VIEWPOINT

HEALTH POLICY

The Pricing of Care Under Medicare for All
Implications and Policy Choices

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Supplemental content

The prices of health care services are a key consideration in the debate over "Medicare for all" and related single-payer proposals. The term *prices* refers to the allowed payment per unit of service. In the broadest versions of these reforms, in which commercial insurance plans would transition into a universal Medicare–like program, physicians and hospitals face the prospect of receiving Medicare prices for all patients they serve. Relative to the status quo, in which commercial insurer prices generally exceed Medicare prices, this price reduction could have important consequences for clinicians and patients.[1,2]

Using 2016 data, the eTable in the Supplement compares traditional Medicare prices to average commercial insurer prices (both in network and out of network) for some of the most common physician services. Commercial prices in network ranged from roughly 100% to more than 300% of Medicare levels, whereas commercial prices out of network, which applied to less than 10% of the volume for most categories of care, exceeded Medicare prices by larger margins, consistent with prior findings.[3] Hospital prices demonstrate a qualitatively similar pattern, with commercial prices for hospital inpatient care averaging about 200% of Medicare levels and those for hospital outpatient services nearly 300% of Medicare.[4]

Behavioral Reponses

Reducing commercial prices to the level of Medicare prices would, at first glance and without any adjustment, substantially reduce the total cost of health care in the United States through lower total revenues for physicians and hospitals. A simple calculation of savings, by summing the differences between commercial and Medicare prices across all services delivered today, would reliably produce a large savings estimate for national spending that could lend support to Medicare-for-all proposals. However, the assumption that physicians and hospitals would not react as their commercial prices are reduced substantially to Medicare levels is likely unrealistic.

Studies show that physicians and hospitals can respond to large price reductions in several ways, which could help policymakers and the public think through the implications of a Medicare-for-all system. First, physicians have often responded to lower fees for a given service by increasing the volume of services delivered, often referred to as an "income effect." In some cases, physicians have substituted other higher-margin services or increased volume in higher-margin populations.[5] For example, in 2005, when Medicare decreased prices for some outpatient chemotherapy agents by 50% to 90%, total chemotherapy use increased and less-profitable agents were replaced by more profitable alternatives.[6] In 2000, when Medicare reduced prices for the most common hospital outpatient procedures by more than 20% on average, the volume of procedures among commercially insured patients increased, and hospitals serving more Medicare patients showed larger increases in commercial volume.[7] When price reductions are small, however, the income effect can be less consequential and empirical evidence has been more mixed. In many areas of medicine in which physicians have discretion over decision-making, patient preferences are limited by a lack of information or experience, or guidelines provide nondefinitive recommendations, it could be difficult for Medicare to predict how much savings for the single-payer system would be offset by a strong income effect due to large price reductions or to regulate its magnitude.

Another way physicians and hospitals have responded to lower prices is by increasing their intensity of billing. When Medicare eliminated billing codes for consultations and required them to be billed as office visits (which are less expensive), physicians billed on average higher-level office visits.[8] When Medicare altered prices for inpatient diagnosis-related groups (DRGs), some hospitalizations were "upcoded" to higher-priced DRGs, notably those with larger price increases.[9] In addition, if Medicare for all results in the shift of patients into value-based or alternative payment models, which have strong incentives to capture comorbidities for quality and risk-adjusted payments, the coding of diagnoses may change. Medicare Advantage enrollees, for example, have received more intensive diagnostic coding than traditional Medicare patients. Similar to the income effect, changes in billing and coding could offset savings from lowering commercial prices to Medicare levels.

Other behavioral responses may also be important. Because services delivered in a facility setting are reimbursed more than in a physician's independent office, physicians could respond by further consolidating with and moving into facilities or hospitals. This trend toward physician employment has already taken shape in recent years with many potential causes. When Medicare reduced office-based prices for some cardiology services, for example, more of those services began to be delivered in hospital-based settings.[10] Thus, changes in site of care could also offset savings from uniform Medicare prices, although recent changes in CMS regulations have scrutinized what settings qualify for hospital-based prices. Additionally, physicians and hospitals could respond to the lower prices by cutting costs and becoming more efficient (for example, administrative costs of interfacing with multiple insurers would lessen), although evidence of pursuing efficiency in lieu of other responses in the short term has been scant.

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On the patient side, the elimination of cost-sharing in Medicare-for-all proposals would be a welcome reprieve to patients and families facing rising deductibles and co-payments in commercial insurance or traditional Medicare's 20% cost-sharing. However, if cost-sharing is eliminated for all health care services in a way that is agnostic to value, it may lead to an increase in low-value care via unconstrained moral hazard, the tendency to demand more care when cost-sharing decreases. That may compound the behavioral responses above to further raise spending without justifiable benefits for patients.

Aside from the fiscal consequences of a Medicare-for-all program, these behavioral responses may have unintended clinical consequences. While guaranteeing access to necessary care for all patients is an important and laudable outcome, the increased potential for overutilization, substitution toward higher-margin services, unnecessary shifts in sites of care, or demand for low-value services might introduce additional waste to the delivery system or harm to patients, such as from overdiagnosis or overtreatment.

Policy Alternatives

That these behavioral responses exist is not a reason to dismiss Medicare for all or Medicare public option proposals; the tenets of equity and access to health care as a human right in those proposals have broad appeal. Behavioral responses are also not a uniquely US phenomenon. Evidence of upcoding, for example, exists in Norway, Italy, Germany, Portugal, and Japan, where health care systems on average more closely resemble a single-payer approach. In addition, some physicians and hospitals (ie, those who primarily serve Medicaid or uninsured populations today) would receive more revenue under Medicare for all, as current Medicaid prices are below Medicare levels and care for uninsured patients may garner no reimbursement.

These behavioral responses do lend some caution to policymakers who support Medicare-for-all proposals because eventual savings in the health care system could be smaller than anticipated and changes to care patterns could be larger than anticipated. These behavioral responses also motivate consideration of less draconian ways to set prices in a Medicare-for-all system, which may ease the transition and help earn physician and hospital buy-in.

Instead of setting all prices to Medicare levels, prices could be set at a fixed percentage above Medicare. If prices were set at 200% of Medicare levels, prices for some services would decline but others would increase. For example, Medicare pays $73.40 for an evaluation and management visit; average commercial prices are $80.24 for in-network and $99.72 for out-of-network visits. Setting prices at 200% of Medicare levels ($146.80) would lead to an 83% increase in payments for in-network and a 47% increase in payments for out-of-network visits. In contrast, the price for an emergency department visit, which is $175.44 in Medicare, compared with $442.46 and $686.28 for commercial in network and out of network, respectively, would decline if commercially insured visits were paid 200% of Medicare prices. Similar calculations for a scenario in which prices were set at 125% of Medicare levels show that this approach would raise prices above some current in-network commercial prices, whereas prices for other in-network services would see reductions as high as 40% to 65%—and even higher for out-of-network services (eTable in the Supplement). These reductions would be counterbalanced by price increases for the Medicare, Medicaid, and uninsured patients of today. Given that physicians and hospitals vary in specialty, payer mix, and share of services delivered out of network, the economic consequences of setting prices at any percentage of Medicare levels will vary across them.

Setting Medicare-for-all prices above current Medicare price levels would be less disruptive for physicians and hospitals than broadly implementing current Medicare prices. Phasing in such price changes over time would also help. Physicians and hospitals that disproportionately serve vulnerable populations or have critical access status could receive higher prices above Medicare levels. This might help alleviate concerns over physicians leaving practice or hospitals closing. With behavioral responses still a concern, additional regulatory oversight of billing and coding may be needed, reducing savings from administrative costs. Linking appropriate cost-sharing to value could help limit the overconsumption of low-value care.

To be successful, Medicare for all and related proposals will likely need the support of the physician and hospital communities, which have yet to broadly back these proposals in part due to the uncertainty around prices. Current proposals in Congress have not specified whether or where prices might land above Medicare levels, frequently deferring the decision to the administration. Finding a path toward universal coverage that is palatable for physicians and hospitals would aid policymakers who champion such reforms.

ARTICLE INFORMATION

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