

Provider Payment Lessons from Medicare History

While Medicare was intentionally designed to mimic provider payment policies that were prevalent in the private sector when it was enacted, subsequent policy changes took the program in a different direction. Only a few years after Medicare was put in place, federal budget pressures began to translate into reductions in hospital and physician payment rates. Over the years, such reductions have compounded and resulted in Medicare payment rates for hospital and physician services that are now substantially below what private plans typically pay.

Medicare's Initial Design

When it was enacted in 1965, Medicare was modeled after private plan coverage in a number of ways, including the methods under which hospitals, physicians and other providers were to be paid for health care services provided to Medicare beneficiaries. Additionally, claims processing was to be based on systems used in the private sector, and private contractors were then engaged to process Medicare claims. The overriding objective in enacting Medicare was to assure the elderly the same access to services and the same freedom of choice of doctors and other providers as enjoyed by the working population under private health plans. Policy makers did not want the new program to disrupt the existing system of health care service delivery and financing.

The initial structure of provider payment under Medicare also followed policies already established in the private sector. Hospitals and other institutions were paid on a cost-related basis, according to certain accounting principles. Linkage to the private sector was made directly with respect to defining reasonable costs: Medicare law required the Secretary to "...consider, among other things, the principles generally applied by national organizations or established prepayment organizations in computing the amount of payment...."

This policy choice was specifically aimed at ameliorating concerns expressed by the American Hospital Association (AHA) and the American Medical Association (AMA) regarding how reasonable costs might be implemented for hospital services. As Medicare legislation was being considered in the Congress, Robert Ball of the Social Security Administration testified that, "We would be following the reimbursement principals that are by and large followed by Blue Cross and those that are advocated by the American Hospital Association..."

Medicare's original payment policy for physicians was intended to mitigate opposition from the AMA, which had been credited with preventing the passage of Medicare legislation for a number of years. Physicians were to receive as payment their usual and customary fee, as long as it was also "reasonable." And physicians would be permitted to bill Medicare beneficiaries directly rather than working through the Medicare program carriers, and could charge patients more than what the government would pay the physician.

The details of Medicare's hospital and physician payment policies were largely shaped through the implementing rules, which were issued by the Social Security Administration (the agency initially responsible for administering Medicare) only after extensive negotiations with the AHA and AMA. Administration officials were acutely concerned that providers participate in the new program and resisted proposals that would have departed from prevailing private sector practices.

Tightening Provider Payment

As early as 1972, however, federal budget pressures led to enactment of changes in Medicare that imposed limits on provider payments. For the first time, increases in allowed physician charges were capped at the growth in the newly developed Medicare Economic Index (MEI), a measure of input costs. These limits affected payment rates substantially. In 1986, the Congressional Budget Office estimated that about half of approved charges for physician services were limited by the MEI. Additional limits were imposed during the 1980s, affecting not only amounts paid to physicians by the Medicare program, but also capping the extent to which physicians could "balance bill" beneficiaries above the Medicare payment amount. Moreover, physicians were required to submit bills directly to Medicare for all services provided to Medicare beneficiaries.

On the hospital side, limits on reasonable cost reimbursement were imposed under what became known as the "Section 223 limits," which capped reimbursements to hospitals that had routine (nursing, room and board) per diem costs that were high relative to those of similar facilities. These limits were subsequently tightened. The Omnibus Budget Reconciliation Act of 1981 required that the limits be reduced from 112 percent of the mean to no higher than 108 percent of the mean. Under the Tax Equity and Fiscal Responsibility Act of 1982, the Section 223 limits were expanded to include ancillary costs, and a new limit on increases in hospital costs per stay was imposed.

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Over time, the Congress acted to replace Medicare's original payment approach based on provider costs and prevailing charges with systems that gave federal policymakers virtually unilateral control over Medicare fees. Beginning in fiscal year 1984, cost-based reimbursement for inpatient hospital services was phased out and replaced by the prospective payment system under which prices are set for hospital stays based on Diagnosis Related Groups (DRGs). Cost-based reimbursement for outpatient hospital services continued (with limits and reductions enacted along the way) until 2000, when it, too, was phased-out in favor of a fixed-price prospective payment system. Since 1992, physician payments have been based on a fee schedule using the Resource Based Relative Value Scale. Payments for skilled nursing care, home health visits, rehabilitation and long-term hospital stays were also shifted from reasonable cost reimbursement to fixed price systems.

In a series of deficit reduction bills enacted in the 1980s and 1990s, the Congress made further provider payment reductions, resulting in Medicare payment rates that are now

much lower than those of private plans. The Medicare Payment Advisory Commission estimates that the rates Medicare pays physicians are only 80 percent of private sector rates, and that for two-thirds of hospitals, payments from Medicare do not cover the costs of caring for Medicare beneficiaries. Payments to hospitals from private payers offset Medicare losses: in 2006, the private payer payments exceeded hospital costs by 24 percent.

The new prospective pricing and fee-schedule payment systems made it relatively easy for the government to address budget concerns by reducing provider fees. The annual update factors applied to prospective payment systems and fee schedules have frequently been reduced for the purpose of deficit reduction. For example, hospital DRG rates were increased by less than the full “market basket” input price index almost every year from 1988 through 2003. Moreover, broad federal budget procedures have reduced provider payments as well. For example, provider payments were subject to a 2 percent reduction under a federal “sequester” requirement effective from November 1987 through March 1988 required by deficit reduction laws.