

service, commodity, or geographic area, the higher the possibility of sampling variability. The length of time the time-series data have been published is also important. A well-established time series is needed to assess the reasonableness of the series and to provide a solid base from which to forecast future price changes in the series. We need to forecast the MEI to make Federal budget and Trustees Report estimates.

The third criterion is timeliness of actual published data. For this reason, we prefer monthly and quarterly data to annual data.

The fourth criterion is public availability. We prefer to use data sources that are publicly available for our indices so that the public may track each of the individual components in the MEI.

The BLS price proxy categories previously described meet the criteria of relevance, reliability and timeliness, and public availability. Below we discuss the price-wage proxies for the rebased and revised MEI (shown in Table 1).

#### (a) Expense Categories in the MEI

##### Physician Time

In the proposed revised and rebased MEI, we are using the AHE for the private nonfarm economy as the proxy for the physician wages/salaries component; this is the same price measure used in the 1996-based MEI. In our judgment, this proxy still most closely comports with Congressional intent as expressed in the Senate Finance Committee's 1972 report (S. Rept. No. 92-1230 at 191 (1972)). AHEs change in accordance with changes in the type and mix of workers.

As we discussed extensively in the November 2, 1998 final rule (63 FR 58848) and again in the December 31, 2002 final rule (67 FR 80019), we believe that the current price proxy for physicians' earnings—AHE in the nonfarm business economy—is the most appropriate proxy to use in the MEI. The AHE for the nonfarm business economy reflects the impacts of supply, demand, and economy-wide productivity for the average worker in the economy. Using this measure as the proxy for physicians' earnings captures the parity in the rate of change in wages for the average worker and for physicians. In addition, use of this proxy is consistent with the original legislative intent that the change in the physicians' earnings portion of the MEI parallel the change in general earnings for the economy. Since earnings are expressed per hour, a constant quantity

of labor input per unit of time is reflected. The use of the AHE data is also consistent with our using the BLS economy-wide multifactor productivity measures since economy-wide wage increases reflect economy-wide productivity increases.

Using the ECI for professional and technical workers or other occupational-specific wage proxies has a major shortcoming; in many instances, occupations such as engineering, computer science, and nursing have unique characteristics that are not representative of the overall economy or the physician market. Specifically, wage changes for such occupations can be influenced by excess supply or demand for these types of workers. We believe it would not be appropriate to proxy the physician earnings portion of the MEI with a wage proxy that reflects these other occupation's unique characteristics.

The current MEI uses the ECI for fringe benefits for total private industry as the price proxy for physician fringe benefits. We are proposing to use the same proxy for the 2000-based MEI. This means that both the wage and fringe benefit proxies for physician earnings are derived from the nonfarm private sector and are computed on a per-hour basis.

##### Nonphysician Employee Compensation

As in the 1996-based MEI, we are proposing to use Current Population Survey data on earnings and employment by occupation to develop labor cost shares for the nonphysician occupational groups shown in Table 6. BLS maintains an ECI for each occupational group, and we propose to use these ECIs as price proxies for nonphysician employee wages in the same manner they are used in the current MEI.

The skill mix shift in employees of physician offices in the last few years has been towards managerial occupations. While these skill mix shifts are captured in the expenditure weights, they are appropriately held constant in a Laspeyres price index such as the MEI. Skill mix shifts, which may reflect the changing intensity of services provided in physicians' offices, are accounted for in the payment system outside of the MEI.

The current MEI uses the ECI for fringe benefits for white collar employees in the private sector as a proxy for nonphysician benefits. Since most nonphysician employees in physicians' offices are white-collar employees, we are again proposing to use the ECI for benefits for white collar

employees in the proposed rebased and revised MEI.

##### Office Expense

Office expenses include rent or mortgage for office space, furnishings, insurance, utilities, and telephone. We are proposing the continued use of the CPI-U for housing because it is a comprehensive measure of the cost of housing, including rent, owner's equivalent rent, and the types of goods and services associated with running an office. This proxy covers about 80 percent of the population.

##### Pharmaceuticals and Medical Materials and Supplies

This cost category includes drugs, outside laboratory work, x-ray films, and other related services. There is not one price proxy that includes this complete mix of materials and supplies. In the absence of one index, we are proposing to separately account for pharmaceuticals and medical materials and supplies in the 2000-based MEI.

###### • Medical Materials and Supplies

We equally weighted two proxies together (the PPI Surgical Appliances and Supplies and the CPI-U for Medical Equipment and Supplies) since one proxy does not accurately measure the price change associated with these types of products used nor the mode of purchase used in physicians' offices. While both indexes include such items as bandages, dressings, catheters, I.V. equipment, syringes, and other general disposable medical supplies and nonprescription equipment, the indexes reflect significant differences in the mode of purchase. The PPI measures actual transaction prices at the wholesale level, the mode most likely used by physicians, while the CPI measures prices at the retail level or the final stage of production. The price movements in these two indexes can be different and we believe that it is appropriate to combine these indexes into one proxy since physicians likely use both purchasing methods when obtaining medical supplies.

###### • Pharmaceuticals

The PPI for ethical prescription drugs is used to proxy pharmaceutical prices in other CMS market baskets and reflects the price change associated with the average mix of pharmaceuticals purchased economy-wide. We propose to use the PPI for ethical prescription drugs, rather than the CPI for prescription drugs, because physicians generally purchase drugs directly from a wholesaler. The PPIs that we use measure price changes at the final stage of production.