The Impact of Medicare-X Choice on Coverage, Healthcare Use, and Hospitals

Supplemental Report

Prepared For:
American Hospital Association
Federation of American Hospitals

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August 6, 2019

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I. Summary

Medicare-X Choice is a legislative proposal that would allow any individual to voluntarily enroll in a public health insurance plan. Individuals and small businesses could enroll in the public plan through the health insurance Marketplaces. The public plan would reimburse providers using Medicare rates which are significantly less than commercial rates. On March 12, 2019, KNG Health released a study that measured the impact of Medicare-X Choice on coverage, healthcare use, and hospitals.[1]

On April 2, 2019, U.S. Senators Michael F. Bennet and Timothy Kaine reintroduced their legislation, which included the following changes:

- Broadened the income-based eligibility of the Marketplace premium tax credits;
- Increased the Marketplace premium tax credit amounts;
- Fully implemented in 2025;
- Authorized $10 billion in reinsurance funding; and
- Established a process for providers to opt out of the public plan.

In this supplement report, we update our model to reflect changes in the bill and regenerate our key findings. As in our original analysis, we find that Medicare-X Choice would result in significant changes in the health insurance landscape, with more than 40 million people enrolling in the public plan, and the majority of enrollment coming from commercial coverage. Between 2025 and 2034, provider payments would decrease by more than $1.2 trillion, with hospital payments falling by more than $800 billion.

II. Methods

We used the KNG Health Reform Model (KNG-HRM) to estimate individual and family insurance coverage decisions. The KNG-HRM is a microsimulation model that uses a parameterized utility function to determine individual insurance coverage choices. More information on the KNG-HRM can be found in both the original report on Medicare-X Choice and in an online appendix.[2] We implemented the new tax credit design according to the schedule specified in the bill (Table 1). We also changed the modeling period to 2025 to 2034, to reflect the first 10-years of full implementation.

[1] The Impact of Medicare-X Choice on Coverage, Healthcare Use, and Hospitals. KNG Health Consulting. March 2019. Available at https://bit.ly/2Xsn4sS.

[2] KNG Health Reform Model: Technical Report. KNG Health Consulting. April 2019. Available at https://bit.ly/2xwxzRw.

Table 1. Tax credits under Medicare-X with S. 981

Tiers of Household Income, as a Percent of the Poverty Line	Initial Premium Percentage	Final Premium Percentage
Up to 138%	1.5	1.5
138%-150%	2.5	3.5
150%-200%	3.5	5.8
200%-250%	5.8	7.55
250%-300%	7.55	9.0
300%-400%	9.0	9.0
400%-600%	9.0	13.0
600% and up	13.0	13.0

We did not model the reinsurance and provider opt-out provisions delineated in the bill. The new bill provides $10 billion for a reinsurance fund annually from 2021 to 2023. We did not model the reinsurance provision because it would no longer be in place in 2025, which is the first year of our model. The bill also requires the Secretary of the Department of Health and Human Services to "…establish a process by which a health care provider may opt out of being a participating provider under the health plan." Our previous model did not model provider participation and assumed enrollees would have access to all their healthcare services. We continue that assumption here.

III. Key Findings

Changes in Insurance Coverage. Enrollment in the public plan would be 42.1 million in 2025 and would increase to 44.2 million by 2034 (Table 2). By 2025, the number of uninsured and the commercially insured on the non-group market would fall by 6.3 and 13.4 million, respectively, while enrollment in employer-sponsored insurance (ESI) would fall by 22.4 million. The greatest percentage change in coverage was seen in the non-group population, with a decrease of 63 percent, compared to a 22 percent decrease for the uninsured and a 15 percent decrease for the ESI.

Table 2. Change in Insurance Coverage Status – 2025 and 2034

					Change in Coverage under Medicare-X Choice	
Source of Coverage	Baseline		Coverage Change		Percent Change	
	2025	2034	2025	2034	2025	2034
Employer	152.8 M	155.3 M	-22.4 M	-21.4 M	-15%	-14%
Non-Group	21.1 M	21.4 M	-13.4 M	-14.8 M	-63%	-69%
Uninsured	29.2 M	31.5 M	-6.3 M	-8.1 M	-22%	-26%
Public			42.1 M	44.2 M	n/a	n/a

Source: KNG Health analysis of public plan options using the KNG-Health Reform Model.
Note: n/a = Not Applicable. Components may not sum to totals because of rounding.

Public plan take-up rates are highest for non-group enrollees (71%) and lowest for those with employer coverage (15%) (Table 3). Despite a lower public plan take-up rate among those with employer coverage, the baseline ESI pool is so large that it still represents the largest source of covered lives in the public plan.

Table 3. Take-up of Public Plan among the Uninsured, Commercially Insured Individuals on the Non-Group Market, and ESI in 2025

		Coverage Levels	
Baseline Coverage	Post Coverage	Baseline	Medicare-X Choice
Employer	Employer	152.8 M	130.4 M
	Non-Group		0.2 M
	Public		22.2 M
	Uninsured		0.0 M
Non-Group	Non-Group	21.1 M	6.1 M
	Public		14.9 M
	Uninsured		0.1 M
Uninsured	Uninsured	29.2 M	22.8 M
	Public		5.0 M
	Non-Group		1.5 M

Source: KNG Health analysis of public plan options using the KNG-Health Reform Model.
Note: Components may not sum to totals because of rounding.

Changes in Healthcare Spending. We estimate that introduction of a public plan would cause spending to fall by $1.3 trillion over a ten-year period (Table 4). The spending reductions occur among populations who previously had private coverage and are the result of lower prices under the public plan.

For those who previously had ESI and non-group coverage, spending would fall by 4 percent and 30 percent, respectively. The larger non-group spending impact is driven by both higher per-person spending and higher take-up rates among that population. Among those uninsured in the baseline, we estimate spending would increase by 10 percent, which is driven by higher service utilization rates for those gaining insurance coverage. This increase in spending for the originally uninsured partially offsets the reduction in spending among the other groups.

Table 4. Spending by Original Source of Coverage in Baseline and Under Medicare-X Choice

Original Source of Coverage	Baseline		Impact	
	2025	2025-2034	2025	2025-2034
Employer	$1,063 B	$12,619 B	-$41 B	-$492 B
Non-Group	$231 B	$2,821 B	-$65 B	-$857 B
Uninsured	$81 B	$988 B	$8 B	$96 B
Total	**$1,375 B**	**$16,428 B**	**-$98 B**	**-$1,253 B**

Source: KNG Health analysis of public plan options using the KNG-Health Reform Model, S. 981 update
Note: Spending excludes populations covered by public coverage (e.g., Medicaid, TRICARE). Components may not sum to totals because of rounding

Effects on spending by category of service. The updated estimates show reductions in payments to hospitals of $836 billion under Medicare-X Choice over the 10-year period from 2025 to 2034 (Table 5). This is an 11 percent reduction in hospital payments over the period. Payments to non-hospital providers would also decrease by 5 percent over the 10-year period.

Table 5. Spending by Type of Service in Baseline and Under Medicare-X Choice

Type of Service			Change in Spending by Service (1-Year and 10-Year)			
	Baseline		Dollars		Percent	
	2025	2025-2034	2025	2025-2034	2025	2025-2034
Hospital	$643 B	$7,693 B	-$66 B	-$836 B	-10%	-11%
Hospitalizations	$270 B	$3,230 B	-$31 B	-$399 B	-12%	-12%
Hospital Outpatient Visits	$139 B	$1,656 B	-$14 B	-$175 B	-10%	-11%
Emergency Department	$88 B	$1,056 B	-$10 B	-$129 B	-12%	-12%
Other Hospital	$146 B	$1,750 B	-$10 B	-$133 B	-7%	-8%
Non-Hospital	$732 B	$8,736 B	-$32 B	-$417 B	-4%	-5%
Physician Visits	$93 B	$1,115 B	-$7 B	-$93 B	-7%	-8%
Prescription Drugs	$273 B	$3,252 B	$1 B	$8 B	0%	0%
Other Non-Hospital	$365 B	$4,369 B	-$26 B	-$333 B	-7%	-8%
Total	**$1,375 B**	**$16,428 B**	**-$98 B**	**-$1,253 B**	**-7%**	**-8%**

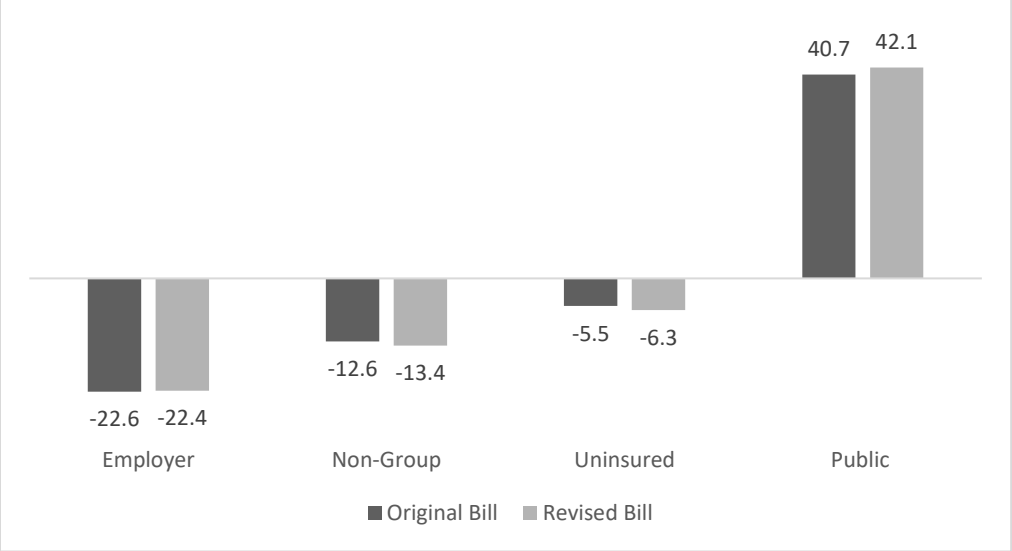
Source: KNG Health analysis of public plan options using the KNG-Health Reform Model.
Note: Spending excludes populations covered by public coverage (e.g., Medicaid, TRICARE). Components may not sum to totals because of rounding.

IV. Conclusions

We find that the modifications to the subsidy structure and delayed implementation of Medicare-X Choice do not change our principal findings of the effects of Medicare-X Choice. We still forecast high-levels of public plan enrollment that reflects some coverage gains among the uninsured but is mostly driven by crowd-out of commercial coverage. Over the period from 2025 to 2034, health care spending for the relevant population would decline by 8 percent, with hospital spending being more affected than other types of spending.

Relative to our original analysis, we find larger reductions in the uninsured (Figure 1). This results from both higher income populations (i.e. above 400% of the Federal Poverty Level) becoming eligible for health insurance subsidies and more generous subsidies at lower income levels. Relative to our original analysis, we also find a decline in non-group enrollment, with those dropping non-group coverage moving onto the public plan. Since the enhanced subsidies also could be used to support the purchase non-group coverage, the decline in non-group enrollment is surprising. This finding is the result of high levels of premium volatility in some markets that have few residual non-group enrollees once a public plan is introduced. In such markets, even small changes in risk pools can have large impacts on premiums, which can produce coverage impacts in our model.

Figure 1. Differences in Coverage Impacts between Original and Revised Bill (in Millions)



We also find that the revised bill would produce larger spending reductions than the original bill. This is partially the result of one-year change in full implementation (from 2024 to 2025) and medical price inflation. In addition, we find higher take-up in the public plan among both the uninsured and non-group enrollees. Higher uninsured take-up decreases spending impacts and higher non-group take-up increases spending impacts. We find the latter effect exceeds the former, resulting in slightly larger health care spending reductions.