-$15.1 B
-$12.7 B
-$7.3 B
-$42.3 B

RESEARCH REPORT

Estimating the Impact of a Public Option or Capping Provider Payment Rates

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Executive Summary

In this report, we examine the coverage and spending implications of various forms of a public health insurance option introduced as an alternative to private plans currently available to consumers. The public option would be a plan structured the same as private insurance plans currently available in the applicable markets, but it would also share some characteristics with the traditional Medicare fee-for-service plan. Its actuarial value, covered benefits, and cost-sharing structure would reflect the private options in the market in which it was introduced (e.g., a Marketplace qualified health plan in the nongroup market or a typical plan in the employer market). However, a public option would have a broad network, like the traditional Medicare plan, and would pay providers at Medicare rates or some multiple thereof that would set prices between Medicare's payment rates and those of commercial insurers today. A public plan is intended to provide a lower-cost insurance option that would reduce health care spending for consumers and government, lower overall spending growth, and potentially catalyze greater competition by private insurers. The option would be particularly attractive for people residing in insurance markets with higher-than-average commercial insurance premiums and/or few commercial insurers. We also discuss capping all private insurers' payments to providers (in the nongroup market alone or in both the nongroup and employer insurance markets) at the same rates, either as an alternative to or in combination with a public option. Capping rates would also allow employers and their employees to lower the cost of their health coverage without changing their current benefit and cost-sharing structure. The capped rate approach follows the precedent of Medicare Advantage (Holahan and Blumberg 2018).

We present multiple reform scenarios because of the significant uncertainties inherent in a public option or capped payment rate reform, such as the size of the payment rate cuts achievable, the markets in which the new rates would apply, which employers (if allowed) would participate, and how providers would respond to lower payment rates.

For ease of exposition, we present all estimates as if reforms have been fully implemented and have reached long-run equilibrium in 2020. We describe our methodological approach in the appendix. Our accompanying brief summarizes each reform's implications for coverage, spending, and the federal deficit (Blumberg et al. 2020).

A Public Option in Nongroup Insurance Markets Only

The public option approaches discussed in bills and by some presidential candidates usually include other reforms, such as enhanced subsidies, reinsurance, and strategies to fill in the Medicaid coverage gap. Unlike those approaches, the reforms we simulate strictly introduce a public option without other reforms. We first examine reforms that would introduce a public option only in the nongroup market. In the nongroup market, the public option's effects on government spending and coverage would be about the same as capping private insurers' payment rates at the same level as a public option would pay, because of the structure of the federal premium subsidies provided.

Our simulated reforms 1, 2, and 3 would be implemented only in the nongroup market. Reform 1 pays Medicare rates to hospitals and physicians in all nongroup markets across the country and reduces prescription drug payments to halfway between Medicaid and Medicare prices via a new rebate program. Reform 2 pays higher prices to providers in rural areas than does reform 1, adding 20 percent to Medicare rates for hospitals and professionals; urban providers are paid Medicare prices. Reform 3 further increases payments for all providers, adding 25 percent and 10 percent to Medicare rates for all hospitals and physicians, respectively.

Table ES.1 summarizes key results for each reform. Reform 1, our base case, reduces median benchmark (second-lowest-priced silver) nongroup market premiums by 28 percent. Reform 2, the rural price adjustment approach, reduces median benchmark premiums by 21 percent, because as payment rates increase, median benchmark premiums fall by smaller degrees. The implications of payment rate differences are even clearer under reform 3, which sets all provider payment rates modestly above Medicare prices nationwide. Under this reform, the median benchmark premium falls by 13 percent, compared with 28 percent in reform 1.

Introducing the public option into the nongroup market only slightly affects overall coverage, reducing the number of uninsured Americans by roughly 155,000 to 230,000. However, the public option could more significantly affect federal spending. Table ES.1 reports estimates of these reforms' effects on the federal deficit, defined here as changes in (1) federal government spending on health care programs for the nonelderly (Marketplace subsidies, Medicaid, and the Children's Health Insurance Program) and (2) income tax revenue resulting from employer savings on premiums being converted to taxable wages.[1] Reform 1 reduces the federal deficit by $15.1 billion, entirely because of reduced Marketplace premium subsidies. In reform 2, the federal deficit decreases by $12.7 billion, because higher payment rates for providers in rural areas increase premiums compared with reform 1, and higher premiums increase federal spending. Reform 3 reduces the deficit by $7.3 billion.

The reforms implemented in the nongroup market alone have virtually no effect on employer spending, but they decrease household spending for people enrolled in the nongroup market. Lower provider payment rates decrease premiums for those enrolled in nongroup coverage but ineligible for premium subsidies and decrease out-of-pocket spending for enrollees when they use services. Depending on the reform, household savings range from $3.8 to $7.0 billion.

A Public Option in Nongroup and Employer Insurance Markets

The number of people enrolled in employer coverage is more than nine times the number in nongroup coverage. Plus, employer-based plans tend to pay health care providers at rates higher than those of nongroup insurers, particularly in the more competitive nongroup Marketplaces. Consequently, introducing the public option or capping provider payment rates in both the nongroup and employer markets has the potential to reach many more consumers and to substantially affect premiums, overall spending, health care provider revenues (e.g., for hospitals, physicians, and prescription drug manufacturers), and the federal deficit.

We assume the public option offered in the employer market is designed to have benefits typical of employer plans today, including an actuarial value of 80 percent. However, the public option would use regulated provider payment rates, therefore lowering premiums compared with current employer-based plans. Firms can offer their workers the public option if the firm prefers its benefits, cost-sharing levels, and lower provider payment rates. In the small-group employer market, premiums are modified community rated, consistent with current rules. In the large-group employer market, the public option is experience rated. Under such reforms, some firms would continue offering their current plans, and others would not offer coverage.

How attractive the public option would be to various employers is uncertain. For illustrative purposes, we assume lower-wage and smaller firms are more likely to offer a public option (appendix A). Smaller firms tend to more frequently change the plans they offer their workers each year, meaning they are less likely to be attached to a particular plan structure or insurer. Lower-wage employers and their workers are more likely to be price sensitive and therefore willing to change coverage. We also assess the implications of capping rates paid to all providers by all insurers in the market, and those results are consistent with assuming all employers choose the public option.

Reform 4, the nongroup and employer base case with Medicare payment rates, makes reform 1 available to employers and results in a 32 percent decrease in median premiums among employers that choose it. In reforms 5 and 6, provider payment rates are set above Medicare rates, modestly above Medicare rates in reform 5 and even further above Medicare rates in reform 6. Consequently, participating employers' premium reductions are smaller than in reform 4 at the median (24 percent in reform 5 and 16 percent in reform 6).

Making the public option available to employers has a larger effect on insurance coverage than when the option is made available in nongroup markets alone. Depending on the simulation, the number of uninsured people drops by 1.5 to 1.7 million, decreasing the number of uninsured people below age 65 by approximately 5 percent.

Aggregate health care spending by employers falls considerably when a public option becomes available as an employer-based coverage alternative. Depending on the public option approach, employer premium spending falls by $38.9 billion (4 percent) to $142.9 billion (15 percent), with the smallest savings achieved with the highest provider payment rates. Depending on the payment rates assumed, employers save even more on premiums, ranging from $223.0 to $257.0 billion under a capped rate model, where all employer plans benefit from lower provider payment rates (under rates capped modestly above Medicare prices in reform 7 and further above Medicare prices in reform 8). These savings equate to all employers choosing the public option. Under reforms 4 through 8, substantial savings, ranging from $24.0 to $109.2 billion, also accrue to households enrolled in plans with lower provider payment rates.

Introducing a public option or capped provider payment rates into the employer insurance market can have important implications for the federal deficit. Economic research indicates that as employer spending on health insurance premiums decreases, those savings are passed back to workers via higher wages. Those increased wages are taxable, but health insurance premium payments are not; therefore, income tax revenue increases. Thus, the larger the decrease in employer health spending, the larger the increase in income tax revenue. Depending on the reform, we estimate reduced federal government health spending (primarily on Marketplace subsidies) and increased income tax revenue to lower the federal deficit by $12.4 billion (reform 6) to $52.4 billion (reform 7).

Conclusion

Introducing a public option into the nongroup insurance market would have a limited effect on overall insurance coverage but would reduce federal spending significantly. Extending the public option to the employer market would lead to greater changes, including potentially large employer premium reductions. Capping provider payment rates for all employer plans, an approach based off the Medicare Advantage program, would lead to the greatest employer premium savings, ranging from 17 to 24 percent. Employer public options and the premium savings they engender would also increase tax revenues.

However, the lower the payment rates used in a public option and the greater the number of people enrolled, the greater the implications for provider revenues. The lower the rates, the fewer providers would participate with the plan voluntarily, and the greater the necessity for tying providers' Medicare program participation to participation with the public option. Provider disruption can be decreased if provider payment rates are higher or if the transition to lower rates is accomplished over an extended period. The trade-off is that managing provider impacts in this way would decrease federal government, employer, and household savings to some degree.

TABLE ES.1

Summary of Simulation Results, 2020

Reform	Availability of public option	Payment policy[a]	Percent Change to Median Premium		Change in number of uninsured (thousands)	Change in federal deficit (billions)[d]	Change in employer health spending	Change in household spending
			Nongroup[b]	Employer[c]				
1. Nongroup base case	Nongroup markets nationwide	Medicare rates for all providers	-28	0	-230	$-15.1	$0.3 B (0%)	-$7.0 B (-1%)
2. Nongroup with rural price adjustment	Nongroup markets nationwide	Medicare rates for urban providers, Medicare rates + 20% for rural providers (higher rural prices than reform 1)	-21	0	-211	$-12.7	$0.3 B (0%)	-$5.8 B (-1%)
3. Nongroup with prices modestly above Medicare rates	Nongroup markets nationwide	Medicare rates + 25% for hospitals, Medicare rates + 10% for professionals (higher hospital and professional prices than reform 1)	-13	0	-155	$-7.3	$0.3 B (0%)	-$3.8 B (-1%)
4. Employer and nongroup base case	Nongroup and employer markets nationwide; subset of employers choose public option	Medicare rates for all providers	-28	-32	-1,698	$-42.3	-$142.9 B (-15%)	-$76.3 B (-14%)
5. Employer and nongroup with prices modestly above Medicare rates	Nongroup and employer markets nationwide; subset of employers choose public option	Medicare rates + 25% for hospitals, Medicare rates + 10% for professionals (higher hospital and professional prices than reform 4)	-14	-24	-1,597	$-27.6	-$104.5 B (-11%)	-$54.6 B (-10%)

Reform	Availability of public option	Payment policy[a]	Percent Change to Median Premium		Change in number of uninsured (thousands)	Change in federal deficit (billions)[d]	Change in employer health spending	Change in household spending
			Nongroup[b]	Employer[c]				
6. Employer and nongroup with prices further above Medicare rates	Nongroup and employer markets nationwide; subset of employers choose public option	Medicare rates + 60% for hospitals, Medicare rates + 15% for professionals (higher hospital and professional prices than reform 5)	-10	-16	-1,478	$-12.4	-$38.9 B (-4%)	-$24.0 B (-4%)
7. Employer and nongroup rates capped modestly above Medicare prices	Nongroup and employer markets nationwide; all employer plans pay lower rates	Medicare rates + 25% for hospitals, Medicare rates + 10% for professionals (same provider prices as reform 5, affects more employers)	-14	-25	-1,597	$-52.4	-$223.9 B (-24%)	-$109.2 B (-20%)
8. Employer and nongroup rates capped further above Medicare prices	Nongroup and employer markets nationwide; all employer plans pay lower rates	Medicare rates + 60% for hospitals, Medicare rates + 15% for professionals (higher hospital and professional prices than reform 7)	-10	-17	-1,478	$-37.2	-$157.0 B (-17%)	-$79.7 B (-14%)

Source: Health Insurance Policy Simulation Model, 2019.

Notes: B = billion. Reforms simulated as fully phased in and in equilibrium in 2020. Data in this analysis include health care spending by people below age 65 not enrolled in Medicare. The changes in median premiums shown in this table differ slightly from those in tables 2–5 because they reflect not only the basic changes in premiums but changes in the risk pool that result from introducing the public option.

[a] Prescription drug prices in each reform scenario are assumed to be set halfway between Medicare and Medicaid prices.

[b] This column shows the change in the national median nongroup benchmark premium.

[c] This column shows the change in the national median premium among employers providing the public option to their workers (reforms 4–6). In reforms 7 and 8, provider payment rates are capped for all employer plans, so the median shown includes all employers providing coverage to their workers.

[d] Estimates in this column equal the change in federal spending on Medicaid/the Children's Health Insurance Program acute care for the nonelderly and Marketplace premiums minus the estimated increase in income tax revenue, which result from turning savings in untaxed health care premiums into taxable worker wages.

Estimating the Impact of a Public Option or Capping Provider Payment Rates

Introduction

Several recent health reform proposals call for developing and introducing a public health insurance plan, an insurance option structured and administered by government or a government contractor. [2] The public option would offer a lower-cost insurance plan (or plans) in private insurance markets, which would reduce health care spending for consumers and government, lower overall spending growth, and catalyze greater competition among private insurers. Such a plan would pay health care providers lower rates than typical commercial plans pay, perhaps at Medicare rates or somewhere between such rates and those of commercial plans. Private insurers paying providers higher rates could compete with the public option on customer service, effective care management, or provider networks; however, the number of private insurers might decrease in at least some markets. As such, we estimate an alternative approach that could potentially achieve many of the same goals with less risk of private insurers exiting the market: capping the provider payment rates of all private insurers offering coverage in a particular market at Medicare rates or some multiple thereof. Capping rates would also allow households and employers to lower the cost of their health coverage without changing their current benefit and cost-sharing structure. This approach is based on the structure used in the Medicare program. Table 1 shows how this approach differs from public option reforms.

We present multiple reform scenarios because of the significant uncertainties inherent in a public option or capped payment rate reform, such as the size of the payment rate cuts achievable, the markets in which the new rates would apply, which employers would participate (if allowed), and how providers would respond to lower payment rates. Across these scenarios, we vary payment rates to providers and employer participation to provide a range of possible outcomes to various approaches. For each reform, we estimate the impacts on the distribution of insurance coverage and levels of health care spending by government, households, and employers.

For ease of exposition and comparison, we estimate these reforms as if they were fully phased in and in equilibrium in 2020. However, each approach considered would require a multiyear phase-in, whereby payment rates would be reduced to target levels incrementally. Depending on the target

payment rates chosen, it is also possible to reach desired levels over an extended period by slowing annual increases in payment rates, as opposed to cutting payment rates. Such incremental implementation would allow providers time to adjust their underlying costs to the lower real payment levels and would allow analysts to monitor and evaluate any changes in access to or quality of care that might signal the need for adjustments in payment rate targets for particular services. Slowing the change in payment rates would decrease potential disruption to the health care delivery system but also means potential savings would be moderated.

Several of the bills introduced in Congress that call for public options make reference to using Medicare-like payment rates or at least using the process of determining Medicare rates as a basis for setting public option rates. Though policymakers, advocates, and stakeholders increasingly debate the merits of public option approaches, information on the magnitude of their potential for creating system savings or their implications for coverage and provider revenues is limited. In particular, current variation in insurer competition across the country means the effects of introducing a public option will vary significantly by geography. Though most public option reform proposals include other strategies, such as enhanced financial assistance, this analysis focuses on the implications of such reform proposals without additional strategies.

Though we believe we use the best available data and methods for estimating the potential effects of introducing differently structured public options and capped payment rates, significant uncertainty surrounds our estimates, because data that would make our estimates more precise are not publicly available. Consequently, we rely on some imputation and proxy measures; appendix A contains a full description of our data and methods.

TABLE 1
A Public Option versus Capped Provider Payment Rates

Two approaches for lowering costs in health insurance markets

Public option	Capped provider payment rates for all private insurers
▪ A government-developed insurance plan that pays providers (doctors, hospitals, prescription drug manufacturers) according to a fee schedule that uses lower rates than those typical of commercial insurers.	▪ A requirement that providers (doctors, hospitals, prescription drug manufacturers) accept payment rates no higher than those specified. Rates capped at lower levels than those typical of commercial insurers.
▪ Available in nongroup or employer markets, or both, either nationwide or in particular geographic areas. May be introduced into "bare counties," areas without private insurance options in a given market.	▪ Applicable to insurers in nongroup or employer markets, or both, either nationwide or in particular geographic areas.
▪ Can be implemented alone or with capped provider payment rates, the latter being similar to the Medicare program's structure.	▪ Can be implemented alone or with a public option, the latter being similar to the Medicare program's structure.
▪ Requires consumers (households and/or employers) to enroll in a new plan to take advantage of full cost savings.	▪ Allows consumers (households and/or employers) to take advantage of full cost savings while enrolling with any preferred insurer, or for employers, self-insuring.
▪ New competition from a public option may catalyze more aggressive negotiations between private insurers and providers for lower rates, possibly lowering private plan premiums as well. ▪ If private insurers cannot successfully negotiate provider rates low enough to compete with the public option, at least some may leave the market.	▪ Likely to result in more private insurers entering a market and staying in markets, because large numbers of enrollees are not needed as leverage for negotiating competitive payment rates with providers.

Source: Urban Institute.

Background

According to the Centers for Medicare & Medicaid Services' estimates, US health care spending amounted to 17.7 percent of gross domestic product (GDP) in 2018. The agency projects health spending will amount to 19.7 percent of GDP by 2026.[3] Though overall increases in national health expenditures since passage of the Affordable Care Act (ACA) have been lower than anticipated (Holahan, Blumberg, Clemans-Cope, et al. 2017), concerns with the levels and growth of health care spending remain. Those concerns are particularly acute in the private sector, because per enrollee health spending growth in the largest public programs (Medicare and Medicaid) has been lower than in private insurance and lower in per capita terms than GDP growth in recent years (Holahan and McMorrow 2019).

Premium levels and growth have varied considerably across the ACA's reformed private nongroup insurance markets; many markets, particularly those in highly populated areas, have low premium levels and slow growth, but many others experience the opposite (Blumberg, Holahan, and Wengle 2016; Holahan, Blumberg, Wengle, et al. 2017; Holahan, Wengle, and Elmendorf 2020). High premiums in these markets create barriers to affordable coverage and care for some people ineligible for federal subsidies while driving up the federal costs of such subsidies for people eligible for them. In addition, continually growing medical costs in employer insurance markets—though lower in recent years than before the ACA—continue to have significant implications that could worsen if underlying medical cost growth reverts to prior high rates.

In employer markets, increasing medical costs tend to displace worker wages, because employers shift compensation more heavily toward insurance premiums and/or increase employee cost-sharing requirements (e.g., reduced covered benefits and higher employee premium contributions, deductibles, coinsurance/copayments, and out-of-pocket maximums). Consequently, analysts and policymakers continue to search for effective, politically viable strategies to contain health care costs.

Lack of competition in insurer markets, provider (especially hospital) markets, or both appears to drive high health care prices in many areas. A dominant or monopolistic hospital system can essentially "name its prices," because insurers cannot sell their product in that area without the hospitals in their networks. Again, high payment rates (here demanded by providers to ensure their participation) translate into high premiums. Without competition, a dominant or monopolistic insurer can maintain high premiums. Although such insurers may choose to negotiate aggressively with providers, depending on the insurer's objectives and time horizons (e.g., profit maximization, enrollment increases, community relations).

Health policy experts are reaching a consensus that effective cost containment will necessarily involve lower provider payment rates (Blumberg and Holahan 2017a; Buntin 2018; Future of Health Care Leaders 2020).[4] Analysts and policymakers are considering regulatory approaches to control provider rates for the private sector, grounded in experience with the Medicare program. One approach debated and ultimately rejected during the ACA legislative process has reemerged: developing and introducing a public plan option that uses government-determined provider payment rates (perhaps related to the Medicare fee schedule) to compete with private insurers.[5] A second approach is capping payments insurers make to providers in a given market, like Medicare Advantage insurers do.[6] Such approaches could be implemented independently or simultaneously.

The public option plan is most frequently proposed as a possible addition to nongroup insurance markets. It would operate much like the Medicare traditional fee-for-service plan, and rates would be set at Medicare levels or some multiple thereof. The public option would cover the same comprehensive benefits and satisfy the same standards as those in ACA Marketplace plans, and the cost-sharing would fit into one or more of the ACA's nongroup market actuarial value (AV) tiers. (At a minimum, the plan would have to have a 70 percent AV in the nongroup market, because the standard ACA coverage is required as well as the cost-sharing reduction options associated with it, but public options at each AV level could be offered.[7]) The public option should be particularly attractive to people living in more expensive insurance markets.

An alternative or possible supplement to the public option would be capping all insurers' provider payment rates for their ACA-compliant nongroup market enrollees. Capping rates paid by private insurers would ensure more competing insurers remain in a market, regardless of whether a public option is added, because private insurers could set their provider payment rates no higher than those used by the public option, regardless of hospitals' or physicians' market power in the area. Plus, limiting provider payment rates would allow new insurers to enter a market, because insurers would not need large initial enrollment to negotiate reasonable rates. Capping private insurers' payment rates would also allay insurer fears that they could not compete with a new public option on price; this has been the case with the Medicare Advantage program, which also effectively caps rates while offering a public option.[8] Capping payment rates would also allow people enrolling in commercial plans to reap the savings associated with government-determined rates, whereas the public option alone would provide those savings primarily to people enrolling in the public option. However, even if private insurer rates are not capped but a public option is introduced, private insurers could reduce their rates in response to competition from the public option through tougher negotiations with providers (Blumberg et al. 2019).

Both the public option and capped rates for private insurers in the nongroup market would likely lead to roughly the same savings for the federal government, because premium tax credits are tied to the second-lowest silver premium, which in either approach would be largely determined by provider payment rates. Thus, coverage and government cost estimates should not be materially affected regardless of whether one or both approaches are used. The expected effects are the same because the public option is expected to be the benchmark plan.

Less frequently proposed is introducing a public option or capped provider payment rates into the employer market.[9] In this case, a public option could be designed like a typical employer plan. In the small-group market, ACA-compliant, fully insured coverage would be essentially the same as that offered in the nongroup insurance market: coverage must meet the same AV standards, be modified community rated, and cover the same essential health benefits, among other requirements. Therefore, a small-group public option could look very much like a nongroup one, though, at a minimum, it must offer an 80 percent AV (gold) plan, which is the most typical employer coverage.

Large employer markets operate under fewer regulations and are experience rated, meaning their premiums largely reflect the expected health care costs of a firm's enrollees. Actuarial values of about 80 percent are also typical in these markets. Therefore, a public option in the large-group market would need an 80 percent AV option with experience-rated premiums to be attractive to many employers. If a large-group public option is not experience rated, it will likely attract higher-than-average-cost employers and/or workers, leading to high premiums and endangering the option's stability. Consequently, an employer public option would be a plan employers can choose to purchase for their workers. The government would define the plan's parameters (e.g., benefits, cost-sharing structure), which would be uniform for any large group enrolling. The plan would use regulated provider payment rates (e.g., Medicare rates or some multiple thereof), but the premiums would vary by the enrolling group's characteristics and expected health care risk. Employers and their workers could choose the public option if the mix of benefits, cost-sharing, and lower payment rates were attractive, or they could

offer a self-insured or alternate fully insured plan. Employer participation rate assumptions are detailed in the appendix and table A.3.

If provider payment rates, in conjunction with or as an alternative to a public option, are capped in the employer market for all private insurers, fully insured or self-insured products could use the capped rates and continue to offer the benefits and cost-sharing requirements employers and their workers prefer. All employers and workers with firm-based insurance could therefore reap savings from the lower provider prices, not just those enrolling in a separate public option. Under any of these scenarios that offer employers the public option or allow employer plans to use capped payment rates, wages increase as employer spending on health insurance decreases, meaning income tax revenue increases as well.

Both the public option and capped rate approaches are intended to provide lower-premium insurance options in at least some areas and markets by requiring providers to accept lower prices, thus lowering government and private-sector spending, and improve affordable access to insurance and ultimately necessary care. Capping rates would likely allow more private insurers to remain active in (or newly enter into) a given market than would the public option, because the capped rates reduce the costs faced by all participating insurers, allowing many to be more competitive. The public option guarantees a single, lower-cost insurer in a market but could also decrease the number of private insurers in some markets.

Either approach will have to induce provider participation by paying sufficiently high rates or requiring that participation be linked to participation in other programs, most likely Medicare.[10] Absent payment rates high enough to attract a sufficient provider network, linking Medicare participation to participation in the nongroup public option could successfully induce provider participation. Medicare enrollees generate a large percentage of revenue for many providers; therefore, being excluded from the Medicare program has greater implications for providers than the nongroup insurance market on its own. Introducing a public plan without capping private insurer rates should provide stronger incentives for private insurers to negotiate lower rates with providers and may provide private insurers with additional leverage in those negotiations.[11] The two approaches can also be used in tandem, but ultimately the effect of either approach will be strongly associated with the payment rates used. If payment rates are capped for all private insurers in the nongroup and employer markets, it would be difficult for providers to reject these rates, because only a small share of consumers could pay the higher cost of care outside an insurance arrangement.

As indicated above, the potential savings from either strategy will vary geographically, because some markets already have high insurer and provider competition, which have led to efficient provider payment rates and premiums. In addition, potential savings from a public plan or capped rates will differ if implemented in the nongroup market alone or in both the nongroup and employer-based markets, because these markets' competitiveness and structures differ considerably.

Overview of Analytic Approach

Estimating the effects of a public option requires two general steps. First, because the public option or capped payment rate reforms studied here are designed to set payments at various levels relative to Medicare rates, we must estimate how current provider payment rates compare with Medicare rates. That first step allows us to compute how much lower a public plan's prices might be relative to current commercial insurance prices, and lower prices translate into lower premiums. However, the availability of data reporting the payment rates currently used by commercial insurers in the nongroup and employer insurance markets is severely limited. These data constraints force us to use proxies for some of the actual payment rate information we would like to use and require that we approach this step in different ways for the nongroup and employer-group insurance markets. The data limitations introduce unavoidable uncertainty in our estimates. Below and in detail in the appendix, we describe the methodology used to generate our estimates.

The second step involves feeding the information from the first step into a microsimulation model of the US health insurance system for the nonelderly population. This step allows us to estimate the number of people affected by the public option reforms and the potential implications for private and government health care spending overall. In both steps, geographic variation is a central interest.

Below, we provide an overview of the first step. Here we describe how premiums under a public option would compare with premiums in the current nongroup and employer markets and how they would differ across geographic areas. Appendix A provides details on step 1 and a description of our approach to step 2, which relies on the Urban Institute's Health Insurance Policy Simulation Model (HIPSM).

Estimating Current Provider Payment Rates in the Nongroup Market

No claims data are available to estimate commercial nongroup market payments relative to those of Medicare. Because available data sources combine all commercial claims across markets, they are most reflective of employer-based insurance claims, by far the largest share of the total. Consequently, we must develop a proxy measure for nongroup market payments relative to those of Medicare. For this purpose, we assume nongroup market premiums in the most competitive markets—those with at least five competing Marketplace insurers and at least modestly competitive hospital markets—reflect provider payment rates of approximately Medicare levels. (We provide validation for this assumption in appendix A.) Using regression techniques, we estimate what the benchmark nongroup premium would be in each rating area if each of them met these competitive standards. We then compare current

benchmark Marketplace premiums in each rating region with the benchmark premiums estimated for each area if it met high standards of competitiveness.[12]

For each rating region, we then compute the implied percent reduction in premiums between the area's predicted competitively priced premium (which proxies Medicare prices) and actual benchmark premium. To estimate overall savings, we include an estimated premium reduction associated with policy-driven savings in prescription drug prices (described below). We also simulate several policy approaches, where the public option is assumed to pay providers more than current Medicare rates in all or some areas (i.e., rural areas) and at different levels relative to Medicare prices for hospitals versus physicians.

Estimating Current Provider Payment Rates Relative to Medicare's Payment Rates in the Employer Group Market

Data on employer-sponsored plans' payment rates to hospitals and physicians are also not readily available. Available data frequently provide list prices but not allowed amounts (the actual prices paid by insurers after discounts). We considered several sources of proprietary commercial claims data that could be used to estimate typical commercial prices relative to Medicare rates for both hospitals and professionals. We ultimately chose to use FAIR Health data, because they have the largest and most geographically representative private insurance claims data available to us.[13] The data we used include imputed allowed payment amounts for commercial payers (including but not limited to employer group plans) and Medicare payment rates for 46 professional procedure codes and 45 hospital outpatient services, representing nearly half of all professional and outpatient spending. The commercial allowed payment amounts were drawn from the FH ® Allowed Benchmarks, which were available at the substate level.[14] For hospital inpatient rates, FAIR Health provided ratios comparing commercial allowed amounts to Medicare payments for all hospital inpatient services at the state level.

For each state, we compute the implied hospital and professional price changes if rates were set at Medicare levels. We then combine these price changes with an estimated 30 percent price cut for prescription drugs (as described below) to generate potential employer premium savings when implementing a public option or capping provider payment rates at Medicare levels. As noted earlier, when a simulation assumed payment rates somewhat above Medicare levels, we made appropriate adjustments. We assume price reductions in each provider sector directly translate into premium reductions proportionate to that provider type's share of premium spending.

Estimating Prescription Drug Savings

We assume the public option would pay prescription drug prices below current Medicare prices, because Medicare has been prohibited from negotiating or setting prescription drug prices. Rather, it has relied on pharmacy benefit managers to obtain the best rebates possible.

We obtained current rebate information for each payer relative to current commercial rebates. Using Market Scan data, Kesselheim and Hwang (forthcoming) estimated that Medicare Part D rebates generate savings worth about 12 percent of commercial insurer prices. The full Medicaid rebate, including both basic and inflation rebates, averages about 48 percent in savings relative to commercial insurer prices after rebates.

Kesselheim and Hwang (forthcoming) also estimates that the Canadian health system pays for prescription drugs at prices about 65 percent below US commercial prices after rebates. Countries such as Germany, Switzerland, and the UK face prices comparable to those in Canada. Thus, the US has not lowered drug prices as successfully as other countries, and we assume this continues to hold true, primarily because of the political strength of pharmaceutical manufacturers. We estimate that the public option could establish rebates halfway between those received through Medicare and Medicaid, implying prices 30 percent below those faced by commercial insurers. We find this rebate feasible, but we acknowledge it would be difficult to achieve. However, the resulting prices would still be well above those of other western nations.

We applied this assumed 30 percent prescription drug savings in each simulation analysis. Because prescription drugs account for about 23 percent of private health care spending for the nonelderly, a 30 percent decrease in commercial prices for prescription drugs would reduce spending for the insured nonelderly by 6.9 percent on average. Using the 30 percent savings estimate, we adjust premiums to reflect public option premiums in both the nongroup and employer markets.[15]

Estimating Premium Savings under Public Option or Capped Rate Reforms in the Nongroup Market

Accounting for potential savings for all health care providers, including on prescription drugs, table 2 shows estimated state average percent differences between current benchmark nongroup premiums and premiums using Medicare payment rates for all providers, with prescription drug rebates halfway between those for Medicare and Medicaid. These are our base case assumptions of the percent changes in nongroup premiums under a public option or via capped rates. Premium adjustments are computed at

the ACA nongroup market rating region level, and state averages shown in the table are computed using the rating region population covered by nongroup insurance as weights.[16] These percent changes in premiums reflect changes in provider payment rates only and do not account for any changes that may result from changes in the mix of people enrolling as premiums change. Our simulations, described in the results section, account for such changes.

Table 2 shows that under reform 1, the base public option scenario, average nongroup benchmark premiums would be 19 percent lower across the US. However, average benchmark premiums would fall by less than 12 percent in six states, because the nongroup insurance Marketplaces in these states tend to be quite competitive today. In comparison, we estimate that premium savings would exceed 35 percent in eight states, reflecting the current lack of competition in these nongroup markets.

Table 3 shows the distribution of benchmark premium savings across the country's 502 nongroup market rating regions. As the distribution shows, we estimate that benchmark nongroup premiums would fall by at least 41 percent in 10 percent of rating regions and would fall by no more than 11 percent in another 10 percent of regions. The median decrease would be 28 percent.[17]

TABLE 2
Percent Change in State Average Benchmark Premium, Reform 1 Payment Rate Assumptions, 2020

	Percent change
Alabama	-38
Alaska	-39
Arizona	-18
Arkansas	-18
California	-11
Colorado	-13
Connecticut	-26
Delaware	-42
District of Columbia	-28
Florida	-22
Georgia	-22
Hawaii	-28
Idaho	-9
Illinois	-23
Indiana	-15
Iowa	-23
Kansas	-25
Kentucky	-25
Louisiana	-27
Maine	-16
Maryland	-12
Massachusetts	-7
Michigan	-10
Minnesota	-17
Mississippi	-43
Missouri	-30
Montana	-18
Nebraska	-38
Nevada	-21
New Hampshire	-17
New Jersey	-18
New Mexico	-14
New York	-8
North Carolina	-35
North Dakota	-18
Ohio	-9
Oklahoma	-28
Oregon	-16
Pennsylvania	-23
Rhode Island	-16
South Carolina	-39
South Dakota	-29
Tennessee	-27
Texas	-16
Utah	-18
Vermont	-24
Virginia	-21
Washington	-17
West Virginia	-33
Wisconsin	-14
Wyoming	-40
United States	**-19**

Source: Urban Institute analysis.
Notes: State averages weighted by population with nongroup coverage in each rating region. Reform 1, the nongroup base case, assumes hospital and physician prices are set at Medicare levels and prescription drug prices are set halfway between Medicare and Medicaid prices in 2020. These percent changes in premiums reflect the changes in provider payment rates only and do not account for any changes that may result from changes in the mix of people enrolling as premiums change.

TABLE 3

Rating Region–Level Distribution of Nongroup Benchmark Premium Changes under Reform 1 Payment Rate Assumptions, 2020

Percent

	Estimated premium change
Mean	-19
Percentile	
10th	-41
25th	-40
50th (median)	-28
75th	-16
90th	-11

Source: Urban Institute analysis.

Notes: Mean is weighted by population with nongroup coverage. Reform 1, the nongroup base case, assumes hospital and physician prices are set at Medicare levels and prescription drug prices are set halfway between Medicare and Medicaid prices in 2020. These percent changes in premiums reflect the changes in provider payment rates only and do not account for any changes that may result from changes in the mix of people enrolling as premiums change.

Estimating Premium Savings under Public Option or Capped Provider Payment Rate Reforms in the Employer Market

Table 4 shows (1) the national distribution of commercial-to-Medicare price ratios for hospitals and professionals at the public use microdata area (PUMA) level, (2) the implied premium cut from moving from commercial to Medicare rates, and (3) prescription drug savings (taken together, these changes comprise reform 1). Again, these changes reflect reductions in underlying costs alone and do not account for any risk pool changes resulting from behavior changes; those are accounted for in our simulation results described below. The table shows that the ratio of commercial to Medicare prices was 2.4 on average for hospitals and 1.2 for professionals (physicians and others). The ratios vary considerably across the country, however, particularly for hospitals.[18] In the appendix, we compare our estimates with those of others.

To compute the implied potential premium cuts resulting from moving from current commercial payment rates to base case assumptions (Medicare rates for hospitals and professionals and prescription drug prices halfway between those for Medicare and Medicaid), we combine the relative differences for hospital and professional payments with the assumed prescription drug price cut (weighted by the share of spending attributable to each).Our estimates suggest the resulting mean and median employer insurance premium decreases would be approximately 35 percent each. This is larger than the 19 percent mean and 28 percent median in the nongroup market.

TABLE 4

PUMA-Level Distribution of Commercial Insurance–to-Medicare Price Ratios for Hospital and Professional Services and Implied Premium and Provider Price Changes under Reform 1 Payment Rate Assumptions, 2020

	Hospital ratio	Professional ratio	Hospital price change (%)	Professional price change (%)	Prescription drug price change (%)	Combined premium change (%)
Mean	2.4	1.2	-57	-14	-30	-35
Percentile						
10th	3.1	1.5	-67	-34	-30	-44
25th	2.7	1.3	-63	-25	-30	-40
50th (median)	2.4	1.2	-58	-14	-30	-35
75th	2.1	1.0	-53	-2	-30	-30
90th	1.9	0.9	-47	6	-30	-25

Source: FAIR Health data on commercial prices relative to Medicare.

Notes: PUMA = public use microdata area. Expenditure-weighted ratios constructed across common procedural technology codes at the geozip level. Geozip ratios are distributed to 2,351 PUMAs, and summary statistics are weighted by 2010 PUMA population. Reform 1, the nongroup base case, assumes hospital and physician prices are set at Medicare levels and prescription drug prices are set halfway between Medicare and Medicaid prices in 2020. These percent changes in premiums reflect the changes in provider payment rates only and do not account for any changes that may result from changes in the mix of people enrolling as premiums change.

The percent reductions in premiums resulting from lower provider payment rates are larger in the employer market than the nongroup market because premiums have been quite low in many ACA nongroup insurance markets, because the structure of the premium tax credits drives intense competition.[19] Though a public option likely cannot reduce benchmark premiums as much as private insurers in highly competitive markets, it can generate substantial savings in less competitive markets.

Currently, employer insurance markets do not appear very price competitive, and their provider payment rates tend to be higher than those in nongroup markets. Employers tend to keep provider networks broader (particularly in larger firms' plans), which avoids alienating employees but leads to higher premiums. This also means employer premiums do not vary much across geographic areas because, unlike the nongroup market, few employer markets have low overall private commercial insurance payment rates, particularly for hospitals.[20]

Table 5 presents state-level estimates averaging commercial-to-Medicare payment ratios for hospital and professional services across PUMAs and shows the implied price and premium cuts that would result from moving from the estimated commercial rates to Medicare rates (our base case assumptions). Assuming Medicare rates, hospital payments from commercial private insurance would fall by more than 60 percent in seven states. Professional payments would decrease by more than 25 percent in seven states but would increase on average in eight states.

Combining the hospital and professional payment cuts and 30 percent reduction in prescription drug prices, our estimates suggest potential average employer premium reductions ranging from an average of 40 percent or more in five states to 25 percent or less in seven states under reform 1. The PUMA-level ratios and implied premium reductions underlying these state-level averages produce the geographic variation that informs our simulated reforms below.

TABLE 5

Summary of Commercial Insurance–to-Medicare Payment Ratios for Hospital and Professional Services and Implied Price and Premium Changes under Reform 1 Payment Rate Assumptions

	Number of PUMAs	PUMA hospital ratio (outpatient and inpatient)	PUMA professional ratio	Hospital price change (%)	Professional price change (%)	Prescription drug price change (%)	Combined premium change (%)
Alabama	34	2.6	1.2	-61	-13	-30	-36
Alaska	5	2.2	1.3	-55	-23	-30	-37
Arizona	54	2.5	1.3	-59	-20	-30	-38
Arkansas	20	1.9	1.1	-47	-10	-30	-29
California	265	2.8	1.1	-64	-5	-30	-34
Colorado	42	3.1	1.0	-66	-4	-30	-34
Connecticut	26	2.2	1.0	-55	-3	-30	-30
Delaware	6	2.3	1.0	-56	-2	-30	-30
District of Columbia	5	2.4	1.0	-58	1	-30	-29
Florida	151	3.2	1.4	-68	-27	-30	-44
Georgia	72	2.5	1.3	-60	-24	-30	-40
Hawaii	10	2.1	1.0	-53	2	-30	-27
Idaho	14	2.1	1.0	-52	-2	-30	-28
Illinois	88	2.5	1.2	-60	-16	-30	-36
Indiana	50	2.3	1.3	-57	-18	-30	-36
Iowa	22	1.8	1.2	-45	-17	-30	-31
Kansas	22	2.1	1.1	-51	-9	-30	-30
Kentucky	34	2.2	1.2	-54	-11	-30	-32
Louisiana	34	2.2	1.4	-53	-28	-30	-39
Maine	10	1.9	1.0	-48	1	-30	-25
Maryland	44	1.4	1.1	-26	-5	-30	-19
Massachusetts	52	1.7	1.1	-41	-11	-30	-27
Michigan	68	2.0	1.1	-51	-4	-30	-28
Minnesota	43	1.9	1.4	-48	-30	-30	-37
Mississippi	21	2.1	1.3	-52	-21	-30	-35
Missouri	47	2.1	1.2	-51	-18	-30	-34
Montana	7	2.0	1.0	-49	0	-30	-26
Nebraska	14	2.0	1.2	-50	-15	-30	-32
Nevada	18	2.9	1.3	-64	-23	-30	-41
New Hampshire	10	2.3	1.1	-57	-7	-30	-32
New Jersey	73	2.6	1.1	-60	-9	-30	-34

	Number of PUMAs	PUMA hospital ratio (outpatient and inpatient)	PUMA professional ratio	Hospital price change (%)	Professional price change (%)	Prescription drug price change (%)	Combined premium change (%)
New Mexico	18	2.4	1.3	-57	-18	-30	-36
New York	145	2.3	1.0	-56	-2	-30	-30
North Carolina	78	2.4	1.2	-58	-14	-30	-35
North Dakota	5	1.7	1.4	-42	-26	-30	-33
Ohio	93	2.3	1.3	-56	-19	-30	-36
Oklahoma	28	2.1	1.2	-53	-14	-30	-33
Oregon	31	2.0	1.3	-50	-22	-30	-35
Pennsylvania	92	2.3	0.9	-54	9	-30	-25
Rhode Island	7	2.2	0.9	-54	15	-30	-22
South Carolina	30	2.7	1.1	-63	-11	-30	-36
South Dakota	6	1.8	1.2	-44	-20	-30	-32
Tennessee	49	2.5	1.3	-60	-24	-30	-39
Texas	212	2.9	1.4	-65	-30	-30	-44
Utah	22	1.9	1.0	-47	2	-30	-24
Vermont	4	2.5	0.9	-60	13	-30	-25
Virginia	56	2.5	1.0	-59	0	-30	-30
Washington	56	2.3	1.2	-57	-16	-30	-35
West Virginia	13	1.3	1.0	-24	2	-30	-15
Wisconsin	40	2.4	1.7	-57	-42	-30	-45
Wyoming	5	2.0	1.5	-50	-31	-30	-39
United States	**2,351**	**2.4**	**1.2**	**-57**	**-14**	**-30**	**-35**
State minimum	**4**	**1.3**	**0.9**	**-24**	**15**	**-30**	**-15**
State maximum	**265**	**3.2**	**1.7**	**-68**	**-42**	**-30**	**-45**

Source: FAIR Health data on commercial prices relative to Medicare.

Notes: PUMA = public use microdata area. Ratios and price changes are population-weighted averages across PUMAs in each state. We calculate PUMA-level ratios by distributing expenditure-weighted, geozip-level hospital and professional ratios across PUMAs based on population. Combined premium changes use Medical Expenditure Panel Survey spending on nonelderly to weight hospital, professional, and drug price cuts. The market for prescription drugs is assumed to be national, so price change does not vary by state. Reform 1, the nongroup base case, assumes hospital and physician prices are set at Medicare levels and prescription drug prices are set halfway between Medicare and Medicaid prices in 2020. These percent changes in premiums reflect the changes in provider payment rates only and do not account for any changes that may result from changes in the mix of people enrolling as premiums change.

Simulating the Coverage and Cost Implications of Implementing Different Public Option and Capped Payment Rate Reforms

Appendix A contains a description of our microsimulation approach. Here we present our findings from simulating eight public option or capped provider payment rate reforms.

Reforms Modeled

Of our eight reforms, the first three institute the public option and/or capped rates in the nongroup market alone.[21] In each reform simulated, we assume prescription drug rebates in the public option and/or applicable market subject to capped provider payment rates are set halfway between current Medicare and Medicaid rebates.

NONGROUP MARKETS ONLY

In the nongroup insurance market, a public option and capping provider payment rates have approximately the same effects on coverage and government costs, though more insurers would likely remain in the market if all insurers' provider payment rates are capped. The effects are similar because federal government premium subsidies provided through the Marketplaces are tied to the benchmark (second-lowest silver) premium where each enrollee lives. Consequently, presuming the public option offers the benchmark premium leads to the same premium subsidies as if all current premiums in the market were adjusted by the same percentage. Therefore, our estimates for the reforms affecting nongroup markets alone can be interpreted as consistent with either a public option or capping provider payment rates paid by all private nongroup insurers at the same levels. For ease of exposition below, we simply call nongroup-only reforms "public option reforms" below.

- **Reform 1, nongroup base case,** sets the public option's payment for hospitals and professionals at Medicare rates.

- **Reform 2, nongroup with rural price adjustment,** is the same as the base case, except rural hospital and physician public option payments are set 20 percent above Medicare rates. This reform generates smaller savings than the base case.

- **Reform 3, nongroup with prices modestly above Medicare rates,** sets public option payment rates to all hospitals at Medicare rates plus 25 percent and payments to all physicians at Medicare rates plus 10 percent. This reform generates smaller savings than reforms 1 and 2.

EMPLOYER AND NONGROUP MARKET PUBLIC OPTIONS

Unlike reforms in the nongroup market, a public option in the employer market would have different effects from capping the provider payment rates for all employer insurers. This is because the number of employers and workers with insurance that pays providers at lower rates will drive employer savings and income tax revenue effects. It is unlikely that all employers would choose to switch to a public option, but all would be affected by capping provider payment rates across this market. Consequently, the next three simulations introduce a public option into the employer group market and include parallel reforms in the nongroup market. Employers can continue to offer their current plan or may enroll their workers in the public option. We assume many employers would prefer their current benefits and cost-sharing and thus would be willing to pay higher payment rates; others would not and would opt for the public option instead. (We assume employer participation rates decrease with employer size and average wage; see appendix A). Under the reforms below, provider payment rates are the same in both the nongroup and employer markets.

- **Reform 4, employer and nongroup base case,** allows all employers to buy coverage through the public option. Payment rates are set as in reform 1. This reform generates greater private savings than reform 1.

- **Reform 5, employer and nongroup with prices modestly above Medicare rates,** allows all employers to buy coverage through the public option as in reform 4, but payment rates in the public option are set to Medicare rates plus 25 percent for all hospitals and Medicare rates plus 10 percent for all physicians. This reform generates lower savings than reform 4.

- **Reform 6, employer and nongroup with prices further above Medicare rates,** is similar to reform 5, but provider payment rates in the public plan are set at Medicare rates plus 60 percent for all hospitals and Medicare rates plus 15 percent for all physicians. This reform generates lower savings than reform 5.

EMPLOYER AND NONGROUP CAPPED PROVIDER PAYMENT RATES

The final two simulations assume provider payment rates for all coverage offered in the employer and nongroup markets are capped. Employers do not have to choose the public option to access these lower

prices. Quantitatively, these estimates are consistent with assuming all employers exclusively offer their workers the public option.

- **Reform 7, employer and nongroup provider payments capped modestly above Medicare rates,** replaces the employer public option with a system within which all providers would be paid by all employer and nongroup insurers at the levels assumed in reform 5. Payments are set at Medicare rates plus 25 percent for all hospitals and Medicare rates plus 10 percent for all physicians. This reform generates greater private savings than reform 5.

- **Reform 8, employer and nongroup provider payments capped further above Medicare rates,** is similar to reform 7, but payment rates are capped at the same level as in reform 6 (Medicare rates plus 60 percent for all hospitals and Medicare rates plus 15 percent for all physicians). This reform generates lower private savings than reform 7 but higher private savings than reform 6.

Results for a Public Option Offered in the Nongroup Market

The changes in premiums under any simulation presented below are different than the cuts shown in table 3. These differences result from both (1) the particular payment levels assumed in the reform and (2) the fact that premium differences in a simulation reflect not only changes in provider payment rates but the ensuing changes in enrollment in different forms of coverage, which can affect insurance risk pools and thus have secondary effects on premiums.

Reform 1: Nongroup Base Case

Offers a nongroup market public option in all rating regions; sets payment rates for hospitals and physicians at Medicare prices and sets prescription drug rebates in the nongroup insurance market halfway between current Medicare and Medicaid rebates

Premium effects. This public option reduces median benchmark premiums in the nongroup market by 28 percent (table 6). For ease of exposition, from here forward, we simply call Marketplace benchmark premiums "premiums."

The premium decrease varies considerably across ACA rating regions. The largest premium decreases (the top 10 percent) are of 43 percent or more, whereas the smallest decreases (the bottom 10 percent) are of 12 percent or less. As noted earlier, insurance and hospital competition in nongroup

markets varies considerably by geography. Premiums in markets that are already highly competitive decease the least under the public option; premiums in the least competitive markets decrease the most. We present these geographic variations for reforms 1, 4, and 5 in a later section.

Rating Region–Level Distribution of Changes in Nongroup Insurance Premiums under Reforms 1 through 3, 2020
Percent change from current premiums

	Reform 1: Nongroup base case	Reform 2: Nongroup with rural price adjustment	Reform 3: Nongroup with prices modestly above Medicare rates
Percentile			
10th	-43	-40	-30
25th	-40	-36	-25
50th (median)	-28	-21	-13
75th	-17	-12	-7
90th	-12	-7	-2

Source: Health Insurance Policy Simulation Model, 2019.
Notes: Reforms simulated as fully phased in and in equilibrium in 2020. These changes in premiums differ slightly from those in tables 2–5 because they reflect not only the basic changes in premiums but also any changes in the risk pool that result from the introduction of the public option.

Under reforms 1 through 3, very small changes occur for a small number of employers when a modest number of workers make different choices about where to obtain insurance given the public option in the nongroup market, but these changes are so small they are not noticeable as percentages. As such, we have excluded them from the table above.

Insurance coverage effects. Because of the premium decreases in the markets, the number of people with nongroup insurance coverage increases modestly by 87,000 (table 7). The number of people receiving Marketplace subsidies decreases because when premiums decrease, fewer people face full premiums that exceed the subsidies' percent-of-income caps. However, this decrease in subsidized coverage is more than offset by the increased number of people purchasing nongroup coverage without a subsidy (i.e., people who pay the full premium in the nongroup market). The decrease in uninsurance is small because only people facing the full nongroup insurance premium (i.e., people with incomes above 400 percent of the federal poverty level or otherwise ineligible for subsidies) can save money under the reform.[22] And because most higher-income people are already insured, coverage increases only slightly, but the federal government and households already paying the full premium achieve savings (shown below).

As more people enroll in nongroup coverage through the Marketplaces, some discover that their dependents (mostly children) are eligible for Medicaid/the Children's Health Insurance Program and they newly enroll, increasing the number of people with such coverage by 208,000 under this reform. The number of people uninsured falls by 230,000, or about 1 percent. An additional 69,000 people drop short-term plans to enroll in minimum essential coverage.

Health spending effects. Federal health spending falls by $15.1 billion (3.5 percent) in 2020 under reform 1 (table 8). This is 3.5 percent of all federal spending on the nonelderly (including Marketplace subsidies and Medicaid and the Children's Health Insurance Program acute care but excluding long-term services and supports and Medicare). The largest source of federal savings is a $15.7 billion (28.0 percent) decrease in Marketplace subsidies, though federal spending on Medicaid increases very modestly by $737.0 million (0.2 percent). Total federal health spending does not change much because the public option only affects the nongroup insurance market, a small share of national insurance coverage. Spending by state governments and employers is virtually unchanged. Household spending (premiums and out-of-pocket costs) falls by $7.0 billion (1.2 percent). Spending for all payers combined falls by $22.0 billion (1.0 percent), which includes both payments to providers for care delivered and insurer administrative costs; as such, it provides insight on the impact on providers.

Reform 2: Nongroup with Rural Price Adjustment

Offers a nongroup public option in all rating regions; sets payments for urban hospitals and physicians at Medicare rates and payments for rural providers at Medicare rates plus 20 percent; sets prescription drug rebates in the nongroup insurance market halfway between current Medicare and Medicaid rebates

Premium effects. This reform modifies reform 1 by increasing hospital and professional provider payment rates to Medicare levels plus 20 percent in rural areas. Consequently, the median rating region's premium decreases by 21 percent, a smaller reduction than in the previously described reform (table 6). Across both the distribution of premium changes and the nation's rating regions, premium decreases are somewhat smaller than under reform 1.

Coverage effects. Under this reform, the number of uninsured falls by 211,000 people compared with current levels, a smaller effect than in reform 1 (table 7). Likewise, nongroup insurance enrollment is slightly lower in reform 2 than in reform 1 because premiums are higher in rural areas. The coverage effects under these two reforms are fairly similar because the higher provider payment rates affect areas with a relatively small share of the US population; the only consumers who face a higher premium under reform 2 than reform 1 are those ineligible for premium tax credits and living in rural areas.

Health spending effects. Like coverage effects, spending levels also differ modestly under reforms 1 and 2 (table 8). Household spending decreases by $5.8 billion under reform 2, compared with $7.0 billion under reform 1, reflecting both the higher premiums for enrollees in rural areas buying nongroup coverage without premium tax credits and the higher out-of-pocket costs for all nongroup enrollees in those areas. Federal spending decreases by $12.7 billion under reform 2, compared with $15.1 billion under reform 1, because the federal government pays more for premium tax credits with the higher premiums in rural areas. Spending by all payers falls by $18.4 billion, or 0.9 percent.

Reform 3: Nongroup with Prices Modestly above Medicare Rates

Offers a nongroup public option in all rating regions; sets payments for all hospitals at Medicare rates plus 25 percent and payments for physicians at Medicare rates plus 10 percent; requires prescription drug rebates in the nongroup insurance market be set halfway between current Medicare and Medicaid rebates

Premium effects. Reform 3 modifies reform 2 by increasing hospital and physician payments across the country (instead of just in rural areas) to Medicare rates plus 25 percent for hospitals and Medicare rates plus 10 percent for physicians. Compared with reform 1, this reform increases underlying costs, and thus premiums, in every rating area. As table 6 shows, the median nongroup market premium decrease is 13 percent under reform 3, compared with 28 percent under reform 1. Likewise, all along the distribution, premiums fall by smaller percentages because of higher payment rates for hospitals and physicians. For example, the highest 10 percent of premium rating regions experience a 30 percent decline in premiums under this approach, compared with 43 percent under reform 1. For the lowest 10th percentile, premiums decrease by 2 percent, compared with a 12 percent decrease in reform 1.

Coverage effects. Because premiums fall by less under reform 3 than under reform 1, the coverage effects are smaller as well. An additional 155,000 people enroll in insurance coverage (table 7). The number of people enrolled in the nongroup market falls modestly by 9,000, the number of people with Marketplace subsidies falls by 165,000, and the number of people in full-pay nongroup coverage increases by 156,000.[23]

Health spending effects. As shown in table 8, federal spending is higher under reform 3 than under reform 1; under reform 3, federal costs drop by $7.3 billion compared with current levels (and compared with $15.1 billion in federal savings under reform 1). Virtually all the difference in federal spending between the reforms owes to higher Marketplace premium tax credits under reform 3. Under this reform, household health care spending falls by 0.7 percent compared with current levels. Employer and state government spending do not change, consistent with the previously described reforms. Under reform 3, spending by all payers falls by $10.8 billion, or 0.5 percent.

TABLE 7

Health Insurance Coverage of the Nonelderly Population Currently and under Nongroup Public Option Reforms 1 through 3, 2020

Thousands of people

	Current	Reform 1: Nongroup base case	Reform 2: Nongroup with rural price adjustment	Reform 3: Nongroup with prices modestly above Medicare rates
Insured (minimum essential coverage)	**240,506**	**240,804**	**240,776**	**240,690**
Employer	147,572	147,575	147,578	147,581
Private nongroup	*15,460*	*15,547*	*15,523*	*15,450*
Marketplace with PTC	9,097	8,753	8,814	8,931
Full-pay nongroup	6,363	6,794	6,709	6,519
Medicaid/CHIP	68,843	69,051	69,043	69,027
Medicare/other public	8,632	8,632	8,632	8,632
Uninsured (no minimum essential coverage)	**34,628**	**34,329**	**34,358**	**34,444**
Uninsured	32,185	31,956	31,974	32,031
Noncompliant nongroup	2,443	2,374	2,384	2,413
Total	**275,134**	**275,134**	**275,134**	**275,134**

Changes from current coverage, thousands of people

Insured (minimum essential coverage)	—	**299**	**270**	**184**
Employer	—	3	6	9
Private nongroup	—	*87*	*64*	*-9*
Marketplace with PTC	—	-344	-283	-165
Full-pay nongroup	—	431	346	156
Medicaid/CHIP	—	208	201	184
Medicare/other public	—	0	0	0
Uninsured (no minimum essential coverage)	—	**-299**	**-270**	**-184**
Uninsured	—	-230	-211	-155
Noncompliant nongroup	—	-69	-59	-30
Total	—	**0**	**0**	**0**

Percent change from current coverage

	Current	Reform 1: Nongroup base case	Reform 2: Nongroup with rural price adjustment	Reform 3: Nongroup with prices modestly above Medicare rates
Insured (minimum essential coverage)	—	**0.1**	**0.1**	**0.1**
Employer	—	0.0	0.0	0.0
Private nongroup	—	*0.6*	*0.4*	*-0.1*
Marketplace with PTC	—	-3.8	-3.1	-1.8
Full-pay nongroup	—	6.8	5.4	2.5
Medicaid/CHIP	—	0.3	0.3	0.3
Medicare/other public	—	0.0	0.0	0.0
Uninsured (no minimum essential coverage)	—	**-0.9**	**-0.8**	**-0.5**
Uninsured	—	-0.7	-0.7	-0.5
Noncompliant nongroup	—	-2.8	-2.4	-1.2
Total	—	**0.0**	**0.0**	**0.0**

Source: Health Insurance Policy Simulation Model, 2019.

Notes: PTC = premium tax credits. CHIP = Children's Health Insurance Program. Cells are marked with a dash when the row does not apply to the column head. Reforms simulated as fully phased in and in equilibrium in 2020. Analysis includes the US population under age 65 not enrolled in Medicare.

TABLE 8

Health Spending for the Nonelderly Population Currently and under Nongroup Public Option Reforms 1 through 3, 2020

Millions of dollars

	Current	Reform 1: Nongroup base case	Reform 2: Nongroup with rural price adjustment	Reform 3: Nongroup with prices modestly above Medicare rates
Household				
Premiums and out-of-pocket costs	560,233	553,266	554,428	556,475
Federal government				
Medicaid/CHIP	347,559	348,296	348,259	348,194
Marketplace subsidies	56,096	40,405	42,819	48,186
Reinsurance	1,227	1,227	1,227	1,227
Uncompensated care	27,531	27,341	27,359	27,463
Subtotal	*432,413*	*417,270*	*419,665*	*425,070*
State government				
Medicaid/CHIP	184,108	184,408	184,394	184,373
Marketplace subsidies	2,990	2,802	2,783	2,778
Reinsurance	475	475	475	475
Uncompensated care	17,207	17,088	17,100	17,164
Subtotal	*204,780*	*204,773*	*204,752*	*204,791*
Employers				
Premium contributions	924,291	924,600	924,619	924,607
Providers				
Uncompensated care	24,089	23,924	23,939	24,030
Total	**2,145,807**	**2,123,832**	**2,127,403**	**2,134,973**

Changes from current spending, millions of dollars

Household				
Premiums and out-of-pocket costs	—	-6,968	-5,806	-3,759
Federal government				
Medicaid/CHIP	—	737	700	635
Marketplace subsidies	—	-15,690	-13,276	-7,909
Reinsurance	—	0	0	0
Uncompensated care	—	-189	-171	-68
Subtotal	—	*-15,143*	*-12,748*	*-7,343*
State government				
Medicaid/CHIP	—	299	286	265

	Current	Reform 1: Nongroup base case	Reform 2: Nongroup with rural price adjustment	Reform 3: Nongroup with prices modestly above Medicare rates
Marketplace subsidies	—	-188	-207	-212
Reinsurance	—	0	0	0
Uncompensated care	—	-118	-107	-43
Subtotal	—	*-7*	*-28*	*10*
Employers				
Premium contributions	—	309	328	316
Providers				
Uncompensated care	—	-166	-150	-60
Total	**—**	**-21,975**	**-18,404**	**-10,834**

Percent change from current spending

	Current	Reform 1: Nongroup base case	Reform 2: Nongroup with rural price adjustment	Reform 3: Nongroup with prices modestly above Medicare rates
Household				
Premiums and out-of-pocket costs	—	-1.2	-1.0	-0.7
Federal government	—			
Medicaid/CHIP		0.2	0.2	0.2
Marketplace subsidies	—	-28.0	-23.7	-14.1
Reinsurance	—	0.0	0.0	0.0
Uncompensated care	—	-0.7	-0.6	-0.2
Subtotal	—	*-3.5*	*-2.9*	*-1.7*
State government				
Medicaid/CHIP	—	0.2	0.2	0.1
Marketplace subsidies	—	-6.3	-6.9	-7.1
Reinsurance	—	0.0	0.0	0.0
Uncompensated care	—	-0.7	-0.6	-0.2
Subtotal	—	*0.0*	*0.0*	*0.0*
Employers				
Premium contributions	—	0.0	0.0	0.0
Providers				
Uncompensated care	—	-0.7	-0.6	-0.2
Total	**—**	**-1.0**	**-0.9**	**-0.5**

Source: Health Insurance Policy Simulation Model, 2019.

Notes: CHIP = Children's Health Insurance Program. Cells are marked with a dash when the row does not apply to the column head. Reforms simulated as fully phased-in and in equilibrium in 2020. Analysis includes the US population under age 65 not enrolled in Medicare. Medicaid/CHIP includes acute care for the nonelderly. Prescription drug prices in each reform scenario are assumed to be set halfway between Medicare and Medicaid prices.

Results for a Public Option in the Employer and Nongroup Markets

Under reforms 4 through 6, the public option is available in both the nongroup and employer markets. Employers decide whether to offer the public option, their traditional group plan, or neither. We assign employers to offering the public option or traditional group coverage using assumptions detailed in table A.3. The provider payment rates are consistent between the nongroup and employer markets. The small-group (50 or fewer workers) and nongroup markets' risk pools are separate, though both operate under the regulations delineated by the ACA. Large employers can choose to offer the public option, but the premiums they pay are experience rated. Again, in each simulation, we assume prescription drug rebates in the nongroup insurance market and for employers offering the public option are set halfway between current Medicare and Medicaid rebates. In reforms 7 and 8, we assume all employers offering insurance to their employees offer insurance plans that limit provider payment rates to no more than the regulated level. The same prescription drug rebates apply to all private insurers in the nongroup and employer markets under reforms 7 and 8.

We expect that public option reforms affecting the employer insurance market would require multiyear transitions before full implementation. The larger the decrease in provider prices and the larger the number of employers that participate, the longer the phase-in should be. This is because the employer insurance market comprises a significantly larger share of health care provider revenue than does the nongroup market. Large price decreases in this market therefore could lead to significant disruptions in health care access or quality if providers have insufficient time to adjust their underlying costs. For ease of comparison across the simulations, our estimates do not account for phasing prices down over time, but we do not intend to diminish the importance of doing so.

Reform 4: Employer and Nongroup Base Case

Offers a public option in all nongroup and employer markets; sets payments for hospitals and physicians at Medicare rates

Premium effects. The median nongroup market premium decreases by 28 percent compared with current circumstances (table 9). The distribution of nongroup premium effects is virtually identical to that in reform 1, the nongroup-only base case. Comparing premium spending before and after reform only for employers offering the public option, the median premium decreases by 32 percent compared with current levels. Accounting for all employers, regardless of whether they offer the public option,

median premiums fall by 18 percent compared with current levels. The top 10th percentile premium decreases by 20 percent, whereas the bottom 10th percentile premium falls by 15 percent.[24]

Coverage effects. The number of uninsured falls by 1.7 million people under reform 4, and an additional 450,000 people obtain ACA-compliant insurance coverage instead of short-term plans (table 10). Compared with today, employer coverage increases by 2.3 million people, and 78.8 million people with employer coverage obtain it through the public option, over half of all people with employer coverage. The number of people with nongroup coverage declines by 326,000 (2.1 percent) compared with current levels. The number of people buying nongroup coverage without subsidies increases modestly, but this is offset by the decrease in subsidized coverage.

Health spending effects. As 78.8 million people take up coverage through the public option, employer health spending falls by $142.9 billion (15.5 percent), lowering employer-based premiums for many. Household spending falls by $76.3 billion, or 13.6 percent, compared with current levels (table 10). Household savings are considerably larger than under any of the previously discussed reforms, because many more people enroll in the public option once it is opened to people with employer-sponsored insurance. Federal spending falls by $17.5 billion, or 4.1 percent, again largely because of lower Marketplace premium tax credits. In addition to lowering federal health spending, reform 4 would increase federal income tax receipts by $24.8 billion, reflecting the substantial number of employer-based public option enrollees. Total health spending by all payers, an indication of the magnitude of the reduction in provider revenue, decreases by $239.5 billion, or 11.2 percent.[25]

Reform 5: Employer and Nongroup with Prices Modestly Above Medicare Rates

Offers a public option in all nongroup and employer markets; sets payments for hospitals at Medicare rates plus 25 percent and payments for physicians and other professionals at Medicare levels plus 10 percent

Premium effects. The difference between reforms 4 and 5 is the higher public option payment rates in reform 5. Consequently, premiums are higher as well (table 9). The median benchmark premium in the nongroup market falls by 14 percent compared with current levels (as opposed to 28 percent under reform 1). Across the distribution of nongroup premiums, reform 5 leads to smaller decreases than does reform 4. The same is true for employer premiums. Focusing the comparison only on employers offering the public option, the median premium decreases by 24 percent. When accounting for all employers, the median premium decreases by 13 percent.

Coverage effects. The number of uninsured falls by 1.6 million people, and another 412,000 people leave substandard coverage for employer or nongroup plans that meet ACA standards (table 10). The

number of people with employer coverage increases by 2.2 million, with 76.6 million people in the employer-based public option. The number of people in the employer public option is slightly lower than in reform 4 (78.8 million) because the premiums are higher. However, overall enrollment in both employer-sponsored and nongroup insurance are about the same under both reforms 4 and 5. The premium savings resulting from the public option are still significant under reform 5, and the vast majority of people enrolling in the public option currently have coverage.

Health spending effects. Under reform 5, employer health spending falls by $104.5 billion, or 11.3 percent, relative to current spending; this is about 73 percent of the employer health savings achieved by reform 4. Household health spending falls by $54.6 billion, or 9.8 percent, compared with current spending (table 11). Federal government health spending declines by $10.1 billion, or 2.3 percent, compared with current spending; higher premiums lead to smaller savings in premium tax credits than under reform 4. In addition to lowering federal health spending, reform 5 would increase federal income tax receipts by $17.5 billion. Spending for all payers would fall by $171.8 billion, or 8.0 percent.

Reform 6: Employer and Nongroup with Prices Further Above Medicare Rates

Offers a public option in all nongroup and employer markets; sets payments for hospitals at Medicare rates plus 60 percent and payments for physicians and other professionals at Medicare rates plus 15 percent

Premium effects. The difference between reforms 5 and 6 is that hospital payment rates are set significantly higher under reform 6, and professional payment rates are also set slightly higher. Consequently, premiums in the nongroup and employer-based public options are higher than under reform 5 (table 9), and employer participation in the public option is lower. The median nongroup benchmark premium decreases by 10 percent relative to current levels. The benchmark premium at the top 10th percentile of rating regions is 26 percent lower than current levels. Because payment levels and premiums are higher than under reform 5, fewer firms anticipate savings greater than 20 percent; consequently, only around 30 percent of people with employer-sponsored insurance are in the public option, down from more than 50 percent under reforms 4 and 5.

When restricting the comparison only to employers choosing the public option, the median premium decreases by 16 percent. Among all employers, the median premium decreases by 6 percent, reflecting the smaller percentage of employers taking up the public option under reform 6 than under reform 5.

Coverage effects. Compared with current levels, the number of uninsured falls by 1.5 million people, and an additional 390,000 people with short-term coverage obtain ACA-compliant insurance coverage

(table 10). Employer coverage increases by 2.2 million people, with 44.8 million people enrolled in employer-based public option coverage, many fewer than under reform 5 because public option premiums are higher under reform 6. Nongroup insurance coverage decreases by about 473,000 people compared with current levels, with small declines in both subsidized and unsubsidized coverage.

Health spending effects. Employer premium contributions fall by $38.9 billion, or 4.2 percent. Household spending declines by $24 billion, or 4.3 percent, compared with current levels (table 11). Household savings are roughly 44 percent of those in reform 5, because of the higher premiums resulting from higher provider payment rates. Federal government spending falls by $7.6 billion, or 1.8 percent, almost entirely because of a 12.1 percent reduction in Marketplace subsidies. In addition to lowering federal health spending, reform 6 would increase federal income tax receipts by $4.8 billion. Spending by all payers falls by $72.8 billion, or 3.4 percent.

Reform 7: Employer and Nongroup Rates Capped Modestly Above Medicare Prices

Caps provider payment rates for all insurers providing coverage in the nongroup and employer markets; provider payment rates are identical to those in reform 6 (hospital payments set at Medicare rates plus 25 percent and physician payments set at Medicare rates plus 10 percent); all employers, regardless of size and average wage, are assumed to benefit from capped provider payment rates

Premium effects. The difference between reforms 5 and 7 is that everyone covered by employer-sponsored insurance is assumed to benefit from the capped payment rates in reform 7; in reform 5, 51 percent of those with employer-sponsored insurance would enroll in the public option. Because this policy difference only affects employer-sponsored insurance, median nongroup benchmark premiums decrease by the same amount as in reform 5, 14 percent relative to current levels (table 9). The median premium decreases by 26 percent when comparing all employers before and after reform, because all people covered by employer-sponsored insurance benefit from rate cuts, not just a portion who opt in to a public option.[26]

Coverage effects. Compared with current levels, the number of uninsured falls by 1.6 million people under reform 7, and an additional 412,000 people with short-term coverage obtain ACA-compliant insurance coverage (table 10). This is the same as under reform 5. Employer coverage increases by 2.2 million people, with all 149.8 million people covered through employers benefiting from the lower provider payment rates; though this is shown in table 9 as "public option coverage," it refers to people enrolled in employer coverage and affected by capped provider payment rates. Nongroup insurance coverage decreases by about 415,000 people.

Health spending effects. Employer premium contributions fall by $223.9 billion, or 24.2 percent, more than double the reduction under reform 5, because all employers offering coverage to their workers can access the lower provider payment rates. Household spending declines by $109.2 billion, or 19.5 percent, compared with current levels (table 11). Household savings are much larger under reform 7 than under reform 5 because contributions for premiums and out-of-pocket costs fall for the much larger number of people with employer-based coverage benefiting from lower provider payment rates. Federal government spending falls by $10.1 billion, or 2.3 percent, just as in reform 5.[27] In addition to lowering federal health spending, reform 7 increases federal income tax receipts by $42.3 billion. Spending by all payers falls by $345.8 billion, or 16.1 percent, illustrating the potential system-wide effect of a capped rate policy.

Reform 8: Employer and Nongroup Rates Capped Further Above Medicare Prices

Caps provider payment rates for all insurers providing coverage in nongroup and employer markets; provider payment rates are identical to those in reform 6 (hospital payments set at Medicare plus 60 percent and physician payments set at Medicare rates plus 15 percent); all employers, regardless of size and average wage, are assumed to benefit from the capped provider payment rates

Premium effects. In reform 8, premiums fall in the nongroup market by 10 percent, just as in reform 6. When comparing all employers before and after reform, the median premium decreases by 19 percent. Again, all people enrolled in employer-sponsored insurance benefit from the rate cuts, a much larger number of people than those who opt into the public option under reform 6.

Coverage effects. Compared with current levels, the number of uninsured people falls by 1.5 million in reform 8, and an additional 390,000 people with short-term coverage obtain ACA-compliant insurance (table 10). Employer coverage increases by 2.2 million people, with 149.7 million insured through employers benefiting from the reform's lower provider payment rates. Nongroup insurance falls by 473,000 people.

Health spending effects. Employer premium contributions fall by $157.0 billion, or 17.0 percent, an increase more than four times that seen under reform 6, because all employers offering coverage to their workers benefit from lower payment rates. Household spending falls by $79.7 billion, or 14.2 percent, relative to current levels. Federal spending falls by $7.6 billion, or 1.8 percent, just as in reform 6. In addition to lowering federal spending, reform 8 increases federal tax receipts by $29.6 billion. Spending by all payers falls by $246.6 billion, or 11.5 percent, illustrating the potential effect of a capped rate policy even with rates significantly above those of Medicare.

Thus, of all reforms, 4, 7, and 8 contain systemwide costs the most. Reform 4 makes a public option paying Medicare rates to all providers available in the nongroup and employer-based insurance markets. Reforms 7 and 8 cap all private insurer payments to providers at rates above those of Medicare, but the provider rates are still lower than current commercial insurance rates and apply to many people. Therefore, higher provider payment rates or rates applied to smaller numbers of people lead to smaller private and public savings.

TABLE 9

Rating Region–Level Distribution of Changes in Nongroup and Employer Premiums under Nongroup and Employer Public Option Reforms 4 through 8, 2020

Percent change from current premiums

	PUBLIC OPTION			CAPPED RATES	
	Reform 4: Employer and Nongroup Base Case	Reform 5: Employer and Nongroup with Prices Modestly Above Medicare Rates	Reform 6: Employer and Nongroup with Prices Further Above Medicare Rates	Reform 7: Employer and Nongroup Rates Capped Modestly Above Medicare Prices	Reform 8: Employer and Nongroup Rates Capped Further Above Medicare Prices
Nongroup					
Percentile					
10th	-43	-29	-26	-29	-26
15th	-40	-24	-18	-24	-18
50th (median)	-28	-14	-10	-14	-10
75th	-17	-6	2	-6	2
90th	-11	0	8	0	8
Employers offering the public option					
Percentile					
10th	-34	-26	-19	-27	-20
15th	-33	-25	-18	-26	-18
50th (median)	-32	-24	-16	-25	-17
75th	-30	-23	-14	-23	-16
90th	-29	-21	-12	-22	-15
All employers					
Percentile					
10th	-20	-15	-8	-28	-21
15th	-19	-14	-7	-27	-20
50th (median)	-18	-13	-6	-26	-19
75th	-16	-12	-5	-25	-17
90th	-15	-11	-4	-23	-16

Source: Health Insurance Policy Simulation Model, 2019.

Notes: Reforms simulated as fully phased in and in equilibrium in 2020. These changes in premiums differ slightly from those in tables 2–5 because they reflect not only the basic changes in premiums, but also any changes in the risk pool resulting from introducing the public option.

TABLE 10

Health Insurance Coverage of the Nonelderly Population Currently and under Nongroup and Employer Public Option Reforms 4 through 8, 2020

Thousands of people

			Public Option		Capped Rates	
	Current	Reform 4: Employer and nongroup base case	Reform 5: Employer and nongroup with prices modestly above Medicare rates	Reform 6: Employer and nongroup with prices further above Medicare rates	Reform 7: Employer and nongroup rates capped modestly above Medicare prices	Reform 8: Employer and nongroup rates capped further above Medicare prices
Insured (minimum essential coverage)	**240,506**	**242,654**	**242,514**	**242,373**	**242,514**	**242,373**
Employer	*147,572*	*149,838*	*149,811*	*149,727*	*149,811*	*149,727*
Traditional	147,572	71,009	73,236	104,958	0	0
Public option	0	78,830	76,575	44,769	149,811	149,727
Private nongroup	*15,460*	*15,133*	*15,044*	*14,986*	*15,044*	*14,986*
Marketplace with PTC	9,097	8,520	8,708	8,703	8,708	8,703
Full-pay nongroup	6,363	6,613	6,337	6,283	6,337	6,283
Medicaid/CHIP	*68,843*	*69,051*	*69,027*	*69,029*	*69,027*	*69,029*
Medicare/other public	*8,632*	*8,632*	*8,632*	*8,632*	*8,632*	*8,632*
Uninsured (no minimum essential coverage)	**34,628**	**32,479**	**32,619**	**32,760**	**32,619**	**32,760**
Uninsured	32,185	30,487	30,588	30,708	30,588	30,708
Noncompliant nongroup	2,443	1,992	2,031	2,053	2,031	2,053
Total	**275,134**	**275,134**	**275,134**	**275,134**	**275,134**	**275,134**

Changes from current coverage, thousands of people

Insured (minimum essential coverage)	—	**2,149**	**2,009**	**1,867**	**2,009**	**1,867**
Employer	—	*2,266*	*2,240*	*2,155*	*2,240*	*2,155*
Traditional	—	-76,563	-74,335	-42,614	-147,572	-147,572
Public option	—	78,830	76,575	44,769	149,811	149,727
Private nongroup	—	*-326*	*-415*	*-473*	*-415*	*-473*
Marketplace with PTC	—	-577	-389	-393	-389	-393
Full-pay nongroup	—	251	-26	-80	-26	-80

| | | Public Option | | | Capped Rates | |
	Current	Reform 4: Employer and nongroup base case	Reform 5: Employer and nongroup with prices modestly above Medicare rates	Reform 6: Employer and nongroup with prices further above Medicare rates	Reform 7: Employer and nongroup rates capped modestly above Medicare prices	Reform 8: Employer and nongroup rates capped further above Medicare prices
Medicaid/CHIP	—	*208*	*184*	*186*	*184*	*186*
Medicare/other public	—	*0*	*0*	*0*	*0*	*0*
Uninsured (no minimum essential coverage)	—	**-2,149**	**-2,009**	**-1,867**	**-2,009**	**-1,867**
Uninsured	—	-1,698	-1,597	-1,478	-1,597	-1,478
Noncompliant nongroup	—	-450	-412	-390	-412	-390
Total	**—**	**0**	**0**	**0**	**0**	**0**

Percent change from current coverage

	Current	Reform 4	Reform 5	Reform 6	Reform 7	Reform 8
Insured (minimum essential coverage)	**—**	**0.9**	**0.8**	**0.8**	**0.8**	**0.8**
Employer	—	*1.5*	*1.5*	*1.5*	*1.5*	*1.5*
Traditional	—	-51.9	-50.4	-28.9	-100.0	-100.0
Public option	—	—	—	—	—	—
Private nongroup	—	*-2.1*	*-2.7*	*-3.1*	*-2.7*	*-3.1*
Marketplace with PTC	—	-6.3	-4.3	-4.3	-4.3	-4.3
Full-pay nongroup	—	3.9	-0.4	-1.3	-0.4	-1.3
Medicaid/CHIP	—	*0.3*	*0.3*	*0.3*	*0.3*	*0.3*
Medicare/other public	—	*0.0*	*0.0*	*0.0*	*0.0*	*0.0*
Uninsured (no minimum essential coverage)	**—**	**-6.2**	**-5.8**	**-5.4**	**-5.8**	**-5.4**
Uninsured	—	-5.3	-5.0	-4.6	-5.0	-4.6
Noncompliant nongroup	—	-18.4	-16.8	-16.0	-16.8	-16.0
Total	**—**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Source: Health Insurance Policy Simulation Model, 2019.

Notes: PTC = premium tax credit. CHIP = Children's Health Insurance Program. Cells marked with a dash when the row does not apply to the column head. Reforms simulated as fully phased in and in equilibrium in 2020. Analysis includes the US population under age 65 not enrolled in Medicare.

TABLE 11

Health Spending for the Nonelderly Population Currently and under Nongroup and Employer Public Option Reforms 4 through 8, 2020

Millions of dollars

		Public Option			Capped Rates	
	Current	Reform 4: Employer and nongroup base case	Reform 5: Employer and nongroup with prices modestly above Medicare rates	Reform 6: Employer and nongroup with prices further above Medicare rates	Reform 7: Employer and nongroup prices capped modestly above Medicare rates	Reform 8: Employer and nongroup prices capped further above Medicare rates
Household						
Premiums and out-of-pocket costs	560,233	483,924	505,610	536,258	450,986	480,557
Federal government						
Medicaid/CHIP	347,559	348,296	348,194	348,200	348,194	348,200
Marketplace subsidies	56,096	39,523	46,965	49,296	46,965	49,296
Reinsurance	1,227	1,227	1,227	1,227	1,227	1,227
Uncompensated care	27,531	25,819	25,973	26,109	25,973	26,109
Subtotal	*432,413*	*414,865*	*422,359*	*424,833*	*422,359*	*424,833*
State government						
Medicaid/CHIP	184,108	184,408	184,373	184,373	184,373	184,373
Marketplace subsidies	2,990	2,504	2,498	2,499	2,498	2,499
Reinsurance	475	475	475	475	475	475
Uncompensated care	17,207	16,137	16,233	16,318	16,233	16,318
Subtotal	*204,780*	*203,524*	*203,579*	*203,666*	*203,579*	*203,666*
Employers						
Premium contributions	924,291	781,420	819,766	885,428	700,386	767,274
Providers						
Uncompensated care	24,089	22,591	22,726	22,846	22,726	22,846
Total	**2,145,807**	**1,906,323**	**1,974,040**	**2,073,031**	**1,800,037**	**1,899,176**

Changes from current spending, millions of dollars

Household						
Premiums and out-of-pocket costs	—	-76,310	-54,623	-23,975	-109,247	-79,676
Federal government						
Medicaid/CHIP	—	737	635	641	635	641
Marketplace subsidies	—	-16,573	-9,130	-6,799	-9,130	-6,799
Reinsurance	—	0	0	0	0	0
Uncompensated care	—	-1,712	-1,558	-1,421	-1,558	-1,421
Subtotal	—	*-17,548*	*-10,054*	*-7,580*	*-10,054*	*-7,580*

	Current	Public Option			Capped Rates	
		Reform 4	Reform 5	Reform 6	Reform 7	Reform 8
State government						
Medicaid/CHIP	—	299	265	265	265	265
Marketplace subsidies	—	-486	-492	-491	-492	-491
Reinsurance	—	0	0	0	0	0
Uncompensated care	—	-1,070	-974	-888	-974	-888
Subtotal	—	*-1,256*	*-1,201*	*-1,115*	*-1,201*	*-1,115*
Employers						
Premium contributions	—	-142,871	-104,526	-38,863	-223,905	-157,017
Providers						
Uncompensated care	—	-1,498	-1,363	-1,244	-1,363	-1,244
Total	**—**	**-239,484**	**-171,767**	**-72,776**	**-345,770**	**-246,631**
Federal tax offset from ESI change	**—**	**24,766**	**17,497**	**4,824**	**42,297**	**29,631**

Percent change from current spending

	Current	Reform 4	Reform 5	Reform 6	Reform 7	Reform 8
Household	**—**					
Premiums and out-of-pocket costs		-13.6	-9.8	-4.3	-19.5	-14.2
Federal government						
Medicaid/CHIP	—	0.2	0.2	0.2	0.2	0.2
Marketplace subsidies	—	-29.5	-16.3	-12.1	-16.3	-12.1
Reinsurance	—	0.0	0.0	0.0	0.0	0.0
Uncompensated care	—	-6.2	-5.7	-5.2	-5.7	-5.2
Subtotal	—	*-4.1*	*-2.3*	*-1.8*	*-2.3*	*-1.8*
State government						
Medicaid/CHIP	—	0.2	0.1	0.1	0.1	0.1
Marketplace subsidies	—	-16.2	-16.5	-16.4	-16.5	-16.4
Reinsurance	—	0.0	0.0	0.0	0.0	0.0
Uncompensated care	—	-6.2	-5.7	-5.2	-5.7	-5.2
Subtotal	—	*-0.6*	*-0.6*	*-0.5*	*-0.6*	*-0.5*
Employers						
Premium contributions	—	-15.5	-11.3	-4.2	-24.2	-17.0
Providers						
Uncompensated care	—	-6.2	-5.7	-5.2	-5.7	-5.2
Total	**—**	**-11.2**	**-8.0**	**-3.4**	**-16.1**	**-11.5**

Source: Health Insurance Policy Simulation Model, 2019.

Notes: CHIP = Children's Health Insurance Program. ESI = employer-sponsored insurance. Cells are marked with a dash when the row does not apply to the column head. Reforms simulated as fully phased-in and in equilibrium in 2020. Analysis includes the US population under age 65 not enrolled in Medicare. Prescription drug prices in each reform scenario are set halfway between Medicare and Medicaid prices.

Geographic Variation in Premium Tax Credits and Employer Spending

Table 12 presents state-specific estimates of the effects of reforms 1, 4, and 5 on federal spending on Marketplace premium tax credits. For each reform, effects vary by the current premiums and competition in the insurer and provider markets in each state; per person premium tax credits are greater when benchmark premiums are higher and enrollees' incomes are lower. The effects of public option reforms vary considerably by geography because federally funded premium tax credits are tied to benchmark nongroup premium levels, which vary based on market characteristics. For example, under reform 1, federal premium tax credits decrease by over 50 percent in Alaska, Delaware, the District of Columbia, Mississippi, and West Virginia. In addition, in states and under reforms where coverage increases the most, savings due to lower per enrollee premium tax credits can sometimes be offset by increased enrollment in subsidized Marketplace plans.

Federal premium tax credits would fall much less in other states, where current nongroup benchmark premiums are already relatively low. Under reform 1, premium tax credits fall by less than 20 percent in California, Idaho, Massachusetts, Michigan, New York, Ohio, and Wisconsin. Reforms 4 and 5 lead to similar state variations.

Table 13 presents state-level changes in total employer spending on premiums under reforms 4 and 5. Under reform 4, when the public option pays providers at Medicare rates, employer spending on premiums falls significantly in all states. When provider payment rates are set above Medicare levels under reform 5, the savings fall. However, employer spending on premiums varies much less by state than do federal premium tax credits. And for reasons discussed earlier, provider payments rates vary less in the employer market than in the nongroup market. For example, under reform 4, employer spending on premiums decreases by as much as 18 percent in New Mexico and by as little as 13 percent in Maine, Massachusetts, New Hampshire, and Utah.

TABLE 12

Percent Change in Federal Spending on Marketplace Premium Tax Credits under Reforms 1, 4, and 5 Relative to Current Spending, by State, 2020

	Reform 1: Nongroup base case	Reform 4: Employer and nongroup base case	Reform 5: Employer and nongroup with prices modestly above Medicare rates
Alabama	-47	-51	-31
Alaska	-63	-53	-25
Arizona	-33	-43	-34
Arkansas	-30	-27	0
California	-18	-9	-4
Colorado	-25	-35	-23
Connecticut	-38	-34	-3
Delaware	-65	-75	-55
District of Columbia	-65	-47	21
Florida	-30	-34	-18
Georgia	-31	-35	-16
Hawaii	-41	-44	-18
Idaho	-13	-16	-14
Illinois	-35	-37	-13
Indiana	-26	-28	-22
Iowa	-29	-27	-8
Kansas	-33	-37	-16
Kentucky	-41	-43	-27
Louisiana	-44	-49	-23
Maine	-26	-24	-13
Maryland	-24	-30	-22
Massachusetts	-13	-12	-12
Michigan	-18	-17	-12
Minnesota	-32	-22	4
Mississippi	-59	-65	-49
Missouri	-42	-45	-25
Montana	-27	-30	-12
Nebraska	-44	-43	-23
Nevada	-41	-59	-37
New Hampshire	-30	-47	-28
New Jersey	-34	-32	3
New Mexico	-24	-27	-19
New York	-9	-7	-8
North Carolina	-46	-48	-29
North Dakota	-49	-63	-18
Ohio	-19	-28	-23
Oklahoma	-35	-38	-13
Oregon	-26	-27	-14
Pennsylvania	-30	-34	-19
Rhode Island	-31	-32	-19
South Carolina	-49	-52	-33
South Dakota	-35	-39	-20
Tennessee	-36	-41	-23
Texas	-22	-26	-16
Utah	-23	-29	-15
Vermont	-42	-43	-4
Virginia	-31	-42	-31
Washington	-24	-22	-11
West Virginia	-51	-72	-18
Wisconsin	-19	-20	-9
Wyoming	-46	-49	-27

Source: Health Insurance Policy Simulation Model, 2019.

Note: Reforms simulated as fully phased in and in equilibrium in 2020.

TABLE 13
Percent Change in Employer Spending on Premiums under Reforms 4 and 5 Relative to Current Spending, by State, 2020

	Reform 4: Employer and nongroup base case	Reform 5: Employer and nongroup with prices modestly above Medicare rates
Alabama	-16	-12
Alaska	-16	-12
Arizona	-17	-12
Arkansas	-17	-13
California	-15	-11
Colorado	-16	-12
Connecticut	-13	-8
Delaware	-16	-11
District of Columbia	-17	-13
Florida	-16	-12
Georgia	-16	-12
Hawaii	-16	-12
Idaho	-15	-11
Illinois	-16	-12
Indiana	-16	-12
Iowa	-15	-11
Kansas	-15	-11
Kentucky	-17	-12
Louisiana	-17	-13
Maine	-13	-8
Maryland	-16	-12
Massachusetts	-13	-8
Michigan	-15	-11
Minnesota	-16	-12
Mississippi	-17	-13
Missouri	-16	-11
Montana	-16	-11
Nebraska	-15	-11
Nevada	-19	-15
New Hampshire	-13	-8
New Jersey	-14	-10
New Mexico	-18	-13
New York	-14	-9
North Carolina	-15	-11
North Dakota	-16	-12
Ohio	-16	-12
Oklahoma	-17	-13
Oregon	-15	-11
Pennsylvania	-14	-9
Rhode Island	-14	-8
South Carolina	-16	-12
South Dakota	-16	-11
Tennessee	-17	-13
Texas	-17	-13
Utah	-15	-10
Vermont	-13	-8
Virginia	-16	-12
Washington	-15	-11
West Virginia	-15	-11
Wisconsin	-17	-13
Wyoming	-16	-12

Source: Health Insurance Policy Simulation Model, 2019.
Notes: Reforms simulated as fully phased in and in equilibrium in 2020. Percent changes calculated over all employer premium spending, regardless of participation in reform.

Limitations of the Analysis

The effects of reforms introducing a public option or capping provider payment rates for all private insurers in the nongroup or nongroup and employer health insurance markets are inherently uncertain. Estimates of current commercial payment rates and their variability, the payment rate reductions ultimately achievable via an inherently political process, households' and firms' decisions to participate in a public insurance option, and the aggregate savings possible from greater regulation of prescription drug prices are all subject to limitations on available data and uncertain responses from stakeholders. Thus, the range of possible outcomes from these reforms is large.

Estimates of Nongroup Reforms

- Because of data limitations, we proxy Medicare payment rates by assuming the benchmark premiums in highly competitive nongroup markets reflect underlying provider payment rates that approximate Medicare rates. Our estimation depends on hospital market concentration and the number of Marketplace insurers in each rating region. High levels of competition are indicators of lower provider payment rates, and we provide evidence that our proxy is reasonable. However, high premiums in noncompetitive regions could owe to unmeasured factors other than higher provider payment rates.

- Our nongroup market public option simulations do not have plans competing with each other within the same actuarial value tier. The plan represented in the silver tier is the benchmark plan in each rating region. Thus, the public option is assumed to be the benchmark plan, and we cannot estimate the number of people enrolling in that versus other competing commercial plans. This is not a problem for estimating changes in federal spending on Marketplace subsidies, which are tied to the benchmark premium, but does affect household spending, which would be higher than shown here for people enrolling in higher-cost plans than the benchmark.

Estimates of Employer Reforms

- Though FAIR Health has the largest and most geographically diverse sample of claims data available to us, the data do not contain all private plans in a state or substate area, and therefore, the contributing insurers in a specific area may not be entirely representative. For

example, if the plan that pays the highest or lowest prices in a particular area is missing from the database, we may under- or overstate the median price paid in the area.

- We use FAIR Health data to represent the distribution of employer plans' payment levels. However, these data are not limited to employer plans, and we cannot separate employer plans or the rates they pay providers from other private insurance plans and their payment rates (i.e., individual market and Medicare Advantage plans). FAIR Health data include plans that cover approximately 75 percent of the privately insured population in the US. Because other data sources show that the employer market represents the majority of the privately insured market, we assume employer claims likely represent a majority of the FAIR Health sample.

- To compute commercial payment rates relative to Medicare rates for professional and outpatient facility services, we use selected Current Procedural Terminology (CPT) codes based on both their frequency and contribution to total spending. Ultimately, the codes we use represent 47 percent of total professional spending and 42 percent of total outpatient facility spending in the FAIR Health data. It is possible that the services chosen do not represent the true average commercial insurance–to-Medicare price ratio for each service category.

- FAIR Health does not release substate data on commercial payment rates for inpatient hospital services. Consequently, our inpatient estimates include all inpatient services provided in a state, but we have no substate information on inpatient care. We apply these state averages to all substate areas.

- We have little evidence on which to predict employer behavior if given the choice to enroll workers in a public option. Thus, our assumptions for take-up by firm size, wage, and expected savings are, by necessity, somewhat arbitrary. This is one reason we simulate a scenario equivalent to all employers using the public option to provide coverage to their workers.

- Employer behavior around the public option could depend on timing; firms may move to (or away from) the public option as they and their employees gain experience with and knowledge of the plan. Our one-year estimates assume the program is fully phased in and at equilibrium; estimating the time path of enrollment is beyond the scope of this report.

- We do not estimate the implications of employers offering workers both the public option and commercial coverage. If this was an option, employer behavior would differ from that modeled here.

Estimates of Prescription Drug Savings

- We assume drug pricing and rebates for various private payers are uniform across the country. If drugs consumed vary geographically, the rebates we estimate will be inaccurate because we do not have data on the underlying variation.

- Medicare pharmacy benefit managers differ by geography. If some can get better rebates from manufacturers, Medicare rebates could differ across states. Because our public option rebates for prescription drugs are computed relative to Medicare and Medicaid levels, any geographic variation in Medicare rebates we miss would affect our public option estimates.

- We estimate that drug rebates for the public option would lead to prices halfway between those in Medicare and Medicaid, or 30 percent below commercial insurance prices. This seems reasonable to us; it is less than what has been achieved in current Medicaid programs and less than similar rebates in other western nations. However, it could still be too optimistic or pessimistic.

- In our nongroup public option estimates, the share of health spending attributable to prescription drugs is set at the national average. In reality, the share may vary by state or region. However, any measurement error of this type should not significantly affect our estimates because prescription drug spending only accounts for 23 percent of the premium dollar nationwide.

Summary of Findings

We examine the potential health coverage and spending implications of eight reforms implementing a public option or capped provider payment rates. We show that the impact of the reform on federal, employer, and household spending depends on whether the public option is available only in the nongroup market or both the nongroup and employer markets. The effects also depend on how much provider payment rates are reduced below current commercial insurance rates and the number of employers using the lower rates. Finally, we show that the reforms have significantly different effects geographically; areas with the highest current provider payment rates would reap the largest relative savings.

We estimate that the median nongroup benchmark premium would decrease by about 28 percent with a nongroup public option paying providers at Medicare-like rates. The mean reduction would be about 19 percent, because regions that currently have low premiums have significantly larger

populations. In other words, highly populated areas are more likely to be competitive and to currently pay rates closer to Medicare's in the nongroup market.

In the employer market, payment rates are higher on average because insurance markets tend to be less competitive. Employers are more likely to accept higher provider payment rates than risk reducing their employees' access to well-liked providers. Our analysis shows that hospital payment rates are, on average, about 2.4 times greater than Medicare rates; at the 90th percentile (lower-priced geographic area), hospital rates are 1.9 times greater than Medicare rates and at the 10th percentile (higher-priced geographic area) they are 3.1 times greater. Commercial payments to physicians are closer to Medicare rates today; the average is 20 percent above Medicare levels. The ratio of commercial payments to physicians to such payments from Medicare ranges from 1.5 at the 10th percentile to 0.9 at the 90th percentile. We assume prescription drugs are sold on a national market, each manufacturer uses national pricing with uniform rebates, and that a public option could provide prescription drug savings of 30 percent relative to current commercial payments (roughly halfway between today's Medicare and Medicaid pricing).

Our simulations show that a nongroup market public option, paying Medicare-like provider payment rates, and reduced prescription drug prices would reduce federal spending on Marketplace subsidies by about 28 percent, assuming the public option becomes the benchmark plan in each area. Federal health spending (including Medicaid acute care for the nonelderly, Marketplace subsidies, reinsurance for states with such programs, and funding for uncompensated care) would fall by 3.5 percent, because Marketplace subsidies constitute a small share of total federal health spending. Assuming modestly higher provider payment rates in the public option, where hospitals and physicians are paid 25 percent and 10 percent above Medicare rates, respectively, Marketplace subsidies would fall by 24 percent, and total federal health spending would fall by 3 percent.

Making the public option available to employers does not materially change spending on the Marketplace or other public programs. However, this extension results in substantial health care savings for employers and consequently increases income tax revenue, because reductions in employer health care spending are converted to taxable wages. With more workers and their dependents in a public option, households save more as well. If the public option paying Medicare rates is available to all employers and a significant share (about half) take up the public plan, employer health care spending drops by $142.9 billion, or 15.5 percent. Increasing provider payment rates in these approaches reduces savings for employers and income tax revenue gains.

The largest systemwide savings across the scenarios presented occur if provider payment rates are capped in all nongroup and employer plans, a regulatory approach similar to that used for the Medicare Advantage program. Even with payment rates set above Medicare levels (e.g., Medicare rates plus 25 percent for hospitals and Medicare rates plus 10 percent for physicians), employer spending on premiums decreases by 24.2 percent. The increase in federal income tax revenue amounts to $42.3 billion dollars under this scenario in 2020. Total spending by all payers falls by $345.8 billion, or 16.1 percent. If payments were set at Medicare rates plus 60 percent for hospitals and Medicare rates plus 10 percent for physicians, employer spending would still fall by 17.0 percent. The increase in federal income tax revenue would be $29.6 billion, and spending by all payers would fall by $246.6 billion, or 11.5 percent.

Discussion

This analysis has shown that a public option that reduces the prices insurers pay to providers to Medicare rates and reduces prescription drug prices below Medicare prices could significantly reduce insurance premiums and government, employer, and household health spending. Depending on the specifics, such an approach can also reduce the number of uninsured people while increasing cash wages and federal revenues. The magnitude of these effects depends critically on how much payment rates are reduced (i.e., how close to Medicare the professional and hospital prices are set) and the specific markets to which the lower rates are applied (nongroup, employer).

Uncertainty surrounds our estimated impacts of the illustrative public option reforms described here, and the major limitations of our methods are summarized on pages 41 to 43. This uncertainty largely owes to some data that would make our estimates more precise not being publicly available. Consequently, we use imputed or proxied information.

Some scenarios we estimated, particularly those including the employer insurance market, would, if implemented, greatly reduce provider revenues, which could lead to disruptions in the health care delivery system, depending on how fast they are implemented. However, providers could adjust their underlying costs over a multiyear phase-in, decreasing the risk of delivery system disruption and allowing analysts to measure (and policymakers to adjust for) possible health care access or quality concerns as prices decrease. The larger the number of insured people included in a public option, the more important such phase-ins become, because ideal prices for all providers and services are unknown. Medicare prices or multiples thereof make convenient benchmarks, but those prices have been set for a health insurance system that includes an array of public and private prices from different

payers. There is nothing to say that Medicare prices or a defined percentage above them would strike an appropriate balance between cost, quality, and access if applied to a much larger share of the population.

In addition, large changes in provider prices and/or revenue could significantly change employment and/or wages in the health sector. Measuring such effects is beyond the scope of this analysis.

Implementation of any of the public option scenarios presented would require a legislative change, and any of the reforms could be quite controversial. Such political challenges are reflected in the recent effort to address "surprise billing," or large out-of-pocket bills sent to people after emergency or other hospital-based situations who were treated by out-of-network physicians through no fault of their own. Current legislative efforts attempt to set payment for out-of-network services at market rates for in-network services yet continue to face strong opposition from providers. The number of health service claims covered by a public option could be considerably larger, and the provider prices assumed in our scenarios are lower, meaning the political pushback from providers over a public option could be at least as strong.

Appendix A. Data and Methods

Estimating the effects of a public option requires two general steps. First, we assess the provider payment rates in current markets and how they vary geographically. Because the public option or capped payment rate reforms studied here are designed to set payments relative to Medicare rates, we must estimate how current provider payment rates compare with Medicare program rates. Doing so allows us to compute how much lower a public plan's premiums might be relative to current commercial insurance premiums. However, information on payment rates currently used by commercial insurers in the individual nongroup and employer insurance markets is limited. These data constraints force us to use some proxies and require that we approach this step differently for the nongroup and employer insurance markets. The data limitations introduce unavoidable uncertainty in our estimates (see the earlier Limitations of the Analysis section).

In the second step, we feed the information from the first step into a microsimulation model of the US health insurance system for the nonelderly population, which allows us to simulate the number of people affected by the reforms and the potential implications for private and government health care spending overall. In both steps, geographic variation is a central interest.

Step 1. Estimating Current Provider Payment Rates Relative to Medicare Rates in Nongroup and Employer Markets

Because there are no nationally or state-representative sources of claims data for private nongroup insurers, we proxy the geographic variation in nongroup provider payment rates using Marketplace premium data at the rating region (substate) level.[28] Consequently, we cannot directly estimate current nongroup insurance provider payment rates for hospitals or physicians relative to Medicare rates. We use data on Marketplace premiums for 2017, the year before the explicit federal cost-sharing reduction payments ended and threats of repealing the ACA's individual mandate, among other regulatory changes, caused turmoil in these markets. This uncertainty led to dramatic premium increases in 2018. Based on our analyses of Marketplace premiums and competition (Holahan et al. 2019; Holahan, Wengle, and Blumberg 2019; Holahan, Wengle, and Elmendorf 2020), both quantitative and qualitative, we assume Marketplace premiums in highly competitive ACA Marketplaces approximate the premiums

insurers would charge if they were paying hospitals and physicians Medicare rates. We provide evidence supporting this assumption in box A.1.

The ACA's Marketplaces tie income-related premium tax credits to the second-lowest silver premium (the benchmark premium). People who choose a plan with a higher premium than this benchmark must pay the full difference between the selected plan's premium and the benchmark premium. At or below the benchmark premiums, people pay no more than the income-related fixed percentage of income specified under the law. Thus, the tax credits' structure strongly incentivizes insurers to price competitively. Consequently, many Marketplace insurers in competitive markets develop limited provider networks, selecting those willing to accept lower payment rates in exchange for patient market share. However, the number of insurers participating in the Marketplaces varies across the country, meaning price competition varies. In many Marketplaces, only one or two insurers participate; in some others, five or more do. More competitive areas tend to include at least one insurer that only offered coverage through the Medicaid program before the ACA's reforms. These insurers usually are the lowest-cost option in the markets in which they participate (Blumberg et al. 2019). For example, out of the 135 rating regions with four or more Marketplace insurers in 2020, 111 (82 percent) have at least one Medicaid insurer.[29]

We estimate equations that regress the benchmark premium in each of the country's 502 rating regions against the number of nongroup Marketplace insurers (one, two, three, four, five, or more), the area's hospital Herfindahl-Hirschman Index (HHI), and various control variables (e.g., the presence of a Blue Cross insurer, Medicaid insurer, provider-sponsored insurer, and national or regional insurer in the market). We also control for rating region population, whether the state has pure community rating in its nongroup market, whether the state had expanded Medicaid eligibility under the ACA as of 2017, and the area average wage index.

The results show that benchmark premiums tend to fall as the number of insurers increase. Stated differently: controlling for other factors, benchmark premiums are typically highest in markets with only one insurer, and they decrease consistently as the number of participating insurers increases to five or more. Benchmark premiums also tend to be lower if a Medicaid insurer participates in the Marketplace. Finally, as hospital HHI decreases (indicating lower hospital market concentration), benchmark premiums tend to decrease as well. Other researchers have found similar results (Dafny, Gruber, and Ody 2015; Van Parys 2018).

For this analysis, we assume benchmark nongroup insurers in highly competitive markets (with five or more competing insurers and hospital HHI of no more than 5,000) set their provider payments at

approximately Medicare rates. Currently, 45 rating regions, accounting for 27 percent of the US population, meet that criteria. We then use the estimated regression to predict the benchmark premium for a 40-year-old single person for each rating region as if the area were highly competitive (with at least five insurers and HHI set at the lesser of 5,000 and the rating region's actual HHI), holding all other regional characteristics constant. Thus, our adjustment lowers premiums for highly concentrated insurer and provider markets. These computed premiums are our proxy for the benchmark premiums in a plan using Medicare rates in each rating region. Further analysis indicates that this proxy for Medicare payment rates is valid (box A.1).

BOX A.1

Validation of the Assumption That Benchmark Premiums in Highly Competitive Nongroup Insurance Markets Approximate Medicare Provider Payment Rates

Using commercial insurer–to-Medicare payment ratios based on claims data from FAIR Health, which we assume broadly represents employer-based insurance plans, we estimate that reducing payment rates to Medicare levels (all else being equal and with rebates for prescription drugs set halfway between Medicare and Medicaid rebates) would decrease medical expenses by approximately 35 percent (details shown below). In other words, Medicare prices combined with our assumed prescription drug pricing would lower commercial insurance prices by 35 percent.

Using HIPSM, we separately estimate the change in health care costs if people with employer-based insurance were moved into a nongroup market 80 percent AV (gold level, typical of employer-based insurance plans) plan priced consistent with the most competitive markets (the assumption used in our nongroup market public option simulations) and with the same savings on prescription drugs assumed in our public option simulations. That analysis found that spending on the people currently enrolled in employer-sponsored insurance would decrease by 37 percent once they were moved into a competitively priced nongroup gold plan.

This finding supports our assumption that competitive nongroup market pricing roughly approximates Medicare rates, because the former would produce about the same overall savings as the latter. Also, nongroup insurers are prohibited from charging high premiums merely to increase their profits, because the law prohibits medical loss ratios from falling below 85 percent in that market. If medical loss ratios are below that percentage in a year, the insurer must issue rebates to its enrollees. Consequently, in equilibrium, premiums charged in competitive markets should reflect insurer costs plus a normal profit.

We compute the percent difference between a rating region's predicted benchmark premium based on the region's 2019 characteristics and our proxy premium. We then apply the computed percent difference to a rating region's actual benchmark premium to calculate the premium for the public option.[30] Premium differences under Medicare proxy rates are smaller in more competitive markets and larger in less competitive ones.

Depending on a reform's specifications, we adjust the proxy premium for higher provider payment rates for rural areas and/or differentially for physicians versus hospitals. When we apply different payment rates for rural versus urban areas, we use an indicator we developed based on the share of rural or urban counties in the rating region. Though Medicare rates already contain various additional payments for sole-community, low-volume, and Medicare-dependent rural hospitals, the current policy discussion around public option proposals often includes suggestions for additional rural-area adjustments. We do not take a position on the necessity of such adjustments; we merely analyze the implications of using them. We also include an adjustment for prescription drug rebates in each simulation (described below).

We calculate the share of health spending attributable to physicians, hospitals, prescription drugs, and other services by region based on the spending patterns among the nonelderly population in the 2016 Medical Expenditure Panel Survey Household Component.[31] Then, we apply sector-specific payment rate adjustments to the appropriate share of the Medicare-rate proxy premium. For example, if we want to increase hospital payment rates by 10 percent above Medicare rates in a region where 45 percent of the premium is attributable to hospital services, we increase total payment rates by *.45 × (0.10)*, with 0.45 being the hospital service share and 0.10 reflecting the additional 10 percent added to Medicare hospital rates. When appropriate, we adjust professional services and prescription drug payments in the same manner.

Prescription drug savings. Though we reduce hospital and physician payments to Medicare rates (or some multiple thereof) for all simulations, we assume the public option would pay lower prices for prescription drugs than Medicare does. The assumed prescription drug savings described here apply to public options or capped provider payment rate strategies in both the nongroup and employer insurance markets. Medicare is not a particularly efficient payer for prescription drugs but does pay lower prices than commercial insurers. The program is prohibited from negotiating with manufacturers over prescription drug prices, let alone setting prices as it does with other providers. Rather, Medicare relies on pharmacy benefit managers to negotiate prices, and these benefit managers have considerably less leverage than Medicare would have if it simply set prices as it does for other medical services.

All payers, including Medicare, Medicaid, and commercial insurers, require prescription drug manufacturers to rebate part of the list price of each drug. Commercial insurers receive the smallest rebates, largely because each one covers a smaller share of the market (giving them less power to negotiate), and when insurance markets are not highly competitive, they often do not have strong incentives to negotiate aggressively. Medicare Part D gets somewhat larger rebates than commercial insurers, but they are modest compared with Medicaid's rebates. Medicaid receives both basic and inflation rebates (where the program receives a rebate for any increase in a prescription drug's price above the inflation rate). Together, these rebates result in Medicaid receiving the largest savings compared with prescription drug list prices in the US.

Kesselheim and Hwang (forthcoming) compares post-rebate commercial prices with estimated prescription drug savings achieved by paying higher rebates under each government program. The authors used Market Scan data to identify the largest brand-name drugs and selected 75 drugs that account for two-thirds of spending by commercial payers. They assume savings on current generic drug prices are not achievable, because these prices are already low, and manufacturers seldom provide commercial insurers with rebates for generic prescription drugs. They also calculate the difference between prices paid by commercial insurers and the Medicare program for the 75 selected drugs, the prices paid by Medicaid when accounting for the full rebates (including the inflation rebates), and prices paid by a group of four federal programs with high prescription drug expenditures (the US Department of Veterans Affairs, the Coast Guard, the Department of Defense, and the Public Health Service, also called the "Big Four"). In addition, they use information on supplemental rebates often negotiated by Medicaid programs or the Big Four. Ultimately, they estimate that basic Medicaid rebates generate average savings between 9 and 15 percent off commercial insurer prices, which are considered roughly equal to Medicare rebates. Relative to commercial insurer prices, the full Medicaid rebate, including the inflation rebate, averages 46 to 49 percent savings, and the Big Four see savings of 28 to 34 percent.

Kesselheim and Hwang (forthcoming) also reports that Canada's published prices are about 65 percent below US commercial prices after rebates. Countries such as Germany, Switzerland, and the United Kingdom have prices comparable to those in Canada.

Given the political strength of pharmaceutical manufacturers, achieving savings sufficient to obtain prices as low as those in other nations seems unlikely. In addition, if the US legislated prices at these levels (i.e., international reference pricing), these prices could be below manufacturers' average costs and result in increases in those reference prices agreed to with other nations. For these reasons, the US has been constrained in lowering drug prices. To estimate the potential savings on prescription drugs under our base case public option (reform 1), we assume rebates or other pricing control strategies that

establish final prices halfway between those paid by Medicare and Medicaid. This rebate seems feasible but politically challenging to achieve. Such rebates are significant compared with those received by commercial insurers but still result in prescription drug prices well above those in other western nations. We assume legislation would mandate these rebates for the public option. To make these rebates effective for a large population, it may be necessary to also regulate increases in list prices (which is beyond the scope of this analysis). The price reductions we estimate could also be sought through reference pricing or negotiations; the results reported would apply regardless.

In each reform, we assume prescription drug savings halfway between Medicare savings and the full Medicaid rebate, which would equal about 30 percent off current commercial prices. We apply this assumed 30 percent savings in our simulation analyses. Though such savings may appear optimistic, they are less aggressive than those in several current proposals.[32] We also assume prescription drugs are sold on a national market, with each manufacturer using national pricing and uniform rebates.

According to the Medical Expenditure Panel Survey's most recent publicly available year of data, prescription drugs account for 23 percent of private health care spending. Thus, we estimate that a 30 percent drop in commercial prices for prescription drugs will, on average, reduce private health spending by 6.9 percent; this reduction is applied to premiums in our nongroup simulations. In the simulations of reforms to employer-sponsored insurance, HIPSM applies the 30 percent savings to each person's private health expenditures (insured or household paid) according to that person's specific prescription drug spending, thereby capturing how these savings vary across people and insurance risk pools depending on prescription drug use.[33]

Estimating Premium Savings under A Public Option or Capped Provider Payment Rates in the Nongroup Market

Accounting for potential savings on all health care services, including prescription drugs, table 2 in the body of this report shows the state average percent differences between current benchmark premiums and premiums when using Medicare payment rates for all providers, with prescription drug rebates halfway between those for Medicare and Medicaid. These are our base case, or reform 1, assumptions. Premium adjustments are computed at the ACA nongroup market rating region level, and state averages shown in the table are weighted by the rating region population covered by nongroup insurance (Giovannelli, Lucia, and Corlette 2014).[34] These percent changes in premiums reflect the changes in provider payment rates only and do not account for any possible changes resulting from different people or more people with different average characteristics enrolling in coverage because of

price changes. We account for these behavioral changes and any resulting changes in insurance risk pools in the simulation work described in the results section of the main report.

Table 2 in the body of this report shows that under the assumptions used in reform 1, average nongroup benchmark premiums would be no more than 11 percent below the current premium in six states (California, Idaho, Massachusetts, Michigan, New York, and Ohio). Average benchmark premium savings from a public option are relatively small in these states primarily because their nongroup insurance Marketplaces tend to be competitive. We estimate that premium savings would exceed 35 percent in eight states (Alabama, Alaska, Delaware, Mississippi, Nebraska, North Carolina, South Carolina, and Wyoming), reflecting the lack of competition in their current nongroup markets. Nationwide, the average savings would be 19 percent.

Table 3 in the body of this report shows the distribution of benchmark premium savings across the country's 502 nongroup market rating regions. The distribution shows that we estimate benchmark nongroup premiums would fall by at least 41 percent in 10 percent of rating regions but would fall by no more than 11 percent in another 10 percent of regions. The median savings would be 28 percent. The large gap between median and mean reductions owes to small rating regions generally having higher prices and therefore needing larger price cuts to achieve Medicare levels.

Estimating Current Provider Payments Relative to Medicare Rates in the Employer Group Market

We assume a public option available to employer purchasers would, like a public option in the nongroup market alone, achieve savings by lowering payment rates to providers. Using Medicare payment rates as a benchmark, we calculate premium savings that could be achieved by bringing commercial provider payment rates closer to Medicare rates.

Estimating the likely savings from reducing provider payment rates is challenging because no data are publicly available on the actual rates commercial insurers pay to providers (also known as the insurers' negotiated rates or allowed amounts). Providers, particularly hospitals, often report list prices or charges for specific services, but insurers negotiate substantial discounts off these list prices, and the resulting negotiated rates are confidential. We considered several sources of proprietary commercial claims data for insurers in the employer market that could be used to construct estimates of typical commercial prices relative to Medicare prices. We ultimately chose to use FAIR Health data,[35] the largest and most geographically representative private insurance claims database available to us.

FAIR Health's National Private Insurance Claims (FH NPIC ®) database contains data submitted by approximately 60 insurers and the third-party administrators covering over 150 million people with private commercial insurance nationwide.[36] The claims analyzed include the allowed amounts negotiated between insurers and the providers participating in their networks; this total negotiated fee includes the amount paid by the insurer and the patient's cost share, if any. To protect the interests of both payers and providers, FAIR Health imputes allowed amounts highly correlated to the actual allowed amounts without disclosing confidential in-network rates.[37] FAIR Health regularly produces and licenses "FH ® Allowed Benchmarks," which report the range of imputed allowed amounts for specific CPT codes in each of 493 geographic areas (known as geozips) that generally correspond to combinations of three-digit zip codes. These benchmarks are available for medical, anesthesia, dental, and outpatient facility services.[38]

FAIR Health does not license an allowed amount benchmark database for inpatient hospital services and does not provide details on payments for prescription drugs. So, to estimate overall premium savings from reducing commercial rates, we combine information on commercial payment rates relative to Medicare rates for physician and hospital outpatient services at the geozip level, state-level inpatient services data from FAIR Health, and the national estimate of prescription drug savings detailed above. We describe the details of the FAIR Health estimates below.

For both hospital outpatient and professional services, FAIR Health identified the top 30 CPT codes by frequency and by expenditure nationwide from their claims database. After accounting for overlap in the top codes by frequency and expenditure, we received data on 46 professional and 45 outpatient CPT codes. These codes represented approximately 47 percent of professional spending and about 42 percent of outpatient facility spending in the FAIR Health database.

For each professional and outpatient code, we received the number of claims, the median commercial price, the average commercial price, and the Medicare price for each of 491 geozips in the US. FAIR Health provided the Medicare rates, which were calculated based on the Medicare fee schedule and adjusted for geographic rate differences. Within each geozip, we then calculated the ratio of the median commercial price to the Medicare price for each CPT code and generated expenditure-weighted averages across the professional and outpatient service codes.[39]

FAIR Health could not provide substate-level commercial payment rates for hospital inpatient services, so we received average commercial insurance–to-Medicare ratios for each state. FAIR Health constructed these ratios by estimating the ratio for each hospital inpatient facility claim in their

database from July 2017 to June 2018 and then averaging the ratios for each state. We then assigned these state-level ratios to all geozips in a state.

The Medicare rate used in the inpatient ratio calculation was based on the diagnosis-related group for the specific claim and adjusted for the geographic wage index. However, the rate does not adjust for hospital characteristics that would result in additional Medicare payments for disproportionate share hospitalstatus, indirect medical education, or rural or isolated hospital status. Thus, the commercial insurance–to-Medicare price ratios were overstated. To adjust the inpatient ratios at the geozip level, we used national estimates of the share of hospital inpatient prospective system spending on these payments from the Medicare Payment Advisory Commission.[40] For urban hospitals, the share of spending on indirect medical education, disproportionate share hospitals, uncompensated care, and rural or isolated hospital add-on payments was 15.1 percent; for rural hospitals, the share of spending on these add-ons was 17.3 percent. To account for this issue, we multiplied the inpatient ratios in urban and rural geozips by 0.849 and 0.827, respectively.[41]

Each geozip then has an inpatient facility ratio, an outpatient facility ratio, and a professional ratio, and the outpatient and professional ratios reflect the expenditure-weighted average ratio across CPT codes for the geozip. We combine hospital inpatient and outpatient facility ratios for each geozip using weights derived from the share of expenditures on the nonelderly population from the 2016 Medical Expenditure Panel Survey Household Component.[42] We estimate the share of hospital spending attributable to outpatient events plus emergency department care (37 percent) versus inpatient stays (63 percent) based on the above distribution. So, our hospital ratio for each geozip is a weighted average of the inpatient and outpatient ratio. Ultimately, we end up with 491 geozip-level hospital and professional ratios.

Because our microsimulation model uses the American Community Survey and its PUMAs, we converted the geozip-level ratios to PUMA-level ratios using a zip code tabulation area–to–PUMA crosswalk obtained from the Missouri Research Data Center's Geocorr program.[43] Because there are more PUMAs than geozips in the US, most PUMAs include data from only one geozip and many geozips provide estimates from multiple PUMAs.[44]

For each PUMA, we then generate the implied hospital and professional price cuts if rates were set at Medicare levels.[45] Finally, we combine these price cuts with an estimated 30 percent reduction in drug costs (as described previously) to generate potential employer premium savings from implementing a public option or capping payments at Medicare rates.[46] The weights for hospital, professional, and drug spending again rely on the Medical Expenditure Panel Survey distribution

above.[47] Here we use these weights for illustrative purposes, but the simulations (described below) use the estimated spending on each service in each insurance risk pool.

Table 4 in the body of the report shows the national distribution of PUMA-level hospital and professional commercial insurance–to-Medicare price ratios and the implied premium cut from moving from commercial to Medicare rates. Again, these changes reflect the reduction in premiums alone and do not account for any risk pool changes resulting from behavioral changes; we account for those in our simulation results. The table shows that the ratio of commercial to Medicare prices was 2.4 on average for hospitals and 1.2 for professionals (physicians and others). The ratios vary considerably across the country, however, particularly for hospitals.

We find some variation between our estimates of private prices relative to Medicare's using FAIR Health data and such estimates from other sources (table A.1), but different sources use different geographies, plans, and services, as well as methodological approaches to estimating relative prices. The Congressional Budget Office analyses using Health Care Cost Institute data are limited to metropolitan areas only (Maeda and Nelson 2017; Pelech 2018), whereas Cooper and colleagues (2018) used Health Care Cost Institute data on hospital referral regions covering the entire US. White and Whaley (2019) compiled data from multiple sources, including all-payer claims data and self-insured employers in 25 states only. The Congressional Budget Office selected and reported on prices for 20 professional services and did not attempt to produce a composite measure, whereas the Medicare Payment Advisory Commission reports a single estimate based on claims for preferred provider organization members of a large national insurer (MedPAC 2019a). The sources also vary in whether and how they adjust for geography and disproportionate share hospital and indirect medical education statuses in their calculations of relevant Medicare prices.

The table below includes several national, or overall, estimates found in both the published and grey literature.

Estimates of Private Insurance Prices Relative to Medicare Prices from Various Sources

		Ratio of Private Insurance to Medicare Prices			
	Data source	Hospital	Inpatient	Outpatient	Physician/ professional
Urban Institute	FAIR Health (2017–18)	2.4	1.9	3.4	1.2
Congressional Budget Office	HCCI (2013–14)	NA	1.9	NA	1.1–2.4 (service-specific)
Cooper and colleagues	HCCI (2007–11)	NA	2.2	NA	NA
White and Whaley	Multiple (2015–17)	2.4	2.0	2.9	NA
Medicare Payment Advisory Commission	2017	NA	NA	NA	1.3

Sources: CBO estimates come from Maeda and Nelson (2017) and Pelech (2018). See Cooper and colleagues (2018), MedPAC (2019a), and White and Whaley (2019).

Notes: HCCI = Health Care Cost Institute. NA = not available.

Though the exact estimates vary somewhat, some consistent patterns emerge. Private inpatient prices appear to average around twice Medicare prices, and private prices relative to Medicare for outpatient facility services appear at least as high, or higher, than relative prices for inpatient care (where separate estimates are available). Moreover, the relative private price for physician services appears lower than that for hospital services, but the estimates vary considerably; this may depend on the services selected to generate the estimates. Our estimates used 46 services representing 47 percent of spending, whereas the Congressional Budget Office focused on 20 specific services. We have no further details on the Medicare Payment Advisory Commission estimate presented in the table.

For the most expensive 10 percent of geographic areas, our data indicate that the hospital payment ratio (commercial prices divided by Medicare prices) was more than 3, whereas commercial hospital payments in the lowest 10 percent of areas were, at most, 1.9 times Medicare prices. For professional services, commercial payment rates were at least 1.5 times Medicare rates in the highest 10 percent of areas and, at most, 0.9 times Medicare rates in the lowest 10 percent of areas.

The relative differences for hospital and professional payments can be combined with the assumed price cut for prescription drugs (weighted by the share of spending attributable to each) to compute implied potential premium cuts from moving from current commercial payment rates to our base case assumptions (Medicare rates for hospitals and professionals and prescription drug prices halfway between Medicare and Medicaid prices). Our estimates suggest that both the mean and median employer insurance premiums would drop by approximately 35 percent after such payment rate

reductions. This is larger than the 19 percent mean reduction and 28 percent median reduction in the nongroup market.

The percent reductions in premiums resulting from lower provider payment rates are larger in the employer market than the nongroup market because premiums have been quite low in many ACA nongroup insurance markets for reasons described previously.[48] A public option is unlikely to offer much lower premiums than private insurers in highly competitive markets, but savings can be substantial in less competitive markets. Employer insurance markets do not appear very price competitive today, and their provider payment rates tend to be higher. Employers tend to keep provider networks broader (particularly in larger firm plans), which avoids alienating employees but leads to higher premiums. This also means employer premiums do not vary much across geographic areas because, unlike the nongroup market, few employer markets have low overall private commercial insurance payment rates, particularly for hospitals.

Our estimates based on FAIR Health data suggest our base case price assumptions could reduce employer premiums by at least 25 percent in 90 percent of PUMAs, with 10 percent of PUMAs seeing decreases of 44 percent or more. These potential premium reductions reflect the relatively high commercial insurance–to-Medicare ratios for hospital payment rates (national average of 2.4) and the much lower ratio for professional services (national average of 1.2). This suggests that moving to Medicare rates for hospitals could save an average of 57 percent on hospital services and 14 percent on professional services.

Table 5 in the body of this report presents state-level estimates averaging commercial insurance–to-Medicare payment ratios for hospital and professional services across PUMAs. It also shows the implied price cuts resulting from moving from the estimated commercial rates to Medicare rates (our base case assumptions). Assuming Medicare rates, hospital payments from commercial private insurance payers would fall by more than 60 percent in Alabama, California, Colorado, Florida, Nevada, South Carolina, and Texas. Professional payments would be cut by more than 25 percent in Florida, Louisiana, Minnesota, North Dakota, Texas, Wisconsin, and Wyoming. Professional payments would increase on average in eight states if Medicare rates were paid. In our simulations, several reforms assume payments would be set above Medicare rates.

Estimating Premium Savings under a Public Option or Capped Provider Payment Rates in the Employer Market

Combining the base case hospital and professional cost reductions and the 30 percent decrease in prescription drug prices, our estimates suggest potential average employer premium reductions ranging from 40 percent or more in Florida, Georgia, Nevada, Texas, and Wisconsin to 25 percent or less in Maine, Maryland, Pennsylvania, Rhode Island, Utah, Vermont, and West Virginia. The PUMA-level ratios and implied premium reductions underlying these state-level averages provide the geographic variation that informs the simulated reforms.

Step 2. Simulating Public Option or Capped Provider Payment Rate Reforms

The Urban Institute's Health Insurance Policy Simulation Model, or HIPSM, is a microsimulation model of the US health insurance system for those under age 65 who are not disabled and therefore covered by Medicare. It simulates the cost and coverage implications of an array of health care reforms and computes health insurance premiums for people in different insurance risk pools (employer groups, households purchasing coverage on the nongroup market with and without subsidies). Here, we use HIPSM to simulate the cost and coverage implications of our eight public option/capped payment rate reforms. The simulations vary by the assumed provider payment rates (all expressed relative to Medicare's payment rates) and the insurance markets (nongroup, employers) in which the public option/capped provider payment rates are available. Estimates of the coverage effects of changing premiums target elasticities drawn from the literature (Blumberg, Nichols, and Banthin 2001). Table A.2 shows elasticity targets for employer-sponsored insurance. Targets for nongroup insurance are calculated by the Congressional Budget Office (CBO 2005).

TABLE A.2

Target Price Elasticity of Employer-Sponsored Insurance Offers, by Firm Size

Firm size	Elasticity
<10	-1.16
10–25	-0.45
25–50	-0.4
50–100	-0.3
100–500	-0.21
500–1,000	-0.047
1,000+	Not available from the literature

Source: Buettgens (2011).

HIPSM uses the estimates of employer and nongroup insurance payments relative to Medicare for each geographic area described above to adjust the premiums for people simulated to enroll in the public option or capped rate plans. The adjustments vary depending on a reform's assumed payment rates and current payment rates in the applicable market(s). Adjustments for assumed hospital, professional services, and prescription drug savings are applied to spending in each insurance risk pool depending on enrollees' spending on each type of service. Those enrolling in the public option or capped rate plans in currently highly competitive nongroup insurance markets see relatively small adjustments to their premiums, whereas those enrolling in either plan in a currently noncompetitive area will see much larger adjustments to their premiums. People enrolling in a public option in an employer market where payment rates are highest will see larger adjustments to their premiums than will people in employer markets where payment rates are lower. We assume the full savings in payment rates are passed on to enrollees as a premium reduction.

Conceptually, our simulations of nongroup public options are consistent with offerings available at each of the ACA's actuarial value tiers. In addition, we assume the Marketplace benchmark premium decreases by the percent difference between the public option premium and benchmark premium in that rating area. Lower benchmark premiums in the nongroup market mean lower federal spending on premium tax credits, lower household out-of-pocket costs (due to lower prices for care), and lower household spending on premiums for those ineligible for premium tax credits. HIPSM does not model a distribution of different nongroup insurance plans within a single actuarial value tier. Therefore, the model implicitly assumes all ACA-compliant nongroup insurance enrollees are affected by the public option. We assume capping provider payments at the specified rates has the same effect, lowering the benchmark premium and enrollees' out-of-pocket costs.

In the employer market, we assume a public option has characteristics typical of employer plans (e.g., fairly broad benefits and 80 percent AV but lower provider payment rates than those currently paid by commercial insurers). Large firms choosing the public option continue to be experience rated, with premiums adjusted depending on the expected health care costs of each firm's enrollees. Small firms face modified-community-rated premiums for the public option, just as they do in the existing fully insured market. We assume firms compare their plans' current benefits, cost-sharing requirements, and premiums with the those in the public option. We also assume some employers would find that their employees prefer the benefits and cost-sharing in the firm's own plan over those in the public option, and that the public option's premium savings are insufficient to overcome those preferences. If a firm's workers, in aggregate, prefer the public option's benefits, cost-sharing requirements, and premium savings, we assume the firm offers the public option.

How individual firms would react to a public option is difficult to predict. When a public option is offered to employers, we assume that among employers offering coverage to their workers, take-up of the public option varies by employer size, the firm's average wage, and the provider prices facing the firm. As employer size increases and/or average worker wage increases, we assume the employer's likelihood of offering the public option decreases. HIPSM's behavioral model also permits employers not currently offering coverage to their workers to begin to offer it based on the lower public option price available. We use the following matrix of participation assumptions (table A.3) along with an assumption about firms' sensitivity to expected savings to illustrate the potential implications of public option reforms in employer markets.

TABLE A.3
Likelihood That Employers Will Offer the Public Option, by Employers' Number of Employees and Average Worker Wage

	Number of Employees in Firm		
Average worker wage	Fewer than 100	100 to 999	More than 1,000
Lowest 25 percent (below 25th percentile)	90%	80%	80%
Middle 50 percent (25th to 75th percentile)	60%	50%	40%
Highest 25 percent (above 75th percentile)	40%	30%	20%

Source: Authors' assumptions used for modeling purposes.

The participation rates used in these simulations are illustrative and somewhat arbitrary. However, they assume employers with a lower-wage workforce are more likely to value the public option's lower premiums, whereas employers with a higher-wage workforce are more likely to value the plans that have been tailored to meet their workers' collective needs. In addition, we assume larger employers, those most efficiently providing coverage to their workers today, would be less likely to adopt the public option. We also assume firms anticipate savings from participation in the public option, but if those savings are small, the firm does not adopt the public option; specifically, we assume a firm will forgo the public option if expected savings are not at least 20 percent of their current premium costs.[49] In these simulations, an employer does not offer insurance to its workers, offers a private plan, or offers the public option; a single firm does not offer both public and private plan options to its workers.

Under the simulated capped payment rate reforms, all firms take advantage of lower provider prices, because they do not have to change benefits or cost-sharing structures to benefit from the lower payment rates. Any commercial insurer or self-insuring firm could use the lower provider payment rate

schedule developed for these reforms. Such scenarios are consistent with Medicare Advantage, wherein private plans' provider payment rates are limited to traditional Medicare plan rates.[50]

Notes

1 We describe the source of changes in income tax revenue under public option reforms in a later section. It relates almost entirely to reforms implemented in the employer market, and consequently, income tax revenue essentially does not change under the three nongroup-only reforms described in this section.

2 Medicare-X Choice Act of 2019, S. 981, 116th Cong. (1st Sess. 2019); Choose Medicare Act, S. 1261, 116th Cong. (1st Sess. 2019); Keeping Health Insurance Affordable Act of 2019, S. 3, 116th Cong. (1st Sess. 2019); Consumer Health Options and Insurance Competition Enhancement Act, S. 1033, 116th Cong. (1st Sess. 2019).

3 "NHE Fact Sheet," Centers for Medicare & Medicaid Services, accessed February 13, 2020, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NHE-Fact-Sheet.

4 Sherry Glied, "Identifying Promising Solutions to Real Problems," New York University Robert F. Wagner Graduate School of Public Service, accessed February 13, 2020, https://altarum.org/sites/default/files/uploaded-related-files/Glied.pdf.

5 Examples include Medicare-X Choice Act of 2017, S.1970, 115th Cong. (1st Sess. 2017); Choose Medicare Act, S. 2708, 115th Cong. (2nd Sess. 2018); and Medicare at 55 Act, S. 1742, 115th Cong. (1st Sess. 2017).

6 The Medicare approach limits Medicare Advantage plan payments for out-of-network providers to traditional Medicare rates. This provides sufficient leverage for Medicare Advantage plans to pay no more than those rates for in-network providers as well. As we have proposed elsewhere (Blumberg and Holahan 2017b), we assume capped payment rates in a public option would explicitly apply to both in- and out-of-network providers.

7 Eligible Marketplace enrollees with incomes below 250 percent of the federal poverty level may purchase Marketplace coverage with reduced cost-sharing requirements when paying an income-related premium for silver coverage. For example, a person with income between 100 and 150 percent of the federal poverty level can choose a 94 percent AV plan when paying an income-related premium for a 70 percent AV plan. These higher value plans lower the out-of-pocket costs (deductibles, coinsurance, copayments) low-income enrollees face when accessing medical care.

8 As noted, the Medicare program includes private Medicare Advantage plans that cap payments at traditional Medicare program rates. Medicare Advantage plans offer coverage as an alternative to traditional Medicare, which is essentially a public option.

9 The Choose Medicare Act (S. 1261) includes a public option for employers.

10 Even under capped payment rates, providers may not want to participate, because a public option operating only in the nongroup insurance market affects a small percentage of the insured population, and providers could therefore choose not to participate with those insurers without substantially affecting their patient base.

11 Some evidence shows that a public option could induce more aggressive negotiation by private insurers. See Blumberg and colleagues (2019).

12 The standard is at least five Marketplace insurers and hospital HHI of at least 5,000.

13 The FAIR Health database contains data submitted by approximately 60 insurers and third-party administrators covering nearly 150 million people with private insurance nationwide.

14 The substate data are available at the geozip level, which we distributed to the PUMA (census-defined geographic areas with at least 100,000 residents that do not cross state lines) level and then aggregated to the state level.

[15] Estimates of public option spending in the employer market are applied as 30 percent cuts to prescription drug spending by region, not by the overall 23 percent of spending used to adjust nongroup premiums.

[16] ACA rating regions are set by states but must meet particular federal guidelines; each area is defined by counties, metropolitan statistical areas, or three-digit zip codes. States generally have multiple rating areas; however, six states (Delaware, the District of Columbia, Hawaii, New Hampshire, New Jersey, Rhode Island, and Vermont) include the entire state in one rating area. See Giovannelli, Lucia, and Corlette (2014).

[17] The large gap between median and mean reductions owes to small rating regions generally having higher prices and therefore requiring larger price cuts to achieve Medicare rates.

[18] For the highest 10 percent of geographic areas, the hospital payment ratio (commercial prices divided by Medicare prices) was more than 3; in the lowest 10 percent of geographic areas, commercial hospital payments were, at most, 1.9 times Medicare rates. For professional payments in the highest 10 percent of areas, commercial payment rates were at least 1.5 times Medicare rates; in the lowest 10 percent of areas, commercial payment rates were at most 0.9 times of Medicare rates.

[19] Consumers enrolling in plans priced above the benchmark premium must pay the full premium difference out of pocket. Those choosing a plan priced below the benchmark receive savings. Thus, the incentive is strong for consumers to choose a lower-priced plan, pushing many insurers to compete aggressively on price.

[20] Our estimates based on FAIR Health data suggest our base case (reform 1) price assumptions could reduce employer premiums by at least 25 percent in 90 percent of PUMAs, with 10 percent of PUMAs seeing premium decreases of 44 percent or more. These potential premium reductions reflect the relatively high commercial insurance–to-Medicare price ratios for hospital payment rates (national average of 2.4) and the much lower ratio for professional services (national average of 1.2), which suggests that moving to Medicare rates could save an average of 57 percent on hospital services and an average of 14 percent on professional services.

[21] Throughout this paper, when we refer to nongroup insurance coverage, we are referring to ACA-compliant nongroup insurance coverage, not short-term, limited-duration plans or other plans not required to comply with consumer protections, such as modified community rating, guaranteed issue, essential health benefits, and AV standards.

[22] In addition, some people with incomes below 400 percent of the federal poverty level who receive small subsidies (because they have higher incomes within that range) may see their premiums drop below their applicable percent-of-income cap. Their subsidy would fall to zero, but they would spend slightly less on premiums.

[23] It may seem surprising that the number of people with nongroup insurance coverage (subsidized and unsubsidized combined) decreases slightly under reform 3 compared with current levels. This is because the higher provider payment rates and higher premiums under reform 3 bring in fewer unsubsidized enrollees than do the lower payment rates and premiums under reform 1. The smaller number of new unsubsidized enrollees is not large enough to offset some modest disenrollment among people currently buying bronze coverage. As we noted earlier, lower provider payment rates translate into lower nongroup premiums and lower federal premium tax credits per person. Though this decrease does not affect the preferences of people buying silver coverage (because their premium and subsidy decline by the same amount), it does negatively affect people buying bronze (60 percent AV) coverage. Though the bronze premium decreases with lower provider payment rates as well, the differential in silver and bronze premiums means a bronze-plan purchaser will pay more out of pocket for the coverage they currently buy when the subsidy decreases. A modest number of those consumers drop their coverage as a result.

[24] When accounting for all employers, effects in the bottom percentile are not zero, because premium changes are computed at the geographic region level, not the employer level. Because at least some employers take up the public option in all regions, every region sees an effect.

[25] Again, the reduction in spending by all payers reflects both payments for claims made to health care providers and insurer administrative costs.

[26] Under reform 7, the distribution of premium changes are different when accounting for all employers versus only employers taking advantage of the lower payment rates, despite all employers using the capped payment rates in this scenario. That is because for both reform options, the premium changes computed for employers taking up the public option/capped rates compare the prices paid by employers taking the up the reform option with those same employers' premiums under current law. Conversely, the "all employers" approach compares the premiums paid by all employers offering insurance coverage to their workers before and after reform, even when those pre- and postreform employers differ.

[27] Federal (and state and local) government costs for employer premiums would also fall, but the costs associated with these premiums are counted as employer spending in the tables here.

[28] Under the ACA, states can define the substate areas in which nongroup insurance premiums for the same plan do not vary (e.g., people of the same age and tobacco use choosing the same insurance plan face the same premium). These areas may consist of a single county, several counties, a metropolitan area, or a three-digit zip code.

[29] Authors' calculations from federally facilitated Marketplace and state-based Marketplace data.

[30] We predicted the current benchmark premiums using actual 2019 values for most Marketplace rating areas. In some states, 2019 premiums are very low and could not realistically be further reduced; in some of these states, the number of insurers had recently dropped, resulting in predicted premiums even further below actual 2019 levels. In these cases, we used the 2017 number of insurers (instead of the 2019 number) to predict current-law benchmark premiums, assuming the 2017 level of competition caused the low premiums currently seen in these states.

[31] Other spending includes dental visits, home health events, and other medical equipment and services.

[32] See, for example, the Lower Drug Costs Now Act, H.R. 3, 116th Cong. (1st Sess. 2019).

[33] The prescription drug savings are applied differently in the nongroup and employer markets. For our nongroup market estimates, we adjust health care costs by rating region, but not service type . Employer health care costs are adjusted by service type, so the 30 percent drop is assigned directly to drug spending.

[34] See note 16 above.

[35] Visit the FAIR Health website at https://www.fairhealth.org/.

[36] "FAIR Health: Your Independent Source for Healthcare Claims Data," FAIR Health, accessed February 13, 2020, https://s3.amazonaws.com/media2.fairhealth.org/resource/asset/FH%20Overview%20-%20Fact%20Sheet.pdf. FAIR Health data are not limited to employer plans only, and we cannot distinguish employer plans or the rates they pay providers from other private insurance plans and their payment rates (i.e., individual market and Medicare Advantage plans). FAIR Health data include more than 30 billion claims from plans that cover approximately 75 percent of the privately insured population in the US. Because other data sources find that the employer market represents the majority of the privately insured market, we assume employer claims likely represent a majority of the FAIR Health sample. As a frame of reference, according to the Urban Institute's Health Insurance Policy Simulation Model's estimates for 2020, health care expenditures (excluding administrative costs) for people enrolled in employer-based insurance are, in aggregate, 12.7 times as large as aggregate health care expenditures for people enrolled in nongroup insurance. Moreover, the FAIR Health database has been determined to meet sufficiency thresholds and requirements for research sample size and reliability with respect to the privately insured population in all 50 states and DC by the Centers for Medicare & Medicaid Services.

37 "Allowed Benchmarks," FAIR Health, accessed February 13, 2020, https://s3.amazonaws.com/media2.fairhealth.org/resource/asset/FH%20Product%20Sheet%20-%20Allowed%20Benchmarks.pdf.

38 FAIR Health also produces and licenses an allowed amount benchmark for Healthcare Common Procedure Coding System codes for equipment, supplies, and services not included in CPT codes, such as ambulance services, durable medical equipment, specialty drugs, prosthetics, orthotics, and supplies when used outside a physician's office.

39 The expenditure weights are generated by multiplying the average price in the geozip by the claim frequency for a specific code.

40 See chart 6-14 in MedPAC (2019b).

41 We made one additional adjustment to Vermont's hospital inpatient ratio because it was an outlier.

42 "Total Expenditures in Millions, by Event Type and Age Groups, United States, 2016," Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, generated interactively on September 20, 2019.

43 "Geocorr 2014: Geographic Correspondence Engine," Missouri Census Data Center, accessed February 13, 2020, http://mcdc.missouri.edu/applications/geocorr2014.html.

44 Geozips are combinations of zip code tabulation areas, so we create a PUMA-to-geozip crosswalk that includes the 2010 Census population for a particular PUMA-geozip intersection. We then generated weighted PUMA-level hospital and professional price ratios using the share of the PUMA population coming from component geozips.

45 Using the commercial insurance–to-Medicare price ratio, the implied price cut equals *(1 / ratio) – 1*.

46 Accounting for professional, hospital, and prescription drug costs, no people live in geographic areas where moving to our base case pricing (reform 1) would increase average health care costs.

47 All nonhospital and nondrug spending is assigned the professional price cut, so the estimated price cut equals *0.396 × hospital price cut + 0.383 × professional price cut + 0.221 × drug price cut.*

48 As noted earlier, this competition often takes the form of insurers contracting with select providers willing to accept lower payment rates, which allows the insurers to lower premiums.

49 HIPSM firms include a distribution of employer-sponsored insurance actuarial values and reflect differences in health status across workforces by employer sizes and industries.

50 More precisely, the Medicare approach limits Medicare Advantage plan payments for out-of-network providers to traditional Medicare program rates. However, this provides sufficient leverage for Medicare Advantage plans to pay no more than those rates for in-network providers as well. Here we assume the capped provider payment rates explicitly apply to both network and nonnetwork providers.

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Linda J. Blumberg is an Institute fellow in the Health Policy Center at the Urban Institute. She is an expert on private health insurance (employer and nongroup), health care financing, and health system reform. Her recent work includes extensive research related to the Affordable Care Act (ACA); in particular, providing technical assistance to states, tracking policy decisionmaking and implementation at the state and federal levels, and interpreting and analyzing the implications of particular policies. Examples of her work include analyses of the implications of congressional proposals to repeal and replace the ACA, delineation of strategies to fix problems associated with the ACA, estimation of the cost and coverage potential of high-risk pools, analysis of the implications of the *King v. Burwell* case, and several studies of competition in ACA Marketplaces. In addition, Blumberg led the quantitative analysis supporting the development of a "Road Map to Universal Coverage" in Massachusetts, a project with her Urban colleagues that informed that state's comprehensive health reforms in 2006.

Blumberg frequently testifies before Congress and is quoted in major media outlets on health reform topics. She serves on the Cancer Policy Institute's advisory board and has served on the *Health Affairs* editorial board. From 1993 through 1994, she was a health policy adviser to the Clinton administration during its health care reform effort, and she was a 1996 Ian Axford Fellow in Public Policy.

Blumberg received her PhD in economics from the University of Michigan.

John Holahan is an Institute fellow in the Health Policy Center, where he previously served as center director for over 30 years. His recent work focuses on health reform, the uninsured, and health expenditure growth, developing proposals for health system reform most recently in Massachusetts. He examines the coverage, costs, and economic impact of the Affordable Care Act (ACA), including the costs of Medicaid expansion as well as the macroeconomic effects of the law. He has also analyzed the health status of Medicaid and exchange enrollees, and the implications for costs and exchange premiums. Holahan has written on competition in insurer and provider markets and implications for premiums and government subsidy costs as well as on the cost-containment provisions of the ACA.

Holahan has conducted significant work on Medicaid and Medicare reform, including analyses on the recent growth in Medicaid expenditures, implications of block grants and swap proposals on states and the federal government, and the effect of state decisions to expand Medicaid in the ACA on federal and state spending. Recent work on Medicare includes a paper on reforms that could both reduce budgetary impacts and improve the structure of the program. His work on the uninsured explores

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Stacey McMorrow is a principal research associate with extensive experience using quantitative methods to study the factors that affect individual health insurance coverage and access to care as well as the impacts of state and national health reforms on employers and individuals. Her current work uses the Affordable Care Act and past Medicaid expansions to explore the effects of expanding insurance coverage on access to care, service use, and health outcomes for various populations. Through this and other work, McMorrow has developed substantial expertise in analyzing data from several federal surveys, including the National Health Interview Survey and the Medical Expenditure Panel Survey. Other research interests include the role of community health centers and safety net providers under health reform, receipt of preventive and reproductive health services among women, barriers to care for low-income children, and the market-level effects of insurance expansions.

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Michael Simpson is a principal research associate in the Health Policy Center with 25 years of experience developing economic models and using survey and administrative data. His current work focuses on using Urban's Health Insurance Policy Simulation Model to project health insurance coverage and spending both in the baseline and under policy alternatives. Before joining Urban, Simpson developed the Congressional Budget Office's long-term dynamic microsimulation model. He analyzed numerous policy reform proposals, investigated differences between various projections of Social Security finances and benefits, quantified the importance of Monte Carlo variation in model results, and created multiple methods to demonstrate uncertainty in projections.

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