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The price physicians charge for every surgery, checkup or other procedure has a precise formula behind it

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Cost of a checkup

The cost of a standard outpatient doctor's visit of 20 to 29 minutes can vary considerably from location to location but always follows the same basic formula. So-called relative value units for the physician's labor, the cost of the facility and malpractice insurance premiums are always the same regardless of the location, but those are then multiplied by their own geographic indexes that factor in variable costs across the country. The total from that is then multiplied by a conversion factor, currently $34.61, and the result is what the doctor can bill the patient.

	San Francisco	Alabama	Alaska
Physician RVU	1.3	1.3	1.3
Physician geographic index	1.077	1	1.5
Practice RVU	1.26	1.26	1.26
Practice geographic index	1.329	0.888	1.118
Insurance RVU	0.1	0.1	0.1
Insurance geographic index	0.458	0.921	0.614
Total relative value units	3.12	2.51	3.42
Conversion factor	$34.61	$34.61	$34.61
Cost	$107.99	$86.90	$118.36

Table: The Conversation, CC-BY-ND • Source: Centers for Medicare and Medicaid Services

Modern medicine is remarkable. Conditions like HIV/AIDS and hepatitis C were once virtual death sentences. Both can now be treated easily and effectively.

But for Americans, the wonders of modern medicine come at a steep cost: Total U.S. health spending exceeded US$4.1 trillion in 2020, or $12,000 per person. How those trillions of dollars are spent can seem like a mystery.

The biggest portion of that—hospital care, which makes up 31% of total spending—is now subject to transparency rules that are supposed to make it easier for patients to understand what their treatments cost. But so far hospitals' compliance has been minimal.

Things are both more transparent and murkier when it comes to the second-biggest chunk of America's annual medical bill: payments to physicians and for clinical services, which account for 20% of total health care spending, or $810 billion. How much a patient is charged for a hip replacement or a flu shot is the result of a highly technical process involving secretive committee meetings, doctor surveys and federal regulations.

A few decades ago, the federal government developed a seemingly scientific approach to solve these questions. As an expert on health care policy, I've learned that the formula is simple. But coming up with numbers for that formula is far more complex.

Physician free-for-all

For the longest time, the federal government tried its best to stay out of the examination room. By and large, medical care was a private endeavor, and physicians and other providers charged what they wanted—or what they thought patients could pay.

Then, in 1965, Congress established Medicare and Medicaid, which are federal programs that provide health insurance for the elderly and poor, respectively. Practically overnight, they turned the government into the largest spender on health care. That meant the Johnson administration had to figure out how to compensate physicians who had long been opposed to government involvement in health care and derided it as "socialized medicine."

To minimize opposition, an agreement was forged that seemed innocuous enough: Physicians would be allowed to charge Medicare "customary, prevailing and reasonable fees," and the federal government would not question them.

Yet the inflationary nature of this approach became quickly apparent as many physicians happily took the federal government up on this offer. Doctors often charged Medicare two to four times more than what they charged commercial insurers. The need for changes seemed inevitable.

A new payment system

It took another two decades to create a more evidence-based approach that relied less on a doctor's discretion and aimed to rein in spending.

After a comprehensive study conducted by Harvard researchers and the American Medical Association, the federal government developed a framework that paid providers based on the resources and skills required for various treatments. The formula, which its creators dubbed the resource-based relative value scale, includes three steps to calculate how much money a physician could charge for a procedure.

First, you have the "relative value unit" for each procedure, which in turn is divided into three components. The main part is a physician's actual labor. To determine that, the researchers used physician surveys as

well as historical payment data to determine how much time, effort and skill each of thousands of medical procedures required. Higher values are assigned to more resource-intensive procedures, such as placing a catheter—6.29 relative value units—and lower values to procedures requiring fewer, like administering a COVID-19 shot—a fifth of a unit.

The Centers for Medicare and Medicaid Services has an updated list of relative value units for every procedure imaginable, from an allergy skin test that requires puncturing the skin, which has one of the lowest values, at 0.01 unit, to the repair of a diaphragm hernia, which is the most expensive one listed, at 108.91 units.

The other two components are for general expenses, such as rent and medical equipment, and malpractice insurance. They are also determined by a similar process involving the cost of resources.

The next step involves adjusting these relative value units for local cost differences. The government developed three geographic cost indexes for each component. These figures are multiplied by their corresponding component to get a relative value unit total for that category. These are updated regularly by the Centers for Medicare and Medicaid Services. Some states have one set of indexes for all cities, while others such as California have several.

Finally, to obtain a dollar value for a medical procedure, the location-adjusted relative value units for each category are added together and multiplied by what is known as a conversion factor to get a dollar amount. The figure is the same across the country and is updated annually, with slight changes from year to year. For 2022, this was set at $34.61.

And voila: You have the prices you'll pay for thousands of medical procedures.

To give you an example of how this all fits together, imagine you had a 20- to 29-minute appointment with your doctor, known as an outpatient visit. If you live in Alabama, your cost would be $86.90. The physician arrives at that figure by multiplying the relative value units for each component by their geographic index, then converting the sum of 2.51 units times the conversion factor of $34.61. That same visit would cost $118.36 in Alaska and $107.99 in San Francisco.

Problems with the process

While on the whole I believe the current system represents an important step toward developing a more evidence-based approach to physician payments, it's not without its problems.

One is how physicians themselves dominate the process, mostly owing to its highly technical nature.

A committee made up of 32 physicians from different specialties from around the country meets multiple times a year and votes on recommended changes to the fees physicians are paid. While in theory these fees are set by federal regulators, in virtually all cases regulators accept the committee's recommendations.

That means a handful of physicians are essentially deciding how the U.S. spends hundreds of billions of dollars annually. Besides potentially having their own personal and specialty interests to pursue, they may also lack the expertise and skills to judge the effectiveness or value of certain treatments over others. There is evidence that relative value units often do not adequately reflect the resources required for many procedures. And the overall process is highly opaque.

Last, the current approach mostly focuses on physician effort and not patient outcomes. This puts it in stark contrast to various efforts to

implement pay-for-performance in health care.

Given the state of hyperpartisanship in Washington, D.C., and beyond, I believe it's unlikely there'll be any dramatic changes to the system any time soon. But incremental changes are possible and could make a meaningful difference—for example, by expanding the role of primary care physicians on the committee and by extending membership beyond physicians.

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