



RESEARCH REPORT

Assessing the Access and Equity Concerns in a Medicare-X-Style Public Option Reform

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Assessing the Access and Equity Concerns in a Medicare-X-Style Public Option Reform

Different stakeholders advocate for the creation of a public option for different reasons (Blumberg 2021). Some are motivated to offer a nonprofit, government-run insurance option, presuming that such an alternative would better protect consumers' interests than commercial insurers do today. Others primarily value the cost-containment potential a public option might provide, presuming it would pay health care providers (hospitals, physicians, pharmaceutical manufacturers, etc.) on a fee schedule lower than the typical provider payment rates private insurers have negotiated. This cost-containment presumption is based on the fact that the Medicare and Medicaid programs pay providers significantly less than do private insurers, and public sector fees tend to grow slower than private sector fees (CBO 2022).

However, whenever substantial cost containment initiatives are explored, providers and others raise concerns that lower provider revenue could decrease access to or quality of necessary medical services. Exploring these concerns and estimating the potential implications of lower payments on access and quality is a responsible, necessary step in designing cost-containment strategies. This is particularly true when contemplating the implications of cost-containment approaches for populations that have historically experienced the greatest barriers to adequate and affordable health care, including Black non-Hispanic, Hispanic, and American Indian and Alaska Native people. A 2021 FTI Consulting report claims that hospitals serving minority populations in particular could be adversely affected by a public option, although this study relies on some unrealistic and unexplained assumptions regarding the changes in coverage and the impacts on hospitals under such a reform (FTI Consulting 2021).¹

Still, unsupported claims of this type should not impinge on policymakers' ability to implement sound reforms that could reduce health care spending, for households and systemwide. Lowering the costs of medical care could increase the affordability of health insurance premiums and decrease the direct costs of necessary services, thereby improving access to care, particularly for populations facing the greatest barriers to obtaining them.

In February 2021, Senators Tim Kaine and Michael Bennet reintroduced their Medicare-X Choice Act. If passed into law, this bill would create a government-administered insurance plan, or public option, available nationwide to those purchasing insurance through the private nongroup (i.e., individually purchased) insurance market or small employers.²

In fact, reducing disparities in access to care and outcomes is an explicit motivation for the Medicare-X Choice Act. The bill itself states that the reform seeks to “reduce health disparities (including racial, ethnic, socioeconomic, geographic, gender, sexual identity, and other disparities, including such disparities experienced by people with disabilities and older adults).”³ In addition, the bill allows reforms to be implemented on different time schedules across geographic locations to prioritize reducing these disparities.

In this analysis, we use individual-level data from the Urban Institute’s Health Insurance Policy Simulation Model (HIPSM), as well as hospital data from the American Hospital Association Annual Survey, the RAND Corporation Hospital Price Transparency Study, and the Centers for Medicare & Medicaid Services Healthcare Cost Report Information System to provide insights into the likely effects of a Medicare-X-style public option reform on hospital revenues and family health care spending. Our particular focus is on how these effects would vary across the country and across different racial and ethnic groups.

This analysis can help contextualize the implications of a public option for access to care. Because hospital spending is the largest single contributor to overall spending on medical care, this analysis focuses largely on the implications of a Medicare-X-style public option for the hospital sector.

Methods and Data

Approach

This analysis expands on the effects of public option provision from a previously published analysis of the Medicare-X proposal (Holahan and Simpson 2022). In that analysis and here, we simulate coverage and cost effects of Medicare-X provisions using HIPSM, a detailed microsimulation model of the health care system designed to estimate the cost and coverage effects of proposed health care policy options in the population not covered by Medicare (Buettgens and Banthin 2020, 2022). The model simulates household and employer decisions for a sample of individuals representative of the nonelderly US population and models how 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).

HIPSM is based on two years of the American Community Survey. These merged data provide a large representative sample of families that is sufficient in size to produce estimates by race, ethnicity, and income, for individual states and smaller regions, such as cities or hospital referral regions (HRRs). HRRs represent regional markets for tertiary medical care; all parts of the United States are assigned into one of 306 regions, each with at least 120,000 people (some with many more).⁴ We combine the HRR-level public option impacts simulated by HIPSM with HRR-level population and hospital data, including estimated Medicare hospital spending, which is not available from HIPSM. Medicare hospital spending is distributed by race and ethnicity according to each group’s share of the Medicare population in the HRR. The impacts of the public option as a percentage of hospital spending are then calculated and the 306 HRRs grouped into quintiles from those with the greatest impact of the public option on hospital spending to those with the least (table A.1).

This analysis of the Medicare-X reform focuses on people “affected by the public option,” which includes all those enrolling in insurance coverage through the nongroup market and people enrolling in coverage through small employers who choose the public option for their workers. All those purchasing nongroup coverage are treated as affected by the public option (although not all would enroll in it) because the presence of competition from the public option is assumed to lower the premium tax credit benchmark premium and force currently higher-priced competing insurance plans to lower their premiums to some degree as well. We assume that commercial insurers lower their premiums by decreasing payment rates paid to providers, either by selective contracting or through broader negotiations with their participating providers. HIPSM assumes these lower payments affect everyone in the nongroup market within each premium rating area equally, and that lower payments affect participating small-group policyholders within an area equally.⁵ Consequently, the changes projected for each HRR are influenced primarily by two factors—the share of people within the HRR affected by the option and each HRR’s premium rating area composition, some of which would experience larger or

smaller changes in provider payments. For example, a Medicare-X public option would likely have larger effects on hospital revenues in premium rating areas where large shares of the population buy nongroup and small-group insurance. The same is true for rating areas with high premiums in their nongroup and small-group insurance markets.

In addition to descriptive analyses, we estimate linear probability models to assess the relationship between the probability of an HRR being in the top two quintiles of public option impact and the following HRR-level covariates: average operating margins; average commercial-to-Medicare price ratio; average Medicaid payer share; average uncompensated care costs as a share of total expenses; indicators for moderate and high hospital market concentration; Medicaid expansion status; and indicators for region, race and ethnicity population share.⁶

Hospital Data

This analysis combines hospital data from the 2019 American Hospital Association Annual Survey, round 4 of the RAND Hospital Price Transparency Study, and the Healthcare Cost Report Information System. We aggregate the measures described below to the HRR-level by weighting each hospital by total adjusted admissions.

The 2019 American Hospital Association Annual Survey provides information on hospitals' organizational characteristics. We use each hospital's adjusted admissions and system affiliation to construct the Herfindahl-Hirschman Index (HHI), a common measure of market concentration, for each HRR. The HHI is calculated by squaring the market share of each firm competing in the HRR and then summing the resulting numbers. To approximate the US Department of Justice and Federal Trade Commission guidelines, we classify markets as not concentrated (HHI under 1,500), moderately concentrated (HHI between 1,500 and 2,500), highly concentrated (HHI over 2,500, up to 5,000), and very highly concentrated (HHI over 5,000).⁷

Round 4 of the RAND study used claims data from various sources—self-insured employers, select state-based all-payer claims databases, and health plans that chose to participate—to estimate detailed price information among more than 4,000 hospitals (Whaley et al. 2022). The price data were constructed from facility and professional claims for inpatient and outpatient services provided by Medicare-certified short-stay hospitals. For each private claim, RAND repriced the service using Medicare's grouping and pricing algorithms and reported price levels and trends for both hospitals and hospital systems identified by name. For this analysis, we use the ratio of commercial-to-Medicare

prices for inpatient and outpatient services, that is, the allowed amount paid by a commercial plan as a percentage of the amount Medicare would pay for the same services to the same hospital.

The Healthcare Cost Report Information System contains annual cost reports submitted by all Medicare-certified hospitals and provides information on hospitals' profitability (operating margins), uncompensated care burden (uncompensated care costs as a share of operating expenses), and financial burden attributable to unfavorable payer mix (Medicaid discharges as a share of total discharges). However, despite providing rich financial information, the Healthcare Cost Report Information System has well-documented limitations with item nonresponse and data quality (Kane 2016; Kane and Magnus 2021; Kane et al. 2021; Ozmeral et al. 2012). To minimize these concerns, we pool 2017–19 data to smooth year-to-year fluctuations for each measure and winsorize operating margins and uncompensated care costs at the 2.5 and 97.5 percentiles.

Analysis

Microsimulation Analysis

EFFECTS OF THE MEDICARE-X PUBLIC OPTION ON OVERALL HOSPITAL SPENDING, IN TOTAL AND BY RACE AND ETHNICITY

Table 1 shows the percentage and average per person dollar changes in hospital spending that we simulate would result under a Medicare-X public option reform. Estimates are shown separately for those living in each quintile of HRR public option impact (largest public option impact to smallest public option impact) and by race and ethnicity groups. The calculations include the total population (all ages, all sources of health insurance coverage, and uninsured) residing in each quintile and their total hospital spending (paid by insurers and directly by households).

Percent impacts on hospital revenues would be small and would vary geographically. As table 1 shows, the Medicare-X public option is estimated to reduce spending on hospital care in total, nationally, by 1.4 percent. This estimate takes into account that hospital spending paid by existing public insurance programs (Medicare, Medicaid, and the Children's Health Insurance Program) would be unaffected by the reform. Prices paid by large employer insurance plans would be unaffected as well: the public option would be available only to those purchasing coverage through nongroup insurance markets or small employers.

Effects on hospital revenues would vary nationally, however. In the quintile of HRRs most affected by the public option reform, spending on hospitals would fall by 2.8 percent while in the quintile least affected, spending would fall by 0.5 percent. The impact of the public option reform in any particular HRR is a function of many variables, including the share of the population enrolling in coverage through the nongroup or small-group markets, the share of firms in the small-group market choosing to enroll in the public option, the hospital prices in the nongroup and small-group markets before reform, and the health care use and costs associated with the enrolling population. For example, in areas where the population is disproportionately older or of lower income, the share of residents enrolled in Medicare and Medicaid will be higher than average. A public option is likely to have a smaller impact on hospital revenues in those areas because larger shares of the population would be unaffected. All else being equal, areas of the country with more competitive insurance or provider markets, where hospital prices tend to be lower than average, are also likely to experience smaller impacts on hospital revenues than areas with higher hospital prices today.

Within-quintile variations in revenue effects by race and ethnicity are generally small. Table 1 also shows that, while impacts vary across race and ethnicity groups within a quintile, this variation tends to be small, particularly in 4 of 5 quintiles. Where noticeable differences within a quintile occur, however, the simulated effects on the white non-Hispanic population tend to be larger than the effects on the Black non-Hispanic population. However, the most noticeable within-quintile difference is the larger effect on the Asian and Pacific Islander population in the highest-impact HRR quintile. Hospital spending on behalf of the Asian and Pacific Islander population living in the highest impact quintile of HRRs is estimated to fall by 4.7 percent, compared with 2.9 percent for the white non-Hispanic population, 3.2 percent for the Hispanic population, and 2.3 percent for the Black non-Hispanic population.

Differences in the effect of the Medicare-X public option across race and ethnicity groups within HRR quintiles are likely the result of differential rates of public option enrollment under the reform as well as differential rates of hospital use today. For example, one group may be more likely than others to be employed in small firms, which would be included in a Medicare-X-style reform. Workers in small firms living in HRRs with high commercial insurance prices will be more likely to enroll in a public option if it is made available. A public option would have the greatest effect on other insurers' prices in HRRs with nongroup markets that currently have little or no insurer competition.

In addition, lower-income people residing in states that have not expanded Medicaid under the ACA are more likely to enroll in Marketplace-based coverage than are their counterparts in expansion states. These low-income residents are particularly sensitive to insurance plan prices and are more

likely to benefit from a public option if one is available. To the extent that particular racial/ethnic groups disproportionately reside in nonexpansion states or disproportionately fall into lower-income groups, they will be more likely to be affected by a public option made available in the subsidized nongroup insurance market. Another factor that will affect the magnitude of differential impacts but that cannot be captured in HIPSM is whether particular racial/ethnic groups tend to use higher-priced hospitals within a given HRR, compared with other groups.

Table 1 shows the same simulated effects in terms of average dollar reductions in spending on hospital care per person, averaged over residents of all ages residing in the HRRs in each quintile. The national reduction in hospital spending per resident if a Medicare-X public option reform is implemented is estimated to be \$42, ranging from a high of \$81 per resident in the highest-impact HRRs down to \$17 per resident in the lowest-impact HRRs. The per person reduction in hospital spending under reform in the highest quintile ranges from \$42 per resident identifying as being multiple races up to \$107 per Asian and Pacific Islander resident.

TABLE 1
Average Change in Hospital Spending, by Quintile of Change in HRR Hospital Spending under Medicare-X Public Option, 2023

	Quintile					All
	Largest change	4th	Middle	2nd	Smallest change	
Percent change (%)						
All races/ethnicities	-2.8	-1.6	-1.2	-0.8	-0.5	-1.4
<i>Race/ethnicity</i>						
American Indian and Alaska Native	-2.8	-1.7	-0.8	-0.6	-0.4	-1.3
Asian and Pacific Islander	-4.7	-1.7	-1.3	-1.1	-0.7	-1.9
Black non-Hispanic	-2.3	-1.1	-1.0	-0.7	-0.4	-1.1
Hispanic	-3.2	-1.8	-1.0	-0.9	-0.4	-1.5
White non-Hispanic	-2.9	-1.7	-1.2	-0.9	-0.5	-1.4
More than one race	-2.2	-1.1	-0.8	-0.6	-0.5	-1.1
Spending per person (\$)						
All races/ethnicities	-81	-49	-36	-26	-17	-42
<i>Race/ethnicity</i>						
American Indian and Alaska Native	-85	-53	-25	-18	-14	-39
Asian and Pacific Islander	-107	-40	-32	-28	-19	-45
Black non-Hispanic	-61	-34	-27	-17	-13	-31
Hispanic	-59	-34	-21	-19	-9	-29
White non-Hispanic	-88	-54	-41	-29	-18	-46
More than one race	-42	-23	-15	-11	-10	-20

Source: Authors' estimates using the Urban Institute Health Insurance Policy Simulation Model (HIPSM).
HRR = hospital referral region.

DISTRIBUTION OF POPULATION AND DISTRIBUTION OF PEOPLE AFFECTED BY THE PUBLIC OPTION BY RACE AND ETHNICITY AND HRR IMPACT QUINTILE

Table 2 shows the distribution of the population (all ages) by race and ethnicity group and by HRR impact quintile, with millions of people shown in the top section and percentage of each race and ethnicity group in the bottom section. The total population is not evenly divided across HRR quintiles because HRRs are not uniform in population size.

TABLE 2
Population of HRRs by Race/Ethnicity, by Quintile of Change in HRR Hospital Spending under Medicare-X Public Option, 2023

	Quintile					All
	Largest change	4th	Middle	2nd	Smallest change	
Millions of people						
All races/ethnicities	50.8	72.3	54.2	86.3	75.6	339.2
<i>Race/ethnicity</i>						
American Indian and Alaska Native	0.7	1.2	1.3	1.5	0.8	5.5
Asian and Pacific Islander	1.1	3.3	3.1	5.6	5.1	18.2
Black non-Hispanic	9.0	9.3	4.7	7.3	9.1	39.4
Hispanic	7.3	14.3	8.8	13.1	11.9	55.3
White non-Hispanic	32.0	43.2	35.5	57.0	47.5	215.2
More than one race	0.7	1.0	0.8	1.7	1.4	5.6
Percent (%)						
All races/ethnicities	15.0	21.3	16.0	25.4	22.3	100.0
<i>Race/ethnicity</i>						
American Indian and Alaska Native	12.3	22.8	23.2	27.5	14.3	100.0
Asian and Pacific Islander	6.3	18.0	16.8	30.8	28.1	100.0
Black non-Hispanic	22.9	23.6	11.9	18.6	23.0	100.0
Hispanic	13.1	25.8	15.9	23.8	21.4	100.0
White non-Hispanic	14.9	20.1	16.5	26.5	22.1	100.0
More than one race	11.7	18.2	15.0	30.8	24.3	100.0

Source: Authors' estimates using the Urban Institute Health Insurance Policy Simulation Model (HIPSM).
HRR = hospital referral region.

Black non-Hispanic people are overrepresented in the top impact HRRs but are less likely to be directly affected by the public option because they are more likely to have other sources of coverage. Table 2 shows that the Black non-Hispanic population disproportionately resides in the highest-impact HRR quintile, compared with the overall distribution of the population. Just under 23 percent of the Black non-Hispanic population lives in the highest impact quintile, compared with 15.0 percent of the total population. The Hispanic population is somewhat underrepresented in the highest-impact HRR quintile (13.1 percent versus 15.0 percent for the full population) and overrepresented in the second highest impact quintile (25.8 percent versus 21.3 percent for the total population). The white non-

Hispanic population is represented across the HRR quintiles approximately on par with the total population.

However, table 3 indicates that Black non-Hispanic and Hispanic people are less likely to be directly affected by the public option once Medicare-X is put in place compared with white non-Hispanic people, even when they live in the same HRRs. For example, 14.5 percent of Black non-Hispanic people living in the highest quintile of HRR impact are affected by the public option (nongroup and some small-employer insurance enrollees) and 16.5 percent of white non-Hispanic people living in the highest quintile are affected.

We simulate that the introduction of a Medicare-X public option will affect provider payment rates for 12.3 percent of the population, or 41.8 million people (table 3). Stated another way, the reform would not change the hospital payment rates of roughly 88 percent of people.

We also see that about two-thirds of people affected by the public option in each HRR quintile are white non-Hispanic people (e.g., 5.3 million out of 8.1 million in the highest-impact HRR). Black non-Hispanic and Hispanic people comprise the bulk of the remaining people affected in each HRR quintile. The share of people affected by the public option reform is greatest in the highest-impact HRR quintile, a finding consistent with the stronger price incentive small firms have to choose a public option when it offers the largest decrease in price. An estimated 16.0 percent of people in the highest-impact HRR quintile would be affected by a Medicare-X public option, compared with 10.5 percent in the lowest impact quintile.

In contrast, consistently across HRR impact quintiles, members of the Asian and Pacific Islander population are the people most likely to be affected by the public option. Across all HRR quintiles, 13.5 percent of the Asian and Pacific Islander population would be affected by the Medicare-X public option, compared with 12.3 percent of people overall. The Asian and Pacific Islander population is most impacted because their participation in nongroup insurance and small-group insurance is the highest of any group. Their insurance rates through Medicare or Medicaid, which are unaffected by the public option, are also lower than average.

TABLE 3

Portion of Race/Ethnicity Group Affected, by Quintile of Change in HRR Hospital Spending under Medicare-X Public Option, 2023

	Quintile					All
	Largest change	4th	Middle	2nd	Smallest change	
Millions of people						
All races/ethnicities	8.1	9.5	6.6	9.6	7.9	41.8
<i>Race/ethnicity</i>						
American Indian and Alaska Native	0.1	0.1	0.1	0.1	0.1	0.6
Asian and Pacific Islander	0.2	0.5	0.4	0.7	0.7	2.5
Black non-Hispanic	1.3	1.2	0.5	0.7	0.9	4.6
Hispanic	1.1	1.5	0.9	1.2	1.0	5.7
White non-Hispanic	5.3	6.0	4.7	6.7	5.1	27.8
More than one race	0.1	0.1	0.1	0.2	0.1	0.6
Percent (%)						
All races/ethnicities	16.0	13.2	12.2	11.1	10.5	12.3
<i>Race/ethnicity</i>						
American Indian and Alaska Native	12.6	11.9	11.3	9.8	10.1	11.0
Asian and Pacific Islander	19.1	14.7	13.5	12.3	12.8	13.5
Black non-Hispanic	14.5	13.0	9.8	9.4	10.1	11.6
Hispanic	15.8	10.8	9.7	8.8	8.7	10.4
White non-Hispanic	16.5	13.9	13.1	11.8	10.8	12.9
More than one race	13.4	12.3	11.2	11.4	10.4	11.5

Source: Authors' estimates using the Urban Institute Health Insurance Policy Simulation Model (HIPSM).

HRR = hospital referral region.

Note: People affected by the public option include all of those enrolled in insurance through the private nongroup insurance market and those enrolled in insurance coverage through small employers that choose to enroll their workers in the public option.

HOUSEHOLD SPENDING ON MEDICAL CARE FOR THOSE AFFECTED BY THE PUBLIC OPTION

While the rest of the quantitative analysis presented here focuses exclusively on hospital spending and spending by all payers (insurers and households), table 4 provides estimates of the simulated effect of the Medicare-X public option on total direct medical spending (hospitals, physicians, prescription drugs, other), specifically by the households affected by the public option reform who would have been insured even without the public option in place. Estimates include household contributions for health insurance premiums and out-of-pocket expenses (e.g., deductibles, copayments, and coinsurance). We provide this information to highlight that the public option would not only lower provider revenues; it would also reduce financial burdens for households, compared with their current insurance.

Table 4 shows the average percentage change in health care spending per previously insured person affected by the public option. Corresponding dollar changes in household spending are in the bottom section of the table. We include only those who were both insured before reform and directly affected by the introduction of the public option (i.e., nongroup insurance enrollees and those enrolled

in the public option through a small employer). We exclude those presently uninsured because moving from uninsured to insured is likely to increase household spending, as people tend to use medical care more often once insured, despite the per unit price of medical care decreasing.

TABLE 4

Average Change in Household Health Spending for Previously Covered People Affected, by Quintile of Change in HRR Hospital Spending under Medicare-X Public Option, 2023

	Quintile					All
	Largest change	4th	Middle	2nd	Smallest change	
Percent change (%)						
All races/ethnicities	-7.6	-5.6	-4.2	-3.9	-2.9	-4.8
<i>Race/ethnicity</i>						
American Indian and Alaska Native	-5.9	-4.6	-3.1	-3.7	1.2	-3.2
Asian and Pacific Islander	-9.9	-6.8	-4.8	-5.4	-3.7	-6.1
Black non-Hispanic	-4.8	-1.7	-2.0	-2.1	-1.4	-2.4
Hispanic	-5.1	-3.3	-3.1	-2.8	-2.6	-3.4
White non-Hispanic	-7.8	-5.9	-4.3	-4.1	-3.0	-5.0
More than one race	-4.9	-5.2	-3.5	-1.6	-3.1	-3.7
Dollars per person (\$)						
All races/ethnicities	-486	-484	-431	-338	-226	-393
<i>Race/ethnicity</i>						
American Indian and Alaska Native	-379	-396	-367	-265	-127	-307
Asian and Pacific Islander	-532	-390	-359	-349	-172	-361
Black non-Hispanic	-281	-312	-290	-218	-171	-255
Hispanic	-340	-356	-299	-281	-179	-291
White non-Hispanic	-543	-527	-468	-372	-241	-430
More than one race	-316	-380	-340	-189	-170	-279

Source: Authors' estimates using the Urban Institute Health Insurance Policy Simulation Model (HIPSM).

HRR = hospital referral region.

Note: People affected by the public option include all of those enrolled in insurance through the private nongroup insurance market and those enrolled in insurance coverage through small employers that choose to enroll their workers in the public option. Spending consists of household-paid premiums and out-of-pocket spending. Spending is calculated per person within a family.

Household savings from the public option would be greatest for people living in the highest-impact HRRs, particularly for white non-Hispanic and Asian and Pacific Islander residents. Previously insured consumers living in the highest-impact HRR quintiles will experience the greatest savings. Savings decline in percentage and dollar terms when moving from the highest-impact HRR quintiles to the lowest. The average consumer affected by the public option and living in the highest-impact HRRs saves 7.6 percent (\$486) per year in combined premium and out-of-pocket-costs while one living in the lowest-impact HRRs saves 2.9 percent (\$226).

Household average and percentage savings tend to be highest across quintiles of HRR impact for white non-Hispanic and Asian and Pacific Islander consumers. For example, in the highest-impact HRRs,

savings average 7.8 percent for white non-Hispanic consumers and 9.9 percent for Asian and Pacific Islander consumers, or \$543 per person and \$532 per person, respectively. Again, these differentials by race and ethnicity group are likely related to a combination of factors, including differences in health status (and thus use of medical care across the groups) and differences in the concentration of residence across HRRs within a particular quintile, which can lead to different groups incurring different average provider prices. Ultimately, differences in household savings will result from variations in the specific hospitals used across race and ethnicity groups (not measured here). Those now using higher-priced hospitals who then enroll in the new public option are most likely to experience the greatest savings.

Hospital Data Analysis

HOSPITAL FINANCIAL DATA BY HRR PUBLIC OPTION IMPACT QUINTILE

HRR impact on hospital revenues is greatest where hospitals are paid the highest commercial insurance prices. Table 5 provides financial data on hospitals situated within each HRR public option impact quintile. There are approximately 60 HRRs in each quintile, 304 nationally.⁸ As expected, those HRRs in the highest public option impact quintile have the highest average commercial-to-Medicare price ratios for inpatient and outpatient care. In the highest impact quintile, average commercial insurance prices are 2.8 times those used by the Medicare program. In the lowest impact quintile, average commercial insurance prices are 2.3 times those used by Medicare. The public option should decrease hospital spending to the greatest extent (i.e., have the biggest impact) in the areas where private insurers pay the highest prices, all else being equal.

The data in this table do not indicate a clear linear relationship between public option impact and average operating margins, although the operating margins are higher in each of the top three impact quintiles than in the bottom two quintiles.

Hospitals with lower Medicaid caseloads would tend to have larger revenue declines with a public option in place. There is a clear association between the share of an HRR's hospital discharges attributable to Medicaid and the quintile of public option impact. Medicaid pays for a smaller share of discharges in HRRs most impacted by the public option than those less impacted. HRRs with a higher share of discharges payable by Medicaid are likely to be largely or entirely situated in a state that has expanded Medicaid under the Affordable Care Act.

As table 5 shows, hospitals in nonexpansion states are much more likely to be in HRRs experiencing the greatest public option impact. In states that have not expanded Medicaid, many adults whose

incomes fall between 100 and 138 percent of the federal poverty level are eligible for substantial financial assistance when enrolling in nongroup insurance, but few are eligible for Medicaid. More people enrolling in insurance through the nongroup market in nonexpansion states means more people will be affected by the public option. In states that now have Medicaid expansions in place and thus a larger share of hospital revenues from Medicaid, the public option will have a smaller average effect on hospital revenues, because Medicaid now pays hospitals at payment rates lower than those the public option is expected to pay.

TABLE 5
Financial Characteristics of Hospitals, by Quintile of Change in HRR Hospital Spending under Medicare-X Public Option, 2023

	Quintile					All
	Largest change	4th	Middle	2nd	Smallest change	
Sample size (number of HRRs)	62	60	62	60	60	304
Mean financial characteristics of HHR hospitals						
Commercial-to-Medicare price ratio for inpatient/outpatient care ^a	2.8	2.6	2.5	2.4	2.3	2.5
Operating margins ^b (%)	4.4	5.3	5.8	4.0	2.3	4.4
Medicaid payer share ^b (%)	12.7	15.6	16.4	18.0	18.5	16.2
Uncompensated care costs as a share of total expenses ^b (%)	4.2	3.3	2.3	1.7	1.3	2.6
2019 HRR concentration^c						
Average HHI	3,843	3,406	3,741	3,165	3,416	3,518
Not concentrated (HHI < 1,500) (%)	4.8	13.3	3.2	18.3	13.3	10.5
Moderate concentration (1,500 ≤ HHI ≤ 2,500) (%)	27.4	21.7	22.6	25.0	25.0	24.3
High concentration (2,500 < HHI ≤ 5,000) (%)	46.8	48.3	59.7	38.3	43.3	47.4
Very high concentration (HHI > 5,000) (%)	21.0	16.7	14.5	18.3	18.3	17.8
Adjusted admissions in Medicaid-expansion state^{c,d} (%)						
	13.1	50.2	73.5	90.8	98.3	64.9

Source: Quintiles of change in HRR hospital spending under Medicare-X public option come from the Urban Institute Health Insurance Policy Simulation Model (HIPSM). Sources for hospital financial characteristics are specified in the notes below.

HHI = Herfindahl-Hirschman Index; HRR = hospital referral region.

Notes: All financial measures are weighted by hospital adjusted admissions.

^a From round 4 of the RAND Hospital Price Transparency Study, 2018–20.

^b From the 2017–19 Healthcare Cost Report Information System.

^c From the 2019 American Hospital Association Annual Survey database.

^d Because some HRRs cross state lines, this measure is defined as the share of hospital discharges that occurred in a Medicaid expansion state.

Hospitals reporting higher spending on uncompensated care would tend to experience larger effects of a public option. Hospitals in higher HRR impact quintiles tend to report higher uncompensated care costs as a share of total expenses than do hospitals in lower-impact HRRs. Hospitals in the highest-impact HRRs report that 4.2 percent of their expenses are attributable to uncompensated care, compared with 1.3 percent for hospitals in the lowest-impact HRRs. This finding is consistent with the higher rates of uninsured people living in the higher-impact HRRs (table A.2), none of which are fully situated in Medicaid expansion states. However, it may also indicate that, in these higher-priced hospitals in the higher impact quintiles, uncompensated care is being valued in hospital reporting using higher prices than in the lower impact quintiles. Still, a concern is whether hospitals in high impact quintiles could reduce their provision of uncompensated care in response to a public option.

HRRs experiencing the highest public option impact tend to have the least competitive hospital markets. Table 5 also shows the average HHI for hospital markets within each HRR public option impact quintile. HRRs in the highest impact quintile are more likely to have very highly concentrated hospital markets than those in the lower impact quintiles. The relationship is not linear, but HRRs in the lowest impact quintile are much more likely to have hospital markets that are not concentrated (i.e., they are more likely to be competitive) than HRRs in the highest impact quintile. In the highest public option impact quintile, only 4.8 percent of hospital markets are competitive, compared with more than 13 percent in the lowest impact quintile.

RELATIONSHIP BETWEEN HRR IN TWO LARGEST-CHANGE QUINTILES AND OTHER FACTORS

Table 6 provides the results of an ordinary least squares regression used here as a simple approach to summarize the correlations between an HRR being in one of the two highest public option impact quintiles and an array of factors, including hospital financial data and the racial/ethnic composition of the HRR's population. This regression is a summary for correlation, not for causation. We estimated the regression with the dependent variable equal to 1 if the HRR falls into either the highest or second-highest impact quintile, as a large share of the HRRs in the highest quintile of public option impact are in Florida (17 of 62, or 27 percent). These Florida HRRs are, in fact, high-priced hospital markets, so it is appropriate that they are in that top quintile. However, if we had performed the regression for HRRs in the first quintile alone, the correlations might overly reflect correlations specific to circumstances in Florida.

High-impact public option HRRs tend to have higher-priced hospitals. The regression results presented in table 6 indicate a statistically significant positive relationship between an HRR being in one of the highest impact quintiles and the ratio of commercial insurance hospital prices relative to Medicare

prices. In other words, HRRs where commercial insurers pay hospitals higher prices are more likely to experience larger impacts from the introduction of a Medicare-X-style public option reform. We find no statistically significant relationship between quintile of public option impact and extent of consolidation in the hospital markets of the HRR. This is consistent with the lack of a visually identifiable linear relationship in the descriptive data shown in table 5.

More hospital admissions in Medicaid expansion states are associated with lower likelihood of high public option impact. Having a greater share of an HRR's hospital admissions in a Medicaid expansion state is associated with a lower likelihood of the HRR experiencing a higher impact of the public option. This finding is consistent with more low-income people in nonexpansion states being eligible for highly subsidized marketplace insurance or otherwise being more likely to buy coverage through nongroup insurance markets. Even controlling for that Medicaid expansion correlation, the results indicate that HRR's in the South are more likely than HRRs in any other region to be in one of the higher impact quintiles.

Notably, taking all the HRR data into account and controlling for other factors, we do not find any statistically significant relationships between an HRR being in a high public option impact quintile and the racial and ethnic composition of the HRR's population.

TABLE 6

Estimated Relationship between the Likelihood of an HRR Being in a High Public Option Impact Quintile and Other Variables

Variable	Coefficient (robust standard error)
Operating margins	-0.48 (0.52)
Commercial-to-Medicare price ratio for inpatient/outpatient care	0.15*** (0.05)
Share of discharges attributable to Medicaid	0.14 (0.54)
Uncompensated care costs as a share of total expenses	3.17 (1.98)
Moderately concentrated HRR ($1,500 \leq \text{HHI} \leq 2,500$)	-0.01 (0.08)
Highly concentrated HRR ($2,500 < \text{HHI} \leq 5,000$)	0.02 (0.07)
Very high concentration ($\text{HHI} > 5,000$)	0.02 (0.08)
Share of adjusted admissions in Medicaid expansion state	-0.36*** (0.09)
Northeast region	-0.38*** (0.08)
Midwest region	-0.24*** (0.08)
West region	-0.15 (0.11)
American Indian and Alaska Native population share	-0.71 (1.63)
Asian and Pacific Islander population share	0.17 (0.68)
Black non-Hispanic population share	-0.03 (0.29)
Hispanic population share	-0.39 (0.25)
Population share of people of more than one race	-2.72 (2.22)
Constant	0.39** (0.17)
Observations	304
R-squared	0.52

Source: Authors' analysis of Urban Institute Health Insurance Policy Simulation Model (HIPSM) combined with data from round 4 of the RAND Hospital Price Transparency Study, the Healthcare Cost Report Information System, and the American Hospital Association Annual Survey database.

HHI = Herfindahl-Hirschman Index; HRR = hospital referral region.

Notes: Model is estimated using ordinary least squares (OLS). Dependent variable = 1 if HRR is in one of the top 2 quintiles for the highest impact of a Medicare-X-style public option. Data include 304 HRRs.

*** $p < 0.01$, ** $p < 0.05$, * $p < 0.1$.

Discussion

Policy Design Implications

Identifying how a public option like the one delineated in the Medicare-X proposal would affect access to care overall and for specific subpopulations in particular is extremely difficult. These outcomes depend upon several factors, some of which are policy design choices and some of which rely on our ability to predict hospital and consumer behavior. Because data are insufficient and past experience in measuring behavioral responses is limited, the answers to the following questions carry some degree of uncertainty:

1. How will the provider payment rates hospitals receive today change for public option enrollees of different characteristics?
2. How do hospitals experiencing larger and smaller changes in their payment rates differ in the share of their patients and revenue coming from patients belonging to different racial and ethnic groups?
3. How will public option enrollees of different characteristics (e.g., race/ethnicity, health care needs) change which hospitals they choose for care if a public option plan is offered?⁹
4. Will hospitals, faced with price cuts for services to public option enrollees, become more efficient and reduce underlying costs, as there is some evidence they have done when faced with Medicare price cuts (McMorrow and Blumberg, forthcoming)? Or will hospitals either avoid public option enrollees or change their care practices when serving them?
5. Will the new payment system used by a Medicare-X-style public option encourage greater use of previously underpriced services while discouraging the use of previously overpriced services, potentially improving quality of care and appropriate access to needed services?

Potential consequences for historically disadvantaged populations should always be a concern in the design of public policies. However, we cannot know, a priori, the provider payment schedule that would create the ideal balance of health care spending, access, and quality. As a consequence, systems for monitoring the effects of provider payment reforms, particularly for populations most likely to face quality and access barriers today, would ideally be developed simultaneously with implementation of any Medicare-X-style reforms. Monitoring systems would allow for adjustments to a reform's payment schedule where appropriate, for example, where access to specific services in specific locations appears to be impeded.

When assessing whether a possible reform could negatively affect historically disadvantaged groups, it is critical to use the best available sources of data and analytic tools to generate the most reliable estimates. Our analysis takes a significant step in doing so.

Access and Equity Implications

Our analysis strongly indicates that a Medicare-X-style public option would not impose negative consequences for Black non-Hispanic or Hispanic populations:

- The overall implications of a Medicare-X-style reform for hospital spending are modest, with simulated decreases of 1.4 percent in hospital spending nationally, 2.8 percent in the highest-impact HRR quintile, and 1.7 percent in the second-highest impact HRR quintile. These findings suggest that any overall changes in access to care would be small.
- Although the Black non-Hispanic population is overrepresented in their residence in the highest impact quintile of HRRs, the Medicare-X public option is simulated to have a lower average impact on this population than on the full population in that quintile. Hospital spending on behalf of Black non-Hispanic people residing in the highest impact quintile is estimated to decrease by 2.3 percent (or \$61) compared with 2.9 percent (or \$88) for white non-Hispanic residents.
- Hispanic people are somewhat underrepresented in the population living in the highest public option impact HRRs, although those who do are estimated to experience a modestly higher relative reduction in hospital spending (3.2 percent compared with 2.9 percent for the white non-Hispanic population). However, because the Hispanic population tends to use hospital care less than other racial/ethnic groups, this slightly higher percent reduction in spending corresponds to a smaller decrease in absolute dollars of \$59 per Hispanic resident in the highest impact quintile (compared with \$88 per white non-Hispanic resident).
- Black non-Hispanic and Hispanic people would be more likely to retain types of insurance coverage other than the public option compared with their white non-Hispanic counterparts. Under a Medicare-X public option, 11.6 percent of Black non-Hispanic people would have the hospital prices paid on their behalf affected, as would 10.4 percent of Hispanic people and 12.9 percent of white non-Hispanic people. The lower public option penetration rates for Black non-Hispanic and Hispanic people persist across all quintiles of public option impact.

Further, if Black non-Hispanic and Hispanic people are more likely to obtain their hospital care from public and nonprofit hospitals than white non-Hispanic people, a public option reform is likely to have smaller effects on their overall hospital spending than our estimates reflect. Unfortunately, our data will not allow us to differentiate the specific hospitals in which people of different races and ethnicities tend to obtain their care. Still, this is a critical piece of the puzzle in predicting effects on hospital spending.

Today, commercial insurance provider payment rates are typically higher in private for-profit hospitals than in nonprofit and public hospitals.¹⁰ Consequently, if all hospitals participate with a public option insurance plan, as the simulation analysis here implicitly assumes, payment rates for higher-priced for-profit hospitals are likely to experience larger decreases when serving public option enrollees. If, however, public option enrollees, particularly those not in the white non-Hispanic group, tend to use public hospitals when obtaining care, the effects on their providers' revenues can be even smaller than indicated here. This is because the payment rates public and nonprofit hospitals receive today are already closer to the rates to be paid under a public option compared with the overall average across all hospitals. At least one study found that public hospitals were the most likely to admit Black non-Hispanic patients for the study's limited set of diagnoses (Cram et al. 2010). At least one other indicated that Black non-Hispanic patients have a stronger preference for obtaining their care in a nonprofit hospital than white non-Hispanic patients.¹¹

Currently uninsured patients may disproportionately use nonprofit and government hospitals and rely upon uncompensated care when they receive services. To the extent that more people become insured under a public option reform, revenue received from a public option would increase those hospitals' revenue, even if public option payment rates are lower than what today's commercial insurers pay. According to HIPSM estimates, the Black population is most likely to obtain insurance after a public option reform.

And, when we use an ordinary least squares regression to summarize the correlation between an HRR being in one of the two highest impact quintiles and an array of factors, we find no statistically significant relationship with the population concentration of any racial or ethnic group. In sum, this analysis finds little indication that the Black non-Hispanic or Hispanic populations affected by a public option would have their access to hospital care affected differently by a public option than the white non-Hispanic population.

Policymakers need to consider how public option reforms would specifically impact populations with historical barriers to medical care. Yet, those concerns should not be limited to whether lower reimbursement rates could reduce access to care. Many system changes would emerge with the

introduction of a Medicare-X-style public option. These include increased affordability for households in the form of lower premiums and out-of-pocket costs. Such savings have the potential to improve access to care for people with financial barriers to obtaining services. In addition, a public option could rely upon a provider payment structure that more closely reflects the resources necessary to provide medical services than current commercial insurance payments do. Commercial insurance payment schedules vary enormously but often reflect relative insurer and hospital bargaining leverage more than resources needed for the service being priced. A more resource-based payment schedule could improve the appropriateness of care delivered, and thereby improve quality.

Appendix A. Detailed Data

TABLE A.1

Impact of Public Option on Hospital Revenues in Each HRR, by Quintile of Change in HRR Hospital Spending under Medicare-X Public Option, 2023

Percent change

Largest change			4th			Middle			2nd			Smallest change		
Fort Myers	FL	-6.4	Greensboro	NC	-2.0	Mesa	AZ	-1.4	Charleston	WV	-1.0	Los Angeles	CA	-0.7
Panama City	FL	-6.3	Metairie	LA	-2.0	Salt Lake City	UT	-1.3	Neenah	WI	-1.0	Binghamton	NY	-0.7
Pensacola	FL	-5.2	Savannah	GA	-1.9	Sacramento	CA	-1.3	Stockton	CA	-1.0	New Brunsw.	NJ	-0.7
Hudson	FL	-4.2	Cape Girardeau	MO	-1.9	Austin	TX	-1.3	Lexington	KY	-0.9	Covington	KY	-0.7
Sarasota	FL	-4.1	La Crosse	WI	-1.9	Petoskey	MI	-1.3	Joliet	IL	-0.9	Richmond	VA	-0.7
Tallahassee	FL	-4.0	Springfield	MO	-1.9	Shreveport	LA	-1.3	Spokane	WA	-0.9	Waterloo	IA	-0.7
Gainesville	FL	-4.0	Winston-Salem	NC	-1.9	Columbus	GA	-1.3	Minneapolis	MN	-0.9	Altoona	PA	-0.7
Ocala	FL	-3.6	Corpus Christi	TX	-1.9	Houma	LA	-1.3	Honolulu	HI	-0.9	Scranton	PA	-0.7
Dothan	AL	-3.5	Bloomington	IL	-1.9	Alexandria	LA	-1.3	Eugene	OR	-0.9	Pittsburgh	PA	-0.7
Asheville	NC	-3.4	Ventura	CA	-1.8	Medford	OR	-1.3	Evanston	IL	-0.9	Boulder	CO	-0.7
Montgomery	AL	-3.3	Tyler	TX	-1.8	McAllen	TX	-1.3	St. Paul	MN	-0.9	Buffalo	NY	-0.7
Florence	SC	-3.2	Bend	OR	-1.8	Chico	CA	-1.3	Newark	NJ	-0.9	Monroe	LA	-0.7
Fort Lauderdale	FL	-3.1	Rockford	IL	-1.8	Grand Forks	ND	-1.3	Lawton	OK	-0.9	Bronx	NY	-0.7
Wichita Falls	TX	-3.0	Lubbock	TX	-1.8	Wichita	KS	-1.3	New Haven	CT	-0.9	Erie	PA	-0.6
Casper	WY	-3.0	Grand Junction	CO	-1.8	El Paso	TX	-1.3	Bismarck	ND	-0.9	Cincinnati	OH	-0.6
Oxford	MS	-2.9	Omaha	NE	-1.8	New Orleans	LA	-1.3	San Bernardino	CA	-0.9	Bakersfield	CA	-0.6
Clearwater	FL	-2.9	Santa Barbara	CA	-1.8	Springdale	AR	-1.2	Knoxville	TN	-0.9	Syracuse	NY	-0.6
Greenville	NC	-2.9	Ormond Beach	FL	-1.8	Fresno	CA	-1.2	Elmira	NY	-0.9	Danville	PA	-0.6
Wilmington	NC	-2.8	Alameda Co.	CA	-1.8	Yakima	WA	-1.2	Huntington	WV	-0.9	Washington	DC	-0.6
Albany	GA	-2.8	Urbana	IL	-1.8	Modesto	CA	-1.2	Seattle	WA	-0.9	Iowa City	IA	-0.6
Miami	FL	-2.8	San Antonio	TX	-1.7	Durham	NC	-1.2	Philadelphia	PA	-0.9	Rochester	NY	-0.6
Columbia	SC	-2.8	Chattanooga	TN	-1.7	Fargo-Moorh.	ND	-1.2	Hartford	CT	-0.9	Johnstown	PA	-0.6
Longview	TX	-2.8	Nashville	TN	-1.7	St. Louis	MO	-1.2	Olympia	WA	-0.9	Wilkes-Barre	PA	-0.6
Spartanburg	SC	-2.7	Texarkana	AR	-1.7	Everett	WA	-1.2	Portland	OR	-0.8	Cleveland	OH	-0.6
Bradenton	FL	-2.7	Beaumont	TX	-1.7	Waco	TX	-1.2	Camden	NJ	-0.8	Salem	OR	-0.6
Tampa	FL	-2.7	Lafayette	LA	-1.7	Kingsport	TN	-1.2	Kettering	OH	-0.8	Elyria	OH	-0.6
Macon	GA	-2.6	Lake Charles	LA	-1.7	Rochester	MN	-1.2	Tucson	AZ	-0.8	Akron	OH	-0.6
Augusta	GA	-2.6	Paducah	KY	-1.7	Ogden	UT	-1.2	Kansas City	MO	-0.8	Muskegon	MI	-0.6
Lakeland	FL	-2.6	Salisbury	MD	-1.7	Gary	IN	-1.2	Denver	CO	-0.8	Saginaw	MI	-0.5

			Quintile											
Largest change			4th		Middle		2nd		Smallest change					
Charlotte	NC	-2.5	Minot	ND	-1.6	Duluth	MN	-1.2	Dayton	OH	-0.8	E. Long Island	NY	-0.5
San Angelo	TX	-2.5	Rome	GA	-1.6	South Bend	IN	-1.2	San Diego	CA	-0.8	Lancaster	PA	-0.5
Huntsville	AL	-2.5	Harlingen	TX	-1.6	Fort Smith	AR	-1.2	Indianapolis	IN	-0.8	Youngstown	OH	-0.5
Mobile	AL	-2.5	Oklahoma City	OK	-1.6	Fort Wayne	IN	-1.2	Colo. Springs	CO	-0.8	Providence	RI	-0.5
Victoria	TX	-2.5	Baton Rouge	LA	-1.6	Mason City	IA	-1.1	Jonesboro	AR	-0.8	White Plains	NY	-0.5
Gulfport	MS	-2.5	Peoria	IL	-1.5	Tulsa	OK	-1.1	Morristown	NJ	-0.8	St. Joseph	MI	-0.5
St. Petersburg	FL	-2.5	Canton	OH	-1.5	Muncie	IN	-1.1	Albuquerque	NM	-0.8	Manhattan	NY	-0.5
Charleston	SC	-2.4	Lafayette	IN	-1.5	San Mateo Co.	CA	-1.1	Arlington	VA	-0.8	Albany	NY	-0.5
Odessa	TX	-2.4	Raleigh	NC	-1.5	Hinsdale	IL	-1.1	Little Rock	AR	-0.8	Cedar Rapids	IA	-0.5
Tupelo	MS	-2.4	Dallas	TX	-1.5	Evansville	IN	-1.1	Paterson	NJ	-0.8	Flint	MI	-0.5
Jacksonville	FL	-2.4	Wilmington	DE	-1.5	Davenport	IA	-1.1	Reading	PA	-0.8	Ridgewood	NJ	-0.5
Orlando	FL	-2.4	Elgin	IL	-1.5	Santa Rosa	CA	-1.1	Hackensack	NJ	-0.8	Toledo	OH	-0.5
Tuscaloosa	AL	-2.4	Las Vegas	NV	-1.5	Milwaukee	WI	-1.1	Missoula	MT	-0.8	Manchester	NH	-0.5
Marquette	MI	-2.4	Phoenix	AZ	-1.5	Munster	IN	-1.1	Rapid City	SD	-0.8	Kalamazoo	MI	-0.4
Slidell	LA	-2.3	Fort Worth	TX	-1.5	Bridgeport	CT	-1.1	Sayre	PA	-0.8	Portland	ME	-0.4
Amarillo	TX	-2.3	Redding	CA	-1.4	Terre Haute	IN	-1.1	Grand Rapids	MI	-0.8	Bangor	ME	-0.4
Hickory	NC	-2.3	Contra Costa	CA	-1.4	Appleton	WI	-1.1	Columbus	OH	-0.8	Ann Arbor	MI	-0.4
Greenville	SC	-2.3	Sioux City	IA	-1.4	Columbia	MO	-1.1	Chicago	IL	-0.8	Morgantown	WV	-0.4
Bryan	TX	-2.2	Madison	WI	-1.4	Lynchburg	VA	-1.0	Salinas	CA	-0.8	Dearborn	MI	-0.4
Wausau	WI	-2.2	Provo	UT	-1.4	Lansing	MI	-1.0	Charlottesville	VA	-0.8	Baltimore	MD	-0.4
San Luis Obispo	CA	-2.2	Jackson	TN	-1.4	San Jose	CA	-1.0	Great Falls	MT	-0.7	Topeka	KS	-0.4
Meridian	MS	-2.2	Joplin	MO	-1.4	Tacoma	WA	-1.0	Takoma Park	MD	-0.7	York	PA	-0.3
Abilene	TX	-2.1	Atlanta	GA	-1.4	Aurora	IL	-1.0	Palm Springs	CA	-0.7	Springfield	MA	-0.3
Hattiesburg	MS	-2.1	Temple	TX	-1.4	San Francisco	CA	-1.0	Blue Island	IL	-0.7	Harrisburg	PA	-0.3
Norfolk	VA	-2.1	Green Bay	WI	-1.4	Fort Collins	CO	-1.0	Louisville	KY	-0.7	Boston	MA	-0.3
Reno	NV	-2.1	Roanoke	VA	-1.4	Memphis	TN	-1.0	Dubuque	IA	-0.7	Worcester	MA	-0.3
Anchorage	AK	-2.1	Newport News	VA	-1.4	Greeley	CO	-1.0	Des Moines	IA	-0.7	Pontiac	MI	-0.3
Birmingham	AL	-2.1	Owensboro	KY	-1.4	Traverse City	MI	-1.0	Sun City	AZ	-0.7	Pueblo	CO	-0.3
Lincoln	NE	-2.0	Houston	TX	-1.4	Billings	MT	-1.0	Orange Co.	CA	-0.7	Lebanon	NH	-0.3
Jackson	MS	-2.0	Napa	CA	-1.4	Winchester	VA	-1.0	St. Cloud	MN	-0.7	Burlington	VT	-0.3
Santa Cruz	CA	-2.0	Johnson City	TN	-1.4	Sioux Falls	SD	-1.0	Allentown	PA	-0.7	Detroit	MI	-0.2
Springfield	IL	-2.0				Melrose Park	IL	-1.0	Idaho Falls	ID	-0.7	Royal Oak	MI	-0.2
Marshfield	WI	-2.0				Boise	ID	-1.0						

Source: Authors' estimates using the Urban Institute Health Insurance Policy Simulation Model (HIPSM).

HRR = hospital referral region.

TABLE A.2

Uninsurance Rate of Racial/Ethnic Groups, by Quintile of Change in HRR Hospital Spending under Current Law, 2023

Percent

	Quintile					All
	Largest change	4th	Middle	2nd	Smallest change	
All races/ethnicities	9.4	10.3	8.0	7.4	6.2	8.1
<i>Race/ethnicity</i>						
American Indian and Alaska Native	11.7	10.9	9.8	10.1	6.8	10.0
Asian and Pacific Islander	12.4	11.5	7.2	8.5	8.5	9.1
Black non-Hispanic	9.7	8.7	7.7	7.4	5.9	7.9
Hispanic	20.5	22.6	18.1	16.1	13.1	18.0
White non-Hispanic	6.7	6.5	5.5	5.2	4.2	5.5
More than one race/ethnicity	7.1	7.6	6.3	5.9	5.5	6.3

Source: Authors' estimates using the Urban Institute Health Insurance Policy Simulation Model (HIPSM).

HRR = hospital referral region.

Notes: Uninsurance rates in table reflect status today, before any provisions of Medicare-X.

Notes

- ¹ The argument that hospitals serving populations of color could be adversely affected by a public option assumes large across-the-board cuts in hospital revenues unrelated to current payer mix or commercial market prices and ignores hospital revenue increases from people becoming newly insured under reform.
- ² Medicare-X Choice Act of 2001, S. 386, 117 Cong. (2021), <https://www.congress.gov/bill/117th-congress/senate-bill/386>.
- ³ Medicare-X Choice Act, § 2209.
- ⁴ “FAQ,” Dartmouth Atlas of Health Care, Dartmouth Institute for Health Policy and Clinical Practice, <https://www.dartmouthatlas.org/faq/>.
- ⁵ Payment rate changes for the nongroup market vary at the ACA rating region level; rates in the commercial (small-group) market vary at the state level for hospital payments and the public use microdata area level for other payments.
- ⁶ Because some HRRs cross state lines, Medicaid expansion status is defined as the share of 2019 hospital discharges that occurred in Medicaid expansion states.
- ⁷ “Herfindahl-Hirschman Index,” US Department of Justice, July 31, 2018, <https://www.justice.gov/atr/herfindahl-hirschman-index>.
- ⁸ For this analysis, we exclude two HRRs in Maryland whose price data are missing from the hospital data.
- ⁹ This question of how enrollees might choose their hospitals relates to whether providers receiving higher or lower reimbursement under the public option for the same medical care they deliver today will decide whether to participate. It also relates to how consumers might change providers if care is made more affordable through the public option. A significant limitation of the existing research is that we do not have data on which specific hospitals enrollees from nongroup and small-group market plans currently receive care, let alone further break-outs by race and ethnicity.
- ¹⁰ Estimates of commercial insurance provider payment rates are calculated from round 4 of the RAND Hospital Price Transparency Study.
- ¹¹ “Preference of For-Profit or Non-Profit Hospitals among US Adults as of 2017, by Ethnicity,” Statista, <https://www.statista.com/statistics/700256/hospitals-for-profit-or-non-profit-preference-among-americans-by-ethnicity/>.

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