The Negative Economic Effects of Medicare Buy-In and Public Option Proposals

BY ALEX BRILL

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INTRODUCTION

Democratic lawmakers and candidates for political office recently have expressed a renewed interest in enlarging government healthcare programs. The specifics of each plan differ, but all proposals would significantly alter the existing healthcare landscape by expanding the share of the population covered by public payors and increasing the government's fiscal responsibility, influence, and control over the healthcare sector.

These efforts may intensify in the coming months, given the possibility of a change in political control after the November elections and the large number of workers losing jobs and employer-sponsored health insurance during the current coronavirus pandemic. It is vital that policymakers and those affected by such a policy change understand the far-reaching adverse consequences of these proposals. This paper discusses recent proposals to expand Medicare or offer a public option and lays out the likely impact such a move would have on various stakeholders.

MEDICARE BUY-IN AND PUBLIC OPTION PROPOSALS

Proposals to expand Medicare or offer a public option were a fixture of Democratic presidential candidates' platforms and have been popular in the 116th Congress. No fewer than 10 bills proposing some kind of public option were introduced in the House and Senate last year (*KFF, 2019*), and presidential candidates associated themselves with various (sometimes multiple) versions of expanded government healthcare programs.

Congressional proposals range from creating single-payer coverage for all U.S. residents – put forward by Senator Bernie Sanders (I-VT) and Representative Pramila Jayapal (D-WA) – to allowing Americans aged 50–64 to "buy in" to Medicare – proposed by Senator Debbie Stabenow (D-MI) and Representative Brian Higgins (D-NY). Other proposals would add a public option to the health insurance marketplace established in the Affordable Care Act (ACA).

While a shift to a single-payer system like Senator Sanders and Representative Jayapal have proposed would be the most disruptive to the U.S. healthcare system, it is the least likely to be adopted. But Medicare buy-in for older individuals and the creation of a public option have gained more traction. Presumptive Democratic presidential nominee Joe Biden has backed a public option for all ages through the ACA marketplace, and the Biden-Sanders Unity Task Force (*2020*) recently recommended that Medicare should be available to Americans beginning at age 60.

Much has been written about the staggering cost and substantial negative impacts of Medicare for All. Less well understood are the negative effects of Medicare buy-in and public option proposals.

Current Role of Medicare in U.S. Healthcare

The Medicare program is the largest single purchaser of healthcare in the United States, spending roughly $700 billion in 2018. This spending represented 3.6 percent of gross domestic product (GDP), while private health insurance spending totaled 6 percent of GDP (*MedPAC, 2020*). According to the Medicare Trustees Report (*2020*), without any expansion of the program, Medicare spending is predicted to grow to 6 percent of GDP by 2045.

Medicare, Medicaid, and the Children's Health Insurance Program cover 42 percent of hospital reimbursement, 35 percent of physician office payments, and 43 percent of retail prescription drug spending (*MedPAC, 2020*).

STAKEHOLDER IMPACT

Like any policy change, Medicare buy-in or a public option would create winners and losers by shifting the burden of paying for the healthcare of more Americans to the government. Proponents claim savings from their proposals, but taxpayers will have to pay for an expansion of Medicare, and promised savings have to come from somewhere. In short, such a policy change would negatively affect more people than is commonly understood, and these proposals should be concerning to a range of stakeholders, including workers, employers, healthcare providers, consumers, and taxpayers.

Impact on Workers and Employers

One promise often made by advocates for Medicare buy-in or a public option is that workers will receive higher wages if employers are not paying for their health insurance. The logic is appealing, as current health insurance benefits have been shown to reduce workers' wages. However, wages will not rise a commensurate amount for all workers. Health economist Austin Frakt answers the question of whether wages will rise thus:

> Research suggests the answer is "yes," with the caveat that it may not be matched dollar for dollar for everyone. The precise relationship depends on the nature of the labor market, which varies across markets and jobs. (*Frakt, 2020*)

In today's workforce, wages are generally equal for similar workers in the firm regardless of whether an individual worker enrolls in the company's health plan or opts for their spouse's coverage or another option. If, for example, workers aged 60 are switched from employer-provided insurance to Medicare, wage adjustments cannot easily be confined to this segment of the workforce.

STAKEHOLDERS AFFECTED BY MEDICARE EXPANSION

WORKERS & EMPLOYERS

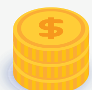
Savings for employers and wage increases for workers could be less than employers' healthcare costs, and workers or employers would likely need to pay for supplemental insurance

HEALTHCARE PROVIDERS

Healthcare providers will be negatively impacted because Medicare pays significantly less than private insurance does

CONSUMERS

The number of uninsured individuals would decrease only 0.2%, while premiums would increase 2–10% for people who remain in the individual market



TAXPAYERS

Expanding Medicare would cost taxpayers trillions of dollars

Even if gross wages do rise if the cost of workers' healthcare is covered by the government, after-tax wages will generally increase significantly less (*Gleckman, 2019a*). This result is due to the differential in tax treatment between wages (subject to income and payroll taxes) and employer-provided health insurance (excluded from tax).

Some employers support expanding Medicare because it possibly could free them from the cost of providing health insurance to employees. In a survey conducted by the Business Group on Health, more than half of businesses supported Medicare buy-in, though they differed on the minimum age for inclusion (*Japsen, 2019*). However, to the extent that workers' earnings rise, the savings that businesses achieve from lower healthcare costs will evaporate. In other words, shifting the cost of health insurance from employers to the government cannot accrue benefit fully to both employers and employees. Moreover, some proposals have included an employer tax to provide a funding source for Medicare expansion, which could negate cost savings for employers and wage increases for workers (*Gleckman, 2019b*).

Perhaps an even greater concern is that Medicare buy-in may not cover as much as private insurance. As Avalere Health (*2016*) has pointed out, there is no out-of-pocket cap in Medicare as there is in private insurance; for Medicare Part B, which covers hospital expenses, beneficiaries are responsible for 20 percent of costs; and Medicare Part D, which covers prescription drugs, could be less generous than other insurance options. Medicare buy-in, therefore, could leave workers with high out-of-pocket costs or the need to purchase supplemental insurance. To the extent that employers need or want to cover these additional costs, employers could be worse off than they were with these workers on the company's health insurance plan.

Finally, employers eager to move workers onto Medicare rolls should recognize the significance that health insurance holds for many people as an employment benefit. In a 2018 employee benefits survey, 55 percent of people named health insurance as "the most important benefit in terms of their job satisfaction" (*Ballou, 2018*). Perceived eagerness by employers to push workers off of employer-sponsored insurance could negatively affect employee morale.

Impact on Healthcare Providers

Proponents of expanding Medicare frequently point to the cost savings of such a shift due to the significant price differential between healthcare provided by Medicare and healthcare covered by private payers. The Congressional Budget Office (CBO) has observed that private insurers pay much higher prices than Medicare does (*Pelech, 2017*). Medicare pays hospitals 59 percent less, on average, than private insurance pays hospitals (*Ippolito and Pope, 2020*). With more people covered by Medicare, providers will see more patients covered by a public program with far lower reimbursement rates. These reductions in reimbursement will likely have consequences for workers in hospitals and across all provider settings, many of whom are not highly paid doctors and hospital administrators. For example, registered nurses comprise 30 percent of all hospital employment, and hospital support staff (nurses' assistants, administrative support staff, and janitorial staff) earn, on average, less than $37,000 per year (*BLS, 2019*). Savings achieved by expanding Medicare would come, at least in part, out of the pockets of these workers.

Impact on Consumers

One rationale for expanding Medicare is to reduce the number of uninsured individuals, but Medicare buy-in proposals for older individuals would have only a minimal impact on coverage. An American Action Forum analysis found that Medicare buy-in for those 50–64 would only reduce the total uninsured rate by 0.2 percent (*Holt, 2019*). In fact, among those aged 60–64, only 8 percent are uninsured (*Ippolito and Pope, 2020*).

A RAND analysis found that Medicare buy-in would cause premiums for those remaining in the individual market to rise between 2 and 10 percent, depending on the specific assumptions and market (*Eibner et al., 2019*). This critical result was derived from a microsimulation model that analyzed the impact of Medicare buy-in for individuals aged 50–64. Similar estimates of Medicare buy-in leading to higher premiums in the individual market have been reported by Kotecki and Westrom (*2019*) and the Blue Cross Blue Shield Association (*2019*). Partially due to increased premiums, out-of-pocket spending for those remaining in the individual market is estimated to increase as much as 9.5 percent (*Eibner et al., 2019*).

In an analysis of the impact of a public option, FTI Consulting warns that the introduction of a public option would drive private insurance plans out of the individual market:

> While the effects would be more gradual than under Medicare for All, the public option would eliminate consumer choice for millions of Americans enrolled in the ACA exchanges and force many current enrollees to lose coverage. (*FTI Consulting, 2019*)

Specifically, FTI estimates that a decade after the introduction of a public option, 2 million people insured through the individual market could lose access to private plans.

Impact on Taxpayers

Some Medicare buy-in and public option proposals are light on financing details, but there is no way around needing taxpayer dollars to pay for what would be an exorbitantly expensive undertaking for the federal government. Individual premiums for Medicare buy-in could cover some of the cost, but federal financing of an expanded program will be needed. As CBO noted last year:

> Currently, national health care spending—which totaled $3.5 trillion in 2017—is financed through a mix of public and private sources, with private sources such as businesses and households contributing just under half that amount and public sources contributing the rest. (*CBO, 2019*)

Estimates of the gross cost of Joe Biden's healthcare proposals, which include increased subsidies in the ACA exchanges along with a Medicare public option, range from $2 trillion to $2.5 trillion over 10 years (*CRFB, 2020*). Additional proposals would reduce federal spending (mostly on prescription drugs) and reduce the overall net cost. However, like reductions in payments to providers, reductions in reimbursement for pharmaceuticals are not without consequence on that industry and the future of new drug development.

LONG-TERM EFFECTS OF EXPANDING GOVERNMENT HEALTHCARE PROGRAMS

In addition to the near-term fiscal and economic impact of expanding Medicare to millions of additional individuals, there are potential adverse long-term effects on access to and quality of care, as well as future innovation.

Access to and Quality of Care

As noted above, expanding Medicare or introducing a public option will cause average reimbursement rates to fall. This could have a long-term impact on access to and quality of care, especially insofar as Medicare buy-in or a public option is a stepping stone to an even larger role for the government as a healthcare payor.

An analysis from the American Hospital Association and the Federation of American Hospitals estimates that the Medicare-X Choice Act – which would be more expansive than Medicare buy-in but less comprehensive than Medicare for All – would result in $774 billion in cuts to hospitals over 10 years and cuts to other providers totaling $388 billion during

the same period. This impact, while disparate across providers, would average 7 percent of total expected spending (*Koenig et al., 2019*).

Hospitals and other healthcare providers that are only marginally profitable are more likely to close if their reimbursement rates decline. While this could yield cost-cutting restructuring to restore financial viability, these changes could have an adverse impact on access to healthcare services, especially in more rural communities. As CBO (*2019*) has noted, "Such a reduction in provider payment rates would probably reduce the amount of care supplied and could also reduce the quality of care."

Innovation

Reducing the number of uninsured individuals, such as occurred with the establishment of Medicare, can have a positive effect on medical innovation. However, if the dominant impact is to reduce average reimbursement and move patients away from coordinated value-based coverage and toward fee-for-service care, the returns on new technologies and innovative delivery services may be diminished.

A report from the Mercatus Center summarizes evidence of the positive effects of Medicare on certain innovations but also details how Medicare has discouraged innovation as it relates to "patient-centered, personalized" care (*Podemska-Mikluch, 2018*). The report concludes, "Five decades of Medicare experiment offer one clear lesson: regulatory complexity overwhelms innovation and efficiency." An even larger Medicare program will likely only increase regulatory complexity and further discourage innovation.

Conclusion

While there is a good argument to be made for healthcare reform in the United States, the best route is not to drive more individuals into traditional, fee-for-service Medicare or a public option. Rather, healthcare reform should look to better align incentives among patients, payors, and providers and, in particular, ensure that providers are rewarded for delivering cost-effective care that reduces unnecessary costs and promotes better health outcomes. There have been positive examples of partnerships in this vein, either broadly through the Medicare Advantage program or more narrowly through certain demonstration programs orchestrated by the Center for Medicare & Medicaid Innovation. However, these examples reflect the government's efforts to more effectively finance healthcare for a fixed population, while Medicare buy-in and public option proposals are generally attempts to broaden the scope of the least market-oriented elements of the current healthcare system.

Expanding the government's role in the healthcare sector and setting lower prices risks the viability of broad swaths of the healthcare system and could be harmful to workers, employers, healthcare providers, consumers, and taxpayers.

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ABOUT THE AUTHOR

Alex Brill is the founder and CEO of Matrix Global Advisors, an economic policy consulting firm in Washington, DC. He served on the staff of the House Ways and Means Committee from 2002 to 2007 and the White House Council of Economic Advisers from 2001 to 2002.

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1350 Connecticut Avenue, NW Suite 610 Washington, DC 20036 | info@GetMGA.com

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