

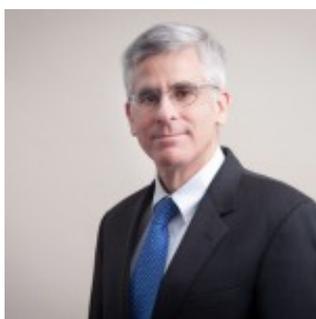
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The Role of Medicare Fee-for-Service in Inefficient Health Care Delivery

Published in [American Enterprise Institute and Robert Wood Johnson Foundation](#) on April 16, 2013

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It is sometimes stated that Medicare, and particularly the very large portion of the program that is run as an unmanaged fee-for-service insurance system, should not be singled out for its rising cost problem. Because the program is simply buying services from the same, broader health system as other insurers, the dysfunction prevalent in the broader health system should be the focus of attention.

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In other words, if the overall health system is likened to a runaway freight train speeding down the tracks at a dangerously fast pace, Medicare is just one of the rail cars getting pulled down the tracks at this accelerated rate. Slowing Medicare spending thus requires slowing the entire train, because trying to slow just the Medicare car will not work or will lead to other problems and inequities.¹

But this perspective depends critically on the assumption that the broader system's cost problems are unrelated to Medicare's current design. What if that assumption is wrong? In other words, what if Medicare is not just another car attached to the runaway cost train, but is actually the engine (or at least one of the engines) at the front of the train pulling the rest of the cars down the track? Then, one's perspective on how to go about reforming American health care changes quite dramatically.

Several very important factors beyond Medicare are no doubt driving up health care costs needlessly, such as the open-ended tax subsidization of employer-sponsored insurance and medical liability standards that encourage ever more expensive levels of care. But because of Medicare's size and dominant position in the marketplace for the past half century, the program's role must not be understated. It is the 800-pound gorilla of American health care.

More than anything else, the powerful **incentives embedded in Medicare** go the furthest in explaining why the system for delivering care to patients looks and operates as it does today. It also follows that, if reforming the delivery system to raise productivity and lower costs is the central goal of health care reform (as it should be), then changing how Medicare works, or, more precisely, how the Medicare fee-for-service program works, should top the list of reform priorities.

BACKGROUND ON MEDICARE FEE-FOR-SERVICE

The American public sees Medicare as one program, but it is really **two very distinct programs** with very different relationships between the federal government and those providing services to patients. Importantly, these different components have different influences on the organization of the care delivery system.

The first part is of course the original fee-for-service (FFS) insurance option, created in 1965. In Medicare FFS, the federal government administers the insurance plan (using contractors) and sets the terms of payment for those providing services to the patients. In this way, the federal government has established a direct financial relationship with every major category of medical service provider: hospitals, physicians, labs, rehabilitation centers, outpatient clinics, hospices, and many others. It is this **direct financial relationship** between the federal government and the provider community that over many years has heavily influenced the organization of the service delivery sector.

The other part of Medicare is the **risk-contracting program now known as Medicare Advantage (MA)**. In this part of Medicare, the federal government makes payments to private insurance plans on behalf of the Medicare enrollees who elected to get their coverage through this option instead of the traditional FFS program. In MA, the private plans, not the federal government, own the relationships with those providing services to the patients.

So beneficiaries have a choice in Medicare. They can choose to get their Medicare coverage delivered through an MA plan or through FFS. But the default option is FFS. As shown in figure 1, about 75 percent of Medicare beneficiaries, or 37 million, were enrolled in the FFS option in 2012.

Medicare has had private plan offerings since 1982, but the program has always been dominated by FFS.² At its enactment in 1965, Medicare's authors wanted to create a program for seniors that generally followed the dominant private insurance plans available to working-age Americans. And, at that time, the only real insurance model was FFS — often provided by Blue Cross and Blue Shield insurance — for hospital and physician services, respectively. Under FFS, the insurance carrier did little more than pay insurance claims. If a plan enrollee was provided services by a licensed medical professional, then the claim for reimbursement was paid, no questions asked.

The primary check on overutilization of services was patient cost sharing. The insurance plans were designed with **upfront deductibles and coinsurance requirements** from the patients for each service rendered. The cost-sharing requirements were **intended to ensure some cost sensitivity on the part of the insurance plan enrollees.**

Medicare's FFS program was built precisely on this 1965 insurance model. Of course, private health insurance has evolved away from this model, while Medicare remains largely as it was originally structured.

Like a typical 1965 insurance plan, Medicare FFS requires rather substantial cost sharing from the beneficiaries. In 2013, Medicare requires a \$1,184 deductible for each inpatient hospital stay, a \$147 deductible for physician and other outpatient services, and a 20 percent coinsurance payment for each physician office visit and service.³

But these cost-sharing requirements have been rendered nearly useless in controlling costs in the Medicare FFS program. As shown in figure 2, the vast majority of FFS beneficiaries — nearly 90 percent, according to the Medicare Payment Advisory Commission (MedPAC) — have supplementary insurance in the form of Medigap coverage (Medicare supplemental insurance), retiree wraparound plans, or Medicaid. These secondary insurance plans fill in virtually all costs not covered by the Medicare law requires substantial cost sharing. Furthermore, Medicare's rules also require providers to accept the Medicare reimbursement rates as payment in full, effectively precluding any additional billing to the patient.

Medicare FFS enrollees, therefore, pay nothing at the point of service even though the Medicare law requires substantial cost sharing. As a consequence, FFS enrollees have strong incentives to utilize as many medical services as their physicians recommend, and their physicians have strong incentives to favor more tests and procedures over fewer because there is no financial downside for the patient when more expensive practice protocols are followed.

The result of this dynamic is hardly surprising. The volume of services paid for by Medicare FFS has been on a steady and steep upward trajectory for decades. For instance, the real price Medicare paid for physician services dropped between 1997 and 2005 by nearly 5 percent (see figure 3), but total spending for physician services rose almost 35 percent because of rising use and more intensive treatment per condition.⁴ And, of course, because physicians are essentially the gatekeepers of the delivery system, as use of their services rises, so does use of every other aspect of medical care, including days in hospitals, outpatient center procedures, lab tests, and prescription drug consumption.

MEDICARE'S SIZE AND INFLUENCE

Medicare's influence on the overall structure of the service-delivery system stems first from its dominant size in the marketplace. Medicare is the single largest payer of medical bills in American health care, and, as a consequence, has the most influence on the organization of that system. As shown in figure 4, according to data from the National Health Expenditure Accounts and MedPAC, Medicare accounted for \$1 out of every \$5 spent on personal health care in 2010.

But these data do not fully capture the importance of Medicare's role in the marketplace because some of the costs driven by Medicare claims are paid by supplemental insurance plans. In such cases, the accounting conventions used to track national health expenditures put the cost within the private insurance category, but Medicare is still setting the terms of the financial transaction with those providing the services to the patients.

Another and perhaps more revealing way of assessing Medicare's influence involves looking at the distribution of personal health expenditures by age and payer. According to national health expenditure data from 2004, 34 percent of all personal health expenditures were on behalf of the elderly (those age 65 and older), virtually all of whom were enrolled in the Medicare program (see figure 5). In addition, another 3 percent of claims were paid by Medicare on behalf of younger persons, most of whom were likely disabled beneficiaries. Together, then, the total amount of health expenditures associated with the elderly and disabled on Medicare in 2004 approached 40 percent.

But even that figure does not fully capture the influence of Medicare because of the tendency of many private insurers, especially those not run as fully integrated HMOs, to piggyback on Medicare's major provider payment systems, especially those for hospitals and physicians. According to a 2006 American Medical Association survey, some 75 percent of non-Medicare private insurance plans used the Medicare physician fee schedule as the basis for physician payments in at least one of their insurance product lines.⁵ Similarly, the vast majority of private insurers use Medicare's Diagnostic-Related Group (DRG) payment structure to make payments to hospitals for inpatient services.

Of course, private insurers do adjust the Medicare payment systems before using them, often paying providers some additional percentage above the Medicare payment rate (for instance, paying 105 percent of a Medicare DRG). But even so, it remains the case that Medicare's approach to paying for services permeates the entire American health system. Hospitals are paid by and large on the basis of Medicare DRGs, even if private insurers pay slightly more than the federal government. Thus, hospitals organize their business operations around maximizing DRG payments, which are largely written in federal Medicare regulations. And the same is true with respect to fees for physicians and other categories of providers.

THE AGGREGATE IMPACT OF MEDICARE FEE-FOR-SERVICE

It is difficult to isolate the influence of Medicare FFS on costs because of the multitude of payers and the complexity of untangling provider financial incentives. Nonetheless, recent studies can help shed light on the important role Medicare FFS has played in the cost problem — particularly the problem of an overbuilt and procedure-driven system.

In a 2006 study, Amy Finkelstein, an economics professor at the Massachusetts Institute of Technology, set out to quantify the impact that the introduction of Medicare had on the supply and expense of medical services. Her methodology focused on resource use before and after enactment of Medicare in 1965 and the change in the supply of services that Medicare (and the spread of taxpayer-subsidized, employer-based insurance) induced.⁶

Her findings are revealing. She argues that the creation of Medicare in the mid-1960s triggered a massive expansion in the health care infrastructure in regions with previously low levels of insurance enrollment among seniors. Hospitals were built and physicians and others opened offices to provide newly enrolled Medicare beneficiaries with a much higher level of service provision.⁷

This was, of course, mainly beneficial, as the primary purpose of Medicare was to improve the quantity and quality of health care services provided to seniors. But it is likewise quite clear that the advent of Medicare FFS was also responsible (along with the expansion of employer plans) for about half of the real cost increase in health care spending in the United States from 1950 to 1990.⁸ This is no small matter, because between 1950 and 1990, per capita health care spending increased from \$100 to more than \$2,800 in nominal terms, which becomes a nearly 600 percent increase when adjusted for inflation.⁹ Thus, the Finkelstein study would imply that Medicare and the widespread availability of federally subsidized, third-party insurance caused about a 300 percent real increase in per capita health care costs in the United States.

COMPARING FEE-FOR-SERVICE AND MEDICARE ADVANTAGE PLANS

We can glimpse the cost problems associated with Medicare FFS by comparing it to the options available in the MA program. Contrary to what is often stated, MA plans are not less efficient than Medicare FFS plans. MedPAC data going back a number of years confirm this fact. Using an apples-to-apples comparison, MA plans, and especially MA HMOs, can provide the Medicare benefit package to seniors at a cost well below that of FFS plans. Based on bids from the plans, in 2012, MedPAC reported that the average MA plan provides Medicare benefits at 98 percent of FFS costs (see figure 6). And the MA HMO plans did so at just 95 percent of FFS costs.¹⁰

Figure 6 clearly demonstrates that MA HMOs, which have, by far, the largest enrollment numbers — 11.4 million as of February 2012, according to MedPAC — have over many years built the capacity to deliver care more efficiently than FFS plans. This should not be surprising because Medicare FFS, with its ineffective cost-sharing structure, is an inefficient model with essentially no control over utilization of services.

A recent study published in *Health Affairs* confirms that utilization of services is far lower in MA plans than in FFS plans. For instance, over the period 2003–09, MA HMO enrollees used the emergency room 25 to 30 percent less frequently than FFS participants. In addition, common surgical procedures were far less common in these MA HMOs, even after controlling for health status. And the lower use is entirely consistent with higher-quality practice patterns.¹¹

Three other recent studies broadly point in the same direction. These studies were all conducted to try to estimate what would happen if MA and FFS plans competed more directly with each other in a competitive model based on bids from the plans. This is the basic concept of the “premium support” model for reforming the Medicare program, and the studies were aimed at assessing the implications of such a reform on beneficiary costs as well as on overall federal government expenditures.

Although the studies used slightly different methodologies and were clearly aimed at delivering slightly different public messages, they all reached the same broad conclusion: in a head-to-head competition, some MA plans would be far less expensive than FFS plans. One of the studies found that the second-lowest bid — which would be used to peg the federal government’s contribution in some “premium support” formulations — would be, on average, just 91 percent of average nationwide FFS costs. Another study estimated that MA plans would be less expensive than FFS plans in just over half of the counties in the United States, as shown in figure 7. And the third study concluded that moving toward a competitive bidding model — with the federal government’s costs pegged to the results of the competition — would produce savings to Medicare of about 5 to 10 percent over the coming decade because MA plans are so much less expensive than FFS plans.¹²

THE SPILLOVER EFFECT AND ITS INVERSE

Several studies in recent years have looked beyond the relative costs of Medicare FFS and MA plans to the possible influence that one part of Medicare might have on the other. In other words, is it possible that MA plans could influence the cost structure of Medicare FFS, or vice versa?

A recent study by Michael Chernew, Philip DeCicca, and Robert Town provides important insight into this question. The authors carefully examined the FFS cost structure in counties with varying levels of MA HMO penetration. They found that, on average, MA HMO plans could deliver Medicare benefits for substantially less than the traditional FFS plan in many parts of the country. But they also found that, in counties with higher MA HMO penetration, the cost of FFS was lower than it otherwise would have been. As shown in figure 8, for every 1.0 percentage point increase in the MA HMO penetration rate, they estimate that per capita FFS costs were 0.9 percent lower than the costs that would have been incurred without a large MA HMO presence in the county.¹³

This is a remarkable finding, with several important implications. First, it is a clear indication that one part of the health system can influence costs in another part because those taking care of patients tend to provide care for enrollees in various insurance platforms in a similar fashion. Thus, the MA HMO plans in high-penetration areas, with their stronger incentives for utilization control, have clearly influenced how physicians and others take care of patients in the Medicare FFS program too. This is the spillover effect.

It follows, of course, that the reverse is also true. In areas where Medicare FFS is dominant and HMOs have less traction, the incentives embedded in FFS Medicare will drive up costs across the board — for the FFS program and the MA HMOs too. Call it the reverse of the spillover effect — a finding that strongly suggests that FFS’s incentives for procedure-driven medicine do in fact have costly ramifications for the entire health delivery system.

It also follows that simplistic assessments that suggest that MA plans are unnecessary and expendable as part of Medicare are unfounded. The route to effective cost control runs through serious and effective

delivery-system reform. Cuts to MA plans that lower the HMO penetration in many counties will only set back that important effort.

AN IMPLICIT CONSENSUS

Despite the often heated rhetoric around Medicare and health care reform, a broader consensus surrounds the problems associated with Medicare FFS than is apparent based on the political rhetoric of national parties.

Where is the evidence for this? In the Patient Protection and Affordable Care Act (PPACA) itself. The law has numerous provisions that its sponsors hope will move the program away from its heavy reliance on the FFS model. Among these are the Accountable Care Organization (ACO) initiative, the Center for Medicare and Medicaid Innovation, and additional use of bundled payments and pay-for-performance models.¹⁴

All of these efforts are aimed at using the regulatory powers of the federal government to gradually alter the basic dynamics of the FFS model. In general, providers of services would no longer get paid more for doing more services, but would instead be held accountable for treating their patients within a fixed budget. So there is now a broad consensus, even if it is somewhat obscured in the political debate, that Medicare FFS needs to be fundamentally altered. The only remaining question is: how?

THE DIFFICULTY OF BREAKING AWAY FROM THE FFS MODEL

The debate over how to reform Medicare comes down to this: can the federal government engineer more cost-effective health care delivery through a regulatory framework, or is another approach necessary? There are several reasons to be very skeptical that the Centers for Medicare and Medicaid Services has the capacity to reverse the incentives for the high costs embedded in Medicare FFS on a permanent and sustained basis.

For starters, it is important to realize that Medicare FFS looks and operates as it does for a reason — what might be called the “political economy” of Medicare. Medicare FFS remains essentially a claims-paying enterprise that does not discriminate among appropriately licensed providers of services. This is the way the politicians who oversee the program like it. Medicare pays the same rate to all service providers in a region, regardless of the quality of care they provide (with relatively minor exceptions now underway under the PPACA).

In other words, Medicare does not try to pick and choose among the providers, or build what might amount to a “preferred provider network.” That approach would involve picking winners and losers, which politicians are reluctant to do. Consequently, the FFS model remains dominant, and cost control efforts focus not on making the delivery system more efficient but on payment rate reductions across the board. It is true that the PPACA attempts to break out of the patterns of the past, but there is little reason to assume it will be effective.

Indeed, the PPACA’s reforms are not the first time Medicare has tried to break free of the dominant FFS mentality. There have been repeated attempts over the years to test new models in Medicare. The results have been discouraging. The Congressional Budget Office (CBO) has systematically examined the demonstration efforts over the past decade, all of which were aimed at carrying out, in various ways, reforms that would move away from unmanaged FFS.¹⁵ CBO Director Douglas Elmendorf summarized the agency’s findings this way:

The demonstration projects that Medicare has done in this and other areas are often disappointing. It turns out to be pretty hard to take ideas that seem to work in certain contexts and proliferate that throughout the health care system. The results are discouraging.¹⁶

Among the attempted demonstrations is a five-year pilot project modeled on the same ACO concept included in the PPACA. The results of that demonstration have already come up well short of expectations.¹⁷

The problem is that the only way to build a high-quality, low-cost network is to exclude low-value and high-cost providers. The private-sector delivery models that are rightly admired — such as Geisinger Health System, the Cleveland Clinic, and Intermountain Health Care — operate very differently. They do not take just any licensed provider into their fold. They operate highly selective — if not totally closed — networks that allow them to control the delivery system. Low-quality performers are dropped or avoided altogether, and tight processes are established to streamline care and ensure some level of uniformity.

Within Medicare, it has been much easier for the political system (and the regulators) to simply impose across-the-board payment reductions for all providers of services without picking winners and losers among physicians and hospitals. This kind of arbitrary cost-cutting remains the default mechanism for hitting budget targets in Medicare. Indeed, in the 2010 health care law, nearly all of the spending reductions in Medicare come from changes in the regulated payments systems for hospitals and other providers, not from ACOs or any of the other concepts that have received so much attention.¹⁸

CONCLUSION

The United States is fast approaching a fiscal crisis of unknown dimensions and consequences. The federal government has made spending commitments that far exceed the country's capacity to pay for them. There is a growing consensus that the status quo cannot hold much longer. Something is going to give, perhaps in the form of a very severe debt crisis.

At the heart of the crisis is rapid growth of entitlement spending driven by health care cost inflation. And at the heart of the health cost problem is Medicare. Put simply, America cannot solve its budget problems without slowing the pace of rising costs, and it cannot slow the pace of rising health costs without fundamental Medicare reform.

The federal government's health care administrators have been trying for many years to bring change to Medicare through a regulatory framework. The available evidence indicates that this approach has not worked because the fundamental political dynamic pushes toward a fragmented delivery system that is built on volume, not quality.

New efforts to change Medicare's basic dynamics may prove to be modestly more effective than previous efforts, but there is no real prospect that these efforts will fully solve the problem. In the end, real change will almost certainly require a more fundamental reform than has been enacted to date, such as using market forces to encourage the kind of far-reaching changes in how services are delivered to Medicare patients that are needed to bring costs under control.

Taking the position that this kind of Medicare reform is essential to the larger goal of health system reform does not mean Medicare is not a highly valued program even in its current form. Quite the contrary. Medicare provides vitally important access to care for those who rely on it, and the same is certain to be true in the future. The push for reform of the program is motivated by the need to ensure Medicare can provide even better security and access to care for future generations than it has for the current generation of program participants.

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ENDNOTES

1 For an example of this argument, see Peter Orszag's statement at a hearing held to consider his confirmation as director of the Office of Management and Budget at the beginning of the Obama administration: Testimony of Peter R. Orszag, Nominee to Serve As Director of the Office of Management and Budget, Before the Committee on Budget, United States Senate, January 13, 2009, http://budget.senate.gov/democratic/index.cfm/files/serve?File_id=56f83e4d-8635-4cf4-a618-dbb128ae9756.

2 From 1982 to 1997, private plans participating in Medicare were called "risk contractors." From 1997 to 2003, the Medicare private plan option was renamed "Medicare+Choice." The 2003 law adding a prescription drug benefit to Medicare again renamed the program "Medicare Advantage."

3 Centers for Medicare and Medicaid Services, *2013 Medicare Costs*, www.medicare.gov/Pubs/pdf/11579.pdf.

4 Congressional Budget Office, *Factors Underlying the Growth in Medicare Spending on Physician Services* (June 2007).

5 American Medical Association, Fee Schedules Based on Medicare's Resource Based Relative Value Scale or the Medicare Physician Fee Schedule (2009), www.cardiosource.org/Science-And-Quality/Quality-Programs/PINNACLE-Network/~media/Files/Science%20and%20Quality/Quality%20Programs/feeschedulesrbrvs.ashx.

6 Amy Finkelstein, "The Aggregate Effects of Health Insurance: Evidence from the Introduction of Medicare" (working paper, National Bureau of Economic Research, September 2005).

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9 Ruth S. Hanft, National Health Expenditures: 1950–1965 (Social Security Bulletin, February 1967); Centers for Medicare and Medicaid Services, "National Health Expenditure Data," www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html; and Bureau of Economic Analysis, "Price Indexes for Gross Domestic Product Data Series."

10 Healthcare Spending and the Medicare Program: A Data Book (Medicare Payment Advisory Commission, June 2012), 146, www.medpac.gov/chapters/Jun12DataBookSec9.pdf.

11 Bruce E. Landon et al., "Analysis of Medicare Advantage HMOs Compared With Traditional Medicare Shows Lower Use of Many Services During 2003–09," *Health Affairs*, December 2012, 2609–17.

12 Zirui Song, David M. Cutler, and Michael E. Chernew, "Potential Consequences of Reforming Medicare Into a Competitive Bidding System," *Journal of the American Medical Association* (August 1, 2012); Gretchen Jacobson, Tricia Neuman, and Anthony Damico, *Transforming Medicare into a Premium Support System: Implications for Beneficiary Premiums* (Henry J. Kaiser Family Foundation, October 2012); and Roger Feldman, Robert Coulam,

and Bryan Dowd, "Competitive Bidding Can Help Solve Medicare's Fiscal Crisis," *AEI Health Policy Outlook no. 2* (February 2012).

13 Michael Chernew, Philip DeCicca, and Robert Town, "Managed Care and Medical Expenditures of Medicare Beneficiaries" (working paper, National Bureau of Economic Research, January 2008).

14 An ACO allows doctors and hospitals to voluntarily join others in new legal entities that are responsible for providing care across institutional and outpatient settings. The idea is to put physicians and hospitals in new organizational arrangements in which they share Medicare revenue and keep the savings if they provide quality care at less cost than FFS Medicare would normally pay. The physicians and hospitals participating in an ACO would keep a substantial portion of the resulting savings. In effect, ACOs are the latest in a long series of efforts to persuade physicians and hospitals to form provider-run — as opposed to insurance driven — managed-care entities.

15 Lyle Nelson, “Lessons from Medicare’s Demonstration Projects on Value-Based Payment” (working paper, Congressional Budget Office, Washington, DC, January 2012), www.cbo.gov/sites/default/files/cbofiles/attachments/WP2012-02_Nelson_Medicare_VBP_Demonstrations.pdf.

16 See Merrill Goozner, “Rising Health Care Curve Won’t Bend, Even for Obama,” *Fiscal Times*, July 13, 2011, www.thefiscaltimes.com/Articles/2011/07/13/Rising-Health-Care-Curve-Wont-Bend-Even-for-Obama.aspx.

17 Amy Goldstein, “Experiment to Lower Medicare Costs Did Not Save Much Money,” *Washington Post*, June 1,

2011.

18 At the time of enactment in 2010, the CBO estimated that the law would cut Medicare and Medicaid spending by a combined \$455 billion over 10 years. The largest cuts included a \$157 billion reduction in the annual inflation increases for numerous payment systems and a \$136 billion reduction in payments to MA plans. See Congressional Budget Office, “Letter to the Honorable Nancy Pelosi,” March 20, 2010, www.cbo.gov/sites/default/files/cbofiles/ftpdocs/113xx/doc11379/amendreconprop.pdf.

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