

The Impact of Medicare for America on the Employer Market and Health Spending

Final Report

Prepared For:
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Executive Summary

The Medicare for America Act of 2019 (MFA) was introduced into the House of Representatives on May 1, 2019. MFA would automatically enroll much of the U.S. population into a single Federal comprehensive health insurance program. This would include legal residents without health insurance coverage, as well as those currently enrolled in coverage through Medicare, Medicaid, and the individual market. However, those enrolled in qualified (i.e. sufficiently generous) employer-sponsored insurance (ESI) would be able to opt out of MFA and maintain their coverage. To encourage firms to maintain coverage, the MFA proposal would require large firms that do not offer coverage to pay a penalty of 8% of their annual payroll.

Like individuals obtaining coverage through the Affordable Care Act (ACA) health insurance Marketplaces, MFA enrollees would be eligible for income-based premium subsidies. There are two key differences between the MFA subsidies and the Marketplace subsidies. First, unlike the ACA, families with a qualified ESI offer would still be eligible for subsidies if they elected Medicare for America. Second, MFA premium subsidies are more generous than under the ACA, with subsidized premiums under MFA expected to be often lower than subsidized ESI premiums.

In this report, we use a microsimulation modeling approach to estimate the impact of Medicare for America on the private-sector employer sponsored insurance market and national healthcare spending.

Methods. We generated coverage and spending impacts using the KNG Health Reform Model (KNG-HRM), a microsimulation model based on the American Community Survey. Our analysis focuses on private sector workers and excludes ESI enrollees obtaining coverage through a government employer. Our approach relies on two key assumptions:

1. Most current ESI enrollees will continue to enroll in ESI if that coverage is affordable (premium < 9.5% of worker's income);
2. Employers will only drop coverage if doing so significantly improves the joint welfare of the firm, the employees, and the employee family members.

To model firm behavior, we evaluate premiums, out of pocket costs, financial penalties, and other costs. We define the savings from dropping coverage as the difference in costs between a scenario where the firm offers coverage and a scenario where the firm drops coverage. If these savings exceed a savings threshold (i.e. 5% of annual payroll in our base model), we assume the firm drops coverage. We report results at different savings thresholds.

We use the KNG-HRM to forecast baseline health spending. We adjust spending for MFA enrollees to account for expected changes in prices and utilization. Based on the legislative text, we base initial MFA

prices on Medicare prices, with additional increases for hospital, primary care, and behavioral health services. We then grew prices for healthcare services by an inflation factor. We adjust utilization to account for uninsured individuals gaining coverage, induced demand from lower cost-sharing levels, the elimination of prior authorization requirements, and expanded coverage of long-term services and supports.

Key Findings. Our baseline model predicts that MFA would result in declines in private-sector ESI enrollment due to fewer firms offering coverage. These declines are slightly offset by higher take-up of ESI among workers and their families at firms that continue to offer coverage. Under MFA, we estimate that:

- Nearly one of every four workers who were previously offered ESI would lose access to ESI via their employer (Figure 5). This increases to about one of every three workers losing access to ESI through their employer by 2032.
- About one-in-nine private-sector ESI enrollees would disenroll by 2023 (16 million) and one-in-four (37 million) would disenroll by 2032 (Figure 6).
- MFA has a disproportionate impact on small employers (i.e. under 50 employees) (Figure 7). Virtually all small employers would incur savings from dropping coverage under MFA.
- Overall healthcare spending would increase under MFA by 3 percent and 11 percent in 2023 and 2032, respectively (Figure 8). Most of this increase is driven by higher health care utilization.

Discussion. Our model predicts that MFA would cause the employer health insurance market to contract, and that this effect would increase over time. Workers at small firms would be disproportionately affected, with more than half losing access to ESI through their employer by 2032. Overall, we estimate that a quarter of ESI enrollees under current law would disenroll from ESI coverage with implementation of MFA, primarily due to their employer dropping coverage. We assumed that firms would only drop coverage if doing so produced savings of at least 5% of their annual payroll. However, if we instead assumed that employers would drop coverage in response to savings of 3% or 7% of payroll, the number of ESI enrollees is predicted to fall by 40% or 20%, respectively. In either case, these are significant reductions in ESI as compared to experience under the ACA.

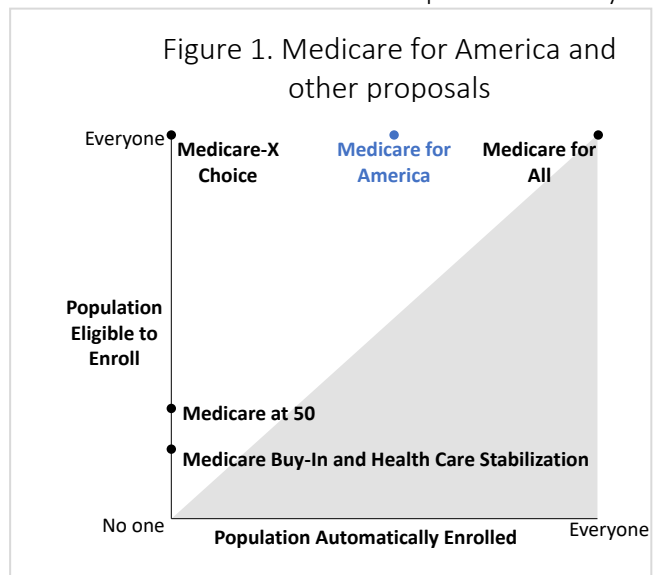
While the projections in this report are uncertain and dependent upon various methodological assumptions, we find that MFA would result in considerable declines in ESI enrollment. In addition, the law would likely amplify long-term health care spending growth by stimulating higher levels of medical utilization and increasing unit prices paid for those already enrolled in public coverage. Policymakers should consider these potential effects when considering MFA and other similar proposals aimed at reforming the U.S. healthcare system.

I. Introduction

Another major health reform effort could be on the horizon. Most of the public continues to believe health care should be a top government priority.¹ Democratic presidential candidates have endorsed a range of proposals. Moreover, a legal challenge to the Affordable Care Act (ACA) is likely once again heading to the Supreme Court, where the entire law is at risk of being invalidated.²

While the focus and prospects of any future health reform effort depend on future election outcomes, there are several options currently being considered by policymakers. In the 116th Congress, Democratic lawmakers introduced ten bills that would expand public healthcare programs.³ The most ambitious proposals would automatically enroll all Americans into a single national health insurance plan, while more temperate proposals create voluntary programs limited to targeted populations (see Figure 1).

The Medicare for America Act of 2019 (MFA) was introduced into the House of Representatives by Representative Rosa DeLauro on May 1, 2019. Like the Medicare for All proposals introduced by Senator Bernie Sanders and Representative Pramila Jayapal, MFA would automatically enroll much of the U.S. population into a single Federal comprehensive health insurance program. This would include legal residents without health insurance coverage, as well as those currently enrolled in coverage through Medicare, Medicaid, and the individual market. In addition, people born in years 2023 and later would also be automatically enrolled in MFA.



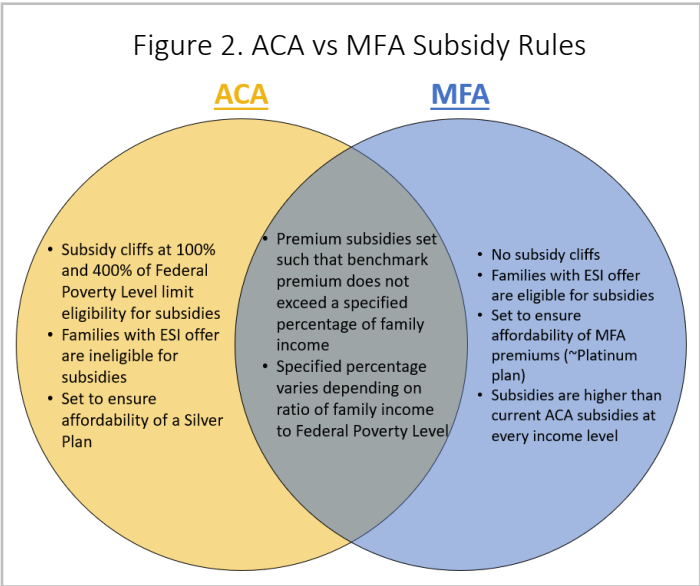
Unlike the Medicare for All proposals, those enrolled in qualified employer-sponsored insurance (ESI) plans would be able to maintain their current coverage under MFA. To qualify, employer health plans would need to have an actuarial value of at least 80% and the employer would need to pay at least 70% of the premium cost for both workers and dependents.⁴ Currently, the average employer health plan would exceed these minimum standards, with average employer health plan actuarial value of approximately 83%⁴, and average employer premium contribution to family coverage of 70%.⁵ However, some ESI plans would need to become more generous to qualify under the MFA standards.

To encourage firms to maintain coverage under MFA, the proposal includes penalties for large firms that do not offer coverage. Beginning in 2023, the penalty would apply to non-offering firms with either more than 100 workers or \$2 million in annual payroll. This penalty would equal 8% of the firm's annual payroll.

⁴ Actuarial value refers to the share of expected health care costs a health plan will cover across a population of enrollees.

In 2016, total private-sector employer contributions to health insurance premiums (\$0.5 trillion) were approximately 8% the size of aggregate U.S. private-sector payrolls (\$6.4 trillion).^{6,7} Thus, the penalty large firms would face under MFA for not offering coverage is comparable to what employers currently spend on premium subsidies.

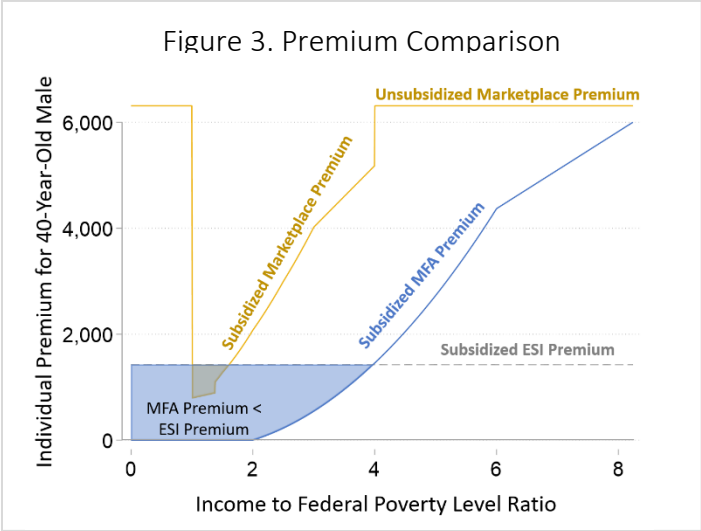
Firms that offer coverage could also face penalties if their workers voluntarily opted into MFA. In such cases, the firm would be required to pay whatever they would have paid in premium contributions had those workers taken up ESI, but those funds would instead be paid towards MFA coverage. In the status quo, only 72% of workers eligible for ESI coverage take up their firm’s coverage, and firms are not obligated to pay any amount to support health benefits for the 28% of workers who do not enroll.⁸ Even if MFA resulted in no additional disenrollment from ESI, this provision would still significantly increase the cost of offering ESI coverage.



Like individuals obtaining coverage through the ACA health insurance Marketplaces, MFA enrollees would be eligible for income-based premium subsidies. However, there are several differences between the MFA subsidies and the Marketplace subsidies (see Figure 2). We highlight two differences that are particularly important for understanding how MFA could affect the employer market. First, unlike the ACA, families with a qualified ESI offer would still be eligible for subsidies if they elected MFA. Second, while subsidized Marketplace premiums are rarely lower than subsidized ESI premiums (i.e. the portion of premiums

paid by the employee), this is frequently true under MFA.

Using an illustrative example, we compare the national average subsidized ESI premium to both a subsidized Marketplace premium and subsidized MFA premium for a 40-year-old single male (Figure 3). While the Marketplace premium is only lower than the ESI premium for a narrow income band, roughly 100% to 160% of the Federal Poverty Level (FPL), the MFA premium is lower than the ESI premium for nearly all incomes below 400% of the FPL. The difference is particularly stark at income levels below 200% of the FPL, where enrollees would be exempt from premiums under MFA.



Sources: MEPS-IC, Table I.C.2, 2018.
 KFF Average Marketplace Premiums by Metal Tier. October 2018.
 Notes: Marketplace premium was based on national average gold premium.
 The subsidized ESI premium accounts for the employer contribution, but not applicable tax exemptions.
 For purposes of this figure, we assumed the MFA premium would exceed \$6,000 per year

If a lower-wage firm dropped coverage, most employees would likely see a reduction in their monthly premiums. In addition, the amount the employer was previously paying in premium contributions could be converted into wages. These commensurate wage increases could mitigate the potential reduction in workforce an employer might otherwise experience from dropping coverage. However, these wage improvements would increase Federal and state income taxes, as well as payroll taxes. Each of these described factors could influence the decision of individuals and employers to maintain or drop ESI.

In this study, we synthesize these and other factors into a model to forecast the effects of MFA on ESI enrollment and healthcare spending.

II. Methods

We generated coverage and spending impacts using the KNG Health Reform Model (KNG-HRM), a microsimulation model based in the American Community Survey. Our analysis focuses on private sector workers and excludes ESI enrollees obtaining coverage through a government employer.^b A detailed description of how we adapted the KNG-HRM to model MFA is included in an online technical appendix.⁹

Our approach relies on two key assumptions:

1. Most current ESI enrollees will continue to enroll in ESI if that coverage is affordable;
2. Employers will only drop coverage if doing so significantly improves the joint welfare of the firm, the employees, and the employee family members.

Individual and Family ESI Take-up Decisions. We characterize ESI as affordable if the subsidized premium is less than 9.5% of the worker’s income. This threshold is similar to how affordability is defined for the highest income bracket in the ACA Marketplaces.^c Our own analysis shows that it is very uncommon for

^b We excluded government employers and their dependents from the analysis (including dependents born after 2023 who would be automatically enrolled in MFA) as public employers may be less sensitive to economic considerations when determining whether to offer coverage.
^c The Urban Institute has previously used this same threshold in their Dynamic Simulation of Income Model (DYNASIM).

ESI-enrolled families to face premiums in excess of this threshold. We make two exceptions to this individual affordability standard. First, we assume half of ESI-enrolled families with incomes below 200% of the FPL would move to MFA, even if ESI premiums are below the affordability threshold. These families would be disproportionately likely to enroll in MFA, as they would be exempt from premiums and cost-sharing. Second, we assume that newborns born in 2023 or later would be automatically enrolled in MFA, as is required by the proposal.

Employer Offer Decisions. To model firm behavior, we evaluate premiums, out of pocket costs, financial penalties, and other costs (see Figure 4).^d We define the savings from dropping coverage as the difference in costs between a scenario where the firm offers coverage and a scenario where the firm drops coverage. If these savings exceed a minimum savings threshold, we assume the firm drops coverage. In our base model, we assume each firm’s minimum savings threshold (i.e. the minimum savings needed for a firm to drop coverage) would equal 5% of their annual payroll. However, we also report results at different savings thresholds.

Figure 4. Description of Components in Firm Cost Model under MFA

Cost Component	If the employer maintains coverage...	If the employer drops coverage...
Premiums for workers and dependents, net of subsidy	The sum of: <ul style="list-style-type: none"> • The employee’s and employer’s share of ESI premiums for those taking-up ESI coverage, reduced by the enrolling family’s marginal tax rate; and • MFA premiums for those opting out of ESI coverage, reduced by the income-based MFA subsidy. 	MFA premiums for all workers and dependents, reduced by the income-based MFA subsidy.
Out of Pocket Costs	Out of pocket health costs of the workers and dependents either participating in the ESI plan or receiving coverage through MFA.	Out of pocket health costs for workers and dependents receiving coverage through MFA.
Financial Penalties	The hypothetical employer’s share of ESI premiums for those opting out of ESI coverage.	For large firms, eight percent of the firm’s annual payroll.
Other Costs	The internal HR administrative burden of offering coverage.	None.

Projecting Health Spending. We use the KNG-HRM to forecast baseline health spending. We adjust spending for MFA enrollees to account for expected changes in prices and utilization.

^d The legislation allows employers to offer MFA coverage directly to their employees. The law also envisions private health plans offering MFA plans, like the Medicare Advantage program in Medicare. We do not model these mechanisms.

Price Effects. In the KNG-HRM, we estimate state-specific Commercial-, Medicaid-, and Uninsured-to-Medicare price ratios for hospitalizations, outpatient visits, physician visits, and prescription drugs. Commercial-to-Medicare prices are estimated by comparing commercial prices from the Health Care Cost Institute with Medicare fee schedule prices, and adjusting these ratios to match aggregate estimates reported in the literature.^{10,11,12} Medicaid-to-Medicare ratios were taken from indices published by the Kaiser Family Foundation and Medicaid and CHIP Payment and Access Commission.^{13,14} We assumed the uninsured paid Medicare rates for hospital care, but commercial rates for physician care. We assumed that Medicaid paid 53% of Medicare prescription drug prices, but assumed similar prescription drug prices across commercial uninsured, and Medicare populations.¹⁵

Based on the legislative text, we made the following adjustments: (1) set MFA hospital prices in each state as the higher of either Medicare or Medicaid prices, increased by 10%; and (2) adjusted MFA rates to account for 30% boosts in primary care and behavioral health rates relative to Medicare rates. These assumptions allowed us to develop MFA price impacts which varied by state, service category, and baseline coverage status. Medicaid enrollees would not be immediately transitioned into MFA, and during the transition years, the legislation stipulates that payment rates for Medicaid beneficiaries would be increased. Our analysis does not account for high Medicaid payment rates during these transition years. We also assume that scheduled Medicare productivity adjustments would not be applied to MFA prices. Healthcare prices for all payers were inflated by 4.2% per year based on medical cost growth projections from the Centers for Medicare and Medicaid Services actuaries.

Utilization Effects. We applied four utilization adjustments for populations shifting into MFA. First, we adjusted for uninsured individuals gaining coverage. Second, we adjusted for induced demand from MFA having lower cost-sharing than most existing insurance options. Third, we adjusted for the elimination of prior authorization requirements. Fourth, we increased spending to account for expanded coverage of long-term services and supports. Additional detail on these adjustments is provided in the online technical appendix.

III. Findings

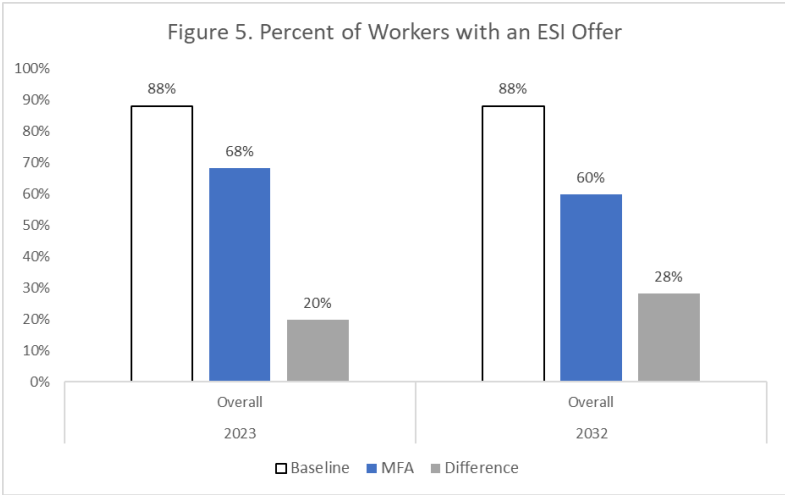
Our baseline model predicts that MFA would result in declines in private-sector ESI enrollment due to fewer firms offering coverage. These declines are slightly offset by higher take up of ESI among workers and their families at firms that continue to offer coverage. Below, we review these findings as well as the potential impact of MFA on healthcare spending.

Workers’ ESI Offer Rate. Under MFA, by 2023, nearly one of every four workers who were previously offered ESI would lose access to ESI via their employer, with offer rates falling from 88 to 68 percent (Figure 5). This increases to about one of every three workers losing access to ESI through their employer by 2032.

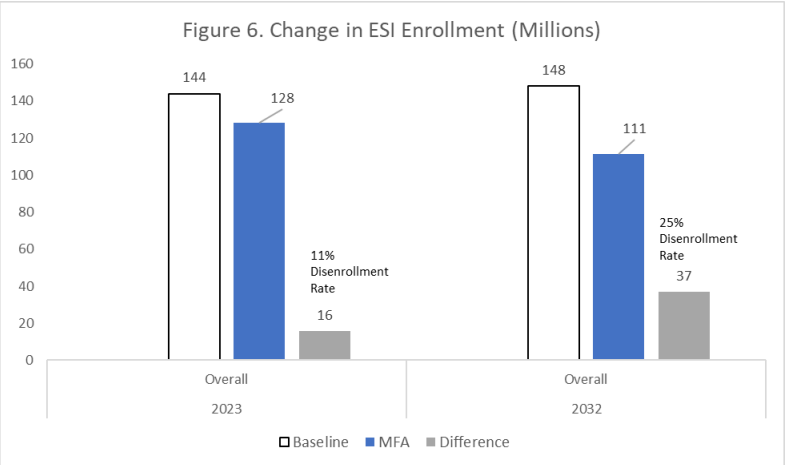
The model projects a deterioration in workers’ access to ESI over time, because we assume that costs of offering coverage will grow faster than penalties associated with dropping coverage under MFA. Specifically, the cost of offering coverage (e.g. ESI premiums) increases with growth in health care spending, while the cost of dropping coverage (e.g. payroll-based financial penalties and income-based MFA premiums) increases with growth in wages.

ESI Enrollment. We estimate that one-in-nine private-sector ESI enrollees would disenroll by 2023 (16 million) and one-in-four (37 million) would disenroll by 2032 (Figure 6). In percentage terms, these declines are smaller than our projected declines in offer rates. ESI offer rates decline more than ESI enrollment for two reasons. First, the employers that dropped coverage in our model had lower baseline take-up rates than those employers that kept coverage.

Second, our model allows families with multiple employment coverage offers to move onto a different employer plan if the family’s originally selected ESI option ceases to be available. Furthermore, between 2023 and 2032, ESI

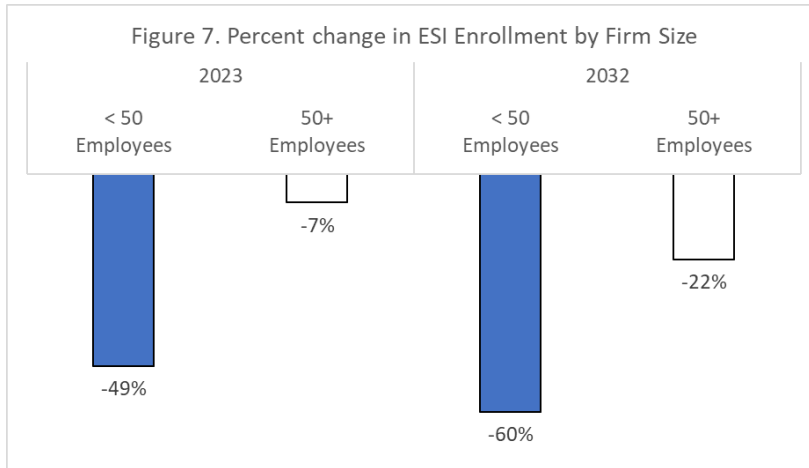


Source: 2019 KNG Health analysis using the KNG-HRM. Notes: Analysis assumes that firms drop coverage if incremental savings from doing so exceeds 5% of annual payroll. Government workers and dependents are excluded from the analysis.



Source: 2019 KNG Health analysis using the KNG-HRM. Notes: Analysis assumes that firms drop coverage if incremental savings from doing so exceeds 5% of annual payroll. Government workers and dependents are excluded from the analysis.

enrollment declines increased from 16 million to 37 million. This is driven both by lower ESI offer rates in 2032 and automatic enrollment into MFA among those born during the intervening years.

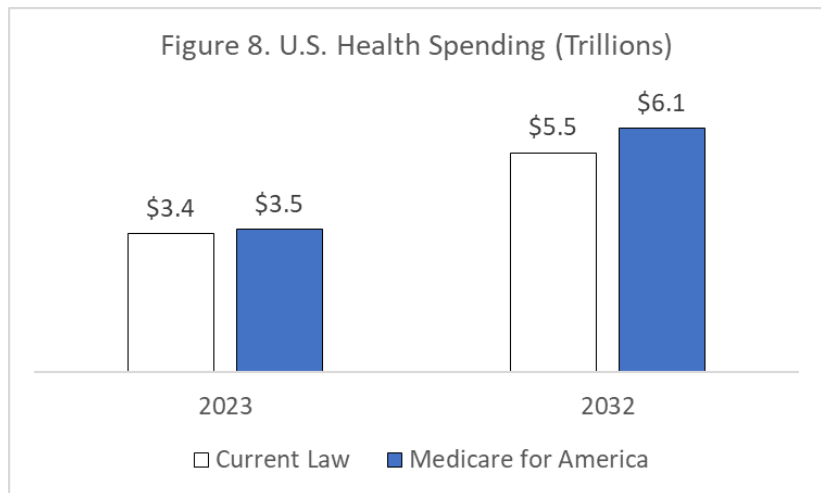


Source: 2019 KNG Health analysis using the KNG-HRM.
 Notes: Analysis assumes that firms drop coverage if incremental savings from doing so exceeds 5% of annual payroll.
 Government workers and dependents are excluded from the analysis.

MFA has a disproportionate impact on small employers (i.e. under 50 employees) (Figure 7). In the status quo, small firms are more likely not to offer health coverage relative to large firms. Under MFA, while large employers dropping coverage would pay a penalty of 8 percent of their annual payroll, small employers are exempt from this requirement. As a result, virtually all small employers would incur

savings from dropping coverage under MFA. Even if only those firms incurring significant savings drop coverage, we forecast that about half of the small group market would disappear by 2032.

Healthcare Spending. Overall healthcare spending would increase under MFA by 3 percent and 11 percent in 2023 and 2032, respectively (Figure 8). Most of this increase is driven by higher health care utilization, which is the result of both lower cost-sharing and more covered services under MFA. We estimate that utilization would increase most significantly for the uninsured, who would gain coverage under MFA (Figure 9). However, we project utilization increases for all populations (note, there is no impact on utilization for Medicaid for 2023 because of the phase-in).



Source: 2019 KNG Health analysis using the KNG-HRM.
 Notes: Analysis assumes that firms drop coverage if incremental savings from doing so exceeds 5% of annual payroll.
 Government workers and dependents are excluded from the analysis.

We assumed that payment rates under MFA would be lower than baseline commercial rates, but higher than baseline rates for public programs. As a result, the model projects that spending would fall for individuals who lose ESI coverage or who were covered under a non-group plan in the baseline. In these instances, spending reductions due to lower prices are not offset by higher utilization. In addition, for those who previously had public coverage, we project a relatively large spending increase due to both higher prices and utilization under MFA.

Figure 9. Impact on Health Spending by Baseline Coverage Status

		Baseline Spending	Price Impact	Utilization Impact	Total Impact	Post Spending
2023	ESI (Keeps ESI)	\$1,172 B	\$0 B	\$17 B	\$17 B	\$1,189 B
	ESI (Drops ESI)	\$322 B	-\$107 B	\$36 B	-\$71 B	\$251 B
	Medicare	\$1,012 B	\$65 B	\$66 B	\$131 B	\$1,144 B
	Medicaid	\$705 B	\$0 B	\$0 B	\$0 B	\$705 B
	Non-Group	\$132 B	-\$44 B	\$21 B	-\$23 B	\$109 B
	Uninsured	\$103 B	\$0 B	\$48 B	\$49 B	\$152 B
	Total	\$3,447 B	-\$85 B	\$188 B	\$103 B	\$3,550 B
2032	ESI (Keeps ESI)	\$1,551 B	\$0 B	\$21 B	\$21 B	\$1,572 B
	ESI (Drops ESI)	\$733 B	-\$244 B	\$79 B	-\$165 B	\$568 B
	Medicare	\$1,713 B	\$149 B	\$151 B	\$300 B	\$2,013 B
	Medicaid	\$1,119 B	\$282 B	\$127 B	\$410 B	\$1,529 B
	Non-Group	\$199 B	-\$66 B	\$32 B	-\$34 B	\$165 B
	Uninsured	\$160 B	\$1 B	\$74 B	\$75 B	\$235 B
	Total	\$5,475 B	\$122 B	\$485 B	\$607 B	\$6,082 B

Notes: Analysis assumes that firms drop coverage if incremental savings from doing so exceeds 5% of annual payroll.

Source: KNG Health analysis using the KNG-HRM

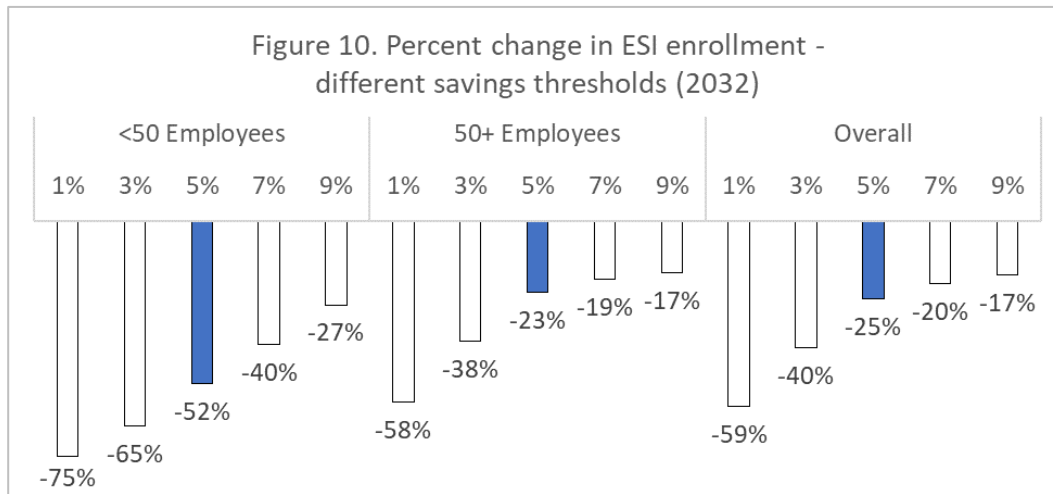
IV. Discussion

Our model predicts that MFA would cause the private sector employer health insurance market to contract, and that this effect would increase over time. Workers at small firms would be disproportionately affected, with more than half losing access to ESI through their employer by 2032. Overall, we estimate that by 2032 a quarter of ESI enrollees under current law would disenroll from ESI coverage with implementation of MFA, primarily due to their employer dropping coverage. Our model also predicts that MFA would increase total health care spending, with the largest spending increases occurring among those who already had public coverage through Medicare or Medicaid. Spending would increase because of both higher utilization and higher overall prices.

As with any simulation model, our results are sensitive to underlying assumptions. These assumptions relate to responses to MFA by employers, employees, and providers. We assume that employers make ESI offer decisions based on considerations of the effects on the firm, employees, and employees' family members. Our model assumes a simple affordability threshold on the part of employees and their families on whether to take up ESI. Finally, we assume no behavioral response from providers as a result of MFA.

Employer Response. We assumed that firms would only drop coverage if doing so produced savings of at least 5% of their annual payroll. Savings are determined by comparing the costs of maintaining an ESI offer to the cost of dropping coverage. The costs of offering or dropping coverage depends on premiums for workers and dependents (net of subsidy), out-of-pocket costs, financial penalties, and administrative costs associated with offering ESI.

To test the sensitivity of our findings to the 5% savings threshold assumption, we examined the effects on ESI enrollment under savings threshold ranging from 1% to 9%. If we instead assumed that employers would drop coverage in response to smaller savings (e.g. 1% of payroll), nearly 60% of the employer market would disenroll by 2032 (see Figure 10). If employers would need to save at least 9% of their payroll before dropping coverage, the magnitude of our 2032 impact estimate would be 17%. In our model, healthcare spending falls as more people disenroll from ESI. Under the 1% savings threshold in which ESI disenrollment is highest, estimated 2032 healthcare spending would still increase by approximately \$400 billion, about \$200 billion less than in our base model. Conversely, lower ESI disenrollment scenarios result in higher spending increases.



Source: 2019 KNG Health analysis using the KNG-HRM.
Notes: The base model's assumed values are highlighted in blue.
Government workers and dependents are excluded from the analysis.

As a falsification test, we examined how our employer choice framework would predict status quo employer offer decisions. Our model predicts that very few (<1%) employers who currently offer coverage would save more than 5% of their annual payroll by dropping coverage. This finding is consistent with the observation that ESI offer rates did not change materially following implementation of the ACA.¹⁶ It also provides support for our framework for assessing employer decisions. We note that the persistence of ESI offers may be driven by a strong cultural expectation that employers offer health insurance. As cultural expectations change, firms may be more willing to drop coverage at lower saving rates.

Employee and Family ESI Take-Up. We assume individuals would be reluctant to voluntarily drop their employer coverage, even in situations where it would be financially advantageous to do so. For example, an individual earning 300% of the FPL (~\$36,000 in 2018) might face an annual subsidized employer premium of \$1,400, which is 4% of their annual income. That same individual's maximum allowable annual MFA premium would be 1.5% of their income, or \$540. Thus, were MFA in-effect 2018, a static analysis suggests that such an individual could reduce their premium cost by about 60% if they enrolled in MFA. Despite this, our model assumes such individuals would keep their employer coverage so long as their employer continued to offer it.

Provider Behavior. We assume providers would have adequate capacity to absorb additional health care utilization driven by MFA. This may not be realistic, particularly given projected physician shortages under current law.¹⁷ As public coverage sometimes pays less than the cost of care, it is often argued that expansions of public coverage would lead providers to shift these costs onto commercial insurers. This could result in higher premiums and cost-sharing for those who maintain employer coverage. However, the existence of cost-shifting is controversial, and it may also be less likely to occur under MFA for two reasons.¹⁸ First, MFA rates would be higher than current Medicare rates. Second, MFA requires providers who accept MFA to make MFA rates available to commercial plans.

Despite this latter provision, we did not assume commercial rates would fall to MFA levels. Doing so would have reduced our modeled spending and enrollment impacts. However, a consumer preference for ESI coverage may be inherently linked to higher commercial prices. Higher prices may result in a more diverse selection of providers and potentially higher quality care.¹⁹ The enrollment experience of an ESI plan with MFA prices may more closely resemble the experience of MFA rather than existing ESI options.

Health Spending. While our model predicts higher total health spending, the impact on Federal health spending is likely to be larger. An analysis of Federal budget impacts is outside the scope of this report. However, we do estimate a large increase in health spending for individuals enrolled in comprehensive public health insurance. MFA spending in 2032 would be about 60% higher than Medicaid and Medicare spending would have been. This is the result of higher public plan enrollment rates, utilization rates, and prices.

The projections in this report are highly uncertain and dependent upon various methodological assumptions relating to individual and firm behavior. Using the described modeling assumptions, we find that MFA would result in considerable declines in ESI enrollment. These declines would be primarily driven by employers choosing to stop offering coverage. In addition, the law would likely amplify long-term health care spending growth by stimulating higher levels of medical utilization and increasing unit prices paid for those already enrolled in public coverage. Policymakers should consider these potential consequences when considering MFA and other similar proposals aimed at reforming the U.S. healthcare system.

End Notes

- ¹ Public's 2019 Priorities: Economy, Health Care, Education and Security All Near Top of List. Pew Research Center. January 2019. <https://pewrsr.ch/2Wvudcc>.
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