Extending Rate Regulation in Nongroup and Employer Markets

Capped Rates Versus a Public Option

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Introduction

A key feature of the Choose Medicare Act proposed by Senators Jeff Merkley and Chris Murphy is the introduction of a new public option that would be available in both the nongroup and employer markets.[1] This would be a new low-cost insurance option operated or administered by a government entity that would pay providers at rates set administratively rather than negotiated by the insurer—rates would be below typical commercial payment levels in current markets. In a recent analysis, we showed that the Choose Medicare Act would increase coverage and reduce spending by households, employers, and the government (Simpson and Holahan 2023).

In this paper, we build on the design structure in the Choose Medicare Act but replace the public option with provider payment rate caps that apply to all insurers and providers participating in the nongroup or employer markets. We set provider payment rates at the same levels as in the public option to compare the effects on coverage and spending of the two approaches, holding everything else constant. While all insurers benefit from payment rate caps, we find that there are smaller coverage increases and larger spending reductions than under the public option policy.

A public option is a government-operated or -sponsored insurance plan that would pay providers at rates that are some multiple of Medicare rates and lower than those typical of commercial insurers.[2] A public option can be available in the nongroup market only or in the nongroup and employer markets. Individuals wanting to maximize the cost savings must change plans to the public option. Competition from the public plan could force other insurers to negotiate more aggressively with providers. If they

cannot bring down provider payments, they would need to compete on management of utilization, network adequacy, and/or customer service. If they cannot overcome the provider payment differences, they may have to leave the market. A public option plan will likely be unpopular with insurers who could lose significant market share. Providers could also feel threatened and might be required to participate in the public plan as a condition of participating in Medicare and Medicaid.

A capped rate policy, in contrast, would require that all providers accept the regulated payment rates. These would be no higher than some multiple of Medicare and lower than typical rates paid by commercial insurers. These rates could apply to insurers in the nongroup or both the nongroup and employer markets. Capped rates would allow households and employers to take advantage of the full cost savings without changing their insurance plan. Employers that self-insure would also benefit. This will likely result in more insurers entering and staying in markets because having many enrollees is less important as leverage for negotiating with providers. However, providers will likely be even more opposed to capped rates than to a public option because the lower payment rates would apply to many more people. Similar participation requirements would likely be necessary.

Background

Senators Jeff Merkley and Chris Murphy and ten other senators introduced the Choose Medicare Act in April 2021. The main feature was a comprehensive public option plan called Medicare Part E that would be offered in the nongroup, small-group, and large-group markets. The public option would aim to counter concentration in hospital and insurance markets by limiting provider payment rates. Payment rates, set by the Secretary of Health and Human Services, would be no lower than current Medicare rates, but the intent is to have rates lower than those paid by most commercial insurers. Our work assumes that rates would be set at Medicare plus 15 percent for physicians and outpatient care and Medicare plus 60 percent for hospitals.

In addition to the public option, the proposed legislation would change the benchmark premium levels for premium tax credits (PTCs) from silver to gold. It would extend premium subsidies to 600 percent of the federal poverty level (FPL) (in our work, we assume PTC subsidies made available in the Inflation Reduction Act would apply).[3] Public option plans would be qualified health plans, would be eligible for the Affordable Care Act's (ACA) premium and cost-sharing subsidies, and could be offered through the ACA Marketplace. The ACA's essential health benefits would be covered. All legal residents would have access to the public option except those eligible for Medicare, Medicaid, and the Children's Health Insurance Program. Any employer could choose the public option. If an employer chooses to retain its existing plan, the current employer firewall would be eliminated, and employees could choose to go into the Marketplace and take advantage of the subsidies offered in the nongroup market.

In this paper, we compare the Choose Medicare Act with a similar reform that caps provider payment rates in both the nongroup and employer markets instead of offering the public option. We assume the same provider rates as in the public option approach—Medicare plus 15 percent for physicians and outpatient care and Medicare plus 60 percent for hospitals. Most other features of the

Murphy–Merkley plan would stay the same. Benchmark premium levels for PTCs would be at the gold medal tier level. The Inflation Reduction Act premium subsidy schedule would apply. The ACA Marketplace structure would remain. The ACA's essential health benefits would be covered. All legal residents would have access to plans with lower payment rates, except those eligible for Medicare, Medicaid, and the Children's Health Insurance Program. All employers offering insurance, regardless of size, would benefit from the lower payment rates. However, in contrast with the public option approach, the current employer firewall would remain because individuals would not have to enter the Marketplace to gain the advantage of lower payment rates and premiums.

Overall, with all the provisions described above, we find that the public option would reduce the uninsured by 3.6 million, and capped rates would reduce the uninsured by 2.3 million. Household, government, and employer spending would fall, but by considerably more under the capped rate policy. Overall health spending would fall by $68 billion (3 percent) under the public option, whereas spending would fall by $274 billion (12 percent) under capped rates. Both reforms have implications for providers and insurers, discussed later in the paper.

Methods

We estimate the coverage and cost effects of the Choose Medicare Act and capped rate reform 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). The model simulates household and employer decisions and models the way changes in one insurance market interact with changes in other markets. 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 and the capped rate reform with a baseline that uses the enhanced PTCs available through 2025 under the Inflation Reduction Act; therefore, both reforms' 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 We assume both reforms will keep subsidy eligibility for those above 600 percent of the FPL.

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

- 3 percentage points (from 87 to 90 percent) for people with incomes between 150 and 200 percent of FPL

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

Federal funding of CSRs under both reforms 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 plans also include negotiated prescription drug prices. We model this provision by setting prices for prescription drugs halfway between those paid by Medicare and Medicaid after rebates. The lower provider payment rates and drug prices are applied to the nongroup market and participating firms under the Choose Medicare Act and to the nongroup market and all firms under the capped rates reform. 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 impacted by reform below what they would have paid for similar coverage without premium reductions.

Under the public option, the Choose Medicare Act provision that the public option be available to all those buying insurance was modeled by dropping the employer firewall for people in firms that did not choose the public option, which would allow employees of those firms to access the public option through the nongroup Marketplace and get subsidies if available to people at their income level. Under the capped rates reform, there is no change to the firewall because everyone with employer-sponsored insurance benefits from the lower provider payment rates.

Medicare does not cover the nondisabled and nonelderly populations, 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 in both reforms by provider type (hospitals or professionals, including physicians and other providers) relative to Medicare rates, according to the share of spending for each service type within the region.

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 and the effect of

Medicare drug price negotiations are 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. 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.

Results

Coverage

With the Choose Medicare Act that makes the public option available, the uninsured would fall by about 3.6 million (table 1). Employers, particularly small firms, would find the public option attractive and begin to offer coverage. As a result, 1.0 million more individuals would have employer coverage. There would also be a large increase in private nongroup coverage, some of which is because of the elimination of the firewall. Some employers, particularly large firms, would forgo the public option and continue to offer their existing coverage, but their employees would no longer be excluded from Marketplace subsidies because of their company's insurance offer. Some of their employees, particularly those eligible for sizable subsidies, would purchase more affordable coverage through the Marketplace. In addition, many of the uninsured would now find nongroup insurance more affordable. Over 700,000 additional people would purchase subsidized nongroup coverage, and another 1.7 million would buy nongroup coverage at the full premium.

Capped provider payment rates would have a smaller effect on the number of uninsured than the public option—a decrease of 2.3 million as opposed to 3.6 million. This is largely because the firewall, which was dropped for people in firms not choosing the public option in the Choose Medicare Act, remains fully in place since all employers now benefit from the lower payment rates. This keeps some people from accessing income-related subsidies in the Marketplace. Employer coverage would be much more affordable because of the lower provider payment rates, resulting in 2.3 million additional people receiving coverage through employers. Because of lower benchmark premiums, 1.9 million fewer would be eligible for subsidies for their nongroup coverage; they would keep the coverage but would now pay the full (now smaller) premium. An additional quarter of a million people would pay for nongroup coverage at the lower price, so overall, 2.2 million more would have full-pay private nongroup coverage. Despite this change, people losing subsidies would be better off under the reform—they go from paying a higher premium with a small subsidy to paying a lower premium without a subsidy and are spending less than they did without reform.

TABLE 1

Coverage of the Nonelderly under Current Law, the Choose Medicare Act, and Capped Rate Reform, 2024 (thousands of people)

	Current Law	Choose Medicare Act	Capped Rates Reform
Insured (MEC)	**252,696**	**256,282**	**255,008**
Employer	149,854	150,890	152,119
Private Nongroup	21,070	23,490	21,327
Subsidized Nongroup	16,338	17,044	14,443
Full-Pay Nongroup	4,733	6,446	6,884
Medicaid/CHIP	73,060	73,191	72,850
Other Public	8,711	8,711	8,711
Uninsured (No MEC)	**26,722**	**23,137**	**24,410**
Total	**279,418**	**279,418**	**279,418**

Change Because of Reform	Choose Medicare Act		Capped Rates Reform	
	Billions of dollars	Percent	Billions of dollars	Percent
Insured (MEC)	**3,585**	**1.4%**	**2,312**	**0.9%**
Employer	1,035	0.7%	2,265	1.5%
Private Nongroup	2,420	11.5%	257	1.2%
Subsidized Nongroup	707	4.3%	-1,895	-11.6%
Full-Pay Nongroup	1,713	36.2%	2,152	45.5%
Medicaid/CHIP	130	0.2%	-210	-0.3%
Other Public	0	0.0%	0	0.0%
Uninsured (No MEC)	**-3,585**	**-13.4%**	**-2,312**	**-8.7%**

Source: Health Insurance Policy Simulation Model 2023.

Notes: MEC = minimal essential coverage; CHIP = Children's Health Insurance Program. Current law includes enhanced nongroup subsidies available in 2024 under the 2022 Inflation Reduction Act. Reform provisions other than the public option or capped rates include a $10 billion reinsurance plan, enhanced CSRs, gold ACA benchmark, and federal funding of CSRs.

Spending

With the Choose Medicare Act with the public option (table 2), overall health care spending would decline by $68.0 billion, a reduction of about 3 percent. This is approximately the reduction in payments to providers for services provided to nonelderly patients. Households save $20.3 billion because of the availability of lower-cost public option plans. Marketplace PTCs fall by $32.0 billion because the lower benchmark premiums in many markets more than offset the increased number of people receiving subsidies from the elimination of the firewall. The federal government saves $20.8 billion, and state governments save $0.9 billion, primarily because of the reduced spending on uncompensated care. Employers spend $23.3 billion less on premiums because of the availability of a lower-cost public option and because fewer individuals take up employer-sponsored insurance when the firewall is lifted.

TABLE 2

Health Spending for the Nonelderly under Current Law, the Choose Medicare Act, and Capped Rate Reform, 2024 (billions of dollars)

		Current Law	Choose Medicare Act	Capped Rates Reform
Household	*Premiums*	325.1	311.9	273.2
	Other health care spending	307.6	300.6	265.9
	Subtotal, household	632.8	612.5	539.0
Federal government	*Medicaid*	416.3	416.8	415.6
	Marketplace PTC	101.6	69.6	60.9
	Marketplace CSR	0.0	4.5	4.1
	Reinsurance	2.3	10.0	10.0
	Uncompensated care	27.6	26.1	26.9
	Subtotal, federal	547.8	527.0	517.5
State government		246.3	245.4	244.5
Employers	Premium contributions	876.4	853.1	729.4
Providers	Uncompensated care	22.2	19.4	20.8
Total, all payers		2,325.5	2,257.4	2,051.2

Change Because of Reform		Choose Medicare Act		Capped Rates Reform	
		Billions of dollars	Percent	Billions of dollars	Percent
Household	*Premiums*	-13.3	-4.1%	-51.9	-16.0%
	Other Health Care Spending	-7.0	-2.3%	-41.8	-13.6%
	Subtotal, household	-20.3	-3.2%	-93.7	-14.8%
Federal government	*Medicaid*	0.5	0.1%	-0.7	-0.2%
	Marketplace PTC	-32.0	-31.5%	-40.7	-40.0%
	Marketplace CSR	4.5	n.a.	4.1	n.a.
	Reinsurance	7.7	333.5%	7.7	333.5%
	Uncompensated care	-1.5	-5.6%	-0.8	-2.7%
	Subtotal, federal	-20.8	-3.8%	-30.3	-5.5%
State government		-0.9	-0.4%	-1.9	-0.8%
Employers	Premium contributions	-23.3	-2.7%	-147.0	-16.8%
Providers	Uncompensated care	-2.7	-12.3%	-1.4	-6.1%
Total, all payers		-68.0	-2.9%	-274.3	-11.8%

Source: Health Insurance Policy Simulation Model 2023.

Notes: PTC = premium tax credit; CSR = cost-sharing reduction; n.a. = not applicable. Current law includes enhanced nongroup subsidies available in 2024 under the 2022 Inflation Reduction Act. Reform provisions other than the public option include a $10 billion reinsurance plan, enhanced CSRs, gold ACA benchmark, and federal funding of CSRs.

With a capped rate option in the Murphy–Merkley framework, overall savings to all payers would amount to $274.3 billion (11.8 percent), approximately four times the savings compared with the public option reform. This total cost savings to payers (e.g., households, government, and employers) is

approximately the same as the reduction in payments to providers from capping rates at Medicare plus 15 percent for physicians and other providers and Medicare plus 60 percent for hospitals.

Under the capped rate option, households would save $93.7 billion, again over four times the household savings under the public option, because so many more individuals would see premium reductions with the lower provider payment rates applied to the entire employer-sponsored insurance market. Marketplace PTCs would fall by $40.7 billion because the lower benchmark premiums would be smaller, and fewer people would receive them than with the public option approach, reducing federal government subsidy costs. The federal government would spend about the same for cost sharing and reinsurance as with a public option plan. The federal government would save $30.3 billion, compared with $20.8 billion with the public option approach. State governments would also save because of the small drop in Medicaid rolls and lower levels of uncompensated care. Employers would spend $147.0 billion less on premiums because the capped rates policy lowers premiums for most employees.

Discussion

In this paper, we explored two options. We repeated the results of our previous paper on the impact of making a public option available in the nongroup, small-group, and large-group markets. We then compare the public option results with a policy that would cap provider payment rates by all payers in these same markets. In both cases, providers would be paid at Medicare rates plus 15 percent for physicians and outpatient care and Medicare plus 60 percent for hospital care.

We found that households would save about $20 billion under the public option because of the availability of lower-cost options. With capped rates, households would save $94 billion. Under the public option, employers would spend about $23 billion less on premiums because of the availability of the low-cost public option and because fewer individuals would pick up employer-sponsored insurance. Under the capped rates policy, employers would spend $147 billion less on premiums because of the availability of less expensive plans.

With the public option, the federal government would save about $21 billion primarily because of the reduction in PTCs. With capped rates, government spending would fall by $30 billion. Overall savings under the public option would be about $68 billion or 3 percent of the current health spending. With capped rates, overall spending for the nonelderly would fall by $274 billion or 12 percent. Overall system savings approximate the reduction in provider revenues.

A public option would help reduce spending for those who enroll, but a capped rate policy would go much further by lowering rates for a much larger group of providers and would thus make a significant dent in health care spending borne by all Americans. On the other hand, a public option approach may permit more aggressive cuts in rates than a capped rate policy because a larger share of providers' revenues would be affected under capped rates. These options would be controversial. The public option would be opposed by insurance companies, who would see a direct threat to market share. Providers would also be opposed because of the reduction in rates with the public option and because other insurers would need to be more aggressive in negotiating provider payment rates. However, the

capped rates policy would be much more of a threat to provider incomes, though not to most insurers. With the policy modeled in this paper, health care spending for the nonelderly would fall by about 12 percent, approximately the same as the reduction in payments to providers for services to nonelderly patients. Some analysts believe reform would lead to access issues for consumers because providers could reduce their supply of services in response to lower prices or increase the volume of services provided (to make up revenue), thereby straining capacity.[4] These issues are not addressed here, and in any case, the provider payment rates under reform are greater than those under Medicare, which most providers accept today. Thus, efforts to obtain meaningful reductions in health care spending would mean significant insurer and provider opposition.

To pursue either of these policies, it would be necessary for a consensus around the need for rate regulation and, implicitly, a recognition that efforts around greater beneficiary cost sharing, price transparency, and other approaches to reduce US health spending will not be sufficient. There are too many markets in which insurer and provider concentration levels inhibit aggressive negotiation over prices. Given this concentration of power, there may be no alternative but to regulate payment rates, either by allowing individuals to purchase a plan that pays at lower rates or by applying cap rates more broadly. There is precedent for the latter in the Medicare Advantage program that, by law, does not permit insurers to pay more than Medicare rates.

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] For more information on public options and capped rates, see Blumberg 2021.

[3] 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 existing subsidy eligibility above 600 percent of FPL.

[4] For more information on provider responses, see McMorrow and Blumberg 2023.

References

Aron-Dine, Aviva. 2019. "Data: Silver Loading Is Boosting Insurance Coverage." *Health Affairs Forefront*. Washington, DC: Health Affairs.

Blumberg, Linda, J., John Holahan, Stacey McMorrow, and Michael Simpson. 2020. *Estimates of the Implications of Public Option and Capped Provider Payment Rate Reforms.* Washington, DC: Urban Institute.

Blumberg, Linda, J. 2021. "Design of Public Option and Capped Provider Price Reforms." Washington, DC: Urban Institute.

Buettgens, Matthew, and Jessica Banthin. 2020. *The Health Insurance Policy Simulation Model for 2020: Current-Law Baseline and Methodology*. Washington, DC: Urban Institute.

———. 2022. "Estimating Health Coverage in 2023: An Update to the Health Insurance Policy Simulation Model Methodology." Washington, DC: Urban Institute.

Glied, Sherry A., Anupama Arora, and Claudia Solís-Román. 2015. "The CBO's Crystal Ball: How Well Did It Forecast the Effects of the Affordable Care Act?" New York: Commonwealth Fund.

Holahan, John, and Michael Simpson. 2021a. "Introducing a Public Option or Capped Provider Payment Rates into Concentrated Insurer and Hospital Markets." Washington, DC: Urban Institute.

———. 2021b. "Introducing a Public Option or Capped Provider Payment Rates into Private Insurance Markets: Updated Estimates." Washington, DC: Urban Institute.

———. 2021c. "Public Option and Capped Provider Payment Rate Proposals That Exempt Rural Areas." Washington, DC: Urban Institute.

———. 2022. "Coverage and Cost Effects of Senators Bennet and Kaine's Medicare X Choice Act." Washington, DC: Urban Institute.

Holahan, John, Erik Wengle, Claire O'Brien. 2023. *Changes in Marketplace Premiums and Insurer Participation, 2022–2023*. Washington, DC: Urban Institute.

McMorrow, Stacey, and Linda J. Blumberg. 2023. "The Evidence on Provider Responses to Payment Rate Cuts." Washington, DC: Urban Institute.

Simpson, Michael, and John Holahan. 2023. *Coverage and Cost Effects of Senators Merkley and Murphy's Choose Medicare Act*. Washington DC: Urban Institute.

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