

# Can Patients Save Medicare?

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# Let's Pay Patients - Not Doctors

- My proposal: Medicare indemnities
  - Why they work in theory
  - Will they work in practice?
  - Let's give them a try
- Focus on Part B – mainly physicians' services – but the approach could be used to pay hospitals and other providers
- History of Medicare physician payment policy
- Goals and flaws of that policy followed by my proposal

# History of Medicare Physician Payment

- In 1965, Congress opted to gain support of physicians, who had opposed inclusion in Medicare
- Borrowed an experimental payment system used by a few Blue Shield plans:
  - Medicare would pay the lesser of the doctor's actual charge, what he usually charged, or a percentile of the prevailing distribution of usual charges in the local area

# A License to Inflate

- Dr. Jones thinks, “If I raise my charge for every ectomy, that will (over time) increase my usual fee”
- All doctors think the same way, so they all raise their charges
- The prevailing charge increases
- Medicare’s reasonable charge increases
- This was understood almost immediately by everyone involved

# Searching for an Answer

- This began a two decade-long attempt to fashion a permanent solution to the problem of MD payment:
  - 1972 – Medicare limits annual increases in prevailing charges by an index of physicians' practice costs
  - 1984 – Usual and prevailing charges are frozen
  - 1986 – Freeze lifted but charges remain controlled; Congress creates the Physician Payment Review Commission (PPRC)
  - 1987 – PPRC recommends adopting a fee schedule
  - 1988 – PPRC makes specific recommendation to base fees on the total work for each service, adjusted by differences in practice and training costs across specialties

# RBRVS

- Legislation to create the Resource-Based Relative Value Scale (RBRVS) is passed in 1989 and the fee schedule is phased in from 1992-96:
  - Proposed fee schedule elicits 95,000 comments
  - Covers 8,000 distinct services
  - By 1997, an MD-run committee makes over 1,000 recommendations for updates, of which HCFA approves 95%
  - From 1998-2004, another MD committee reviews practice expenses for 6,500 payment codes

# Goal of the Medicare Fee Schedule

- Universal agreement that the goal of RBRVs is to simulate a perfectly functioning competitive market
- In such a market:  $V_A/V_B = P_A/P_B = U_A/U_B$ 
  - A,B = any two services
  - V = doctor's marginal willingness to supply
  - U = patient's marginal willingness to pay
  - P = price

Recommended reading: J Baumgardner, American Economic Review, 1992

# Problems with Fee Schedule

- In practice we observe average (rather than marginal) willingness to supply or pay
- Doctors have market power to raise prices
- Patients have supplementary insurance that shields them from the market prices
  - 70-78% have private supplementary insurance
  - Original framers of Medicare had no idea this would happen
  - Additional 15% have full or limited Medicaid

# Fixes Worse than Problems

- Suppose doctors have monopoly power to mark up the price of service B:
  - Demand shifts from B to A, which is now cheaper
  - But the marginal cost of A rises relative to B
  - So the price of B is too high but the marginal cost of B is too low
  - A cost-based fee schedule sets the fee for B too low
  - Result: ‘overshooting’ the competitive equilibrium

# Doctors and Patients Do Respond

- Androgen deprivation therapy with drugs and surgical castration are equally effective for treating prostate cancer, but drug therapy was reimbursed by Medicare at 10-20 times the cost of surgery
- In 2003, ADT was the one of the most expensive services in Medicare Part B (\$1.23 billion)
- MMA mandated price cuts of approximately 50%
- Total allowed charges for ADT dropped 65% by 2005

Source: J Weight, EA Klein, JS Jones, Cancer, May 15, 2008

# Real Competition: Let's Pay Patients

- Indemnities are fixed amounts of money paid to an individual after the occurrence of a well-defined event
- Mark Pauly (1971) described perverse incentives associated with traditional insurance
- Susan Feigenbaum (1992) coined the term 'body-shop economics' to emphasize similarity between medical indemnities and auto collision insurance

MV Pauly, Economic and Business Bulletin, 1971

S Feigenbaum, CATO Regulation, 1992

# Why Indemnities Work in Theory

- Patient has incentive to use the right amount of medical care:
  - Marginal value of medical care = marginal cost of medical care
  - As if she were paying with her own money
- In the insurance market, the consumer buys the right amount of coverage:
  - Marginal utility of income is the same whether consumer is sick or well
  - ‘Full insurance’ – elimination of risk

# Why Aren't Medical Indemnities Used?

- Pauly: (1) Some of the benefits would be captured by patients with traditional insurance; and (2) It is difficult to specify precisely the severity of the condition for which a payment is made – too much risk
- Feigenbaum: Indemnities were once popular, but they declined because providers had a vested interest in developing their own insurance plans that linked benefits to subsidized medical care

# Pauly (2): Is Risk too Great?

Type of Cancer	Mean Cost for Initial Treatment	16% of Patients Have Costs Greater Than:	2.5% of Patients Have Costs Greater Than:
Breast	\$12,141	\$22,575	\$33,009
Colorectal	\$24,910	\$39,780	\$54,650
Lung	\$21,351	\$36,164	\$50,977
Prostate	\$14,361	\$25,577	\$36,793

Source: L Penberthy et al., Health Care Management Science, 1999, and author's calculations

# Solutions to Risk Problem

- Risk-adjust the indemnity
  - Would cover 40-50% of the variance in costs
  - Variant is small initial payment with appeal for further payment
- Supplement the indemnity with partial coverage for expenses above the indemnity level
  - Require coinsurance on the excess charges
  - Require a deductible before excess charges are covered
- Carve out items like emergency hospitalizations
- Organize networks of providers who agree to accept the indemnity as payment in full

# Reasons to Restrict Indemnity

- Public medical programs involve an externality: donors *want* the money to be spent on medical care
- Contracts to eschew the use of medical care may not be enforceable
  - Demonstration of unrestricted indemnities actually took place in 1996 – and failed
- Restricted indemnities would reduce fraud and abuse

# Indemnities and Balance Billing

- Data indicate little need for balance billing: 93% of physicians agreed to accept Medicare fee as payment in full for all services in 2007\*
- Even if balance billing were widespread, it would not be efficient compared with indemnity:
  - Indemnity results in  $MC(Q^*) = MV(Q^*)$
  - Balance billing results in  $MC(Q) = MV(Q) + FEE$
  - This means  $Q > Q^* \rightarrow$  quantity is too high under balance billing

\*Source: MedPAC, Report to Congress, March 2008, Chapter 2B

# Long-term Care Indemnities

- LTC is a favorable setting for indemnities because desired services differ greatly from person to person
- Cash and Counseling Demonstration tested the feasibility of ‘cashing out’ the LTC benefit
  - 3/4 of cash allowance group used money to hire family caregivers
  - High levels of satisfaction and assistance on all measures (e.g. help with shopping)
- LTC indemnities are also popular in Germany

# Let's Give It a Try

- Some facts:
  - The rate of back surgery in the U.S. is almost 40% higher than in any other developed country and it varies linearly with the number of neurosurgeons in the area
  - Medicare patients in Fort Myers FL are twice as likely to have back surgery as those in Miami, without objective indicators that they need more surgery
  - 2-year RCT of 2,000 patients with sciatica found no difference in outcomes for surgery vs. waiting
- Let's give patients this information and an indemnity worth a fraction of the cost of back surgery

Sources: GM Gaul, Washington Post, July 24, 2004; DC Cherkin et al, Spine, 1994; JN Weinstein et al, JAMA, November 22-29, 2006

# Supplementary Insurance Must go

- Supplementary insurance removes price as a factor influencing demand:
  - Individual supplemental plans without Rx increase Medicare expenditures by \$914 annually\*
- Supplements might disappear quietly under indemnities
- But patients could buy supplements to cover the gap between indemnity and spending under worst-case scenario
- Medicare needs to insist on COB: supplements cannot cover the same conditions as Medicare

\*Source: A Atherly, Int. J. of Health Care Finance and Economics, 2002

# Thank You!

- Roger Feldman, How to Fix Medicare: Let's Pay Patients, Not Physicians, AEI Press, 2008
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