The United States health care system is under tremendous clinical pressure from the Covid-19 pandemic. Less appreciated is that it is also under tremendous financial pressure. Social distancing and other epidemic control strategies are cancelling all elective inpatient and outpatient surgical procedures, as well as all elective physician visits. Telemedicine is replacing some of the latter, but clinical volumes nationally have still plummeted, and revenue has also plummeted accordingly. Many hospitals lack a financial cushion. Ambulatory practices have significant fixed expenses and no access to capital and other sources of liquidity. Provider bankruptcies or closures are likely. Shuttered hospitals and physician offices could decrease the capacity to provide care during and after the pandemic. Smaller independent practices and hospitals may be acquired, accelerating consolidation of the health care system and making it harder to contain rising health care costs. While the federal government has taken some steps to support providers financially, these won’t in themselves be enough to forestall a serious collapse of the health care system. Private insurers need to adopt and expand on some of the policies that Medicare has already introduced, including offering advanced payments for practices to stay afloat. The actions taken in the coming weeks will impact the solvency of the system for years to come.
To address the threat of Covid-19, health care organizations have followed a similar playbook; elective procedures, ranging from inpatient and outpatient surgery and procedures for orthopedic ailments to colonoscopies for colon cancer screening, have been cancelled, as have virtually all elective outpatient visits to primary care and other physicians.1 These actions free up inpatient bed capacity, equipment, and health care providers and also decrease the risk of spread of the virus. Telemedicine, in the form of video and phone visits, is replacing some of the outpatient visits, but clinical volumes nationally have still plummeted.

As reported by the Office of the Inspector General, together these changes have resulted in a dramatic drop in revenue to hospitals.1,2 Many have had to invest significant resources in opening and staffing new areas for screening and treatment of potentially infected patients, and in obtaining personal protective equipment in unprecedented quantities. The intensity of care required for treating Covid-19 patients and maintaining isolation has strained both labor and supply costs. Hospitals must pay increased overtime as they cope with a shortage of qualified nurses, and some must cover costs for providing childcare and transportation.

Sources of Revenue Drain

How can revenue be dropping with so many sick patients? It depends on the case mix and type of care being provided, and hospitals and ambulatory practices face different challenges.

Hospitals have cancelled almost all elective procedures and outpatient visits, which include the highest margin services such as orthopedic, cardiac, and neurosurgical procedures. Although surgical admissions account for just over a quarter of hospital admissions, they account for almost half of hospital revenue.3 Moreover, since many surgical costs are fixed (e.g., operating rooms and equipment), cancelling surgeries has little impact on reducing the overall cost of running the hospital.

“The actions taken in the coming weeks will impact the solvency of the health care system for years to come.”

In the coming weeks, Covid-19 will lead to increased hospital admissions and critically ill patients will require extensive ICU time, with many requiring extended mechanical ventilator support. However, payments for patients with pneumonia or sepsis with long ICU stays are unlikely to cover the costs of those stays or make up for additional lost revenue, even with a planned boost to Covid-19 hospital payments from Medicare. Payments for diagnoses like pneumonia or respiratory failure are fixed for each hospitalization and based on a pre-Covid-19 estimate of resource use, which could be inaccurate in the current pandemic. Many, though not all, hospitals lack a financial cushion as hospital margins overall have been falling and almost a third of hospitals nationally already had negative operating margins.4

Ambulatory practices have also delayed nonurgent visits such as annual physicals and moved as many visits as possible to telemedicine in the form of telephone or video visits. Even in practices
that have managed to pivot quickly, total visit volumes through any medium are down. And despite dramatic expansions in telehealth capacity in just the last few weeks, reimbursement for telehealth visits remains lower than for office visits. Many payers and practices are still navigating how to provide or bill such visits.

Procedure-based specialty practices face even larger challenges. Specialties such as orthopedic surgery, ophthalmology, and gastroenterology make the majority of their revenue from procedures, and elective procedure volumes have come to a full halt. Many of these practices also operate ambulatory surgery centers. These are lucrative when operating but like hospital operating rooms they have high fixed costs. Ambulatory practices have significant fixed expenses (e.g., rent and personnel) and, in contrast to hospitals, lack access to capital and other sources of liquidity to maintain their operations in the face of this large drop in revenue.

**Financial Fallout**

We are already seeing the impact. Hospital financial reserves are depleted, and hospitals have already taken drastic steps like layoffs and reducing salaries. Ambulatory practices are already exploring options such as closing down. There are accumulating reports of large-scale layoffs or furloughs, and bankruptcies or closures are likely to follow. In the past weeks, the U.S. Department of Labor has reported millions of new unemployment insurance claims with the health care industry cited as a heavy contributor.5

> Federal emergency funds appropriated so far are unlikely to be enough to forestall a serious collapse of the health care system.

There are substantial negative consequences of this financial stress. First, shuttered hospitals and physician offices could decrease the capacity to provide care during and after the pandemic. In the aftermath of Covid-19, there will be significant pent-up demand for health care services, and a significant loss of providers could reduce the system’s capacity to the point where it is impossible to catch up on the accumulation of deferred care while also meeting ongoing demand.

Second, this financial stress will affect smaller independent practices and hospitals first, further accelerating consolidation of the health care system and potentially representing a death knell to independent private practices.6 The challenges of rising health care costs and market power will still be with us after Covid-19 has passed, and further consolidation will make costs even harder to restrain.

Third, ambulatory practices and hospitals in rural and underserved areas will likely face the greatest financial strain. These areas faced significant access problems prior to Covid-19, and a further shock of layoffs and closures could exacerbate an already vexing public health and policy challenge.
The Federal Response

To its credit, the federal government has responded to the health care system’s financial peril in many ways. The Centers for Medicare and Medicaid Services (CMS) has made a series of regulatory changes to expand the use of telemedicine, such as releasing the requirement for patients to be rural residents for reimbursement and encouraging any form of telemedicine visits, including telephone, regardless of data privacy compliance.

Moreover, the CARES Act included $100 billion in emergency funds to hospitals to help counteract lost revenue related to Covid-19 such as from canceled elective procedures: a 20% bump in payments for any inpatient admission with Covid-19, a 50% payroll tax cut, and the ability to receive 6 months of Medicare payments as an advance lump sum. CMS also announced that as part of the CARES Act, physicians who have billed Medicare in the past 6 months can also apply for a 3-month advance payment. Finally, smaller practices can obtain loans through the new $350 billion Paycheck Protection Program for small businesses.

“Private insurers should adopt and expand on some of the policies that Medicare has already put in place.”

Unfortunately, these steps are unlikely to be enough to forestall a serious collapse of the health care system. While $100 billion is an impressive sum, it is less than 5% of the $2.2 trillion in national health expenditures paid to hospitals and physicians in 2018. More stimulus payments are likely to come to hospitals, but with elective procedures canceled, outpatients stuck at home, and hospital costs soaring, the shortfall will almost certainly be much greater, particularly if current distancing actions are extended for months. The effect of distancing measures could persist for even longer if patients remain wary of returning to health care settings.

What else can be done? The federal government’s first steps are a helpful guide, but only a start. Medicare is a large payer but accounts for only about 20% of health care spending nationally. Private insurers need to step up to the plate. At least in the short term, private insurers could easily see lower expenses given the precipitous drop in claims filed for non-Covid-19 related care. Covid-19-related care will spike, of course, but it is unlikely to exceed the enormous costs incurred every month in routine health care.

Private insurers should adopt and expand on some of the policies that Medicare has already put in place, including offering advanced payments for practices to stay afloat. Advanced payments could function essentially as capitated budgets for practices and hospitals. For the near future, payments could be fixed at a certain percentage of historical spending to keep practices financially viable and prevent massive layoffs. As we assess the financial impact of Covid-19 in the coming months, it may be that such payments should not be deducted from future revenue, in essence providing a subsidy to practices. This is because a substantial fraction of care that has been “deferred” may never happen in the future, depressing revenue for many months to come.
It is becoming a cliché to say we are living through an unprecedented challenge, but it’s hard to describe the looming threat to the U.S. health care system in any other way. Unlike other developed countries, our health care system is not nationalized and cannot rely on the stability of the government to cushion the blow. The actions taken in the coming weeks will impact the solvency of the system for the years to come.

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