Research Briefs
IN ECONOMIC POLICY

CATO INSTITUTE

February 24, 2021 | Number 252

How Would Medicare for All Affect Health System Capacity?

Evidence from Medicare for Some

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Investments in a health system's capacity determine the amount of care it can provide. Countries and regions that have invested in more physicians and more hospital beds provide more care, and more intensive treatments, to their residents. While this marginal care may not always be efficient, the COVID-19 pandemic reveals some important benefits from having these investments in place, even if capacity may be excessive under normal conditions. To have capacity in place when it is needed, the health system's incentives must be conducive to forward-looking investments during ordinary times. So as policymakers consider proposals such as Medicare for All, it is critical for them to consider what incentives such systems would create for these investments.

At prevailing private-sector prices, government insurance for all 330 million Americans would likely be unaffordable. To achieve affordability, proposals for a national Medicare for All insurance scheme have thus assumed significant reductions in payment rates to health care providers. Economist Charles Blahous estimates that provider payments would fall by 40 percent, or $384 billion per year, under the version of Medicare for All proposed by Sen. Bernie Sanders (I-VT). Kevin A. Schulman and Arnold Milstein suggest that such cuts would bring payment rates below hospitals' current costs, requiring them to make major operational changes to reduce their costs and remain solvent.

Lowering payments would undoubtedly save money in the short term. But what would it do to physicians' incentives to invest for the long term? Knowing that they face lower payment rates, would physicians reduce investments in their practices and hence in the health system's capacity? Existing evidence from the hospital and pharmaceutical industries suggests that payment rules influence investments in physical capital and innovation. But the health sector is intensive in labor and human capital. Physicians' investments in their human capital and entrepreneurial capital may be as consequential as traditional investments for how the market evolves. We study how a change in the level of government payments to physicians—such as that which Medicare for All would entail—influences these critical investment outcomes. Existing research on physicians' responses to payment rates focuses on the number of services they provide and the time they spend treating patients. There is extensive, controversial literature arguing for backward-bending labor supply—when payment rates are cut, the supply of physician care supposedly expands. More-recent work tends to find standard upward-sloping responses.

We argue that both of these views miss an important element of physicians' decisions: how much to invest in future productivity. As the literature on human capital theory has long understood, overall work effort includes both revenue-generating activities and investments in human

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capital, which influence future productivity. These activities are as important among physicians as they are elsewhere in the economy and provide a natural channel by which government policy can influence the long-run supply of medical treatments.

We exploit data that divide physicians' overall working time into patient care hours, which generate revenues, and time spent on other medical activities. These other activities include the recruitment of new patients, investments in physicians' professional networks, and investments in continuing education, such as studying to maintain board certification. Some of these investments augment a physician's human capital while others build managerial capacity. Both set the stage for increases in care provision over longer time horizons and increase a physician's future earnings potential. We examine how such investments and labor supply vary over a physician's career and in response to government-induced price shocks.

The Medicare policy shock we employ changed the price of physicians' output (that is, the care they provide) differentially across specialties. We find that a substantial reduction in reimbursements led physicians in adversely affected specialties to reduce their investment activities. They allocate fewer hours to nonreimbursable activities and become less willing to accept new patients.

Notably, the decline in physicians' willingness to accept new patients is larger for Medicaid patients than for Medicare patients. This suggests that changes in capacity can significantly impact patients whose own payments may not change. At baseline, Medicaid is a less attractive payer than Medicare: it offers physicians lower rates and requires more cumbersome paperwork, so physicians are less likely to treat Medicaid beneficiaries. If physicians prefer to treat patients with Medicare or private insurance, Medicaid patients may be the residual claimants on excess capacity—this could relax otherwise binding capacity constraints and increase access to care for Medicaid patients, even when an expansion is driven by Medicare rates.

Our results are consistent and complementary with existing evidence on investments in physical capacity. The literature finds that both hospitals' and physicians' capital investments respond positively to payment rates, consistent with standard profit maximization. For instance, hospitals increase capital intensity and invest in new technologies when it is profitable to do so. In the physician context, the overall level of Medicare payments influences physicians' treatment intensity and technology choices. We find the same for physicians' investments in their careers. If these investments increase provider capacity in the future, overall health care supply responses can be very different in the short run and long run. Policy decisions based exclusively on the short-run responses would miss a crucial part of the impacts of those policy decisions.

Physician behavior has broad implications for government spending and overall economic performance. In 2016, the United States spent $725 billion, or 3.5 percent of gross domestic product, on physician care and similar medical services alone. Recurrent concerns about physician shortages highlight the need to understand doctors' investments. Our analysis suggests that some aspects of physicians' investments in their careers may be quite responsive to government payment policies. While we are able to examine some important margins, others remain underexplored. More research is needed to understand how physicians choose their specialties, their locations, the structure of their practices, and the form of their human capital investments.

NOTE:

This research brief is based on Jeffrey Clemens, Joshua D. Gottlieb, and Jeffrey Hicks, "How Would Medicare for All Affect Health System Capacity? Evidence from Medicare for Some," NBER Working Paper no. 28062, November 2020, http://doi.org/10.3386/w28062.

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