



Introducing a Public Option or Capped Provider Payment Rates into Private Insurance Markets

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Several recent policy proposals include provisions for developing and introducing a public health insurance plan,¹ an insurance option structured and administered by government or a government contractor, into private insurance markets. 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. Such a plan would pay health care providers lower rates than typical commercial plans pay, perhaps paying Medicare rates or somewhere between Medicare's and commercial payers' rates. An alternative that could achieve many of the same goals as the public option with lower risk of private insurers exiting markets is capping provider payments at Medicare rates or some multiple thereof for all private insurers offering coverage in a particular market. This approach follows the precedent of Medicare Advantage and would lower the cost of health coverage for enrollees while they maintained their preferred plans, benefits, and cost-sharing structure (Blumberg and Holahan 2018).

As policymakers, advocates, and stakeholders increasingly debate the merits of these public policies, they have little information on the magnitude of the policies' potential for creating system savings or their implications for coverage and provider revenues. As such, we present eight reform options and summarize their effects on coverage, premiums, spending, and the federal deficit. We delineate 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. We estimate each reform's impacts on premiums, the distribution of insurance coverage, and health care spending by government, households, and employers (Blumberg et al. 2020).² Our analysis accounts for geographic variation in payment rates under current law, which leads to variation in savings potential across the country. Our full analysis and detailed methodological approach are available in the accompanying [full report](#) (Blumberg et al. 2020).

Public Option and Capped Provider Payment Rate Reforms Modeled

Several bills introduced in Congress and discussed by presidential candidates include introducing a public option into private nongroup insurance markets.³ Less frequently, policymakers suggest making a public option available in both employer and nongroup markets. Even less frequently do policymakers discuss limiting the provider prices paid by all private insurers in an insurance market (Blumberg and Holahan 2017).⁴ Because the number of people enrolled in employer coverage is more than nine times the number in nongroup coverage, and because employer-based plans tend to pay health care providers higher rates than do nongroup insurers, introducing the public option or capping provider payment rates in both markets could have far-reaching, substantial impacts on both spending and health care provider revenues (e.g., for hospitals, physicians, and prescription drug manufacturers). Consequently, we simulate public option and capped payment rate reforms in the nongroup market alone and in both the nongroup and employer group markets.

Though several public option proposals are actively being debated in political and policy circles, they tend not to specify the provider prices the public plan would pay. Most suggest the public option would use traditional Medicare prices as a reference point but are no more specific than that. Paying lower prices to providers would generate greater system savings; however, the lower the prices are set, the greater the political resistance from providers and insurers and the greater the potential for disruptions in at least some parts of the health system. Therefore, we simulate public options that assume a range of provider prices.

We simulate a public option or capped payment rate reform alone, excluding other reforms included in many active proposals, such as changes to Marketplace subsidies or public program eligibility. In this way, our estimates isolate the effects of these strategies alone. All estimates include people under age 65 not enrolled in Medicare.

We simulate three public options introduced only into private nongroup insurance markets. Assuming the public option would become the benchmark plan (second-lowest-premium silver plan) in each rating area, the implications of a nongroup public option reform for federal government costs and coverage would be virtually the same as capping private insurers' payment rates at the same level as a public option would pay. This is because federal subsidies in the nongroup insurance Marketplaces are tied to the second-lowest silver plan premium in each geographic area. For simplicity, we call the nongroup market reforms public options.

- **Reform 1, nongroup base case.** Prices for hospitals and professionals are set or capped at Medicare rates; prescription drug prices are set halfway between Medicare and Medicaid prices.⁵ The public option is available in nongroup markets nationwide.
- **Reform 2, nongroup with rural price adjustment.** Prices for hospitals and professionals in urban areas are set at Medicare rates, and in rural areas they are set at Medicare rates plus 20 percent. Prescription drug prices are assumed to be set halfway between Medicare and Medicaid prices. The public option is available in nongroup markets nationwide.
- **Reform 3, nongroup with prices modestly above Medicare rates.** Nationwide, prices for hospitals are set at Medicare rates plus 25 percent, and professional prices are set at Medicare rates plus 10 percent. Prescription drug prices are set halfway between Medicare and Medicaid prices. The public option is available in nongroup markets nationwide.

We simulate five additional reforms that offer a public option or capped provider payment rates in both the nongroup and employer insurance markets using the same prices. The nongroup and employer insurance risk pools remain separate, however. Premiums for small employers are modified community rated, and premiums for large employers are experience rated, consistent with current law. Our analysis of public options and capped provider payment rates differ in the employer market because the savings resulting from the reforms differ markedly depending on the number of affected employers. That all employers would choose to switch from their current insurance to the public option is unlikely, whereas capping all employer-based insurance prices would affect all people enrolled in coverage through their employers. We assume the public option would be more attractive to small and lower-wage employers.⁶ We also simulate two approaches that cap provider payment rates for all private insurers. Table 1 summarizes how capped provider payment rates and public option reforms differ.

- **Reform 4, employer and nongroup base case.** Prices for hospitals and professionals are set at Medicare rates, and prescription drug prices are set halfway between Medicare and Medicaid prices. The public option is available to all employers and in all nongroup markets.
- **Reform 5, employer and nongroup with prices modestly above Medicare rates.** Prices for hospitals are set at Medicare rates plus 25 percent, and professional prices are set at Medicare rates plus 10 percent. Prescription drug prices are set halfway between Medicare and Medicaid prices. The public option is available to all employers and in all nongroup markets.
- **Reform 6, employer and nongroup with prices further above Medicare rates.** Prices for hospitals are set at Medicare rates plus 60 percent, and professional prices are set at Medicare rates plus 15 percent. Prescription drug prices are set halfway between Medicare and Medicaid prices. The public option is available to all employers and in all nongroup markets.
- **Reform 7, employer and nongroup payments capped modestly above Medicare rates.** Nationwide, nongroup and employer group insurers' provider payments are capped at Medicare rates plus 25 percent for hospitals, and professional prices are capped at Medicare rates plus 10 percent. Prescription drug prices are set halfway between Medicare and Medicaid prices. All private insurers and self-insuring employers take advantage of these rates.

- **Reform 8, employer and nongroup prices capped further above Medicare rates.** Nationwide, nongroup and employer group insurers’ provider payments are capped at Medicare rates plus 60 percent for hospitals, and professional prices are capped at Medicare rates plus 15 percent. Prescription drug prices are set halfway between Medicare and Medicaid prices. All private insurers and self-insuring employers take advantage of these rates.

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
<ul style="list-style-type: none"> ▪ 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. 	<ul style="list-style-type: none"> ▪ 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.
<ul style="list-style-type: none"> ▪ 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. 	<ul style="list-style-type: none"> ▪ Applicable to insurers in nongroup or employer markets, or both, either nationwide or in particular geographic areas.
<ul style="list-style-type: none"> ▪ Can be implemented alone or with capped provider payment rates, the latter being similar to the Medicare program’s structure. 	<ul style="list-style-type: none"> ▪ Can be implemented alone or with a public option, the latter being similar to the Medicare program’s structure.
<ul style="list-style-type: none"> ▪ Requires consumers (households and/or employers) to enroll in a new plan to take advantage of full cost savings. 	<ul style="list-style-type: none"> ▪ Allows consumers (households and/or employers) to take advantage of full cost savings while enrolling with any preferred insurer, or for employers, self-insuring.
<ul style="list-style-type: none"> ▪ 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. 	<ul style="list-style-type: none"> ▪ 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.

Highlights of Findings

Though we believe we use the best available data and methods for estimating the potential effects of introducing differently structured public options and capped rates, we recognize that significant uncertainty surrounds our estimates. Much of the uncertainty owes to data that would help make our estimates more precise being unavailable. Consequently, we rely on some imputation and proxy measures. Our full report describes our data, methods, and their limitations (Blumberg et al. 2020).

- **Central effects.** A public option's largest effects are on government and private spending—not on insurance coverage, unless paired with other reforms, such as enhanced premium tax credits and strategies to provide subsidized coverage for more low-income adults in states that have not expanded Medicaid eligibility.
- **Premium effects in the nongroup market.** Across the provider prices simulated, a nongroup public option lowers median premiums by 13 to 28 percent, with the greatest reductions under the reform assuming lower provider payment rates.
- **Federal and household health spending in the nongroup market.** The lower nongroup premiums translate into lower federal premium tax credits, lowering federal health care spending by \$7.3 to \$15.1 billion in 2020 across the reforms simulated. Household health spending falls by \$3.8 to \$7.0 billion.
- **Coverage effects in the nongroup market.** Introducing the public option into the nongroup market has only small effects on overall coverage, ranging from roughly 155,000 to 230,000 fewer uninsured Americans (less than 1 percent decrease). These effects are small because the nongroup public option only lowers the premium price for the small segment of potential new purchasers ineligible for Marketplace subsidies.
- **Premium effects in the employer market.** Public option or capped provider payment reforms tend to lower premiums more in the employer market than in the nongroup market, because employer coverage tends to pay higher prices to providers, and employer markets are generally less competitive. Across the approaches simulated, median employer premiums for those taking up the public option or using capped rates fall by 16 to 32 percent, with greater decreases when we assume larger reductions in provider payment rates.
- **Employer spending effects.** Across the simulated reforms in employer markets, employer health spending falls by \$38.9 to \$223.9 billion in 2020, and the capped payment rate approaches lead to the greatest savings. Household spending falls by \$24.0 to \$109.2 billion.
- **Coverage effects in the employer market.** Offering the public option or capped payment rates in employer markets could reduce the number of uninsured people by approximately 1.5 million, about 5 percent.
- **Income tax revenue effects.** As employers spend less on premiums, economic research indicates that they will convert the savings into higher wages for their workers. Because wages are taxable as income but health insurance is not, income tax revenue increases. Across the

approaches simulated, we estimate that income tax revenue could increase by \$4.8 billion under a public option with provider payment rates set well above Medicare rates (reform 6) and by \$42.3 billion in a capped payment reform with provider rates set modestly above Medicare rates (reform 7).

- **Effects on national health spending.** Total health spending on the nonelderly falls by 1 percent or less if the public option is limited to the nongroup market. If the public option is available to all employers as well, spending by all payers could fall by as much as 11 percent, depending on the payment rates used. With a capped rate scenario, spending by all payers could fall by as much as 16 percent.
- **Trade-offs between a public option and capped provider payment rates in the employer market.** Capping provider payment rates for all employer and nongroup insurers could broadly reduce private spending on health care. However, the wider the reach of regulated provider prices, the greater the resistance of health care providers (e.g., hospitals, physicians, prescription drug manufacturers) and the greater the potential for health care delivery system disruption.

Public Options: Projected Impacts

Below we present estimated changes in median nongroup and employer premiums, health insurance coverage, and health care spending by employers, the federal government, and households. We also show the estimated increase in federal income tax revenue resulting from employer premium savings and the consequent increase in worker wages, which only occurs under reforms affecting the employer market. To compute the federal deficit effect, we combine the increase in income tax revenue (resulting from higher taxable wages paid to workers) with the decrease in federal government spending (resulting predominantly from lower spending on Marketplace premium tax credits).

For ease of exposition and comparison, we estimate these reforms as if they were fully phased in and in equilibrium in 2020, meaning the supply of providers can meet demand for services, and households and employers have completely adjusted their coverage decisions in response to policy changes. However, each approach considered would, in reality, require a multiyear phase-in, whereby payment rates would decrease toward target levels incrementally. Depending on the target rates chosen, such rates could be achieved over an extended period by slowing annual increases in payment rates, as opposed to lowering prices from one year to the next. Such incremental implementation would allow providers time to adjust their underlying costs to the lower real payment rates and would allow analysts to monitor and evaluate any changes in access to or quality of care that might signal the need for adjusting payment rate targets for particular services.⁷ Slowing the change in payment rates would decrease potential disruption to the health care delivery system but would also mean potential savings would be moderated.

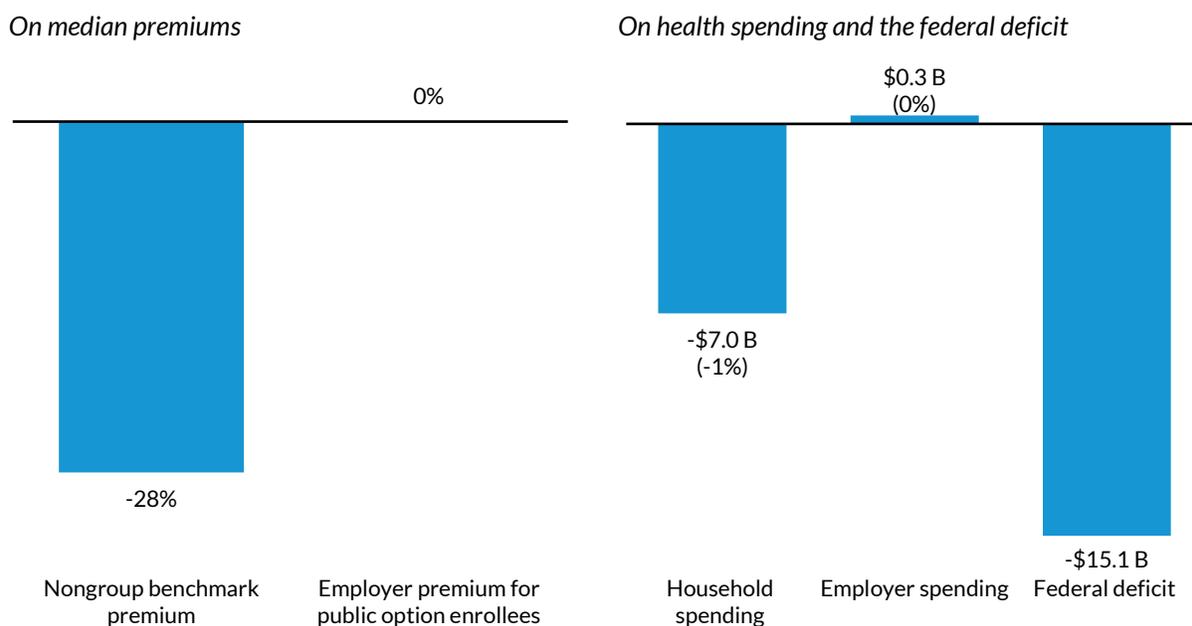
Reform 1: Nongroup Base Case

- public option in private nongroup insurance markets nationwide
- pays Medicare rates for hospitals and professionals
- prescription drug prices set halfway between Medicare and Medicaid prices

Premium and coverage effects. Across rating regions nationwide, the median benchmark premium falls by 28 percent. Because the public option is not available to employers, this approach has no discernible effect on employer premiums, though a very small number of workers leave employer coverage for nongroup insurance. The number of uninsured people falls by 230,000, a small effect because only households facing the full (unsubsidized) nongroup market premium achieve savings.⁸

Health care spending. As benchmark nongroup premiums fall, premium tax credits also decrease, because the credits are tied to those premiums. Consequently, federal health spending on the nonelderly decreases by \$15.1 billion (net of a small increase in Medicaid spending), or approximately 4 percent.⁹ Employer spending remains essentially unchanged. Household spending decreases by \$7.0 billion, a 1 percent decline reflecting the small share of the population affected by the reform, which is restricted to nongroup insurance enrollees. Because employer spending on premiums does not change, federal income tax revenue also stays constant, so the change in the deficit is due to lower premium tax credits alone.

FIGURE 1
Effects of Reform 1
On median premiums



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Source: Health Insurance Policy Simulation Model, 2019.

Notes: Reform simulated as fully phased in and in equilibrium in 2020. Federal deficit effects are the sum of the change in federal spending on health care and the increase in federal income tax revenue.

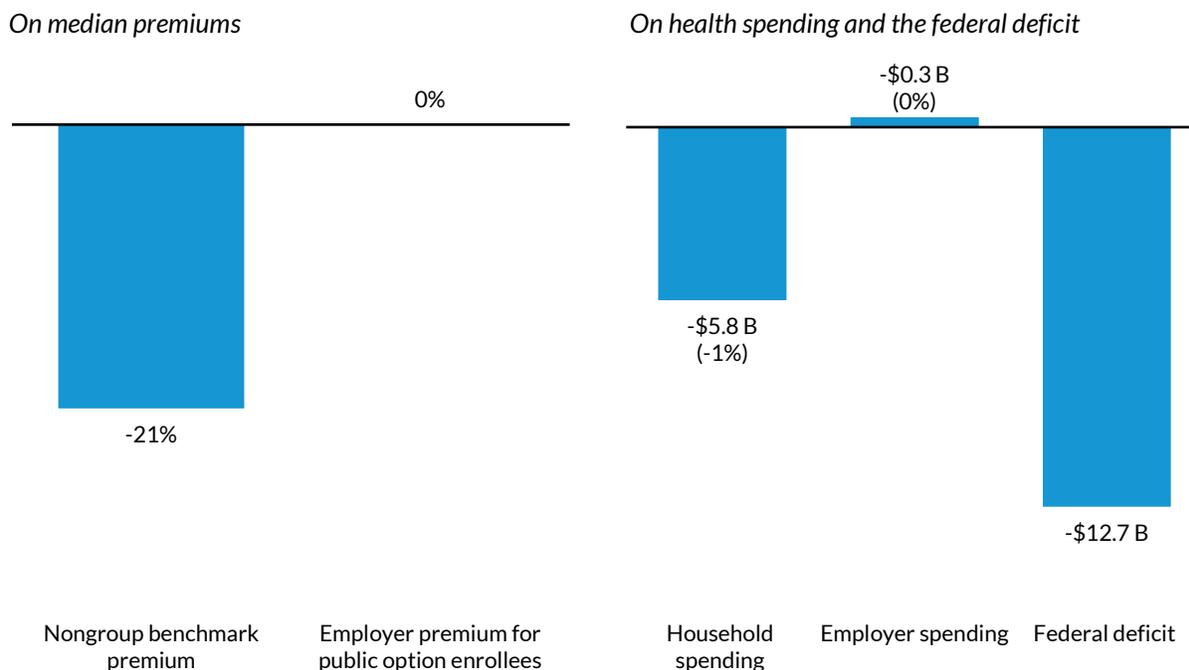
Reform 2: Nongroup with Rural Price Adjustment

- public option in private nongroup insurance markets nationwide
- pays Medicare rates for hospitals and professionals in urban areas and Medicare rates plus 20 percent for hospitals and professionals in rural areas
- prescription drug prices set halfway between Medicare and Medicaid prices

Premium and coverage effects. Across rating regions nationwide, the median benchmark premium falls by 21 percent. The number of uninsured people falls by 211,000. These effects are somewhat smaller than those resulting from reform 1 because of the higher provider prices in rural areas.

Health care spending. Lower premiums decrease the size of federal premium tax credits; consequently, federal health spending decreases by \$12.7 billion, or approximately 3 percent. Household spending decreases by \$5.8 billion, a small decline because only a small share of the population is affected by the reform, which is limited to the nongroup market. Because employer spending on premiums does not change, federal income tax revenue also stays constant, so the change in the deficit is due to lower premium tax credits alone.

FIGURE 2
Effects of Reform 2
On median premiums



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Source: Health Insurance Policy Simulation Model, 2019.

Notes: Reform simulated as fully phased in and in equilibrium in 2020. Federal deficit effects are the sum of the change in federal spending on health care and the increase in federal income tax revenue.

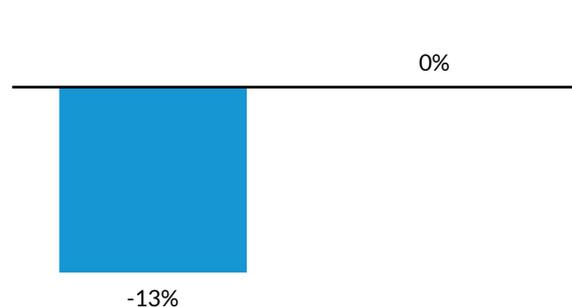
Reform 3: Nongroup with Prices Modestly Above Medicare Rates

- public option in private nongroup insurance markets nationwide
- pays Medicare rates plus 25 percent for hospitals and Medicare rates plus 10 percent for professionals
- prescription drug prices set halfway between Medicare and Medicaid prices

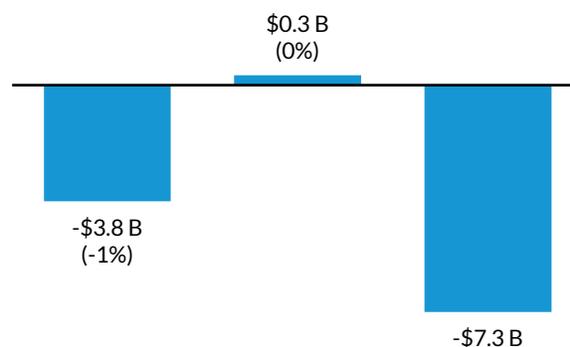
Premium and coverage effects. Across rating regions nationwide, the median benchmark premium falls by 13 percent. The number of uninsured people falls by 155,000. These effects are smaller than those resulting from reforms 1 or 2 because of the higher provider prices in nongroup markets.

Health care spending. Federal health spending decreases by \$7.3 billion, or approximately 2 percent. Household spending decreases by \$3.8 billion. Again, higher provider prices in this reform than in reforms 1 and 2 mean smaller savings for government and private payers. Income tax revenues remain constant, so the change in the deficit is due to lower premium tax credits alone.

FIGURE 3
Effects of Reform 3
On median premiums



On health spending and the federal deficit



Nongroup benchmark premium

Employer premium for public option enrollees

Household spending

Employer spending

Federal deficit

URBAN INSTITUTE

Source: Health Insurance Policy Simulation Model, 2019.

Notes: Reform simulated as fully phased in and in equilibrium in 2020. Federal deficit effects are the sum of the change in federal spending on health care and the increase in federal income tax revenue.

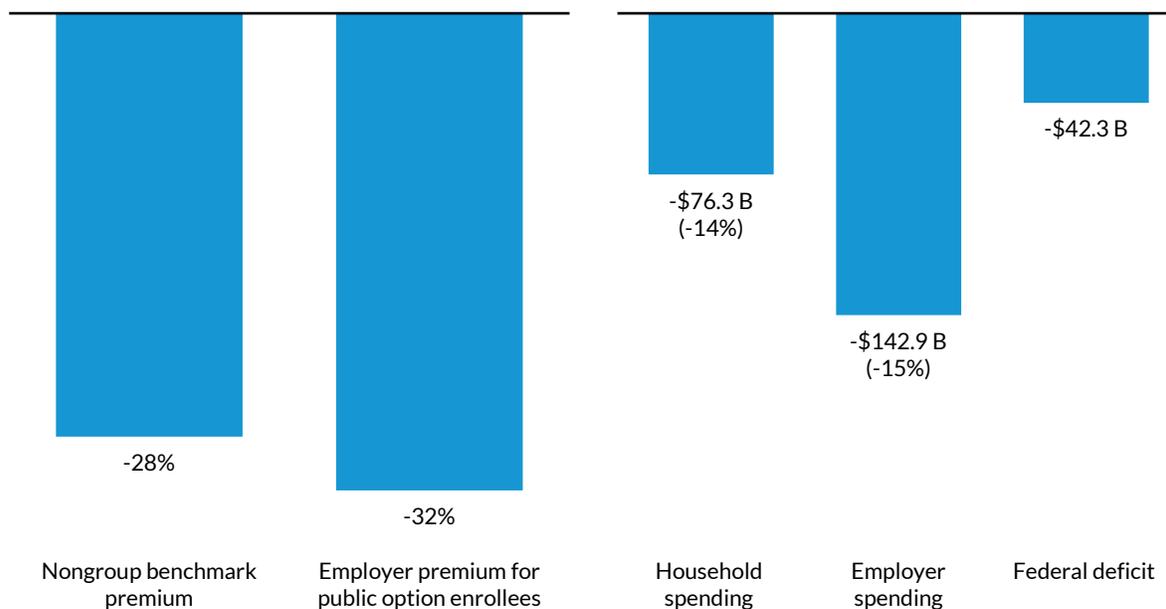
Reform 4: Employer and Nongroup Base Case

- public option available to all employers and in all private nongroup insurance markets
- pays Medicare rates for hospitals and professionals
- prescription drug prices set halfway between Medicare and Medicaid prices

Premium and coverage effects. The median premium among employers exclusively offering their workers the public option falls by 32 percent. Across rating regions nationwide, the benchmark nongroup premium falls by 28 percent. The premium decrease for employer insurance is larger because employer insurance markets tend to be less competitive and therefore tend to have higher premiums than nongroup markets. The number of uninsured people falls by 1.7 million, a substantially larger number than under the nongroup-only reforms.

Health care spending. Household spending decreases by \$76.3 billion, or 14 percent. Employer health care spending decreases by \$142.9 billion, or 15 percent. A \$17.6 billion decrease in federal health spending plus a \$24.8 billion increase in income tax revenue reduces the federal deficit by \$42.3 billion.

FIGURE 4
Effects of Reform 4
On median premiums



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Source: Health Insurance Policy Simulation Model, 2019.

Notes: Reform simulated as fully phased in and in equilibrium in 2020. Federal deficit effects are the sum of the change in federal spending on health care and the increase in federal income tax revenue.

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

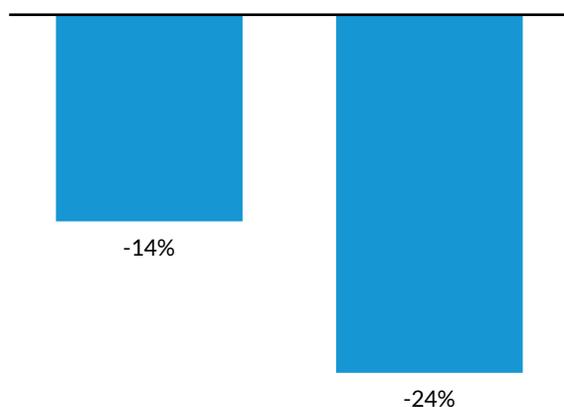
- public option available to all employers and in all private nongroup insurance markets
- pays Medicare rates plus 25 percent for hospitals and Medicare rates plus 10 percent for professionals
- prescription drug prices set halfway between Medicare and Medicaid prices

Premium and coverage effects. The median premium among employers exclusively offering their workers the public option falls by 24 percent. Across rating regions nationwide, the median benchmark nongroup premium falls by 14 percent. The number of uninsured people falls by 1.6 million. These effects are smaller than under reform 4 because this reform's premiums are somewhat higher.

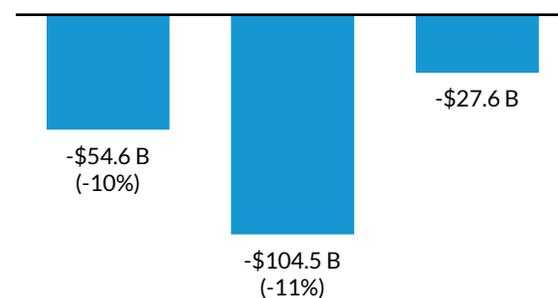
Health care spending. Household spending decreases by \$54.6 billion, or 10 percent. Employer health care spending decreases by \$104.5 billion, or 11 percent. A \$10.1 billion decrease in federal health spending plus a \$17.5 billion increase in income tax revenue reduces the federal deficit by \$27.6 billion.

FIGURE 5
Effects of Reform 5

On median premiums



On health spending and the federal deficit



Nongroup benchmark premium

Employer premium for public option enrollees

Household spending

Employer spending

Federal deficit

URBAN INSTITUTE

Source: Health Insurance Policy Simulation Model, 2019.

Notes: Reform simulated as fully phased in and in equilibrium in 2020. Federal deficit effects are the sum of the change in federal spending on health care and the increase in federal income tax revenue.

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

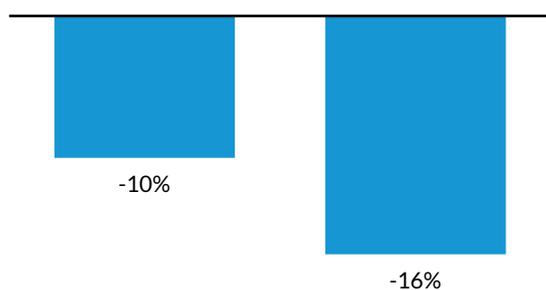
- public option available to all employers and in all private nongroup insurance markets
- pays Medicare rates plus 60 percent for hospitals and Medicare rates plus 15 percent for professionals
- prescription drug prices set halfway between Medicare and Medicaid prices

Premium and coverage effects. The median premium among employers exclusively offering their workers the public option falls by 16 percent. Across rating regions nationwide, the median benchmark nongroup premium falls by 10 percent. The number of uninsured people falls by 1.5 million. These effects are smaller than under reform 5 because this reform’s premiums are higher.

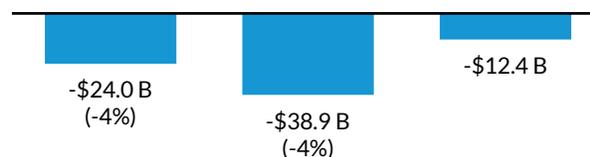
Health care spending. Household spending decreases by \$24.0 billion, or 4 percent. Employer health care spending decreases by \$38.9 billion, or 4 percent. A \$7.6 billion decrease in federal health spending plus a \$4.8 billion increase in income tax revenue reduces the federal deficit by \$12.4 billion.

FIGURE 6
Effects of Reform 6

On median premiums



On health spending and the federal deficit



Nongroup benchmark premium

Employer premium for public option enrollees

Household spending

Employer spending

Federal deficit

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Source: Health Insurance Policy Simulation Model, 2019.

Notes: Reform simulated as fully phased in and in equilibrium in 2020. Federal deficit effects are the sum of the change in federal spending on health care and the increase in federal income tax revenue.

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

- capped payment rates used by employers nationwide (optionally in conjunction with a public option); public option and/or capped provider payment rates in private nongroup insurance markets nationwide
- pays Medicare rates plus 25 percent for hospitals and Medicare rates plus 10 percent for professionals
- prescription drug prices set halfway between Medicare and Medicaid prices

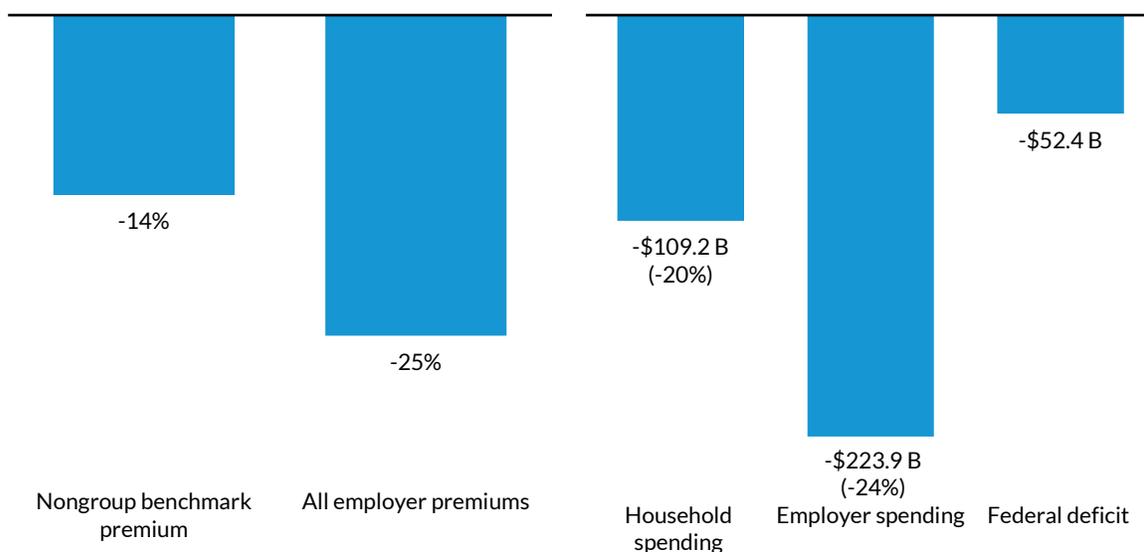
Premium and coverage effects. The median premium among all employers falls by 25 percent. Across rating regions nationwide, the median benchmark nongroup premium falls by 14 percent. The number of uninsured people falls by 1.6 million. These effects are the same as under reform 5, except all employers and their workers benefit from the premium reductions under this reform.

Health care spending. Household spending decreases by \$109.2 billion, or 20 percent. Employer health care spending decreases by \$223.9 billion, or 24 percent. A \$10.1 billion decrease in federal health spending plus a \$42.3 billion increase in income tax revenue reduces the federal deficit by \$52.4 billion. Private and government savings are much larger than under reform 5 because all people covered by employer or nongroup insurance achieve savings.

FIGURE 7
Effects of Reform 7

On median premiums

On health spending and the federal deficit



URBAN INSTITUTE

Source: Health Insurance Policy Simulation Model, 2019.

Notes: Reform simulated as fully phased in and in equilibrium in 2020. Federal deficit effects are the sum of the change in federal spending on health care and the increase in federal income tax revenue.

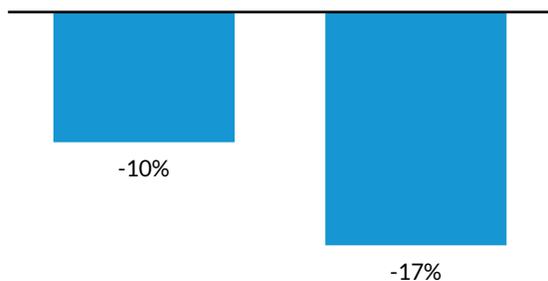
Reform 8: Employer and Nongroup Prices Capped Further Above Medicare Rates

- capped payment rates used by employers nationwide (optionally in conjunction with a public option); public option and/or capped provider payment rates in private nongroup insurance markets nationwide
- pays Medicare rates plus 60 percent for hospitals and Medicare rates plus 15 percent for professionals
- prescription drug prices set halfway between Medicare and Medicaid prices

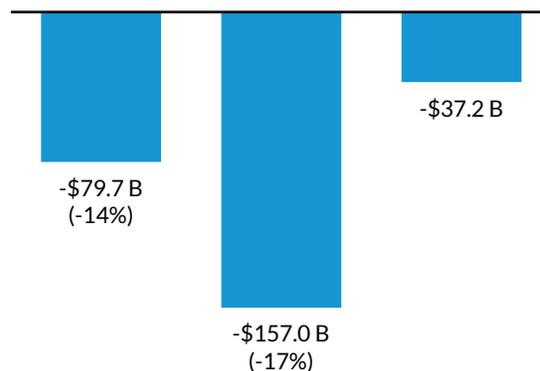
Premium and coverage effects. The median employer premium falls by 17 percent. Across rating regions nationwide, the median nongroup benchmark premium falls by 10 percent. The number of uninsured falls by 1.5 million people, owing entirely to increases in employer-based coverage.

Health care spending and coverage. Household spending decreases by \$79.7 billion, or 14 percent. Employer health care spending decreases by \$157.0 billion, or 17 percent. A \$7.6 billion decrease in federal health spending plus a \$29.6 billion increase in income tax revenue reduces the federal deficit by \$37.2 billion. Private and government savings are lower than under reform 7 because this reform’s provider prices are higher.

FIGURE 8
Effects of Reform 8
On median premiums



On health spending and the federal deficit



Nongroup benchmark premium

All employer premiums

Household spending

Employer spending

Federal deficit

URBAN INSTITUTE

Source: Health Insurance Policy Simulation Model, 2019.

Notes: Reform simulated as fully phased in and in equilibrium in 2020. Federal deficit effects are the sum of the change in federal spending on health care and the increase in federal income tax revenue.

Discussion

This analysis has shown that a public option that (1) reduces the prices insurers pay to providers to rates close to those used by the Medicare program and (2) 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 while increasing cash wages and federal revenues. The magnitude of these effects depends critically on the provider payment rate reductions (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). Yet even with payment rates substantially higher than Medicare's, significant savings are achievable, particularly when the reform extends to employer-based insurance markets. Table 2 summarizes our central findings.

Our simulations show that making a public option available or capping private insurer payment rates in the nongroup market at Medicare rates and reducing prices for prescription drugs would reduce federal spending on Marketplace subsidies by about 28 percent, assuming the public option becomes the benchmark plan. These savings owe to decreases in nongroup premiums that then lower premium tax credits. Across the reforms simulated, the largest systemwide savings 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. If payment rates were set at Medicare rates plus 60 percent for hospitals and at Medicare rates plus 10 percent for physicians, employer health spending would fall by 17.0 percent. The federal deficit would decrease by \$37.2 billion, and spending by all payers would fall by \$246.6 billion, or 11.5 percent (data shown in full report).

Uncertainty surrounds the impact estimates of the illustrative public option approaches described here, and we summarize the major limitations of our methods below. 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 of the scenarios we estimated, particularly those including the large employer insurance market, would, if implemented, significantly reduce provider revenues, potentially leading 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. This would decrease the risk of delivery system disruption and allow analysts to measure 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 the ideal prices for all providers and services are unknown. Medicare prices or multiples thereof make a convenient benchmark, 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 no evidence that Medicare prices (or some multiple thereof) would strike an appropriate balance between cost, quality, and access when applied to a much larger share of the population.

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

Implementation of any public option scenario presented would require a legislative change, which could be quite controversial. Such political challenges are reflected in the recent effort to address “surprise billing,” large out-of-pocket bills sent to people following 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 payments for out-of-network services at market rates for in-network services yet continue to face strong opposition from providers. Compared with that legislative effort, the number of health service claims covered by a public option could be considerably larger, and the prices assumed in our scenarios are lower, meaning the political pushback from providers would likely be stronger.

TABLE 2

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, more employers affected)	-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 (same provider prices as reform 6, more employers affected)	-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 of the full report because these 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/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 increased taxable worker wages.

Methods Overview

Our analysis relies on the Urban Institute Health Policy Center’s Health Insurance Policy Simulation Model (HIPSM). HIPSM is a detailed microsimulation model of the health care system designed to estimate the cost and coverage effects of a broad array of proposed health care policy reforms for the nonelderly (US residents below age 65 not enrolled in Medicare). We regularly update the model to reflect published Medicaid and Marketplace enrollment and costs in each state. For example, the current version accounts for each state’s Marketplace premiums and enrollment after the 2019 open enrollment period. Enrollment in each state under current law affects how the model simulates policy alternatives.

We begin each simulation with a current-law baseline in 2020, and we then estimate the effects of implementing each of the eight public option or capped provider payment rate reforms. The different simulations vary by the assumed provider payment rates (all expressed relative to Medicare’s payment rates), the geographic areas in which the rates are offered, and the insurance markets (nongroup, employers) in which the public option and/or capped provider payment rates are available. All estimates assume reforms are fully phased in and in equilibrium in 2020.

Because Medicare does not provide benefits to nondisabled nonelderly people, we estimate possible Medicare payment rates for those people. We assume that Medicare rates for people with nongroup insurance would equal what payment rates would be if the region had a highly competitive insurance market and a reasonably competitive hospital market, and these rates vary significantly by rating region (this assumption is described further and validated in the appendix to the full report). We then set payments by provider type (hospitals or other providers) relative to Medicare rates, according to the assumption for each reform and the share of spending for each type of service within regions. For people with employer-sponsored insurance, our approach is different. We obtained estimates of the ratio of commercial insurer payment rates to Medicare payment rates from FAIR Health for specific procedures by region and provider type. We then used those ratios to estimate costs for people with employer-based insurance entering the public option or having provider payments capped. For all public option or capped payment rate reforms, prices for prescription drugs are set halfway between those paid by Medicare and Medicaid after rebates.

Savings in the nongroup market apply to all enrollees under either a public option or capped provider payment rates. The model implicitly assumes all enrollees are affected by the public option because we assume the Marketplace benchmark premium would decrease by the percent difference between the public option and baseline premiums. For people with employer-sponsored insurance, only those in firms that opt in to the public option see savings. We assume that firms that are small, pay lower average wages, and expect significant savings are more likely to choose the public option than large firms, those paying higher wages, and those expecting small savings from the switch. Reforms 7 and 8 cap provider payments, reducing payments for everyone with employer-sponsored coverage.

We discuss additional methodological issues in the full report (Blumberg et al. 2020).

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 in both the nongroup and employer health insurance markets are inherently uncertain. Estimates of current commercial payment rates and their variability, payment rate reductions ultimately achieved 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. Consequently, the range of possible outcomes from the policy process is large.

Estimates of Nongroup Reforms

- Because of data limitations, we proxy Medicare payment rates by assuming the benchmark nongroup premiums in highly competitive areas reflect underlying provider payment rates that approximate Medicare prices. Our estimation depends on the number of Marketplace insurers in a rating region and hospital market concentration. High levels of competition are an indicator for lower provider payment rates, and we provide evidence in the full report 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 because subsidies are tied to the benchmark premium, but this 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 claims data available to us, the data do not contain all private plans in a state or substate area, meaning 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 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 represent a majority the FAIR Health sample.

- To compute commercial payment rates relative to Medicare rates for professional and outpatient facility services, we use Current Procedural Terminology codes selected 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 equal to all employers taking up the public option.
- Employer behavior around the public option could depend on time, with firms moving to (or away from) the public option as they and their employees gain experience with and knowledge of the program. Our one-year estimates assume the program is fully phased in and in equilibrium; estimating the time path of enrollment is beyond the scope of this work.
- We do not estimate the implications of employers offering workers both a 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 from various private payers are the same across the country. If the drugs consumed vary geographically, the rebates we estimate will be inaccurate, because we do not know 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 prices, any geographic variation in Medicare rebate missed would affect our estimates for the public option.
- We estimate that the rebates for the public option would lead to prices halfway between Medicare and Medicaid prices, 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 in other western nations. However, this assumption could still be too optimistic or pessimistic.

- In our estimates of nongroup public options, we set the share of health spending attributable to prescription drugs at the national average. The effect of this possible measurement error is mitigated by the fact that prescription drug spending accounts for only 23 percent of the premium dollar nationwide.

Notes

¹ 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).

² In addition, we include state-level estimates in the full report.

³ See note 1 above.

⁴ Linda J. Blumberg and John Holahan, “Capping Provider Payment: An Alternative to a Public Option,” *American Prospect*, January 5, 2018, <https://prospect.org/health/capping-provider-payment-alternative-public-option/>.

⁵ We assume these prices would be achieved by the federal government requiring manufacturers to pay higher rebates than those provided for current-law Medicare prescription drug plans. This estimate of potential savings on prescription drugs is based on Kesselheim and Hwang (forthcoming).

⁶ We show public option take-up assumptions in the full report’s appendix.

⁷ The research literature indicates that hospitals can and do adjust their costs in response to changes in payment rates. See Stensland, Gaumer, and Miller (2010) and White (2013).

⁸ 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.

⁹ We compute percent changes relative to current spending on Medicaid and the Children’s Health Insurance Program acute care for the nonelderly and Marketplace premium tax credits.

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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 reasons for the growth in the uninsured over time and the effects of proposals to expand health insurance coverage on the number of uninsured and the cost to federal and state governments.

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