



Designing a Medicare Buy-In and a Public Plan Marketplace Option

Policy Options and Considerations

Linda J. Blumberg and John Holahan

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Presidential candidate Hillary Clinton has indicated interest in exploring both a Medicare buy-in option for those ages 55 to 64 and a public plan option for the Affordable Care Act's (ACA's) Marketplaces as mechanisms for increasing the affordability of insurance available outside employer-sponsored insurance. Medicare buy-in proposals originally emerged before passage of the ACA as an approach to increasing access to comprehensive insurance for the near elderly (e.g., those age 55 to 64), who faced high rates of coverage denials and were charged high premiums for limited coverage in pre-ACA private nongroup insurance markets (Johnson, Moon, and Davidoff 2002; Smolka and Thomas 2009). Policy analysts have discussed a public option in the context of health care reform for the past 15 years, before and during the debate over the ACA, as both a catalyst for insurer competition and a backup to the private market if such competition did not emerge (Hacker 2008; Holahan and Blumberg 2009; Holahan, Nichols, and Blumberg 2001).

Medicare is an attractive basis for developing an insurance alternative (either a direct buy-in or a public option based in some way on Medicare rates)¹ because the program generally has lower provider payment rates and lower administrative costs than private insurers. However, Medicare's structure and cost-sharing requirements are different from private insurers' as well. A Medicare-related proposal could provide more plan choice for those eligible, which would have a significant effect where few or even only one insurer offers coverage in the nongroup insurance market. Depending upon how the proposal is structured, it could reduce costs for younger adults in the private insurance market as older adults leave the risk pool. However, designing such programs raises myriad issues, each with specific implications for costs and benefits to different age groups.

Background

Historically, Medicare has paid providers significantly less than have private insurers. The Medicare Payment Advisory Commission found that in 2008, Medicare paid physicians 80 percent of private payment rates, a level consistent over the previous decade (Nguyen, Kronick, and Sheingold 2013). A recent analysis indicates that the difference between Medicare's and private insurers' payment rates for inpatient hospital stays has been increasing substantially, with private rates being approximately 75 percent greater than Medicare's in 2012 (Selden et al. 2015). However, these relative rates vary considerably across geographic areas (Ginsburg 2010). Further, provider payment rates for ACA Marketplace plans may be significantly below traditional private insurer rates in some areas. Medicare's administrative load also is thought to be significantly lower than that of private nongroup insurance plans (Sullivan 2013).

Although the ACA has significantly improved affordability for many, direct costs to some remain high (Blumberg, Holahan, and Buettgens 2015). Advanced premium tax credits limit eligible enrollees' premium contributions to a percentage of their income (the percentage increases with increasing income), but those with incomes over 400 percent of the federal poverty level (FPL) are not eligible for tax credits.² Moreover, unsubsidized premiums vary considerably by geography, even for comparable types of coverage. Our research and that of others clearly indicates that insurance Marketplaces are more price competitive in some areas than in others (Blumberg, Holahan, and Wengle 2016).

In addition, although the ACA redistributes health care costs in the private nongroup health insurance market to some extent by age, premiums can still be high for those ages 55 to 64.³ The 3:1 age-rating limits mean that the full, unsubsidized premium charged to a 64-year-old cannot be set at more than three times that charged to the youngest adult for identical coverage. This approach tends to increase premiums for younger adults and decrease them for older adults relative to what they would be without age-rating limits, but they can still be high relative to income for older adults paying the full premium. The redistribution of health care costs from older to younger adults is, however, another potential motivation for a Medicare buy-in directed to older adults because the option can be designed to reduce or eliminate that redistribution.

A Medicare buy-in plan or a public option could help improve affordability for both high-risk individuals and all individuals in high-cost markets. However, although both approaches are promising in many respects, both require many design decisions. The Medicare buy-in, in particular, could be quite complicated. In this paper we delineate the central policy-design decisions that would be required for both approaches.

The first section delineates the issues surrounding a direct buy-in to Medicare for adults ages 55 to 64. The second section delineates considerations in designing a government-based Marketplace-qualified health plan, or a public option, available to all Marketplace enrollees or to those in particular geographic areas that have weaker competition.

Medicare Buy-In for 55- to 64-Year-Olds: Enrollment in Traditional Medicare, Medicare Advantage or Both

A Medicare buy-in for 55- to 64-year-olds would provide Medicare as an insurance option, in addition to Marketplace coverage, for older adults. Traditional Medicare is made up of three separate programs, each with its own premium and cost-sharing requirements: Part A (hospital insurance), Part B (medical insurance), and Part D (prescription drugs). Not all enrollees participate in all three components, although most do. Individuals enrolling in traditional Medicare under a buy-in program would have to buy into each component separately, though they could decide to enroll in some but not all. There are no out-of-pocket maximums, which has led many Medicare beneficiaries to purchase private supplemental coverage (e.g., “Medigap” or retiree plans through previous employers) to cover some cost-sharing requirements and to limit total out-of-pocket spending. The cost-sharing structure in each part is generally more complicated than in private insurance designs.

Part C is Medicare Advantage, which offers Medicare enrollees managed-care plans as an alternative to Parts A, B, and D. Depending on enrollees’ costs relative to a benchmark, Medicare Advantage plans may provide additional benefits or reduced cost-sharing compared with the traditional Medicare option. However, neither option (traditional Medicare or Medicare Advantage) has the same cost-sharing requirements as Marketplace-qualified health plans. A Medicare buy-in could include traditional Medicare, Medicare Advantage, or both as options. Although covered benefits may be different, both Marketplace-qualified health plans and Medicare provide a broad spectrum of benefits. However, cost-sharing options currently offered to Medicare beneficiaries are quite different from those provided through the nongroup Marketplaces. The latter look more like typical private insurance plans, with a single deductible (although some plans have separate prescription drug deductibles), defined copayments, coinsurance, and an out-of-pocket maximum, covering the essential health benefits delineated in the ACA. Marketplace plans must fit into one of four actuarial value levels: 60 percent, 70 percent, 80 percent and 90 percent. Enrolling 55- to 64-year-olds directly into traditional Medicare, Medicare Advantage, or a choice of either Medicare option would mean moving them out of these existing coverage arrangements.

We assume that a Medicare buy-in option would offer enrollees the same covered benefits and cost-sharing structures offered to current Medicare beneficiaries. Even so, a buy-in directly into the existing Medicare options would lead to questions necessitating policy decisions:

- Would potential enrollees have the choice of traditional Medicare, Medicare Advantage, or both?
- Would eligibles be able to choose between a Medicare option and Marketplace-qualified health plans for which they are currently eligible, or would Medicare be their only option outside of employer-sponsored insurance?

- Would enrollees be allowed to make separate purchase decisions for Medicare Parts A, B, and D, or would they have to purchase all if they purchase any?⁴ How will consumers respond to offers of coverage that, unlike private insurance options, have no out-of-pocket maximum? Would Medigap or some other supplemental plans be available to the 55- to 64-year-olds?
- How would the unsubsidized cost of coverage be determined? For example, what premium would be charged to individuals with high incomes? Would 55- to 64-year-olds be charged the same premiums as those age 65 and older, even though the premiums would not reflect the cost of coverage for those enrolled? Or would actuaries set premiums based on the benefits provided and cost-sharing requirements for each component? Would the high income surcharges in the current Medicare program apply to the buy-in population?
- Assuming that 55- to 64-year-old enrollees would *not* pay the same premiums as current-law Medicare enrollees, would premiums reflect the health care costs of only the 55- to 64-year-olds enrolling? Or would premiums be set to reflect enrollees' health care costs being shared by others? For example, their costs could be shared with other nongroup market enrollees or perhaps with current-law Medicare enrollees, but that would require the development of a mechanism for achieving it.
- Would the 55- to 64-year-olds buying in to Medicare be eligible for financial assistance similar to that for Medicare beneficiaries today (e.g., 75 percent of Medicare Part B costs for all but the high-income beneficiaries? Would they be eligible for ACA-like financial assistance, advanced premium tax credits and cost-sharing reductions? Or would no financial assistance be offered at all? If subsidies are provided, how would they be structured? Would actuarial differences between Medicare and Marketplace silver coverage be taken into account, affecting both advanced premium tax credits and cost-sharing reductions?
- Would 55 to 64 year olds with access to an affordable employer insurance plan be permitted to enroll in a Medicare buy-in option?

Given differences in the insurance packages, individuals would undoubtedly have personal preferences among Marketplace plans, traditional Medicare, or Medicare Advantage plans, depending upon the generosity of coverage and the out-of-pocket requirements for their health care needs. The greatest effect of a direct buy-in to Medicare for those younger than 55 would occur if the 55- to 64-year-olds were given *only* Medicare as an option, prohibiting them from buying into the private nongroup insurance market (either inside or outside the Marketplace, because the entire ACA-compliant nongroup insurance market is treated as a single risk pool).⁵ However, although this approach would reduce the Marketplace premiums most for those younger than 55, it would reduce options for those ages 55 to 64. In addition, 55- to 64-year-olds with younger family members would be required to hold separate coverage from the rest of the family, not allowing them to take advantage of combined family deductibles, a disadvantage for current-law Medicare beneficiaries as well.

Because traditional Medicare is made up of three distinct parts, 55- to 64-year-olds enrolling in some but not all components could obtain less comprehensive coverage than they would through the

Marketplaces. Would they face the same late enrollment penalties if they decided to enroll in additional components later, or would they face the individual mandate penalties faced by other nonelderly individuals not enrolling in coverage in a given year? As we have described elsewhere, Medicare's late-enrollment penalties are simply an individual mandate penalty structured differently than that included in the ACA (Blumberg and Holahan 2015b). Imposing two separate penalties would not make policy sense. One option would be to require enrollees to purchase all three components—A, B, and D— together or to choose a Medicare Advantage plan; those not enrolling for the year would then face the same individual mandate penalties for periods without coverage as the rest of the nonelderly population.

If traditional Medicare is a choice, the lack of an out-of-pocket maximum would create a demand for Medigap policies. The federal government could require Medigap insurers to sell to those ages 55 to 64 as well as to older adults, although it is not clear whether the premiums should be set in combination with or separately from older purchasers. It also is not clear whether 55- to 64-year-olds would be considered less stable customers from the Medigap insurers' perspectives (if they were allowed to move between Medicare and Marketplace coverage from one year to the next, or given their ability to move between Medicare and uninsurance annually) and therefore more prone to adverse selection.

Policy decisions related to premiums, sharing health care risk, and subsidies for purchasing coverage would necessarily be interrelated. Unlike private insurance premiums, Medicare premiums are set in statute and do not reflect the full aggregate costs of covered services provided to enrollees. Medicare premiums vary to some limited degree by income, but the current program's premiums are abstracted from the costs of providing care because beneficiaries contribute payroll tax payments into Part A over their working lives and because of other policy decisions. Medicare enrollees have a complicated set of subsidies that are not always income related. All who enroll in Part B (except for those with high incomes) have 75 percent of their costs paid by general revenues; they are charged a premium for the remainder. Most of those with incomes below 120 percent of FPL have no premiums or cost-sharing for Part B if they enroll in a Medicare Savings Program, but participation in these programs is low (Dorn and Shang 2012). Above 120 percent of FPL, premiums are not income related until \$85,000 of income for a single adult or \$170,000 for a couple. Part A is financed primarily by payroll taxes, but if taxes paid are less than benefits received, enrollees are subsidized by current taxpayers. Part D also has low-income subsidies, but above 150 percent of FPL, all beneficiaries have the same choice of plans with different premiums and cost-sharing requirements. Premium setting for the buy-in population could be based on current-law premiums for those age 65 and over, but that would mean providing them a different subsidy structure than those enrolling in Marketplace coverage.

Developing premiums for Medicare benefits based on their average value would seem to require providing subsidies at least as valuable as those currently offered through the Marketplaces. If subsidies are not provided at all, few individuals would enroll, limiting the potential impact of the reform considerably. Although premium tax credits available through the Marketplaces could be made available to new, younger Medicare enrollees (for example, with the amount provided still tied to the second-lowest-cost Marketplace option), providing equivalent cost-sharing reductions within Medicare

would be more challenging.⁶ In the Marketplace plans, insurers offer plans with higher actuarial values to those eligible for them, thereby reducing cost-sharing requirements, increasing silver plans (those with 70 percent actuarial value) to 94 percent actuarial value, for example, for eligible individuals with incomes below 150 percent of FPL. Because the actuarial value of Medicare coverage is different from that of Marketplace coverage and because traditional Medicare is made up of three components (not all of which individuals may enroll in), the approach to providing equivalent assistance through Medicare is unclear. In this respect, it might be more straightforward to enroll the buy-in population through Medicare Advantage plans only instead of through traditional Medicare, yet these plans may not necessarily offer price advantages relative to Marketplace plan options.

Finally, enrolling individuals in traditional Medicare or Medicare Advantage would be akin to pulling them out of the Marketplaces and into the other programs. Doing so could have implications for financing ongoing Marketplace operations. Most Marketplaces finance their administrative costs, at least in part if not in full, on assessments added to Marketplace plan premiums. Fewer enrollees would reduce the base of funding for these costs, many of which are fixed (i.e., they do not vary with enrollment). In addition, the reduced size of the Marketplace could make it less attractive for insurers to participate.

A Public Option for All Age Groups: Enrollment through a Government-Based Qualified Health Plan

A public option is a qualified health plan that would be sold through the ACA's government-created Marketplaces (either federal or state). The public option would bear health insurance risk like other insurers, complying with the ACA's insurance reforms (e.g., modified community rating, guaranteed issue, and essential health benefits) and offering coverage in the same actuarial value tiers. Premiums would be set based on expectations about nongroup market enrollees' health care costs, using something like Medicare payment rates for participating health care providers, risk adjustment, and administrative costs. The public option could offer plans in all of the ACA's actuarial value tiers (i.e., 60, 70, 80, and 90 percent) or it could just offer plans in the tiers in which insurers are required to participate (silver [70 percent] and gold [80 percent] nationally; some state Marketplaces impose additional requirements). In addition to the public option ensuring that premiums were actuarially fair, it would require that premiums reflect the development of reserves. Taxpayers thus would not bear the risk for underpricing plans, and the public option would not competitively disadvantage private insurers. Marketplace premium tax credits and cost-sharing reductions would apply to public option plans with the same rules applied to other insurers.

A public option avoids complexities associated with a Medicare buy-in for 55- to 64-year-olds. Because the option would be structured and operated in much the same way as any other Marketplace-qualified health plan, it would not have different actuarial values, cost-sharing structures, or premium structures than other Marketplace options. The appropriateness of applying a Marketplace subsidy

structure to a Medicare product would not be an issue, and risk-sharing questions across different age groups would not arise. Yet several design decisions would remain:

- How would provider payment rates be set? Would they be set consistent with Medicare rates, set consistent with Medicare rates plus some percentage, or based on some other fee schedule? Many states have self-insured plans for their employees; this is another potential platform for creating a public option offered in a state Marketplace.
- If rates are set at the Medicare level (or at some other level that falls below those paid by private insurers), what leverage would the plan have to ensure sufficient provider participation? How does a state's leverage compare with that of the federal government in this respect?
- Should public options be set up in all geographic areas or only those with high premiums, high premium growth, or otherwise weak insurer or provider competition? If the latter, who will judge appropriate locales, and by what metric will an area's appropriateness be assessed?

Medicare's lower provider payment rates and historically lower rate of per enrollee growth in expenditures makes it an attractive basis, from a cost-saving standpoint, for provider payment rates under a public option. The program and its structure for updating rates are well established, and its rate schedules would be immediately available for use. Although raising payments by some percentage above Medicare rates might increase providers' voluntary participation in the new option, the demonstrated acceptability of the Medicare rates themselves would make such raises difficult to justify. Several states provide health insurance to their government employees through a self-insured plan:⁷ the state either develops or rents a provider payment schedule, and the state itself bears health care risk for those enrolled. Such plans could also serve as a platform for developing a state-specific public option.

If a public option's provider payment rates (either based on Medicare fees or some other schedule) are lower than prevailing rates for private insurers in a particular area, at least some providers may resist participating in that plan. Without a sufficient provider network, a public option would be unable to meet the goal of providing an attractive, efficient option that could catalyze competition in markets with weak insurer and/or provider competition. The federal government could use the leverage of Medicare to increase provider participation, requiring providers to participate at the public option's rates or be excluded from Medicare. Such a requirement likely would go a long way toward helping the public option develop a broad network, but undoubtedly, it would be politically challenging. State governments would seem to have less leverage for creating a solid provider network, although perhaps tax penalties for nonparticipation or other strategies could be considered.

A public option might be more politically palatable if it were not offered in all markets nationally but instead in select areas where insurer or provider competition is low. However, the appropriate criteria for selectively offering the public option is not clear. Although in some obvious candidate areas the number of insurers is down to one, the number of insurers in an area does not always determine the strength of competition. For example, an area could have three insurers, but only one with significant market share and the others unable to negotiate competitive provider payment rates. The governor of

each state could be given authority to choose where a public option would be introduced. However, doing so would bring political considerations into the decision, whereby consumers in areas that could benefit from a public option may never have the opportunity to access one. Having the federal government choose areas for the option to be implemented would undoubtedly raise other concerns.

A public option based on Medicare rates would not be the lowest-priced option in every nongroup insurance rating area. Rating areas with active price competition are likely to offer consumers lower-priced options than could be offered at Medicare payment rates, particularly from private insurers that used to only operate in the Medicaid market but now offer private nongroup coverage through the ACA's Marketplaces or areas with provider-sponsored insurers. However, even where the public option would not be one of the lowest-cost insurers, it could add value if it offered a broad network at a somewhat higher price, giving consumers a different type of option if their market is largely or entirely made up of plans with narrow provider networks. In addition, the presence of an additional insurer, even one priced somewhat higher than at least some of an area's competitors, could have a stabilizing effect on premiums, giving other insurers a strong incentive to manage their costs and hold down premium growth. For all these reasons, offering the public option nationally is likely preferable, albeit more politically challenging.

Summary and Conclusion

Some consumers, particularly those with incomes at or above 400 percent of FPL, continue to pay high premiums when purchasing coverage in the ACA's nongroup insurance Marketplaces. These high premiums are caused by at least two possible sources: markets with little insurer or provider competition and markets in which nongroup enrollees have disproportionately more medical need (or some combination of those two sources).⁸ For some, even average-priced insurance feels unaffordable without financial assistance at this still-modest income. These circumstances may be particularly burdensome for near-elderly adults not yet eligible for Medicare, who face the highest unsubsidized premiums in the nongroup market because of age rating. A Marketplace public option and a Medicare buy-in program provide several promising ways to address these sources of high premiums. Considering possible avenues for taking advantage of such options is worthwhile, but the path to tapping that potential is not necessarily simple.

A Medicare buy-in approach raises policy questions related to the sharing of health care risk, levels of coverage, and subsidization. Separating all or some of the 55- to 64-year-olds into a different risk pool than younger adults would reduce costs for the younger adults but could increase premium costs for the older group. Whether that is the case and how much costs would increase depends on savings achieved by Medicare's lower provider payment rates.

A public option, available to all Marketplace enrollees (i.e., not limited to a specific age group), either nationally or in specific geographic areas, could provide a competitive catalyst in some nongroup insurance markets. It would not be a complete answer to high premiums caused by adverse selection into the nongroup insurance market as a whole, but it could address high premiums caused by weak

competition in insurance and/or provider markets. Marketplace-qualified health plans based on Medicare payment rates (or possibly some other metric) could integrate seamlessly within the existing Marketplace structure. Such plans would be among the low-cost plans in some areas, but even in markets where they were somewhat higher priced, they could serve as a broader provider network option and a check on other insurers' premium growth. A key issue for a government-based qualified health plan's ability to compete in currently noncompetitive markets, however, would be its ability to develop a strong provider network. This means that strong incentives for provider participation would be necessary. The leverage of participating in Medicare would appear to be the strongest leverage available; this is a tool available to the federal government but not to states.

Regardless of the approach taken, providers are likely to resist new insurance options that may move more patients into plans paying lower rates. While this is to be expected, it highlights the perpetual quandary of health care cost containment. Health care spending and its growth cannot be reduced without either paying less, on average, per unit of service rendered or reducing the quantity of services provided. No matter the strategy for containing costs, achieving that goal will take money out of the pockets of providers. To protect providers financially means abdicating cost-containment efforts of any type.

Others are surely concerned that private insurers would pull out of nongroup insurance markets if forced to compete against a public option. As we have indicated, in some areas, a public option would not be one of the lower-cost options in the Marketplaces. But even where it was a low-cost option, other insurers would not necessarily exit. In areas with little provider competition, a public option may be a strong incentive for provider systems to begin to negotiate better rates with private insurers, allowing them to lower premiums so that the providers will not have the state or federal government as their sole payer. Further, we already see many areas of the country where many insurers continue to participate in the Marketplaces, offering a range of options at different prices. Although private insurers would have the incentive to provide care more efficiently to compete with a public option, private insurers also would continue to compete for enrollees on quality of service and care management, as they do today in markets where they compete with lower-priced insurers. Although some high-cost, low-enrollment insurers have left Marketplaces, the nature of competition is to encourage those that can provide high-quality products at efficient prices and to provide those who cannot with strong incentives to restructure to better meet that challenge. A public option may serve as the catalyst to creating that competitive dynamic where it is currently lacking.

Notes

1. The Clinton campaign has not suggested that a public option of their design would rely on Medicare provider payment rates or some multiple of Medicare rates. In fact, they emphasize helping interested states to structure their own public options. However, we and others have assumed that a public option based in some respects on Medicare rates (perhaps Medicare plus some percentage) would be an obvious and attractive approach.
2. Nor are some families caught in the "family glitch" (Blumberg and Holahan 2015a).

3. Linda J. Blumberg and John Holahan, “Don’t Let the Talking Points Fool You: It’s All about the Risk Pool,” *Health Affairs Blog*, March 15, 2016, <http://healthaffairs.org/blog/2016/03/15/dont-let-the-talking-points-fool-you-its-all-about-the-risk-pool/>.
4. Under current law, Medicare coverage can be used to satisfy the ACA’s individual responsibility requirement (i.e., the individual mandate) as long as the individual has, at a minimum, Medicare Part A (Section 1501).
5. A risk-adjustment mechanism redistributes a portion of premium revenue from insurers enrolling healthier individuals to insurers enrolling sicker ones, and these adjustments are made across Marketplace and non-Marketplace insurers. In addition, insurers may not charge different premiums for the same coverage offered inside and outside the Marketplaces.
6. Setting the premium tax credit to the second-lowest-cost silver option in the Marketplace for someone of the same age could, however, be complicated as well. To follow this approach would require a policy that allows some 55- to 64-year-olds to continue purchasing coverage through the Marketplaces, otherwise there would be no relevant population to tie the tax credit amounts to. In addition, assuming they have a choice to do so, the 55- to 64-year-olds enrolling in Medicare rather than Marketplace coverage could be quite different. Without any risk sharing across the Marketplace and Medicare enrollees, the premium tax credits tied to premiums charged to Marketplace enrollees may not appropriately reflect the premiums available to the same age group in Medicare.
7. “State Employee Health Benefits, Insurance and Costs,” National Conference of State Legislatures, last updated May 1, 2016, accessed September 19, 2016, www.ncsl.org/research/health/state-employee-health-benefits-ncsl.aspx.
8. Some feel that even premiums in nongroup markets with lower-than-average costs are unaffordable at the unsubsidized price for those with incomes above 400 percent of FPL. Addressing that concern would require additional federal investment in tax credits or cost-sharing assistance. We discuss this issue elsewhere (Blumberg and Holahan 2015a).

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About the Authors



Linda J. Blumberg is a senior fellow in the Health Policy Center at the Urban Institute, having joined in 1992. She is an expert on private health insurance (employer and nongroup), health care financing, and health system reform. Her recent work includes extensive research related to the Affordable Care Act (ACA); in particular, providing technical assistance to states, tracking policy decisionmaking and implementation efforts at the state level, and interpreting and analyzing the implications of particular policies. She codirects a large, multiyear project using qualitative and quantitative methods to monitor and evaluate ACA implementation in select states and nationally. Examples of other research include codirecting 22 state case studies of stakeholder perspectives on ACA implementation, assessing the implications of self-insurance among small employers on insurance reforms, and comparing the importance of employer and individual mandates in reaching ACA objectives. She also led the quantitative analysis supporting the development of a "Roadmap to Universal Coverage" in Massachusetts, a project with her Urban colleagues that informed the 2006 comprehensive reforms in that state. She received her PhD in economics from the University of Michigan.



John Holahan is an Institute fellow in the Health Policy Center at Urban, where he previously served as center director for over 30 years. His recent work focuses on health reform, the uninsured, and health expenditure growth, developing proposals for health system reform most recently in Massachusetts. He examines the coverage,

costs, and economic impact of the Affordable Care Act (ACA), including the costs of Medicaid expansion as well as the macroeconomic effects of the law. He has also analyzed the health status of Medicaid and exchange enrollees, and the implications for costs and exchange premiums. Holahan has written on competition in insurer and provider markets and implications for premiums and government subsidy costs as well as on the cost-containment provisions of the ACA.

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