



## MEDICARE'S ROLE IN DETERMINING PRICES THROUGHOUT THE HEALTH CARE SYSTEM

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Payments for Medicare benefits substantially influence the prices paid by private-sector insurers. Many private insurers simply adopt Medicare's levels of reimbursement to providers, and those that do not still are affected when Medicare changes its rates. Although analysts disagree about whether the link leads to lower or higher private payments, Medicare's administrative pricing system clearly cannot replicate a well-functioning competitive market. What can be done to move Medicare closer to the optimal prices corresponding to those produced by a competitive market?

A new study published by the Mercatus Center at George Mason University assesses the numerous problems with Medicare's price calculations and looks at how they affect prices in commercial insurance policies. The study proposes an arrangement of competitive bidding on bundles of services as a promising alternative to Medicare's price-fixing regime.

Below is a brief overview of the analysis. To read the entire study and learn more about its authors, Roger Feldman and Bryan Dowd of the University of Minnesota and Robert Coulam of Simmons College, please see "[Medicare's Role in Determining Prices throughout the Health Care System.](#)"

### KEY FINDINGS

This study has four purposes: (1) it explains the relationship between the prices that Medicare pays and the prices paid by private health plans, (2) it defines the optimal prices for Medicare and private insurers and the problems encountered in pursuing them, (3) it describes how Medicare prices are set in the "real world" and the problems created by that approach, and (4) it examines different ways that fee-for-service Medicare could set prices that are closer to the optimal prices. Among the key findings are the following:

- Reductions in Medicare hospital prices are unlikely to result in increases in the prices that private health plans pay for hospital services.

For more information, contact  
Camille Walsh, 703-993-4895, [cwalsh@mercatus.gmu.edu](mailto:cwalsh@mercatus.gmu.edu)  
Mercatus Center at George Mason University  
3434 Washington Boulevard, 4th Floor, Arlington, VA 22201

- Lower Medicare prices will reduce the supply of hospital services to Medicare beneficiaries and are likely to result in lower hospital quality.
- Reductions in Medicare payments to physicians are associated with decreases in private prices and worse access to physicians' services for Medicare patients.
- Medicare's process for setting prices is dominated by the medical specialty societies that receive a large share of Medicare revenues.
- There is no incentive to reduce the prices for services with productivity increases, such as imaging and tests. As a result, there have been few price reductions even in services for which physicians' productivity increased and volumes expanded.
- Medicare prices are based on small and nonrandom samples of physicians, and the results of the samples are cherry-picked.
- Recent reforms have turned previously accepted practice—small or zero annual increases in Medicare prices—into law.
- Competitive bidding on bundles of services or on the calculations that determine actual fees is a promising alternative to the current price-setting approach.

#### THE RELATIONSHIP BETWEEN MEDICARE PRICES AND PRIVATE PRICES

There are two models for evaluating the relationship between Medicare prices and the prices paid by private health plans. The **standard economic model** assumes that providers maximize profits; it predicts that private patients become more attractive when Medicare cuts prices, and so providers cut private prices to capture more private patients. The **cost-shifting model** assumes that providers have some unexploited ability to increase their profits before any change in Medicare prices; it predicts that when Medicare cuts its prices, providers exploit their market power more systematically by raising prices for private plans.

A review of a large set of studies generally supports the predictions of the standard economic model:

- Reductions in Medicare hospital prices are unlikely to result in increases in the prices that private health plans pay for hospital services.
- Lower Medicare prices will result in reduced supply of hospital services to Medicare beneficiaries and are likely to result in lower hospital quality.
- Reductions in Medicare payments to physicians are associated with decreases in private prices and worse access to physicians' services for Medicare patients.

## WHAT ARE THE OPTIMAL PRICES FOR PUBLIC AND PRIVATE HEALTH PLANS?

Assuming society is satisfied with the fairness of Medicare pricing, determining optimal prices for public and private plans has to account for the following:

- *The effect of insurance.* By reducing consumers' out-of-pocket price for health care, insurance tends to increase the use of health care services and weakens consumers' incentives to protect their health. These effects increase with the generosity of coverage, which is fueled by policies that subsidize the price of insurance, including the tax deductibility of employer-based insurance and the government's implicit subsidy of Medigap premiums.
- *Imperfectly competitive provider markets.* Many health care markets are concentrated, giving providers market power to raise prices above their marginal costs.

Fees should be based on "contingent-claim insurance"—that is, lump-sum payments tied to illness—so that consumers use the efficient levels of services, including those that prevent illness and protect their health. Optimal fees, therefore, are those that *produce the level of demand for health care corresponding to demand under a contingent-claim insurance contract in a competitive market that is free of poor information, restricted entry, and distorted prices for health insurance.*

## HOW ARE MEDICARE PRICES SET IN THE REAL WORLD?

Medicare does not rely on a competitive market to generate physician prices through the choices of millions of consumers and producers operating independently. Since the program began, physician prices have been set through a series of administrative calculations. Since 1992, Medicare has set prices using the Resource-Based Relative Value Scale (RBRVS), which calculates the estimated amount of work and practice expense involved in delivering specific services. The original purpose of the RBRVS was to bring physician prices more into line with the costs of providing services.

The challenge with such an administrative-pricing approach is finding data to compute the RBRVS values. The task requires annual updates for more than 10,000 prices built on various sources of information. The Centers for Medicare & Medicaid Services (CMS) relies on a special committee of the American Medical Association (AMA) to propose data on which to base the prices.

Among the problems with this price-setting model are the following:

- Medical specialty groups dominate the AMA committee.
- The committee has no incentive to reduce the value calculations for services in which productivity has improved.
- There have been few reductions in the estimates of values even for procedural services in which physicians' productivity increased and volumes expanded.
- The RBRVS work values are based on small, nonrandom samples of physicians that are not representative of the broader network of medical practitioners.

- The expert panels cherry-pick results, often developing more favorable (higher-cost) estimates if they deem the survey data to be “flawed or incomplete.”

Certain components of the estimates, such as productivity, are subjective and prone to error, and the AMA committee often overstates the intensity of effort involved in providing services. Yet, historically, the CMS usually accepted the committee’s recommendations. With expanded legislative authority and funding, the CMS in recent years has exercised more critical and frequent review of the key values in the RBRVS calculations, though this activity falls short of the substantial administrative reforms that have been suggested by some.

#### HOW CAN MEDICARE FIND OPTIMAL PRICES?

Markets for both health insurance and health care suffer from many types of market failure. The most important are poor information, provider pricing power, and prices that are distorted by health insurance, which is subsidized for both working people and Medicare beneficiaries. Even if these failures were corrected, however, Medicare’s administrative prices are insensitive to supply and demand and would not be optimal unless Medicare somehow produced a fee schedule that exactly replicated the results achieved by a perfectly competitive market. A movement away from administrative prices could take several forms:

- Fee-for-service providers could submit bids on the calculations that determine actual fees.
- Services could be bundled together, and providers could bid on the bundle rather than on individual services.
- Accountable Care Organizations in Medicare could move away from fee-for-service payment and toward a blend of fee-for-service and capped payments, coupled with competitive bidding on the fee schedule calculations.
- Providers could set fees wherever they like, but then be placed in cost-sharing “tiers” based on their bids for bundles of services, or related price calculations. Beneficiaries could choose any provider, but would pay higher coinsurance, copayments, or balance bills for providers in higher cost tiers.
- Medicare could allow more flexibility in balance billing (billing more than Medicare’s allowed charges).

A well-designed bidding system can find the efficient cost of production if providers have an incentive to bid low. That could occur with some beneficiary cost-sharing, which would require providers to charge some out-of-pocket costs. This would move real-world Medicare prices closer to ideal market prices.