Medicare’s payments system affects the whole US healthcare sector

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The United States health care system is known for the private sector’s uniquely large role. Of the $3.2 trillion that the U.S. spent on health care in 2015, private individuals and private insurance directly financed at least 44 per cent, or $1.4 trillion. In a recent paper, we ask whether this system is as different as it might seem from one dominated by the public sector.

Why might the public sector continue to have a key role in this mixed system? Despite the private sector’s prominence, the largest single insurer in the U.S. is Medicare, the federal insurer of the elderly and disabled. Medicare spent $646 billion in 2015, and $144 billion on the type of care we focus on: physician and professional services. This care cost $635 billion in total, so Medicare alone bought 23 percent of this sector’s output. In addition to being the single largest buyer of medical care, Medicare enjoys the federal government’s backing. Its heft and reputation may give it outsized influence on the industry. We study the extent of this influence and the channels through which it works.

How important are payment systems?

Payment systems are the structures through which the government or market rewards health-care providers. If hospitals, physicians and pharmaceutical companies respond to the incentives these systems create, then their design can influence the costs and efficiency of the entire health sector.

Recent studies show that physicians do respond to the incentives provided by state Medicaid programs, private insurance arrangements and Medicare. Among numerous other examples, pediatricians spent less time with patients following expansions in low-paying public coverage, and capitation-based managed care induces more conservative treatment of heart attacks than fee-for-service arrangements. We found previously that physicians expand total service supply when Medicare’s fees rise across the board, in particular for elective services.

Medicare's Influence on Private Payment Systems

Industry participants describe a simple institutional mechanism by which Medicare can influence the private sector's payment system: Medicare's fee schedule creates a platform around which insurers and physicians often negotiate. As we show in related work, insurers bargain with doctors' practices over a fixed markup relative to Medicare's payment menu. A midsize practice might be offered 110 per cent of Medicare's rates, while a larger group with a monopoly in its region might be offered 140 per cent.

This structure implies a strong link between the relative prices of, for example, angioplasty and office visits in the public and private sectors. Once the parties have agreed on a markup relative to Medicare's rates, this relationship becomes mechanical. If Medicare increases payments for primary care relative to more intensive services, private rates would automatically follow suit.

To investigate Medicare's importance, we studied the private sector's response to a large legislative change in Medicare's fee schedule. In 1998, Medicare reduced its payments for surgical procedures by 17 per cent relative to its payments for other medical services. Using a database of more than 144 million private-sector insurance claims, we found that private prices closely tracked Medicare's changes. On average, a $1 decrease in Medicare's payment for a surgical service relative to other services led to a $1.20 change in the relevant private payments. This *price-following* coefficient of 1.2 is close to the average ratio between Medicare and private payment rates, suggesting that a mechanical relationship between private rates and the Medicare fee schedule may indeed prevail.

Why copy Medicare?

Because of well-known inefficiencies built into Medicare's fee schedule, private markets' choice to copy it may be a cause for concern. Medicare's relative payments are based primarily on estimates of input costs. Congress prohibits Medicare from adjusting its payments to reflect value added or cost effectiveness of different types of care. Consequently, one might hope that physicians and insurers would innovate beyond Medicare's menu to increase the value of insurance arrangements. Greater payment system innovation would be a more-than-welcome product of competition among private insurers.

At the same time, bargaining over and implementing alternative payment systems can be complicated and costly. Medicare and private insurers recognize more than 10,000 distinct billing codes. Code-specific negotiations could carry on interminably. Health care billing administration consumes substantial resources, and those costs could escalate further if each insurer and physician group established a unique payment structure.

This explanation for Medicare's influence has testable implications: larger physician groups will be less likely to follow Medicare's lead. When insurers bargain with small physician groups, the cost of haggling over service-specific prices is unlikely to be worthwhile, since fine-tuning the incentives facing a single physician adds relatively little value. But when insurers negotiate with large physician groups, more value is at stake. Large groups' billing departments may also be better equipped to manage variation in payment models.

We tested these implications by examining the strength of the public-private price linkage across markets. In markets dominated by small physician groups, we found that Medicare's price transmission is particularly strong. Markets with large physician groups exhibit more independence from Medicare's prices. These results support the transaction-cost theory.

Our results show that, in most markets, Medicare's pricing menu exerts significant influence over private payments for physicians' services. When Medicare pays generously for a low value service, incentives in private markets echo that mistake. The evidence suggests that a public good problem may limit the development of value-oriented payment systems. Because private players are small, they have insufficient incentives to innovate beyond Medicare's menu. The expense of bargaining and subsequent billing may lead market participants to use Medicare as a reference around which they can coordinate. The benefit of getting Medicare's payments right, or at least

improving them around the margins, is thus likely to extend well beyond Medicare itself.

Policy Implications

The literature is building a powerful case that payment systems matter, with Medicare's perhaps the most influential of all. Medicare's incentive structures influence treatment decisions, investments in medical technologies, and the long-run development of these technologies themselves. Private insurers' adoption of Medicare's payment methods magnifies these effects. So reducing inefficiencies in Medicare payments should be a major health-policy priority.

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Notes:

- *This blog post is based on the authors' paper In the Shadow of a Giant: Medicare's Influence on Private Physician Payments, in the Journal of Political Economy, 125, no. 1 (February 2017): 1-39.*
- *The post gives the views of its author, not the position of LSE Business Review or the London School of Economics.*
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