12).

WHY IS THE PRIMARY CARE–SPECIALTY INCOME GAP WIDENING?

The Resource-Based Relative Value Scale (RBRVS) system (13), adopted by Medicare in 1992 and copied in part by private insurers, was designed to lessen the fee disparity between office visits—the bread and butter of primary care—and procedures provided by specialists. What happened? Why has the primary care–specialty income gap widened rather than narrowed? (**Appendix**, available at www.annals.org).

Under the RBRVS system, the 2005 Medicare fee for a typical 25- to 30-minute office visit to a primary care physician in Chicago was \$89.64 for a patient with a complex medical condition (Current Procedural Terminology [CPT] code 99214). The fee is calculated by multiplying the relative value unit (RVU) for the 99214 CPT code (2.18) by the 2005 Medicare conversion factor (37.8975) and adding a geographic adjustment. The 2005 Medicare fee was \$226.63 for a gastroenterologist in the outpatient department of a Chicago hospital performing a colonoscopy (CPT code 45378), which is of similar duration to the office visit. Colonoscopy performed in a private office in Chicago, which differs from the hospital setting because the gastroenterologist pays for equipment and nursing time, would cost \$422.90. Office visits are considered evaluation and management services (history, physical examination, and medical decision making), whereas colonoscopies are an example of a procedural service.

See also:

Web-Only

Appendix

Conversion of tables into slides

Table 1. Median Pretax Compensation of Physicians, 1995–2004*

Specialty	Median Compensation, U.S.\$			10-Year Change, %	5-Year Change, %
	1995	2000	2004	1995–2004	2000–2004
All primary care	133 329	147 232	161 816	21.4	9.9
Family practice (without obstetrics)	129 148	145 121	156 011	20.8	7.5
Internal medicine	139 320	149 104	168 551	21.0	13.0
Pediatric/adolescent medicine	129 085	141 676	161 188	24.9	13.8
All specialists	215 978	256 494	297 000	37.5	15.8
Anesthesiology	240 666	280 353	325 999	35.5	16.3
Cardiology: invasive	337 000	365 894	427 815	26.9	16.9
Cardiology: noninvasive	239 406	300 073	351 637	46.9	17.2
Dermatology	176 948	213 876	308 855	74.5	44.4
Emergency medicine	176 439	198 423	221 679	25.6	11.7
Gastroenterology	209 913	281 308	368 733	75.7	31.1
Hematology/oncology	188 569	258 403	350 290	85.8	35.6
Neurology	164 295	175 143	211 094	28.5	20.5
Obstetrics/gynecology	215 000	223 207	247 348	15.0	10.8
Ophthalmology	209 736	236 353	280 353	33.7	18.6
Orthopedic surgery	301 918	335 646	396 650	31.4	18.2
Otorhinolaryngology	220 000	235 415	296 623	34.8	26.0
Psychiatry	132 477	156 486	182 799	38.0	16.8
Pulmonary medicine	170 529	195 557	230 688	35.3	18.0
Radiology: diagnostic	247 505	298 824	406 852	64.4	36.2
Surgery: general	216 562	245 541	282 504	30.4	15.1
Urology	213 448	301 772	335 731	57.3	11.3

* Data are from the Medical Group Management Association, Englewood, Colorado, December 2005. Compensation refers to net income.

WHY IS THE GASTROENTEROLOGIST PAID MUCH MORE THAN THE PRIMARY CARE PHYSICIAN FOR WORK TAKING ABOUT THE SAME AMOUNT OF TIME?

Three factors determine RVUs: work, practice expense, and malpractice costs. Work and practice expenses each account for about half of the RVU value; malpractice is a small fraction. The main difference between the office visit and the colonoscopy lies in the work portion of the RVU. The colonoscopy work RVU is higher because the “intensity” (skill, effort, judgment, and stress) is deemed to be greater for procedures than for cognitive visits. In the research on which the RBRVS is based, the intensity component was determined by surveys and interviews with physicians in many specialties (13); procedural specialists tended to view procedural work as being more intense than cognitive visits.

To explain the widening income gap between procedural specialists and primary care physicians, it is helpful to examine 4 factors.

1. The Key Role of Volume

Physician income is the product of the number of services performed multiplied by the fee for each service. Volume growth may increase income even if the fee per service decreases. For example, a Medicare colonoscopy performed in 2004 paid 15% less than a colonoscopy performed in 2001. Yet, the number of Medicare colonoscopies in those years increased by 30%.

From 1999 to 2003, the Medicare volume of evaluation and management services (mainly office visits) in-

creased by 15%. Major procedures (mostly surgeries) increased at a similar pace of 14%, but “other procedures” (endoscopies and minor surgeries) increased by 26%, diagnostic tests increased by 36%, and imaging increased by 45% (14) (Table 2 [15]). This trajectory continued in 2004 (16), and patterns for non-Medicare populations are similar (17). The reasons for volume growth are discussed elsewhere (18).

The volume trend—evaluation and management services growing more slowly than imaging and “other procedures”—hurts primary care because evaluation and management services account for more than 80% of Medicare payments to primary care physicians (19, 20). “Other procedures” account for 73% of such payments to dermatologists and 53% to gastroenterologists. Radiologists and cardiologists receive the bulk of Medicare payments for imaging (16). Because of technologic improvement and increasing efficiency over time, specialists can perform many procedures more quickly (21), whereas office visits cannot be shortened without reducing the quality of care or patient and physician satisfaction (10, 22–24).

In summary, the volume of many procedures performed by specialists has increased more rapidly than office visits, at times in dramatic fashion, contributing to faster income growth of some specialists compared with that of primary care physicians.

2. The Relative Value Scale Update Process

Medicare agreed to allow the American Medical Association (AMA) to create a consensus process for recom-

mending updated RVU values. The AMA, along with specialty societies, created the Relative Value Scale Update Committee (RUC) to recommend RVU changes to the Centers for Medicare & Medicaid Services (21, 25).

The RUC is composed of 29 members, of whom 23 are named by specialty societies (including 3 from primary care specialties); 26 are voting members. Although primary care physicians provide about half of Medicare physician visits, primary care makes up only 15% of RUC's voting members. Specialty societies request changes in RVUs for procedures performed by their members.

Each year, the RUC meets to recommend RVUs for new CPT codes. Through the creation of new codes, many specialties receive increased RVUs for procedures they can bill under more highly reimbursed codes. For example, in 2004, 20 new codes were created for placement, revision, and repair of central venous catheters, replacing 4 previous codes.

In addition, every 5 years the RUC considers potential revisions to RVUs for all existing CPT codes. In this update process, the RUC requires that specialty societies survey at least 30 of their members to provide data justifying a proposed RVU change. The Medicare Payment Advisory Commission (MedPAC) has criticized this survey method as biased toward reviewing procedures felt to be undervalued because specialty societies have little incentive to request evaluation of potentially overvalued procedures that might result in a reduced RVU. Potentially overvalued procedures are rarely discussed at the RUC (21).

At the 5-year update meetings, a two-thirds vote is required to recommend an RVU change. Observers report that many RUC members from procedural specialties tend to vote in favor of requested increases. If a proposed RVU change does not receive sufficient votes, it does not die but is referred to a subcommittee that generally proposes an acceptable compromise.

The 1995 RUC 5-year review resulted in gains for primary care and some specialties. In 2000, evaluation and management codes were not discussed, which hurt primary care. The RUC recommended 469 increases and only 27 reductions in non–evaluation and management codes. The Centers for Medicare & Medicaid Services accepted more than 95% of RUC recommendations (25). Some examples of surgical procedures whose work RVUs have increased since 2000 are gastrectomy, colectomy, simple mastectomy, and lower leg amputation (26). In contrast, office visit RVUs did not increase from 1995 to 2005.

In the RUC, discussion of evaluation and management code valuation is contentious because of the sustainable growth rate (SGR) formula for Medicare physician payment. Under the SGR, the total amount that Medicare pays physicians each year is limited by a formula based on growth of the Medicare population, increase in physician practice expenses, and change in gross domestic product. If total expenditures exceed an SGR-defined target because of service volume increases, Medicare reduces the conversion

Table 2. Change in Volume of Services per Medicare Beneficiary, 2000 to 2005*

Service	Change, %
Office visit, established patient	12
Laboratory tests	530
Knee replacement	47
Arthroscopy	65
Colonoscopy	40
Coronary angioplasty	34
Cardiovascular stress test	45
Computed tomography	65
Magnetic resonance imaging	94

* Data are from reference 15.

factor in the subsequent year, thereby cutting fees equally for all physicians. Physician payment under SGR is a pie: If 1 specialty receives a larger slice, others must accept smaller portions.

Evaluation and management services make up more than 50% of total Medicare physician payments. Even small increases in office visit RVUs would create a dramatic increase in total Medicare physician spending, thus triggering a conversion factor reduction. Specialists making little income from evaluation and management services are therefore wary of such RVU increases. Procedure increases are less contentious because no single procedure has sufficient volume to perceptibly increase total Medicare spending.

In summary, the RUC process favors increases in procedural and imaging reimbursement for 3 reasons: specialty society influence in proposing RVU increases, the specialist-heavy RUC membership, and the desire of RUC specialists to avoid increases in evaluation and management RVUs. With their ability to create new codes and influence RVU updates, many procedural specialists can influence fees in a way that observers find to substantially overvalue procedural and imaging services. Moreover, high fees may encourage physicians to increase the volume of profitable services, leading to even higher income gains and greater spending growth (27).

For a service to qualify for an RVU increase, a requester must prove to the RUC that the work of performing the service has increased over the past 5 years. In the 2005 to 2006 negotiation over evaluation and management increases, the cognitive specialists who requested work RVU increases for evaluation and management services presented evidence that the intensity of these services was greater because 1) the patient population is aging and is being seen more often for multiple chronic illnesses as opposed to being seen for single, acute symptoms, 2) patients are taking more medications, and 3) decision making is more complex because of the availability of more diagnostic information and treatment options (28).

In the RVC deliberations, some members questioned

the evidence showing that evaluation and management services were increasing in intensity. Furthermore, they believed that higher work RVUs were inappropriate because primary care physicians could bill a higher level of service for patients with more complicated conditions. Some observers thought that money played a role in the deliberations because evaluation and management services account for such a large portion of Medicare spending; an increase in evaluation and management RVU values would trigger a substantial reduction in the Medicare conversion factor.

After 6 months of discussion, including 2 face-to-face meetings and several conference calls, the RUC recommended increases in RVUs for some evaluation and management codes. Some observers thought that MedPAC's recent criticism of the RUC (20), questioning the domination of specialists over primary care, heightened the pressure on the RUC to increase evaluation and management RVUs.

On 21 June 2006, the Centers for Medicare & Medicaid Services proposed a 37% increase in the work RVU for intermediate office visits (99213) and substantial increases for some other evaluation and management codes commonly used by primary care physicians (29) in accordance with RUC recommendations. This announcement left the impression that primary care physicians would enjoy major increases in Medicare payments. In fact, the net increase is far smaller: 5% for 2007. As 1 payment expert commented, "The large print giveth, the small print taketh away." A careful reading of the CMS proposal reveals that family physicians and general internists will receive 5% more in allowed Medicare charges in 2007 than in 2006 (30). This increase is far lower than might be expected because work RVUs represent only half of the total RVU and because SGR-related budget neutrality requirements reduce the payment increase.

3. Sustainable Growth Rate Hurts Primary Care

From 1999 to 2004, total Medicare physician payments increased rapidly because of volume growth from imaging, minor procedures, and diagnostic tests—not from evaluation and management services (14). This volume growth is largely responsible for Medicare physician payments that exceed the SGR target, thereby triggering a reduction in the Medicare conversion factor. The decrease in the conversion factor affects not only those responsible (specialists benefiting from imaging, minor procedures, and diagnostic tests) but all physicians. Volume-based income gains of procedural and imaging specialists can create fee-based income losses for primary care physicians.

The 2005 Medicare conversion factor was 1% below the 2001 level. The 2006 conversion factor was scheduled to decrease by 4.4%, but Congress acted to hold it at the 2005 level. Under the SGR formula, however, the conversion factor is scheduled to decrease by 5% per year from 2007 through 2015 (31). If such a reduction actually occurs, primary care gains from increased evaluation and

management payment resulting from the 2005 five-year review would be canceled out.

4. Private Insurance Aggravates the Income Gap

Compared with the inequities of Medicare's physician payment, the situation for private insurance is even more problematic. For most specialties, the majority of payments derive from privately insured patients. A 2002 study of 34 private insurers found that most use a fee schedule modeled on RBRVS, but that many offer specialty-specific conversion factors. On average, private insurers paid primary care physician office visits at 104% of Medicare's fee, whereas surgical, diagnostic procedure, and imaging codes were paid at 119% to 120% of Medicare fees. Markets with large single-specialty groups were associated with even higher specialty fees. Surgical codes have been paid as high as 330% of Medicare fees while radiology and diagnostic procedures may attain 250% of Medicare fees. The primary care–specialty fee gap is greater for private plans than for Medicare (32).

Another study independently corroborated that private insurers paid an average of 104% of Medicare fees for office visits and 133% for procedures and imaging studies in 2001 (33).

These studies confirm that private insurer payment favors specialty care over primary care to a greater degree than does Medicare. The long-standing ability of specialists to negotiate higher rates than those of primary care physicians from private plans has been enhanced by the recent advent of market-dominant, single-specialty groups with market power to command higher fees (34). Moreover, the trend toward performance of procedures in ambulatory surgery centers and other facilities owned by specialist physicians enables these physicians to earn both professional and facility fees.

ADDRESSING THE PRIMARY CARE–SPECIALTY INCOME GAP

Patients, specialists, and the entire health system need a healthy primary care base. In a 1997 patient survey, 94% valued having a primary care physician who knew their medical problems. Eighty-nine percent wanted their primary care physician to participate in the specialty referral process (35). Patients with a regular generalist physician have lower overall costs than those without a generalist physician (36–38). Increased ratios of primary care physicians to population are associated with reduced hospitalization rates for 6 ambulatory care–sensitive conditions (39). Health care costs are higher in regions with greater specialist-to-population ratios (40–43).

Primary care practice is not viable without a substantial increase in the resources available to primary care physicians. The American College of Physicians (ACP), the American Academy of Family Physicians (AAFP), and MedPAC have recommended changes to rescue primary care from what the ACP has called an "impending col-

lapse” (12). The MedPAC, whose 17 members are appointed for 3-year terms by the U.S. Comptroller General, has been concerned with primary care because, as a watchdog of Medicare costs, it views a high ratio of specialists to population as a cost driver while a greater number of primary care physicians may help contain costs (21).

In the short term, Medicare and private payers need to review and modify their reimbursement approaches to shift payments from procedural and imaging services to evaluation and management services. The 2006 increase in some evaluation and management codes recommended by the RUC is a small and inadequate step in that direction. The MedPAC has suggested that RUC membership include more primary care physicians, has recommended that CMS review overvalued services, and has discussed altering the SGR system to protect primary care physicians who are the victims of, but are not responsible for, most expenditure growth (21). Furthermore, MedPAC has recommended payments for care coordination services targeted to chronically ill Medicare patients, many of whom are managed by primary care physicians (44). The ACP recommends that Medicare substantially increase evaluation and management RVUs, pay for time spent on telephone and e-mail consultations, and reimburse care coordination for patients with chronic conditions (12). The ACP and AAFP call for a revision of the SGR process.

For the long term, it would be desirable to develop new payment models that blend the best of fee-for-service, capitation, and salary, while mitigating each approach’s deficiencies (45, 46). For example, primary care physicians who are caring for patients with multiple chronic conditions could be paid on the basis of capitation-like principles, though avoiding the problems created by previous managed care capitation systems. (47, 48). Surgeons and other specialists responsible for episodes of care over a delimited time period might be paid case rates on the basis of diagnoses, and specialists providing one-time professional services might continue to be paid fee-for-service.

It is unclear whether the medical profession—with different specialties having distinct monetary interests and different estimations of the professional value of their work—can agree on substantial changes in payment policy on its own. Public and private payers, working with physicians, have a common interest in promoting a vibrant primary care sector as a medical home for patients and families, a home that, if properly supported, can contribute to substantial reductions in health care costs (49).

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