VIEWPOINT

HEALTH POLICY

The Implications of "Medicare for All" for US Hospitals

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Editorial

Author Audio Interview

Health care has already emerged as a major 2020 campaign topic for the Democrats, with some candidates advancing the concept of "Medicare for all." As an aspiration, the initiative is intended to offer affordable health insurance as an essential right for all individuals in the United States. With health care costs at 18% of the gross domestic product and the number of uninsured persons once again increasing, finding a policy approach that insures more individuals while attenuating projected increases in health care spending remains a goal that has been elusive for more than 5 decades of US policy making.[1]

One consideration for those developing health care proposals is an understanding of how universally applying Medicare payment rates will affect hospitals. Hospitals consume the largest share of health care costs. In 2017, hospitals accounted for approximately 35% of the $3.5 trillion spent.[2] Currently, hospitals receive payments from public and private health insurers through several different payment mechanisms. The largest publicly funded insurance plans, Medicaid and Medicare, generally pay hospitals via unilaterally set fee schedules. Current federal statute requires that the traditional form of Medicare pay what the Centers for Medicare & Medicaid Services determine to be the costs that "efficient" hospitals are expected to incur.

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Medicare Advantage plans have the right to pay hospitals the same amounts. In contrast, private health plans must negotiate payment rates agreeable to each hospital in their network, regardless of whether a hospital operates efficiently. These contentious negotiations often rest on market leverage to achieve the most favorable payment for hospitals.

The costs of caring for Medicare beneficiaries and all patients are not fixed but instead represent the product of a business strategy for a hospital; the costs are the direct result of decisions made by hospital executives over time (reflecting local market conditions, payer environment, and regulatory requirements). There is considerable variability in hospital costs across markets—and even in the same city—in providing the same services.

Starting in about 2000, when Medicare payments were equal to the average US hospital's costs (**Figure**), many hospitals began investing in property, facilities, equipment, and services that typically drove their costs much higher than Medicare's efficient hospital standard. Operating at a much higher cost proved feasible for hospitals because most were able to negotiate increasingly higher payment rates with private payers to offset their mounting losses on publicly funded care.

The cumulative effect of this hospital management strategy, as well as Medicare payment policy enacted in the Affordable Care Act that mandates annual productivity gains, is that Medicare and Medicaid now pay hospitals significantly less than their estimated average costs (86.8% and 88.1% of costs, respectively; Medicaid and Medicare payments include Disproportionate Share Hospital payments in this calculation), whereas private payers pay hospitals more than their average costs (144.8% of costs on average).[3] Covering the financial shortfall of hospitals on publicly funded care by increasing payment rates for patients covered by private insurance is often described as unavoidable "cost shifting," although the alternative explanation recognizes that the cost of care results from strategic decisions by hospital leaders over time that have driven their costs above sustainable public reimbursement levels.

A Medicare-for-all plan that extends the current Medicare fee schedule to all patients would therefore lead to a marked decline in revenue from formerly privately insured patients and a small decrease in revenue from formerly Medicaid-covered patients. Given the relative proportion of patients with each type of insurance, the estimated net effect on hospitals would be a 15.9% decline in revenue, equal to a loss of $151 billion nationally incurred by 5262 US community hospitals. Given a current average profit margin of 7% including nonoperating income, hospitals could quickly face the prospect of margins as negative as 9%, equal to an $85.6 billion annual loss, unless they could rapidly reduce waste and become more efficient.[3] Most hospitals would have access to the financial reserves that they have built up over the last decades.

Hospitals currently operating at costs substantially above Medicare payment rates may have limited ability to reduce their costs quickly. Because the most flexible hospital costs are labor costs, an estimated 1.5 million hospital clinical and administrative jobs could be lost if hospitals reduced labor costs to compensate for the entire revenue shortfall or 855 999 jobs if hospitals buffered job losses by sacrificing their current average operating margin of 7% (assuming $100 000 per full-time equivalent).

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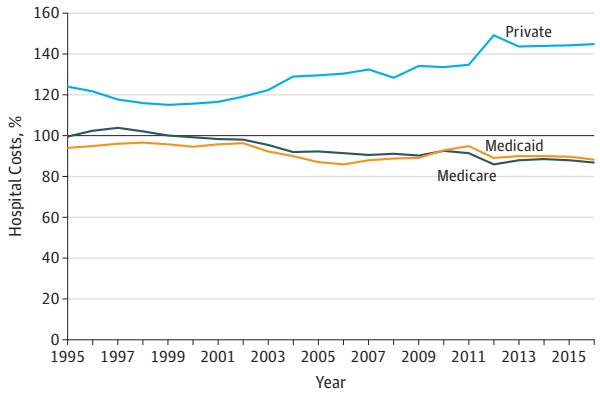
Figure. Payment Rates as a Percentage of Hospital Costs for Public and Private Forms of Health Insurance in the United States



In 2016, distribution of hospital cost by payer type was as follows: Medicare, 40.8%; Medicaid, 18.5%; private payers, 33.4%; uncompensated, 4.2%; other, 3.6%.[3] Medicare and Medicaid payments include Disproportionate Share Hospital payments. Adapted from American Hospital Association data.[3]

Less disruptive employment scenarios would unfold if hospitals' margins are currently understated. It is also feasible, and perhaps likely, that hospitals would be forced to become more efficient in other ways; for example, by not replacing retiring employees, incurring less debt, foregoing planned capital expenditures for facility upgrades, negotiating better rates for other products and services in the supply chain, or negotiating stable salaries of clinical staff and other employees.

From a national economic perspective, since growth in health care spending substantially in excess of gross domestic product growth is associated with job loss in non–health care industries, job losses in health care may be offset by job gains elsewhere in the economy.[4] Thus, reductions in health care spending from a Medicare-for-all program could stimulate a growth in employment (or wages) outside of the health care industry.

A hospital could be more adversely affected if it had a higher than average percentage of privately insured patients or had disproportionately invested in services that are more generously reimbursed by private payers, such as oncology and procedural specialties.[5] Hospitals that had previously pursued an aggressive market consolidation strategy to increase leverage in price negotiations with private insurers (with consequent relaxed pressure to provide care at the Medicare-efficient level of cost) may be the most challenged.[6] Such hospitals could easily document to policy makers that Medicare-for-all prices will be far below their cost of providing services. However, policy makers should consider that hospitals in more price-competitive markets have already made more parsimonious investment decisions, reflecting the fiscal constraints of a price-competitive marketplace. For example, the 26% of hospitals that experience the greatest price pressure from private payers have costs 7% below the national average and do not lose money treating Medicare beneficiaries.[7] Thus, observers can readily contrast these different hospital investment strategies and the resulting costs of care.

Given the magnitude of these effects, Congress can expect very substantial lobbying by hospitals (and their associations) to protect current levels of revenue. Potential responses are varied. For example, a Medicare-for-all plan could increase the payment rates for public insurers to 100% of each hospital's actual costs. However, this would be a very expensive approach and do little to encourage hospital efficiency. Such a policy would require an estimated 15.2% increase in Medicare payment rates and a 13.5% increase in Medicaid payment rates.[3] Under this scenario, annual Medicare spending by the federal government would increase by $40.7 billion and annual Medicaid spending by the federal and state governments would increase by $25.6 billion.[2] Increasing payment rates further to provide hospitals with positive margins would require substantially greater public spending on health care.

Alternatively, introducing a gradual shift in payment over several years from current cost to the cost of efficiently provided care could buffer political pressure from hospitals. This approach was taken in the 1980s when Medicare moved to a single national diagnosis-related group payment (subject to a narrow list of adjustment factors) from its original policy of paying each hospital based on its average actual cost of delivering care. However, such a gradual approach runs the risk that hospitals will lobby to perpetually postpone the transition in payments as physicians did with payment reductions resulting from the sustainable growth rate payment formula.

Developing a political coalition for the most expansive visions of Medicare for all would be extremely challenging under any circumstance. In the absence of exceptional public-mindedness among hospital leaders, supporters of Medicare for all should anticipate strong hospital political opposition, especially from leaders who have pursued strategies less focused on efficiency than on extracting ever-increasing payment rates from private payers.

ARTICLE INFORMATION

Published Online: April 4, 2019. doi:10.1001/jama.2019.3134

Conflict of Interest Disclosures: Dr Schulman reported receiving personal fees from The Business Roundtable and American Hospital Association. Dr Milstein reported receiving personal fees from the Business Roundtable and being an unpaid trustee of Intermountain Healthcare, unpaid board member of The Leapfrog Group, and the medical director of the Pacific Business Group on Health.

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