



Reducing Private Insurance Hospital Payments Will Require a Lengthy Phase-In Period

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In 2019, nearly one-third of national health care spending went to hospitals.¹ A large body of evidence shows private insurers pay far more than Medicare for inpatient and outpatient hospital services (Blumberg et al. 2020; Cooper et al. 2018; Lopez et al. 2020; Maeda and Nelson 2017; MedPAC 2019; White and Whaley 2019). A 2020 meta-analysis of hospital price studies found private insurers pay between 1.4 and 2.6 times Medicare fees for hospital services.³ Using 2017–18 FAIR Health data, the Urban Institute found private insurers paid 2.4 times Medicare fees for all hospital services, and the ratio of private insurers' to Medicare's hospital fees ranged from 1.3 to 3.2 across states (Blumberg et al. 2020). This disparity between Medicare and private hospital fees has led to calls for reining in hospital payments.

Despite increased scrutiny of hospital prices, they have continued growing rapidly (CBO 2021; Cooper et al. 2019; Whaley et al. 2020). One study found that private insurance hospital fees grew 5.1 percent per year relative to Medicare fees between 2016 and 2018 (Whaley et al. 2020). The Congressional Budget Office projects that private hospital fees will grow 4.2 percent per year between 2020 and 2030 under current law CBO (2021).

Several policy options could reduce hospital fees, however. First, Congress could *cap hospital payment rates* in private insurance, including the employer-sponsored insurance market and/or the nongroup insurance market (Blumberg et al. 2020). The Medicare Advantage program provides a template for this approach; in the program, out-of-network charges are capped at Medicare rates, effectively giving Medicare Advantage plans leverage to cap payments at Medicare rates in network as

well (Holahan et al. 2018). Introducing capped hospital payment rates, either directly or by limiting out-of-network charges, would reduce premiums and lower subsidies paid by the federal government in the Marketplaces, because federal subsidies are tied to Marketplace premiums (Fiedler 2020; Holahan and Simpson 2021a).

Other policies, like a public option or Medicare for All, would pay hospitals lower fees, on average, than private insurance while expanding health insurance coverage. For example, a *public option* could be established that would pay Medicare hospital fees or some multiple thereof, and the resulting savings could be passed on to enrollees. The federal and consumer savings generated would depend on the markets in which the public option is available (e.g., nongroup only or both nongroup and employer-sponsored) and how hospital fees in the public option compare with current fees (Blumberg et al. 2020; Fiedler 2020; Holahan and Simpson 2021a). High enrollment in a broadly available public option plan may pressure hospitals to accept lower payments from private insurers as well. But if payments are set too low, some hospitals may choose not to participate, reducing access to care.

As noted, proposals like *Medicare for All* would also reduce hospital fees while covering more Americans.² Instead of the current mix of Medicare, Medicaid, and private insurance payments, hospitals would be paid the same amount for each patient receiving the same care. By setting hospital payment rates lower than the current average of private and public insurance rates, Medicare for All would save consumers and the federal government money, but it could change hospital revenue significantly, depending on the payment rates used (CBO 2020).

Reducing hospital payment rates in the above reforms would reduce health care spending, but introducing any of the reforms would require a phase-in period to limit disruptions in health care delivery. Though research evidence indicates hospitals can and do adjust their underlying cost structures to reflect changes in payment rates (Robinson 2011; White and Wu 2014), hospitals need time to adapt to significant reductions in payment rates while maintaining or even expanding the supply of care.³ Rural hospitals, in particular, may need additional support to maintain operations under lower payment rates (Blumberg et al. 2020; Holahan and Simpson 2021b).

This paper explores scenarios for phasing in reductions in hospital fees. We do not explore phase-in periods for reductions in physician fees, because private insurers pay them just 1.2 times Medicare rates, on average (Blumberg et al. 2020). The regulated or capped hospital payment rates could be set at any level, but here we focus on achieving significant savings relative to current hospital spending. Consequently, each scenario seeks to reduce private payment rates to parity with Medicare (i.e., achieve a ratio of 1.0) or lower them to 25 percent above Medicare rates (i.e., achieve a ratio of 1.25), as opposed to the current average of 2.4 times Medicare rates.

1. Freeze private insurance hospital fees at 2017–18 levels and increase Medicare fees by 2.2 percent per year until the private insurance-to-Medicare hospital fee ratio reaches 1.25 or 1.0.

2. Reduce private insurance hospital fees by 2.0 percent per year while increasing Medicare fees by 2.2 percent per year until the private insurance-to-Medicare hospital fee ratio reaches 1.25 or 1.0.
3. Reduce private insurance hospital fees as needed to achieve a private insurance-to-Medicare hospital fee ratio of 1.25 or 1.0 in 10 years.

Data and Methods

This brief builds on work by the Urban Institute exploring the effects of capped provider payment rates or a public option in the private insurance market (Blumberg et al. 2020). That research included estimates of private insurance-to-Medicare hospital fee ratios by state in 2017–18, based on commercial health insurance claims data from FAIR Health. We used these ratios to project the number of years needed to phase in two approaches to lowering hospital payment rates in the private market: lowering private insurance hospital fees to (1) no more than Medicare rates or (2) no more than 125 percent of Medicare rates.

We did not trend the 2017–18 FAIR Health ratios up to 2021. Therefore, our results represent conservative estimates of the number of years needed to phase in hospital payment reductions, as the Congressional Budget Office expects the gap between private and Medicare hospital fees to grow steadily between 2020 and 2030 (CBO 2021).

We used existing data on private insurance-to-Medicare hospital fee ratios to project the effects of the following phase-in scenarios:

- **Scenario 1.** How many years would it take to achieve a private insurance-to-Medicare hospital fee ratio of 1.25 or 1.0 in each state if private insurance rates were frozen at 2017–18 levels and Medicare fees increased 2.2 percent per year?
- **Scenario 2.** How many years would it take to achieve a private insurance-to-Medicare hospital fee ratio of 1.25 or 1.0 in each state if private insurance fees were reduced by 2.0 percent per year and Medicare fees increased by 2.2 percent per year?
- **Scenario 3.** What annual percent reduction in private insurance hospital fees would be needed to achieve a private insurance-to-Medicare hospital fee ratio of 1.25 or 1.0 in 10 years?

In each scenario, we assume baseline Medicare hospital fee growth of 2.2 percent per year using estimates of expected annual long-term growth from the Centers for Medicare & Medicaid Services' Office of the Actuary (Heffler et al. 2020). To estimate the number of years needed to achieve the endpoints in scenarios 1 and 2, we increased the denominator of each state's private insurance-to-Medicare hospital fee ratio by 2.2 percent per year and then either held the numerator constant (scenario 1) or decreased it by 2.0 percent per year (scenario 2). In scenario 3, we estimate the annual percent decrease in private hospital fees needed to achieve a private insurance-to-Medicare hospital

fee ratio of 1.25 or 1.0 in 10 years, assuming Medicare fees grow as projected by the Centers for Medicare & Medicaid Services.

Results

Scenario 1. If private insurance hospital fees were frozen at 2017–18 levels and Medicare rates increased 2.2 percent per year, it would take an average of 31 years to phase in a private insurance–to-Medicare hospital fee ratio of 1.25 across the country (table 1). Under this scenario, equalizing private insurance and Medicare hospital fees, or achieving a private insurance–to-Medicare hospital fee ratio of 1.0, would take an average of 41 years.

The time needed to phase in a private insurance hospital fee limit of 125 percent or 100 percent of Medicare rates would vary substantially across the country. For example, in West Virginia, where the ratio of private insurers’ to Medicare’s hospital fees was 1.32 in 2017–18, it would take only 3 years to achieve a private insurance–to-Medicare hospital fee ratio of 1.25 and 13 years to achieve a ratio of 1.0, because average private insurer hospital payment rates in the state are currently only 32 percent above Medicare fees. In contrast, private insurers in Florida paid hospitals an average of 323 percent of what Medicare paid, so it would take 44 years and 54 years to achieve private insurance–to-Medicare hospital fee ratios of 1.25 and 1.0, respectively.

TABLE 1

Private Insurance–to-Medicare Hospital Fee Ratios and Number of Years to Achieve Ratios of 1.25 and 1.0, by State and Year, Assuming Medicare Fees Grow by 2.2 Percent per Year and Private Fees Are Frozen at 2017–18 Levels

	Initial private insurance–to-Medicare hospital fee ratio	Ratio at year 1	Ratio at year 5	Ratio at year 10	Ratio at year 20	Years to get to 1.25 ratio	Years to get to 1.0 ratio
US	2.45	2.39	2.19	1.97	1.58	31	41
AL	2.62	2.56	2.35	2.11	1.70	34	45
AK	2.22	2.17	1.99	1.78	1.43	27	37
AZ	2.46	2.41	2.21	1.98	1.59	31	42
AR	1.92	1.88	1.72	1.54	1.24	20	30
CA	2.83	2.77	2.54	2.28	1.83	38	48
CO	3.06	2.99	2.74	2.46	1.98	41	52
CT	2.23	2.18	2.00	1.80	1.44	27	37
DE	2.25	2.20	2.02	1.81	1.46	27	38
DC	2.36	2.31	2.12	1.90	1.53	30	40
FL	3.23	3.16	2.90	2.60	2.09	44	54
GA	2.53	2.48	2.27	2.04	1.64	33	43
HI	2.12	2.07	1.90	1.70	1.37	25	35
ID	2.08	2.04	1.87	1.67	1.35	24	34
IL	2.48	2.43	2.22	2.00	1.61	32	42
IN	2.34	2.29	2.10	1.88	1.51	29	39
IA	1.84	1.80	1.65	1.48	1.19	18	28
KS	2.15	2.10	1.93	1.73	1.39	25	35
KY	2.18	2.13	1.96	1.75	1.41	26	36
LA	2.16	2.11	1.94	1.74	1.40	25	36

	Initial private insurance-to-Medicare hospital fee ratio	Ratio at year 1	Ratio at year 5	Ratio at year 10	Ratio at year 20	Years to get to 1.25 ratio	Years to get to 1.0 ratio
ME	1.93	1.88	1.73	1.55	1.25	20	30
MD	1.36	1.33	1.22	1.10	1.00	4	14
MA	1.70	1.66	1.52	1.37	1.10	14	25
MI	2.04	2.00	1.83	1.64	1.32	23	33
MN	1.93	1.89	1.73	1.55	1.25	20	31
MS	2.12	2.08	1.90	1.71	1.37	25	35
MO	2.09	2.04	1.87	1.68	1.35	24	34
MT	1.98	1.93	1.77	1.59	1.28	21	32
NE	2.01	1.96	1.80	1.62	1.30	22	32
NV	2.89	2.83	2.59	2.33	1.87	39	49
NH	2.31	2.26	2.07	1.86	1.49	29	39
NJ	2.55	2.50	2.29	2.05	1.65	33	43
NM	2.36	2.31	2.12	1.90	1.53	30	40
NY	2.29	2.24	2.05	1.84	1.48	28	38
NC	2.38	2.33	2.14	1.92	1.54	30	40
ND	1.74	1.70	1.56	1.40	1.12	15	26
OH	2.27	2.22	2.04	1.83	1.47	28	38
OK	2.15	2.10	1.93	1.73	1.39	25	35
OR	1.98	1.94	1.78	1.60	1.28	22	32
PA	2.27	2.22	2.04	1.83	1.47	28	38
RI	2.17	2.13	1.95	1.75	1.41	26	36
SC	2.69	2.63	2.41	2.16	1.74	35	46
SD	1.80	1.77	1.62	1.45	1.17	17	27
TN	2.51	2.46	2.25	2.02	1.62	32	43
TX	2.92	2.86	2.62	2.35	1.89	39	50
UT	1.88	1.84	1.69	1.51	1.22	19	29
VT	2.51	2.45	2.25	2.02	1.62	32	43
VA	2.48	2.43	2.23	2.00	1.61	32	42
WA	2.32	2.27	2.08	1.86	1.50	29	39
WV	1.32	1.29	1.19	1.06	1.00	3	13
WI	2.35	2.30	2.11	1.89	1.52	29	40
WY	2.02	1.97	1.81	1.62	1.30	22	32

Sources: Urban Institute analysis of private insurance-to-Medicare hospital fee ratios presented in Linda Blumberg, John Holahan, Stacey McMorro, and Michael Simpson, *Estimating the Impact of a Public Option or Capping Provider Payment Rates* (Washington, DC: Urban Institute, 2020) and projected Medicare hospital fee growth rates from Stephen K. Heffler, Todd G. Caldis, Sheila D. Smith, and Gigi A. Cuckler, *The Long-Term Projection Assumptions for Medicare and Aggregate National Health Expenditures* (Baltimore: Centers for Medicare & Medicaid Services, Office of the Actuary, 2020).

Note: In scenario 1, Medicare rates increase by 2.2 percent per year, and private rates remain frozen at 2017–18 levels until a private insurance-to-Medicare hospital fee ratio of 1.25 or 1.0 is reached.

Scenario 2. In this scenario, private insurance hospital fees drop 2.0 percent per year while Medicare fees rise 2.2 percent per year. Under this approach, it would take an average of 16 years for the private insurance-to-Medicare hospital fee ratio to reach 1.25 nationally (table 2). Achieving a ratio of 1.0 would take 22 years.

Like in scenario 1, reaching the hospital payment goals in scenario 2 would take substantially different amounts of time for different states. In Florida, it would take 23 years to reach a private insurance-to-Medicare hospital fee ratio of 1.25 and 28 years to reach a ratio of 1.0. In contrast, it

would take only 2 years to achieve a private insurance-to-Medicare hospital fee ratio of 1.25 and 7 years to reach a ratio of 1.0 in West Virginia. Five states with the highest current private insurer hospital payment rates would need a phase-in period of at least 20 years to achieve a private insurance-to-Medicare hospital fee ratio of 1.25 (California, Colorado, Florida, Nevada, and Texas). Twenty-three states and the District of Columbia would need a phase-in period of 15 years or more to achieve a ratio of 1.25.

TABLE 2

Private Insurance-to-Medicare Hospital Fee Ratios and Number of Years to Achieve 1.25 and 1.0 Ratios, by State and Year, Assuming Medicare Fees Grow 2.2 Percent per Year and Private Fees Fall 2 Percent per Year

	Initial private insurance-to-Medicare hospital fee ratio	Ratio at year 1	Ratio at year 5	Ratio at year 10	Years to get to 1.25 ratio	Years to get to 1.0 ratio
US	2.45	2.35	1.98	1.61	16	22
AL	2.62	2.51	2.12	1.72	18	23
AK	2.22	2.13	1.80	1.46	14	19
AZ	2.46	2.36	1.99	1.62	17	22
AR	1.92	1.84	1.55	1.26	11	16
CA	2.83	2.72	2.30	1.86	20	25
CO	3.06	2.93	2.48	2.01	22	27
CT	2.23	2.14	1.81	1.47	14	20
DE	2.25	2.16	1.83	1.48	14	20
DC	2.36	2.26	1.91	1.55	16	21
FL	3.23	3.10	2.62	2.12	23	28
GA	2.53	2.43	2.05	1.66	17	23
HI	2.12	2.03	1.72	1.39	13	18
ID	2.08	2.00	1.69	1.37	13	18
IL	2.48	2.38	2.01	1.63	17	22
IN	2.34	2.24	1.90	1.54	15	21
IA	1.84	1.76	1.49	1.21	10	15
KS	2.15	2.06	1.74	1.41	13	19
KY	2.18	2.09	1.77	1.43	14	19
LA	2.16	2.07	1.75	1.42	13	19
ME	1.93	1.85	1.56	1.27	11	16
MD	1.36	1.31	1.10	1.00	2	8
MA	1.70	1.63	1.38	1.12	8	13
MI	2.04	1.96	1.66	1.34	12	17
MN	1.93	1.85	1.57	1.27	11	16
MS	2.12	2.03	1.72	1.39	13	18
MO	2.09	2.00	1.69	1.37	13	18
MT	1.98	1.90	1.60	1.30	11	17
NE	2.01	1.93	1.63	1.32	12	17
NV	2.89	2.77	2.34	1.90	20	26
NH	2.31	2.21	1.87	1.52	15	20
NJ	2.55	2.45	2.07	1.68	17	23
NM	2.36	2.27	1.92	1.55	16	21
NY	2.29	2.19	1.85	1.50	15	20
NC	2.38	2.29	1.93	1.57	16	21
ND	1.74	1.66	1.41	1.14	8	14

	Initial private insurance-to-Medicare hospital fee ratio	Ratio at year 1	Ratio at year 5	Ratio at year 10	Years to get to 1.25 ratio	Years to get to 1.0 ratio
OH	2.27	2.18	1.84	1.49	15	20
OK	2.15	2.06	1.74	1.41	13	19
OR	1.98	1.90	1.61	1.30	11	17
PA	2.27	2.18	1.84	1.49	15	20
RI	2.17	2.08	1.76	1.43	14	19
SC	2.69	2.58	2.18	1.77	19	24
SD	1.80	1.73	1.46	1.19	9	14
TN	2.51	2.41	2.03	1.65	17	22
TX	2.92	2.80	2.37	1.92	21	26
UT	1.88	1.80	1.52	1.24	10	15
VT	2.51	2.41	2.03	1.65	17	22
VA	2.48	2.38	2.01	1.63	17	22
WA	2.32	2.22	1.88	1.52	15	20
WV	1.32	1.27	1.07	1.00	2	7
WI	2.35	2.26	1.91	1.55	15	21
WY	2.02	1.93	1.63	1.32	12	17

Sources: Urban Institute analysis of private insurance-to-Medicare hospital fee ratios presented in Linda Blumberg, John Holahan, Stacey McMorro, and Michael Simpson, *Estimating the Impact of a Public Option or Capping Provider Payment Rates* (Washington, DC: Urban Institute, 2020) and projected Medicare hospital fee growth rates from Stephen K. Heffler, Todd G. Caldis, Sheila D. Smith, and Gigi A. Cuckler, *The Long-Term Projection Assumptions for Medicare and Aggregate National Health Expenditures* (Baltimore: Centers for Medicare & Medicaid Services, Office of the Actuary, 2020).

Note: In scenario 2, Medicare rates increase by 2.2 percent per year, and private rates fall by 2.0 percent per year until a private insurance-to-Medicare hospital fee ratio of 1.25 or 1.0 is reached.

Scenario 3. Under this scenario, we calculate the reductions in private insurance hospital fees needed to achieve a private insurance-to-Medicare hospital fee ratio of 1.25 or 1.0 in 10 years, assuming Medicare hospital fees maintain their average 2.2 percent annual increase. To reach a 1.25 ratio in 10 years, private insurers' hospital fees would need to fall an average of 4.4 percent per year (table 3). Reaching a ratio of 1.0 in 10 years would require private insurers' hospital fees to decrease by an average of 6.5 percent per year.

Private hospital fees in every state but Maryland and West Virginia would have to fall by between 0.9 percent (Massachusetts) and 7.1 percent per year (Florida) to reach a private insurance-to-Medicare hospital fee ratio of 1.25 in 10 years. In Maryland and West Virginia, where regulatory requirements keep private insurers' hospital fees reasonably close to Medicare's (Murray and Berenson 2015), average private insurance payment rates would reach 1.25 times Medicare rates in 10 years if private insurer hospital fees increase by no more than 1.3 percent and 1.6 percent per year, respectively. Overall, seven states would have to impose a fee reduction of 5.0 percent or more per year for private insurers to achieve a private insurance-to-Medicare hospital fee ratio of 1.25 in 10 years.

Even deeper cuts would be required to reach a private insurance-to-Medicare hospital fee ratio of 1.0 in 10 years. Private hospital fees would have to fall in all states, including in Maryland (0.9 percent per year) and West Virginia (0.6 percent per year). In Florida, the state with the highest private

insurance-to-Medicare hospital fee ratio in 2017–18, private hospital fees would have to fall 9.1 percent per year to achieve a 1.0 ratio in 10 years, assuming Medicare fees grow 2.2 percent per year, on average.

TABLE 3

Annual Private Insurance Rate Reduction Needed to Achieve Private Insurance-to-Medicare Hospital Fee Ratios of 1.0 and 1.25 in 10 Years, by State, Assuming Medicare Fees Grow 2.2 Percent per Year

	Initial private insurance-to-Medicare hospital fee ratio	Annual percent change in private rates needed to achieve 1.25 ratio in 10 years	Annual percent change in private rates needed to achieve 1.0 ratio in 10 years
US	2.45	-4.4	-6.5
AL	2.62	-5.1	-7.2
AK	2.22	-3.5	-5.6
AZ	2.46	-4.5	-6.6
AR	1.92	-2.1	-4.2
CA	2.83	-5.8	-7.9
CO	3.06	-6.6	-8.6
CT	2.23	-3.6	-5.7
DE	2.25	-3.7	-5.8
DC	2.36	-4.1	-6.2
FL	3.23	-7.1	-9.1
GA	2.53	-4.8	-6.9
HI	2.12	-3.1	-5.2
ID	2.08	-2.9	-5.0
IL	2.48	-4.6	-6.7
IN	2.34	-4.0	-6.1
IA	1.84	-1.7	-3.8
KS	2.15	-3.2	-5.3
KY	2.18	-3.3	-5.5
LA	2.16	-3.3	-5.4
ME	1.93	-2.1	-4.3
MD	1.36	1.3	-0.9
MA	1.70	-0.9	-3.1
MI	2.04	-2.7	-4.9
MN	1.93	-2.2	-4.3
MS	2.12	-3.1	-5.2
MO	2.09	-2.9	-5.0
MT	1.98	-2.4	-4.5
NE	2.01	-2.5	-4.7
NV	2.89	-6.0	-8.1
NH	2.31	-3.9	-6.0
NJ	2.55	-4.8	-6.9
NM	2.36	-4.1	-6.2
NY	2.29	-3.8	-5.9
NC	2.38	-4.2	-6.3
ND	1.74	-1.1	-3.3
OH	2.27	-3.7	-5.8
OK	2.15	-3.2	-5.3
OR	1.98	-2.4	-4.6
PA	2.27	-3.7	-5.9
RI	2.17	-3.3	-5.4
SC	2.69	-5.3	-7.4

	Initial private insurance– to-Medicare hospital fee ratio	Annual percent change in private rates needed to achieve 1.25 ratio in 10 years	Annual percent change in private rates needed to achieve 1.0 ratio in 10 years
SD	1.80	-1.5	-3.7
TN	2.51	-4.7	-6.8
TX	2.92	-6.1	-8.2
UT	1.88	-1.9	-4.0
VT	2.51	-4.7	-6.8
VA	2.48	-4.6	-6.7
WA	2.32	-3.9	-6.0
WV	1.32	1.6	-0.6
WI	2.35	-4.1	-6.2
WY	2.02	-2.6	-4.7

Sources: Urban Institute analysis of private insurance–to-Medicare hospital fee ratios presented in Linda Blumberg, John Holahan, Stacey McMorow, and Michael Simpson, *Estimating the Impact of a Public Option or Capping Provider Payment Rates* (Washington, DC: Urban Institute, 2020) and projected hospital fee growth rates from Stephen K. Heffler, Todd G. Caldis, Sheila D. Smith, and Gigi A. Cuckler, *The Long-Term Projection Assumptions for Medicare and Aggregate National Health Expenditures* (Baltimore: Centers for Medicare & Medicaid Services, Office of the Actuary, 2020).

Note: In scenario 3, Medicare rates increase by 2.2 percent per year, and private rates rise or fall as needed to achieve a private insurance–to-Medicare hospital fee ratio of 1.25 or 1.0 in 10 years.

Discussion

In 2019, \$0.31 of every health care dollar were spent on hospital services.⁴ Reducing hospital payment rates would decrease premiums in the affected markets and save the federal government money by lowering premium tax credits in the nongroup market and/or lowering the tax subsidy for employer-based insurance premiums (Blumberg et al. 2020; Holahan and Simpson 2021a). Caps on payments or new payment rates set significantly below private insurers' current payment levels should be phased in to prevent substantial disruptions to the delivery system. This is especially important when a large segment of the privately insured population is affected by a reform, as would be the case under Medicare for All or reforms in the employer-based market. Smaller reforms, like a public option available only in the nongroup market or reforms that primarily affect the uninsured, would have a smaller effect on the hospital market and could be phased in more quickly.

Phasing in reductions so hospital payment rates reach no more than 125 percent of Medicare's rates would take many years. Trying to achieve this payment rate ratio in 10 years would require an average national reduction in hospital payments of 4.4 percent per year. Such a reduction is likely unachievable without significant disruptions in care. Only Maryland and West Virginia, which both already regulate private insurers' hospital payments (Heffler et al. 2020), could reach these payment rates with little disruption in hospital markets and access to care. CBO expects private hospital fees to grow 4.2 percent per year between 2020 and 2030 under current law (CBO 2021), making the distance between the current status quo and an annual 4.4 percent reduction in fees even larger.

Hospital fee reductions would not have the same effects for every state, locality, or hospital. In 2017–18, private insurers paid hospitals 2.4 times Medicare rates, but that ratio varied widely across states and localities (Blumberg et al. 2020). This variation was larger for outpatient hospital services

than inpatient hospital services, suggesting hospitals providing more outpatient services could face steeper payment reductions. Additionally, hospital fee reductions could hit rural hospitals particularly hard.

Policymakers could blunt the effects of hospital payment reductions on rural areas by establishing separate payment rates for them (Holahan and Simpson 2021b). Though these policies would help bolster hospital revenues and help maintain the current supply of care, they would also lower the potential savings in rural areas and lower potential savings for the federal government from more significant health care reforms, like rate caps, a public option, or Medicare for All.

This analysis has important implications for proposed public option programs and Medicare for All, both of which would use Medicare fees as a benchmark for setting hospital payment rates (CBO 2020, 2021). If, for example, a Medicare for All policy used a long phase-in to reach Medicare payment levels nationwide while avoiding disruptions in health care delivery, the approach would reduce potential federal and private savings over the phase-in period relative to some expectations (CBO 2020).

Reducing hospital fees could also increase demand for inpatient and outpatient hospital services, lowering net savings and potentially creating bottlenecks in access to care. More research is needed to determine the likely effect of induced demand on savings from and access to care under capped hospital payment rates, a broadly available public option, or Medicare for All.

Notes

- ¹ Rabah Kamal, Daniel McDermott, Giorlando Ramirez, and Cynthia Cox, “How Has U.S. Spending on Healthcare Changed Over Time?” Peterson-KFF Health System Tracker, December 23, 2020, https://www.healthsystemtracker.org/chart-collection/u-s-spending-healthcare-changed-time/#item-usspendingovertime_7.
- ² Medicare for All Act of 2021, H.R. ___, 117th Cong. 1st Sess. (2021).
- ³ For example, proposals like Medicare for All or a broadly available public option seek to expand insurance coverage while lowering the costs of care.
- ⁴ Kamal, McDermott, Ramirez, and Cox, “How Has U.S. Spending on Healthcare Changed Over Time?” Peterson-KFF Health System Tracker.

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