

Addressing Costs in the Medicare Program

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Preface and Acknowledgements

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Executive Summary

The following report addresses the issue of high costs in the Medicare program. It explores the uniquely high and rapidly rising costs of healthcare in the United States and within Medicare specifically, assessing trends in spending and the contributing factors to rising spending.

Following a robust analysis of key costs drivers and proposed initiatives to curb spending in Medicare, it lays out four policy alternatives to address Medicare costs: first, continuing with traditional Medicare; second, continuing with Medicare Advantage; third, offering a new public option plan to the currently-eligible Medicare population; and fourth, offering a similar public option to the currently-eligible population and all Americans over 50.

These alternatives are assessed based on five criteria detailed in the body of the report, the most important of which are the cost-effectiveness of each alternative and the total number of people each alternative would insure. I recommend the third alternative – a Medicare public option – because it scores highly on cost-effectiveness and the total number of people insured, as well as comparing favorably on the other relevant criteria.

Problem Definition

The problem my project aims to address is as follows: *Medicare costs are too high*. Momentum for healthcare reform has been building for some time, even after the Affordable Care Act (ACA), which was the most significant healthcare reform since the creation of Medicare and Medicaid in 1965. America has yet to achieve universal health coverage, despite the fact that the ACA was a major step in that direction. Medicare, the single largest payer for healthcare in the country, is likely to be the path forward toward further healthcare reform. However, it is not currently cost-effective enough to sustain its recent growth rate, much less expand to new populations – the trust funds that pay for Medicare beneficiaries' healthcare will not be able to cover the program's full costs within the next 10 years.¹

¹ <http://files.kff.org/attachment/Issue-Brief-Facts-on-Medicaid-Spending-and-Financing>

Healthcare spending in the U.S. is higher per capita than most comparable Organization for Economic Cooperation and Development (OECD) countries, and has been outpacing spending in other industries within the country as well. Over the past 20 years, per capita healthcare spending has more than doubled.² Spending on Medicare in particular has been rising even faster – now accounting for over 15% of the federal budget³ – which is why it’s so crucial to address this problem. The following report will discuss these rising costs in greater detail, and introduce four alternatives that aim to address the problem of cost within the Medicare program.

Cost to Society

Healthcare spending in the U.S. accounts for almost one-fifth of the country’s GDP, and has been rising rapidly for years.⁴ These health care cost levels are mostly unique to the U.S. – other OECD countries spend about half as much per capita on health care, and that disparity has grown significantly since about 1980.⁵ The total cost of healthcare to American society – our country’s national health expenditures (NHE) – reached \$3.6 trillion in 2018, over \$11,000 per American citizen.⁶ For the purposes of clarity in my analysis, I’ll organize the discussion of these costs around two categories: the costs to society of America’s high uninsured and underinsured rates, and the direct costs to the Medicare program. Both are critical to understanding and addressing this policy problem. This section will consider general costs to

² <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/highlights.pdf>

³ <https://www.kff.org/medicare/issue-brief/the-facts-on-medicare-spending-and-financing/>

⁴ <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/highlights.pdf>

⁵ <https://www.healthsystemtracker.org/chart-collection/health-spending-u-s-compare-countries/#item-since-1980-the-gap-has-widened-between-u-s-health-spending-and-that-of-other-countries> 2018

⁶ <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NHE-Fact-Sheet>

society, and will be followed by a more focused section on the costs to the Medicare program in particular.

Aside from the direct costs of paying for care, there are numerous indirect costs that society bears as a result of the nation's relatively high uninsured rate. When people don't have access to the healthcare they need due to lack of insurance or prohibitively expensive insurance plans, they forgo or delay the treatment they need, which leads to much more expensive healthcare interventions in the long run. This often takes the form of unnecessary hospitalizations, particularly emergency room visits. A study of over 400 million emergency department visits between 2005 and 2011 found that over 3% of visits could be characterized as "avoidable."⁷ The most common reasons for these visits were toothaches, back pain, and headaches, all of which could be treated with earlier interventions in primary care or preventive care if patients had better access to those services. Research shows that there are about 145 million emergency room visits in America annually, with an average cost of about \$1,400 each.⁸

These statistics demonstrate that about 4.35 million emergency department visits every year are avoidable, and the total cost of those avoidable visits is over \$6 billion annually. This is a huge cost to society, and while moving toward universal coverage would not eliminate the problem entirely, it would reduce the cost burden by increasing access and routing some of those patients to more appropriate early interventions, instead of the less cost-effective and medically effective emergency care they receive now.

In addition to spending on unnecessary emergency care, society bears the cost of lost economic output due to illnesses that may have been preventable with earlier interventions if people had access to better primary care. A 2018 study found that the cost to employers of lost output due to workers' illness is about \$530 billion annually.⁹ Not all of that loss could be

⁷ <https://www.ncbi.nlm.nih.gov/pubmed/28992158>

⁸ <https://www.debt.org/medical/emergency-room-urgent-care-costs/>

⁹ <https://www.globenewswire.com/news-release/2018/11/15/1652374/0/en/Poor-Health-Costs-US-Employers-530-Billion-and-1-4-Billion-Work-Days-of-Absence-and-Impaired-Performance-According-to-Integrated-Benefits-Institute.html>

recouped with better health insurance coverage; there are some major caveats. That statistic includes losses due to chronic conditions and family leave, for example – neither of which improved coverage rates would necessarily address. But hundreds of billions of dollars in losses are due to sick days and impaired performance (working while sick), categories that better primary care interventions, a function of better healthcare coverage, could address.

Background

This background section will further explore the current situation in U.S. healthcare spending and examine spending within Medicare specifically.

Current Spending

The federal government and households are the two biggest contributors to the \$3.6 trillion America spends on health care annually, each accounting for about 30% of that total.¹⁰ Medicare alone accounts for about 20% of national health care spending and 15% of total federal spending, as of 2018.¹¹ Private businesses and state or local governments are the next biggest payers for healthcare, each accounting for about 20% of total spending.¹²

Contributing Factors

In the year 2000, health care spending in the U.S. was 13.8% of GDP, just under \$5,000 per capita each year.¹³ As of 2017, it made up 17.9% of GDP and cost almost \$11,000 per capita – a drastic increase that is not sustainable in the long term.¹⁴

¹⁰ <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/highlights.pdf>

¹¹ <https://www.kff.org/medicare/issue-brief/the-facts-on-medicare-spending-and-financing/>

¹² <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/highlights.pdf>

¹³ <https://www.kff.org/report-section/health-care-costs-a-primer-2012-report/>

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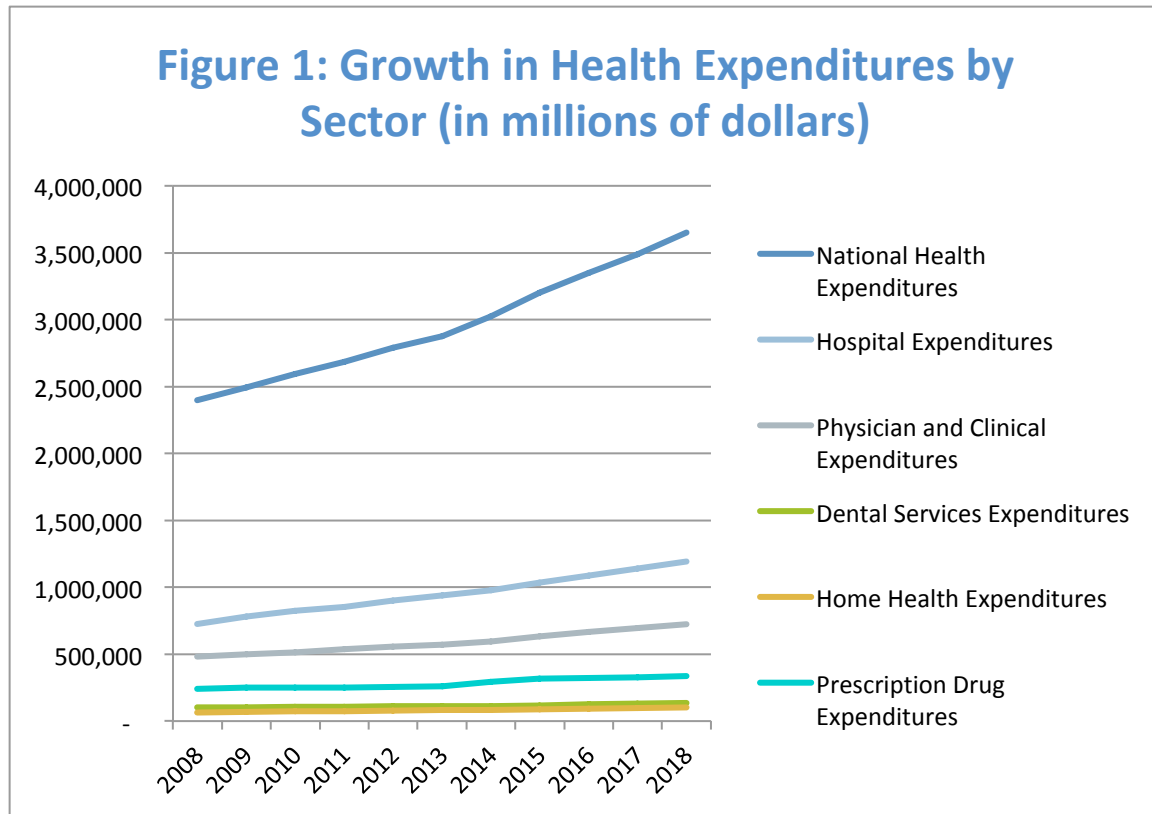


Figure 1 shows the growth in healthcare spending in America over roughly the past 20 years, broken down by sector to illustrate the services America's trillions in healthcare expenditures finance. As the trend lines display, hospital care accounts for the largest share of health spending in the country, at 33% of total costs.¹⁶ Hospital care and physician services together make up just over half of all national health care expenditures.¹⁷ Spending on those services

¹⁴ <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/highlights.pdf>

¹⁵ <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical>

¹⁶ <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/highlights.pdf>

¹⁷ <https://www.kff.org/report-section/health-care-costs-a-primer-2012-report/>

grew by 88% from 2000 to 2010, while prescription drug spending, though a smaller percentage of the overall costs, grew even more rapidly, by 114%.¹⁸ Though those rates of increase slowed in the early 2010s, CMS analysts observed “similar” growth rates for these key services as recently as 2017.¹⁹ It’s difficult to isolate one single driver of cost, as all of these sectors have contributed significantly to the issue. Hospital and physician care are consistently the top line-items in a breakdown of national health expenditures because they are the most commonly utilized, but new, expensive prescription drugs and increased utilization of prescription drugs have driven rapid spending in that sector in recent years. Regardless of the breakdown by services within healthcare, it’s inarguably true that the price of care in the U.S. has been consistently rising year over year for decades. Health care costs have continued to rise faster than costs in other industries, outpacing GDP by about 2.5 percentage points annually on average since 1970.²⁰ As the single largest purchaser of healthcare services, Medicare bears many of these rapidly rising costs, but can also play a major role in slowing the rate of increase and improving cost-effectiveness in the ways America pays for healthcare services.

Medicare Spending

The costs described in the preceding sections paint a picture of healthcare expenditures nationwide. Many of these costs are borne directly by the Medicare program. Medicare cost the federal government (and society as a whole) over \$750 billion in 2018.²¹ Importantly, Medicare has been experiencing disproportionately high spending growth even relative to other federal health expenditures and private health care spending.²² In 2008, benefit payments under Medicare totaled \$462 billion, but just 10 years later in 2018, they’d reached

¹⁸ <https://www.kff.org/report-section/health-care-costs-a-primer-2012-report/>

¹⁹ <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/highlights.pdf>

²⁰ <https://www.kff.org/health-costs/issue-brief/health-care-costs-a-primer/>

²¹ <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NHE-Fact-Sheet>

²² <https://www.kff.org/report-section/health-care-costs-a-primer-2012-report/>

\$731 billion.²³ And this trend is not projected to slow down in the foreseeable future – spending growth is only expected to accelerate, “in part due to growing enrollment in Medicare related to the aging population, increased use of services and intensity of care, and rising health care prices.”²⁴ In less than ten years, net outlays on Medicare are projected to exceed \$1 trillion annually.²⁵

This level of spending is unsustainable. While some politicians’ claims that Medicare is on the verge of going “bankrupt” are false, the program does face serious financial constraints. By 2026, Medicare will only be able to pay about 90% of the hospital insurance costs it covers, and that share is projected to fall below 80% in the next 30 years.²⁶ According to the Center on Budget and Policy Priorities, the shortfall “will need to be closed through raising revenues, slowing the growth in costs, or most likely both.”

The breakdown of healthcare spending by sector showed that spending on hospital care is the largest single sector driving rising healthcare costs in the U.S. Benefit payments for hospital care are also the most pressing financial issue for Medicare, accounting for a large proportion of the program’s costs.

Trends in Medicare Spending

This section will discuss some of the key factors driving rising costs in the Medicare program, as well as several initiatives intended to address those cost drivers.

Key Cost Drivers

Healthcare analysts have identified numerous factors responsible for rapidly rising Medicare costs. One of the most salient among these factors is the prevalence of chronic disease in America, and particularly within the Medicare-eligible population. Chronic diseases are quite

²³ <http://files.kff.org/attachment/Issue-Brief-Facts-on-Medicaid-Spending-and-Financing>

²⁴ <http://files.kff.org/attachment/Issue-Brief-Facts-on-Medicaid-Spending-and-Financing>

²⁵ <http://files.kff.org/attachment/Issue-Brief-Facts-on-Medicaid-Spending-and-Financing>

²⁶ <https://www.cbpp.org/research/health/medicare-is-not-bankrupt>

common in the U.S. at large, and the Medicare-eligible population may be particularly susceptible to chronic disease and illness because it's composed of elderly people as well as those with chronic disabilities and end-stage renal disease. An analysis by Leavitt Partners identified diabetes, heart disease, and hypertension as the chronic conditions most strongly associated with increased Medicare costs.²⁷ Those with chronic conditions will always have higher healthcare costs per capita – this is hardly an issue that can easily be fixed with changes in federal health policy. But expanding affordability and access to healthcare services, particularly preventive services to encourage healthier lifestyles, could reduce the prevalence of these conditions and mitigate some complications that result from them.

The same Leavitt Partners report identified several other relevant contributing factors to Medicare costs, among them hospital quality, socioeconomic status, environmental factors, and market concentration of insurers and hospitals.²⁸ Better hospital quality, intuitively, was associated with lower costs, while lower-quality hospitals experiencing higher readmission rates were more costly to Medicare. Market concentration of insurers was associated with higher costs, while market concentration of hospitals, perhaps surprisingly, was associated with lower costs – possibly suggesting that large health systems actually do generate new efficiencies. Beneficiaries with lower socioeconomic status and those without insurance tended to have higher costs, supporting the hypothesis that affordable insurance coverage improves access to necessary preventive services. Lower air quality and higher average air temperatures were associated with higher costs. These environmental factors may compound the negative impacts of lower socioeconomic status on health outcomes – an issue that recent population health efforts have aimed to address.

Finally, one of the most commonly cited drivers of cost in Medicare is the fee-for-service (FFS) payment system. One of the key reasons Medicare has experienced such uniquely rapid spending growth is that it still pays for care on a FFS basis, reimbursing providers for each

²⁷ <https://leavittpartners.com/whitepaper/market-factors-associated-with-medicare-costs-and-cost-growth/>

²⁸ <https://leavittpartners.com/wp-content/uploads/2018/06/Market-Factors-Associated-with-Medicare-Costs-and-Cost-Growth-2018.pdf>

individual service they deliver at a set rate. Since provider reimbursement is based on the number and type of services provided and not patient outcomes, the system incentivizes volume of care over value. The impacts of these perverse incentives can be seen across the American healthcare system. A study in the American Journal of Medicine found that from the mid-1900s to 2016, the percentage of American doctors practicing general medicine decreased from 50% to just 33% as doctors chose more lucrative specialties and subspecialties instead of primary care.²⁹ Another academic study, comparing the rates of utilization for expensive medical imaging in the U.S. relative to Canada, found that CT scans and MRIs are between two and three times as common in America as they are in Canada.³⁰ The FFS system has oriented much of U.S. healthcare, especially the Medicare program, toward paying for lots of expensive care, but not much value.

Value-Based Payments

There have been several initiatives to reform these delivery and payment services to incentivize more value and less volume, with varying degrees of success. Two key examples of these efforts at innovation are described below.

The first initiative is the creation of *Accountable Care Organizations (ACOs)* under the ACA. In ACOs, providers take on some financial responsibility for the patients in their care. Providers in ACOs are required to meet certain quality metrics for the care they provide, and if they meet those quality benchmarks while simultaneously saving money for Medicare, they receive a bonus payment. This is known as a one-sided ACO. In a two-sided ACO agreement, providers may also be financially penalized if they fail to meet quality and cost targets, in addition to the potential to earn bonus payments. While many ACOs are still participating in one-sided arrangements with CMS (they can earn bonuses but don't face the risk of penalties), CMS aims to rapidly move most ACOs into two-sided risk arrangements to further encourage savings.³¹

²⁹ [https://www.amjmed.com/article/S0002-9343\(17\)30134-1/pdf](https://www.amjmed.com/article/S0002-9343(17)30134-1/pdf)

³⁰ <https://www.ncbi.nlm.nih.gov/pubmed/31479136>

³¹ <https://www.jdsupra.com/legalnews/cms-final-rule-aggressively-moves-acos-20998/>

Medicare still reimburses ACO providers on a FFS basis, but the shared risk agreements are intended to generate savings for the program. Early evidence on the efficacy of ACOs has been somewhat mixed, but there is reason to believe they still hold promise for Medicare's cost-effectiveness. In total, Medicare ACOs saved the program almost \$740 million in 2018.³² Perhaps unsurprisingly, two-sided ACOs, those that include downside financial risk for providers, saved an average of \$96 per beneficiary, relative to just \$68 in savings for one-sided ACOs.³³ This suggests CMS's push for two-sided risk in all ACOs will continue to make the program more cost-effective. However, some analysts have noted that net of the bonus payments to ACOs, the cost savings are much more modest, and may have some unintended consequences. Since ACO savings are measured against a benchmark based on the provider's costs in years before they join the ACO, the bonus payments may be disproportionately rewarding cost-ineffective providers in one-sided risk agreements.³⁴ Providers with high costs and wasteful spending in their benchmark years find it much easier to generate cost savings than those who were already very cost-effective – these high-cost providers can easily collect bonus payments for making simple changes to make themselves efficient.

Bundled payments are another innovation to the payment and delivery systems intended to create savings for Medicare. Bundled payments actually move Medicare away from the FFS system by reimbursing based on an "episode of care" rather than the individual services provided.³⁵ Instead of paying providers per service, Medicare establishes a benchmark for a standard episode of care, for example a hip or knee replacement or an acute hospitalization, and reimburses the provider at that rate for all the services provided during the episode of care. If the provider manages to meet quality targets for their services at a cost below the benchmark, they get to keep some of the savings, but if their costs exceed the benchmark, they'll incur losses. This initiative is intended to remove incentives for volume of care and

³² <https://www.healthaffairs.org/doi/10.1377/hblog20190930.702342/full/>

³³ <https://www.healthaffairs.org/doi/10.1377/hblog20190930.702342/full/>

³⁴ <https://gisthealthcare.com/acos-still-arent-saving-money-medicare/>

³⁵ <https://innovation.cms.gov/initiatives/bundled-payments/>

instead push providers toward offering only the necessary services that create the most value for patients. Early evidence for this initiative is encouraging: bundled payments Model 1 generated \$10 million in savings for Medicare over 2 years, and bundled payments for hip and knee replacements saved about \$1,300 per episode relative to FFS.³⁶

More Potential Medicare Savings

Finally, Medicare price negotiations could generate even more savings. Medicare currently does not negotiate prices for prescription drugs or medical services, unlike private health insurance companies. The idea of introducing negotiations has historically been considered in reference to prescription drug prices. House bill H.R. 3, passed by the House in December 2019, would require the Department of Health and Human Services (HHS) to negotiate maximum prices for insulin products and “at least 25 single-source, brand-name drugs that do not have generic competition and that are among the 125 drugs that account for the greatest national spending or the 125 drugs that account for the greatest spending under the Medicare prescription drug benefit.”³⁷ Analysis shows quite conclusively that allowing Medicare to negotiate prescription drug prices could generate significant savings for the program. The Congressional Budget Office (CBO) estimates that price negotiations would save over \$450 billion in the next 10 years.³⁸

Though this would be an even more significant change to the program, Medicare could also negotiate prices for all medical services it purchases to generate further savings. Currently, Medicare does not negotiate prices for medical services either; instead, it pays providers based on a fee schedule.³⁹ Introducing negotiated reimbursement for all healthcare services under Medicare (as opposed to solely for prescription drugs) is a proposal that has not received as much attention historically, but has recently become more popular. Several Democratic presidential candidates in the 2020 primaries have proposed public option plans

³⁶ <https://innovation.cms.gov/initiatives/bundled-payments/>

³⁷ <https://www.congress.gov/bill/116th-congress/house-bill/3>

³⁸ <https://www.cbo.gov/publication/55936>

³⁹ <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FeeScheduleGenInfo>

that would allow Medicare to negotiate provider payment rates, including former Vice President Joe Biden.⁴⁰ Some public option proposals in Congress also include provisions for Medicare price negotiation, including Rep. Jan Schakowsky's (D-IL) CHOICE Act.⁴¹ Though the CBO has yet to offer analyses or budget scores for these proposals, third-party analyses suggest negotiating these payments could generate significant savings. A recent study by the Urban Institute found that reimbursing providers even just at current Medicare rates, as opposed to the higher rates private insurers pay, could lower premiums by 35% for beneficiaries of a public option plan.⁴²

Current Medicare Eligibility and Enrollment

The primary population eligible for Medicare is those aged 65 or older, but some younger people with disabilities can also qualify for Medicare coverage.⁴³ Those under 65 can receive Medicare coverage if they have received Social Security disability benefits for 24 months or if they have end-stage renal disease and are receiving regular dialysis or waiting for a kidney transplant.⁴⁴

As of 2019, about 38.5 million people were enrolled in traditional Medicare's hospital and/or medical insurance (Parts A and/or B).⁴⁵ About 23 million were enrolled in hospital and/or medical insurance through Medicare Advantage (Part C, which provides both types of insurance).⁴⁶ About 25.5 million people were enrolled in prescription drug coverage through

⁴⁰ <https://www.kff.org/health-reform/issue-brief/10-key-questions-on-public-option-proposals/>

⁴¹ <https://www.kff.org/health-reform/issue-brief/10-key-questions-on-public-option-proposals/>

⁴² <https://www.urban.org/sites/default/files/estimating-the-impact-of-a-public-option-or-capping-provider-payment-rates.pdf>

⁴³ <https://www.hhs.gov/answers/medicare-and-medicaid/who-is-eligible-for-medicare/index.html>

⁴⁴ <https://www.cms.gov/Medicare/Eligibility-and-Enrollment/OrigMedicarePartABEligEnrol>

⁴⁵ <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CMSProgramStatistics/Dashboard>

⁴⁶ <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CMSProgramStatistics/Dashboard>

traditional Medicare, and another 20.25 million received the prescription drug benefit through Medicare Advantage.⁴⁷

Current Medicare Financing and Payments

Medicare funds currently come from three major sources: general revenues, including the Hospital Insurance and Supplemental Insurance Trust Funds, payroll taxes (6.2% each for employers and employees), and beneficiary payments.⁴⁸ General revenues account for about 43% of the costs, payroll taxes 36%, and beneficiary payments 15%.⁴⁹

Medicare pays for care primarily on a FFS basis. This means that Medicare processes claims for the services its beneficiaries utilize, and pays healthcare providers a set fee for each service that they provide. The FFS system is commonly cited as a key driver of rising Medicare costs, and healthcare costs generally, because it means Medicare pays for healthcare services based on volume, rather than quality. As a result, providers are incentivized to give *as much* care as possible to their patients, rather than *the best* care possible.

However, Medicare Advantage (MA) uses a different system for payments, and still does not generate cost savings relative to traditional Medicare. MA accepts bids from private health plans to provide Medicare-level coverage to beneficiaries who opt in to the program. MA pays the plans a capitated rate based on their bids, and the plans can receive rebates if their bids are below the benchmark MA has set. Capitated rates are a set monthly payment per beneficiary – for example, a plan might submit a bid with a capitated rate of \$1,000, meaning they intend to provide benefits to enrollees at an average cost of \$1,000 per person per month (though some enrollees will be more or less expensive). If the benchmark set by MA were, for example, \$1,500 per month, then the plan would receive a rebate – they'd get some portion of the \$500 savings per beneficiary, and Medicare would keep the remaining portion.

⁴⁷ <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CMSProgramStatistics/Dashboard>

⁴⁸ <https://www.irs.gov/taxtopics/tc751>

⁴⁹ <http://files.kff.org/attachment/Issue-Brief-Facts-on-Medicaid-Spending-and-Financing>

Theoretically, this design would save money for the Medicare program by encouraging plans to submit bids below the benchmark and generating savings for both themselves and for Medicare. Historically, though, it has not achieved the savings that policymakers may have hoped for – throughout the 2000s, MA cost 100-110% of what traditional Medicare costs the federal government on a per beneficiary basis, and currently it costs about the same per beneficiary.⁵⁰

Legal and Regulatory Landscape

Much of Medicare is governed by regulations set forth by HHS. HHS regularly engages in rulemaking to make changes to the Medicare program. This includes everything from adjusting the fee schedules for provider payments, to adding new services to Medicare coverage (telehealth services are a recent addition), to instituting new quality measures.

However, some aspects of the Medicare program are laid out in law, and would require Congressional action in the form of new legislation in order to change them. Medicare was initially created under President Lyndon Johnson’s administration in 1965.⁵¹ The original law established Medicare Parts A and B – hospital and physician insurance – and extended eligibility to those over 65. Seven years later, eligibility was expanded to cover those with long-term disabilities and end-stage renal disease.⁵² In 1982, a hospice care benefit was added, and in 1983, another Social Security Amendment established the FFS payment system.⁵³ The next major change to the program was in 1997, when the Balanced Budget Act established Medicare Part C, now known as Medicare Advantage.⁵⁴ In 2003, the Medicare Modernization

⁵⁰ <https://www.commonwealthfund.org/publications/issue-briefs/2017/dec/evolution-private-plans-medicare>

⁵¹ <https://interactives.commonwealthfund.org/medicare-timeline/>

⁵² <https://interactives.commonwealthfund.org/medicare-timeline/>

⁵³ <https://interactives.commonwealthfund.org/medicare-timeline/>

⁵⁴ <https://interactives.commonwealthfund.org/medicare-timeline/>

Act permanently established the Medicare prescription drug benefit (Part D).⁵⁵ All of these aspects of the program are codified in law, and could not be adjusted with HHS rulemaking alone; they'd require new legislation.

Several of the following policy alternatives involve major changes that would require legislative action. For example, allowing Medicare to negotiate prescription drug prices or provider payments would require legislation from Congress authorizing that change. The same is true of changing the eligibility requirements for the program.

Policy Alternatives

This section includes a list of four policy options – two existing options and two new proposals – to address my stated policy problem: *Medicare costs are too high*. Medicare is one of the largest single payers for healthcare in America, but is not cost-effective enough per beneficiary. Finding a more cost-effective way to administer the program is especially important given that there is significant political momentum for expanding Medicare to a larger population, with the goal of achieving universal coverage. Below are four ways to structure the program: traditional Medicare, Medicare Advantage, and two Medicare public options.

I. Traditional Medicare

This alternative involves preserving the traditional Medicare program as it exists today. It offers a baseline against which to compare the other alternatives. Traditional Medicare currently consists of Medicare Part A, Part B, and Part D, which are the hospital benefit, outpatient care benefit, and prescription drug benefit, respectively.⁵⁶ Medicare establishes networks with providers directly, and pays them in a traditional fee-for-service (FFS) structure.

⁵⁵ <https://www.modernhealthcare.com/article/20110404/SUPPLEMENT/304049982/creation-of-the-medicare-part-d-prescription-drug-benefit-events-category-contestant>

⁵⁶ <https://www.medicare.gov/what-medicare-covers>

As a result of numerous factors – the FFS system, the rising cost of care, and the growing Medicare population – Medicare expenditures have been rising rapidly in recent years. It's one of the largest federal programs, accounting for about 15% of total federal outlays in 2018.⁵⁷ It's expected to rise to 18% of total federal outlays in the next 10 years. About 44 million people are currently covered by traditional Medicare, though more are eligible.⁵⁸

Total benefit payments in 2018 reached \$731 billion, and the net cost to the federal government (accounting for beneficiaries' contributions) was about \$605 billion. These funds come primarily from two Medicare trust funds: the Hospital Insurance Trust Fund and the Supplementary Medical Insurance Trust Fund.⁵⁹ Contributions to these trust funds come primarily through Medicare payroll taxes.

Beneficiaries also contribute through premiums and cost-sharing requirements. As described above, beneficiary payments cover almost \$130 billion of the total annual cost of the program. In 2016, the average Medicare beneficiary was responsible for about \$5,500 in out-of-pocket costs – about \$2,300 in premiums and about \$3,200 in cost-sharing for medical services like long-term care, doctors' visits, and prescription drugs.

II. Medicare Advantage

Medicare Advantage (MA), also known as Medicare Part C, is part of the Medicare program but differs significantly in its structure. Instead of paying providers directly on a FFS basis, MA contracts with private insurers and pays them a capitated rate per beneficiary covered. The private insurers are required to provide insurance with at least the same benefits as traditional Medicare Parts A and B. They may also offer Part D benefits (the prescription drug benefit) and additional benefits beyond that, like dental or vision care.

⁵⁷ <http://files.kff.org/attachment/Issue-Brief-Facts-on-Medicaid-Spending-and-Financing>

⁵⁸ <https://www.kff.org/medicare/fact-sheet/medicare-advantage/>

⁵⁹ <https://www.pgpf.org/budget-basics/medicare>

The program is still much smaller in terms of beneficiaries enrolled than traditional Medicare, but its growth has been rapid – about 22 million people were enrolled in MA as of 2019, up from less than 11 million in 2009.⁶⁰ Part of the reason for MA’s rising popularity among beneficiaries is the fact that many plans offer benefits not included in traditional Medicare – a large majority of MA beneficiaries receive a dental, vision, or fitness benefit that they would not get in the traditional program. MA beneficiaries must pay the Medicare premiums for Part A and B, and in some cases an additional premium to their MA insurer – on average, this additional premium is about \$350 per year.⁶¹

MA uses a bidding process to establish contracts with its private insurers. Plans that wish to provide MA coverage must submit a bid to Medicare, which is measured against a benchmark for the capitated rate. If the plan’s bid is below the benchmark, Medicare and the private plan each share in the savings. If the bid is above the benchmark, the plan must charge its beneficiaries premiums or cost-sharing requirements to cover the difference – Medicare will not pay more than the benchmark capitated rate. Despite this cost-control mechanism, MA does not generate significant savings relative to traditional Medicare. In 2017, the program cost the federal government almost exactly the same amount per beneficiary as traditional Medicare, and in previous years it cost slightly more on a per-beneficiary basis.

III. Medicare Public Option

This alternative would be a public option plan available only to people who are currently eligible for Medicare. The public option would offer all of the same benefits that traditional Medicare currently covers, and would be structured in the same way. The major difference between this public option plan and traditional Medicare is that the public option plan would negotiate payment rates for both provider payments and prescription drugs. Traditionally, Medicare has not been authorized to negotiate rates for either of these. Medicare currently pays providers and purchases prescription drugs based on a fee schedule and does not

⁶⁰ <https://www.kff.org/medicare/fact-sheet/medicare-advantage/>

⁶¹ <https://www.kff.org/medicare/fact-sheet/medicare-advantage/>

negotiate on behalf of its beneficiaries.⁶² Fees are set based on a combination of factors, most importantly the value of the care provided, cost of providing the care, and adjustments based on geographic area.⁶³ Unlike current Medicare, beneficiaries would be required to opt in to the prescription drug benefit. This is necessary to gather a large enough beneficiary population to generate significant savings on drug price negotiations.

By negotiating payments for services and prescription drugs, the public option could generate cost savings for the Medicare program and for its beneficiaries. Though the plan would only be offered to those currently eligible for traditional Medicare, it could increase overall coverage rates by picking up Medicare-eligible people who do not currently have Medicare coverage due to the cost of Medicare premiums and cost-sharing requirements. The premiums and cost-sharing requirements for the public option would be set at an actuarially fair price – enough to cover the cost of paying benefits and administering the plan. These costs would likely be lower for beneficiaries than they are under traditional Medicare.

IV. Medicare at 50 Public Option

This alternative would offer a new Medicare public option plan to current Medicare beneficiaries *and* anyone over 50 for an initial trial period of 5 years. This alternative is modeled after S. 470, the Medicare at 50 Act.⁶⁴ Current Medicare and MA beneficiaries would be allowed to switch to this public option plan, as well as any American aged 50-64. The plan would cover traditional Medicare Part A, B, and D benefits. Cost-sharing requirements and premiums for this plan would be set nationally at an actuarially fair cost – enough to cover benefit payments plus administrative costs. The same providers who currently contract with Medicare would be required to accept the Medicare public option plan as well. Like in Alternative III, this public option plan would be authorized to negotiate payment rates for prescription drugs and all other healthcare services. Like Alternative III, this plan would

⁶² <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FeeScheduleGenInfo>

⁶³ <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FeeScheduleGenInfo>

⁶⁴ <https://www.congress.gov/116/bills/s470/BILLS-116s470is.pdf>

generate cost savings thanks to negotiations and could pick up Medicare-eligible individuals who do not currently pay for Medicare coverage. It could also lead to greater cost-effectiveness on a per-beneficiary basis since the population aged 50-64 will likely be cheaper to insure than the current 65 and up Medicare population. Therefore, the premiums and cost-sharing requirements under this plan would likely be lower than under the public option plan described in Alternative III.

Criteria

Below is a list of the five criteria on which I will evaluate the above alternatives: cost-effectiveness, political feasibility, equity, ease of implementation, and reduction in the uninsured rate. Each criterion has been assigned a weight according to its importance in my analysis.

Cost-Effectiveness

Weight: 45%

For this criterion, I will perform a cost-effectiveness analysis (CEA) of each of my alternatives. For the purposes of my analysis, cost-effectiveness will be defined as the total cost of the alternative divided by the total number of beneficiaries covered by the alternative. The number of beneficiaries is technically an output of the program, but it is an appropriate proxy for the desired outcome. The implicit assumption is that improving access to care by increasing coverage rates will, generally, improve long-run health outcomes.

The costs included in the CEA will primarily be administrative costs and the costs of paying for benefits. All alternatives will have varying net costs for benefit payments, depending on which benefits are covered and what shares of costs are covered by beneficiary premiums and cost-sharing. Some alternatives involve significant changes or expansions to the program, which could involve increased administrative costs.

The timeline for the CEA will be 11 years, from 2020 to 2030. This is enough time for a trial run of each alternative, to see how each might perform before considering more changes to the system – like expanding a public option to the whole population. The CEA will include appropriate discounting at a rate of 7% over the course of the 11-year timeline. The units for this criterion will be dollars per person insured.

Methodology

In my cost-effectiveness analysis, I began by constructing a base case for enrollment and costs for Alternatives I and II, Medicare and MA. I retrieved projections of spending on benefits and administrative costs from CMS' 2019 Trustees Report,⁶⁵ and used historical and projected CMS data to estimate enrollment growth as well. As previously mentioned, I discounted costs and enrollment at a rate of 7%. One important caveat on this base case is that since MA and traditional Medicare draw funding from the same sources, there is no publicly available data on the breakdown in administrative costs between Medicare and MA. Instead, administrative costs listed in CMS datasets for Medicare include those costs for both Medicare and Medicaid. As a result, my CEA likely overestimates costs for Medicare and underestimates costs for MA.

In projecting costs for Alternatives III and IV, the Medicare Public Option and the Medicare at 50 Public Option, I used the same base estimates for Medicare costs and discounted them according to my assumptions on reimbursement cuts due to negotiation. I assumed Medicare would be able to negotiate a 1% cut in reimbursement in years 0-3, a 4% cut in years 4-7, and a 6% cut in years 8-10. Then, using a measure of the price elasticity of demand for Medicare insurance from a Mathematica literature review,⁶⁶ I calculated the number of new beneficiaries who would likely switch from Medicare to each public option given the lower, negotiated rates of reimbursement. My analysis assumes that premiums and cost-sharing under the public option will be reduced in direct proportion to the reduction in

⁶⁵ <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds>

⁶⁶ <https://www.mathematica.org/our-publications-and-findings/publications/price-and-income-elasticity-of-the-demand-for-health-insurance-and-health-care-services>

reimbursement rates, because CMS will charge an actuarially fair price for the public option plans. Finally, I increased the costs for each alternative in accordance with the increased beneficiary population, using estimates of the per-beneficiary costs of the Medicare program.

Political Feasibility

Weight: 10%

For any healthcare reform on the national level, political feasibility will be one of the major hurdles. Politically, it is never easy to achieve large-scale changes in national policy, so this criterion will have high importance in my analysis.

This political analysis will focus on key decision-makers within the legislative process. These include the Chairperson and Ranking Member of the Senate Health, Education, Labor, and Pensions Committee and the same authorities on the House Energy and Commerce Committee. As these committees would be the first to consider a healthcare reform bill, their members and particularly their leaders will be important actors in the political process. Also included in the analysis will be Speaker of the House and Senate Majority Leader, as well as the heads of the minority party in each chamber of Congress. Finally, I'll consider the likelihood of each alternative gaining the President's approval, since he will have the final say on whether an alternative will be passed into law.

Stakeholders outside of government will factor into this analysis as well. There are countless stakeholders who could be affected by major federal healthcare reform, but in the context of my alternatives, there are just a few groups of stakeholders to consider: insurance companies, healthcare providers, prescription drug companies, and patients. These are the key groups most likely to be affected by each of my alternatives, and therefore they are likely to take action to influence legislative action on the issue. Those actions could make new legislation more or less likely to pass, and must be included in my analysis.

Based on all of these actors' policy positions, past votes, and public comments on related healthcare reform initiatives, I'll analyze which of my alternatives would be most likely to earn their support, and therefore most likely to pass through Congress.

Political feasibility will be measured in three categories: high, medium, and low feasibility.

Equity

Weight: 15%

The problem my alternatives ultimately aim to address, in addition to cost, is the United States' lack of universal health coverage and the nation's resultant poor health outcomes. Key factors in this policy problem are the barriers to healthcare coverage and access that particularly afflict low-income Americans. Any alternative aiming to advance the cause of universal coverage must therefore account for those distributional effects. An alternative that would lead to government-sponsored insurance being affordable primarily for higher-income Americans would hardly address the problem effectively, whereas one that is accessible for low-income Americans would be much more effective – even if the program offered coverage to the same total number of people in each case.

To analyze the distributional impacts of my alternatives, I'll consider the cost burden each would place on enrollees to the given program, with a particular focus on low-income beneficiaries. For example, an alternative that involves high premiums and significant cost-sharing would be considered less equitable than one with lower premiums and minimal cost-sharing requirements. This criterion will also be measured in three categories: high, medium, and low equity.

Ease of Implementation

Weight: 10%

Like political feasibility, implementation is a very significant barrier to achieving healthcare reform at the national level. A new public option program would likely involve the government insuring millions of new Americans, and it's difficult to overstate the administrative difficulties

that could be involved in doing so. Therefore, making implementation as easy as possible will be a top priority.

To analyze the ease of implementation of each alternative, I'll begin by identifying the key agencies that would be responsible for implementation – it'll likely involve multiple, mostly under the Department of Health and Human Services (HHS), but also including the IRS and other agencies if the given alternative includes new taxes. Then, similar to in my political analysis, I'll examine how likely it is that each alternative would have the necessary buy-in from key agency heads, beginning with the heads of HHS and the Centers for Medicare and Medicaid Services (CMS). I'll analyze how much administrative work each alternative would require of the relevant executive agencies. My analysis will also account for the financial costs of implementation – alternatives that would require significant funding for implementation alone will likely be more difficult to implement than those with a lower financial cost. These analyses of the administrative burden, the likelihood of “buy-in” from the agencies on which the burdens fall, and the cost of implementation will lead to my assessment of ease of implementation.

Ease of implementation will also be measured in three categories: high, medium, and low ease of implementation.

Total Number of People Insured

Weight: 20%

The ultimate goal of healthcare reform and expansion is to reduce the number of uninsured people in America and move the country toward universal coverage. Insuring as many Americans as possible is one of the key goals of this policy intervention. Therefore, this criterion is necessary to quantify how well each alternative addresses the problem of high uninsured rates and improving access to healthcare through insurance coverage.

This criterion will be measured in the number of people who would be offered health insurance by each alternative insurance program according to my projections.

Findings

The results of my analysis are displayed in the outcomes matrix below, followed by a discussion of the key results. In each column, the alternative or alternatives scoring highest on the given criterion is in bold. The discussion of results is organized by criterion.

| | Cost- Effectiveness (45%) | Political Feasibility (10%) | Ease of Implementation (10%) | Equity (15%) | Total # Insured (20%) |
|-------------------------------|--|--|---|-------------------------|--------------------------------------|
| Medicare | \$22,748 | High | High | Medium | 39.4M |
| Medicare Advantage | \$10,730 | High | High | Low | 29.5M |
| Public Option | \$16,688 | Low | Low | High | 76.6M |
| 50+ Public Option | \$17,358 | Low | Low | High | 181.9M |

Cost-Effectiveness

MA emerged as the most cost-effective alternative in my analysis, though this is likely due to the caveat listed previously – because of the lack of publicly available data from CMS, I was forced to count some of the administrative costs of MA under the traditional Medicare alternative. Historical data cited in previous sections of this report demonstrates that the cost-effectiveness of MA is very similar to traditional Medicare, confirming that my estimate on this alternative is very low.

Setting aside MA, the most cost-effective alternative in my analysis was the Medicare Public Option. This is to be expected – despite covering many more beneficiaries than traditional Medicare, the public option is empowered to negotiate directly with provider networks to reduce reimbursement rates and therefore keep overall costs down. Even if my assumptions on rate cuts were overly optimistic – for example, if the public option plan were only able to

negotiate a maximum reimbursement reduction of 4% by the end of the 11-year analysis – the public option would still be significantly more cost-effective than traditional Medicare.

Political Feasibility

The political feasibility of Alternatives I and II is very high, since they are existing programs that would require no political action, simply preserving the status quo for Medicare and MA. The political feasibility of either of the public option alternatives is very low, since they would involve significant changes to the Medicare program and would require new legislation to be passed through Congress and signed into law by the President. The political feasibility of Alternative IV is lowest of all, since it involves the most significant expansion of the Medicare program. Currently, there is virtually no Republican support at the federal level for a Medicare public option. Several public⁶⁷ option⁶⁸ bills have been proposed during the most recent session of Congress, and none have bipartisan support. Most do not even have a majority of Democrats as cosponsors. One such bill, the Medicare at 50 Act, is quite similar to Alternative IV, and currently has just 20 cosponsors in the Senate, all of whom are Democrats. The political obstacles facing a public option are massive.

Ease of Implementation

The ease of implementation for Alternatives I and II, like their political feasibility, is also very high, since they are existing programs and the relevant federal agencies have already implemented them and are currently administering them. The ease of implementation for either of the public option alternatives is also very low. These alternatives would place a large new administrative burden on HHS and CMS, since Medicare would have to establish its own networks directly with providers and begin to negotiate reimbursement rates, neither of which CMS has ever attempted. Implementation would be quite complex and very uncertain, even assuming full buy-in from the relevant agencies, which is not guaranteed. It would likely take

⁶⁷ <https://www.congress.gov/bill/116th-congress/house-bill/2000?q=%7B%22search%22%3A%5B%22medicare+x%22%5D%7D&s=5&r=1>

⁶⁸ <https://www.congress.gov/bill/116th-congress/house-bill/2085?q=%7B%22search%22%3A%5B%22public+option%22%5D%7D&s=2&r=5>

years or even decades for CMS and providers to fully adjust to these changes to the system. As with political feasibility, the ease of implementation for the Medicare at 50 Public Option would be even lower than for the Medicare Public Option, since CMS would not only have to set up provider networks and negotiate with providers, but it would also have to handle tens of millions of new beneficiaries aged 50-64 who were not previously eligible for Medicare.

Equity

MA is rated at the lowest relative equity among the given alternatives, because most MA beneficiaries pay a small premium in addition to their traditional Medicare Part A and B premiums. Traditional Medicare, then, receives a slightly higher rating for equity, at medium – beneficiaries pay premiums and have some modest cost-sharing requirements. The two Medicare public option alternatives receive a rating of high on equity. My analysis assumes that CMS would set premiums at an actuarially fair price for the Medicare public option alternatives, which means that if negotiations lead to even a small reduction in reimbursement to providers, beneficiaries would receive those savings in the form of reduced premiums and cost-sharing requirements. Accordingly, the public option plans would pick up some individuals who may have been eligible for traditional Medicare, but forwent it due to cost. Indeed, my CEA shows that even under Alternative III, which does not expand the Medicare-eligible population, the public option plan would bring on millions of new beneficiaries. Since Alternatives III and IV make health insurance coverage significantly more affordable for low-income Americans, the equity rating for each is high.

Total Number of People Insured

According to my CEA, traditional Medicare will cover approximately 40 million people over the next 11 years, and MA will cover almost 30 million. These results are reasonable based on historical data on the two programs from recent years – Medicare's beneficiary population has been growing, and MA's beneficiary population has been growing even more rapidly due to the program's increasing popularity among beneficiaries. But each of the public option plans would cover far more beneficiaries – over 75 million under the Medicare Public Option and over 180 million under the Medicare at 50 Public Option. As with the estimates of cost-

effectiveness, these estimates are somewhat sensitive to the assumptions in my analysis, primarily the reduction in reimbursement rates and the elasticity of demand for Medicare insurance. However, within what my research has shown to be reasonable ranges for each of those values, the public option plans would still cover more people than either traditional Medicare or MA.

Recommendation

Based on the analysis above, I recommend Alternative III, the Medicare Public Option. Both of the public option alternatives performed so well on the two most important criteria – cost-effectiveness and total number insured – that they should be considered superior to either traditional Medicare or MA despite the massive challenges they face in political feasibility and ease of implementation. Alternatives III and IV also both perform better on equity, the third most highly weighted criterion in my analysis, than Alternatives I and II.

I've chosen to recommend the Medicare Public Option over the Medicare at 50 Public Option because of it compares favorably on cost-effectiveness, political feasibility, and ease of implementation. Though the Medicare at 50 Public Option would insure far more people than the Medicare Public Option, it would do so less cost-effectively and would face even greater barriers both in the political process and the implementation process. Its weaknesses on both these criteria are because it involves more major changes to Medicare than the Medicare Public Option. Implementation would likely be a particularly severe problem for the Medicare at 50 Public Option – the challenge of simultaneously covering millions of newly eligible beneficiaries and establishing and negotiating with provider networks would be incredibly complex for CMS. Therefore, I recommend the Medicare Public Option as the best alternative.

Since implementation of this policy will be quite complex and involves significant uncertainty for CMS, beneficiaries, and providers and drug manufacturers, it should not be implemented immediately following the passage of legislation creating the public option. Instead, there should be a period of 2-3 years for CMS to work with providers to create networks, begin negotiations, and, if necessary, hire additional administrative staff to handle the increased

burden that will come with the growing beneficiary population (my CEA accounts for these increased administrative costs). Then, when the public option is actually offered to beneficiaries, I expect decreases in provider reimbursement to happen gradually, as both the federal government and providers adjust to the new system – this gradual phase-in is also accounted for in my CEA. If the public option I've recommended performs as expected over the initial 11-year period, policymakers should consider the Medicare at 50 Public Option as a potential next step, since it is only slightly less cost-effective than the Medicare Public Option I've recommended and would expand coverage to millions more beneficiaries.

Appendix B: Alternative II CEA

[illegible]

Appendix C: Alternative III CEA

| | A | B | C | D | E | F | G | H | I | J | K | L | M | N | O |
|---|-------------|-------------|-----------|-------------------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|------------|----------|----------|
| | Assumptions | | | | | | | | | | | | | | |
| | | | | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 | 2026 | 2027 | 2028 | 2029 | 2030 | |
| Discount Rate | | 0.07 | | | | | | | | | | | | | |
| Reduction in Costs from Reimbursement Negotiations - Years 0-3 | | 0.01 | | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | |
| Reduction in Costs from Reimbursement Negotiations - Years 4-7 | | 0.04 | | | | | | | | | | | | | |
| Reduction in Costs from Reimbursement Negotiations - Years 8-10 | | 0.06 | | | | | | | | | | | | | |
| 10-Year Part D Cost Savings from Drug Price Negotiation (CBO Projection) | | 4.56E+11 | | Annual Cost | 21984.84 | 23668.578 | 24556.227 | 27421.431 | 29511.199 | 31698.018 | 33991.142 | 36295.647 | 39699.5101 | 43319.65 | 47278.47 |
| Average Annual Part D Cost Savings over 10 Years | | 4.56E+10 | | Annual Admin | 254.01017 | 268.75555 | 285.9869 | 305.68153 | 322.69471 | 334.49656 | 353.86225 | 380.72357 | 409.951596 | 439.0014 | 471.8984 |
| U.S. 50+ Population, 2020 (U.S. Census Projection) | | 119344516 | | Total Traditional | 38581132 | 36165304 | 33900748 | 31777991 | 29788154 | 27922914 | 26174470 | 24535508 | 22999172.5 | 21559037 | 20209079 |
| U.S. 50+ Population, 2021 (U.S. Census Projection) | | 121096837 | | Total Annual | 37902156 | 35841580 | 33832165 | 31890902 | 120164956 | 113244782 | 106619116 | 100420262 | 141864753 | 1.34E+08 | 1.26E+08 |
| U.S. 50+ Population, 2022 (U.S. Census Projection) | | 122580558 | | Difference in | -678976.6 | -323723.9 | -68582.78 | 112911.7 | 90376802 | 85321868 | 80444646 | 75884754 | 118865580 | 1.12E+08 | 1.06E+08 |
| U.S. 50+ Population, 2023 (U.S. Census Projection) | | 123852790 | | | | | | | | | | | | | |
| U.S. 50+ Population, 2024 (U.S. Census Projection) | | 125028541 | | | | | | | | | | | | | |
| U.S. 50+ Population, 2025 (U.S. Census Projection) | | 126286319 | | | | | | | | | | | | | |
| U.S. 50+ Population, 2026 (U.S. Census Projection) | | 127392661 | | | | | | | | | | | | | |
| U.S. 50+ Population, 2027 (U.S. Census Projection) | | 128573207 | | | | | | | | | | | | | |
| U.S. 50+ Population, 2028 (U.S. Census Projection) | | 129754013 | | | | | | | | | | | | | |
| U.S. 50+ Population, 2029 (U.S. Census Projection) | | 130971908 | | | | | | | | | | | | | |
| U.S. 50+ Population, 2030 (U.S. Census Projection) | | 132406309 | | | | | | | | | | | | | |
| Price Elasticity of Demand for Medicare | | -0.24 | | | | | | | | | | | | | |
| Increase in Demand for Medicare Given 1% Cost Reduction (%) | | 0.24 | | | | | | | | | | | | | |
| Increase in Demand for Medicare Given 4% Cost Reduction (%) | | 0.96 | | | | | | | | | | | | | |
| Increase in Demand for Medicare Given 6% Cost Reduction (%) | | 1.44 | | | | | | | | | | | | | |
| COSTS | | | | | | | | | | | | | | | |
| Medicare at 50 Public Option | | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 | 2026 | 2027 | 2028 | 2029 | 2030 | NPV | | |
| Year | | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | | | |
| Total Benefit Payments, Medicare Part A | | 3.4254E+11 | 3.421E+11 | 3.433E+11 | 3.44E+11 | 3.333E+11 | 3.329E+11 | 3.317E+11 | 3.39E+11 | 3.282E+11 | 3.313E+11 | 3.344E+11 | 3.7025E+12 | | |
| Total Benefit Payments, Medicare Part B | | 3.8848E+11 | 3.943E+11 | 3.688E+11 | 4.052E+11 | 3.997E+11 | 4.063E+11 | 4.115E+11 | 4.15E+11 | 4.207E+11 | 4.351E+11 | 4.5E+11 | 4.4952E+12 | | |
| Total Benefit Payments, Medicare Part D | | 1.098E+11 | 1.121E+11 | 1.132E+11 | 1.146E+11 | 1.155E+11 | 1.151E+11 | 1.155E+11 | 1.158E+11 | 1.163E+11 | 1.186E+11 | 1.21E+11 | 7.6614E+11 | | |
| Change in Benefit Payments Due to Change in Enrollment (Medicare v Public Option) | | -1.4927E+10 | -7.66E+09 | -1.68E+09 | 3.096E+09 | 2.667E+12 | 2.705E+12 | 2.734E+12 | 2.754E+12 | 4.719E+12 | 4.855E+12 | 5.003E+12 | 2.5416E+13 | | |
| Total Administrative Costs, Part A | | 5700000000 | 5.701E+09 | 5.677E+09 | 5.714E+09 | 5.645E+09 | 5.633E+09 | 5.597E+09 | 5.605E+09 | 5.82E+09 | 5.874E+09 | 5.927E+09 | 6.2894E+10 | | |
| Total Administrative Costs, Part B | | 3400000000 | 3.364E+09 | 3.406E+09 | 3.347E+09 | 3.357E+09 | 3.28E+09 | 3.265E+09 | 3.301E+09 | 3.201E+09 | 3.209E+09 | 3.253E+09 | 3.6384E+10 | | |
| Total Administrative Costs, Part D | | 7000000000 | 654205607 | 611407110 | 653038302 | 610316170 | 427791708 | 399805334 | 435924819 | 407406373 | 380753620 | 355844504 | 5636493547 | | |
| Change in Administrative Costs Due to Change in Enrollment (Medicare v Public Option) | | -172466973 | -87002597 | -19613776 | 34515022 | 2.916E+10 | 2.854E+10 | 2.847E+10 | 2.889E+10 | 4.873E+10 | 4.92E+10 | 4.993E+10 | 2.6268E+11 | | |
| Total Cost | | 8.3552E+11 | 8.505E+11 | 8.333E+11 | 8.767E+11 | 3.554E+12 | 3.597E+12 | 3.631E+12 | 3.662E+12 | 5.642E+12 | 5.799E+12 | 5.968E+12 | 3.4747E+13 | | |
| OUTCOMES | | | | | | | | | | | | | | | |
| Medicare at 50 Public Option | | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 | 2026 | 2027 | 2028 | 2029 | 2030 | NPV | | |
| Year | | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | | | |
| Traditional Medicare Annual Enrollment (Non-Discounted) | | 38581132.2 | 38696876 | 38812966 | 38929405 | 39046193 | 39163332 | 39280822 | 39398664 | 39516860 | 39635411 | 39754317 | | | |
| Total U.S. 50+ Population | | 119344516 | 121096837 | 122580558 | 123852790 | 125028541 | 126286319 | 127392661 | 128573207 | 129754013 | 130971908 | 132406309 | | | |
| Public Option-Eligible Population Not Enrolled In Medicare | | 80763383.8 | 82399961 | 83767592 | 84923385 | 85982348 | 87122987 | 88111839 | 89174543 | 90237153 | 91336497 | 92651992 | | | |
| Beneficiaries Switching from Traditional Medicare to Public Option | | 9259471.73 | 9287250.1 | 9315111.9 | 9343057.2 | 37484346 | 37596799 | 37709589 | 37822718 | 56904279 | 57074992 | 57246217 | | | |
| Non-Medicare Beneficiaries Opting in to Public Option | | 28642683.8 | 29063241 | 29419334 | 29724670 | 120027399 | 121234866 | 122296955 | 123430279 | 186845779 | 188599548 | 190650858 | | | |
| Total Annual Public Option Enrollment | | 37902155.6 | 38350491 | 38734446 | 39067727 | 157511745 | 158831665 | 160006544 | 161252997 | 234750058 | 245674539 | 247911302 | | | |
| Public Option Enrollment Growth | | 37902155.6 | 44833546 | 383954.79 | 333281.02 | 118444018 | 1319919.9 | 1174878.7 | 1246452.9 | 82497061 | 1924481.6 | 2236762.4 | | | |
| Total Public Option Beneficiaries | | 37902155.6 | 419005.1 | 335360.98 | 272056.59 | 90360374 | 941084.66 | 782871.3 | 776228.24 | 48014041 | 1046790.5 | 1137056.6 | 181987025 | | |
| Results | | | | | | | | | | | | | | | |
| Total NPV of Medicare at 50 Public Option Costs | | 3.4747E+13 | | | | | | | | | | | | | |
| Total Number Insured by Medicare at 50 Public Option | | 181987025 | | | | | | | | | | | | | |
| Total Cost Per Person Insured Over 11 Years | | 190933.04 | | | | | | | | | | | | | |

Appendix E: Initial Research and Policy Alternatives for Medicare Advantage Public Option

My initial focus for this project was on the possibility of a public option administered through Medicare Advantage. Though I shifted my focus to costs in Medicare more generally in coordination with my advisor, I completed a significant amount of research and developed policy alternatives for that original problem statement. That work is included below for my client's and others' edification.

MA Public Option Literature Review

Introduction

Health care spending in the U.S. accounts for almost one-fifth of the country's GDP, and has been rising rapidly for years.⁶⁹ These health care cost levels are mostly unique to the U.S. – other OECD countries spend about half as much per capita on health care, and that disparity has grown significantly since about 1980.⁷⁰ One key focus of health care expansion plans is to slow the rate of spending growth to a more sustainable level.

The majority of OECD countries have achieved universal, or near-universal, healthcare coverage.⁷¹ The World Health Organization (WHO) defines universal health coverage as “ensuring that all people have access to needed health services...while also ensuring that the use of these services does not expose the user the financial hardship.”⁷² The U.S. lags behind other developed nations and has yet to achieve universal coverage. According to the U.S. Census Bureau, about 8.5% of Americans, almost 30 million people, did not have health insurance at any point during 2018.⁷³ Along with reducing costs, the other major priority for healthcare expansion is reaching universal coverage.

⁶⁹ <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/highlights.pdf>

⁷⁰ https://www.healthsystemtracker.org/chart-collection/health-spending-u-s-compare-countries/#item-since-1980-the-gap-has-widened-between-u-s-health-spending-and-that-of-other-countries__2018

⁷¹ https://www.oecd-ilibrary.org/social-issues-migration-health/data/oecd-health-statistics/oecd-health-data-social-protection_data-00544-en?parentId=http%3A%2F%2Finstance.metastore.ingenta.com%2Fcontent%2Fcollection%2Fhealth-data-en

⁷² https://www.who.int/healthsystems/universal_health_coverage/en/

⁷³ <https://www.census.gov/library/publications/2019/demo/p60-267.html>

Almost all major healthcare expansion policy proposals would expand Medicare to additional populations in order to achieve these goals, and very few incorporate Medicare Advantage (MA). MA is a program in which Medicare contracts with private insurance companies to provide plans that meet or exceed the standards of traditional Medicare plans. *My client is interested in promoting the idea of a public option plan administered by MA, but lacks key information and analysis policymakers will need in considering the policy, primarily how such a plan would be financed.*

A MA public option is occasionally mentioned in discussions about healthcare expansion,⁷⁴ and some analysts have suggested it could be a more practical and cost-effective path to universal coverage.⁷⁵ Still, there is a lack of in-depth analysis of key questions about how it would work, especially how it could be financed, which is needed before policymakers can begin to seriously consider the proposal. This information gap is the problem I hope to solve for my client.

Unsustainable Medicare Spending

A financing plan for healthcare expansion through Medicare or MA must account for current and projected trends in spending. While some politicians' claims that Medicare is on the verge of going "bankrupt" are false, the program does face serious financing issues. By 2026, Medicare will only be able to pay about 90% of the hospital insurance costs it covers, and that share is projected to fall below 80% in the next 30 years.⁷⁶ According to the Center on Budget and Policy Priorities, the shortfall "will need to be closed through raising revenues, slowing the growth in costs, or most likely both." Funding for Medicare is already tight, even without the massive expansion that would be required for a public option plan.

Spending within MA is similarly unsustainable – the size of the program has been growing rapidly, but it has not generated significant cost savings relative to traditional Medicare. Today, MA accounts for over one-third of all Medicare recipients. Its size as a percentage of Medicare as a whole has nearly doubled in the past 20 years (from 18% to 34%) and its total enrollees have more than tripled (from 7 million to 22 million).⁷⁷

MA differs from traditional Medicare primarily in that it uses capitated monthly payments rather than a fee-for-service (FFS) model. In the traditional FFS model, payments are based on the services performed by providers. In the capitated model used to reimburse MA plans, Medicare pays the plans a set amount (or

⁷⁴ <https://www.modernhealthcare.com/insurance/industry-battles-medicare-all-traction>

⁷⁵ <https://www.healthaffairs.org/doi/10.1377/hblog20181219.912615/full/>

⁷⁶ <https://www.cbpp.org/research/health/medicare-is-not-bankrupt>

⁷⁷ <https://www.kff.org/medicare/fact-sheet/medicare-advantage/>

capitated payment) per enrollee.⁷⁸ The capitated payment is based on the enrollee's health status and a few other factors.

This reimbursement system was designed in part to save money relative to FFS Medicare, but has failed to do so. The capitated payments to private insurers cost the Medicare program slightly more, on average per recipient, than FFS Medicare coverage, and costs have risen in recent years.⁷⁹ This cost issue is only exacerbated by MA's rapid enrollee growth.

Current Medicare Advantage Financing

Medicare does not list funding details for MA specifically on its website; it only describes the Hospital Insurance Trust Fund and Supplemental Medical Insurance Trust Fund, which are used to finance Medicare Parts A, B, and D (MA is also known as Medicare Part C).

Other⁸⁰ sources⁸¹ suggest that MA funding comes from a combination of cost-sharing paid by enrollees (premiums, deductibles, and co-pays) and general revenues collected by the federal government. The Hospital and Supplemental Trust Funds also help to fund the program.⁸²

The cost-sharing burden on enrollees accounts for a significant portion of funding. Enrollees are required to pay the standard Part B premium, which averages about \$135 per month,⁸³ and an additional premium for their MA plan, which averages about \$29 per month.⁸⁴ MA enrollees must also have Medicare Part A coverage, but the majority of beneficiaries receive Part A without paying any premiums.⁸⁵

It's difficult to tell exactly what proportion of MA is financed by cost-sharing as opposed to government spending, since MA is not separately financed from the rest of Medicare. But it's possible to make a rough estimate – MA now covers 22 million enrollees and total benefit payments add up to about \$233 billion annually.⁸⁶ The average Part B and Part C premiums add up to \$164 monthly or \$1,968 annually per enrollee.

⁷⁸ <https://www.kff.org/medicare/fact-sheet/medicare-advantage/>

⁷⁹ <https://www.commonwealthfund.org/publications/issue-briefs/2017/dec/evolution-private-plans-medicare>

⁸⁰ <https://www.medicareresources.org/faqs/how-is-medicare-funded/>

⁸¹ <https://pocketsense.com/medicare-advantage-funded-6793921.html>

⁸² <https://www.pgpf.org/budget-basics/medicare>

⁸³ <https://www.medicare.gov/Pubs/pdf/12026-Understanding-Medicare-Advantage-Plans.pdf>

⁸⁴ <https://www.kff.org/medicare/fact-sheet/medicare-advantage/>

⁸⁵ <https://www.medicare.gov/your-medicare-costs/part-a-costs>

⁸⁶ <http://files.kff.org/attachment/Issue-Brief-Facts-on-Medicaid-Spending-and-Financing>

Based on these averages, premiums cover about 18.5% of MA's annual spending, while the other government funding sources listed above bear the other approximately 80%. This balance is similar to traditional Medicare, in which about 15% of costs are paid through premiums, about 35% through payroll taxes, and the remaining balance through government revenues.⁸⁷

Other Financing Options

MA financing operates at about an 80:20 ratio of cost-sharing to government financing. This balance between premiums and government spending is one viable option for financing a healthcare expansion plan, but other proposals offer additional alternatives. Some reduce cost-sharing drastically, some strike a balance like MA, and some depend primarily on cost-sharing with little government spending.

Reduced Cost-Sharing

Sen. Sanders' Medicare for All proposal is one of the most generous healthcare expansion plans; it eliminates virtually all cost-sharing for beneficiaries and relies almost exclusively on government revenue raised through tax increases.⁸⁸ In several white⁸⁹ papers,⁹⁰ Sanders outlined some possible options for raising these revenues, including:

- More progressive income taxes, with a 70% marginal tax rate for income above \$10 million;
- More progressive estate taxes, with a 77% marginal tax rate for inheritances over \$1 billion;
- Other wealth taxes;
- Closing loopholes and eliminating tax deductions for the wealthy;
- Creating a tax on extreme wealth;
- A 7.5% income-based premium for employers; and
- A 4% income-based premium paid by households.

⁸⁷ <http://files.kff.org/attachment/Issue-Brief-Facts-on-Medicaid-Spending-and-Financing>

⁸⁸ <https://www.kff.org/interactive/compare-medicare-for-all-public-plan-proposals/>

⁸⁹ <https://www.sanders.senate.gov/download/options-to-finance-medicare-for-all?inline=file>

⁹⁰ <https://www.sanders.senate.gov/download/medicare-for-all-2019-financing?id=860FD1B9-3E8A-4ADD-8C1F-0DEDC8D45BC1&download=1&inline=file>

Sen. Warren, who endorses the same Medicare for All bill, has released a different proposal for financing that plan. Her plan avoids taxes or cost-sharing for the middle class, and instead makes up the difference by requiring every employer to contribute 98% of their current healthcare spending to a federal trust fund for Medicare.⁹¹

Combination Cost-Sharing and Government Funding

There are a number of more moderate public option proposals (all focused primarily on traditional Medicare) that would expand the role of government-subsidized health insurance while also leaving some of the cost burden with the beneficiaries.

One illustrative example is the “Medicare for America Act,” a far-reaching public option plan that would cover everyone through Medicare with the only exception being those who already have employer coverage. Beneficiaries would be responsible for the following costs, according to the bill’s sponsors⁹²:

- A premium set by HHS for those above 200% of the poverty line, not to exceed 10% of monthly income;
- A deductible of \$350 for individuals or \$500 for families; and
- Total out-of-pocket costs capped at \$3,500 for individuals and \$5,000 for families.

Government revenues would finance the rest of the costs. The funds would be raised through a variety of tax increases: repealing the recent Trump administration tax cuts, a new 5% surtax on income over \$500,000, and increases in Medicare payroll taxes and investment income taxes.⁹³

Since beneficiaries would have to pay some costs, this plan would be more affordable to the federal government than the Sanders-Warren Medicare for All proposal. However, that cost-sharing is much more limited than insurance plans for many Americans today, thanks to the increased government revenues that would subsidize the plan. Currently, over 17 million people with employer-sponsored private insurance spend over 10% of their income on premiums, and more than 10 million spend more than 10% of their income on out-of-pocket costs.⁹⁴ Both these categories of individual spending would be capped under the Medicare for America plan.

⁹¹ <https://www.vox.com/policy-and-politics/2019/11/4/20946215/sanders-warren-medicare-payroll-tax>

⁹² https://delaware.house.gov/sites/delauro.house.gov/files/Medicare_for_America_Summary.pdf

⁹³ https://delaware.house.gov/sites/delauro.house.gov/files/Medicare_for_America_Summary.pdf

⁹⁴ <https://www.commonwealthfund.org/publications/issue-briefs/2019/may/how-much-us-households-employer-insurance-spend-premiums-out-of-pocket>

Primarily Cost-Sharing

Other expansion plans would be financed exclusively through premiums and cost-sharing. The “Medicare-X Choice Act,” the “Choose Medicare Act,” and the “CHOICE Act” are a few examples of public option plans that would not be funded by tax increases. They propose setting premiums to cover the payments the public plan would make, plus administrative costs.⁹⁵ In insurance, this structure is considered the “actuarially fair” price – enough to pay the insurer’s costs for covering the individual, but no more. Private insurers never offer actuarially fair premiums because they have to make a profit, but a government-sponsored insurance plan would be able to do so.

Still, even an actuarially fair premium could be expensive. The public option plans mentioned above mostly intend to offer plans to individuals who are currently buying insurance on the individual exchanges.⁹⁶ In these cases, a government-sponsored plan would compete with private insurers for that consumer population, but mostly would not attempt to replace or improve upon the employer-sponsored insurance most Americans have (unlike more generous plans like Medicare for America or Medicare for All). These plans would also have out-of-pocket limits, but they’d be higher than under Medicare for America – generally about \$7,900.

Premiums might be higher than under taxpayer-funded expansion plans, too. Since these plans would operate on the exchanges, those plans offer a useful estimate – in 2019, the average monthly premium for an exchange plan was \$478 per month (though it should be noted they vary widely by state).⁹⁷ Median per capita monthly income in America is about \$2650, so Medicare for America would cap monthly premiums, on average, at about \$265 per month.

Some of the disparity in costs, however, could be due to private insurers’ profit margins. It may be that a nonprofit, government-run public option financed fully by premiums would actually have lower premiums than the current \$478 private average. The ACA set medical-loss ratios for private insurers dictating that 80% of premiums paid to private insurers for exchange plans must be used for paying claims and improving quality, while no more than 20% can go to administrative costs including profits and salaries.⁹⁸ If insurers are currently using the full 20% on exchange plans, and if a government plan eliminated those costs entirely, it could reduce the average premium by almost \$100. There are major caveats, though: first, some insurers are probably

⁹⁵ <http://files.kff.org/attachment/Table-Side-by-Side-Comparison-Medicare-for-all-Public-Plan-Proposals-116th-Congress>

⁹⁶ <http://files.kff.org/attachment/Table-Side-by-Side-Comparison-Medicare-for-all-Public-Plan-Proposals-116th-Congress>

⁹⁷ <https://www.kff.org/health-reform/state-indicator/marketplace-average-benchmark-premiums/?currentTimeframe=0&sortModel=%7B%22collId%22:%22Location%22,%22sort%22:%22asc%22%7D>

⁹⁸ <https://www.verywellhealth.com/what-is-the-medical-loss-ratio-and-why-does-it-matter-4161024>

spending over 80% of premiums on claims and quality, and second, a government plan would still have some administrative costs. This suggests that a public option plan would have to set a relatively high premium – perhaps over 10% of monthly income for an average person – in order to be fully self-funded.

Conclusions

A review of the literature demonstrates that healthcare costs and universal coverage are serious problems in the U.S., as are spending levels and financing mechanisms within Medicare and MA. Because these issues are so pressing, there are numerous healthcare expansion proposals in the literature, and their financing plans offer lessons for how to pay for a MA expansion. Eliminating cost-sharing completely would require very significant tax increases, while avoiding tax increases entirely would require very expensive premiums. Some balance in-between, with beneficiary and government funding, might be able to move the country toward universal coverage with manageable costs to individuals and the federal government. Since MA does already draw funding from both sources, this seems feasible – the question is exactly what balance is appropriate.

MA Public Option Policy Alternatives

Introduction

This memo includes a list of four potential policy alternatives to address the following policy problem: *My client, The Daschle Group, is interested in promoting the idea of a public option plan administered by MA, but lacks key information and analysis policymakers will need in considering the policy, primarily how such a plan would be financed.*

A MA public option plan would get its funds primarily from two sources: payments from beneficiaries and funding from the federal government. The alternatives listed below span the spectrum from fully beneficiary-funded to fully government-funded. Also included in the interest of being comprehensive is the status quo, though this option is shown to be untenable.

I. Status Quo

Currently, MA funding comes from a combination of cost-sharing and premiums paid by enrollees as well as general revenues collected by the federal government.⁹⁹¹⁰⁰ The Hospital and Supplemental Trust Funds also

⁹⁹ <https://www.medicareresources.org/faqs/how-is-medicare-funded/>

help to fund the program.¹⁰¹ MA now covers 22 million enrollees, and total benefit payments add up to about \$233 billion annually.¹⁰² The average premiums add up to \$164 monthly or \$1,968 annually per enrollee. Based on these averages, premiums cover about 18.5% of MA's annual spending, while the other government funding sources listed above bear the other approximately 80%. This balance is similar to traditional Medicare, in which about 15% of costs are paid through premiums, about 35% through payroll taxes, and the remaining balance through government revenues.¹⁰³

However, continuing with the same financing system for a MA public option plan is not a very viable option. If current trends continue, Medicare will only be able to pay about 90% of the hospital insurance costs it covers by 2026, and that share is projected to fall below 80% in the next 30 years.¹⁰⁴ This shortage would only be exacerbated if MA were expanded to a much larger population. Any expansion of Medicare or MA will likely need to incorporate a new financing plan, as the current trends are unsustainable.

II. Fully Government-Funded

One alternative for financing is to fund the MA public option primarily through increased tax revenues and perhaps a modest income-based premium. This financing plan is included in the "Medicare for All" bill supported by Sens. Bernie Sanders and Elizabeth Warren.¹⁰⁵ If an MA public option were financed in this way, beneficiaries would not have any co-pays or deductibles, and would likely have to pay only a monthly premium based on their income.¹⁰⁶ Income-based premiums should be capped at 10% of monthly household income – individuals paying more than this are generally considered to have too-high premiums for their budget.¹⁰⁷ The rest of the funds for the plan would come from government revenues, which would require

¹⁰⁰ <https://pocketsense.com/medicare-advantage-funded-6793921.html>

¹⁰¹ <https://www.pgpf.org/budget-basics/medicare>

¹⁰² <http://files.kff.org/attachment/Issue-Brief-Facts-on-Medicaid-Spending-and-Financing>

¹⁰³ <http://files.kff.org/attachment/Issue-Brief-Facts-on-Medicaid-Spending-and-Financing>

¹⁰⁴ <https://www.cbpp.org/research/health/medicare-is-not-bankrupt>

¹⁰⁵ <https://www.congress.gov/bill/116th-congress/senate-bill/1129/text>

¹⁰⁶ <https://www.congress.gov/bill/116th-congress/senate-bill/1129/text>

¹⁰⁷ <https://www.commonwealthfund.org/publications/issue-briefs/2019/may/how-much-us-households-employer-insurance-spend-premiums-out-of-pocket>

significant tax increases. Sens. Sanders^{108 109} and Warren¹¹⁰ have each proposed a variety of new taxes they'd institute to raise these revenues.

This approach guarantees affordability and access for nearly everyone, as the cost of utilization (going to the doctor or hospital or purchasing prescription drugs) would essentially be zero; care would be free at the point of service. This is the policy alternative's major strength. The downside is that it places a massive cost burden on the federal government, since beneficiaries' contributions would be so small relative to the cost of the program. It's safe to assume that if an MA public option plan were to offer a competitive benefit package with capped premiums and no cost-sharing, millions of Americans would enroll, leading to significant costs. This would lead to the same problems Medicare is already facing: not enough funding from tax revenues to cover the full cost of paying out benefits. Therefore, this alternative requires the federal government to also institute new and higher taxes to cover the cost, which is very unpopular and hampers the political feasibility of the policy.

III. Combination Cost-Sharing and Government Funding

This policy alternative would entail splitting the cost of financing the public option plan between premiums and cost-sharing paid by the beneficiaries and government funds. This is similar to the way MA is currently financed – beneficiaries currently pay premiums and some co-pays accounting for nearly 20% of the program's costs while the government funds the other 80%, as described under the status quo alternative. But the key difference in this alternative is that it would involve raising new government revenues through taxes in order to make the expansion affordable. Premiums would still be capped at 10% of monthly income to avoid a high cost burden on beneficiaries, and there would be small deductibles and caps on out-of-pocket costs (\$350 and \$3,500, respectively). These are the guidelines laid out in the "Medicare for America Act of 2019," which is an example of a public option plan that uses a combination of cost-sharing and new tax revenues for financing.¹¹¹

That plan also includes some tax increases that would be necessary to cover the costs that remain after accounting for beneficiaries' contributions. These include repealing the recent Trump administration tax cuts, a new 5% surtax on income over \$500,000, and increases in Medicare payroll taxes and investment income

¹⁰⁸ <https://www.sanders.senate.gov/download/options-to-finance-medicare-for-all?inline=file>

¹⁰⁹ <https://www.sanders.senate.gov/download/medicare-for-all-2019-financing?id=860FD1B9-3E8A-4ADD-8C1F-0DEDC8D45BC1&download=1&inline=file>

¹¹⁰ <https://medium.com/@teamwarren/ending-the-stranglehold-of-health-care-costs-on-american-families-bf8286b13086>

¹¹¹ <https://www.congress.gov/bill/116th-congress/house-bill/2452>

taxes.¹¹² While the inclusion of tax hikes still harms the political feasibility of this financing plan, the new taxes would be far fewer than if beneficiaries did not share any of the costs.

The key advantage of this financing structure is that it would be more affordable to the federal government *and* to many beneficiaries, in comparison to some current private insurance options. Today, over 17 million people with employer-sponsored private insurance spend over 10% of their income on premiums, and more than 10 million spend more than 10% of their income on out-of-pocket costs.¹¹³ Both these categories of individual spending would be capped under a MA public option with this financing plan, relieving many individuals of an onerous cost burden.

IV. Self-Funded by Cost-Sharing and Premiums

Another approach to financing an MA public option would be to set premiums and cost-sharing requirements such that they would cover the full cost of the program, eliminating the need for the government to contribute new funds. Several existing public option proposals take this approach, including the “Medicare-X Choice Act,” the “Choose Medicare Act,” and the “CHOICE Act.” They propose setting premiums to cover the payments the public plan would make, plus administrative costs.¹¹⁴ In insurance, this structure is considered the “actuarially fair” price – enough to pay the insurer’s costs for covering the individual, but no more. Private insurers never offer actuarially fair premiums because they have to make a profit, but a government-sponsored insurance plan would be able to do so.

The obvious advantage of this plan is that aside from initial administrative costs of designing and implementing the new public option, the federal government wouldn’t have to allocate any new funds for the program. This makes it much more appealing to policymakers and is likely the reason so many existing proposals include self-funding through premiums.

The downside is that premiums would necessarily be higher than under financing plans that incorporate government funding. Even an actuarially fair premium might be expensive for some households. Since these plans would operate on the exchanges, those plans offer a useful estimate – in 2019, the average monthly

¹¹² https://delauero.house.gov/sites/delauro.house.gov/files/Medicare_for_America_Summary.pdf

¹¹³ <https://www.commonwealthfund.org/publications/issue-briefs/2019/may/how-much-us-households-employer-insurance-spend-premiums-out-of-pocket>

¹¹⁴ <http://files.kff.org/attachment/Table-Side-by-Side-Comparison-Medicare-for-all-Public-Plan-Proposals-116th-Congress>

premium for an exchange plan was \$478 per month (though it should be noted they vary widely by state).¹¹⁵ Median per capita monthly income in America is about \$2650, so the income-based premiums with a 10% cap (as described for alternatives II and III) would average \$265 per month.

Those average exchange premiums, however, may skew high because of private insurers' profit margins. It may be that a nonprofit, government-run public option financed fully by premiums would actually have lower premiums than the current \$478 private average. The ACA set medical-loss ratios for private insurers dictating that 80% of premiums paid to private insurers for exchange plans must be used for paying claims and improving quality, while no more than 20% can go to administrative costs including profits and salaries.¹¹⁶ If insurers are currently using the full 20% on exchange plans, and if a government plan eliminated those costs entirely, it could reduce the average premium by almost \$100. There are major caveats, though: first, some insurers are probably spending over 80% of premiums on claims and quality, and second, a government plan would still have some administrative costs. This suggests that a public option plan would have to set a relatively high premium – perhaps over 10% of monthly income for an average person – in order to be fully self-funded.

¹¹⁵ <https://www.kff.org/health-reform/state-indicator/marketplace-average-benchmark-premiums/?currentTimeframe=0&sortModel=%7B%22collId%22:%22Location%22,%22sort%22:%22asc%22%7D>

¹¹⁶ <https://www.verywellhealth.com/what-is-the-medical-loss-ratio-and-why-does-it-matter-4161024>

