Introducing a Public Option or Capped Provider Payment Rates into Concentrated Insurer and Hospital Markets

John Holahan and Michael Simpson

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In recent years, we have conducted several analyses of public option and capped provider payment rate proposals, policies primarily intended to reduce health care spending (Blumberg et al. 2019, 2020; Blumberg, Simpson, and Buettgens 2019). Here and in two accompanying papers (Gangopadhyaya and O'Brien 2021; Holahan and Simpson 2021a, 2021b), we consider such policies that would be introduced into either the nongroup health insurance market alone or both the nongroup and employer insurance markets. For this analysis, we consider reforms that would introduce these options only into markets where either insurers or hospitals or both are concentrated. Though a public option and capped rates are controversial policy tools, limiting such reforms to markets where provider or insurer concentration has led to higher costs might make them more politically acceptable, because the reforms would not interfere in competitive markets.

We show introducing a public option into nongroup markets only in concentrated areas would increase coverage and reduce spending almost as much as introducing them nationwide (i.e., in both concentrated and competitive areas). Introducing these reforms into concentrated markets has a considerable impact, because 42 percent of the population below age 65 lives in a region with a concentrated hospital market and 55 percent live in a region with either a concentrated hospital or nongroup insurance market. In addition, because premiums in concentrated markets are higher, premium reductions can be larger under reforms. Finally, even though the public option or capped rates are applied to concentrated markets, we find some spillover to competitive markets, because the

reforms affect firms providing insurance to workers in both concentrated and competitive markets. The savings resulting from the public option or capped rates in nongroup markets is relatively small; savings are greater when the public option is extended to employer markets, and greater yet when payment rates by all insurers are capped.

We consider concentration in both hospital and insurance markets. When the hospital market is concentrated, payments for health services are high because the limited number of hospital options gives hospitals considerable market power in negotiating with private insurers. When insurance markets are concentrated, particularly in the nongroup market, costs are high because, though insurers may have leverage relative to hospitals, they have fewer incentives to pass on the savings. Consequently, insurance premiums are higher than they would be absent additional competition or rate regulation. Across rating regions established under the Affordable Care Act, insurer and hospital concentration overlaps considerably.

As we have described elsewhere (Blumberg et al. 2020), the public option would be a government-developed insurance plan that uses a fee schedule and pays providers (doctors, hospitals, and prescription-drug manufacturers) rates below those typical of commercial insurers. Capped payment rates would establish maximum rates any insurer would pay providers. The public option could be introduced alone or with capped provider payment rates, as with Medicare Advantage. The public option could be available in, and thereby increase competition in, the markets with only one or two insurers, as well as in markets with high hospital concentration. Individuals would have to enroll in a new plan to take advantage of the full cost savings. The competition from a public option could result in more aggressive negotiations between private insurers and providers, resulting in lower private plan premiums. If private insurers cannot successfully negotiate payment rates with providers, they may have to leave the market.

Capping provider payment rates would require all providers to accept payments no higher than a specified rate, typically lower than commercial insurers' current rates. As noted, capped rates could be implemented alone or along with a public option, as they currently work in Medicare Advantage. Capped provider payments would allow consumers to take advantage of cost savings with any participating insurer (i.e., without having to enroll in a public option), because those insurers would benefit from the capped provider payment rates. Unlike implementing a public option alone, implementing capped rates alone would likely result in more private insurers entering and staying in markets.

In this paper, we estimate the effects of applying a public option or capped provider payment rates just in concentrated markets. Payment rates in competitive markets are unaffected. We consider hospital markets concentrated if the hospital Herfindahl-Hirschman Index (HHI) is 5,000 or greater and insurer markets concentrated if they have one or two insurers. The reforms would decrease premiums in concentrated markets. With lower caps on payment rates in concentrated markets, provider payment rates could drop to the level seen in some competitive markets.

We also analyze approaches that would extend the public option or capped provider payment rates to both nongroup and employer insurance markets. To take advantage of potential savings from a public option, an employer would have to switch coverage for the firm's workers into that new plan. Consistent with our earlier work, we assume a firm's decision about whether to switch into the public option varies with its wages and size: The smaller the firm and the lower its average wage, the more likely it will switch from its current insurance to the public option. Large and high-wage firms would be more likely to remain with their current coverage, despite its higher payment rates relative to those for the public option, because they can tailor benefit packages, cost sharing, out-of-pocket limits, and provider networks to their employees' needs. We also assume employers would have to save at least 20 percent in premiums to make switching sufficiently attractive.

As noted, the reforms simulated do not affect payment rates in competitive markets. In concentrated markets, we set payment rates at Medicare levels in public option 1, Medicare levels plus 10 percent for professionals and plus 25 percent for hospitals in public option 2, and Medicare levels plus 15 percent for professionals and plus 60 percent for hospitals in public option 3. In public options 4 and 5, the public option is available to employers in concentrated hospital markets. In concentrated markets, public option 4 would pay providers Medicare rates plus 10 percent for professionals and plus 25 percent for hospitals. Public option 5 would pay Medicare rates plus 15 percent for professionals and plus 60 percent for hospitals. At firms with employees living in both concentrated and competitive areas, hospital and provider payments would be reduced only for employees in concentrated areas. However, the resulting premium reductions would be spread across the entire firm. In the two capped provider payment rate options we examine, capped rates would be introduced into concentrated nongroup and employer markets. The first of those reforms, capped rates 1, sets payment rates at Medicare plus 10 percent for professionals and plus 25 percent for hospitals. The second reform, capped rates 2, pays Medicare rates plus 15 percent for professionals and plus 60 percent for hospitals. In each policy option, we assume prescription drug savings would apply in both concentrated and competitive markets. We also assume legislation establishing a public option would set prescription drug rebates halfway between those for Medicare and Medicaid and would take effect nationally, reflecting that prescription drugs are sold in a national market, not local markets. Markets for prescription drugs differ from those for hospitals and professionals, and the arguments for exempting competitive areas do not apply to prescription drugs; under the reforms examined, access to prescription drugs is unlikely to be affected, because drugs are priced nationally. We estimate elsewhere these savings approximate a 30 percent cut relative to commercial payments (Hwang and Kesselheim 2020).

Characteristics of Concentrated and Competitive Markets

Table 1 shows that 117 million people live in a concentrated hospital market in 2022, whereas 160 million reside in a competitive hospital market. Including concentrated nongroup insurance markets, 154 million people live in a concentrated hospital or insurer market (or where both are concentrated).[1] Those living in competitive markets tend to have higher average family incomes than those in concentrated markets ($77,800 versus $64,700). Forty-two percent of the population below age 65 live in a concentrated hospital market, and 55 percent live where either the hospital or insurance market is concentrated (table 1). In addition, almost all rural residents live in concentrated markets, far more than urban residents. On the other hand, 58 percent of those in concentrated hospital markets live in urban markets, and 67 percent of those in concentrated insurer or hospital markets live in urban markets. Thus, a policy targeted at concentrated markets will have a larger impact on urban areas.

TABLE 1

Characteristics of Concentrated and Competitive Regions, 2022

	Hospital markets[a]		Hospital markets and/or ACA nongroup insurance markets[b]	
	Competitive	**Concentrated**	**Competitive**	**Concentrated**
Population				
Millions under age 65	160	117	124	154
Share under age 65	58%	42%	45%	55%
Average age	38.8	40.0	38.6	39.9
Average age of people younger than 65	31.8	32.1	31.7	32.1
Health insurance coverage among people under 65				
Employer	54%	54%	54%	53%
ACA-compliant nongroup	6%	5%	6%	5%
Medicaid/CHIP	26%	25%	26%	26%
Other public	2%	4%	2%	4%
Uninsured	12%	11%	11%	11%
Short-term, limited duration plan	1%	1%	1%	1%
Average family income among people under 65				
Thousands of dollars	77.8	64.7	78.0	67.7
As a share of FPL	400%	336%	399%	351%
Share of population below age 65 in				
Urban areas	70%	30%	54%	46%
Rural areas	7%	93%	6%	94%
Share of people under 65 living in concentrated/competitive areas in				
Urban areas	98%	58%	98%	67%
Rural areas	2%	42%	2%	33%
Millions of people under 65 if hospital concentration threshold were HHI > 2,500	**87**	**190**	**77**	**201**

Source: Health Insurance Policy Simulation Model (HIPSM), 2021.

Notes: ACA = Affordable Care Act. CHIP = Children's Health Insurance Program. FPL = federal poverty level. HHI = Herfindahl-Hirschman Index. HIPSM models coverage and incomes by public-use microdata areas (PUMAs). PUMA borders do not always align with those for rating regions established under the Affordable Care Act.

[a] Concentrated hospital markets (HHI > 5,000) only; used in nongroup and employer reforms.

[b] Concentrated hospital markets (HHI > 5,000) and/or concentrated ACA nongroup insurers (2 or fewer); used in nongroup-only reforms.

Table 1 also shows the number of people affected under a less restrictive definition of hospital concentration; using HHI of 2,500, per the Federal Trade Commission guideline (rather than 5,000), the number of people living in concentrated hospital regions would be 190 million (rather than 117 million), meaning a public option or capped rates would affect more rating regions and more people.

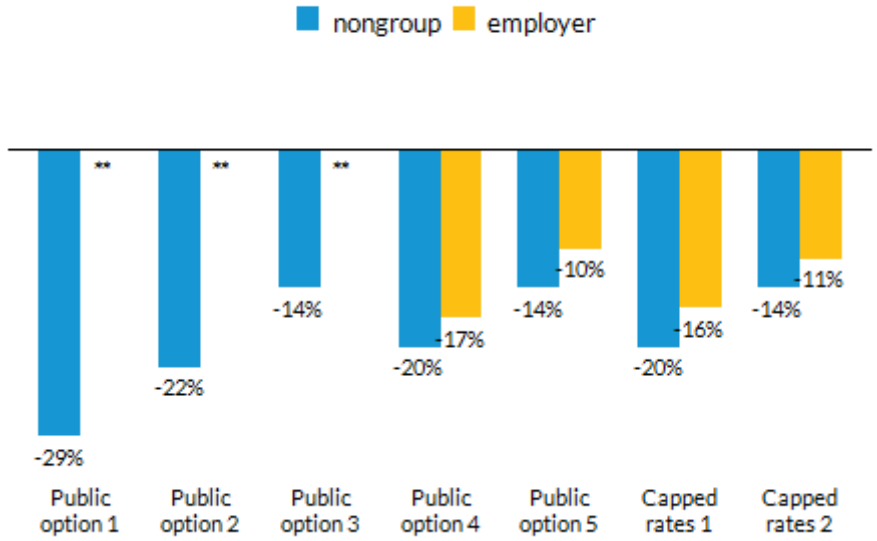
Highlights of Findings

In this section, and in figure 1 and table 2, we summarize our main findings; supplementary tables at the end of the paper show additional details. All estimates assume reforms are fully implemented in 2022. We acknowledge considerable uncertainty surrounding these estimates, which we detail in the methods section. Our primary limitation is the absence of ideal data sources, which forces us to make assumptions and use proxy measures in some areas.

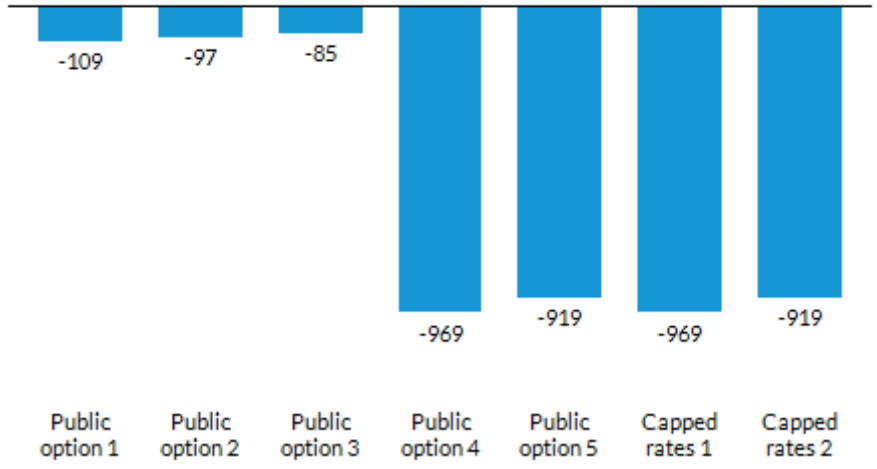
FIGURE 1

Summary of Effects of Reform Options on Concentrated Areas, 2022

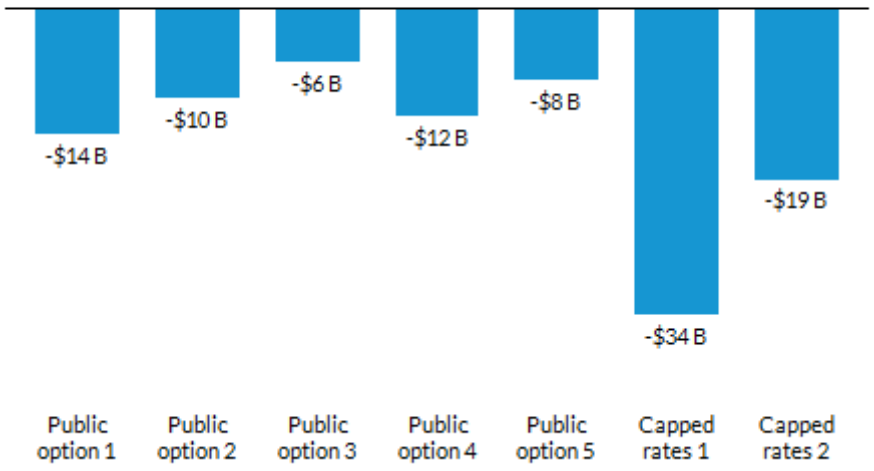
On median premiums



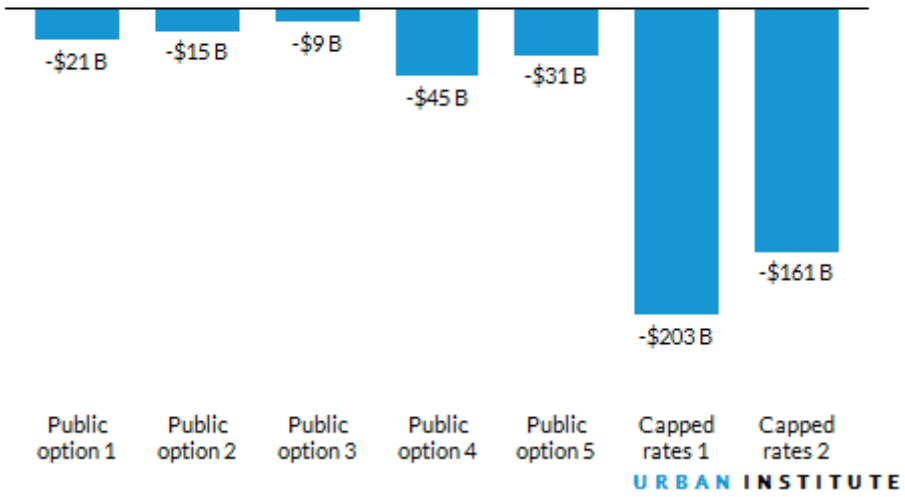
On thousands of people uninsured



On the federal deficit



On health system spending



Source: Health Insurance Policy Simulation Model, 2021.
Notes: B = billion. Reform simulated as fully phased in and in equilibrium in 2022.

- **Premium and coverage in the nongroup market.** We estimate a nongroup public option would lower median premiums by 14 to 29 percent in concentrated markets. The greatest reductions in premiums would occur under reforms with the greatest impact on provider payment rates. We estimate premiums in competitive markets would fall by 7 percent, because we apply increases in prescription-drug rebates to all areas. The coverage effects would be small;

additional policies that expand subsidies would be needed to improve coverage, but we do not consider them here.

- **Federal household and employer health spending in the nongroup market.** Lower nongroup premiums would result in lower federal spending, primarily on premium tax credits; the reduction would range from $6 to $14 billion. Household spending would fall by $3 to $7 billion, about 1 percent of aggregate household spending. Employer spending would be unaffected.
- **Premiums and coverage in the employer market**. A public option or capped provider payment rates tend to lower premiums about the same in concentrated employer and nongroup markets. Under reforms that extend the public option to employer markets, we estimate median premiums for participating employers would fall by 10 to 17 percent. Reductions in premiums would be larger for options with greater reductions in provider payment rates. Offering the public option or capped payment rates in the employer market could reduce the number of people uninsured by 919,000 to 969,000.
- **Employer and household spending**. Extending the public option or capped rates to the employer market would have significant effects. When the public option is extended to employer markets, employer spending falls from between $10 to $16 billion in 2022. Savings under capped provider payment rates are greater, ranging from $91 to $117 billion. With a public option alone, household spending falls by $13 to $19 billion; under capped rates, household spending falls by $62 to $75 billion. Savings for employers and households are significantly larger under capped rates because all employers benefit; under the public option many employers choose not to participate given limited savings.
- **Federal spending and income tax revenue.** Economic research indicates employers convert savings on premiums into higher wages for their workers, which are taxable and therefore contribute to a reduction in the federal deficit. When the reforms are introduced into the employer market, the federal deficit falls by $8 to $12 billion under a public option and by $19 to $34 billion under capped rates.
- **National health spending**. National health spending on the nonelderly falls by less than 1 percent when the public option is limited to the nongroup market in concentrated areas. If a public option is available to employers as well, spending by all payers could fall by as much as 2 percent, depending on the payment rates used. Under capped provider payment rates, spending by all payers could fall by as much as 10 percent.
- **The effect of limiting policy to concentrated markets only**. When the nongroup market reforms in concentrated markets simulated here are extended nationally, spending by employers, households, and the health system changes little, particularly in the nongroup market. That is, extending these reforms to competitive nongroup markets does not generate much savings. Extending the public option and capped rates to employer markets nationally would have larger effects on employer, household, and health system spending. When rate cuts are available only in concentrated areas under a public option, only firms with a

significant share of employees in concentrated areas will save enough to select into the public option. Many more firms will select the option when all employees see savings under a national reform. Savings under capped rates increase with the number of employees eligible. For example, extending public option 4 to all markets would reduce national health spending by $111 billion more than limiting the reform to concentrated markets ($156 billion versus $45 billion); extending capped rates 1 to all markets would reduce national health spending by $129 billion more than limiting the reform to concentrated markets ($331 billion versus $203 billion).

TABLE 2

Public Option and Capped Provider Payment Rate Reform Options for Concentrated Markets, 2022

Reform	Availability of public option	Payment policy[a]	Change						
			In median nongroup premiums[b]	In median employer premiums[c]	In number of uninsured	In the federal deficit[d]	In employer spending	In household spending	In health system spending
Public option 1	Nongroup in concentrated hospital or insurer markets	Medicare rates	-29%	NA	-109,000	-$14 B	*	-$7 B (-1%)	-$21 B (-1%)
Public option 2	Nongroup in concentrated hospital or insurer markets	Medicare rates plus 10% for professionals and plus 25% for hospitals	-22%	NA	-97,000	-$10 B	*	-$5 B (-1%)	-$15 B (-1%)
Public option 3	Nongroup in concentrated hospital or insurer markets	Medicare rates plus 15% for professionals and plus 60% for hospitals	-14%	NA	-85,000	-$6 B	*	-$3 B (-1%)	-$9 B (**)
Public option 4	Nongroup and employer markets; concentrated hospital markets; subset of firms choose public option	Medicare rates plus 10% for professionals and plus 25% for hospitals	-20%	-17%	-969,000	-$12 B	-$16 B (-2%)	-$19 B (-3%)	-$45 B (-2%)
Public option 5	Nongroup and employer markets; concentrated hospital markets; subset of firms choose public option	Medicare rates plus 15% for professionals and plus 60% for hospitals	-14%	-10%	-919,000	-$8 B	-$10 B (-1%)	-$13 B (-2%)	-$31 B (-1%)
Capped rates 1	Nongroup and employer markets; concentrated hospital markets; all employers pay lower rates	Medicare rates plus 10% for professionals and plus 25% for hospitals	-20%	-16%	-969,000	-$34 B	-$117 B (-15%)	-$75 B (-13%)	-$203 B (-10%)

Reform	Availability of public option	Payment policy[a]	Change						
			In median nongroup premiums[b]	In median employer premiums[c]	In number of uninsured	In the federal deficit[d]	In employer spending	In household spending	In health system spending
Capped rates 2	Nongroup and employer markets; concentrated hospital markets; all employers pay lower rates	Medicare rates plus 15% for professionals and plus 60% for hospitals	-14%	-11%	-919,000	-$19 B	-$91 B (-11%)	-$62 B (-10%)	-$161 B (-8%)

Source: Health Insurance Policy Simulation Model, 2021.

Notes: B = billion. NA = not applicable. Reforms simulated as fully phased in and in equilibrium in 2022. Data are limited to health care spending among people below age 65 not enrolled in Medicare. Federal deficit effects are the sum of the change in federal spending on health care and the increase in federal income tax revenue.

[a] Prescription drug prices in each reform scenario are assumed to be halfway between Medicare and Medicaid prices in all (concentrated and unconcentrated) markets.

[b] This column shows the change in the median nongroup benchmark premium in concentrated markets.

[c] This column shows the change in median premiums in concentrated markets among employers providing the public option to their workers in public options 4 and 5. In capped rates 1 and 2, this column shows the change in median premiums for all employers in concentrated markets.

[d] Estimates in this column equal the change in federal spending on Medicaid/the Children's Health Insurance Program acute care for the nonelderly and Marketplace premiums minus the estimated increase in income tax revenue, which results from turning savings in untaxed health care premiums into taxable worker wages.

* = less than +/- $500 million. ** = less than +/- 0.5%.

Projected Impacts of Public Option and Capped Provider Payment Rate Proposals Limited to Concentrated Markets

In the results below, we present estimated changes in median nongroup and employer premiums, health insurance coverage, and health care spending by households, employers, and the federal government. We show the estimated increase in federal income tax revenue that results when employers save on health insurance costs and pass those savings on to workers via higher wages, which, in turn, results in higher tax payments. We show the impact on the federal deficit, which is a combination of the reduction in federal government spending (primarily from lower spending on Marketplace premium tax credits) and the increased income tax revenue.

All estimates assume the reforms are fully phased in and in equilibrium in 2022. This means the supply of services is assumed to expand to meet the increased demand for services. (We also assume services provided are unaffected by decreased provider payments.) In reality, it is more likely the reforms would require a multiyear phase-in, over which payment rates would decrease toward target levels. How long the phase-in would take would determine the underlying savings to households, employers, and the federal government. The slower the pace of payment rate reductions, the less potentially disruptive to the health system and the more politically feasible the reform will likely be. The results below are for policies exempting competitive markets (except when estimating prescription-drug savings), which reduces premiums in all nongroup markets by 7 percent.

Public Option 1: Medicare Rates in Nongroup Markets

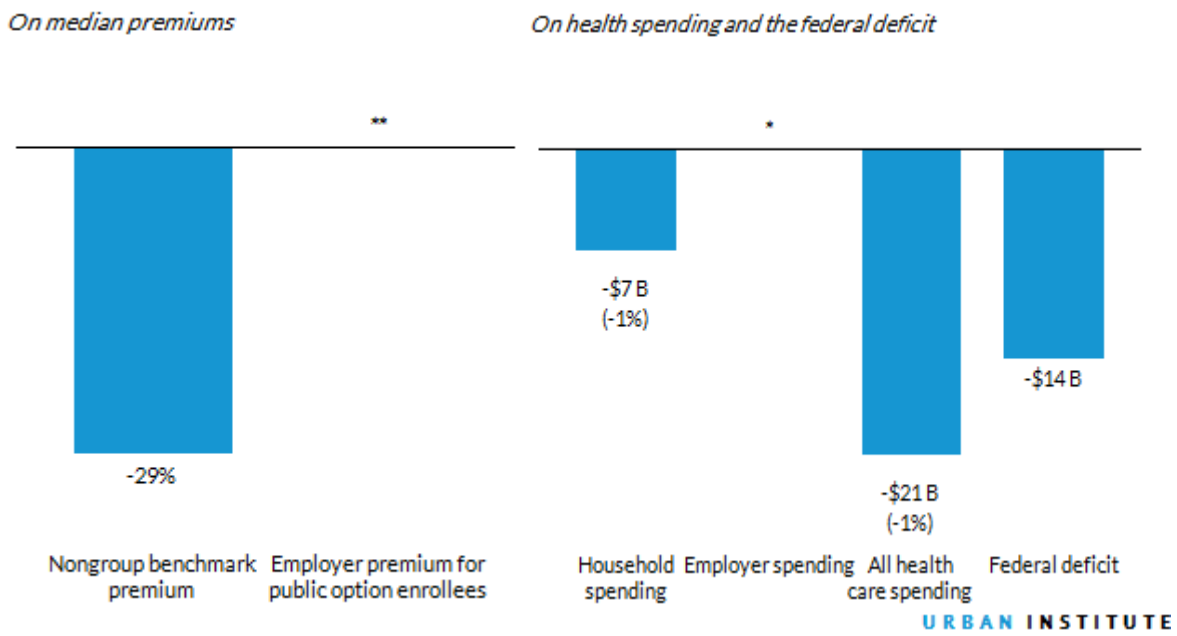
- a public option in the private nongroup insurance market in concentrated areas
- pays Medicare rates to hospitals and professionals in concentrated markets
- prescription drug prices set halfway between Medicare and Medicaid prices in all nongroup markets

Premium and coverage effects. Under this reform, the median benchmark premium in the nongroup market falls by 29 percent in concentrated markets. The number of uninsured people falls by 109,000, a small effect because the reform only affects households facing full, unsubsidized nongroup premiums.

Health care spending. Because benchmark nongroup premiums fall in concentrated markets and tax credits are tied to premiums, tax credits also fall in these areas. Federal health spending, and thus the federal deficit, falls by $14 billion, or 3 percent. Aggregate household spending falls by $7 billion, or 1 percent. Employer spending is essentially unaffected. Overall health spending falls by $21 billion, or 1 percent.

FIGURE 2

Effects of Public Option 1



Source: Health Insurance Policy Simulation Model, 2021.

Notes: B = billion. Reform simulated as fully phased in and in equilibrium in 2022. Federal deficit effects are the sum of the change in federal spending on health care and the increase in federal income tax revenue.

* = less than +/- $500 million. ** = less than +/- 0.5%.

Public Option 2: Medicare Rates with Modest Upward Adjustments in Nongroup Markets

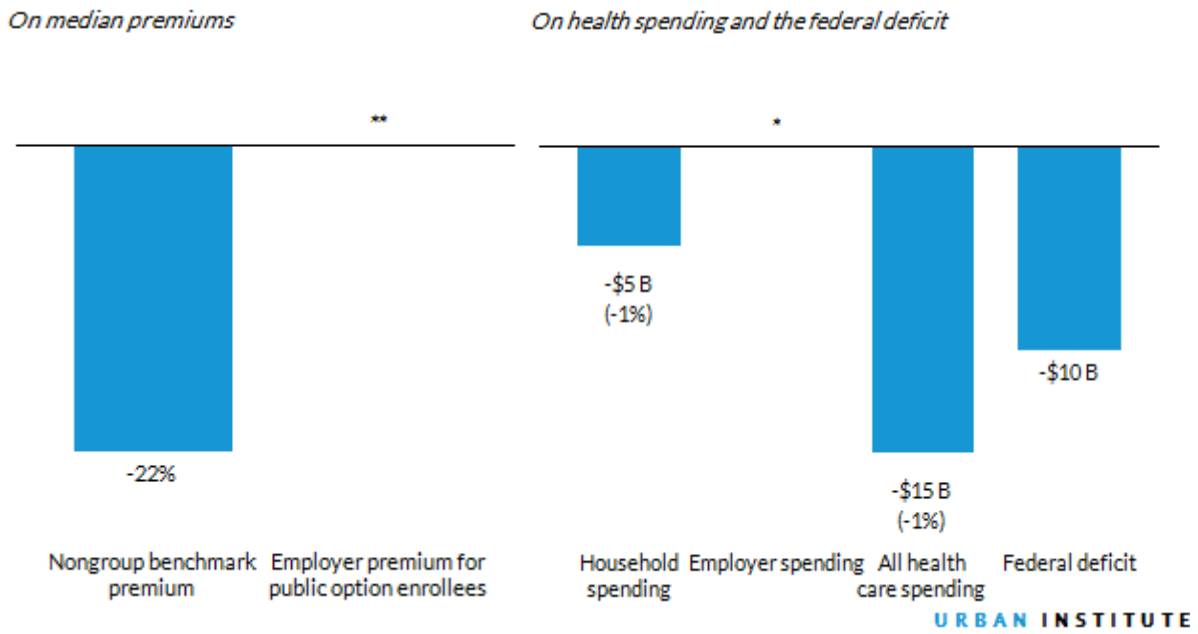
- a public option in nongroup markets in concentrated areas
- pays Medicare rates plus 10 percent for providers and plus 25 percent for hospitals in concentrated markets
- prescription drug prices set halfway between Medicare and Medicaid prices in all nongroup markets

Premium and coverage effects. The median benchmark premium falls by 22 percent in this scenario, because higher provider payment rates than those in public option 1 reduce the impact on premiums, meaning premium savings are lower. The impact on the uninsured population is also smaller; 97,000 fewer people are uninsured.

Health care spending. Federal health spending, primarily on Marketplace premium tax credits, falls by $10 billion. Aggregate household spending falls by $5 billion, or 1 percent. Again, employer spending is largely unaffected. Overall spending falls by $15 billion, or 1 percent.

FIGURE 3

Effects of Public Option 2



Source: Health Insurance Policy Simulation Model, 2021.
Notes: B = billion. Reform simulated as fully phased in and in equilibrium in 2022. Federal deficit effects are the sum of the change in federal spending on health care and the increase in federal income tax revenue.
* = less than +/- $500 million. ** = less than +/- 0.5%.

Public Option 3: Medicare Rates with Large Upward Adjustments in Nongroup Markets

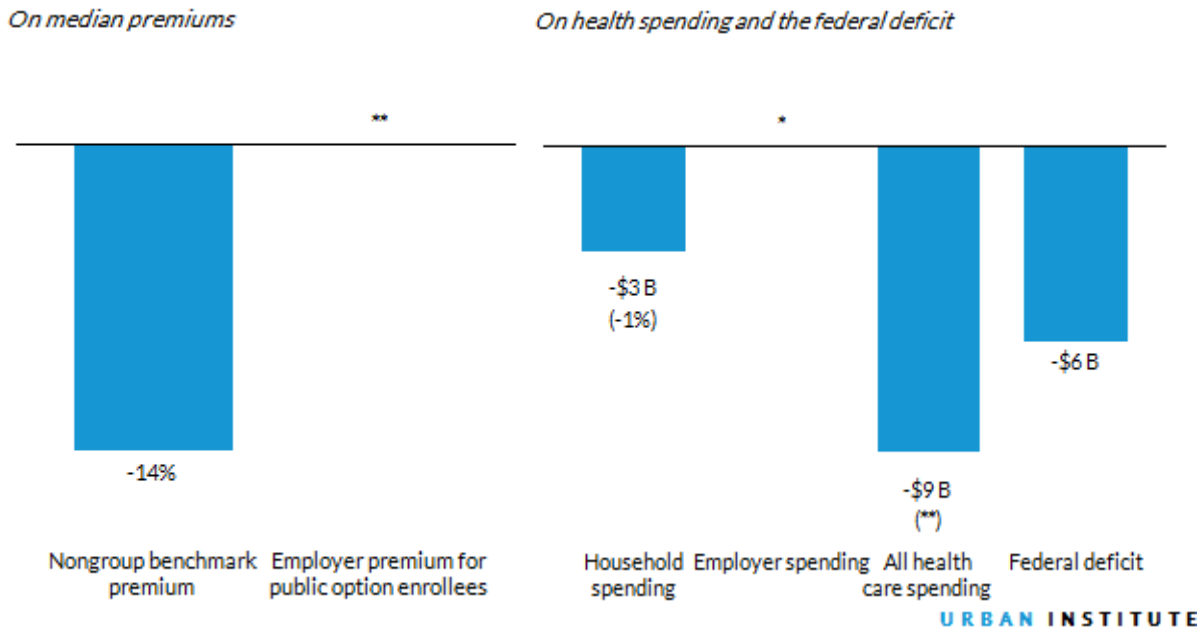
- a public option in private nongroup insurance markets in concentrated areas
- pays Medicare rates plus 15 percent for providers and plus 60 percent for hospitals in concentrated markets
- prescription drug prices set halfway between Medicare and Medicaid prices in all nongroup markets

Premium and coverage effects. Premiums fall by 14 percent because of the higher provider payment rates. The number of uninsured falls by 85,000, which is a smaller reduction than under public options 1 and 2 because of the smaller reduction in premiums.

Health care spending. Federal health spending falls by $6 billion, because smaller reductions in premiums under this reform mean smaller savings than under public options 1 and 2. Aggregate household spending falls by $3 billion, or 1 percent. Employer spending is again unaffected. Overall spending falls by $9 billion, or less than 0.5 percent.

FIGURE 4

Effects of Public Option 3



Source: Health Insurance Policy Simulation Model, 2021.
Notes: B = billion. Reform simulated as fully phased in and in equilibrium in 2022. Federal deficit effects are the sum of the change in federal spending on health care and the increase in federal income tax revenue.
* = less than +/- $500 million. ** = less than +/- 0.5%.

Public Option 4: Payment Rates Modestly above Medicare Levels in Nongroup and Employer Markets

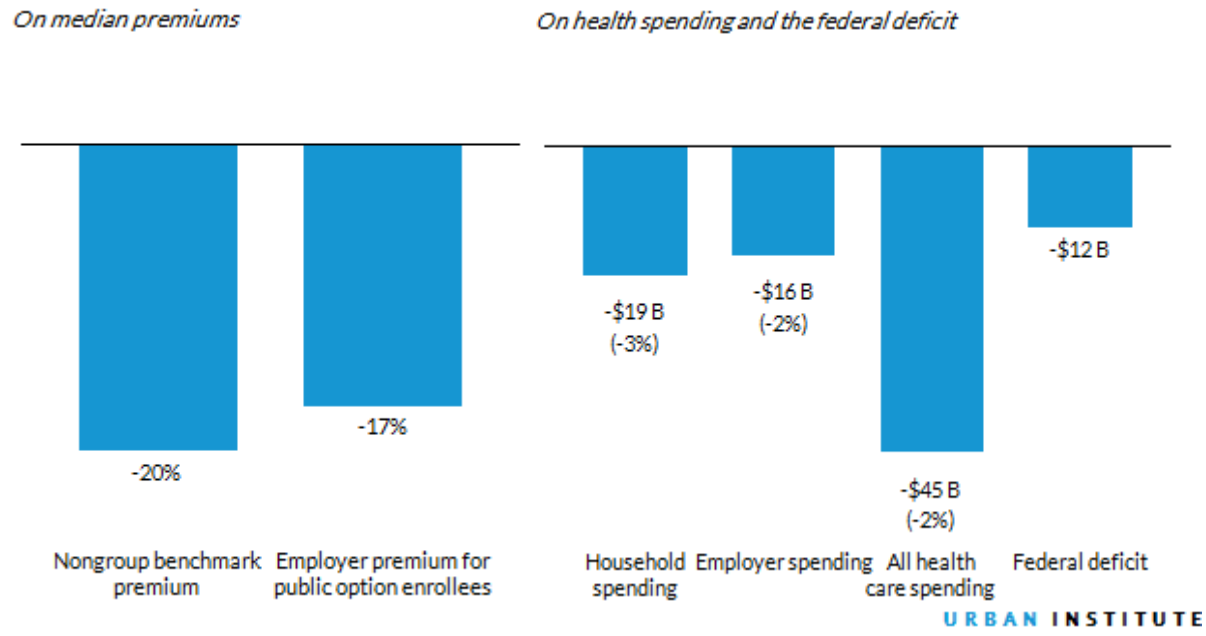
- a public option available to employer and nongroup insurance markets in concentrated areas
- public option pays Medicare rates plus 10 percent for professionals and 25 percent for hospitals in concentrated markets
- public option prescription drug prices set halfway between Medicare and Medicaid prices in all markets

Premium and coverage effects. Median premiums fall by 20 percent in nongroup markets and by 17 percent for employers choosing the public option. Employer coverage increases by 1.2 million people (not shown), and the number of people uninsured falls by 969,000.

Health care spending. Federal spending, primarily on premium tax credits, declines by $10 billion, or 2 percent. Aggregate household spending falls by $19 billion, or by 3 percent. Employer spending falls by $16 billion, or 2 percent. Lower employer spending on health care results in higher wages and, in turn, increases federal tax payments, generating $2 billion in new tax revenue. The net effect on the federal deficit is a $12 billion reduction. Overall health spending declines by $45 billion, or 2 percent.

FIGURE 5

Effects of Public Option 4



Source: Health Insurance Policy Simulation Model, 2021.
Notes: B = billion. Reform simulated as fully phased in and in equilibrium in 2022. Federal deficit effects are the sum of the change in federal spending on health care and the increase in federal income tax revenue.

Public Option 5: Payment Rates Considerably above Medicare Levels in Nongroup and Employer Markets

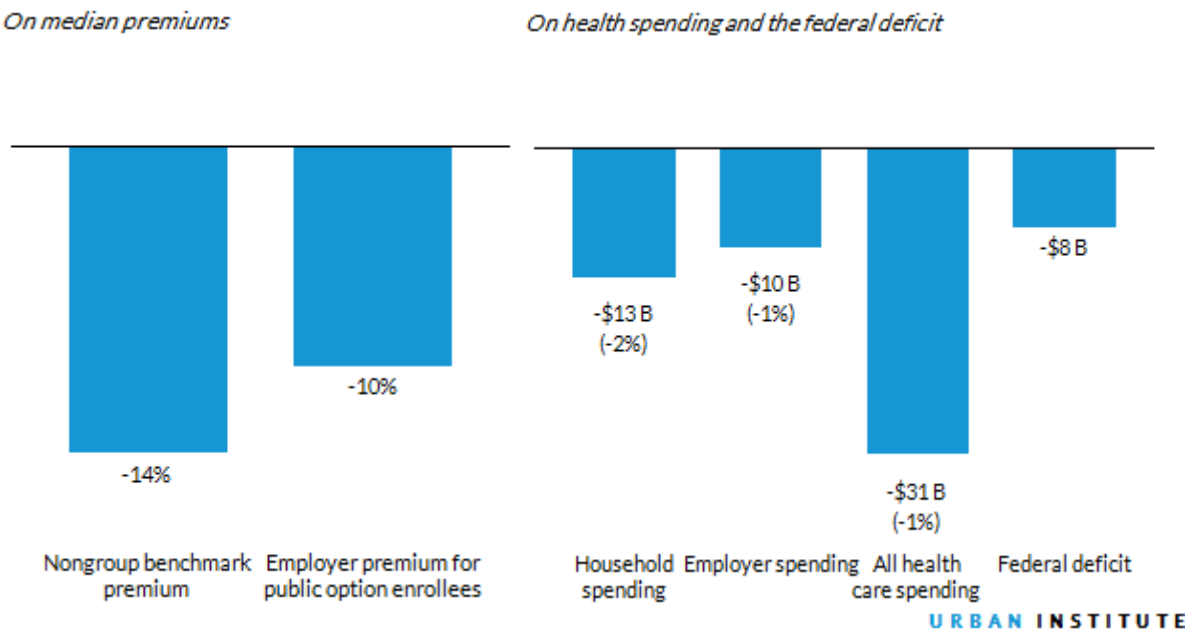
- a public option available to employer and nongroup insurance markets in concentrated areas
- public option pays Medicare rates plus 15 percent for professionals and plus 60 percent for hospitals in concentrated markets
- public option prescription drug prices set halfway between Medicare and Medicaid prices in all markets

Premium and coverage effects. Because of higher payment rates, premiums fall only by 14 percent in the nongroup market. Premiums for employers choosing the public option fall by 10 percent. Extending the new, less expensive public option to the employer market increases employer coverage by 1.1 million people and reduces the number of people uninsured by 919,000.

Health care spending. Spending by the federal government falls by almost $8 billion, less than in public option 4 because the higher provider payment rates reduce the impact on premiums. Households save $13 billion, or 2 percent. Employers save $10 billion, or 1 percent. Employer savings translate to increased wages, which results in about $500 million in new federal revenues. The federal deficit is reduced by $8 billion. Overall spending declines by $31 billion, or 1 percent.

FIGURE 6

Effects of Public Option 5



Source: Health Insurance Policy Simulation Model, 2021.
Notes: B = billions. Reform simulated as fully phased in and in equilibrium in 2022. Federal deficit effects are the sum of the change in federal spending on health care and the increase in federal income tax revenue.

Capped Rates 1: Payment Rates Capped Somewhat above Medicare Levels in the Nongroup and Employer Markets

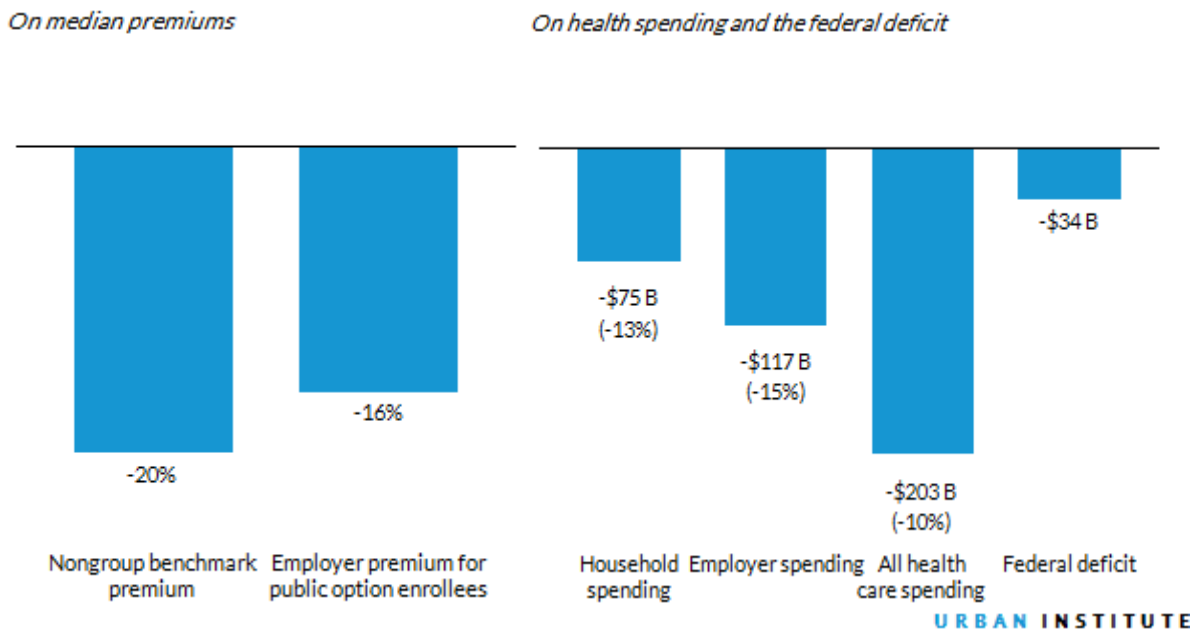
- payment rates capped for all insurers in employer and nongroup markets in concentrated areas
- pays Medicare rates plus 10 percent for professionals and plus 25 percent for hospitals in concentrated markets
- prescription drug prices set halfway between Medicare and Medicaid prices in all markets

Premium and coverage effects. Premiums fall by 20 percent in nongroup markets and by 16 percent in employer markets. About 1.2 million people gain employer coverage, and 969,000 fewer people are uninsured.

Health care spending. Capped provider payment rates decrease spending more than public option–only reforms because all insurers benefit from capped provider payment rates. Federal spending falls by $10 billion, or 2 percent, almost entirely because of lower premium tax credits in the nongroup market. Household spending falls by $75 billion, or 13 percent. Employers save $117 billion, or 15 percent. As employers pass savings on to workers via higher wages, tax payments increase by $24 billion, reducing the federal deficit by $34 billion. Overall spending falls by $203 billion, or 10 percent.

FIGURE 7

Effects of Capped Rates 1



Source: Health Insurance Policy Simulation Model, 2021.

Notes: B = billion. Reform simulated as fully phased in and in equilibrium in 2022. Federal deficit effects are the sum of the change in federal spending on health care and the increase in federal income tax revenue.

Capped Rates 2: Payment Rates Capped Considerably above Medicare Levels in the Nongroup and Employer Markets

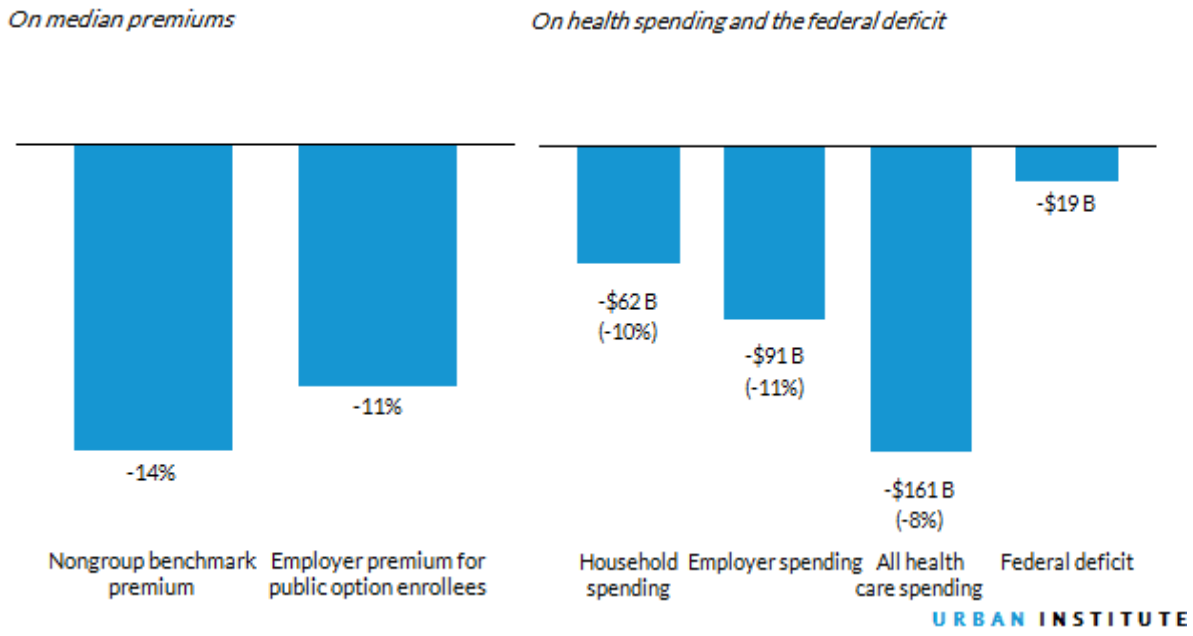
- payment rates capped for all insurers in employer and nongroup markets in concentrated areas
- pays Medicare rates plus 15 percent for professionals and plus 60 percent for hospitals in concentrated markets
- prescription drug prices set halfway between Medicare and Medicaid prices in all markets

Premium and coverage effects. Premiums fall by 14 percent in the nongroup market and 11 percent in the employer market. The number of people uninsured falls by 919,000.

Health care spending. Under this reform, savings are smaller than under capped rate 1 because of the higher provider payment rates. Households save $62 billion, or 10 percent. Employers save $91 billion, or 11 percent. Federal spending on subsidies falls by almost $8 billion. Increased tax revenues (because of higher wages) total almost $12 billion. Thus, the net effect on the deficit is a $19 billion reduction. Overall spending falls by $161 billion, or 8 percent.

FIGURE 8

Effect of Capped Rates 2



Source: Health Insurance Policy Simulation Model, 2021.
Notes: B = billion. Reform simulated as fully phased in and in equilibrium in 2022. Federal deficit effects are the sum of the change in federal spending on health care and the increase in federal income tax revenue.

Impact of Extending Reforms to All Regions

Introducing a public option or capping provider payment rates in concentrated areas in the nongroup market would capture most of the reductions in uninsurance, medical spending, and the federal deficit that would result from a similar reform applied nationally (table 3), because most of the reductions in uninsurance, medical spending, and the federal deficit resulting from a national reform would occur in concentrated markets. That is, if public option 2 were extended to all areas, spending would decrease very little because competition in nongroup markets without concentrated hospital or insurer markets have, by our estimation, already lowered prices to about Medicare levels. The reform modeled pays providers whichever is lower: Medicare levels plus 10 percent for professionals and plus 25 percent for hospitals or the current rates providers receive. Thus, most of these regions would see no change in payment rates under reform (other than the prescription drug savings all regions get). Because costs change little, uninsurance also changes little.

TABLE 3

Additional Effect of Expanding Reform to Competitive Areas, 2022

Change	Public option 2	Public option 4	Capped rates 1
In uninsurance			
Thousands of people	-12	-149	-149
Percent	12	15	15
In the federal deficit[a]			
Billions of dollars	*	-16	-19
In employer spending			
Billions of dollars	*	-70	-85
Percent[b]	**	435	72
In household spending			
Billions of dollars	*	-40	-42
Percent[b]	**	214	56
In health system spending			
Billions of dollars	*	-111	-129
Percent[b]	**	246	63

Source: Health Insurance Policy Simulation Model, 2021.

Notes: B = billion. Reforms simulated as fully phased in and in equilibrium in 2022. Data are limited to health care spending among people below age 65 not enrolled in Medicare. Prescription drug prices in each reform scenario are assumed to be set halfway between Medicare and Medicaid prices in all (concentrated and competitive) markets.

[a] Estimates in this row equal the change in federal spending on Medicaid/the Children's Health Insurance Program acute care for the nonelderly and Marketplace premiums minus the estimated increase in income tax revenue, which results from turning savings in untaxed health care premiums into taxable worker wages.

[b] Percentages are additional percent savings beyond those for a reform affecting only competitive areas.

* = less than +/- $500 million. ** = less than +/- 0.5 percent.

If reforms that involve employer-sponsored insurance, like public option 4 and capped rates 1, were extended to all areas, spending would decrease more. Prices paid in these markets have farther to fall than those in the nongroup market, and low prices are not as strongly linked to concentrated areas. If extended to all areas, capped rates 1 would result in additional savings of $85 billion for

employers, $42 billion for households, and $129 billion overall relative to implementing the reform in concentrated regions alone. This is because more people with employer-sponsored insurance would be exposed to the reduced rates (both in firms in competitive regions and in firms spanning both concentrated and competitive regions). Applying the public option in employer markets nationwide would result in greater savings than implementing it in concentrated regions alone for two reasons: First, employers who choose the public option in the restricted reform (because many of their employees are in concentrated regions) would incur reduced costs for any employees living in competitive regions. Second, more firms would choose to participate in the public option because the savings would be great enough to make the change worthwhile (reaching an assumed 20 percent savings threshold, as described below). For example, if public option 4 were applied nationwide, employer and household spending would fall by an additional $70 billion and $40 billion, respectively, and health system savings would be $111 billion greater than if it were implemented only in concentrated areas.

Discussion

In this analysis, we examine seven public option and capped provider payment rate proposals that would apply only to concentrated markets; competitive markets would not have a public option, and their hospital and professional payment rates would not be reduced. Competitive markets, however, would benefit from reductions in prescription drug prices under the reforms. The proposals vary by whether they are limited to the nongroup market, whether the public option is extended to the employer market, or whether capped provider payment rates apply to both the nongroup and employer markets. The impacts also depend on how payment rates are established: whether at Medicare levels, a relatively small multiple above Medicare rates, or a larger multiple above such rates. Targeting concentrated markets is intended to focus cost-cutting measures on the most expensive markets. We know from past research that both insurer and hospital concentration result in higher premiums.

We show public option policies have fairly large effects on nongroup premiums in all simulations. Premiums are higher under current law in concentrated markets and thus have farther to fall. We also show that limiting public option policies to the concentrated nongroup markets affects coverage little. Public option policies provide savings to the federal government and households by lowering premiums, but these effects are fairly small because the nongroup market is relatively small.

Extending the public option to employers reduces the number of people uninsured by nearly 1 million and provides more savings to the federal government. Employers see substantial savings from lower premiums and, in response, increase wages. Tax revenues increase, reducing the federal deficit by between $500 million and $2 billion. The largest effects occur under capped rates 1 and 2, under which provider payment rates are capped for all insurers. All employers benefit and, in turn, workers' wages and federal tax revenues increase. Under capped rates 1 and 2, we estimate the federal deficit drops by $19 to $34 billion in 2022.

The coverage and spending effects of any public option proposal are greater the more payment rates are reduced. The largest savings come from reducing payment rates to Medicare levels in a public option in the nongroup market. But such large payment rate cuts, even in concentrated markets, may not be politically feasible, especially if extended to the employer market. A public option that pays higher rates, Medicare plus 15 percent for health care professionals and plus 60 percent for hospitals, may be more feasible. But extending this public option to the employer market would have a small effect on premiums and thus on federal, household, and employer spending. Capping payment rates to all providers by all insurers in concentrated markets, even at Medicare rates plus 15 percent for professionals and plus 60 percent for hospitals in the employer market, would greatly reduce government, household, and employer spending on health care, because it extends to payments by all insurers.

Introducing a public option with lower provider payment rates would lower premiums and household and employer spending. But, concentrated markets would also lose federal dollars. And many of these concentrated markets are in rural areas, possibly contradicting goals of protecting providers in these areas. Nonetheless, most concentrated markets are in urban areas, and payment rate cuts in these markets may be less controversial.

Finally, we show that limiting a public option and capped provider payment rates to concentrated markets still achieves significant savings. Extending the reforms to competitive markets has few benefits for the nongroup market, but it reduces employer, household, and system spending, because more firms would choose to enroll workers in the public option. If we had used a less restrictive definition of hospital concentration, more rating regions and more people would be affected, but the proposals might thereby be less appealing. Still, with a more expansive definition of hospital concentration, the reforms would offset costs in more markets and federal, aggregate employer, household, and overall spending would be lower.

Methods

Our analysis relies on the Urban Institute Health Policy Center'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 an array of proposed health care policy reforms for the nonelderly (US residents below age 65 not enrolled in Medicare). We regularly update the model to reflect published Medicaid and Marketplace enrollment and costs in each state. For example, the current version accounts for each state's Marketplace premiums and enrollment after the 2020 open enrollment period. Enrollment in each state under current law affects how the model simulates policy alternatives.

We begin each simulation with a current-law baseline in 2022 that includes the estimated effects of, and a partial recovery from, the COVID-19 recession. For this analysis, we assume the federal medical assistance percentage for Medicaid and maintenance-of-effort provisions in the Families First Coronavirus Response Act would have expired before 2022. However, in a letter to governors sent in late January 2021, the acting secretary of the US Department of Health and Human Services indicated

the department planned to extend its public health emergency declaration through calendar year 2021.[2] This means the maintenance-of-effort requirement, which prohibits states from disenrolling Medicaid enrollees unless they request it, will last through January 2022, and the enhanced federal medical assistance percentage will be available through March 2022. Consequently, Medicaid enrollment will be notably higher in early 2022 than indicated in our estimates, but it will decline to the levels we show later in the year. Also, the federal government will pay a higher share of Medicaid costs in the first quarter of 2022 than we indicate.

We then estimate the effects of implementing each of the seven reforms modeled. Each reform affects prescription drug prices in all regions but professional and hospital payment rates in concentrated regions only. The different simulations vary by the assumed provider payment rates (all expressed relative to Medicare's payment rates) and the insurance markets (nongroup, employer) in which the public option and/or capped provider payment rates are available. All estimates assume reforms are fully phased in and in equilibrium in 2022.

Because Medicare does not provide benefits to nondisabled nonelderly people, we estimate possible Medicare payment rates for those people. We assume Medicare rates for people with nongroup insurance would equal what payment rates would be if the region had a highly competitive insurance market and a reasonably competitive hospital market, and these rates vary significantly by rating region. We then set payments by provider type (hospitals or professionals, including physicians and other providers) relative to Medicare rates, according to the assumption for each reform, the share of spending for each type of service within regions, and if the region is concentrated. Concentrated areas see reduced payments for all services and drugs, whereas competitive areas see only reduced payments for drugs.

We use a different approach for people with employer-sponsored insurance. We obtained estimates of the ratio of commercial insurers' payment rates to Medicare payment rates from FAIR Health for specific procedures by region and provider type. We then used those ratios to estimate costs for people in concentrated areas with employer-based insurance entering the public option or having provider payments capped. For all reforms, prices for prescription drugs in all areas are set halfway between those paid by Medicare and Medicaid after rebates.

Under both a public option and capped provider payment rates, all nongroup insurance enrollees see savings. HIPSM 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. For people with employer-sponsored insurance, only those in firms opting in to the public option would see savings. We assume firms that are small, pay lower average wages, and expect significant savings from the switch are more likely to choose the public option than large firms, those paying higher wages, and those expecting small savings. Capped rates 1 and 2 limit all provider payments in concentrated areas, reducing payments for everyone with employer-sponsored coverage. We discuss additional methodological issues in an earlier report (Blumberg et al. 2020).

Limitations

Uncertainty surrounds our estimates of the impacts of a public option or capping provider payment rates for several reasons: a lack of data on commercial payment rates in the nongroup market, the relevance of claims data to estimate the ratio of commercial payment rates to Medicare rates in the employer market, the need to estimate households' and firms' decisions to participate in the public option, and the need to make assumptions about the savings possible from regulating prescription drug prices. For each factor, different data can be used and assumptions made. Thus, our results may differ from actual results or those projected in other analyses.

- For the nongroup reform estimates, we lack actual payment rate data. We estimate Medicare payment rates using regression analyses. We assume markets with a large number of insurers and low hospital concentration have payment rates that approximate Medicare prices and thus premiums. Markets lacking these characteristics have been shown to have higher premiums. We estimate high premiums in markets with high insurer and hospital concentration will decrease to the levels seen in more competitive markets. But, the high premiums we observe in noncompetitive regions could owe to factors other than higher provider payment rates.
- We assume the public option is the benchmark plan. We cannot estimate how many people choose plans that have higher premiums than the benchmark. To the extent individuals enroll in more expensive plans, our estimates of nongroup reforms may underestimate household spending.
- We use data from FAIR Health, which collects data from a large number of firms. However, the data do not contain all private plans in a state or substate area. Thus, the contributing insurers may not be entirely representative, despite their very large amount of data. Further, these data cover plans for 75 percent of the privately insured population in the United States, but they include some Medicare Advantage and other plans participating in the nongroup market.
- FAIR Health provided us data on payment for professionals and outpatient facilities representing 47 percent of total professional spending and 42 percent of total outpatient facility spending. However, the services may not fully represent the ratio of average commercial payment rates to Medicare rates. More importantly, FAIR Health does not release substate data on commercial payment rates for inpatient hospital services; our estimates include all inpatient services provided in the state, but lacking this information could lead to some error at the substate level.
- We have made assumptions about employer take-up of the public option by firm size, wages, and expected savings. Take-up of the public option is assumed to be higher for small and low-wage firms, and we assume a firm will choose the public option only when the resulting savings exceed 20 percent. Our assumptions are somewhat arbitrary, and different

assumptions would have different results. Our capped rate simulations estimate the extreme case of all employers choosing the public option.

- Employers may gravitate to the public option over time. Our analysis assumes the policy is fully phased in and in equilibrium in 2022 and therefore accounts for all long-term employer behavior.
- In our estimates of prescription drug savings, we assume drug pricing rebates from various private payers are the same across the country. If the mix of drugs consumed varies geographically, our rebates may be estimated with error. In addition, Medicare pharmacy benefit manufacturers differ by geography, with some getting better rebates from manufacturers than others. Thus, Medicare rebates could differ across states, but we do not account for this.
- We estimate rebates for the public option would lead to prescription-drug prices halfway between Medicaid, Medicare, and Medicaid prices, or 30 percent below commercial insurance prices. These prices seem reasonable because they are lower than those currently achieved in Medicaid and considerably lower than those in other Western nations. We may also have underestimated the savings a public option could achieve. However, it has been politically difficult to achieve lower drug prices in the US, so we are cautious in our estimates. Any differences or errors in our savings estimates would be tempered by the fact that prescription drug spending accounts for only 23 percent of the premium dollar nationwide.

Supplementary Tables

TABLE 4

Rating Region–Level Distribution of Changes in Nongroup and Employer Premiums in Concentrated Areas under Nongroup and Employer Reforms, 2022

Percent change from current-law premiums

	Public option 1	Public option 2	Public option 3	Public option 4	Public option 5	Capped rates 1	Capped rates 2
Nongroup[a]							
Percentile							
10th	-43	-37	-31	-39	-34	-39	-34
25th	-41	-33	-22	-35	-27	-35	-27
50th (median)	-29	-22	-14	-20	-14	-20	-14
75th	-16	-9	-6	-7	-5	-7	-5
90th	-8	-4	-1	-4	**	-4	**
All employers[b]							
Percentile							
10th	NA	NA	NA	-6	-4	-20	-15
25th	NA	NA	NA	-4	-3	-19	-15
50th (median)	NA	NA	NA	-3	-2	-17	-13
75th	NA	NA	NA	-3	-2	-15	-12
90th	NA	NA	NA	-2	-1	-14	-11
Employers offering public option[b]							
Percentile							
10th	NA	NA	NA	-22	-15	-18	-14
25th	NA	NA	NA	-20	-13	-17	-13
50th (median)	NA	NA	NA	-17	-10	-16	-11
75th	NA	NA	NA	-13	-7	-14	-10
90th	NA	NA	NA	-10	-3	-13	-9

Source: Health Insurance Policy Simulation Model, 2021

Notes: NA = not applicable. Reforms simulated as fully phased in and in equilibrium in 2022. Data are limited to health care spending by people below age 65 not enrolled in Medicare. Prescription drug prices in each reform scenario are assumed to be set halfway between Medicare and Medicaid prices in all (concentrated and competitive) markets.

[a] These rows show the change in the median nongroup benchmark premium in concentrated markets.

[b] These rows show the change in the median premiums in concentrated markets among employers providing the public option to their workers in public options 4 and 5. For capped rates 1 and 2, it shows the change in median premiums for all employers in concentrated markets.

** = less than +/- 0.5%.

TABLE 5

Health Insurance Coverage of the Nonelderly Population under Current Law and Nongroup and Employer Reforms Affecting Concentrated Areas, 2022

Coverage (thousands of people)

	Current law	Public option 1	Public option 2	Public option 3	Public option 4	Public option 5	Capped rates 1	Capped rates 2
Insured (MEC)	**244,113**	**244,221**	**244,210**	**244,197**	**245,082**	**245,032**	**245,082**	**245,032**
Employer	149,325	149,266	149,266	149,269	150,506	150,461	150,506	150,461
Traditional	149,325	149,266	149,266	149,269	122,760	127,418	0	0
Public option	0	0	0	0	27,745	23,042	150,506	150,461
Private nongroup	14,960	15,045	15,037	15,030	14,683	14,683	14,683	14,683
Medicaid/CHIP	71,162	71,245	71,241	71,233	71,228	71,223	71,228	71,223
Other public	8,665	8,665	8,665	8,665	8,665	8,665	8,665	8,665
Uninsured (no MEC)[a]	**33,333**	**33,225**	**33,236**	**33,249**	**32,365**	**32,414**	**32,365**	**32,414**
Total	**277,446**	**277,446**	**277,446**	**277,446**	**277,446**	**277,446**	**277,446**	**277,446**
Changes from current law (thousands of people)								
Insured (MEC)	**—**	**109**	**97**	**85**	**969**	**919**	**969**	**919**
Employer	—	-60	-59	-56	1,180	1,135	1,180	1,135
Traditional	—	-60	-59	-56	-26,565	-21,907	-149,325	-149,325
Public option	—	0	0	0	27,745	23,042	150,506	150,461
Private nongroup	—	85	77	69	-278	-278	-278	-278
Medicaid/CHIP	—	84	79	71	66	62	66	62
Other public	—	0	0	0	0	0	0	0
Uninsured (no MEC)[a]	**—**	**-109**	**-97**	**-85**	**-969**	**-919**	**-969**	**-919**
Total	**—**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Change from current law (%)								
Insured (MEC)	**—**	**	**	**	**0.4**	**0.4**	**0.4**	**0.4**
Employer	—	**	**	**	0.8	0.8	0.8	0.8
Traditional	—	0.0	0.0	0.0	-17.8	-14.7	-100.0	-100.0
Public option	—	NA	NA	NA	NA	NA	NA	NA
Private nongroup	—	0.6	0.5	0.5	-1.9	-1.9	-1.9	-1.9
Medicaid/CHIP	—	0.1	0.1	0.1	0.1	0.1	0.1	0.1
Other public	—	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Uninsured (no MEC)[a]	**—**	**-0.3**	**-0.3**	**-0.3**	**-2.9**	**-2.8**	**-2.9**	**-2.8**
Total	**—**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Source: Health Insurance Policy Simulation Model, 2021.

Notes: MEC = minimum essential coverage. CHIP = Children's Health Insurance Program. NA = not applicable. Dashes indicate the column heading does not apply. Reforms simulated as fully phased in and in equilibrium in 2022. Prescription drug prices in each reform scenario are assumed to be set halfway between Medicare and Medicaid prices in all (concentrated and competitive) markets.
[a] Includes those without insurance and those with short-term limited-duration plans.
** = less than +/- 0.05%.

TABLE 6

Health Spending for the Nonelderly Population under Current Law and Nongroup and Employer Reforms Affecting Concentrated Areas, 2022

Health spending (millions of dollars)

Reform	Current law	Public option 1	Public option 2	Public option 3	Public option 4	Public option 5	Capped rates 1	Capped rates 2
Household	587,856	580,748	582,843	584,581	569,335	574,547	512,629	526,283
Federal government	467,105	453,521	457,561	461,167	456,710	459,321	456,710	459,321
State government	220,370	220,393	220,394	220,393	220,343	220,361	220,343	220,361
Employers	800,116	800,008	800,015	800,011	784,040	789,928	683,145	709,011
Providers	27,475	27,389	27,393	27,397	27,359	27,395	27,359	27,395
Total, all payers	**2,102,923**	**2,082,058**	**2,088,205**	**2,093,548**	**2,057,786**	**2,071,552**	**1,900,185**	**1,942,370**
Change from current law (millions of dollars)								
Household	—	-7,109	-5,013	-3,275	-18,522	-13,309	-75,227	-61,573
Federal government	—	-13,584	-9,544	-5,938	-10,395	-7,784	-10,395	-7,784
State government	—	23	24	23	-27	-9	-27	-9
Employers	—	-108	-101	-105	-16,076	-10,188	-116,971	-91,105
Providers	—	-86	-83	-79	-117	-80	-117	-80
Total, all payers	**—**	**-20,865**	**-14,717**	**-9,375**	**-45,137**	**-31,370**	**-202,738**	**-160,552**
Federal tax offset from ESI change	**—**	**NA**	**NA**	**NA**	**2,029**	**528**	**23,620**	**11,596**
Change from current law (%)								
Household	—	-1.2	-0.9	-0.6	-3.2	-2.3	-12.8	-10.5
Federal government	—	-2.9	-2.0	-1.3	-2.2	-1.7	-2.2	-1.7
State government	—	**	**	**	**	**	**	**
Employers	—	**	**	**	-2.0	-1.3	-14.6	-11.4
Providers	—	-0.3	-0.3	-0.3	-0.4	-0.3	-0.4	-0.3
Total, all payers	**—**	**-1.0**	**-0.7**	**-0.4**	**-2.1**	**-1.5**	**-9.6**	**-7.6**

Source: Health Insurance Policy Simulation Model, 2021.
Notes: NA = not applicable. Dashes indicate the column heading does not apply. Reforms simulated as fully phased in and in equilibrium in 2022. Data are limited to health care spending by people below age 65 not enrolled in Medicare. Prescription drug prices in each reform scenario are assumed to be set halfway between Medicare and Medicaid prices in all (concentrated and competitive) markets.** = less than +/- 0.05%.

Notes

[1] Throughout this paper, areas with concentration in either hospital or nongroup insurer markets or both markets are referred to as "concentrated markets;" areas with concentration only in the hospital market are called "concentrated hospital markets."

[2] Norris Cochran (acting Secretary of Health and Human Services), letter to state governors regarding extension of COVID-19 public health emergency, January 22, 2021, https://ccf.georgetown.edu/wp-content/uploads/2021/01/Public-Health-Emergency-Message-to-Governors.pdf

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About the Authors

John Holahan is an Institute fellow in the Health Policy Center at the Urban Institute, 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. Holahan has conducted significant work on Medicaid and Medicare reform, including analyses on the recent growth in Medicaid expenditures, implications of block grants and swap proposals on states and the federal government, and the effect of state decisions to expand Medicaid in the ACA on federal and state spending. Recent work on Medicare includes a paper on reforms that could both reduce budgetary impacts and improve the structure of the program. His work on the uninsured explores reasons for the growth in the uninsured over time and the effects of proposals to expand health insurance coverage on the number of uninsured and the cost to federal and state governments.

Michael Simpson is a principal research associate in the Health Policy Center with 25 years of experience developing economic models and using survey and administrative data. His current work focuses on using Urban's Health Insurance Policy Simulation Model to project health insurance coverage and spending both in the baseline and under policy alternatives. Before joining Urban, Simpson developed the Congressional Budget Office's long-term dynamic microsimulation model. He analyzed numerous policy reform proposals, investigated differences between various projections of Social Security finances and benefits, quantified the importance of Monte Carlo variation in model results, and created multiple methods to demonstrate uncertainty in projections.

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500 L'Enfant Plaza SW
Washington, DC 20024

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