



# Coverage and Cost Effects of Senators Bennet and Kaine's Medicare-X Choice Act of 2021

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## Introduction

Senators Michael Bennet and Tim Kaine have introduced a bill called the Medicare-X Choice Act of 2021 (Medicare-X) that would phase in a public option insurance plan into the nongroup and small-group markets.<sup>1</sup> Their proposal is a response to high premiums in areas with considerable insurer or provider concentration. Although national average Affordable Care Act Marketplace premiums have declined over the past four years, the benefits of competition in the Marketplace do not extend to all rating regions and states. Research has shown that premiums are substantially higher in concentrated markets than they are in markets with robust competition. High premiums increase the cost of federal subsidies and reduce health insurance coverage rates.

## The Medicare-X Proposal

The Medicare-X legislation would phase in a public option insurance plan into the nongroup and small-group markets over four years. The public option would be similar to Medicare in many ways. It would establish provider payment rates, provide an overall administrative structure, and bear financial risk if claims costs exceed premiums. As with Medicare, administrative functions in the public option plan would be contracted to private organizations. Payment rates would be set at Medicare fee-for-service levels, although rates in rural areas could be set as much as 50 percent higher than Medicare rates. The public option would offer, at a minimum, gold and silver metal tier plans. Providers wishing to participate in Medicare and/or Medicaid would be required to participate in the public option plan.

Medicare-X would direct the secretary of health and human services to incrementally make the public option available in the nongroup market through state and federal exchanges. Regions with only

one insurer in the Affordable Care Act Marketplace, rural regions, and regions with high health care costs due to a shortage of providers or a lack of competition would be prioritized. The secretary would have discretion to decide on the regions and timing for public option implementation, but by the fourth year of the phase-in, the public option would be available in nongroup markets nationwide and could serve almost 19 million people. Also in that year, the public option would be extended to the small-group employer-sponsored market, which also serves almost 19 million people. Combining these markets, nearly 14 percent of nonelderly people would have the option to participate in the public option.

The proposal has several provisions beyond the public option. It would use the same enhanced premium subsidy schedule specified in the Inflation Reduction Act. It would also lower the threshold above which employer coverage is deemed unaffordable from 9.6 to 8.5 percent of income, reducing the “firewall” that currently prohibits some families from accessing subsidized Marketplace coverage, and would address the “family glitch,” in which family members are ineligible for Marketplace tax credits if a member has an offer of single coverage deemed affordable, even if family coverage is prohibitively expensive.<sup>2</sup> In addition, it would introduce a \$10 billion federal reinsurance program and allow the federal government to negotiate prescription drug prices for the Medicare-X public option and Medicare Part D. The public option plan would eliminate cost sharing for primary care services. The legislation would provide start-up funds that we assume would go toward allowing the public option to build up reserves and establish an administrative infrastructure. The public option plan would support telehealth and value-based purchasing.

In this paper, we model the effects of the major Medicare-X provisions beginning in 2023. We initially examine provisions other than the public option: the 8.5 percent firewall threshold and the \$10 billion federal reinsurance program. Medicare-X’s focus is on high premiums, and Marketplace premiums and insurer and hospital concentration are highly correlated. Thus, we divide rating regions into quartiles of the population based on Marketplace premiums, ranging from highest to lowest, where the first quartile represents the quarter of the population who lives in the rating regions with the highest Marketplace premiums and so on. We use this definition of quartiles throughout. We then introduce the public option, including negotiation for prescription drugs, first in the quartile with the highest premiums in 2023 (Holahan, Wengle, and O’Brien 2022). In the next year, the public option would be made available to people in the quartile with the second-highest premiums, followed in subsequent years by the third and fourth (lowest-premium) quartiles, at which point the public option would be available nationwide. In the same year, 2026, the public option would be made available in employer small-group markets nationwide.

We find that all of the Medicare-X provisions modeled here would reduce the number of uninsured people by 1.1 million (3.9 percent) while cutting federal spending by \$20.3 billion in 2023.<sup>3</sup> Effects in the nongroup market would be concentrated primarily in the half of regions with the highest premiums. Households would save \$10.9 billion in 2023 and employers would spend \$10.8 billion less on health insurance premiums that year. Over 10 years, from 2023 to 2032, federal spending would fall by \$250 billion, equaling 3.9 percent of all federal spending on acute health care for the nonelderly population

over those years. Employers would spend nearly \$100 billion less on premiums and households would save nearly the same amount over the same 10 years.

## Methods

We estimate the coverage and cost effects of the Medicare-X provisions using the Urban Institute’s Health Insurance Policy Simulation Model (HIPSM), a detailed microsimulation model of the health care system designed to estimate the cost and coverage effects of proposed health care policy options (Buettgens and Banthin 2020, 2022). The model simulates household and employer decisions and models the way changes in one insurance market interact with changes in other markets. HIPSM is designed for quick-turnaround analyses of policy proposals. It can be rapidly adapted to analyze various new scenarios—from novel health insurance offerings and strategies for increasing affordability to state-specific proposals—and can describe the effects of a policy option over several years. Results from HIPSM simulations have been favorably compared with actual policy outcomes and other respected microsimulation models (Glied, Arora, and Solís-Román 2015). HIPSM has a well-developed capacity to model public options in both the nongroup and employer markets. It has been used to estimate the coverage and spending effects of public options at various payment rates, including public options limited to specific geographic areas and areas of high provider or insurer concentration (Blumberg et. al. 2020; Holahan and Simpson 2021a, 2021b, 2021c).

We compare the estimated coverage and spending effects of Medicare-X with a baseline that uses the enhanced premium tax credits (PTCs) available through 2025 under the Inflation Reduction Act; the 10-year estimates presented later assume the enhanced PTCs have been extended permanently. Thus, the Medicare-X provision to use the enhanced PTC schedule has no additional effect relative to the baseline. If Congress had not extended enhanced PTCs, this Medicare-X provision would have decreased uninsurance by 3.3 million people in 2023 (Buettgens, Banthin, and Green 2022). We first show the coverage and detailed spending effects of Medicare-X provisions and public option phase-in steps simulated in 2023, allowing us to show the effects of a change in policy without the confounding effects of population change and medical price inflation. To illustrate the effects of Medicare-X’s higher payment rates for rural areas, we show the effect of limiting provider payment rates in rural areas to Medicare levels, instead of up to 50 percent greater than such rates as allowed under the legislation. Finally, we present projected health spending for the nonelderly population over 10 years (2023–32), this time including the effects of population growth and medical inflation.

We exclude some Medicare-X provisions from this analysis. The effect of negotiating prices for prescription drugs in Medicare Part D is outside the scope of these estimates, which cover only nonelderly (and nondisabled) people. We do not include effects for the elimination of cost sharing for primary care services because it would likely have little effect on the uptake of the public option, since the actuarial value of a given metal tier would be unchanged. However, the no-cost services may appeal to some people and could increase enrollment in the public option by a small amount (Skopec and Banthin 2022); we do not model that effect. We exclude addressing the family glitch because it is

expected to be addressed administratively in 2023.<sup>4</sup> The change will affect both the baseline and any reform, leaving the coverage and spending effects of Medicare-X provisions largely unchanged.

Also excluded are provisions to (1) offer start-up funds that we assume would go toward allowing the public option to build up reserves and establish an administrative infrastructure (because these costs would be paid separately, they are excluded from premiums), (2) study the impact of adding additional services to the public option, (3) address health care market consolidation, and (4) support telehealth and value-based purchasing. We do not assume the public option would pay premium taxes because they are state taxes and, thus, modeling them would be burdensome. Consequently, premiums for the public option could be modestly understated.

## Results

This section examines the coverage and cost effects of selected provisions of the Medicare-X bill. We also separately analyze the coverage and cost implications of phasing in the public option and of setting provider payment rates at 50 percent above Medicare rates. Lastly, we present estimates of the spending impacts of the Medicare-X provisions over 10 years, from 2023 to 2032.

### Medicare-X Bill Provisions

**Impacts on coverage.** Table 1 shows health insurance coverage under separate provisions of the Medicare-X bill simulated in 2023. The second column shows the Inflation Reduction Act subsidies, which we regard as the baseline for the analysis of Medicare-X provisions. The third column provides results for Medicare-X reform provisions other than the public option: reducing the firewall from 9.6 to 8.5 percent and introducing a national reinsurance program. The fourth column shows the results of adding the fully phased-in public option, including negotiation for prescription drugs, in the individual nongroup market to the reform options other than public option. The fifth column shows the effects of adding extension of the public option into the small-group market to the previous two reforms (columns four and three). The final column shows all provisions together (and so equals column five).

The table's second panel shows the incremental change in coverage under each provision, and its final column shows the cumulative effect of the entire package of reforms. The Medicare-X provisions other than the public option would add 535,000 people to the nongroup market, both because premiums would fall (largely because of reinsurance) and because people with employer-sponsored insurance offers with premiums between 8.5 and 9.6 percent of income would be newly eligible for nongroup PTCs. About 269,000 people would have new subsidized nongroup coverage, most of whom would have gained eligibility with the lowered firewall threshold; 232,000 would leave employer-sponsored coverage. Around 266,000 people would have new unsubsidized nongroup coverage. Some of them would have moved from subsidized to full-pay nongroup coverage because the decline in premiums would reduce the amount of PTCs. Overall, 311,000 fewer people would be uninsured or lacking comprehensive health insurance.

With the public option available in nongroup markets nationwide, another 862,000 people would gain nongroup coverage because of lower premiums resulting from lower provider payments and prescription drug price negotiation. Because premiums, and therefore PTCs, would fall, 557,000 people would no longer be eligible for subsidies. However, the PTCs lost by this group would be small, and the full premium amount they would pay in the public option would be smaller than what they would pay for subsidized coverage without the reform. The number of people with no coverage or noncompliant coverage would fall by 779,000.

TABLE 1

**Coverage of the Nonelderly Population under Fully Phased-In Medicare-X Provisions, 2023**

*Thousands of people*

	IRA subsidies baseline	+ provisions other than public option	+ nongroup public option in all regions	+ small- group public option	All reform provisions
<b>Insured (MEC)</b>	<b>249,982</b>	<b>250,293</b>	<b>251,071</b>	<b>251,091</b>	<b>251,091</b>
Employer	151,839	151,607	151,410	151,652	151,652
Private nongroup	18,895	19,429	20,292	20,278	20,278
Subsidized	14,433	14,702	14,144	14,140	14,140
Full pay	4,462	4,728	6,147	6,137	6,137
Medicaid/CHIP	70,560	70,568	70,681	70,473	70,473
Other public	8,688	8,688	8,688	8,688	8,688
<b>Uninsured (no MEC)</b>	<b>28,451</b>	<b>28,140</b>	<b>27,361</b>	<b>27,341</b>	<b>27,341</b>
Uninsured	25,960	25,693	25,106	25,086	25,086
Noncompliant nongroup	2,490	2,446	2,255	2,255	2,255
<b>Total</b>	<b>278,432</b>	<b>278,432</b>	<b>278,432</b>	<b>278,432</b>	<b>278,432</b>

*Change (thousands of people)*

	IRA subsidies baseline	Change due to provisions other than public option	Change due to nongroup public option in all regions	Change due to small- group public option	Overall change from baseline
<b>Insured (MEC)</b>	—	<b>311</b>	<b>779</b>	<b>20</b>	<b>1,109</b>
Employer	—	-232	-197	242	-187
Private nongroup	—	535	862	-14	1,383
Subsidized	—	269	-557	-4	-293
Full pay	—	266	1,420	-10	1,675
Medicaid/CHIP	—	8	113	-208	-86
Other public	—	0	0	0	0
<b>Uninsured (no MEC)</b>	—	<b>-311</b>	<b>-779</b>	<b>-20</b>	<b>-1,109</b>
Uninsured	—	-267	-588	-20	-874
Noncompliant nongroup	—	-44	-191	0	-235
<b>Total</b>	—	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>

Source: Health Insurance Policy Simulation Model, 2022.

Notes: IRA = Inflation Reduction Act of 2022; MEC = minimum essential coverage; CHIP = Children’s Health Insurance Program; — = not applicable. “Reform provisions other than the public option” includes the \$10 billion reinsurance plan and the 8.5 percent affordability threshold. In the top panel, + indicates the addition of the reform provision to the provision(s) in the preceding column(s). The bottom panel shows the incremental change in coverage under each provision.

The coverage effects of introducing the public option into the small-group market, which would happen at the same time as the expansion of the nongroup public option to all regions but would largely affect different people, are very small. Only 20,000 people would gain coverage, although 242,000 people would gain employer coverage. Most of those people—208,000—would leave Medicaid for employer coverage; many of them would be children who would be added to a family member's employer policy. People switching would find employer-sponsored insurance more attractive than Medicaid coverage, which is consistent with the fact that many Medicaid-eligible people choose employer coverage, likely because of larger provider networks.

Together, all modeled provisions of the Medicare-X proposal would reduce uninsurance by 1.1 million people. The number of people with employer coverage would decline by 187,000 because the decline in employer coverage under the first two reform provisions would exceed the employer coverage gains from the small-group public option. The number of people with private nongroup coverage would increase by 1.4 million. The full-pay nongroup market would increase by 1.7 million people, but this would be offset by a decline in subsidized nongroup coverage of almost 300,000 people.

**Impacts on spending.** Table 2 shows the estimated effects of Medicare-X provisions on household, government, and employer spending. Under the reform provisions other than the public option (the federal reinsurance program and reduction of the firewall threshold), households would see small overall savings of \$0.1 billion. Premiums would be lower overall (-\$1.4 billion) because of the new reinsurance plan, but other (out-of-pocket) spending would increase by \$1.3 billion, largely because of the increase in the number of people with insurance. The federal government would spend slightly more (\$0.2 billion), and lower PTC spending would nearly offset new spending for reinsurance.<sup>5</sup> Employers would spend \$1.3 billion less on health insurance because some people would drop employer-sponsored insurance for nongroup coverage when made eligible by the lower firewall threshold.

When the nongroup public option is made available nationwide, households will save an estimated \$2.5 billion in out-of-pocket spending. Total premiums for households would be unchanged because new premiums paid by people gaining nongroup coverage would be offset by lower household spending on premiums among people keeping nongroup coverage and those leaving noncompliant coverage. People with PTCs who pay a fixed percentage of income for premiums would see no effect from the lower premiums. The federal government would save \$19.4 billion, largely because of reduced spending on Marketplace PTCs. Employers would spend \$0.6 billion less on premiums because fewer people would have employer-sponsored insurance.

Introducing the public option into the small-group market would have a much greater effect on spending than it does on coverage. This is because payment rates in the small-group market are much higher than those in the nongroup market and because the public option would largely affect people who already had coverage. Household spending would fall by \$8.3 billion, reflecting the fact that premiums (for people not receiving PTCs) and out-of-pocket costs would be lower because of lower provider payment rates in the public option. The federal government would save an additional \$1.0 billion. Employers would spend \$9.0 billion less on health because premiums would be significantly reduced for small employers who choose to participate in the public option.

TABLE 2

## Health Spending for the Nonelderly Population under Fully Phased-In Medicare-X Provisions, 2023

Billions of dollars

	IRA subsidies baseline	+ provisions other than public option	+ nongroup public option in all regions	+ small- group public option	All reform provisions
<b>Household</b>					
Premiums	311.5	310.1	310.1	306.6	306.6
Other health care spending	298.3	299.5	297.0	292.2	292.2
<i>Subtotal</i>	609.8	609.6	607.2	598.8	598.8
<b>Federal government</b>					
Medicaid	386.8	386.9	387.3	386.4	386.4
Marketplace PTC	92.9	84.6	64.9	64.8	64.8
Reinsurance	1.3	10.0	10.0	10.0	10.0
Uncompensated care	28.1	27.9	27.7	27.7	27.7
<i>Subtotal</i>	509.2	509.4	489.9	488.9	488.9
<b>State government</b>					
Spending	224.5	224.4	224.4	224.1	224.1
<b>Employers</b>					
Premium contributions	850.0	848.7	848.1	839.2	839.2
<b>Providers</b>					
Uncompensated care	23.3	22.9	22.5	22.5	22.5
<b>Total, all payers</b>	<b>2,216.7</b>	<b>2,215.0</b>	<b>2,192.2</b>	<b>2,173.6</b>	<b>2,173.6</b>

Change (billions of dollars)

	IRA subsidies baseline	Change due to provisions other than public option	Change due to nongroup public option in all regions	Change due to small- group public option	Overall change from baseline
<b>Household</b>					
Premiums	—	-1.4	0.0	-3.5	-4.9
Other health care spending	—	1.3	-2.5	-4.8	-6.1
<i>Subtotal</i>	—	-0.1	-2.5	-8.3	-10.9
<b>Federal government</b>					
Medicaid	—	0.0	0.5	-0.9	-0.4
Marketplace PTC	—	-8.3	-19.7	-0.1	-28.1
Reinsurance	—	8.7	0.0	0.0	8.7
Uncompensated care	—	-0.2	-0.2	0.0	-0.4
<i>Subtotal</i>	—	0.2	-19.4	-1.0	-20.3
<b>State government</b>					
Spending	—	-0.1	0.0	-0.3	-0.4
<b>Employers</b>					
Premium contributions	—	-1.3	-0.6	-9.0	-10.8
<b>Providers</b>					
Uncompensated care	—	-0.3	-0.4	0.0	-0.7
<b>Total, all payers</b>	—	<b>-1.7</b>	<b>-22.8</b>	<b>-18.6</b>	<b>-43.1</b>

Source: Health Insurance Policy Simulation Model, 2022.

Notes: IRA = Inflation Reduction Act of 2022; PTC = premium tax credit; — = not applicable. "Reform provisions other than the public option" includes the \$10 billion reinsurance plan and the 8.5 percent firewall affordability threshold. In the top panel, +

indicates the addition of the reform provision to the provision(s) in the preceding column(s). The bottom panel shows the incremental change in spending under each provision.

Comparing all provisions combined with the baseline of permanent Inflation Reduction Act subsidies, households would save \$10.9 billion because of lower spending on premiums and other health care. The federal government would save \$20.3 billion because of the sharp reduction in Marketplace subsidies, mostly because of lower PTCs resulting from the public option's lower provider payment rates and prescription drug price negotiation. Employers would spend \$10.8 billion less on premiums. Though the nongroup and small-group markets represent a relatively small share of the overall market, introducing the public option in these markets would reduce overall health spending for the nonelderly population by \$43.1 billion, or about 2 percent.

## Phasing In the Public Option

**Impacts on coverage.** Table 3 displays the coverage impacts of phasing the public option into the nongroup market by quartiles of the population based on the level of premiums in different areas; it describes in more detail the changes between columns three and four of tables 1 and 2. As with the previous results, all policies are modeled in 2023 to focus on the effects of the reform provisions without needing to account for health care cost inflation and population growth over time. The public option would be made available first in the quartile with the highest premiums, then the next highest quartile in the following year, and so on. Unsurprisingly, the phase-in would have the largest effects on the two quartiles with the highest premiums.

With the public option introduced into the highest-premium quartile, 240,000 people would gain coverage (beyond the effects of the non-public-option provisions). Private nongroup coverage would expand by 265,000 people. Many more people would have full-pay nongroup coverage (751,000), and the reduction in subsidized nongroup coverage would be 485,000 people. The effects on this quartile would be limited because payment rates in rural areas would be increased by up to 50 percent above Medicare levels (the effect of keeping rates at Medicare levels is shown below), and regions with the highest premiums are predominantly rural. This reduces the impact on premiums and, in turn, on coverage.

The quartile with the second-highest premiums would be less affected by higher provider payment rates in rural areas because this quartile is more of a mix of urban and rural counties. Private nongroup coverage would increase by 307,000 people. Because of the reduction in premiums, some nongroup coverage enrollees would no longer be eligible for subsidies; subsidized nongroup coverage would decrease by 91,000 people. Full-pay nongroup coverage would increase by 399,000 people. In addition, 72,000 people would leave employer-sponsored insurance because nongroup coverage would be more attractive, so the overall number of people uninsured would fall by 272,000.

Introducing the public option into the third-highest quartile would have a smaller effect, reducing the number of people uninsured by 196,000. Again, the increase in nongroup coverage (213,000) would occur among those paying full premiums. Introducing the public option into the lowest-premium

quartile of regions, which has payment rates close to Medicare rates, would generate little savings in these regions and therefore have a much smaller effect on the nongroup market and coverage overall.

Introducing the public option nationwide would increase overall private nongroup coverage by 862,000 people, reduce employer coverage by 197,000 people, and reduce the number of uninsured or underinsured people by 779,000 (2.8 percent).

**TABLE 3**

**Coverage of the Nonelderly Population under Medicare-X Provisions and Phase-In of the Nongroup Public Option, 2023**

*Thousands of people*

	Provisions other than public option	+ Extension of the Nongroup Public Option into				All regions
		Highest quartile of premium regions	2nd-highest quartile of premium regions	3rd-highest quartile of premium regions	Lowest quartile of premium regions	
<b>Insured (MEC)</b>	<b>250,293</b>	<b>250,532</b>	<b>250,805</b>	<b>251,000</b>	<b>251,071</b>	<b>251,071</b>
Employer	151,607	151,535	151,462	151,425	151,410	151,410
Private nongroup	19,429	19,695	20,002	20,213	20,292	20,292
Subsidized	14,702	14,216	14,125	14,123	14,144	14,144
Full pay	4,728	5,478	5,877	6,090	6,147	6,147
Medicaid/CHIP	70,568	70,615	70,652	70,674	70,681	70,681
Other public	8,688	8,688	8,688	8,688	8,688	8,688
<b>Uninsured (no MEC)</b>	<b>28,140</b>	<b>27,900</b>	<b>27,628</b>	<b>27,432</b>	<b>27,361</b>	<b>27,361</b>
Uninsured	25,693	25,529	25,320	25,166	25,106	25,106
Noncompliant nongroup	2,446	2,371	2,308	2,266	2,255	2,255
<b>Total</b>	<b>278,432</b>	<b>278,432</b>	<b>278,432</b>	<b>278,432</b>	<b>278,432</b>	<b>278,432</b>

*Change (thousands of people)*

	Provisions other than public option	Change Due to Extension of the Nongroup Public Option into				Overall change from provisions other than public option
		Highest quartile of premium regions	2nd-highest quartile of premium regions	3rd-highest quartile of premium regions	Lowest quartile of premium regions	
<b>Insured (MEC)</b>		<b>240</b>	<b>272</b>	<b>196</b>	<b>71</b>	<b>779</b>
Employer	—	-73	-72	-37	-15	-197
Private nongroup	—	265	307	211	78	862
Subsidized	—	-485	-91	-1	21	-557
Full pay	—	751	399	213	58	1,420
Medicaid/CHIP	—	47	37	22	8	113
Other public	—	0	0	0	0	0
<b>Uninsured (no MEC)</b>	<b>—</b>	<b>-240</b>	<b>-272</b>	<b>-196</b>	<b>-71</b>	<b>-779</b>
Uninsured	—	-164	-210	-153	-60	-588
Noncompliant nongroup	—	-76	-63	-42	-11	-191
<b>Total</b>	<b>—</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>

Source: Health Insurance Policy Simulation Model, 2022.

**Notes:** MEC = minimum essential coverage; CHIP = Children’s Health Insurance Program; – = not applicable. “Reform provisions other than the public option” includes the \$10 billion reinsurance plan and the 8.5 percent firewall affordability threshold. In the top panel, columns under the “+ extension of nongroup public option into” heading show the effects of the public option in both the specified quartile and the quartile(s) in the preceding column(s). The bottom panel shows the incremental change in coverage under extension of the public option into each new quartile.

**Impacts on spending.** Table 4 shows the impact on spending of introducing the public option into each of the quartiles; again, all policies are modeled in 2023 to focus on the effects of the provisions (year-by-year spending estimates including health care inflation and population growth are presented later). Savings would be concentrated in the two highest premium regions, and more than two-thirds of the overall savings (\$2.2 billion for households and \$13.2 billion for the federal government) would come from extending the public option into the highest-premium quartile. Overall health care spending across all payers would fall by \$15.3 billion with the public option introduced only in the highest-premium quartile.

**TABLE 4**  
**Health Spending for the Nonelderly Population under Medicare-X Provisions and Phase-In of the Nongroup Public Option, 2023**

*Billions of dollars*

	Provisions other than public option	+ Extension of the Nongroup Public Option into				All regions
		Highest quartile of premium regions	2nd-highest quartile of premium regions	3rd-highest quartile of premium regions	Lowest quartile of premium regions	
<b>Household</b>						
Premiums	310.1	309.6	310.0	310.1	310.1	310.1
Other health care spending	299.5	297.9	297.3	297.1	297.0	297.0
<i>Subtotal</i>	609.6	607.5	607.3	607.3	607.2	607.2
<b>Federal government</b>						
Medicaid	386.9	387.1	387.2	387.3	387.3	387.3
Marketplace PTC	84.6	71.1	67.1	65.3	64.9	64.9
Reinsurance	10.0	10.0	10.0	10.0	10.0	10.0
Uncompensated care	27.9	27.9	27.8	27.8	27.7	27.7
<i>Subtotal</i>	509.4	496.2	492.1	490.4	489.9	489.9
<b>State government</b>						
Spending	224.4	224.5	224.5	224.5	224.4	224.4
<b>Employers</b>						
Premium contributions	848.7	848.7	848.4	848.2	848.1	848.1
<b>Providers</b>						
Uncompensated care	22.9	22.9	22.7	22.6	22.5	22.5
<b>Total, all payers</b>	<b>2,215.0</b>	<b>2,199.7</b>	<b>2,195.0</b>	<b>2,193.0</b>	<b>2,192.2</b>	<b>2,192.2</b>

Change (billions of dollars)

	Change Due to Extension of the Nongroup Public Option into					Overall change from provisions other than public option
	Provisions other than public option	Highest quartile of premium regions	2nd- highest quartile of premium regions	3rd- highest quartile of premium regions	Lowest quartile of premium regions	
<b>Household</b>						
Premiums	—	-0.5	0.4	0.2	0.0	0.0
Other health care spending	—	-1.6	-0.6	-0.2	-0.1	-2.5
<i>Subtotal</i>	—	-2.2	-0.2	0.0	-0.1	-2.5
<b>Federal government</b>						
Medicaid	—	0.2	0.1	0.1	0.0	0.5
Marketplace PTC	—	-13.4	-4.1	-1.7	-0.5	-19.7
Reinsurance	—	0.0	0.0	0.0	0.0	0.0
Uncompensated care	—	0.0	-0.1	-0.1	-0.1	-0.2
<i>Subtotal</i>	—	-13.2	-4.0	-1.7	-0.5	-19.4
<b>State government</b>						
Spending	—	0.1	0.0	0.0	0.0	0.0
<b>Employers</b>						
Premium contributions	—	0.0	-0.3	-0.2	-0.1	-0.6
<b>Providers</b>						
Uncompensated care	—	0.0	-0.2	-0.1	-0.1	-0.4
<b>Total, all payers</b>	—	<b>-15.3</b>	<b>-4.7</b>	<b>-2.0</b>	<b>-0.8</b>	<b>-22.8</b>

Source: Health Insurance Policy Simulation Model, 2022.

Notes: PTC = premium tax credit; — = not applicable. “Reform provisions other than the public option” includes the \$10 billion reinsurance plan and the 8.5 percent firewall affordability threshold. In the top panel, columns under the “+ extension of nongroup public option into” heading show the effects of the public option in both the specified quartile and the quartile(s) in the preceding column(s). The bottom panel shows the incremental change in spending under extension of the public option into each new quartile.

Introducing the public option into lower-premium quartiles would have smaller effects. Provider payments in these regions are already close to Medicare rates, so savings would be small. Extending the public option to the second-highest quartile of premiums would reduce overall household spending by \$200 million, reduce federal government spending by \$4.0 billion, and reduce overall spending by all payers by \$4.7 billion. Because premiums are relatively low in the third and fourth quartiles, introducing the public option in those quartiles would have much smaller effects. With the public option available in the third-highest and lowest quartiles, federal government spending would fall by \$1.7 billion and by \$0.5 billion, and overall spending on health would fall by \$2.0 billion and \$0.8 billion.

With the public option available in nongroup markets nationwide, health spending would fall by \$2.5 billion among households, by \$19.4 billion for the federal government, and by about \$1 billion between employers and providers of uncompensated care. Total spending would fall by \$22.8 billion.

## Effect of Setting Provider Payment Rates at up to 50 Percent above Medicare Rates

In the simulations above, we adopted the Medicare-X provision that provider payment rates in rural areas be set up to 50 percent above Medicare rates to assure the financial viability of providers in these areas. To illustrate the effect of that provision, table 5 compares changes in coverage and spending with and without that provision (without the provision, we simulate the public option as paying Medicare rates in all regions) relative to the Inflation Reduction Act subsidies baseline.

The effects on coverage would be small, but the impacts on household, federal government, and employer spending would be significant. If provider payment rates in rural areas were not raised above Medicare rates (i.e., were set at Medicare rates), more people would retain their employer coverage and some people would switch from Medicaid to other coverage, which would now be more affordable. Around 39,000 more people would have nongroup coverage, but fewer would receive Marketplace PTCs and more would pay the full premium. The net effect is an increase in overall coverage of only 15,000 people.

As noted, the impact on spending would be larger. Premiums and out-of-pocket spending would be lower, so households would save \$9.1 billion, federal spending would be \$5.7 billion lower, and employer spending on premiums would fall by \$10.0 billion. Overall spending on health care would fall by \$24.7 billion. Thus, under the payments proposed in Medicare-X, households, employers, and the federal government would all spend more money to keep payment rates at higher levels in rural communities, but that may be the price of maintaining access to care.

TABLE 5

### Change from IRA Subsidies Baseline under Medicare-X Provisions and Provider Payments in Rural Areas Set Either at Medicare Rates Plus 50 Percent or Medicare Rates, 2023

*Change in coverage*

	Payment Rates at Medicare Rates + 50%		Payment Rates at Medicare Rates (Alternative)		Difference	
	1,000s	%	1,000s	%	1,000s	p.p.
<b>Insured (MEC)</b>	<b>1,109</b>	<b>0.4</b>	<b>1,124</b>	<b>0.4</b>	<b>15</b>	<b>0.0</b>
Employer	-187	-0.1	-122	-0.1	65	0.0
Private nongroup	1,383	7.3	1,422	7.5	39	0.2
Subsidized	-293	-2.0	-591	-4.1	-298	-2.1
Full pay	1,675	37.5	2,012	45.1	337	7.6
Medicaid/CHIP	-86	-0.1	-176	-0.2	-90	-0.1
Other public	0	0.0	0	0.0	0	0.0
<b>Uninsured (no MEC)</b>	<b>-1,109</b>	<b>-3.9</b>	<b>-1,124</b>	<b>-4.0</b>	<b>-15</b>	<b>-0.1</b>
Uninsured	-874	-3.4	-859	-3.3	15	0.1
Noncompliant nongroup	-235	-9.4	-265	-10.6	-30	-1.2
<b>Total</b>	<b>0</b>	<b>0.0</b>	<b>0</b>	<b>0.0</b>	<b>0</b>	<b>0.0</b>

## Change in spending

	Payment Rates at Medicare Rates Plus 50%		Payment Rates at Medicare Rates (Alternative)		Difference	
	\$billion	%	\$billion	%	\$billion	p.p.
<b>Household</b>						
Premiums	-4.9	-1.6	-9.9	-3.2	-5.0	-1.6
Other health care spending	-6.1	-2.0	-10.1	-3.4	-4.0	-1.4
<i>Subtotal</i>	-10.9	-1.8	-20.0	-3.3	-9.1	-1.5
<b>Federal government</b>						
Medicaid	-0.4	-0.1	-0.8	-0.2	-0.4	-0.1
Marketplace PTC	-28.1	-30.3	-33.5	-36.1	-5.4	-5.8
Reinsurance	8.7	646.1	8.7	646.1	0.0	0.0
Uncompensated care	-0.4	-1.5	-0.3	-1.1	0.1	0.3
<i>Subtotal</i>	-20.3	-4.0	-26.0	-5.1	-5.7	-1.1
<b>State government</b>						
Spending	-0.4	-0.2	-0.5	-0.2	-0.1	0.0
<b>Employers</b>						
Premium contributions	-10.8	-1.3	-20.9	-2.5	-10.0	-1.2
<b>Providers</b>						
Uncompensated care	-0.7	-3.1	-0.6	-2.4	0.2	0.7
<b>Total, all payers</b>	<b>-43.1</b>	<b>-1.9</b>	<b>-67.9</b>	<b>-3.1</b>	<b>-24.7</b>	<b>-1.1</b>

Source: Health Insurance Policy Simulation Model, 2022.

Notes: IRA = Inflation Reduction Act of 2022; p.p. = percentage point; MEC = minimum essential coverage; PTC = premium tax credit.

## Spending over 10 Years

Health spending for the nonelderly population grows from year to year even if health policy remains fixed. The largest drivers of this increase are population growth and medical inflation. Table 6 shows health care spending for the nonelderly population by payer, projected over the four years that the public option would phase in (2023–26) and over 10 years (2023–32). The estimates include the effects of population growth and medical inflation throughout the decade, in contrast to earlier tables where we simulated results in 2023 to highlight only the effects of reform. Therefore, 2023 spending estimates in table 6 match 2023 spending estimates presented earlier for the combination of Medicare-X provisions other than the public option and the introduction of the public option in the highest-premium quartile of the nongroup market. For later years, the spending and reform effects are greater than those shown earlier because they include health care inflation and population growth.

Federal savings would total \$250 billion over 10 years, and savings would increase with each year over which the reform is introduced. Overall savings for households would total just under \$100 billion and would be small before the introduction of the public option into the small-group market in 2026. Similarly, reduced health spending by employers would also total just under \$100 billion and would be small before the small-group public option introduction.

TABLE 6

**Health Spending for the Nonelderly Population under Medicare-X Provisions, by Payer, during Public Option Phase-In (2023–26) and over 10 Years (2023–32)**

Baseline, Permanent IRA Subsidies (\$Billions)					
	2023	2024	2025	2026	2023–32
Households	609.8	631.6	654.5	678.2	7,191
Federal government	509.2	534.9	561.7	585.3	6,339
State government	224.5	235.8	247.6	257.7	2,789
Employers	850.0	886.9	925.2	965.3	10,363
Providers	23.3	24.1	24.9	25.8	273
<b>Total, all payers</b>	<b>2,216.7</b>	<b>2,313.3</b>	<b>2,413.9</b>	<b>2,512.4</b>	<b>26,955</b>
Medicare-X (\$Billions)					
	2023	2024	2025	2026	2023–32
Households	607.5	629.3	652.2	666.6	7,094
Federal government	496.2	516.7	540.3	561.6	6,089
State government	224.5	235.7	247.5	257.5	2,787
Employers	848.7	885.3	923.4	953.5	10,265
Providers	22.9	23.5	24.2	24.9	264
<b>Total, all payers</b>	<b>2,199.7</b>	<b>2,290.5</b>	<b>2,387.7</b>	<b>2,464.0</b>	<b>26,499</b>
Changes from Baseline under Medicare-X (\$Billions)					
	2023	2024	2025	2026	2023–32
Households	-2.3	-2.3	-2.3	-11.6	-97
Federal government	-13.0	-18.3	-21.4	-23.8	-250
State government	*	-0.1	-0.1	-0.3	-2
Employers	-1.3	-1.6	-1.8	-11.8	-98
Providers	-0.3	-0.6	-0.7	-0.9	-9
<b>Total, all payers</b>	<b>-17.0</b>	<b>-22.8</b>	<b>-26.2</b>	<b>-48.3</b>	<b>-456</b>
Percent Change from Baseline under Medicare-X					
	2023	2024	2025	2026	2023–32
Households	-0.4	-0.4	-0.3	-1.7	-1.4
Federal government	-2.6	-3.4	-3.8	-4.1	-3.9
State government	**	**	**	-0.1	-0.1
Employers	-0.2	-0.2	-0.2	-1.2	-0.9
Providers	-1.5	-2.3	-2.7	-3.6	-3.2
<b>Total, all payers</b>	<b>-0.8</b>	<b>-1.0</b>	<b>-1.1</b>	<b>-1.9</b>	<b>-1.7</b>

Source: Health Insurance Policy Simulation Model, 2022.

Notes: IRA = Inflation Reduction Act of 2022; \* = less than +/- \$50 million; \*\* = less than +/- 0.05%. The baseline with permanent IRA subsidies assumes the enhanced premium tax credits under the IRA are extended permanently instead of expiring after 2025 as under current law.

## Discussion

The largest coverage effects of the Medicare-X proposal would come from the introduction of the public option into the nongroup market. The number of people uninsured would decline by 311,000 under Medicare-X provisions other than the public option (introducing a federal reinsurance plan and reducing the firewall threshold) and would decline by 779,000 with the nongroup public option available in all regions. Most of the reform's effects would occur in the two quartiles with the highest

premiums, where more than two-thirds of the increase in nongroup coverage would occur and which would generate almost 90 percent of the savings to the federal government from the nongroup public option. Finally, extending the public option to the small-group market would have little effect on coverage (decreasing uninsurance by 20,000 people) but would substantially reduce spending on health for households and employers because of the availability of lower-premium coverage options.

Overall, if fully phased in by 2023, Medicare-X would reduce the number of people uninsured by 1.1 million and would generate savings of \$10.9 billion for households and \$20.3 billion for the federal government. Employers would spend \$10.8 billion less on premiums. National health spending would fall by \$43.1 billion, or almost 2 percent. From 2023 to 2032, accounting for population growth, health care inflation, and the timing of the Medicare-X provisions, the legislation would cut spending by \$250 billion for the federal government and by \$456 billion for all payers. These reductions—of 3.9 percent and 1.7 percent—would occur despite the relatively small size of the nongroup and small-group markets. Federal PTCs would fall by 23 percent because of the introduction of the public option into the nongroup market.

Underlying this analysis is the assumption that provider payment rates and prescription drug costs can be reduced without adverse consequences. If payment rates are too low, access to care, provider finances, and the availability of medications may be compromised. However, Medicare-X requires participation in the public option for all providers who accept Medicare or Medicaid, so we do not expect a significant impact on access to care.

## Notes

- <sup>1</sup> [Medicare-X Choice Act of 2021](#), S. 386 117th Cong. 1st Sess. (2021–22).
- <sup>2</sup> The firewall threshold is indexed and changes slightly each year. In 2021, it was 9.83 percent (see [Examination of Returns and Claims for Refund, Credit, or Abatement; Determination of Correct Tax Liability](#), 26 C.F.R. 601.105 [2020]), and in 2022 it is 9.61 percent (see [Part III, Administrative, Procedural, and Miscellaneous of 26 C.F.R. 601.105](#) [2020]).
- <sup>3</sup> Throughout this brief, we refer to people without insurance that meets the Affordable Care Act’s standard of minimum essential coverage as uninsured. Most of these people have no insurance whatsoever, though a fraction has short-term limited-duration plans.
- <sup>4</sup> These reforms exclude the effects of the Biden administration’s proposed rule change—Affordability of Employer Coverage for Family Members of Employees, 87 Fed. Reg. 20354 (Apr. 7, 2022)—that would fix the family glitch. If the glitch were fixed, affected family members (but not the employees) would be eligible for PTCs. The marginal effects on coverage and the costs of the reforms would remain nearly the same as shown. That is because the results of the fix—about 200,000 fewer people being uninsured and around 700,000 people newly having Marketplace coverage with PTCs, most of whom would have shifted from employer coverage—would be accounted for in both the baseline and the reforms shown here (Buettgens and Banthin 2021).
- <sup>5</sup> The Medicare-X plan calls for a \$10 billion reinsurance fund. We assume the new fund would replace the \$1.3 billion in current federal spending on reinsurance through waivers with states. The net new federal spending would be \$8.7 billion; we assume states currently spending for reinsurance would continue to do so.

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