

## HEALTHCARE

# MEDICARE EXPANSION: A PRELIMINARY ANALYSIS OF HOSPITAL FINANCIAL IMPACTS

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Though the 2020 Presidential election is still 20 months distant, it seems likely that the expansion of the 60 million-person Medicare program may be the pivot point of health policy debate. This paper takes a cautious first look at the impact of various Medicare expansion scenarios on the finances of a hypothetical medium sized multi-hospital system. The extent of Medicare expansion directly correlates to financial stress on hospitals and will place a premium on their having coherent revenue and expense control strategies.

The last major health insurance coverage expansion, the 2010 Affordable Care Act (ACA), used two main mechanisms to increase health coverage: Medicaid and commercial insurance. Both were fraught. Medicaid expansion was left to state option by the 2012 Supreme Court decision. The health exchange experiment proved both technically complex and fragile, and fell far short of enrollment expectations.

Medicare expansion, on the other hand, relies on a popular national program with a largely settled payment methodology. Unlike Medicaid, it does not rely upon the voluntary collaboration of 50 state governors and legislatures. Unlike private insurance, whose competitive structure and costs vary dramatically between communities, Medicare has a uniform and predictable cost profile.

Because Medicare pays providers considerably less than commercial insurance does, the “savings” from relying on Medicare rates reduces the cost of a coverage expansion. These lower payment rates, however, are a major concern of the hospital community, as they markedly reduce hospital revenues and disrupt the delicate balance of cross-subsidization between higher commercial rates and lower government rates.

## SCENARIO AND ASSUMPTIONS OVERVIEW

Below, we evaluate the impact of three different policy scenarios, each with two variations, on a hypothetical medium-sized health system (Table I). The three policy scenarios are: 1.) Voluntary Medicare buy in after age 50; 2.) Medicare as a public option; and 3.) Medicare as a single-payer (excluding Medicaid). As can be seen from Table I, the two latter scenarios each have a pair of Medicare payment rate assumptions.



We have simulated the impact of these Medicare expansion scenarios of the financial performance of a hypothetical, medium-sized, regional, non-profit multi-hospital system, "Excelsior Health System." Excelsior operates 1,000 beds across five hospitals, has annual combined patient revenues of about \$1.2 billion, and a current operating margin of 2.3%. Its commercial insurance contracts pay about 200% of Medicare rates, and represent approximately 25% of patient volume by charges.

**Table I: Medicare Expansion Scenarios**

Scenario	Status Quo	SCENARIO 1 VARIATIONS		SCENARIO 2 VARIATIONS		SCENARIO 3 VARIATIONS	
		1A: Voluntary Buy-in 50+	1B: Voluntary Buy-in with Employer Choice	2A: Public Option 100% MCR	2B: Public Option @ 110% MCR	3A: Medicare as Single Payer	3B: Medicare as Single Payer @ 120% MCR
Age-In	Age 65	Age 50+	Age 50+	All Lives	All Lives	All Lives	All Lives
Employer Leakage	None	None via Penalty (e.g., tax)	Choice between employer vs MCR	Choice between employer vs MCR	Choice between employer vs MCR	Single Payer	Single Payer
Medicare Payment Relief	None	None	None	None	Payments at 110% MCR	None	Payments at 120% MCR
Revenue Cycle Management	0%	0%	0%	1.5% Reduction	1.5% Reduction	2.5% Reduction	2.5% Reduction
DSH Payment Reduction	None	15% of current Medicare & Medicaid DSH Payments		70% of current Medicare & Medicaid DSH Payments		100% of current Medicare & Medicaid DSH Payments	
Enrollment	Continued margin deterioration due to payer mix shifts and other impacts	85% shift of >50 individual to MCR 70% shift of >50 uninsured to MCR 0% Employer shift to MCR	85% shift of >50 individual to MCR 70% shift of >50 uninsured to MCR 50% Employer shift to MCR	50% shift of all employer sponsored to MCR (all ages) 85% shift of >50 individual to MCR 70% shift of all uninsured to MCR		100% Mandatory Enrollment of all Commercial, Uninsured, Lives	

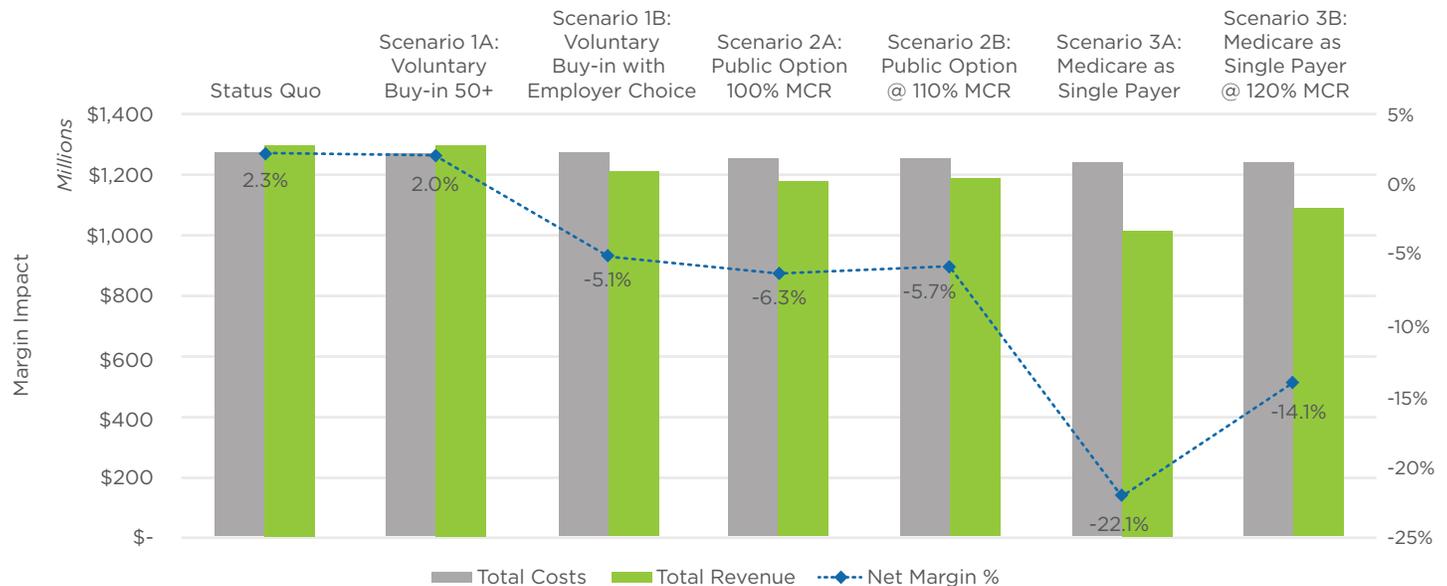
Because all these scenarios reduce the number of uninsured, we have assumed that Medicare disproportionate share payments (DSH) would be reduced in proportion to the reductions in uninsured in all six scenarios. We also assumed that the public option and single-payer scenarios modestly reduced the complexity and cost of Excelsior's revenue cycle functions and administrative expenses accordingly.

We left alone the complexities associated with Medicare Advantage, which presently enrolls about a third of Medicare's current beneficiaries. That is, we have assumed all the care for new beneficiaries will be paid for based on the regular Medicare fee/rate schedule. We also held Medicaid populations and payment levels constant in this policy simulation.

## MEDICARE EXPANSION REDUCES HOSPITAL REVENUES AND MARGINS

As noted in Table II, the effects of these scenarios on Excelsior vary dramatically. These scenarios are “single treatments,” where the complete impact is shown in a single year, rather than phased in over a period of years.

**Table II: Excelsior Health System Medicare Expansion Financial Impact**



### Scenario 1A and 1B: Voluntary Buy-In 50+

In Scenario 1A, the voluntary Medicare buy-in for age 50+ policy limits enrollment to the 50+ uninsured and present healthcare exchange populations. Within this scenario, the effect on Excelsior’s finances is negligible. Self-pay patient write-offs are reduced but offset by a reduction in payments for a portion of the exchange-eligible population as they shift from exchange plans (i.e., commercial) to Medicare rates. These shifts result in a \$9.6 million reduction in revenues, leaving the system with a 2% positive operating margin. This policy scenario would require mechanisms to ensure that the 50+ employer-insured population do not shift over to Medicare plans (i.e., barriers to leakage).

Scenario 1B is the “leaky” version of the prior scenario, resulting from no barriers to employers shifting their employees to Medicare. In this scenario, we have assumed an estimated 50% of employed 50+ workers shift to Medicare. This leakage reduces Excelsior’s revenues by \$97 million and moves Excelsior’s operating margin from +2.3% to -5.1%. The mechanisms that determine the difference between leaky and leak-proof “Medicare for more” scenarios may become a crucial factor in the intensity of hospital industry concerns about the policy.

### Scenario 2A and 2B: Public Option

In the public option scenarios 2A and 2B, the negative margin impacts on Excelsior are larger. In Scenario 2A, given our enrollment assumptions and holding Medicare rates at current levels (i.e., 100% Medicare rate), hospital revenues drop approximately \$153 million and margins are reduced to a -6.3%. If, however, Congress raised Medicare’s present hospital payment rates by about 10% (i.e., 110% current Medicare rates), hospital revenues drop “only” approximately \$97 million, with a new margin of -5.7%.

### Scenario 3A and 3B: Single-Payer

The effects of the Medicare as a single-payer scenario are, predictably, much more dramatic. Scenario 3A eviscerates Excelsior’s operating margins, reducing revenues by approximately \$330 million and leaving a new margin of -22%. Under scenario 3B where, for political reasons, Medicare enhances payment to 120% of the current Medicare rates, Excelsior loses “only” about \$158 million in revenue, resulting in a new margin of -14%.

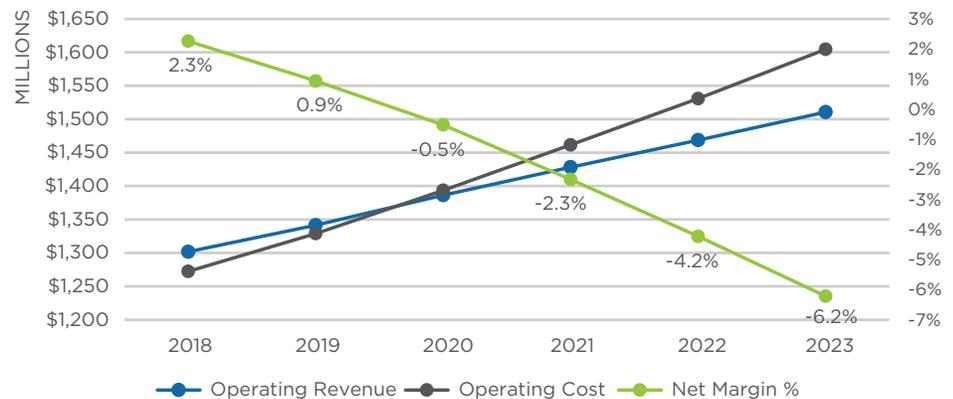


## CONTINUATION OF THE STATUS QUO DOES NOT LEAVE HOSPITALS UNHARMED

It is worth noting that if Congress does nothing about Medicare expansion after 2020, the continued migration of baby boom vintage older people from employer-based coverage onto Medicare, along with other contributing factors, has a financial impact comparable to the more adverse Medicare buy in scenario. Spread out over a period of years, this would result in a reduction of \$94 million in operating margin.

**Table III: Excelsior Status Quo Medicare Margin Impact**

5-Year Status Quo Projections Without Cost Reduction Initiatives



In 2016, the latest year for which we have data, hospitals lost almost \$50 billion treating Medicare patients because of the disparity between the delivered cost of care and Medicare’s current payment rates.<sup>1</sup>

Hospitals’ present losses in treating Medicare patients accelerate dramatically under Medicare expansion. A hospital’s current Medicare cost coverage (e.g., loss) ratios are a direct indicator of a hospital’s political vulnerability to a major coverage expansion, as described above.

Even if Congress declines to expand Medicare in the post-2020 policy cycle, hospitals will have to manage the delivered cost of serving Medicare patients more effectively or face ruinous out year financial losses.<sup>2</sup> In other words, Medicare expansion heightens the need for a coherent management response to Medicare payment rates.

Responsible payment for care to Medicare beneficiaries is the fiscal obligation of the program. Medicare’s purpose is not sustaining the hospital (or insurance) industry, but rather balancing the needs of Medicare beneficiaries against the federal government’s fiscal capacity.

Many of the claimed savings of the most ambitious Medicare expansion scenarios — Medicare as the single payer — rely upon the presumed political feasibility of sunseting a \$1 trillion industry (health insurance) and dramatically reducing the income of another \$1 trillion industry (hospitals).

1. <https://www.aha.org/system/files/2018-07/2018-aha-chartbook.pdf>

2. <https://hbr.org/2017/11/5-ways-u-s-hospitals-can-respond-to-medicare-mounting-costs>

## HOW WOULD HOSPITALS RESPOND TO MEDICARE EXPANSION?

In scenarios that leave private insurance plans on the field, one can presume that hospitals would attempt to shift as much of the cost of the lost revenues onto private insurers as possible (through cost shifting). This is obviously a major business risk for health insurers, which would likely respond by doubling down on strategies that tier or narrow their hospital networks, and by offering patients enhanced incentives to reduce hospital use.

It is worth noting that there is little evidence of major cost shifting after the ACA coverage expansion. If hospitals had been successful in shifting the ACA Medicare rate reductions (and those of the 2012 sequester) onto private insurance plans, hospital margins would not have plummeted as they did from 2015 to 2017.<sup>3</sup>

To the extent that hospitals' cost shifting was not able to mitigate the effect of Medicare payment shortfalls, the only management recourse would be non-incremental cost reduction, about which we have written elsewhere.<sup>4</sup> This includes reducing not only FTE employment but also the salaries of clinical and management personnel, as well as dramatic reductions in contracted services outlays, such as outsourcing and clinical staffing firms and technology and pharmaceutical suppliers, to reduce their rates and perhaps also the scope of their contracts. Ripple effects would expand the circle of layoffs into the broader community and economy.

In addition, hospitals would necessarily reduce duplicative clinical services in neighboring facilities and collaborate with their clinicians in rigorously examining care patterns for Medicare beneficiaries, reducing needless variation and care defects which result in avoidable hospital expense.

Depending on the policy course chosen, Medicare expansion could also compromise hospital access to capital and potentially force the closure of essential hospitals. Ratings agencies would almost certainly react to the uncertainties created by Medicare expansion by downgrading much existing hospital tax-exempt debt. Debt markets would likely demand higher rates (e.g. cost of capital) for those systems fortunate enough to be able to continue borrowing in tax exempt markets.

How much cost reduction is actually achievable will determine the actual level of harm to the hospital industry, as well as the political challenges of achieving expansion. Unfortunately, this capacity to reduce/manage cost will vary markedly from system to system and hospital to hospital, meaning that saving themselves may be beyond the capability of many hospitals and systems.

Some of the most dramatic expansion scenarios, such as Medicare as a single-payer, appear to have financial effects that exceed the capacity of hospital managements to reduce their expenses. Under all but the leak-proof Medicare buy in scenario, increased Medicare enrollment would pose major challenges to health system management and boards.

3. <https://www.modernhealthcare.com/article/20180912/TRANSFORMATION02/180919977/health-systems-scale-not-linked-to-higher-revenue>

4. <https://hbr.org/2018/11/health-systems-need-to-completely-reassess-how-they-manage-costs>



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