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Author

Robinson, James C

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Invited Commentary

HEALTH CARE REFORM

Medicare Advantage Reimbursement to Physicians

James C. Robinson, PhD

The most annoying aspect of the public discourse on physician payment is the tone of victimization. Physicians complain that insurers have consolidated and are underpaying them relative to the value they generate. Insurers complain that clinicians and health care institutions have consolidated and are demanding unaffordable rates. This is uninspiring. Can some new light be shed in the darkness?

It can. In their article on physician payment rates for procedures provided to patients covered by commercial insurance, private Medicare Advantage (MA) plans, and public traditional Medicare (TM) insurance, Trish et al¹ report that MA payment rates track those in TM closely but fall meaningfully below those paid by commercial insurance. This might be unremarkable except that the data reflect rates paid for the same *Current Procedural Terminology* codes in the same local markets by the same private health plan, which sponsors coverage for both commercial and MA enrollees.

Wait a minute. Are we saying that this large for-profit insurer is able to pay physicians approximately at TM rates for its MA members but then chooses to pay those same physicians 10% to 50% more for its commercial members? What about its duty to maximize profits for shareholders? Are we saying that physicians have the bargaining power (presumably due to consolidating with hospitals) to charge rates 10% to 50% above TM for commercially insured patients but then acquiesce to TM rates for their MA patients? Since when do physicians gift their bargaining leverage to insurers?

Is there a method to this madness?

There is no real method to the madness of the US health care system. The system is absurd. Nevertheless, the findings of Trish et al¹ shed light on the dynamics of market competition that might be of utility if someone ever wishes to make the system slightly less so.

First, physicians do have bargaining leverage with insurers. Trust me, if the health plan studied here could pay physicians at TM rates for their commercial as well as their MA patients, they would. Consolidation works, especially when physicians combine with hospitals that are protected from competition through mergers, acquisitions, and regulatory barriers to entry.

Second, TM does stiffen the back of MA plans. The MA plans are paid by Medicare on a per-beneficiary basis pegged to TM per-beneficiary costs. These depend, in turn, on the TM payment rates mandated by the governmental program. Medicare Advantage plans cannot pay physicians at rates much above the TM benchmark or they will lose money, which would be a violation of their mandate. Ultimately, the insurers are required to make a take-it-or-leave-it offer to physicians, limiting MA payment rates to the TM level regardless of the clini-

cians' consolidation and potential bargaining leverage. Some physicians accept those rates and some do not. The facts on the ground say that enough clinicians accept TM rates for MA patients to ensure the growth of the MA program.

Why do physicians do this? Maybe they love Medicare and will work long hours for low pay to care for elderly patients, without complaining about stingy government bureaucrats and greedy corporate executives. Or maybe physicians are willing to accept low payment rates for MA patients in exchange for an expectation of high payment rates for commercially insured patients.

Why do insurers do this? Why do they pay high rates to physicians for treating their commercial members when they can pay low rates for treatment of their MA members? Why do the insurers not just focus on MA and let the commercial members go, if payment rates for the latter are so high? There is a lot of room still to grow in MA, which still covers less than half of the Medicare population.

To grow their MA enrollment, insurers need to have physicians willing to treat them. Although we must never assume rationality in health care economics, it is possible that physicians consider their entire book of business, commercial and MA, and join the insurer's network if the net revenue from the entire book is attractive. In this view, insurers subsidize the growth of their MA networks by paying high rates for commercial patients.

Where high payments are not necessary to induce clinicians to participate in MA, insurers do not provide them. As reported by Trish et al,¹ MA plans are able to negotiate commercial payment rates for some services, such as clinical laboratory tests and durable medical equipment, that are lower than the rates paid by TM. (To understand why TM pays such high rates to these nonphysician providers, ask Congress.) For these services, their MA plans pay the lower commercial rate rather than the higher TM rate.

Insurers are playing the long game. Medicare Advantage is the most lucrative niche in the insurance market (as long as Congress wants to keep it as such). It is not subject to the slow but steady loss of interest among employers in offering commercial insurance to their employees. Medicare is demographically favored in an aging nation. The same dynamic holds for Medicaid managed care, in spades.

How long can this go on? How long will the employers who purchase commercial insurance be willing to pay the high premiums that derive, in part, from high physician payment rates that subsidize MA? The natives already are restless. Employers are shifting an ever-increasing fraction of insurance costs to their employees through deductibles and other forms of cost sharing. Some are dropping coverage for dependents and retirees. A few are dropping health insurance altogether.

Medicare Advantage is growing, implicitly subsidized by commercial insurance. Medicaid managed care is booming, with similar implicit subsidies. Commercial insurance is shrinking, burdened by these implicit subsidies. Will the last commercial insurer please turn out the lights?

ARTICLE INFORMATION

Author Affiliation: School of Public Health, University of California–Berkeley.

Corresponding Author: James C. Robinson, PhD, Berkeley Center for Health Technology, School of Public Health, University of California–Berkeley, University Hall, Room 247-B, Berkeley, CA 94720-7360 (james.robinson@berkeley.edu).

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with traditional Medicare and commercial health insurance [published online July 10, 2017]. *JAMA Intern Med*. doi:[10.1001/jamainternmed.2017.2679](https://doi.org/10.1001/jamainternmed.2017.2679)

REFERENCES

1. Trish E, Ginsburg P, Gascue L, Joyce G. Physician reimbursement in Medicare Advantage compared