

a. Work Geographic Practice Cost Indices

Data from the 20 percent sample of census data of median hourly earnings for the same six categories of professional specialty occupations as used in the 1992 through 1994 work GPCIs were used in calculating the 1995 through 1997 work GPCIs. The 1992 through 1994 work GPCIs were calculated using 1980 census data of earnings for professionals with 5 or more years of college. That sample was no longer available with the 1990 census. The 1990 census educational classifications are by highest degree earned, rather than the 1980 census classification by years of schooling. Thus, it was not possible to obtain earnings data exactly comparable to the 1980 data.

For 1990, data were available for all-education and advanced-degree samples, but not for 5 or more years of college. We elected to use the all-education sample because its larger sample sizes made it more stable and accurate in the less populous areas. Although it could be argued that physicians' earnings might more closely approximate the earnings of professionals with advanced degrees, the differences between the all-education and advanced-degree indices were negligible in all but a few of the smallest localities. We believed that the small sample sizes of advanced-degree occupations in these small localities would produce inaccurate results.

The 1992 through 1994 work GPCIs used metropolitan-wide median wages for each county within an MSA. That is, all counties within an MSA were assigned the MSA-wide median wage even if there were wage variations within the MSA. We believed that this was appropriate for all but Consolidated Metropolitan Statistical Areas (CMSAs), the largest of the MSAs, such as New York. In these CMSAs, we replaced metropolitan-wide earnings with county-specific earnings. We believed this change was appropriate because costs were, in fact, higher in central city areas (for example, Manhattan and San Francisco) than in the rest of the CMSA. County earnings were a better account of the cost variation within these large metropolitan areas.

b. Practice Expense Geographic Practice Cost Indices

(1) Employee Wage Indices.

Data from the 20 percent sample of census data of median hourly earnings for the same categories of medical and clerical occupations used in the 1992 through 1994 practice expense GPCIs

were also used in the 1995 through 1997 practice expense GPCIs. The 1995 through 1997 practice expense GPCIs used 1990 rather than 1980 census data. As with the work GPCIs, county level data were used for CMSAs to better reflect the cost variations within these large metropolitan areas.

(2) Rent Indices.

As with the original rent indices, the HUD fair market rental (FMR) data for residential rents were again used as the proxy for physician office rents. The 1995 through 1997 practice expense GPCIs reflect 1994 HUD FMRs. Like the work GPCI and the employee wage index of the practice expense GPCIs, county level data were used in CMSAs to recognize the variations within the CMSA.

The major criticism of the rent indices was that residential rather than commercial rent data were used. As mentioned earlier, for constructing the GPCIs we needed data that were widely and consistently available across all physician fee schedule areas.

As with the original GPCIs, we again searched for private sources of commercial rent data that were widely and consistently available. The private sources we found were not adequate. None of the sources collected data for non-metropolitan areas, nor did any collect data for all metropolitan areas. The sources did not reflect the average commercial space in the area, but rather the particular type of space most relevant to the needs of a particular source's clients. In addition, the sample sizes were small. A comparison of the average rental for any particular city showed significant variation depending upon the source. Also, the private commercial rent data tended to be for very high priced real estate of the type likely to be used by large institutions such as banks, insurance companies, or financial firms and not for the type of office space most likely used by physicians.

Among the sources of commercial rent data that were available, the most promising were data from the Building Owners and Managers Association, the General Services Administration, and the U.S. Postal Service. These data were analyzed in depth. We did not use data from the Building Owners and Managers Association and the General Services Administration because of poor geographic coverage, especially outside of large metropolitan areas. That is, data were not widely and consistently available for all physician fee schedule areas. The U.S. Postal Service data had much better geographic coverage, but sample sizes in many areas were

unacceptably small and could have led to erroneous results.

No acceptable national commercial rent data were readily available for physician office rents. Thus, some proxy needed to be used for this portion of the index. In addition, commercial rent data were not available for all areas from published statistical sources. We believed that the HUD FMR data remained the best available data for constructing the office rental index. HUD FMR data were available for all areas, were updated on an annual basis, and were consistent among areas and from year to year. Moreover, we believed that physicians frequently locate in areas and office space that are residential rather than commercial, for example, in apartment complexes and small strip commercial centers adjacent to residential areas. Residential rents may, in fact, be a better measure of the differences among areas in the physician office market than a general commercial rental index.

(3) Medical Equipment, Supplies, and Miscellaneous Expenses.

Consistent with the original 1992 through 1994 update for medical equipment, supplies, and miscellaneous, this index assumes a national market in which input prices do not vary among geographic areas. We were unable to find any data sources that demonstrated price differences by geographic area. Anecdotal and interview data with suppliers and manufacturers were inconclusive. While some price differences may exist, we believed they were more likely to be based on volume discounts rather than on geographic areas. Generally, it appears that manufacturers' prices do not vary among areas except for shipping costs. Since manufacturers and suppliers are located all over the country, shipping costs do not vary significantly.

c. Malpractice Geographic Practice Cost Indices

Again, malpractice premium data for a \$1 million to \$3 million mature "claims made" policy were collected, with mandatory Patient Compensation Funds (PCFs) considered. Some States have legally required physicians to join PCFs that provide coverage for catastrophic claims. The PCF charges a premium or surcharge just as any other insurer. However, more recent and more comprehensive malpractice insurance data were used in calculating the 1995 through 1997 malpractice GPCIs. The 1995 through 1997 malpractice GPCIs were based on 1990 through 1992 malpractice premium data. Since malpractice premiums may change