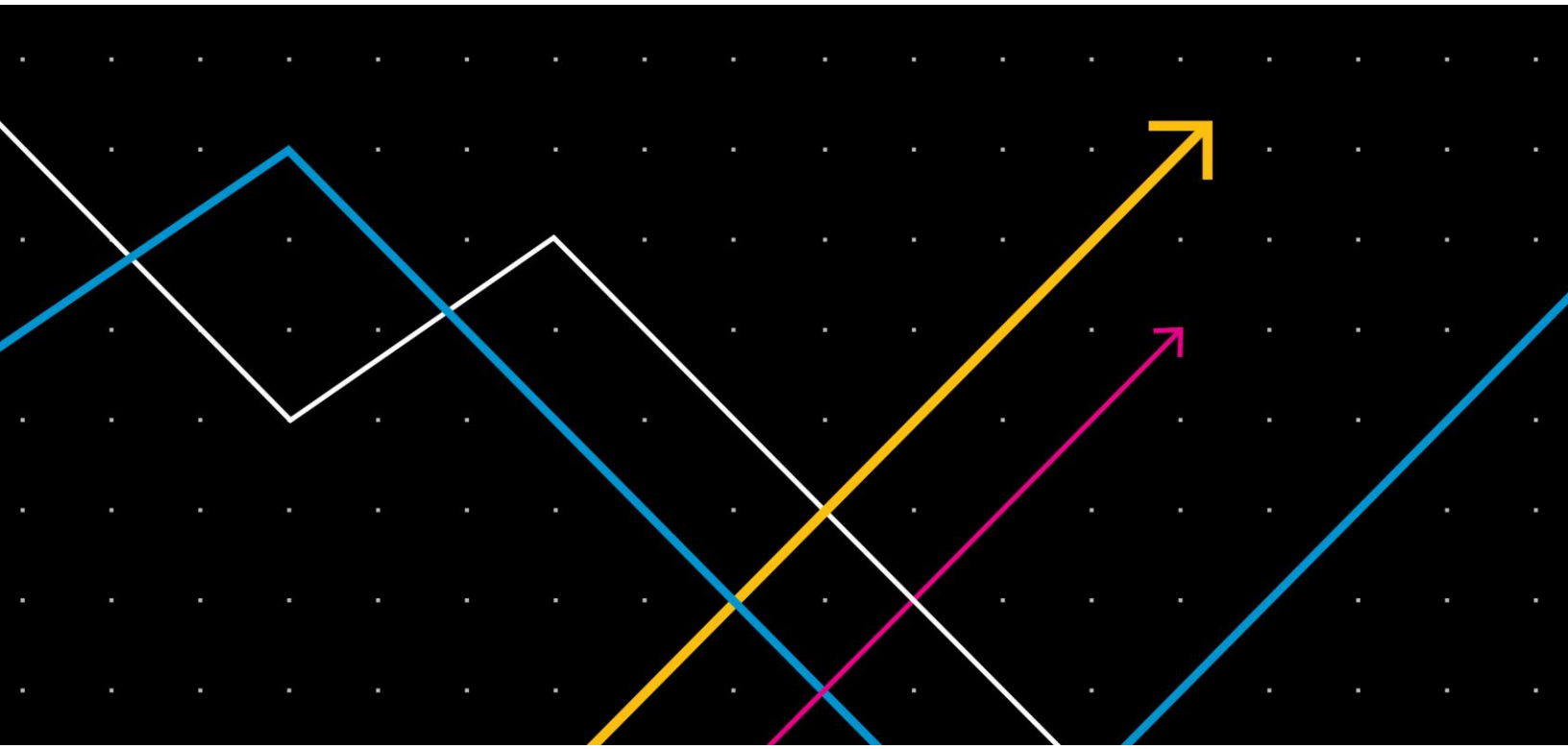

RESEARCH REPORT

Coverage and Cost Effects of Senators Merkley and Murphy's Choose Medicare Act

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Executive Summary

This paper examines the coverage and cost impacts of Senators Jeff Merkley and Chris Murphy's Choose Medicare Act. The Act's key feature is a public option plan that would be available in the nongroup, small group, and large group markets. The intent is to address the high premiums of plans in areas with concentrated insurance and hospital markets. The plan would begin with improvements in the nongroup market, including tying benchmark premiums to the gold metal tier rather than silver (80 percent actuarial value rather than 70 percent), enhancing Marketplace cost-sharing reductions, and providing a national reinsurance plan. The public option would be introduced in the nongroup and employer insurance markets and would have provider payment rates at or above Medicare rates, but below most commercial rates. In this analysis, we assume that provider payment rates would be set at Medicare plus 15 percent for physicians and other providers and Medicare plus 60 percent for hospitals. We also show the impact of setting provider payment rates at Medicare plus 10 percent for providers and Medicare plus 25 percent for hospitals.

We estimate the coverage and cost effects of the Choose Medicare Act provisions that affect the nonelderly population using the Urban Institute's Health Insurance Policy Simulation Model (HIPSM). When all provisions are included, we estimate that the number of uninsured falls by 3.6 million because insurance coverage is now more affordable. Household spending falls by $20.3 billion because of lower premiums and out-of-pocket spending through the public option. Marketplace premium tax credits are lower because of the reduction in premiums. The federal government saves $32.0 billion on premium tax credits and $20.8 billion overall. The savings on premium tax credits are offset somewhat by spending for the improved cost-sharing subsidies and reinsurance. Employer spending on premiums falls by $23.3 billion. Overall health spending falls by $68 billion, about 3 percent, approximately the reduction in payments to providers. When provider payment rates are set at lower levels (Medicare plus 10 percent for physicians and Medicare plus 25 percent for hospitals), overall savings are about 6 percent.

Over 10 years, households would save $241 billion because of lower premiums and out-of-pocket costs. The federal government would save $266 billion largely because of lower premium tax credits in the nongroup market. Employers would spend $284 billion less on premiums because of the availability of the lower-cost public option. Some employers would now offer the public option; for employers who keep their current coverage, some employees would enroll in subsidized Marketplace coverage because the firewall would be eliminated. We assume most of the savings would be passed back to workers

through higher wages, leading to tax payments on this increased income. Thus, the federal deficit would be reduced by about $388 billion over 10 years.

A public option would give employers and households more insurance choice as a new plan, likely with lower cost, and would be available alongside their current plans. However, a public option will be disruptive in many markets. There may be little effect in already competitive insurance markets, but in less competitive markets, the public option would introduce a new choice and could be opposed by insurers. Providers will also face lower payment rates, and there could be serious financial pressures in the markets with the greatest impacts. Reductions in payment rates will affect powerful providers, particularly hospitals in more concentrated markets, and could be strongly opposed.

Coverage and Cost Effects of Senators Merkley and Murphy's Choose Medicare Act

Introduction

In April 2021, Senators Jeff Merkley, Chris Murphy, and ten others introduced the Choose Medicare Act, a major initiative that would introduce a comprehensive public option plan called Medicare Part E offered in the nongroup, small group, and large group markets. Many insurer and hospital markets are concentrated, and this limited competition contributes to high health care costs (Holahan, Wengle, and O'Brien 2022; Scheffler, Arnold, and Fulton 2019). This proposed legislation aims to expand consumer choice, lower health care costs, and improve affordability by injecting competition in health insurance markets, allowing Medicare to negotiate prescription drug prices, and increasing the generosity of, and eligibility for, Marketplace subsidies.[1]

The legislation would change the benchmark premium levels for the premium tax credit (PTC) from silver to gold. It would extend premium subsidies to 600 percent of the federal poverty level (FPL),[2] increase the generosity of cost-sharing subsidies, and introduce a national reinsurance plan. Medicare Part E plans would be qualified health plans as defined by the Affordable Care Act (ACA), so they could be offered through the ACA Marketplace and qualify for the ACA's PTC and cost-sharing reductions (CSRs). All ACA essential health benefits and additional benefits covered by Medicare would be covered. Medicare Part E would provide gold-level coverage.

All legal residents would be eligible for Part E except those covered by Medicare, Medicaid, and the Children's Health Insurance Program. The public option plan would be available to all employers regardless of size and would be voluntary for the firms. Medicare Part E would be portable; individuals could retain the same Part E plan if they lose employer coverage in the small or large group market.[3] Premiums would be set by the Secretary of Health and Human Services and would differ depending on whether the plan is offered in the nongroup, small group, or large group market. Premiums would vary by rating region and be set to fully finance administrative costs and the cost of health benefits provided by the plans.

Provider payment rates would be set by the Secretary and would be no lower than current Medicare rates but not higher than the average rates paid by health insurers offering coverage through an exchange. Payment rates to providers in the Marketplace are generally higher than those paid by Medicare but lower than those paid by employer-sponsored insurance. Providers participating in Medicare would be required to participate in Medicare Part E, and additional providers could participate. Balance billing would be limited as it is in the current Medicare program.[4] Prescription drug prices would be negotiated.

A startup fund of $2 billion would go towards establishing the plan and developing an initial reserve fund, so building up reserves would not have to come from premiums. There would also be separate funding for navigators in the legislation. Another $30 billion would be appropriated to establish a reinsurance fund of $10 billion per year for three years that would be available in the nongroup market. Reinsurance lowers premiums by protecting insurers against the risk of high claim costs.

In this report, we first show the effects on coverage and spending of the Choose Medicare Act's provisions other than the public option, such as tying benchmark premiums to the gold metal tier, enhancing cost-sharing subsidies, and introducing a national reinsurance policy. We then show the effects of introducing the public option sequentially in the nongroup market, the small group market, and finally in the large group market, assuming the public option plan pays providers at Medicare rates plus 15 percent and hospitals at Medicare rates plus 60 percent (or at current rates, if higher). We then show the effects by the size of the impact on costs by geographic area. As a sensitivity test, we also show the effects of setting lower payment rates, at Medicare plus 10 percent for providers and Medicare plus 25 percent for hospitals. Rates this low are probably too aggressive to be politically feasible but may be more consistent with the bill language that provider rates be between Medicare and those of Marketplace plans. Finally, for both payment rate scenarios, we present projected health spending for the nonelderly population over 10 years (2024–2033), including the effects of population growth and medical inflation. All estimates assume reforms are fully implemented and in equilibrium by 2024.

Methods

We estimate the coverage and cost effects of the Choose Medicare Act provisions that affect the nonelderly population 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).[5] 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 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, 2022).

We compare the estimated coverage and spending effects of the Choose Medicare Act with a baseline that uses the enhanced PTCs available through 2025 under the Inflation Reduction Act; therefore, the Choose Medicare Act's provision to extend the PTC schedule to people with incomes up to 600 percent of the FPL has no additional effect relative to the baseline under the Inflation Reduction Act. We assume the Choose Medicare Act will keep subsidy eligibility for those above 600 percent of the FPL and in the 10-year estimates, assuming the enhanced PTCs are extended permanently.

We model CSRs that are federally funded and increase the actuarial value (AV) of a Marketplace plan above current law by the following:

- 3 percentage points (from 87 percent to 90 percent) for people with incomes between 150 percent and 200 percent of the FPL
- 12 percentage points (from 73 percent to 85 percent) for people with incomes between 200 percent and 250 percent of the FPL
- 15 percentage points (from 70 percent to 85 percent) for people with incomes between 250 percent and 300 percent of the FPL

Federal funding of CSRs under the Choose Medicare Act would also lower premiums by reversing the "silver loading" of nongroup premiums—a practice where insurers built the cost of CSRs into premiums in response to the Trump administration's 2017 decision to stop reimbursing insurers for CSRs (Aron-Dine 2019). Reinsurance also lowers premiums, so these two provisions would move premiums lower than under current law.

We model the public option part of the Choose Medicare Act by defining a new plan that pays lower professional and hospital payment rates than many private insurers' current commercial payment rates. These lower payment rates are expressed relative to Medicare's payment rates (i.e., "Medicare plus X percent"). The new plan also includes negotiated prescription drug prices. In all nongroup regions and firms we expect to offer the public option, we model this provision by setting prices for prescription drugs halfway between those paid by Medicare and Medicaid after rebates. Because premiums are set to cover the insurer's cost plus an administrative load, these reductions in provider payment rates reduce premiums and out-of-pocket health care spending for people with the public option below what they would have paid for similar coverage without the public option.

Medicare does not cover the nondisabled and nonelderly population, but the Choose Medicare Act specifies that payment rates should not be lower than Medicare rates and we specify rates as a multiple of Medicare rates. To bridge this gap, we model Medicare payment rates by assuming Medicare rates for people with nongroup insurance would equal payment rates if the region had a highly competitive insurance market and reasonably competitive hospital market (Blumberg et al. 2020). We rely on previous research to show that nongroup premiums in the most competitive regions are substantially lower than in less competitive regions, with considerable variation by regions and states (Holahan, Wengle, and O'Brien, 2023). Using estimated models from previous research, we set payments by provider type (hospitals or professionals, including physicians and other providers) relative to Medicare rates, according to the assumption for each reform and the share of spending for each service type within the region. Savings in the nongroup market apply to all enrollees under the public option. The model implicitly assumes all enrollees are affected by the public option because we assume the Marketplace benchmark premium would decrease by the percent difference between the public option and baseline premiums.

Our approach differs for people with employer-sponsored insurance because we can access summary data on commercial payment rates. We obtained estimates of the ratio of commercial insurer payment rates to Medicare rates from FAIR Health for specific procedures by region and provider type. We then used those ratios to set payments by provider type (hospitals or professionals, including physicians and other providers) relative to Medicare rates, again according to the assumption for each reform and the share of spending for each service type within the region to estimate costs for people with employer-based insurance entering the public option. For people with employer-sponsored insurance, only those in firms opting into the public option see savings. The methods used for nongroup and employer-sponsored markets can be found in Blumberg et al. 2020.

In our model, each firm decides to offer the public option or keep its current coverage—we don't allow firms to add the public option alongside their current plans. In this version of our model, we have expanded the number of factors that influence the firm's decision. The decision to offer coverage considers a firm's size, average wage, and the relative decrease in premiums compared with baseline. In this version of the model, we also incorporate a measure of the difference in the generosity of coverage firms currently offer. When all other factors are held constant, overall participation by firms in the public option is expected to be greater when the public option reimburses providers at lower rates, making coverage less expensive for the firm. Most employer-sponsored insurance has an AV around 80 percent, meaning on average, the plan pays about 80 percent of the cost of covered benefits, with the rest paid by employees through deductibles, co-pays, and other cost sharing. The model reflects our assumption that firms currently offering coverage with an AV near 90 percent would not participate, given that they have already chosen a higher-cost and higher-benefit plan.[6] Firms that offer less comprehensive coverage, with AV near 60 percent, are more likely to offer the option.

Each firm's choice to take up the public option also encompasses other factors of the reform. To proxy for a public option-like plan, we assume the public option attracts firms that now offer an existing HMO or PPO; we use data from 5 years (2017–2021) of the Kaiser Family Foundation Employer Health Benefits Survey to estimate the probability that a firm currently offers either an HMO or PPO plan, as opposed to offering only other types of plans like indemnity or EPO plans, then assign similar firms in HIPSM a higher probability of choosing the public option.[7] The model incorporates separate estimates for firms in the small and large group markets and includes the firm's industry, region, size, whether the firm has many low-wage workers, and the firm's current highest deductible. Considering this information and a multiplier that varies by the firm's current offering (by AV), HIPSM predicts whether a firm will offer the public option.

Because employers would not be required to offer the public option (Part E), but the bill states that all residents would be eligible to enroll, we drop the ACA's affordable offer test (the "firewall") for employees of firms that forgo the pubic option and keep their current health insurance plans.[8] In our modeling, workers in those firms and their families could participate in the public option through the ACA Marketplace and would be eligible for any subsidies available to families at their income levels. [9]

We exclude some provisions of the Choose Medicare Act from this analysis. The effect of capping out-of-pocket expenses at $6,700 for people enrolled in Medicare Parts A and B is outside the scope of these estimates since HIPSM only covers the nonelderly and nondisabled. We do not model the provision that would apply the ACA's community rating rules to the large group market, which could significantly impact the health care system. If we had included this provision, firms' choices to

participate in the public option would likely differ from those modeled here, and the net changes in coverage or spending could be greater or smaller than those shown. We exclude the provisions of start-up funds that 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). Finally, we exclude the provision to limit balance billing as it is limited in the current Medicare program. Since the Choose Medicare Act was introduced, balance billing has been limited by provisions in titles I and II of the Consolidated Appropriations Act of 2021, enacted on December 27, 2020. We assume no additional effect on balance billing under the Act plan.

We do not assume the public option would pay premium taxes because they are state taxes; thus, modeling them would be burdensome. Consequently, premiums for the public option could be modestly understated.

Results

Base Provisions

Modeling the Choose Medicare Act begins with showing the effects of the base reforms other than the public option, which include tying benchmark premiums to the gold category, enhancing federal funding for cost-sharing subsidies, and introducing a national reinsurance policy. In effect, this set of policies lowers premiums, provides richer benefits, and, as a result, reduces the number of uninsured by 841,000 as shown in Table 1.[10] Of the 1.4 million increase in nongroup coverage, 827,000 now receive subsidies, and another 535,000 purchase unsubsidized nongroup coverage. We also estimate that about 558,000 people leave employer coverage because of the increased attractiveness of nongroup insurance.

Table 1 also shows the impact of the base provisions on spending by households, government, and employers. Households experience a total reduction of $2.8 billion in spending because of lower premiums and other health care spending. Overall, federal government spending increases by $13.8 billion largely because the federal government spends more on reinsurance and now funds CSRs. Government spending for Marketplace premium tax credits also increases on net, as the greater number of new beneficiaries outweighs the effect of lower premiums. Employer spending falls by $3.3 billion largely because the number of people taking up employer coverage is lower.

TABLE 1

Effect of the Choose Medicare Act's Nonpublic Option Provisions on Coverage and Health Spending for the Nonelderly, 2024

	IRA Subsidies	Reform Provisions Other than Public Option	Change	Percent Change
		Thousands of people		
Insured (MEC)	252,696	253,537	841	0.3%
Employer	149,854	149,297	-558	-0.4%
Private nongroup	21,070	22,432	1,362	6.5%
Subsidized nongroup	16,336	17,163	827	5.1%
Full-pay nongroup	4,734	5,269	535	11.3%
Medicaid/CHIP	73,060	73,097	37	0.1%
Other public	8,711	8,711	0	0.0%
Uninsured (No MEC)	26,722	25,882	-841	-3.1%
Total	279,418	279,418	0	0.0%
		Billions of dollars		
Household				
Premiums	325.1	323.9	-1.3	-0.4%
Other health care spending	307.6	306.1	-1.6	-0.5%
Subtotal, household	632.8	629.9	-2.8	-0.4%
Federal government				
Medicaid	416.3	416.4	0.1	0.0%
Marketplace PTC	101.6	102.8	1.2	1.2%
Marketplace CSR	0.0	5.4	5.4	n.a.
Reinsurance	2.3	10.0	7.7	335.5%
Uncompensated care	27.6	27.0	-0.7	-2.4%
Subtotal, federal government	547.8	561.6	13.8	2.5%
State government	246.3	245.9	-0.4	-0.2%
Employers				
Premium contributions	876.4	873.1	-3.3	-0.4%
Providers				
Uncompensated care	22.2	21.0	-1.2	-5.4%
Total, all payers	2,325.5	2,331.6	6.1	0.3%

Source: Health Insurance Policy Simulation Model (HIPSM), 2023. Reform simulated in 2024.

Notes: IRA = Inflation Reduction Act of 2022; PTC = Premium Tax Credit; MEC = minimum essential coverage; CSR = cost-sharing reductions; CHIP = Children's Health Insurance Program. Reform provisions other than the public option include a $10 billion reinsurance plan, enhanced CSRs, gold ACA benchmark, and federal funding of CSRs.

Introducing the Public Option in the Nongroup Market

Table 2 shows that on net, the overall number of uninsured declines by 482,000 in response to lower premiums resulting from introducing the public option into the nongroup market. All individuals purchasing nongroup coverage are treated as affected by the public option (although not all would enroll in it) because competition from the public option will lower the premium tax credit benchmark and will force currently higher-priced competing insurance plans to lower their premiums as well. Surprisingly, subsidized coverage falls by 1.6 million because more people are no longer eligible for subsidies because premiums are lower, i.e., they no longer exceed 9.1 percent of income. There is an increase of 1.9 million in the full-pay nongroup market, comprising people keeping nongroup coverage but no longer eligible for subsidies and new enrollees (because the public option makes this coverage more attractive to those previously uninsured). Employer coverage increases by 91,000 because some people who lose subsidies choose to take up employer offers. This offsets the number leaving employer coverage to enter the Marketplace to obtain subsidies.

TABLE 2

Effect of the Choose Medicare Act's Nongroup Market Public Option Provisions on Coverage and Health Spending for the Nonelderly, 2024

	Reform Provisions Other than Public Option	Public Option in the Nongroup Market	Change	Percent Change
		Thousands of people		
Insured (MEC)	253,537	254,019	482	0.2%
Employer	149,297	149,387	91	0.1%
Private nongroup	22,432	22,724	292	1.3%
Subsidized nongroup	17,163	15,598	-1,566	-9.1%
Full-pay nongroup	5,269	7,127	1,858	35.3%
Medicaid/CHIP	73,097	73,196	99	0.1%
Other public	8,711	8,711	0	0.0%
Uninsured (No MEC)	25,882	25,400	-482	-1.9%
Total	279,418	279,418	0	0.0%
		Billions of dollars		
Household				
Premiums	323.9	321.8	-2.1	-0.6%
Other health care spending	306.1	302.3	-3.7	-1.2%
Subtotal, household	629.9	624.1	-5.8	-0.9%
Federal government				
Medicaid	416.4	416.9	0.5	0.1%
Marketplace PTC	102.8	68.7	-34.1	-33.2%
Marketplace CSR	5.4	4.4	-1.0	n.a.
Reinsurance	10.0	10.0	0.0	0.0%
Uncompensated care	27.0	27.2	0.2	0.9%
Subtotal, federal government	561.6	527.3	-34.4	-6.1%
State government	245.9	246.0	0.1	0.1%
Employers				
Premium contributions	873.1	874.0	0.8	0.1%
Providers				
Uncompensated care	21.0	21.4	0.4	2.0%
Total, all payers	2,331.6	2,292.8	-38.8	-1.7%

Source: Health Insurance Policy Simulation Model (HIPSM), 2023. Reform simulated in 2024.

Notes: PTC = Premium Tax Credit; MEC = minimum essential coverage; CSR = cost-sharing reductions; CHIP = Children's Health Insurance Program. Reform provisions other than the public option include a $10 billion reinsurance plan, enhanced CSRs, gold ACA benchmark, and federal funding of CSRs.

When the public option is introduced into the nongroup market, premiums fall for Marketplace coverage largely because of lower payments to providers. Nationwide premiums fall by about 25 percent. As a result, household spending falls by $5.8 billion from the reduction in premiums and other healthcare spending. Marketplace premium tax credits fall by $34.1 billion. Overall federal spending

declines by $34.4 billion. Because of the small increase in employer coverage, employer spending on premiums increases by $0.8 billion.

Introducing the Public Option in the Small Group Market

Extending the public option to the small group market increases employer coverage by 1.4 million because the public option is attractive to small employers who face higher premiums than large employers in the current market (table 3). The increase in employers offering the public option results in some switching from subsidized and full-pay nongroup coverage. Private nongroup coverage decreases by 415,000 in total, a decline of 53,000 in the number receiving subsidies and 362,000 in the full-pay nongroup market. This reflects the increased attractiveness of employer offers once the public option is introduced. The decline in private nongroup coverage offsets some of the increases in employer coverage, resulting in a reduction in the number of uninsured of 838,000.

TABLE 3

Effect of the Choose Medicare Act's Small Group Market Public Option Provisions on Coverage and Health Spending for the Nonelderly, 2024

	Public Option in the Nongroup Market	Public Option in the Nongroup and Small Group Markets	Change	Percent Change
		Thousands of people		
Insured (MEC)	254,019	254,856	838	0.3%
Employer	149,387	150,755	1,367	0.9%
Private nongroup	22,724	22,309	-415	-1.8%
Subsidized nongroup	15,598	15,545	-53	-0.3%
Full-pay nongroup	7,127	6,765	-362	-5.1%
Medicaid/CHIP	73,196	73,081	-114	-0.2%
Other public	8,711	8,711	0	0.0%
Uninsured (No MEC)	25,400	24,562	-838	-3.3%
Total	279,418	279,418	0	0.0%
		Billions of dollars		
Household				
Premiums	321.8	319.6	-2.2	-0.7%
Other health care spending	302.3	301.0	-1.3	-0.4%
Subtotal, household	624.1	620.7	-3.5	-0.6%
Federal government				
Medicaid	416.9	416.4	-0.5	-0.1%
Marketplace PTC	68.7	66.7	-2.0	-2.9%
Marketplace CSR	4.4	4.3	-0.1	n.a.
Reinsurance	10.0	10.0	0.0	0.0%
Uncompensated care	27.2	26.9	-0.3	-1.2%
Subtotal, federal government	527.3	524.4	-2.9	-0.5%
State government	246.0	245.7	-0.3	-0.1%
Employers				
Premium contributions	874.0	873.5	-0.5	-0.1%
Providers				
Uncompensated care	21.4	20.8	-0.6	-2.7%
Total, all payers	2,292.8	2,285.1	-7.7	-0.3%

Source: Health Insurance Policy Simulation Model (HIPSM), 2023. Reform simulated in 2024.

Notes: IRA = Inflation Reduction Act of 2022; PTC = Premium Tax Credit; MEC = minimum essential coverage; CSR = cost-sharing reductions; CHIP = Children's Health Insurance Program.

When the public option is introduced in the small group market, household spending declines by another $3.5 billion because premiums and other health care spending fall. This results from the lower premiums in the public option now available to small employers and lower out-of-pocket spending for enrollees moving into plans with higher AV. Marketplace premium tax credits fall by $2.0 billion because fewer people receive subsidized coverage. Employer spending falls by $0.5 billion. There are

more people now covered by employers, but employers are now saving on all workers that either take up employer coverage in the public option or enter the nongroup market.

Introducing the Public Option in the Large Group Market

Finally, extending the public option to the large group market increases coverage by an additional 1.4 million on net (table 4). There is a small increase of 135,000 in employer coverage as people in firms choosing the public option find the more affordable coverage attractive. But most employers continue to offer their existing plans. This means that workers in these firms no longer face the firewall and can enter the nongroup market and receive PTCs if entitled. As a result, subsidized nongroup coverage increases by 1.5 million people, almost all of whom (1.4 million) gained eligibility for PTCs because their firms did not choose the public option. Without the public option, around 5 percent would have had employer coverage, while less than half would have been uninsured, and a little less than half would have purchased nongroup coverage without subsidies.

TABLE 4

Effect of the Choose Medicare Act's Large Group Market Public Option Provisions on Coverage and Health Spending for the Nonelderly, 2024

	Public Option in the Nongroup and Small Group Markets	Public Option in the Nongroup, Small, and Large Group Markets	Change	Percent Change
		Thousands of people		
Insured (MEC)	254,856	256,282	1,425	0.6%
Employer	150,755	150,890	135	0.1%
Private nongroup	22,309	23,490	1,181	5.3%
Subsidized nongroup	15,545	17,044	*1,500*	9.6%
Full-pay nongroup	6,765	6,446	*-319*	-4.7%
Medicaid/CHIP	73,081	73,191	109	0.1%
Other public	8,711	8,711	0	0.0%
Uninsured (no MEC)	24,562	23,137	-1,425	-5.8%
Total	279,418	279,418	0	0.0%
		Billions of dollars		
Household				
Premiums	319.6	311.9	-7.8	-2.4%
Other health care spending	301.0	300.6	-0.4	-0.1%
Subtotal, household	620.7	612.5	-8.2	-1.3%
Federal government				
Medicaid	416.4	416.8	0.4	0.1%
Marketplace PTC	66.7	69.6	2.9	4.4%
Marketplace CSR	4.3	4.5	0.1	n.a.
Reinsurance	10.0	10.0	0.0	0.0%
Uncompensated care	26.9	26.1	-0.8	-2.9%
Subtotal, federal government	524.4	527.0	2.6	0.5%
State government	245.7	245.4	-0.3	-0.1%
Employers				
Premium contributions	873.5	853.1	-20.4	-2.3%
Providers				
Uncompensated care	20.8	19.4	-1.4	-6.6%
Total, all payers	2,285.1	2,257.4	-27.6	-1.2%

Source: Health Insurance Policy Simulation Model (HIPSM), 2023. Reform simulated in 2024.

Notes: PTC = Premium Tax Credit; MEC = minimum essential coverage; CSR = cost-sharing reductions; CHIP = Children's Health Insurance Program.

Overall, extending the availability of a public option in the large group market reduces spending by all payers by $27.6 billion. Household spending declines by $8.2 billion because of lower-cost coverage now available through employers and in the Marketplace through the public option. Marketplace premium tax credits increase by $2.9 billion because of the increased enrollment, largely because of the elimination of the firewall for people employed in firms not choosing the public option. Overall federal

government spending increases by $2.6 billion. The largest effect is on employers who see a reduction of $20.4 billion in premium contributions because of lower premium coverage available through the public option and because so many leave employer-sponsored insurance to enter the Marketplace and receive subsidies. This effect, however, differs from savings to households or the government. As employers spend less on premiums, economic research indicates they eventually convert the savings into higher wages for their workers.

Overall Impact of the Choose Medicare Act

The Choose Medicare Act would increase coverage by 3.6 million relative to the baseline (table 5). Employer coverage increases by 1.0 million as more employers offer coverage and more employees take up the lower cost and, in some cases, more generous health insurance offers under the public option. This increase offsets the number of individuals leaving employer coverage to enter the Marketplace (from firms that do not offer the public option) where they are eligible for subsidies. The number receiving subsidized nongroup coverage increases by 708,000. Some people lose subsidies for coverage because the lower premiums mean they are no longer eligible because premiums no longer exceed 9.1 percent of income. Most of these individuals, however, continue to purchase nongroup coverage (most had small subsidies before the reform) and others, including many of the uninsured, now purchase full-pay nongroup coverage, which increases by 1.7 million. Thus, the overall effect of this policy package is to increase employer and nongroup coverage and reduce the number of uninsured by 3.6 million.

TABLE 5

Effect of the Choose Medicare Act on Coverage and Health Spending for the Nonelderly, 2024

	IRA Subsidies	Choose Medicare Act	Change	Percent Change
		Thousands of people		
Insured (MEC)	252,696	256,282	3,585	1.4%
Employer	149,854	150,890	1,035	0.7%
Private nongroup	21,070	23,490	2,420	11.5%
Subsidized nongroup	16,336	17,044	708	4.3%
Full-pay nongroup	4,734	6,446	1,712	36.2%
Medicaid/CHIP	73,060	73,191	130	0.2%
Other public	8,711	8,711	0	0.0%
Uninsured (no MEC)	26,722	23,137	-3,585	-13.4%
Total	279,418	279,418	0	0.0%
		Billions of dollars		
Household				
Premiums	325.1	311.9	-13.3	-4.1%
Other health care spending	307.6	300.6	-7.0	-2.3%
Subtotal, household	632.8	612.5	-20.3	-3.2%
Federal government				
Medicaid	416.3	416.8	0.5	0.1%
Marketplace PTC	101.6	69.6	-32.0	-31.5%
Marketplace CSR	0.0	4.5	4.5	n.a.
Reinsurance	2.3	10.0	7.7	335.5%
Uncompensated care	27.6	26.1	-1.5	-5.6%
Subtotal, federal government	547.8	527.0	-20.8	-3.8%
State government	246.3	245.4	-0.9	-0.4%
Employers				
Premium contributions	876.4	853.1	-23.3	-2.7%
Providers				
Uncompensated care	22.2	19.4	-2.7	-12.3%
Total, all payers	2,325.5	2,257.4	-68.0	-2.9%

Source: Health Insurance Policy Simulation Model (HIPSM), 2023. Reform simulated in 2024.
Notes: IRA = Inflation Reduction Act of 2022; PTC = Premium Tax Credit; MEC = minimum essential coverage; CSR = cost-sharing reductions; CHIP = Children's Health Insurance Program.

The result of all Choose Medicare Act plan provisions is to reduce household spending by $20.3 billion because of lower premiums available through the public option. Marketplace premium tax credits are lower because of the reduction in premiums. Overall, the federal government saves $32.0 billion on premium tax credits and $20.8 billion overall (overall reductions in federal spending are lower than the reduced costs of premium tax credits because of the increased costs of improved cost-sharing subsidies and reinsurance). Employer spending on premiums falls by $23.3 billion. Overall health spending will fall by $68 billion in 2024, despite the increase of 3.6 million people covered by health insurance. The $68 billion, about 3 percent, is approximately the reduction in payments to providers.

Geographic Quartiles of Impact

Because the ratios of commercial-to-Medicare payment rates vary across geographic areas, as do the types of coverage people have with and without reform, the impacts of a reform with a public option policy should also vary. We use Public Use Microdata Areas (PUMAs) to divide the country into areas with the greatest, second greatest, third greatest, and smallest impact under the Choose Medicare Act. The impact is measured as the percent change in average per-person health spending within each PUMA, limited to people covered by Medicaid, nongroup including short-term limited-duration, or employer-sponsored insurance.

Areas with low nongroup premiums, which tend to have competitive nongroup insurance markets, see a smaller impact from the public option. Those with the greatest impacts have the largest reductions in spending for employer, nongroup, and Medicaid coverage, reflecting underlying provider payment differences and differences in coverage without reform. PUMAs in states that have not expanded Medicaid to low-income adults under the ACA tend to have a high impact under reform. Without expansion, relatively more people are in the nongroup and employer markets, and thus more are subject to payment cuts. Table 6 shows the states distributed by the level of impact aggregated across PUMAs within the state; all 10 nonexpansion states are in the top half of states ranked by impact.

TABLE 6

Average Impact of Choose Medicare Act by State

Greater than 5.0%	5.0%–3.5%	3.5%–2.5%	Less than 2.5%
Wyoming*	Delaware	Oregon	Ohio
Florida*	Nevada	Iowa	Montana
South Carolina*	New Mexico	Vermont	Maine
Alaska	Oklahoma	Virginia	Michigan
Mississippi*	North Carolina	Washington	Massachusetts
Texas*	North Dakota	Connecticut	New Jersey
Alabama*	Kansas*	California	Rhode Island
Georgia*	South Dakota	Idaho	Maryland
Nebraska	Louisiana	Minnesota	District of Columbia
Tennessee*	Arizona	Hawaii	New York
	Wisconsin*	New Hampshire	
	West Virginia	Pennsylvania	
	Utah	Indiana	
	Illinois	Kentucky	
	Colorado	Arkansas	
	Missouri		

Source: Health Insurance Policy Simulation Model (HIPSM), 2023. Reform simulated in 2024.
Notes: * = States that have not expanded Medicaid. Impact is the change under the Choose Medicare Act in average per-person health spending for nonelderly people covered by Medicaid, nongroup including short-term limited-duration, or employer-sponsored insurance and is calculated by Public Use Microdata Areas.

Table 7 shows changes in coverage and health spending by quartile of impact. The highest impact quartile shows the largest increases in coverage because there is the greatest change in coverage affordability. The areas with the greatest impacts have the largest increases in employer coverage because these areas have the largest takeup of the public option by firms and because some people previously eligible for nongroup subsidies no longer are (because the benchmark premium has fallen). The full-pay nongroup market also increases more than in other areas because premiums for nongroup coverage have fallen the most and some people previously eligible for PTCs no longer are. The number of uninsured in the largest impact quartile falls by 1.6 million, which accounts for nearly half of the total decline in the uninsured (3.6 million) under the Choose Medicare Act. As we look across lower-impact areas, the increases in employer and nongroup coverage fall off, while subsidized nongroup coverage increases because of the greater likelihood of employers maintaining their own coverage and not offering a public option, which encourages workers to go into the Marketplace and seek subsidized coverage. The number of uninsured also falls by less in each of these lower-impact areas.

TABLE 7

Change from IRA Subsidies in Coverage and Health Spending for the Nonelderly by Quartile of Policy Impact Under Provisions of the Choose Medicare Act, 2024

	Change under Choose Medicare Act				
	Total	Greatest impact	2nd greatest impact	3rd greatest impact	Smallest impact
	Thousands of people				
Insured (MEC)	3,585	1,563	940	667	416
Employer	1,035	493	235	137	171
Private nongroup	2,420	1,033	674	502	211
Subsidized nongroup	708	-76	243	347	194
Full-pay nongroup	1,712	1,109	431	155	18
Medicaid/CHIP	130	37	31	29	34
Other public	0	0	0	0	0
Uninsured (no MEC)	-3,585	-1,563	-940	-667	-416
	Billions of dollars				
Household					
Premiums	-13.3	-2.4	-4.0	-4.0	-2.9
Other health care spending	-7.0	-4.1	-2.3	-1.2	0.5
Subtotal, household	-20.3	-6.5	-6.2	-5.2	-2.4
Federal government					
Medicaid	0.5	0.1	0.1	0.1	0.1
Marketplace PTC	-32.0	-19.9	-7.1	-3.5	-1.5
Marketplace CSR	4.5	1.7	0.9	0.7	1.1
Reinsurance	7.7	2.5	2.0	1.9	1.4
Uncompensated care	-1.5	-0.6	-0.4	-0.3	-0.2
Subtotal, federal government	-20.8	-16.2	-4.6	-1.0	0.9
State government	-0.9	-0.4	-0.3	-0.2	-0.1
Employers					
Premium contributions	-23.3	-5.4	-7.1	-6.7	-4.2
Providers					
Uncompensated care	-2.7	-1.1	-0.7	-0.5	-0.4
Total, all payers	-68.0	-29.6	-18.8	-13.6	-6.1

Source: Health Insurance Policy Simulation Model (HIPSM), 2023. Reform simulated in 2024.
Notes: IRA = Inflation Reduction Act of 2022; PTC = Premium Tax Credit; MEC = minimum essential coverage; CSR = cost-sharing reductions; CHIP = Children's Health Insurance Program. Impact is the change under Choose Medicare in average per-person health spending for nonelderly people covered by Medicaid, nongroup including short-term limited-duration, or employer-sponsored insurance and is calculated by Public Use Microdata Areas.

The lower panel of Table 7 shows the changes in spending. Most of the drop in federal government spending occurs in the greatest impact area. Federal government spending is most affected by what happens in the nongroup market because of the impact on PTCs. More than half of the drop in Marketplace premium tax credits and $16.2 billion out of the $20.8 billion reduction in overall federal government spending occur in the greatest half of impact areas. There is much less variability in the

reductions in total employer premium contributions across the four areas, as the areas with the largest percentage decrease in premiums have the greatest increases in coverage. The same is generally true for household spending, though the decline in household spending does fall off in the smallest impact area. Overall, this amounts to a reduction of 5.3 percent in spending relative to the baseline in the greatest impact areas; spending falls by 3.2 percent in the second greatest impact areas, 2.3 percent in the third greatest impact areas, and 1.0 percent in the smallest impact areas (data not shown).

Effects of Further Reducing Provider and Hospital Payment Rates

As an alternative assumption, we examine a public option plan that pays Medicare rates plus 10 percent for physicians and other providers and 25 percent for hospitals, instead of Medicare rates plus 15 percent for physicians and 60 percent for hospitals. This results in a substantial reduction in public option plan premiums and more savings to various payers and the health care system at the expense of a more significant cut to providers. Thus, there is likely to be even more political opposition.

Table 8 compares the two policies. In the lower rate policy, employer coverage increases because it becomes even more attractive for employers to offer public option coverage and for workers to take up those offers. Employer coverage increases by 179,000 more than with the higher rate policy. Private nongroup coverage would be lower because more employers offer the public option, so the elimination of the firewall in firms that don't offer the public option affects fewer people and fewer people are newly eligible for subsidized Marketplace coverage. As a result, subsidized coverage is lower by 538,000 under the larger cuts. Coverage in the full-pay market increases by 134,000 because premiums are even lower. Because employer coverage does not increase as much as nongroup coverage declines, the increase in coverage is smaller with the policy of lower payment rates. The number of uninsured is 249,000 higher than in the policy with higher payment rates.

TABLE 8

Change from IRA Subsidies in Coverage and Health Spending for the Nonelderly under the Choose Medicare Act with Lower Provider Payments, 2024

	Payment Rates at Medicare Rates Plus 15% for Providers and Plus 60% for Hospitals		Payment Rates at Medicare Rates Plus 10% for Providers and Plus 25% for Hospitals		Change Because of Lower Payment Rates	
	Change	Percent change	Change	Percent change	Change	Percentage point change
			Thousands of people			
Insured (MEC)	3,585	1.4%	3,337	1.3%	-249	-0.1%
Employer	1,035	0.7%	1,215	0.8%	179	0.1%
Private nongroup	2,420	11.5%	2,016	9.6%	-404	-1.9%
Subsidized nongroup	708	4.3%	170	1.0%	-538	-3.3%
Full-pay nongroup	1,712	36.2%	1,846	39.0%	134	2.8%
Medicaid/CHIP	130	0.2%	106	0.1%	-24	0.0%
Other public	0	0.0%	0	0.0%	0	0.0%
Uninsured (no MEC)	-3,585	-13.4%	-3,337	-12.5%	249	0.9%
			Billions of dollars			
Household						
Premiums	-13.3	-4.1%	-24.0	-7.4%	-10.8	-3.3%
Other health care spending	-7.0	-2.3%	-19.4	-6.3%	-12.4	-4.0%
Subtotal, household	-20.3	-3.2%	-43.4	-6.9%	-23.2	-3.7%
Federal government						
Medicaid	0.5	0.1%	0.4	0.1%	-0.1	0.0%
Marketplace PTC	-32.0	-31.5%	-33.5	-33.0%	-1.6	-1.5%
Marketplace CSR	4.5	n.a.	4.4	n.a.	-0.1	n.a.
Reinsurance	7.7	335.5%	7.7	335.5%	0.0	0.0%
Uncompensated care	-1.5	-5.6%	-1.4	-5.1%	0.1	0.5%
Subtotal, federal government	-20.8	-3.8%	-22.4	-4.1%	-1.6	-0.3%
State government	-0.9	-0.4%	-0.9	-0.4%	0.0	0.0%
Employers						
Premium contributions	-23.3	-2.7%	-60.1	-6.9%	-36.8	-4.2%
Providers						
Uncompensated care	-2.7	-12.3%	-2.5	-11.2%	0.2	1.1%
Total, all payers	-68.0	-2.9%	-129.3	-5.6%	-61.2	-2.6%

Source: Health Insurance Policy Simulation Model (HIPSM), 2023. Reform simulated in 2024.

Notes: IRA = Inflation Reduction Act of 2022; PTC = Premium Tax Credit; MEC = minimum essential coverage; CSR = cost-sharing reductions; CHIP = Children's Health Insurance Program.

Table 8 also shows changes in spending. Savings to households increased by $23.2 billion because of the lower premiums. Marketplace premium tax credits fall by more because premiums are lower. This offsets the fact that fewer people receive premium tax credits. Because of lower premium tax credits, federal spending declines relative to the previous policy by $1.6 billion. Employer savings increased considerably because of lower premiums which more than offsets the increase in employer coverage. Compared to the baseline, employers' spending on premiums falls by $60.1 billion under this policy. Overall spending by all payers falls by $129.3 billion, an increase of $61.2 billion relative to the previous policy. Spending by all payers follows by 5.6 percent; this is approximately the reduction in savings to providers.

Ten-Year Estimates

Table 9 provides 10-year estimates from 2024 to 2033 for the higher payment rate (15/60, in which the public option pays Medicare rates plus 15 percent to providers and Medicare rates plus 60 percent to hospitals) and lower payment (10/25), in which the payment rates are Medicare plus 10 percent for providers and Medicare rates plus 25 percent for hospitals) scenarios. Under the higher payment scenario, households would save $241 billion because of lower premiums and lower out-of-pocket costs, the federal government would save $266 billion largely because of lower premium tax credits, and employers would spend $284 billion less on health care because of the availability of the lower cost public option and because some employees would drop employer coverage and enroll in subsidized Marketplace coverage because of the elimination of the firewall. We assume that employer savings on premiums will eventually be passed back to workers through higher wages and that workers will pay more taxes on this increased income. Thus, the impact on the federal deficit is greater than the federal government savings mentioned above.

TABLE 9

Health Spending for the Nonelderly Under Provisions of the Choose Medicare Act, by Payer, 2024, and Over 10 Years

Billions of Dollars

Baseline, IRA Subsidies Extended

	2024	2024–2033
Households	632.8	7,468
Federal Government	547.8	6,769
State Government	246.3	3,037
Employers	876.4	10,683
Providers	22.2	260
Total, All Payers	**2,325.5**	**28,217**

Reform, Choose Medicare Act

	2024		2024–2033	
	15/60	10/25	15/60	10/25
Households	612.5	589.3	7,227	6,954
Federal Government	527.0	525.4	6,504	6,484
State Government	245.4	245.4	3,027	3,027
Employers	853.1	816.3	10,399	9,951
Providers	19.4	19.7	228	231
Total, All Payers	2,257.4	2,196.2	27,385	26,647

Changes from Extended IRA

	2024		2024–2033	
	15/60	10/25	15/60	10/25
Households	-20.3	-43.4	-241	-514
Federal Government	-20.8	-22.4	-266	-285
State Government	-0.9	-0.9	-10	-10
Employers	-23.3	-60.1	-284	-732
Providers	-2.7	-2.5	-32	-29
Total, All Payers	-68.0	-129.3	-833	-1,570
Revenue increase	10.1	28.5	123	347
Federal deficit impact	-30.8	-50.9	-388	-632

Percent Changes from Extended IRA

	2024		2024–2033	
	15/60	10/25	15/60	10/25
Households	-3.2%	-6.9%	-3.2%	-6.9%
Federal Government	-3.8%	-4.1%	-3.9%	-4.2%
State Government	-0.4%	-0.4%	-0.3%	-0.3%
Employers	-2.7%	-6.9%	-2.7%	-6.9%
Providers	-12.3%	-11.2%	-12.3%	-11.2%
Total, All Payers	-2.9%	-5.6%	-3.0%	-5.6%

Source: Health Insurance Policy Simulation Model (HIPSM), 2023. Reform simulated 2024.

Notes: IRA = Inflation Reduction Act of 2022; "Extended IRA" assumes PTC subsidies under the IRA are extended to 2026–2033. "15/60" means the public option pays Medicare rates plus 15 percent to providers and Medicare rates plus 60 percent to hospitals; "10/25" means the public option pays Medicare rates plus 10 percent to providers and Medicare rates plus 25 percent to hospitals.

Over the same period, with lower payment rates (10/25), households would save $514 billion, more than twice the amount relative to the higher payment scenario, because of even lower premiums and out-of-pocket costs. The federal government would save $285 billion because of lower premium tax credits, which is comparable to the amount of federal savings under the other scenario. Employers would save around 2.6 times as much on premiums under this scenario ($732 billion) because payments to providers be much lower than in the higher payment rate scenario.

Overall spending in the health system under the lower payment rate scenario would fall by $1.6 trillion compared with a decline of $833 billion in the higher payment rate scenario. In addition, the overall federal deficit would fall by $388 billion and $632 billion in the higher and lower payment rate scenarios, respectively.

Discussion

The bottom-line result is that introducing a public option into the nongroup, small group, and large group markets would substantially affect coverage and spending. With all markets included, the number of uninsured falls by 3.6 million. We also estimate lower health care spending for households, employers, and the federal government and lower overall spending, despite richer benefits in the public option. At the same time, we estimate reductions of 3 percent in payments to providers. Thus, much is achieved for a relatively small reduction in provider payments.

Employers face new choices. They can retain current coverage; in this case, the firewall facing their workers is lifted, and they can enter the Marketplace and have access to subsidies, either in the public option or another plan. If they choose to offer coverage in the public option, many people will take up these offers because they are now lower cost than existing coverage. More firms also would offer coverage because the cost of offering insurance has been reduced. Employers also can continue to not offer coverage.

Households also have new choices. They save substantially if their employer continues offering their existing plan because they can leave it and obtain subsidized coverage in the Marketplace. Or they benefit if their employer offers a lower-cost public option.

Federal government costs are lower because premiums are lower, thus affecting premium tax credits. Government savings are the largest from the public option in the nongroup market. These savings are somewhat offset because of the richer benefits package offered through the plan. The

federal government does not save much from making the public option available in the small and large group markets, but employers and households see benefits.

We estimate that savings to households will amount to $241 billion over 10 years. Employers will see savings of $284 billion and the federal government $266 billion over the same period. Overall savings are about $833 billion, or 3 percent, approximating the reductions in provider payments. Savings would be greater if the public option plan was more aggressive in setting payment rates, but the lower rates would engender even greater political opposition.

The public option would give employers and households more insurance choices. However, a public option will be disruptive in many markets. Most insurers would end up with less market share. There may be little effect in already competitive insurance markets because premiums are already low; the public option is just one more choice. In less competitive markets, the public option would introduce a new choice and might be opposed by insurers.

Providers will face lower payment rates. There could be serious financial pressures in the markets with the greatest impacts, particularly on rural hospitals. Reductions in payment rates will affect powerful providers, particularly hospitals in more concentrated markets, and could be strongly opposed. But failure to address the issues that come from concentration means accepting higher health care costs resulting from monopoly or oligarchy market power.

Capping rates paid by all insurers, as in Medicare Advantage, is an alternative to a public option. Capping provider payment rates would have less effect on insurers because all would benefit from being able to pay providers at lower rates. Capped rates would have a bigger effect on providers because they would see payment reductions from all insurers.

Notes

[1] US Congress, Senate, Choose Medicare Act, S.1180, 117th Cong., 1st sess., introduced in Senate April 15, 2021, https://www.congress.gov/bill/117th-congress/senate-bill/1180/text.

[2] Since the bill was introduced, the Inflation Reduction Act has extended premium tax subsidies for ACA Marketplace coverage to all income levels (although many people with higher incomes are not eligible for subsidies because the benchmark plan in their area costs less than 9.1 percent of income), so the extension to 600 percent of FPL has no additional effect in 2024. We do not assume the bill would limit already existing subsidy eligibility above 600 percent of FPL.

[3] While a person could keep a plan when moving or changing jobs, the premium could differ depending on where and in what market (nongroup, small group employer, large group employer) the plan is purchased. Tax advantages could differ as well.

[4] Since the bill was introduced, balance billing has been limited by provisions in titles I and II of the Consolidated Appropriations Act of 2021, which was enacted on December 27, 2020. We assume no additional effect on balance billing under the Choose Medicare Act.

[5] HIPSM simulates health coverage and costs for people not covered by Medicare including the elderly and people under 65 who are disabled.

[6] By assumption, state and local governments that currently offer 90 percent AV plans are expected to participate in the public option.

[7] For more information on the Kaiser Family Foundation's Employer Health Benefits Survey, see https://files.kff.org/attachment/Report-Employer-Health-Benefits-2022-Annual-Survey.pdf.

[8] The Choose Medicare Act states that individuals who are United States residents will be eligible to enroll but leaves the definition of "resident" to be determined by the Secretary (of Health and Human Services). In this report, we do not assume eligibility will be extended to people who are not legally present in the United States.

[9] The Choose Medicare Act does not specify that *subsidized* access to the public option would be available to all, nor a mechanism for portability when changing jobs. We assume the intention is to ensure the portability of public option coverage without loss of the tax subsidies provided in the nongroup market through premium tax credits and in the employer market through the tax treatment of premium payments. Lowering the firewall for firms not participating in the public option would allow this portability.

[10] Throughout this report, we refer to people without insurance that meets the ACA'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.

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