



# Commercial Health Insurance Markups over Medicare Prices for Physician Services Vary Widely by Specialty

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Private insurers generally pay physicians substantially higher rates than Medicare does for the same service. Policy proposals to reduce commercial prices and curb health care spending by benchmarking private payment rates to Medicare prices could therefore significantly affect physician payments, but the effects will likely vary considerably by specialty. In this study, we assess the variation across physician specialties in commercial markups over Medicare prices for professional services. To do so, we use March 2019 to February 2020 data from FAIR Health's private health insurance claims database covering more than 150 million people nationwide. Our sample includes 17 physician specialties and approximately 20 services per specialty that represent about 40 percent of total professional spending. Our findings have important implications for debates over physician payment reforms, public option and single-payer policies, and Medicare payment reforms. We find the following:

- Family medicine, obstetrics and gynecology, dermatology, ophthalmology, and psychiatry had the lowest commercial markups relative to Medicare prices, averaging about 110 percent of Medicare rates or less.
- Nine specialties received commercial payments between 120 and 150 percent of Medicare rates, on average. These included gastroenterology, cardiology, general surgery, and orthopedics.

- Radiology and neurosurgery received commercial payment rates of 180 and 220 percent of Medicare rates, whereas emergency department and critical care specialties received commercial payment rates of 250 percent of Medicare rates. Anesthesia received the highest markup at 330 percent of Medicare rates.

## Background

Health care prices have long been considered the driving force behind high US health care spending, and private insurers pay providers substantially more than public payers, on average (Anderson et al. 2003; Anderson, Hussey, and Petrosyan 2019; Lopez 2020). This issue has inspired multiple policy proposals to address high commercial prices, including introducing a public option to compete with private plans in the individual health insurance market and more direct efforts to cap commercial payments to providers. Recent Urban Institute work has shown that that the premium reductions and associated household and government cost savings from such policies depend heavily on the health insurance markets included and the assumptions about the resulting provider payment rates (Holahan and Simpson 2021). Lower provider payment rates create more savings but will also create more pushback from providers, especially if these rates are introduced in the employer market. Low rates may also result in access problems for enrollees if providers can opt out of specific networks or limit their service provision in response to lower payments.

Many studies have focused on payments to hospitals, finding commercial-to-Medicare payment ratios ranging from 1.4 to 2.6, on average, with ratios greater than 3.0 for some hospitals, states, and markets (Blumberg et al. 2020; Cooper et al. 2019; Maeda and Nelson 2017; White and Whaley 2019). Physicians also receive higher rates from private insurers, but estimates of the commercial-to-Medicare payment ratio for physicians are often limited to a relatively small number of specific procedure codes (Pelech 2018; Song 2019; Trish et al. 2017). Studies have found wide variation across services, with ratios ranging from just over 1.0 for office visits to well over 2.0 for emergency department visits and imaging services. Geographic variation has been found to be considerable as well. Pelech (2018) finds that commercial payers paid physicians 270 percent of the Medicare rate for a hip replacement in the metropolitan statistical area at the 90th percentile of the geographic distribution, compared with 124 percent at the 10th percentile. Moreover, commercial rates at the lower end of the geographic distribution fell below Medicare rates for several services examined.

Existing studies do not provide sufficient information, however, to assess how the implications of proposed payment reforms might vary across specialties. Summary estimates across procedures, specialties, and geographies suggest commercial-to-Medicare payment ratios between 1.2 and 1.4 for physician services overall (Blumberg et al. 2020; Johnson et al. 2020; MedPAC 2019), but the service-specific estimates noted above show much higher commercial markups for many services. Thus, the variation in relative prices across specialties will likely vary according to the mix of services provided. Ginsburg (2010) explored commercial markups across six specialties in eight communities and found the highest ratios for anesthesiology and the lowest ratios for internal and family medicine.

We build on this evidence by providing commercial-to-Medicare payment ratios for 17 physician specialties using data from FAIR Health’s nationwide commercial claims database from March 2019 to February 2020. Within each specialty, we selected about 20 procedure codes, estimated the commercial-to-Medicare payment ratio for each service, and constructed weighted averages across services for each specialty. Our results have important implications for debates over physician payment reforms, including public option and single payer policy debates, as well as Medicare payment reform.

## Data and Methods

This analysis relies on professional claims from the FAIR Health database between March 1, 2019, and February 29, 2020. FAIR Health’s database includes commercial claims from approximately 60 insurers and third-party administrators covering more than 150 million people nationwide. To protect the confidentiality of proprietary rates negotiated between individual payers and providers, FAIR Health does not share actual contracted rates, known as allowed amounts. Instead, it constructs “imputed allowed amounts” for each claim line, which are computed using the relationship between actual allowed amounts and provider charges in their database. Specifically, FAIR Health generates the ratio of the actual allowed amount to the provider charge for each individual claim line (i.e., each line representing a specific procedure or service) and then calculates the average of the ratios across claim lines within groups of services (CPT codes) and geographies (Northeast, South, Midwest, and West). The average of the ratios is then 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 (FAIR Health 2021). Importantly, the groups of codes across which the ratio of the allowed amount to the provider charge is averaged are made up of closely related procedures, many of which are dominated by a single specialty. Thus, we feel confident that the imputed allowed amounts adequately reflect the actual allowed amounts for a given specialty.

After the imputed allowed amounts are constructed, outliers are excluded at the CPT code level for each of about 500 geographies known as geozips, using a median absolute deviation approach. FAIR Health excludes amounts above or below four times the median absolute deviation within each geozip (FAIR Health, n.d.). Ultimately, FAIR Health finds a correlation of about 0.9 between imputed allowed amounts and actual allowed amounts for all codes at both the national and the geozip levels.

### Selecting Specialties and Codes

We selected 17 specialty groups based on the available identifiers in the FAIR Health data. We excluded all pediatric and geriatric specialties, excluded nonphysician providers, and grouped some medical and surgical subspecialties (table 1). For each specialty group, FAIR Health provided the top 30 procedure codes by frequency and the top 30 procedure codes by expenditure for commercial enrollees under age 65, where expenditures are the imputed allowed amount multiplied by the claim frequency. Claims include hospital inpatient, outpatient, and office-based locations but exclude ambulatory surgery centers. From that list, we selected 20 codes for each specialty, largely the top 20

by expenditure with a few modifications. These codes represent about 41 percent of all professional spending in FAIR Health’s database, and these specialties account for about 59 percent of all FAIR Health professional spending (table 1). Within each specialty, the selected codes represent between 43 and 84 percent of commercial professional spending. After the initial code selection, we excluded codes with modifiers, J codes indicating physician-administered drugs, clinical laboratory services, and services without a relevant Medicare comparison rate.

**TABLE 1**  
**Selected Specialties and Share of FAIR Health Commercial Professional Spending in Selected Specialties and Codes**

Specialty group	Included specialties	% of professional spending in selected codes within each specialty	% of professional spending in selected specialty	% of specialty spending in selected codes
Internal medicine	Internal medicine	4.8	6.4	75
Family medicine	Family practice	6.4	8.4	76
Urology	Urologist	0.9	1.3	64
Ophthalmology	Ophthalmologist	2.2	2.6	84
Psychiatry	Psychiatrist	1.1	1.5	76
Dermatology	Dermatologist	2.0	2.4	81
Gastroenterology	Gastroenterologist	1.5	1.9	82
Obstetrics and gynecology	Obstetrics and gynecology physician	4.0	5.4	74
General surgery	General surgeon	0.8	1.8	43
Cardiology	Cardiology, interventional cardiology, cardiovascular disease, vascular medicine	2.3	3.2	72
Cardiovascular surgery	Cardiac surgery, thoracic surgery, vascular surgery	0.3	0.8	44
Emergency and critical care	Emergency medicine, critical care	4.7	5.1	93
Surgical and radiation oncology	Gynecological oncology, surgical oncology, radiation oncology	0.7	1.0	70
Radiology	Radiologist, nuclear medicine, mammography screening center	4.0	6.7	59
Neurosurgery	Neurosurgeon	0.5	0.9	53
Anesthesia	Anesthesiologist	2.6	5.1	50
Orthopedics	Orthopedics, hand surgery, sports medicine	2.6	4.4	59
<b>Sum</b>		<b>41.2</b>	<b>58.8</b>	

**Source:** FAIR Health commercial professional claims from March 2019 to February 2020.

**Notes:** Commercial professional spending is based on imputed allowed amounts and excludes outliers. Selected codes are the top 20 CPT codes by expenditure within each specialty.

## Constructing Ratios

For each code within a specialty, we obtained the national and state-specific average imputed allowed amount from FAIR Health's database. To calculate the Medicare comparison rate, FAIR Health used Medicare prices from the 2020 Medicare physician fee schedule that were adjusted using the Medicare geographic practice cost index. It then generated national and state-specific averages using the geographic distribution of FAIR Health specialty claims for each code. Where applicable, we obtained Medicare rates for both office-based and facility settings because Medicare pays physicians higher rates for certain physician services provided in an office-based setting. The total payment for a service provided in a hospital or other facility-based setting, including the facility fee, is higher than that for the same service provided in an office-based setting, however. For example, Medicare pays a physician approximately \$200 for a colonoscopy provided in a facility with about a \$1,000 facility fee, and it pays about \$350 to a physician who provides the colonoscopy in an office. We then constructed a weighted average Medicare price based on the share of FAIR Health commercial claims provided in facility versus nonfacility settings for a given code.

Using the above elements, we calculated the commercial-to-Medicare payment ratio for each code within a specialty. These ratios compare the average commercial imputed allowed amount with the geographically weighted average Medicare price for a particular code within a specialty. We then constructed a weighted average across codes for each specialty. Our preferred estimate is an expenditure-weighted average across codes, using the claim frequency and average imputed allowed amount to estimate total expenditures on each code within a specialty. Weighting by expenditures produces estimates that better reflect the likely implications for premiums or physician incomes of setting commercial payments closer to Medicare rates. We also construct frequency-weighted average ratios, average commercial imputed allowed amounts, and Medicare prices for each specialty.

We also classified all codes into six broad service categories defined by the Berenson-Eggers Type of Service, or BETOS, 2.0 classification system: anesthesia, evaluation and management, procedures, imaging, treatments, and tests (Berenson and Braid-Forbes 2020). We then constructed weighted average ratios across codes within each category. Finally, we estimated weighted average ratios across all of the specialty-code combinations at the national level and for 12 states that had data for all specialties and services.

To assess data validity, we compared our estimated commercial-to-Medicare payment ratios for several individual services with those reported in the literature. Though we expect differences based on data source, year, and methodology, we wanted to ensure estimates using FAIR Health's imputed allowed amounts fell within a reasonable range of those using actual contracted rates from other data sources. We focused on estimates from three studies that reported commercial-to-Medicare payment ratios for selected CPT codes: Pelech (2018), Song (2019), and Trish and colleagues (2017).

Pelech relied on 2014 data from the Health Care Cost Institute, excluded claims outside metropolitan statistical areas, and constructed ratio estimates at the claim level before averaging across claims for a given code. Trish and colleagues used 2012–17 data from a single insurer and

constructed average commercial and Medicare prices at the core-based statistical area level for each year. The authors then averaged these ratios across areas based on commercial utilization, and these national ratios were then averaged across years. Using 2016 data from Truven’s MarketScan database, Song estimated a national average commercial price for each service and then compared that with the Medicare price from the physician fee schedule. Song’s approach was most similar to ours, but it did not adjust the Medicare comparison price for geography or place of service.

Despite differences in data sources and approaches, our estimates for office visits, psychotherapy, hospital care, colonoscopies, electrocardiograms, emergency room visits, brain MRIs, and knee replacements are consistent with the range of estimates in the literature (table 2). Office visits had a low commercial-to-Medicare payment ratio across all studies (1.0–1.1). Moreover, our estimated ratio for psychotherapy (0.8) aligned with Song’s, and our estimate for emergency department visits (2.7) was similar to both Song’s (2.5) and Trish and colleagues’ (2.6). For Mohs surgery, hysteroscopy biopsy, and gall bladder surgery, our estimated ratios are lower than estimates from Pelech. On the contrary, our estimated ratio for cataract surgery (1.7) is higher than estimates from Pelech (1.3) and Trish and colleagues (1.3). Differences across studies have numerous potential explanations, but we find estimates within the range of others in the literature for specific services. Thus, we feel comfortable aggregating across services to produce the specialty-specific ratios of interest for this study.

**TABLE 2**  
**Ratio of Commercial Imputed Allowed Amount to Medicare Price for Selected Specialty and Code Combinations**

Service	CPT code	FAIR Health specialty	FAIR Health commercial-to-Medicare ratio	Comparison commercial-to-Medicare ratio	Comparison source
Subsequent hospital care	99232	Internal medicine		1.1	Trish et al.
			1.2	1.2	Pelech
Office visit	99213	Family medicine		1.1	Song
				1.1	Pelech
			1.0	1.1	Trish et al.
Cataract removal	66984	Ophthalmology		1.3	Trish et al.
			1.7	1.3	Pelech
Psychotherapy	90837	Psychiatry	0.8	0.8	Song
Mohs surgery	17311	Dermatology	0.8	1.2	Pelech
Colonoscopy	45385	Gastroenterology		1.8	Pelech
			1.5	1.5	Trish et al.
Hysteroscopy biopsy	58558	Obstetrics and gynecology	0.9	1.7	Pelech
Gall bladder surgery	47562	General surgery		1.8	Pelech
			1.2	1.5	Song
Electrocardiogram	93000	Cardiology	1.5	1.7	Pelech
	93010		1.7	1.9	Song
Emergency department visit	99285	Emergency and critical care		2.5	Song
			2.7	2.6	Trish et al.
Brain MRI	70553	Radiology	2.2	2.4	Pelech
Knee replacement	27447	Orthopedics		1.8	Pelech
			1.6	1.3	Trish et al.

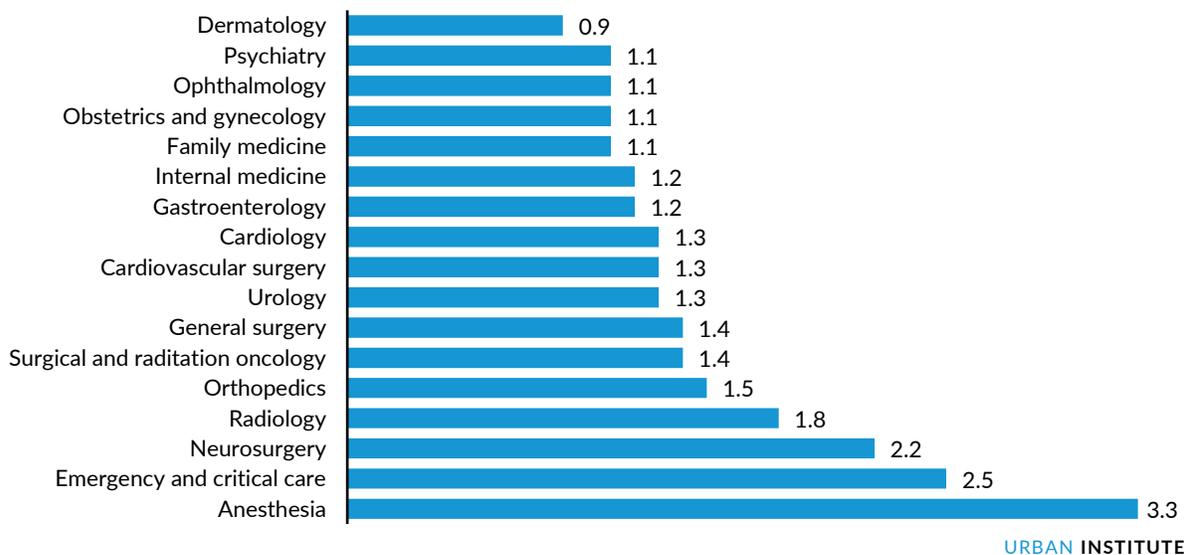
**Sources:** Authors' analysis of FAIR Health professional claims from March 2019 to February 2020, the Medicare physician fee schedule, and the following sources: Daria Pelech, "An Analysis of Private-Sector Prices for Physicians' Services," Working Paper 2018-01 (Washington, DC: Congressional Budget Office, 2018); Zirui Song, "The Pricing of Care under Medicare for All: Implications and Policy Choices," *JAMA* 322, no. 5 (2019): 395–97; and Erin Trish, Paul Ginsburg, Laura Gascue, and Geoffrey Joyce, "Physician Reimbursement in Medicare Advantage Compared with Traditional Medicare and Commercial Health Insurance," *JAMA Internal Medicine* 177, no. 9 (2017): 1287.

**Notes:** CPT is current procedural terminology. MRI is magnetic resonance imaging. FAIR Health ratio reflects the specialty-specific national average imputed allowed amount relative to the Medicare price for each code adjusted for geography and place of service. Trish and colleagues (2017) uses 2012–17 data from a single insurer. Pelech (2018) uses 2014 Health Care Cost Institute data. Song (2019) uses 2016 Truven MarketScan data. Trish and colleagues and Pelech adjust Medicare prices for geography and place of service. Song uses unadjusted office-based physician fee schedule estimates.

## Results

We find significant variation in relative prices across specialties. We focus on the expenditure-weighted ratios (figure 1), but patterns for frequency-weighted ratios are similar (table 3). Commercial imputed allowed amounts for dermatology were about 90 percent of Medicare prices, on average. Such amounts for ophthalmology, psychiatry, family medicine, and obstetrics and gynecology were only modestly higher than Medicare rates, having commercial-to-Medicare payment ratios of about 1.1. Nine specialties received commercial payments between 120 and 150 percent of Medicare rates, on average, including gastroenterology (120 percent), cardiology (130 percent), general surgery (140 percent), and orthopedics (150 percent). Radiology and neurosurgery received commercial payment rates of 180 and 220 percent of Medicare rates, and emergency and critical care and anesthesia received commercial payment rates of 250 and 330 percent of Medicare rates.

**FIGURE 1**  
National Average Expenditure-Weighted Commercial-to-Medicare Payment Ratios across Selected Codes, by Specialty



**Sources:** Authors' analysis of FAIR Health professional claims from March 2019 to February 2020 and the Medicare physician fee schedule.

**Notes:** Estimated ratios reflect the specialty-specific national average imputed allowed amount relative to the Medicare price for each underlying code adjusted for geography and place of service. Service-specific ratios are averaged across codes within a specialty and weighted by expenditures (claim frequency\*average imputed allowed amount).

**TABLE 3**  
**National Average Commercial-to-Medicare Payment Ratios across Selected Codes, by Specialty**

Specialty	Expenditure-weighted ratio	Frequency-weighted ratio	Average commercial imputed allowed amount (\$)	Average Medicare price (\$)
Dermatology	0.9	1.0	75.55	84.88
Psychiatry	1.1	1.0	101.26	99.30
Ophthalmology	1.1	1.0	98.37	95.23
Obstetrics and gynecology	1.1	1.2	235.22	217.72
Family medicine	1.1	1.2	96.34	88.41
Internal medicine	1.2	1.2	108.86	95.92
Gastroenterology	1.2	1.1	171.38	142.13
Cardiology	1.3	1.4	111.81	88.66
Cardiovascular surgery	1.3	1.2	375.87	303.07
Urology	1.3	1.4	149.24	119.42
General surgery	1.4	1.2	301.15	228.12
Surgical and radiation oncology	1.4	1.3	261.60	191.89
Orthopedics	1.5	1.2	164.72	119.11
Radiology	1.8	1.5	247.86	147.69
Neurosurgery	2.2	1.7	689.60	366.17
Emergency and critical care	2.5	2.4	277.57	119.07
Anesthesia	3.3	2.9	862.33	274.27

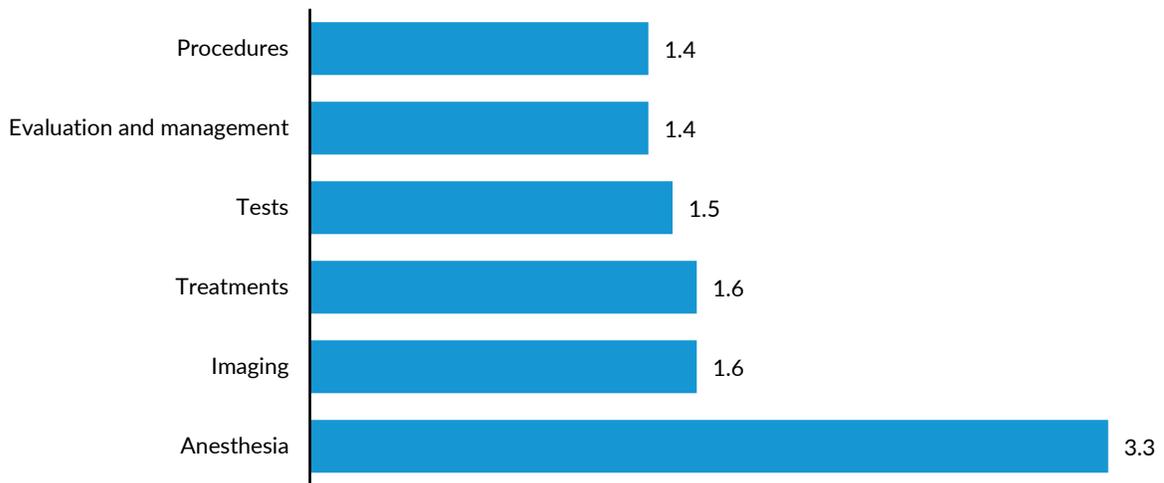
**Sources:** Authors' analysis of FAIR Health professional claims from March 2019 to February 2020 and the Medicare physician fee schedule.

**Notes:** Estimated ratios reflect the specialty-specific national average imputed allowed amount relative to the Medicare price for each underlying code adjusted for geography and place of service. Service-specific ratios are averaged across codes within a specialty and weighted by expenditures (claim frequency\*average imputed allowed amount) or claim frequency. Average commercial imputed allowed amount and average Medicare price are averaged across codes within a specialty and weighted by claim frequency.

When we examine ratios across broader service categories, we find that commercial payments for selected evaluation and management services, tests, and procedures average approximately 140 to 150 percent of Medicare rates in these 17 specialties (figure 2). Imaging services and treatments, such as radiation oncology services, have a slightly higher commercial markup over Medicare rates of about 160 percent, whereas anesthesiology services have by far the highest markup at 330 percent.

FIGURE 2

**National Average Expenditure-Weighted Commercial-to-Medicare Payment Ratios across Selected Specialties, by BETOS Category**



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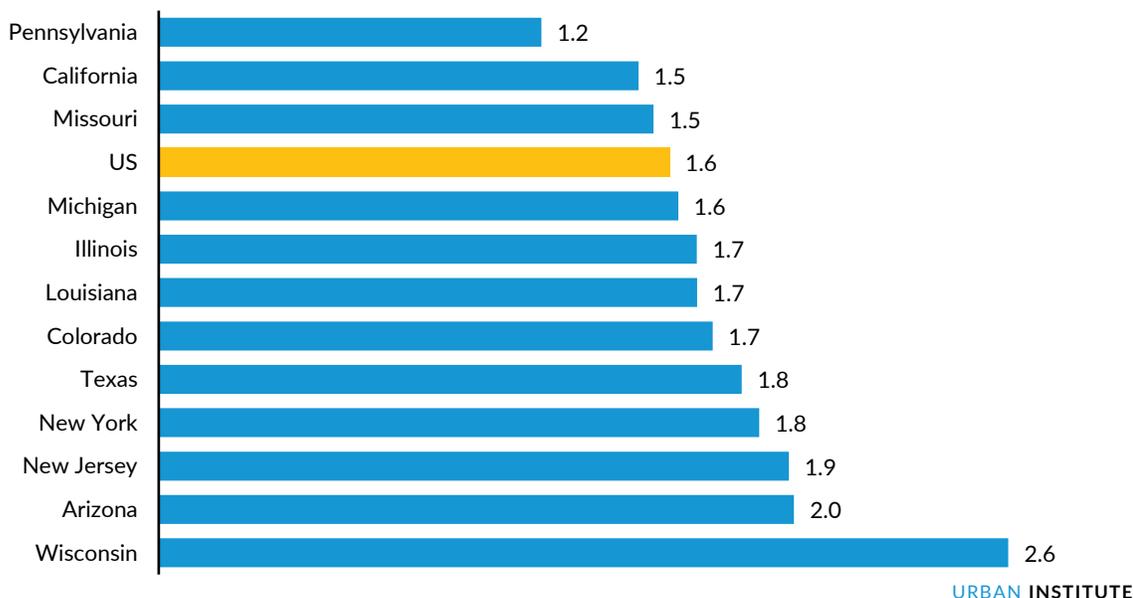
**Sources:** Authors' analysis of FAIR Health professional claims from March 2019 to February 2020 and the Medicare physician fee schedule.

**Notes:** BETOS = Berenson-Eggers Type of Service. Services are classified into six BETOS categories based on CPT codes, using the BETOS 2.0 classification system. Estimated ratios reflect the national average imputed allowed amount relative to the Medicare price for each underlying code adjusted for geography and place of service. Service-specific ratios are averaged across codes within a BETOS category and weighted by expenditures (claim frequency\*average imputed allowed amount).

The commercial-to-Medicare payment ratio across all selected services for these 17 specialties averages about 1.6 using an expenditure-weighted approach (figure 3). This is higher than summary estimates of commercial-to-Medicare payment ratios presented in the literature, which typically range from about 1.2 to 1.4. Our frequency-weighted approach is more consistent with approaches used in the literature, however, as is the resulting ratio of 1.3 (table 4). In the 12 states in our sample that had data for all specialties and services, we found expenditure-weighted ratios ranging from 1.2 in Pennsylvania to 2.6 in Wisconsin. These patterns are similar to those presented by the Health Care Cost Institute, where Wisconsin also had the highest ratio and Pennsylvania had among the lowest (Johnson et al. 2020). Though it is challenging to compare across analyses of hospital and physician price variation, some evidence suggests wider geographic variation in physician prices than in hospital prices (Maeda and Nelson 2020; Pelech 2018). This may reflect considerable variation in physician market structure across areas, such as differences in the distribution of practice sizes, ownership, and market shares (Austin and Baker 2015; Baker et al. 2014; Baker, Bundorf, and Royalty 2013).

FIGURE 3

**National and State-Specific Average Expenditure-Weighted Commercial-to-Medicare Payment Ratios across Selected Specialties**



**Sources:** Authors' analysis of FAIR Health professional claims from March 2019 to February 2020 and the Medicare physician fee schedule.

**Notes:** Estimated ratios reflect the national or state average imputed allowed amount relative to the Medicare price for each underlying code adjusted for geography and place of service. Service-specific ratios are averaged across codes within states and weighted by expenditures (claim frequency\*average imputed allowed amount).

TABLE 4

**National and State-Specific Average Commercial-to-Medicare Payment Ratios across Selected Specialties**

	Expenditure-weighted ratio	Frequency-weighted ratio
US	1.6	1.3
Pennsylvania	1.2	1.0
California	1.5	1.3
Missouri	1.5	1.3
Michigan	1.6	1.2
Illinois	1.7	1.4
Louisiana	1.7	1.3
Colorado	1.7	1.2
Texas	1.8	1.3
New York	1.8	1.3
New Jersey	1.9	1.2
Arizona	2.0	1.3
Wisconsin	2.6	2.1

**Sources:** Authors' analysis of FAIR Health professional claims from March 2019 to February 2020 and the Medicare physician fee schedule.

**Notes:** Estimated ratios reflect the national or state average imputed allowed amount relative to the Medicare price for each underlying code adjusted for geography and place of service. Service-specific ratios are averaged across codes within states and weighted by expenditures (claim frequency\*average imputed allowed amount) or claim frequency.

## Discussion

Policy proposals that seek to use Medicare rates as a benchmark for commercial payments face considerable opposition. Though a multiyear transition and plans for access monitoring would likely be included in any proposal, concerns remain that such policies could be quite disruptive to physician practices and could threaten access to care. This analysis finds that only a small number of physician specialties receive commercial markups over Medicare payment rates above 150 percent. These include hospital-based specialties like emergency physicians and anesthesiologists, along with neurosurgeons and radiologists. These specialties would face the largest income losses if forced to accept Medicare rates from private payers. In some cases, these specialists may be hospital employees and benefit from the hospital's market power in negotiations with private payers. In other cases, the specialists may simply be must-have providers in an insurer's network because of reputation, lack of competition, or other factors. For example, Ginsburg (2010) reported that insurers tend to include most anesthesiology groups in their networks because patients cannot choose these providers, giving anesthesiologists more negotiating power than other specialties.

Our analysis also finds that many specialties receive more modest commercial markups over Medicare rates, around 130 to 150 percent, including cardiology, cardiovascular surgery, general surgery, and orthopedics. Thus, these specialties would see smaller payment reductions in the face of proposed policies. This is notable because existing estimates for specific services, like electrocardiograms and joint replacements, often find commercial-to-Medicare payment ratios closer to 2.0, which might suggest surgical and other procedure-based specialties would receive similarly high markups. However, our approach accounts for these specialties' considerable number of office visits, which have relatively small commercial markups. Thus, we find that the average markup for these specialties is lower than a few selected services would indicate.

We also find that primary care physicians, including those specializing in internal medicine, family medicine, and obstetrics and gynecology, already receive commercial prices relatively close to Medicare prices, as do dermatologists, ophthalmologists, and psychiatrists. Thus, we would not expect these specialties to experience major payment reductions under proposed policies. Moreover, these specialties are the most likely to receive commercial payments below Medicare rates for specific services or in certain geographic areas. This could result in price increases for some services and geographies if Medicare benchmarks were strictly applied. Thus, it will be important to consider this issue when analyzing policy proposals or planning their implementation.

Concerns about the size of potential payment reductions across specialties should also be considered in the context of total physician compensation. Specialties with the largest potential payment reductions also have high baseline compensation, ranging from about \$350,000 a year for emergency physicians to more than \$800,000 a year for neurosurgeons, according to a recent analysis of physician compensation (Zuckerman et al. 2019). Moreover, all of the specialties with moderate potential payment reductions also have average annual compensation rates of more than \$400,000. For psychiatrists, family practitioners, and internists, lower commercial-to-Medicare payment ratios

align with external data on lower total compensation for these specialties estimated at around \$260,000 per year. However, for obstetricians and gynecologists, dermatologists, and ophthalmologists, annual compensation averages at least \$350,000 per year. This suggests these specialties are similarly well compensated by both Medicare and commercial insurers.

Our findings also have implications for debates over Medicare payment policy, where there have been long-standing concerns that evaluation and management services are underpriced relative to other services, including procedures, imaging, and tests (MedPAC 2018). This study suggests that the discrepancy is even wider in commercial insurance; primary care specialties and services receive payment rates similar to Medicare's, but most procedural and surgical specialties receive higher rates. Thus, proposals to use Medicare as a benchmark for commercial rates should also incorporate recommendations from the Medicare Payment Advisory Commission and others for evaluating and addressing existing distortions in the Medicare physician fee schedule (Berenson and Ginsburg 2019; MedPAC 2018). Lowering Medicare rates for services that have been overvalued would lead to even higher commercial-to-Medicare payment ratios for many services and specialties and thereby require a longer phase-in period for moving commercial rates closer to revised Medicare rates. But, raising Medicare rates for evaluation and management services could help alleviate access concerns by enhancing incentives for the provision of preventive care, chronic care, and primary care services.

Though FAIR Health data provide a large sample of commercial claims from various payers with wide national representation, we could not confirm whether the sample used in this study is nationally representative, and the mix of payers included in each region could affect our estimates. In addition, though we sought to exclude nongroup and Medicare Advantage claims from the data, we could not exclude a small share of claims from such plans, which may pay lower rates than employer plans. Our estimates also exclude out-of-network rates to providers, and such payments may disproportionately affect certain specialties. Further, we could not systematically assess whether the FAIR Health imputation process and exclusion of outliers affect individual specialties differently. Finally, though we have tried to carefully account for the place of service, the use of modifiers, geographic adjustments, and other complexities when comparing commercial payments with Medicare payments, we may not have captured an apples-to-apples comparison for a particular service in some cases. This has ambiguous implications for our estimated ratios.

Despite these potential limitations, our findings suggest wide variation across physician specialties in potential payment rate reductions if commercial rates were set closer to current Medicare rates. Whether such payment rate reductions would threaten patient access is unknown but will be important to consider as specific policies are developed or implemented. Ultimately, however, narrowing the payment disparity between primary care and other specialties, improving access to primary care, and reducing health system costs will require physician payment reforms aimed at all payers.

## References

- Anderson, Gerard F., Peter S. Hussey, and Varduhi Petrosyan. 2019. "It's Still the Prices, Stupid: Why the US Spends So Much on Health Care, and a Tribute to Uwe Reinhardt." *Health Affairs (Millwood)* 38 (1): 87–95. <https://doi.org/10.1377/hlthaff.2018.05144>.
- Anderson, Gerard F., Uwe E. Reinhardt, Peter S. Hussey, and Varduhi Petrosyan. 2003. "It's the Prices, Stupid: Why the United States Is So Different from Other Countries." *Health Affairs (Millwood)* 22 (3): 89–105. <https://doi.org/10.1377/hlthaff.22.3.89>
- Austin, Daniel R., and Laurence C. Baker. 2015. "Less Physician Practice Competition Is Associated with Higher Prices Paid for Common Procedures." *Health Affairs (Millwood)* 34 (10): 1753–60. <https://doi.org/10.1377/hlthaff.2015.0412>.
- Baker, Laurence, M. Kate Bundorf, and Anne Royalty. 2013. "Private Insurers' Payments for Routine Physician Office Visits Vary Substantially across the United States." *Health Affairs (Millwood)* 32 (9): 1583–90. <https://doi.org/10.1377/hlthaff.2013.0309>.
- Baker, Laurence C., M. Kate Bundorf, Anne B. Royalty, and Zachary Levin. 2014. "Physician Practice Competition and Prices Paid by Private Insurers for Office Visits." *JAMA* 312 (16): 1653. <https://doi.org/10.1001/jama.2014.10921>.
- Berenson, Robert A., and Mary Jo Braid-Forbes. 2020. *Development and Structure of BETOS 2.0 with Illustrative Data*. Washington, DC: Urban Institute.
- Berenson, Robert A., and Paul B. Ginsburg. 2019. "Improving the Medicare Physician Fee Schedule: Make It Part of Value-Based Payment." *Health Affairs (Millwood)* 38 (2): 246–52. <https://doi.org/10.1377/hlthaff.2018.05411>.
- Blumberg, Linda J., John Holahan, Stacey McMorrow, and Michael Simpson. 2020. *Estimating the Impact of a Public Option or Capping Provider Payment Rates*. Washington, DC: Urban Institute.
- Cooper, Zack, Stuart V. Craig, Martin Gaynor, and John Van Reenen. 2019. "The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured." *Quarterly Journal of Economics* 134 (1): 51–107. <https://doi.org/10.1093/qje/qjy020>.
- FAIR Health. 2021. "FH Allowed Benchmarks." New York: FAIR Health.
- . n.d. "Median Absolute Deviation (MAD) Methodology." New York: FAIR Health.
- Ginsburg, Paul B. 2010. "Wide Variation in Hospital and Physician Payment Rates Evidence of Provider Market Power." Washington, DC: Center for Studying Health System Change.
- Holahan, John, and Michael Simpson. 2021. "Introducing a Public Option or Capped Provider Payment Rates into Private Insurance Markets." Washington, DC: Urban Institute.
- Johnson, Bill, Kevin Kennedy, Daniel Kurowski, Aaron Bloschichak, Elianna Clayton, Jean Fuglesten Biniek, and Katie Martin. 2020. "Comparing Commercial and Medicare Professional Service Prices." Washington, DC: Health Care Cost Institute.
- Lopez, Eric, Tricia Neuman, Gretchen Jacobson, and Larry Levitt. 2020. "How Much More Than Medicare Do Private Insurers Pay? A Review of the Literature." San Francisco: Kaiser Family Foundation.
- Maeda, Jared Lane, and Lyle Nelson. 2017. "An Analysis of Private-Sector Prices for Hospital Admissions." Working Paper 2017-02. Washington, DC: Congressional Budget Office.
- MedPAC (Medicare Payment Advisory Commission). 2018. "Chapter 3: Rebalancing Medicare's Physician Fee Schedule toward Ambulatory Evaluation and Management Services." In *Report to the Congress: Medicare and the Health Care Delivery System*, 63–84. Washington, DC: Medicare Payment Advisory Commission.
- . 2019. *Report to the Congress: Medicare Payment Policy*. Washington, DC: Medicare Payment Advisory Commission.

- Pelech, Daria. 2018. "An Analysis of Private-Sector Prices for Physicians' Services." Working Paper 2018-01. Washington, DC: Congressional Budget Office.
- Song, Zirui. 2019. "The Pricing of Care under Medicare for All: Implications and Policy Choices." *JAMA* 322 (5): 395–97. <https://doi.org/10.1001/jama.2019.8245>.
- Trish, Erin, Paul Ginsburg, Laura Gascue, and Geoffrey Joyce. 2017. "Physician Reimbursement in Medicare Advantage Compared with Traditional Medicare and Commercial Health Insurance." *JAMA Internal Medicine* 177 (9): 1287. <https://doi.org/10.1001/jamainternmed.2017.2679>.
- White, Chapin, and Christopher M. Whaley. 2019. *Prices Paid to Hospitals by Private Health Plans Are High Relative to Medicare and Vary Widely: Findings from an Employer-Led Transparency Initiative*. Santa Monica, CA: RAND Corporation.
- Zuckerman, Stephen, Adele Shartzter, Robert A. Berenson, Ken Marks, Sutapa Das, and Chris Brandt. 2019. *Analysis of Disparities in Physician Compensation*. Washington, DC: Medicare Payment Advisory Commission.

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