



RESEARCH REPORT

# Comparing Public Option and Capped Provider Payment Rate Proposals

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*March 2021*



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# Contents

<b>Acknowledgments</b>	<b>iv</b>
<b>Comparing Public Option and Capped Provider Payment Rate Proposals</b>	<b>1</b>
Policy Objectives	4
Implementation Issues	5
Modeling the Differences in Outcomes between a Public Option and Capped Provider Payment Rates	8
Modeling Assumptions	9
Base Case Simulation Results	11
Rating Region 6: Alameda County, California, Noncompetitive Insurance Marketplace	11
Rating Region 16: West Los Angeles, California, Competitive Insurance Marketplace	19
Sensitivity Analyses	22
Conclusions	25
<b>Appendix A. Sensitivity Analysis to Higher Provider Payment Rates</b>	<b>28</b>
<b>Appendix B. Sensitivity Analysis to a Smaller Share of Premiums Being Attributable to Differences in Provider Payment Rates</b>	<b>33</b>
<b>Notes</b>	<b>38</b>
<b>References</b>	<b>40</b>
<b>About the Authors</b>	<b>41</b>
<b>Statement of Independence</b>	<b>42</b>

# Acknowledgments

This report was funded by Arnold Ventures. We are grateful to them and to all our funders, who make it possible for Urban to advance its mission.

The views expressed are those of the author and should not be attributed to the Urban Institute, its trustees, or its funders. Funders do not determine research findings or the insights and recommendations of Urban experts. Further information on the Urban Institute's funding principles is available at [urban.org/fundingprinciples](https://urban.org/fundingprinciples).

The author is grateful for research assistance from Erik Wengle, for comments and suggestions from John Holahan and Jessica Banthin, and editorial assistance from Rachel Kenney.

# Comparing Public Option and Capped Provider Payment Rate Proposals

In recent years, policymakers and analysts have discussed and debated two initiatives for lowering consumers' health insurance premiums and government costs in subsidized insurance markets. One initiative, a public option, would create a government-designed and administered (directly or via contract) health insurance plan or set of insurance plans that would be introduced in one or more insurance markets. The federal government would set rates paid to providers (e.g., doctors, hospitals, pharmaceutical manufacturers) participating with a public option. A second initiative, capping provider payment rates, would require providers participating in designated insurance markets to accept payment rates at or below a government-designated level. Thus, these capped rates would apply to providers participating in any private insurance plan offering coverage in the specified markets. The two options overlap on some key objectives but differ on others, and their implementation issues, distributional effects on consumers, and potential to reduce government spending vary as well.

This analysis explores the conceptual similarities and differences between a public option and capped provider payment rates, as well as potential differences in their distributional consequences. The two policies' differential distributional effects would have implications for consumers' and federal government spending.

Implementing either of these policies would involve the government using its leverage to set or limit provider payment rates. However, where those payment rates are ultimately set (or capped) and how they grow over time will require the government to predict (1) how insurers and providers will likely respond to a particular payment schedule, (2) how providers are likely to use their more limited bargaining power in response, and (3) how insurers will respond to greater potential competition. Though these policies are not explicitly based on negotiation, both would involve political negotiation and strategic planning based on expected industry responses. For example, insurers can compete with a public option or leave the market. Greater insurer competition could lower prices for all consumers, even those remaining enrolled in private plan options. Fewer private options could decrease consumer

satisfaction for at least some enrollees, depending on how they value the public option versus other private plans available. Capping provider payment rates would likely have different implications for private insurer pricing than would a competing public option, and the former could increase insurer participation in some markets. Capping payment rates could alienate providers and decrease their participation in affected plans if rates are set too low. Alternatively, payment rates set too high will eradicate potential savings for the government and consumers. Overall, though the federal government could exert substantial pricing power, the ultimate outcomes would reflect both insurers' and health care providers' bargaining powers.

The financial implications of a public option or capped payment rates could also differ markedly over time. Rate negotiations could occur every year, or a defined growth rate could be used over a specified period before renegotiations take place. How growth rates are determined can have implications for cost and provider/insurer participation at least as significant as the implications for where initial rates/caps are set.

Past experience does not allow us to estimate insurers' and providers' responses to a given set of public option payment rates. Therefore, we make clear assumptions about the effects of both approaches on private insurer pricing. Our analysis assumes private insurers continue competing once a public option is in place. However, we recognize this will not always be the case and will vary depending on these plans' abilities to maintain sufficient market share. We also assume sufficient numbers of providers will participate in the affected markets, even at somewhat reduced payment rates. We provide further detail in the section on modeling assumptions below. We delineate our specific assumptions so others can adjust them if they feel different assumptions would more likely reflect particular circumstances.

This analysis focuses on the private nongroup insurance market, in which a public option or capped provider payment rates are most likely to be considered and implemented in the coming years. Yet the reforms examined here could be extended to the employer-based insurance market, too. In earlier microsimulation work, we assumed both a public option and capped provider payment rates would have the same effects on federal government spending if implemented using the same payment rate proposals (Blumberg et al. 2020; Blumberg, Holahan, Buettgens, et al. 2019). We made this necessary assumption because of the microsimulation model's data limitations.<sup>1</sup> In this analysis, we explore whether that is true. Importantly, our analysis excludes other reforms often considered along with a public option or capped payment rates, namely increases in the generosity of premium tax credits and expansion of eligibility for both tax credits and cost-sharing subsidies. Instead, we provide insight into these two policy options in isolation.

We apply the following logic when analyzing these two policy options:

- In general, markets with greater insurer and provider competition today have lower nongroup insurance premiums. Therefore, the potential savings under either reform studied are lower if competition in the area is already strong.
- When introducing a public insurance option into a market, competition for private insurance plans increases, and insurers respond as if the market were more competitive. The public option is an additional insurer, likely paying providers rates below those paid by the highest-priced insurers today and perhaps below others' rates as well. Providers recognize some commercial insurers can be driven out of a market unless their payment rates, and thus premiums, can be reduced somewhat; it is in providers' interest that these insurers remain in the market.
- Insurers with the highest nongroup premiums today tend to pay providers the highest rates. This may owe to a lack of competition among insurers, providers, or both, or it may owe to broader provider networks necessitating higher payments to gain greater provider participation. When provider payment rates are capped close to Medicare rates, premiums for higher-priced plans decrease the most, reducing the variation across plans. This may owe to providers accepting lower rates because of the reform or higher-priced insurers being forced to reduce the breadth of their networks.
- These reforms change the distribution of premiums in a market and therefore likely change the market's benchmark premium. Because nongroup premium tax credits are tied to the benchmark premium, these changes have significant implications for federal government spending and households' abilities to afford existing private insurance plans.
- The reforms lead to lower payments for hospitals and physicians and would be accompanied by cost controls applied to prescription drug manufacturers as well.

We first discuss the policy objectives associated with a public option and capped provider payment rates. Next, we describe how we approach modeling these reforms and their potential consequences.

# Policy Objectives

**Public option.** Advocates for a public option do not always share the same objectives for such a policy. For some, support for this reform arises from a desire to create a broad-based provider network similar to that associated with the traditional Medicare program. This contrasts with the narrower-network insurance plans that increasingly dominate the Affordable Care Act's nongroup Marketplaces (Wengle et al. 2020). This objective is not necessarily associated with a desire to contain consumer spending or government spending on financial assistance for people purchasing nongroup insurance, though some advocates for a public option hope and expect such a policy will significantly contain costs.

Advocates who emphasize the public option as a mechanism to **reduce health care spending** focus on the federal government's ability to determine the provider payment levels under public option plans. (A public option can be thought of as a set of plans, but model the reform as a single plan in the following analysis.) Setting provider payment rates significantly below those typically paid by private insurers would provide a lower-cost health insurance option to consumers than is currently available and could reduce federal subsidy costs to the extent the public option alters the premium tax credit benchmark. Some also anticipate the public option could operate at lower administrative costs than private insurers.

**Capped provider payment rates.** Capping provider payment rates is, in comparison, explicitly designed to **contain costs** by limiting the amounts insurers can pay health care providers in specified markets. Insurers able to build provider networks by paying providers less than the caps would be allowed to do so. The reform would set caps in such a way that reduces insurer premiums for some or even all insurance plans in an affected market. Lower premiums would make more plan options affordable or attractive for more consumers. And if the approach lowers the benchmark premium, the federal government could save on premium tax credits as well. As noted in our discussion of a public option's objectives and discussed further below, these capped payment rates could be set in myriad ways. The Medicare Advantage program is a current-law example of the effectiveness of capping provider payment rates for private insurers.



# Implementation Issues

A public option and capped provider payment rates share some implementation issues and differ on others. Here, we first delineate three implementation issues that apply to both a public option and capped payment rates, followed by two that differ across the two approaches.

**The payment rates chosen.** The government must designate the rates paid to providers under a public option and the caps above which providers cannot be paid under capped payment rates. The initial payment rates used will undoubtedly be the outcome of political negotiation and will be based significantly on expectations of how insurers and providers may respond to particular payment schedules. Frequently, however, discussions of these approaches presuppose providers would be paid at Medicare rates or some percentage above them. Using median commercial insurance payment rates or some percentage thereof is another option. Alternatively, entirely new provider payment schedules could be developed.

Though no provider fee schedule is ideal in all circumstances, Medicare rates are known and already in wide use nationally throughout the Medicare program. Thus, implementing a reform based on them would be faster than developing a new approach or relying on commercial prices. Medicare payment rates are also based on relative value units based on resource use.<sup>2</sup> They are not necessarily correlated with commercial rates, however, and switching to them could lead to some redistribution across providers and/or medical services. Commercial prices are likely to have some political appeal, particularly with health care providers. However, no data on these prices currently exist, and, therefore, an enormous data collection effort would be required. In addition, the limited data available that have been analyzed by researchers indicate extreme variation in payment rates by both provider and service across the US. In addition, commercial payment rates can depend on particular provider competition in an area, as opposed to a schedule determined analytically based on resource use for particular procedures and services. For example, an area with a single anesthesiology group generally pays those providers much higher payment rates than an area with multiple competing anesthesiology groups, even at the median. Therefore, the relative payments across services result from many dynamics unrelated to value. Conversely, Medicare sets payments relative to their value to each other.

Regardless of the approach to developing the payment rate schedule for either reform, policymakers must decide

- how the target payment rates should vary across providers and specialties;
- the period over which target payment rates should be achieved;

- and, once the target payment rates are achieved, how they should grow over time.

These design decisions will substantially affect the extent to which health care providers' finances and, by extension, health care delivery will be disrupted by reform (e.g., change in supply of some services and procedures, impacts on quality of care provided). The larger the decreases in provider payment rates are relative to current law and the faster they are implemented, the greater the potential for disruptions in care provision, at least in the near term. However, smaller changes in provider payment rates and slower implementation lead to lower savings for the government and consumers.

**Provider participation.** The provider payment rates chosen affect provider participation in the affected plans. The lower the payments are set in a public option or the lower payment rate caps are set, the less likely health care providers will participate in those plans. However, these risks are small because nongroup insurance markets constitute a small share of the typical provider's caseload. However, the objectives of broad provider networks and cost containment intrinsically compete against each other;<sup>3</sup> achieving broad networks likely requires higher provider payment rates than policymakers or advocates seeking significant cost containment would choose, particularly for physicians.

Policymakers could develop requirements tying provider participation in the public option or in capped rate nongroup markets to their participation in other public insurance programs, such as Medicare and Medicaid. However, this is unlikely to be politically popular among providers or to survive a political negotiation required for either reform. Additionally, policing participation and compliance with physicians would be challenging for the federal government.

**Markets where reforms would be implemented.** Designers of a public option or capped rates would have to decide the specific insurance markets in which the reforms would be implemented. Most commonly, public option and capped rate proposals have focused on nongroup insurance markets, but some have suggested implementation in both the nongroup and employer markets.<sup>4</sup> The larger the number of insured people affected, the greater the potential for consumer and government savings. But the potential for health care delivery system disruptions is greater as well when more insured people are affected. Among people under age 65 (i.e., below Medicare age), enrollment in employer-sponsored insurance is roughly 8.5 times greater than enrollment in compliant nongroup insurance. Therefore, both savings and health system impacts are substantially larger if employer-based insurance markets are included in a reform.

In addition, some have suggested only a subset of markets should be included in these reforms. This might include areas that do not meet minimum competitiveness levels in their insurer and/or

provider markets, which tends to increase provider payment rates and therefore premiums. Relatedly, the reforms' implementation could vary by rural versus urban status, or otherwise focus on geographic areas with high premiums and/or provider payment rates. However, limiting a public option or capped payment rates to certain geographic areas is complex and could be overly disruptive; circumstances like insurer or provider competitiveness in a market can change over time, and it is unclear how these policies would adapt to changes in competition in the local market. Also, limiting such reforms to certain areas would have significant implications for the savings achieved nationally (Holahan and Simpson 2021a, 2021b, and 2021c).

***Creation of an insurance product or set of products.*** Unlike capped payment rates, which modify the payment rates for providers in existing private insurance plans, a public option requires the government or a government contractor to create an insurance product or products, risk bearing entities that contract with various provider types. Even if the public option relied on a Medicare-like payment schedule, the structure of the set of plans would differ from Medicare's structure. Assuming the public option would only be available in the nongroup insurance market, the plans would presumably be structured consistent with the rules for a qualified health plan.

The public option would require administrators to develop and contract with a nationwide network of physicians, hospitals, and other providers and create a system for filing and paying claims. In addition, the public option requires a system for utilization review and oversight, marketing, and other roles insurers play. These tasks are feasible, but they require time, resources, and a team to be implemented. In contrast, capping provider payment rates does not require creating a new insurance entity or systems. Insurers would continue to contract with providers independently, but they would have the additional negotiating leverage of the payment rate caps; the plans for which the caps would be used are already established.

***Impact on private insurers' participation.*** Depending on the chosen provider payment rates and the reform's success building broad-based provider networks, a public option could decrease insurer participation in some insurance markets. Private insurers may struggle to compete for enrollees if (1) insurers cannot negotiate provider payment rates as favorable as those under a public option or (2) a public option can develop a broader provider network than those of many commercial insurers in the same market. At least one preliminary analysis using former Medicaid managed-care organizations as a proxy for a public option indicated private insurers may be able to use a public option's presence as leverage in negotiating lower provider payment rates with their networks of physicians and hospitals (Blumberg, Holahan, Wengle, et al. 2019). However, the analysis suggested modest premium savings, below 10 percent, could be achievable. Depending on private insurers' actual abilities to negotiate

better deals with providers and whether any prescription drug savings achieved by a public option would also be shared with private insurers, insurers may see their enrollment fall to levels that make remaining in the market disadvantageous. Whether this is a positive outcome depends on the objectives of establishing a public option.

In contrast, capping provider payment rates is likely to increase the number of private insurers participating in an affected market. Today, without market share, it is challenging for an insurer new to an area to negotiate favorable provider payment rates that allow it to set competitive premiums. Therefore, capping provider payment rates across all private insurers removes a significant barrier to market entry for additional insurers.

## Modeling the Differences in Outcomes between a Public Option and Capped Provider Payment Rates

As noted above, the key differences in outcomes between a public option and capped payment rates are likely distributional, relating to (1) how the affordability of available plans differs under each reform type and relative to current law and (2) how these differences vary across enrollees of different subsidy eligibility levels. Consequently, including data on all insurance plan options in a particular area is essential for highlighting the potential differences in outcomes. Here, we use a spreadsheet model that accounts for these data, allowing us to focus on the distributional implications of a set of reforms in example rating areas. As noted, we make our assumptions about how premiums for different plans would be affected by the reforms explicit so others can modify those assumptions or perform sensitivity analyses to alternative approaches.

## Modeling Assumptions

Our estimates assume the following:

- Additional reforms (e.g., more generous Marketplace subsidies) are not included with the public option or capped payment rates.
- For ease of exposition, the public option is introduced at the silver level only, but a public option at the other coverage tiers could easily be created and introduced simultaneously. The silver tier is necessary, at a minimum, because it is the tier to which premium tax credits are tied under current law. Additionally, enrollees with incomes up to 250 percent of the federal poverty level (FPL) must purchase silver-level coverage to enroll in cost-sharing reduction plans. More than one public option could be introduced in a given tier as well; for example, one public option plan could require higher deductibles but lower coinsurance than another. Here, only one silver-tier public option is introduced.
- We estimate the public option premium in each rating area in a manner consistent with our prior analyses.<sup>5</sup> We proxy public option premiums at Medicare provider payment rates as equaling the premiums resulting from high insurer competition and reasonable hospital competition in a market, accounting for other rating region differences. The same cited earlier work provides evidence to support using this proxy. We use a regression-based technique to estimate the current-law benchmark premium in each rating area as a function of the number of competing insurers, level of hospital concentration, and other Marketplace characteristics. We then predict the public option premium at Medicare rates in each rating area, assuming five or more insurers compete and the hospital Herfindahl-Hirschman Index (HHI) is at least 5,000. Then, we apply the percent difference between the actual benchmark premium and predicted public option premium in a rating area to compute the savings difference associated with introducing a public option that uses Medicare payment rates. For the sensitivity analysis using Medicare rates plus 10 percent, we reduce calculated savings by 10 percent. We then add savings resulting from prescription drug cost-containment strategies, as described below.
- Private insurers currently operating in noncompetitive or minimally competitive insurance markets may reduce their costs when the public option, and thus greater competition, is introduced in their market. Both economic theory and earlier studies support this assumption. One way insurers can reduce costs is negotiating lower provider payment rates. We assume private insurers can lower their premiums to an extent consistent with the premium differential we currently see between private insurers in otherwise similar markets with and

without a competing Medicaid managed-care organization. Consistent with earlier work (Blumberg, Holahan, Wengle et al. 2019), we estimate a regression that uses the presence of a Medicaid insurance plan in the Marketplace as a proxy for the impact a public option could have on non-Medicaid insurers' premiums in that area.<sup>6</sup> Based on the results of that regression analysis, we assume a public option will tend to lower premiums of competing insurers to a greater extent in less competitive areas. For example, private insurer premiums decrease by 5.3 percent in rating areas with two private insurers and not at all in areas with five or more competing insurers. Depending on how the public option premium compares with current-law premiums in the market, the private plans will have greater or weaker abilities to successfully negotiate lower payment rates with providers. For example, plans in already highly competitive areas will presumably be less able to achieve such savings, because their premiums are already lower because of existing competition.

- Capping provider payment rates has larger effects on the highest-priced insurers' premiums and smaller effects (or sometimes no effect) on lower-priced insurers' premiums.<sup>7</sup> In essence, this approach decreases all provider payment rates to no more than the designated levels, so plans paying providers the most today see premiums decrease the most. Insurers paying providers at or below those rates today are unlikely to see decreases. We estimate the effect of capping provider payment rates on the lowest silver premium available in each rating region using a similar regression-based approach to that described above.<sup>8</sup> However, this method would not work for plans priced above the benchmark; such plans vary in number across markets, and capping rates should have a larger effect on higher premiums. Therefore, we make another assumption that two-thirds of the difference between the current-law benchmark premium and silver premiums exceeding the benchmark is attributable to the difference in provider payment rates between the plans. We also conduct a sensitivity analysis of this assumption, where one-half of the difference is attributable to differences in payment rates. If more of the differential is attributable to payment rates differences, we have overstated the variance in private plan premiums in the capped payment rate simulations and vice versa.
- Prescription drug savings are achieved through requirements that manufacturers pay an affected insurer higher rebates than those currently provided to commercial insurers. These rebates are assumed to be halfway between those provided to Medicare and Medicaid under current law (Hwang and Kesselheim 2020). We assume only the public option is entitled to these larger rebates under a public option approach, but we assume these rebates are provided to all private insurers in the Marketplace under capped payment rates.

- Insurers maintain sufficient provider networks while taking advantage of capped provider payments.<sup>9</sup>
- The public option pays health care providers Medicare rates in the main results; Medicare rates plus 10 percent are used as a sensitivity test. Similarly, capped provider payment rates limit private insurer payment rates to Medicare levels (Medicare plus 10 percent in the sensitivity analysis).

## Base Case Simulation Results

Table 1 shows full (unsubsidized) monthly premiums for a 40-year-old single enrollee in each of the plans offered in the Marketplace in California’s rating regions 6 (Alameda) and 16 (Los Angeles West) in 2020. Region 16 was a highly competitive insurance market, with eight insurers, whereas region 6 was far less competitive, with only two insurers that year.

### Rating Region 6: Alameda County, California, Noncompetitive Insurance Marketplace

**Full (presubsidy) premiums.** The current-law benchmark insurance premium (second-lowest silver) in rating region 6 (the less competitive region) was substantially higher than in rating region 16 (\$546.19 versus \$362.61 per month) in 2020. Though these differences are not necessarily fully attributable to southern California insurance and hospital systems being more competitive than those in northern California, their premiums relative to each other are consistent with that national pattern. The typical premiums in the bronze and gold coverage tiers follow a similar pattern.

**If a public option using Medicare provider payment rates were introduced into rating region 6,** the option would have multiple effects on the Marketplace’s available insurance options:

- The public option would become the lowest-premium silver option in the market. At \$402.54 per month, the public option premium would be considerably lower than the current-law lowest-priced silver option, the Kaiser Permanente plan with a \$479.94 monthly premium. We estimate the public option would be 26.3 percent lower than the current-law benchmark plan because of lower medical claims costs and would be another 6.9 percent lower because of large prescription drug rebates required of manufacturers.
- Introducing the public option would inject new competition into this market. Other insurers would respond by lowering their premiums by 5.3 percent, the savings we estimate are

possible to achieve through more aggressive negotiations with providers. Consequently, full premiums for each plan across all metal tiers would be somewhat lower than under current law, making them more affordable for consumers buying coverage without tax credits.

- The benchmark premium would fall from \$546.19 under current law (for the Blue Shield of California silver 70 Trio health maintenance organization, or HMO) to \$454.50 with the public option. The large decrease would owe to (1) the Kaiser Permanente plan (the lowest-priced silver plan under current law) becoming the benchmark plan and (2) the roughly 5 percent decrease in private insurer premiums resulting from heightened competition from the public option.
- The differential between the highest and lowest premiums in the silver tier would increase relative to current law, whereas the differential between the highest and lowest premiums in the bronze and gold tiers would shrink modestly.

**If private insurers' provider payment rates were capped at Medicare levels in rating region 6,** the approach would have multiple effects on the Marketplace's available insurance options:

- All premiums would fall significantly across metal tiers, from about 26 percent decreases for the Kaiser Permanente and Blue Shield of California (hereafter "Blue Shield") HMO plans to about a 33 percent decrease for the Blue Shield preferred provider organization (PPO) plans (the highest-priced options under current law). The premiums would fall differentially across product lines because insurers with higher premiums today are assumed to currently pay providers higher rates than their lower-premium counterparts; capping provider payment rates would therefore drive provider payment rates closer to one another across product lines.
- The benchmark premium would still be associated with the silver 70 Trio HMO plan, as is the case under current law. However, the benchmark premium would be \$402.54 per month, compared with \$546.19 per month under current law.
- The benchmark premium under capped payment rates would be significantly lower than that in the public option, because decreases in private insurer premiums are much larger under capped rates. This significantly lower benchmark premium translates into larger federal savings than under the public option, because premium tax credits are tied to the benchmark premium.
- Capped provider payment rates would affect all insurers in this market to a greater extent than would the public option, thereby dramatically decreasing variation in premiums within



each coverage tier. The differentials between the lowest- and highest-priced insurers would drop by roughly 50 percent. This compression could create more intense competition across insurers, bringing higher-priced insurers into reach for more consumers.

- Reducing a substantial barrier to entry for new insurers, lower provider payment rates may prompt new entrants to a rating area, including possibly opening up avenues for additional broader network plans.

TABLE 1

**Full (Unsubsidized) Monthly Premium for a 40-Year-Old Single Enrollee for Bronze, Silver, and Gold Plan Offerings in California Rating Regions 6 and 16 under Current Law, a Public Option, and Capped Provider Payment Rates, 2020**

*Base case assumptions*

Insurer	Plan name	CURRENT LAW		REFORM SCENARIOS			
		Rating region 6	Rating region 16	Rating Region 6		Rating Region 16	
				Public option	Capped rates	Public option	Capped rates
Bronze-tier plans							
Blue Shield	60 PPO	495.64	NA	469.37	332.82	NA	NA
Blue Shield	60 HDHP PPO	477.73	NA	452.41	320.80	NA	NA
Kaiser Permanente	60 HMO	387.15	NA	366.63	284.17	NA	NA
Kaiser Permanente	60 HSA HMO	368.18	NA	348.67	270.24	NA	NA
Anthem	60 HMO	NA	335.92	NA	NA	335.92	288.33
Blue Shield	60 PPO	NA	417.60	NA	NA	417.60	299.35
Blue Shield	60 HDHP PPO	NA	402.51	NA	NA	402.51	288.54
Health Net Life	60 EnhancedCare PPO	NA	344.82	NA	NA	344.82	261.08
Health Net Life	60 HDHP EnhancedCare PPO	NA	342.06	NA	NA	342.06	258.99
Health Net of CA	60 PureCare HSP	NA	344.72	NA	NA	344.72	318.87
Kaiser Permanente	60 HMO	NA	314.54	NA	NA	314.54	278.14
Kaiser Permanente	60 HSA HMO	NA	299.13	NA	NA	299.13	264.51
L.A. Care	60 HMO	NA	287.21	NA	NA	287.21	262.95
Molina	Choice Care	NA	330.25	NA	NA	330.25	307.46
Oscar	60 EPO	NA	272.26	NA	NA	272.26	253.47
Silver-tier plans							
Blue Shield	70 PPO	634.05	NA	600.45	425.77	NA	NA
Blue Shield	70 Trio HMO	546.19	NA	517.24	402.54	NA	NA
Kaiser Permanente	70 HMO	479.94	NA	454.50	352.28	NA	NA
Federal government	Public option	NA	NA	402.54	NA	NA	NA

Insurer	Plan name	CURRENT LAW		REFORM SCENARIOS			
		Rating region 6	Rating region 16	Rating Region 6		Rating Region 16	
				Public option	Capped rates	Public option	Capped rates
Anthem	70 HMO	NA	406.97	NA	NA	406.97	349.32
Blue Shield	70 PPO	NA	534.22	NA	NA	534.22	382.95
Blue Shield	70 Trio HMO	NA	452.30	NA	NA	452.30	361.30
Health Net Life	70 EnhancedCare PPO	NA	490.52	NA	NA	490.52	371.40
Health Net of CA	70 CommunityCare HMO	NA	365.90	NA	NA	365.90	338.46
Kaiser Permanente	70 HMO	NA	389.94	NA	NA	389.94	344.81
L.A. Care	70 HMO	NA	371.22	NA	NA	371.22	339.87
Molina	Choice Care silver	NA	362.61	NA	NA	362.61	337.59
Oscar	70 EPO	NA	362.33	NA	NA	362.33	337.33
Federal government	Public option	NA	NA	NA	NA	337.59	NA
<b>Gold-tier plans</b>							
Blue Shield	80 PPO	748.81	NA	709.12	502.83	NA	NA
Blue Shield	80 Trio HMO	667.66	NA	632.27	492.07	NA	NA
Kaiser Permanente	80 HMO copayment	573.94	NA	543.52	421.27	NA	NA
Kaiser Permanente	80 HMO coinsurance	545.49	NA	516.58	400.39	NA	NA
Anthem	80 HMO	NA	449.60	NA	NA	449.60	385.91
Blue Shield	80 PPO	NA	630.91	NA	NA	630.91	452.26
Blue Shield	80 Trio HMO	NA	552.90	NA	NA	552.90	441.66
Health Net Life	80 EnhancedCare PPO	NA	584.10	NA	NA	584.10	442.26
Health Net of CA	80 CommunityCare HMO	NA	435.41	NA	NA	435.41	402.76
Kaiser Permanente	80 HMO copayment	NA	466.31	NA	NA	466.31	412.35
Kaiser Permanente	80 HMO coinsurance	NA	443.19	NA	NA	443.19	391.90
L.A. Care	80 HMO	NA	383.79	NA	NA	383.79	351.37
Molina	Choice Care gold	NA	373.74	NA	NA	373.74	347.95
Oscar	80 EPO	NA	412.53	NA	NA	412.53	384.07

**Sources:** Current-law premiums are from [CoveredCA.com](https://www.coveredca.com/); public option and capped payment rate premiums are the product of Urban Institute analysis.

**Notes:** Blue Shield is Blue Shield of California. Health Net of CA is Health Net of California. NA indicates the plan is not available in the region or scenario. AV is actuarial value. PPO is preferred provider organization. HDHP is high-deductible health plan. HMO is health maintenance organization. HSA is health savings account. HSP is health care services plan. EPO is exclusive provider organization. The benchmark premium in each scenario is shaded grey. Public option premiums assume Medicare provider payment rates; capped provider payment rates assume caps for all plans are set at Medicare provider payment rates.

**Postsubsidy premiums.** Table 2 shows the monthly household premium contribution for a 40-year-old single enrollee of two subsidy-eligible incomes in each of the region 6 insurance options in the bronze, silver, and gold tiers under current law, a public option, and capped provider payment rates. The illustrative income levels are 200 percent of FPL (\$25,520 for a single adult) and 400 percent of FPL (\$51,040 for a single adult). The full premiums delineated in the previous section would apply to higher-income enrollees and those ineligible for premium tax credits for other reasons (e.g., having an affordable offer of health insurance available through an employer).

If a public option using Medicare provider payment rates were introduced in region 6, the public option would be the lowest-priced silver plan offered. However, the presence of the public option would mean the benchmark (second-lowest-priced silver) premium would shift to a different plan with a lower premium. Consequently, the amount of the subsidies for all people eligible for them would decrease. Thus, required premium contributions for subsidized enrollees choosing the same coverage they have under current law would be higher in the presence of a public option. For the same reason, the lowest-contribution requirement for a silver plan would be higher than that under current law.

The public option would require a 40-year-old single enrollee with income of 200 percent of FPL to contribute \$86.06. However, the benchmark premium in this scenario is considerably lower than that under current law (\$454.50 versus \$546.19; table 1), and the public option premium is significantly lower than the benchmark premium that corresponds to it (\$402.54 versus \$454.50; table 1). Thus, this lowest-contribution requirement for the subsidized population would actually be higher with the public option in place than under current law. Under current law, for example, the silver Kaiser Permanente HMO is available to our illustrative enrollee for \$71.77 per month. However, the least expensive silver plan would be available to her for \$86.06 per month with the public option in place. Likewise, within each actuarial value tier and at each subsidized income level, the lowest household contribution requirement would be higher with a public option in place than under current law. Additionally, the household contribution required for those receiving subsidies for almost every private insurance option in each actuarial value tier would be higher under the public option than under current law.<sup>10</sup>

TABLE 2

**Subsidized Monthly Premium for a 40-Year-Old Single Enrollee at Two Income Levels Relative to the Federal Poverty Level in California Rating Region 6 under Current Law, a Public Option, and Capped Provider Payment Rates, 2020**

*Base case assumptions*

Insurer	Plan name	200% of FPL			400% of FPL		
		Current law	Public option	Capped rates	Current law	Public option	Capped rates
Bronze-tier plans							
Blue Shield	60 PPO	87.47	152.89	68.30	365.43	430.84	332.82
Blue Shield	60 HDHP PPO	69.56	135.93	56.28	347.52	413.88	320.80
Kaiser Perm.	60 HMO	0.00	50.15	19.65	256.94	328.10	284.17
Kaiser Perm.	60 HSA HMO	0.00	32.18	5.72	237.97	310.14	270.24
Silver-tier plans							
Blue Shield	70 PPO	225.88	283.96	161.24	503.84	561.92	425.77
Blue Shield	70 Trio HMO	138.02	200.76	138.02	415.98	478.71	402.54
Kaiser Perm.	70 HMO	71.77	138.02	87.75	349.73	415.98	352.28
Federal gov.	Public option	NA	86.06	NA	NA	364.01	NA
Gold-tier plans							
Blue Shield	80 PPO	340.64	392.64	238.31	618.60	670.60	502.83
Blue Shield	80 Trio HMO	259.49	315.79	227.54	537.45	593.75	492.07
Kaiser Perm.	80 HMO copay	165.77	227.04	156.75	443.73	504.99	421.27
Kaiser Perm.	80 HMO coins.	137.32	200.10	135.87	415.28	478.05	400.39

**Sources:** Current-law premiums from [CoveredCA.com](https://www.coveredca.com/); public option and capped payment rate premiums are the product of Urban Institute analysis.

**Notes:** FPL is federal poverty level. Blue Shield is Blue Shield of California. Kaiser Perm. is Kaiser Permanente. Gov. is government. PPO is preferred provider organization. HDHP is high-deductible health plan. HMO is health maintenance organization. HSA is health savings account. Coins. is coinsurance. NA indicates the plan is not available in the scenario. The benchmark premium in each scenario is shaded grey. Public option premiums assume Medicare provider payment rates; capped provider payment rates assume caps for all plans are set at Medicare provider payment rates.

If two or more public option plans were introduced at the silver level (a situation not modeled here), the two public option plans could become both the lowest-premium and the second-lowest-premium plans in a rating region. If this were to occur, it would push the benchmark premium even lower than we show here, requiring consumers to pay still more to enroll in competing commercial plans than these results indicate.

**Alternatively, if provider payment rates for private insurers were capped at Medicare levels in region 6,** the distributional implications for subsidized enrollees would differ somewhat. Like under the public option, the absolute level of the premium tax credits would fall as the benchmark premium falls. For our illustrative 40-year-old single enrollee with income of 400 percent of FPL, the subsidy would fall to \$0, because the full benchmark premium would have decreased enough that the full premium would be below 9.78 percent of the enrollee's income. Under the caps, subsidized enrollees would find plans offered by insurers paying higher provider payment rates become less expensive than under

current law, whereas plans offered by those paying lower provider payment rates would become more expensive.

In this scenario, subsidized enrollees in the Kaiser Permanente bronze and silver plans, the lower-priced options in these actuarial value tiers, would pay more for their plans under capped rates than under current law. This is because the benchmark, here tied to the mid-priced Blue Shield HMO, would fall by a larger amount than the premiums for the lower-priced options. Consequently, the lower subsidy would outweigh the savings from choosing a lower-priced plan. For example, the subsidy for our illustrative enrollee with income of 200 percent of FPL would drop by \$143.65 per month relative to current law. But the lowest-priced silver Kaiser Permanente plan premium would drop by only \$127.66, because Kaiser Permanente's payment rates were already lower than Blue Shield's before the caps' implementation. So though the Kaiser Permanente plan's premium would fall, it would not make up for the drop in the subsidy, leaving the households choosing that plan to pay somewhat more.

Meanwhile, people with subsidies choosing the benchmark plan would pay the same amount as under current law for that option (their applicable percentage-of-income cap). Within each actuarial value tier of coverage, household contributions for the higher-priced (Blue Shield) plans would be smaller than under current law. These savings for the higher-priced plans in each tier materialize because premiums for the higher-priced plans decrease the most under capped payment rates, significantly decreasing the premium differences between higher- and lower-priced plans.

Comparing this scenario with the parallel public option scenario, however, we find household premiums for the same plan would be universally lower under capped rates, except for enrollees who would otherwise choose the public option if it were available. Because it would be the lowest-cost option if it were offered, the public option would provide a lower-cost silver plan than would any of the capped rate private silver plans. Private plans would be more affordable under capped rates because explicitly limiting private plan payment rates would have a much larger effect on private insurer premiums than would increasing competition through a public option. The higher subsidy under the public option (because of the higher benchmark premium) would counteract that and make the public option less expensive for subsidized households than the private plan under capped rates.

## Rating Region 16: West Los Angeles, California, Competitive Insurance Marketplace

**Full (presubsidy) premiums.** As shown in table 1, full premiums in the coverage tier with the highest enrollment (silver) ranged from \$362.33 to \$534.22 per month under current law in 2020; the benchmark plan premium was only slightly more expensive than that for the lowest-priced insurer. Nine silver plan options were offered across the eight insurers participating in the region.

**If a public option using Medicare provider payment rates were introduced into rating region 16,** it would become the lowest-priced silver option in the market. However, its introduction cannot be expected to affect private plans' premiums in the area. This is because the market is already so highly competitive under current law that any negotiating leverage plans have with providers has already played out in their current premiums. The public option premium is estimated to be \$337.59 per month, and its savings relative to the lowest-priced private plans in the market would be entirely attributable to the assumed higher prescription drug rebates the public option would require (and which, in these base case estimates, are assumed to be unavailable to the competing private plans). Because the two lowest-premium plans in this market have such similar premiums (\$362.33 for Oscar's silver EPO and \$362.61 for Molina's Choice Care silver plan), introducing the public option would move the benchmark premium by less than 30 cents per month, not a noticeable change.

In addition to the modest premium savings it would offer, the public option could attract enrollees for reasons unrelated to price. This could be particularly true if it offers a provider network that is broader than or perceived as somehow superior to those offered by other lower-priced insurers in the market.

**If private insurers' provider payment rates were capped at Medicare levels in rating region 16,** all insurance plans' premiums in this market would be affected; the savings would range from 6.9 percent (prescription drug savings only) to 28.3 percent (savings for the higher-priced plan options). The benchmark premium would fall from \$362.61 to \$337.59 per month. Thus, the full premiums for all private plans would be lower than they are under current law. In addition, the premiums for each private plan option at all coverage tiers would be lower with capped provider payment rates than under the public option. Plus, the lowest-priced silver private insurance plan under this approach, Oscar's EPO, would have a full premium nearly identical to that of the public option, if that approach were taken instead.

**Postsubsidy premiums.** Table 3 shows the postsubsidy premium contribution required for our illustrative enrollee living in California's rating region 16 at two income levels under current law, the public option, and capped provider payment rates.

TABLE 3

**Subsidized Monthly Premium for a 40-Year-Old Single Enrollee at Two Income Levels Relative to the Federal Poverty Level in California Rating Region 16 under Current Law, a Public Option, and Capped Provider Payment Rates, 2020**

*Base case assumptions*

Insurer	Plan name	200% of FPL			400% of FPL		
		Current law	Public option	Capped rates	Current law	Public option	Capped rates
Bronze-tier plans							
Anthem	60 HMO	111.33	111.61	88.76	335.92	335.92	288.33
Blue Shield	60 PPO	193.01	193.29	99.78	417.60	417.60	299.35
Blue Shield	60 HDHP PPO	177.92	178.20	88.97	402.51	402.51	288.54
Health Net Life	60 EnhancedCare PPO	120.23	120.51	61.51	344.82	344.82	261.08
Health Net Life	60 HDHP EnhancedCare PPO	117.47	117.75	59.42	342.06	342.06	258.99
Health Net of CA	60 PureCare HSP	120.13	120.41	119.30	344.72	344.72	318.87
Kaiser Perm.	60 HMO	89.95	90.23	78.57	314.54	314.54	278.14
Kaiser Perm.	60 HSA HMO	74.54	74.82	64.94	299.13	299.13	264.51
L.A. Care	60 HMO	62.62	62.90	63.38	287.21	287.21	262.95
Molina	Choice Care	105.66	105.94	107.89	330.25	330.25	307.46
Oscar	60 EPO	47.67	47.95	53.90	272.26	272.26	253.47
Silver-tier plans							
Anthem	70 HMO	182.38	182.66	149.75	406.97	406.97	349.32
Blue Shield	70 PPO	309.63	309.91	183.38	534.22	534.22	382.95
Blue Shield	70 Trio HMO	227.71	227.99	161.73	452.30	452.30	361.30
Health Net Life	70 EnhancedCare	265.93	266.21	171.83	490.52	490.52	371.40
Health Net of CA	70 CommunityCare HMO	141.31	141.59	138.89	365.90	365.90	338.46
Kaiser Perm.	70 HMO	165.35	165.63	145.24	389.94	389.94	344.81
L.A. Care	70 HMO	146.63	146.91	140.30	371.22	371.22	339.87
Molina	Choice Care silver	138.02	138.30	138.02	362.61	362.61	337.59
Oscar	70 EPO	137.74	138.02	137.76	362.33	362.33	337.33
Federal gov.	Public option	NA	113.28	NA	NA	337.59	NA
Gold-tier plans							
Anthem	80 HMO	225.01	225.29	186.34	449.60	449.60	385.91
Blue Shield	80 PPO	406.32	406.60	252.69	630.91	630.91	452.26
Blue Shield	80 Trio HMO	328.31	328.59	242.09	552.90	552.90	441.66
Health Net Life	80 EnhancedCare PPO	359.51	359.79	242.69	584.10	584.10	442.26
Health Net of CA	80 CommunityCare HMO	210.82	211.10	203.19	435.41	435.41	402.76
Kaiser Perm.	80 HMO copayment	241.72	242.00	212.78	466.31	466.31	412.35
Kaiser Perm.	80 HMO coinsurance	218.60	218.88	192.33	443.19	443.19	391.90
L.A. Care	80 HMO	159.20	159.48	151.80	383.79	383.79	351.37
Molina	Choice Care gold	149.15	149.43	148.38	373.74	373.74	347.95
Oscar	80 EPO	187.94	188.22	184.50	412.53	412.53	384.07

**Sources:** Current-law premiums from [CoveredCA.com](https://www.coveredca.com/); public option and capped payment rate premiums are the product of Urban Institute analysis.

**Notes:** FPL is federal poverty level. Blue Shield is Blue Shield of California. Health Net of CA is Health Net of California. Kaiser Perm. is Kaiser Permanente. Gov. is government. HMO is health maintenance organization. PPO is preferred provider organization. HDHP is high-deductible health plan. HSP is health care service plan. HSA is health savings account. EPO is exclusive provider organization. NA indicates plan not available in the scenario. The benchmark premium in each scenario is shaded grey. Public option premiums assume Medicare provider payment rates; capped provider payment rates assume caps for all plans are set at Medicare provider payment rates.



**If a public option using Medicare provider payment rates were introduced in region 16,** the postsubsidy household contributions required for subsidized enrollees taking up a private Marketplace plan would be almost identical to those faced under current law. This is because the benchmark premium would decrease by only 28 cents per month, and private plan premiums would be unaffected by the public option's introduction into this already highly competitive market. However, the public option could command lower net prescription drug prices through higher rebates than the commercial insurance plans in the market, meaning it would provide an insurance option for subsidized silver plan enrollees that would require lower household contributions than the lowest-priced option available under current law.

For example, the illustrative 40-year-old single enrollee with income of 200 percent of FPL could enroll in the public option for \$113.28 per month, compared with \$137.74 for the Oscar EPO, the lowest-contribution silver option under current law. For the same enrollee with income of 400 percent of FPL, the public option contribution would be \$337.59 per month, a savings of about \$25 per month compared with the lowest-priced silver option under current law. Again, if the public option offers a broader provider network or other valued differences in plan design, it could be more attractive to enrollees than the modest price difference alone would suggest.

**If provider payment rates for private insurers were capped at Medicare levels in region 16 instead,** subsidized enrollees would generally be required to contribute less to enroll in the private insurance options than they contribute under current law. Again, the higher the current-law premiums are relative to the benchmark plan, the greater the decrease in premiums under capped rates and the greater the savings for subsidized enrollees choosing those plans. For example, the Blue Shield PPO is the highest-priced silver plan under current law. Our illustrative 40-year-old enrollee with income of 400 percent of FPL would pay \$534.22 per month for that option under current law but only \$382.95 per month under the capped provider payment rates, a savings of more than \$150 per month. The same enrollee with income of 200 percent of FPL would save \$126.25 per month (\$183.38 versus \$309.63 under current law).

In a few exceptions, however, subsidized household premium contributions would increase very slightly for our illustrative enrollee with income below 400 percent of FPL choosing certain bronze-level coverage options. L.A. Care, Molina, and Oscar offer very competitively priced plans under current law, and, as such, would achieve minimal percent savings from provider payment rates being capped. For people of modest income buying these bronze-level plans, the premium savings relative to current law would be smaller than the cut in their subsidy due to the benchmark premium decreasing.

However, these are isolated occurrences, and the increases in household contributions are small (less than \$1 per month for L.A. Care, about \$2 per month for Molina, and about \$6 per month for Oscar).

Because private plan premiums under the public option are almost identical to those under current law, enrollee contributions under capped rates would generally fall below those required in the public option as well. However, the public option would be available to subsidized enrollees with incomes of 200 percent of FPL for a contribution about \$24.50 below that of the lowest-cost silver option under capped payment rates.

## Sensitivity Analyses

***Higher provider payment rates for public option and private insurer caps.*** As we have noted elsewhere (Blumberg et al. 2020), phase-in and/or political concerns may make it challenging to set public option payment rates or private insurance payment rate caps at Medicare levels, at least in the short run. Consequently, we present results for each approach in the same rating regions used in the base case analysis, instead assuming a public option or payment rate caps are set at Medicare levels plus 10 percent. We show these results in appendix tables A.1 through A.3, which parallel tables 1 through 3 for the base case. For rating region 6 (weak insurer competition), the sensitivity results and those for the base case differ as follows:

- The presubsidy benchmark premium under both the public option and capped rates would be higher than in the base case. This means the federal subsidy cost per enrollee would be higher with the higher payment rate caps than under the base case.
- With payment rates set to Medicare levels plus 10 percent, the public option would still be the lowest-priced silver option. However, because the public option would be more expensive than in the base case, it would not introduce sufficient additional price competition into the market to provide leverage or incentive for the private insurers to negotiate lower provider payment rates. Thus, premiums for the private plans would be the same as under current law, each higher than they would be under the base case public option.
- In this noncompetitive market, the implications for subsidized households of introducing a public option with higher payment rates would vary depending on the plan chosen. Those choosing the benchmark (Kaiser Permanente silver 70 HMO) would face the same percentage-of-income premium contribution as they would in the base case. But those choosing private plans in the silver and gold tiers would face postsubsidy premiums at least

modestly higher than under the base case public option, given the higher full premiums. For example, the public option full premium would be about \$55 higher per month than in the base case, but the benchmark premium would only be about \$25 higher per month. Therefore, the higher subsidy would not be large enough to offset the higher premiums. The exception to this would be the lower-priced bronze plans, for which the higher subsidy would outweigh the modestly higher premiums, making these plans less expensive after subsidies.

- The lowest-priced options under capped rates, those offered by Kaiser Permanente, are less expensive for subsidized households with the higher payment rate caps than in the base case. As indicated with the public option approach, the higher subsidy associated with a higher benchmark premium outweighs the higher premiums for these Kaiser Permanente options. The Blue Shield options, which have higher premiums, would generally cost subsidized households more than in the base case. The exception is the benchmark plan itself, for which households would still pay the applicable percentage-of-income cap.
- Higher provider payment rates in this sensitivity analysis mean capped payment rates would offer lower-premium options to families with subsidies than would the public option. For example, the lowest-priced silver option for our illustrative enrollee with income of 200 percent of FPL would be \$115.24 per month under the public option, which is the price for the public option. Under capped rates, the lowest-priced silver premium for the same person would be \$81.13 per month for the Kaiser Permanente HMO.

For rating region 16 (strong insurer competition), the sensitivity analysis results and those for the base case differ as follows:

- Assuming it would reimburse providers at Medicare rates plus 10 percent, the public option would be the fifth-lowest-premium silver option in this rating region (as opposed to the lowest-priced option assuming Medicare rates in the base case). However, the tight price competition among the lowest-priced private plans in this rating area means the benchmark premium does not differ significantly between this sensitivity analysis and the base case.
- Because the public option does not affect private plan premiums in the base case or sensitivity analysis, postsubsidy premiums for households purchasing private plans differ little across the two scenarios. The biggest difference is that under higher payment rates in the sensitivity analysis, the public option would not provide subsidized households with a lower-priced insurance option than they have under current law; choosing it would require households to spend somewhat more than their applicable percentage-of-income cap.

- Because two insurers (Oscar and Molina) already pay providers at roughly Medicare rates under current law, setting private insurers' provider payment rates at Medicare levels plus 10 percent would not change their premiums relative to the base case. However, the insurers paying higher provider payment rates would have higher premiums if higher payment rates were used. The biggest premium differences between the two scenarios would occur among higher-premium plans.
- The benchmark premium is the same in the base case and sensitivity analysis, but higher-priced insurers have higher premiums under the sensitivity analysis. Thus, higher payment rates would lead to higher postsubsidy premiums for households choosing insurance plans other than those offered by Oscar and Molina.
- With higher caps, capped provider payment rates would offer subsidized enrollees across income levels at least somewhat lower premium options than would the public option. The postsubsidy premium differences between the capped rate and public option approaches would be greatest for the highest-priced plan options.

***Smaller share of premium differences assumed attributable to provider payment rate differences.*** No publicly available dataset provides representative information on the provider payment rates used by private nongroup insurers in or outside the Marketplaces. However, our previous work provides evidence that the most competitive markets have benchmark premiums consistent with those under provider payment rates roughly equal to Medicare's. In our capped rate base case analysis, we assume two-thirds of the difference in premiums between the benchmark silver plan and higher-premium silver plans is attributable to differences in provider payment rates. We then assume those provider payment rates are consistent across the same plans offered in each actuarial value tier of coverage. We assume this because provider payment rates seem to significantly affect premiums, but premiums are shaped by other factors, too. However, we lack data to estimate the extent to which payment rate differences drive premium differences. Thus, we include a sensitivity analysis of this assumption, assuming instead only 50 percent of the difference in premiums within a coverage tier owes to provider payment rate differences. Appendix tables B.1 through B.3 parallel the base case tables 1 through 3 but instead use the 50 percent assumption (instead of 67 percent). The only differences from the base case are for the capped rate results; this sensitivity analysis does not apply to current-law or public option estimates. We find the following for rating region 6 (weak insurer competition):

- The full premium for the Blue Shield PPO, the only plan with a premium higher than the benchmark under capped provider payment rates, would be higher under this alternate assumption (\$440.41 per month for our illustrative 40-year-old versus \$425.77 in the base case).
- Likewise, postsubsidy premiums for the Blue Shield PPO plans at all actuarial value tiers would be somewhat higher than in the base case. For example, a gold-level Blue Shield PPO enrollee with income of 200 percent of FPL would pay \$255.60 per month, compared with \$238.31 per month in the base case.

We find the following for rating region 16 (strong insurer competition):

- Full premiums would be higher under this assumption for all plans with premiums higher than the benchmark. For most plans, assuming provider payment rates contribute less to premium differences means capping rates has a smaller effect on premiums, leaving premiums higher than in the base case. The Molina and Oscar plans were already priced at levels that indicated they were paying providers less than Medicare rates under current law, so they would be unaffected by the caps in either case. Under reform, the savings generated for those insurers' plans would come solely from the assumed increase in prescription drug rebates, which is the same in the base case and the sensitivity analysis.
- Because full premiums are higher for plans priced higher than the benchmark under this assumption, the postsubsidy premiums for these plans would also be higher than in the base case. The higher the full premiums are relative to the benchmark, the larger the increase in postsubsidy premiums.
- This alternative assumption does not, however, materially change the relative advantages of capped payment rates versus the public option.

## Conclusions

Introducing a public option paying regulated rates to providers and capping provider rates paid by private Marketplace insurers have both been discussed as potential strategies for improving health care affordability for households and lowering federal government subsidy costs. As demonstrated in the policies simulated here, both reforms can do so, but they would have significantly different effects on benchmark premiums and the affordability of private insurance plans before and after premium tax

credits. Plus, these implications differ considerably across markets with different levels of competition and thus private insurance premiums.

This analysis has two central limitations: First, it is based out of necessity on several assumptions. The ultimate effects of a public option or capped payment rates are based on many unknowns, most importantly,

- the initial provider payment rates, which will be the outcome of a political negotiations;
- the extent to which current differences in premiums reflect differences in provider payment rates;
- public and private insurers' abilities to develop provider networks at lower payment rates;
- and possible changes to insurer participation in markets in response to greater price competition.

We have made our assumptions explicit and based them on economic theory and available evidence, and we believe they are reasonable. However, we provide sensitivity analyses to other assumptions and acknowledge our findings on outcomes would differ if our assumptions proved to be faulty. Second, we focus on short-term effects of these reforms, and, as such, our analysis may not capture longer-term shifts in insurer behavior. Longer-term effects would depend largely on how initial provider payment rates change over time (e.g., whether rates would be negotiated annually, whether particular growth rates would be set in law, and if so, how they would be determined). Still, understanding short-term effects is critical for understanding the longer run, because they set the stage for what follows.

Directly capping provider payment rates of all private plans in a market can decrease private insurance plan premiums more than can introducing a public option. The former may increase competitive pressures in noncompetitive areas but will have little to no effect in competitive markets. Capping provider payment rates for all private plans can dramatically compress the variance in premiums across all plans, bringing higher and lower premiums closer and providing consumers a broader array of affordable health insurance options.

In assessing how either reform affects subsidized enrollees' plan affordability in particular, one must consider how it would alter the benchmark premium relative to private insurer premiums. For example, when using Medicare payment rates and our other base case assumptions, a public option can introduce a plan premium that would be more affordable to many consumers eligible for subsidies than the lowest-priced option available under the capped provider payment rates. However, if the

benchmark premium falls to a greater degree than private plans achieve savings, a public option can make private plans more expensive for subsidized enrollees. This could mean subsidized enrollees feel their plan choices are more limited with a public option in place, and this could decrease incentives for private insurers to participate in at least some of these markets.

And, as shown in one of our sensitivity analyses, if a public option were to pay providers even modestly above Medicare rates, it would have less potential to provide a more affordable health insurance option than would capping private payment rates. This is true in both competitive and noncompetitive areas. However, enrollees may value a public option over private plans for reasons beyond price. For example, a public option that offers a broad provider network may find a consumer niche in the Marketplaces, but achieving such a network would likely require that the public option pay providers above Medicare rates.

This analysis highlights the importance of clearly identifying the goals of a reform such as a Marketplace public option or capped provider payment rates. How important is federal cost containment, which will be driven by the postreform benchmark premium? How important is improved consumer affordability, and should that affordability goal emphasize subsidized or unsubsidized consumers? How negative would the effects be of a policy that provides a new public option but makes private options less affordable than they are under current law, potentially driving some or even many insurers out of these markets? The answers to these questions will lead policymakers to an approach that most effectively balances the trade-offs inherent in these strategies. Alternatively, it could lead them to consider a combination approach that both introduces a public option and caps provider payment rates for competing private insurers.

# Appendix A. Sensitivity Analysis to Higher Provider Payment Rates

APPENDIX TABLE A.1

Full (Unsubsidized) Monthly Premium for a 40-Year-Old Single Enrollee under Current Law, a Public Option, and Capped Provider Payment Rates, 2020

In California rating regions 6 and 16

Insurer	Plan name	CURRENT LAW		REFORM SCENARIOS			
		Rating	Rating	Rating Region 6		Rating Region 16	
		Region 6	Region 16	Public option	Capped rates	Public option	Capped rates
Bronze-tier plans							
Blue Shield	60 PPO	495.64	NA	495.64	403.98	NA	NA
Blue Shield	60 HDHP PPO	477.73	NA	477.73	389.39	NA	NA
Kaiser Permanente	60 HMO	387.15	NA	387.15	322.88	NA	NA
Kaiser Permanente	60 HSA HMO	368.18	NA	368.18	307.06	NA	NA
Anthem	60 HMO	NA	335.92	NA	NA	335.92	312.74
Blue Shield	60 PPO	NA	417.60	NA	NA	417.60	346.60
Blue Shield	60 HDHP PPO	NA	402.51	NA	NA	402.51	334.07
Health Net Life	60 EnhancedCare PPO	NA	344.82	NA	NA	344.82	303.57
Health Net Life	60 HDHP EnhancedCare PPO	NA	342.06	NA	NA	342.06	301.14
Health Net of CA	60 PureCare HSP	NA	344.72	NA	NA	344.72	320.93
Kaiser Permanente	60 HMO	NA	314.54	NA	NA	314.54	292.84
Kaiser Permanente	60 HSA HMO	NA	299.13	NA	NA	299.13	278.49
L.A. Care	60 HMO	NA	287.21	NA	NA	287.21	267.39
Molina	Choice Care	NA	330.25	NA	NA	330.25	307.46
Oscar	60 EPO	NA	272.26	NA	NA	272.26	253.47
Silver-tier plans							
Blue Shield	70 PPO	634.05	NA	634.05	516.80	NA	NA
Blue Shield	Silver 70 Trio HMO	546.19	NA	546.19	457.16	NA	NA
Kaiser Permanente	Silver 70 HMO	479.94	NA	479.94	400.27	NA	NA
Federal government	Public option	NA	NA	457.16	NA	NA	NA



Insurer	Plan name	CURRENT LAW		REFORM SCENARIOS			
		Rating region 6	Rating region 16	Rating Region 6		Rating Region 16	
				Public option	Capped rates	Public option	Capped rates
Anthem	70 HMO	NA	406.97	NA	NA	406.97	378.89
Blue Shield	70 PPO	NA	534.22	NA	NA	534.22	443.39
Blue Shield	70 Trio HMO	NA	452.30	NA	NA	452.30	421.09
Health Net Life	70 EnhancedCare PPO	NA	490.52	NA	NA	490.52	431.84
Health Net of CA	70 CommunityCare HMO	NA	365.90	NA	NA	365.90	340.65
Kaiser Permanente	70 HMO	NA	389.94	NA	NA	389.94	363.03
L.A. Care	70 HMO	NA	371.22	NA	NA	371.22	345.61
Molina	Choice Care silver	NA	362.61	NA	NA	362.61	337.59
Oscar	70 EPO	NA	362.33	NA	NA	362.33	337.33
Federal government	Public option	NA	NA	NA	NA	373.85	NA
<b>Gold-tier plans</b>							
Blue Shield	80 PPO	748.81	NA	748.81	610.34	NA	NA
Blue Shield	80 Trio HMO	667.66	NA	667.66	558.83	NA	NA
Kaiser Permanente	80 HMO copayment	573.94	NA	573.94	478.67	NA	NA
Kaiser Permanente	80 HMO coinsurance	545.49	NA	545.49	454.94	NA	NA
Anthem	80 HMO	NA	449.60	NA	NA	449.60	418.58
Blue Shield	80 PPO	NA	630.91	NA	NA	630.91	523.64
Blue Shield	80 Trio HMO	NA	552.90	NA	NA	552.90	514.75
Health Net Life	80 EnhancedCare PPO	NA	584.10	NA	NA	584.10	514.22
Health Net of CA	80 CommunityCare HMO	NA	435.41	NA	NA	435.41	405.37
Kaiser Permanente	80 HMO copayment	NA	466.31	NA	NA	466.31	434.13
Kaiser Permanente	80 HMO coinsurance	NA	443.19	NA	NA	443.19	412.61
L.A. Care	80 HMO	NA	383.79	NA	NA	383.79	357.31
Molina	Choice Care gold	NA	373.74	NA	NA	373.74	347.95
Oscar	80 EPO	NA	412.53	NA	NA	412.53	384.07

**Sources:** Current-law premiums from [CoveredCA.com](https://www.coveredca.com/); public option and capped payment rate premiums are the product of Urban Institute analysis.

**Notes:** Blue Shield is Blue Shield of California. Health Net of CA is Health Net of California. PPO is preferred provider organization. HDHP is high-deductible health plan. HMO is health maintenance organization. HSA is health savings account. HSP is health care service plan. EPO is exclusive provider organization. NA indicates the plan is not available in the region or scenario. The benchmark premium in each scenario is shaded grey. Public option premiums assume Medicare provider payment rates plus 10 percent; capped provider payment rates assume caps for all plans are set at Medicare provider payment rates plus 10 percent.

## APPENDIX TABLE A.2

### Subsidized Monthly Premium for a 40-Year-Old Single Enrollee at Two Income Levels Relative to the Federal Poverty Level under Current Law, a Public Option, and Capped Provider Payment Rates, 2020

In California rating region 6

Insurer	Plan name	200% of the Federal Poverty Level			400% of the Federal Poverty Level		
		Current law	Public option	Capped rates	Current law	Public option	Capped rates
Bronze-tier plans							
Blue Shield	60 PPO	87.47	153.72	84.84	365.43	431.68	362.80
Blue Shield	60 HDHP PPO	69.56	135.81	70.25	347.52	413.77	348.20
Kaiser Permanente	60 HMO	0.00	45.23	3.74	256.94	323.19	281.70
Kaiser Permanente	60 HSA HMO	0.00	26.26	0.00	237.97	304.22	265.88
Silver-tier plans							
Blue Shield	70 PPO	225.88	292.13	197.66	503.84	570.09	475.61
Blue Shield	70 Trio HMO	138.02	204.27	138.02	415.98	482.23	415.98
Kaiser Permanente	70 HMO	71.77	138.02	81.13	349.73	415.98	359.08
Federal government	Public option	NA	115.24	NA	NA	393.20	NA
Gold-tier plans							
Blue Shield	80 PPO	268.33	406.89	291.20	618.60	684.85	569.15
Blue Shield	80 Trio HMO	187.18	325.74	239.69	537.45	603.70	517.65
Kaiser Permanente	80 HMO copayment	93.46	232.02	159.53	443.73	509.98	437.48
Kaiser Permanente	80 HMO coinsurance	65.01	203.57	135.80	415.28	481.53	413.75

**Sources:** Current-law premiums from [CoveredCA.com](https://www.coveredca.com/); public option and capped payment rate premiums are the product of Urban Institute analysis.

**Notes:** Blue Shield is Blue Shield of California. PPO is preferred provider organization. HDHP is high-deductible health plan. HMO is health maintenance organization. HSA is health savings account. NA indicates the plan is not available in the scenario. The benchmark premium in each scenario is shaded grey. Public option premiums assume Medicare provider payment rates plus 10 percent; capped provider payment rates assume caps for all plans are set at Medicare provider payment rates plus 10 percent.

APPENDIX TABLE A.3

**Subsidized Monthly Premium for a 40-Year-Old Single Enrollee at Two Income Levels Relative to the Federal Poverty Level under Current Law, a Public Option, and Capped Provider Payment Rates, 2020**

*In California rating region 16*

Insurer	Plan name	200% of the Federal Poverty Level			400% of the Federal Poverty Level		
		Current law	Public option	Capped rates	Current law	Public option	Capped rates
Bronze-tier plans							
Anthem	60 HMO	111.33	111.33	113.17	335.92	335.92	312.74
Blue Shield	60 PPO	193.01	193.01	147.03	417.60	417.60	346.60
Blue Shield	60 HDHP PPO	177.92	177.92	134.50	402.51	402.51	334.07
Health Net Life	60 EnhancedCare PPO	120.23	120.23	104.00	344.82	344.82	303.57
Health Net Life	60 HDHP EnhancedCare PPO	117.47	117.47	101.57	342.06	342.06	301.14
Health Net of CA	60 PureCare HSP	120.13	120.13	121.37	344.72	344.72	320.93
Kaiser Perm.	60 HMO	89.95	89.95	93.27	314.54	314.54	292.84
Kaiser Perm.	60 HSA HMO	74.54	74.54	78.92	299.13	299.13	278.49
L.A. Care	60 HMO	62.62	62.62	67.82	287.21	287.21	267.39
Molina	Choice Care	105.66	105.66	107.89	330.25	330.25	307.46
Oscar	60 EPO	47.67	47.67	53.90	272.26	272.26	253.47
Silver-tier plans							
Anthem	70 HMO	182.38	182.38	179.32	406.97	406.97	378.89
Blue Shield	70 PPO	309.63	309.63	243.82	534.22	534.22	443.39
Blue Shield	70 Trio HMO	227.71	227.71	221.52	452.30	452.30	421.09
Health Net Life	70 EnhancedCare PPO	265.93	265.93	232.27	490.52	490.52	431.84
Health Net of CA	70 CommunityCare HMO	141.31	141.31	141.08	365.90	365.90	340.65
Kaiser Perm.	70 HMO	165.35	165.35	163.46	389.94	389.94	363.03
L.A. Care	70 HMO	146.63	146.63	146.04	371.22	371.22	345.61
Molina	Choice Care silver	138.02	138.02	138.02	362.61	362.61	337.59
Oscar	70 EPO	137.74	137.74	137.76	362.33	362.33	337.33
Federal gov.	Public option	NA	149.26	NA	NA	373.85	NA
Gold-tier plans							
Anthem	80 HMO	225.01	225.01	219.01	449.60	449.60	418.58
Blue Shield	80 PPO	406.32	406.32	324.07	630.91	630.91	523.64
Blue Shield	80 Trio HMO	328.31	328.31	315.18	552.90	552.90	514.75
Health Net Life	80 EnhancedCare PPO	359.51	359.51	314.65	584.10	584.10	514.22
Health Net of CA	80 CommunityCare HMO	210.82	210.82	205.80	435.41	435.41	405.37
Kaiser Perm.	80 HMO copayment	241.72	241.72	234.57	466.31	466.31	434.13
Kaiser Perm.	80 HMO coinsurance	218.60	218.60	213.04	443.19	443.19	412.61
L.A. Care	80 HMO	159.20	159.20	157.74	383.79	383.79	357.31
Molina	Choice Care gold	149.15	149.15	148.38	373.74	373.74	347.95
Oscar	80 EPO	187.94	187.94	184.50	412.53	412.53	384.07

**Sources:** Current-law premiums from [CoveredCA.com](https://www.coveredca.com); public option and capped payment rate premiums are the product of Urban Institute analysis.

**Notes:** Blue Shield is Blue Shield of California. Health Net of CA is Health Net of California. Kaiser Perm. is Kaiser Permanente. Gov. is government. HMO is health maintenance organization. PPO is preferred provider organization. HDHP is high-deductible health plan. HSA is health savings account. HSP is health care service plan. EPO is exclusive provider organization. NA indicates the plan is not available in the scenario. The benchmark premium in each scenario is shaded grey. Public option premiums assume Medicare provider payment rates plus 10 percent; capped provider payment rates assume caps for all plans are set at Medicare provider payment rates plus 10 percent.

# Appendix B. Sensitivity Analysis to a Smaller Share of Premiums Being Attributable to Differences in Provider Payment Rates

APPENDIX TABLE B.1

Full (Unsubsidized) Monthly Premium for a 40-Year-Old Single Enrollee under Current Law, a Public Option, and Capped Provider Payment Rates, 2020

In California rating regions 6 and 16

Insurer	Plan name	CURRENT LAW		REFORM SCENARIOS			
		Rating region 6	Rating region 16	Rating Region 6		Rating Region 16	
				Public option	Capped rates	Public option	Capped rates
Bronze-tier plans							
Blue Shield	60 PPO	495.64	NA	469.37	344.27	NA	NA
Blue Shield	60 HDHP PPO	477.73	NA	452.41	331.83	NA	NA
Kaiser Permanente	60 HMO	387.15	NA	366.63	284.17	NA	NA
Kaiser Permanente	60 HSA HMO	368.18	NA	348.67	270.24	NA	NA
Anthem	60 HMO	NA	335.92	NA	NA	335.92	294.43
Blue Shield	60 PPO	NA	417.60	NA	NA	417.60	321.71
Blue Shield	60 HDHP PPO	NA	402.51	NA	NA	402.51	310.09
Health Net Life	60 EnhancedCare PPO	NA	344.82	NA	NA	344.82	276.07
Health Net Life	60 HDHP EnhancedCare PPO	NA	342.06	NA	NA	342.06	273.86
Health Net of CA	60 PureCare HSP	NA	344.72	NA	NA	344.72	319.38
Kaiser Permanente	60 HMO	NA	314.54	NA	NA	314.54	281.81
Kaiser Permanente	60 HSA HMO	NA	299.13	NA	NA	299.13	268.01
L.A. Care	60 HMO	NA	287.21	NA	NA	287.21	264.06
Molina	Choice Care	NA	330.25	NA	NA	330.25	307.46
Oscar	60 EPO	NA	272.26	NA	NA	272.26	253.47

Insurer	Plan name	CURRENT LAW		REFORM SCENARIOS			
		Rating region 6	Rating region 16	Rating Region 6		Rating Region 16	
				Public option	Capped rates	Public option	Capped rates
Silver-tier plans							
Blue Shield	Silver 70 PPO	634.05	NA	600.45	440.41	NA	NA
Blue Shield	Silver 70 Trio HMO	546.19	NA	517.24	402.54	NA	NA
Kaiser Permanente	Silver 70 HMO	479.94	NA	454.50	352.28	NA	NA
Federal government	Public option	NA	NA	402.54	NA	NA	NA
Anthem	70 HMO	NA	406.97	NA	NA	406.97	356.71
Blue Shield	70 PPO	NA	534.22	NA	NA	534.22	411.55
Blue Shield	70 Trio HMO	NA	452.30	NA	NA	452.30	376.25
Health Net Life	70 EnhancedCare PPO	NA	490.52	NA	NA	490.52	392.72
Health Net of CA	70 CommunityCare HMO	NA	365.90	NA	NA	365.90	339.01
Kaiser Permanente	70 HMO	NA	389.94	NA	NA	389.94	349.37
L.A. Care	70 HMO	NA	371.22	NA	NA	371.22	341.30
Molina	Choice Care silver	NA	362.61	NA	NA	362.61	337.59
Oscar	70 EPO	NA	362.33	NA	NA	362.33	337.33
Federal government	Public option	NA	NA	NA	NA	337.59	NA
Gold-tier plans							
Blue Shield	80 PPO	748.81	NA	709.12	520.12	NA	NA
Blue Shield	80 Trio HMO	667.66	NA	632.27	492.07	NA	NA
Kaiser Permanente	80 HMO copayment	573.94	NA	543.52	421.27	NA	NA
Kaiser Permanente	80 HMO coinsurance	545.49	NA	516.58	400.39	NA	NA
Anthem	80 HMO	NA	449.60	NA	NA	449.60	394.07
Blue Shield	80 PPO	NA	630.91	NA	NA	630.91	486.04
Blue Shield	80 Trio HMO	NA	552.90	NA	NA	552.90	459.93
Health Net Life	80 EnhancedCare PPO	NA	584.10	NA	NA	584.10	467.64
Health Net of CA	80 CommunityCare HMO	NA	435.41	NA	NA	435.41	403.41
Kaiser Permanente	80 HMO copayment	NA	466.31	NA	NA	466.31	417.79
Kaiser Permanente	80 HMO coinsurance	NA	443.19	NA	NA	443.19	397.08
L.A. Care	80 HMO	NA	383.79	NA	NA	383.79	352.86
Molina	Choice Care gold	NA	373.74	NA	NA	373.74	347.95
Oscar	80 EPO	NA	412.53	NA	NA	412.53	384.07

**Source:** Current-law premiums from [CoveredCA.com](https://www.coveredca.com/); public option and capped payment rate premiums are the product of Urban Institute analysis.

**Notes:** Blue Shield is Blue Shield of California. Health Net of CA is Health Net of California. PPO is preferred provider organization. HDHP is high-deductible health plan. HMO is health maintenance organization. HSA is health savings account. HSP is health care service plan. EPO is exclusive provider organization. NA indicates the plan is not available in the region or scenario. The benchmark premium in each scenario is shaded grey. Public option premiums assume Medicare provider payment rates; capped provider payment rates assume caps for all plans are set at Medicare provider payment rates. Fifty percent of the full premium differential in each tier is assumed to be attributable to differences in provider payment rates.

## APPENDIX TABLE B.2

### Subsidized Monthly Premium for a 40-Year-Old Single Enrollee at Two Income Levels Relative to the Federal Poverty Level under Current Law, a Public Option, and Capped Provider Payment Rates, 2020

In California rating region 6

Insurer	Plan name	200% of the Federal Poverty Level			400% of the Federal Poverty Level		
		Current law	Public option	Capped rates	Current law	Public option	Capped rates
Bronze-tier plans							
Blue Shield	60 PPO	87.47	152.89	79.75	365.43	430.84	344.27
Blue Shield	60 HDHP PPO	69.56	135.93	67.31	347.52	413.88	331.83
Kaiser Permanente	60 HMO	0.00	50.15	19.65	256.94	328.10	284.17
Kaiser Permanente	60 HSA HMO	0.00	32.18	5.72	237.97	310.14	270.24
Silver-tier plans							
Blue Shield	70 PPO	225.88	283.96	175.89	503.84	561.92	440.41
Blue Shield	70 Trio HMO	138.02	200.76	138.02	415.98	478.71	402.54
Kaiser Permanente	70 HMO	71.77	138.02	87.75	349.73	415.98	352.28
Federal government	Public option	NA	86.06	NA	NA	364.01	NA
Gold-tier plans							
Blue Shield	80 PPO	340.64	392.64	255.60	618.60	670.60	520.12
Blue Shield	80 Trio HMO	259.49	315.79	227.54	537.45	593.75	492.07
Kaiser Permanente	80 HMO copayment	165.77	227.04	156.75	443.73	504.99	421.27
Kaiser Permanente	80 HMO coinsurance	137.32	200.10	135.87	415.28	478.05	400.39

**Source:** Current-law premiums from [CoveredCA.com](https://www.coveredca.com); public option and capped payment rate premiums are the product of Urban Institute analysis.

**Notes:** Blue Shield is Blue Shield of California. PPO is preferred provider organization. HDHP is high-deductible health plan. HMO is health maintenance organization. HSA is health savings account. NA indicates the plan is not available in the scenario. The benchmark premium in each scenario is shaded grey. Public option premiums assume Medicare provider payment rates; capped provider payment rate premiums assume caps for all plans are set at Medicare provider payment rates. Fifty percent of the full premium differential in each tier is assumed to be attributable to differences in provider payment rates.

### APPENDIX TABLE B.3

#### Subsidized Monthly Premium for a 40-Year-Old Single Enrollee at Two Income Levels Relative to the Federal Poverty Level under Current Law, a Public Option, and Capped Provider Payment Rates, 2020

In California rating region 16

Insurer	Plan name	200% of the Federal Poverty Level			400% of the Federal Poverty Level		
		Current law	Public option	Capped rates	Current law	Public option	Capped rates
Bronze-tier plans							
Anthem	60 HMO	111.61	111.61	94.86	335.92	335.92	294.43
Blue Shield	60 PPO	193.29	193.29	122.14	417.60	417.60	321.71
Blue Shield	60 HDHP PPO	178.20	178.20	110.52	402.51	402.51	310.09
Health Net Life	60 EnhancedCare PPO	120.51	120.51	76.50	344.82	344.82	276.07
Health Net Life	60 HDHP EnhancedCare PPO	117.75	117.75	74.29	342.06	342.06	273.86
Health Net of CA	60 PureCare HSP	120.41	120.41	119.82	344.72	344.72	319.38
Kaiser Permanente	60 HMO	90.23	90.23	82.24	314.54	314.54	281.81
Kaiser Permanente	60 HSA HMO	74.82	74.82	68.44	299.13	299.13	268.01
L.A. Care	60 HMO	62.90	62.90	64.49	287.21	287.21	264.06
Molina	Choice Care	105.94	105.94	107.89	330.25	330.25	307.46
Oscar	60 EPO	47.95	47.95	53.90	272.26	272.26	253.47
Silver-tier plans							
Anthem	70 HMO	182.66	182.66	157.14	406.97	406.97	356.71
Blue Shield	70 PPO	309.91	309.91	211.98	534.22	534.22	411.55
Blue Shield	70 Trio HMO	227.99	227.99	176.68	452.30	452.30	376.25
Health Net Life	70 EnhancedCare PPO	266.21	266.21	193.15	490.52	490.52	392.72
Health Net of CA	70 CommunityCare HMO	141.59	141.59	139.44	365.90	365.90	339.01
Kaiser Permanente	70 HMO	165.63	165.63	149.80	389.94	389.94	349.37
L.A. Care	70 HMO	146.91	146.91	141.73	371.22	371.22	341.30
Molina	ChoiceCare silver	138.30	138.30	138.02	362.61	362.61	337.59
Oscar	70 EPO	138.02	138.02	137.76	362.33	362.33	337.33
Federal gov.	Public option	NA	113.28	NA	NA	337.59	NA
Gold-tier plans							
Anthem	80 HMO	225.29	225.29	194.51	449.60	449.60	394.07
Blue Shield	80 PPO	406.60	406.60	286.47	630.91	630.91	486.04
Blue Shield	80 Trio HMO	328.59	328.59	260.36	552.90	552.90	459.93
Health Net Life	80 EnhancedCare PPO	359.79	359.79	268.07	584.10	584.10	467.64
Health Net of CA	80 CommunityCare HMO	211.10	211.10	203.84	435.41	435.41	403.41
Kaiser Permanente	80 HMO copayment	242.00	242.00	218.22	466.31	466.31	417.79
Kaiser Permanente	80 HMO coinsurance	218.88	218.88	197.51	443.19	443.19	397.08
L.A. Care	80 HMO	159.48	159.48	153.29	383.79	383.79	352.86
Molina	Choice Care gold	149.43	149.43	148.38	373.74	373.74	347.95
Oscar	80 EPO	188.22	188.22	184.50	412.53	412.53	384.07



**Source:** Current-law premiums from [CoveredCA.com](https://www.coveredca.com); public option and capped payment rate premiums are the product of Urban Institute analysis.

**Notes:** Blue Shield is Blue Shield of California. Health Net of CA is Health Net of California. Gov. is government. PPO is preferred provider organization. HDHP is high-deductible health plan. HMO is health maintenance organization. HSA is health savings account. HSP is health care service plan. EPO is exclusive provider organization. NA indicates the plan is not available in the scenario. The benchmark premium in each scenario is shaded grey. Public option premiums assume Medicare provider payment rates; capped provider payment rate premiums assume caps for all plans are set at Medicare provider payment rates. Fifty percent of the full premium differential in each tier is assumed to be attributable to differences in provider payment rates.

# Notes

- <sup>1</sup> Within each nongroup market rating region, the Health Insurance Policy Simulation Model uses Marketplace benchmark premiums and average premiums at each metal tier consistent with Marketplace data, but it does not currently model competing premiums within metal tiers in each rating region.
- <sup>2</sup> “RBRVS Overview,” American Medical Association, accessed February 24, 2021, <https://www.ama-assn.org/about/rvs-update-committee-ruc/rbrvs-overview>.
- <sup>3</sup> The Medicare program achieves both broad provider networks and reasonably low provider payment rates simultaneously by prohibiting higher rates and balanced billing for Medicare enrollees. Because Medicare enrollees account for a large share of total health care spending (because they are elderly or have significant disabilities), few health care providers can opt out of participating with the Medicare program. The same is not true of those with nongroup health insurance, a small segment of the total health insurance market. In addition, Medicare Advantage plans can negotiate in-network provider payment rates close to Medicare payment rates and much lower than commercial payment rates. This is because of a provision in the Social Security Act that prohibits out-of-network providers from charging more than Medicare fee-for-service payment rates to treat Medicare beneficiaries.
- <sup>4</sup> See, for example, the [Choose Medicare Act](#), S. 1261, 116th Cong. (2019–20).
- <sup>5</sup> See pages 7 and 8 of Blumberg and colleagues (2020).
- <sup>6</sup> We estimated a regression with a dependent variable equal to the silver premium for each plan offered by a non-Medicaid insurer in 2019 in every Marketplace rating region nationally. Independent variables were rating region population; average Medicare wage index; binary variables for whether the rating region had two, three, four, or five or more insurers; interaction terms between the number of insurers in the rating region and whether a Medicaid insurer participated in the region that year; census region indicators (south, northeast, west); an indicator for whether the state had a pure community-rated nongroup insurance market; an indicator for whether the rating region was urban; an indicator for whether the rating region was in a Medicaid expansion state; an indicator for whether the rating region was in a federally facilitated Marketplace state; and indicators for hospital market concentration in the rating region (HHI between 2,501 and 5,000, HHI between 5,001 and 7,500, and HHI between 7,501 and 10,000). We compute the average effect on a private insurance premium of a Medicaid plan competing in the market as the difference between (1) the coefficient on the indicator for there being two insurers in the market and (2) the coefficient on the interaction term for there being two insurers competing and a Medicaid insurer present. We then compute the percentage effect by comparing that negative dollar difference with the average premium for insurers in markets with two non-Medicaid insurers competing.
- <sup>7</sup> We estimated capped payment rate savings for the lowest-priced and the second-lowest-priced silver plans using parallel regressions, the first with a dependent variable equal to the lowest silver premium in each rating region and the second with a dependent variable equal to the second-lowest silver premium in each rating region. Independent variables in each regression were rating region population; Medicare average wage index; hospital HHI; indicators for whether a Medicaid insurer, Blue Shield-affiliated insurer, a co-op, a national insurer, a provider-sponsored insurer, or a regional insurer participated in the market; an indicator for whether the rating region is in a state with pure community-rated nongroup markets; and indicators for the number of competing insurers in the Marketplace in the rating region (one, two, three, or four, with five or more excluded from the category). We used each regression to predict the expected premium if the market had at least five competing insurers and hospital HHI of at least 5,000. We used the difference between the average actual premium (lowest silver or second-lowest silver) and the predicted premium to calculate the expected savings if provider payment rates were capped at Medicare rates. For premiums above the benchmark premium, we assume in the base case that the plan premium falls by the estimated savings for the benchmark plan *plus two-*

thirds of the difference between that plan's and the benchmark's premiums. In the sensitivity analyses, we limit the additional savings to one-half the difference between the two premiums. We then computed the expected savings as a percentage of the current premium and applied this percent savings to the insurer's same product offered at different actuarial values. For example, we estimated capped payment rates at Medicare levels in California's rating region 16 would lower the Blue Shield silver PPO premium by about 28 percent. We then applied that 28 percent savings to Blue Shield bronze and gold PPO plans in the same rating region.

- <sup>8</sup> We estimate a regression with a dependent variable equal to the lowest-priced silver plan in the rating area and the same independent variables in the regression used to estimate the public option premium. In the same manner, we compute the percent change in premiums for the lowest-priced silver plan under highly competitive market conditions.
- <sup>9</sup> Lower payment rates may cause longer-run changes in supply, but those changes are beyond the scope of this analysis, which focuses on short-term effects.
- <sup>10</sup> Though not shown, one exception to this is the two bronze-tier Kaiser Permanente HMO plans would continue to be available at no household premium contribution for the illustrative 40-year-old with very low income (e.g., 150 percent of FPL).

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# About the Author

**Linda Blumberg** is an Institute fellow in the Health Policy Center at the Urban Institute. 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 at the state and federal levels, and interpreting and analyzing the implications of particular policies. Examples of her work include analyses of the implications of congressional proposals to repeal and replace the ACA, delineation of strategies to fix problems associated with the ACA, estimation of the cost and coverage potential of high-risk pools, analysis of the implications of the *California v. Texas* and *King v. Burwell* cases, and several studies of competition in ACA Marketplaces. In addition, Blumberg led the quantitative analysis supporting the development of a “Road Map to Universal Coverage” in Massachusetts, a project with her Urban colleagues that informed that state’s comprehensive health reforms in 2006.

Blumberg frequently testifies before Congress and is quoted in major media outlets on health reform topics. She has served on the Cancer Policy Institute’s advisory board and has served on the *Health Affairs* editorial board. From 1993 through 1994, she was a health policy adviser to the Clinton administration during its health care reform effort, and she was a 1996 Ian Axford Fellow in Public Policy.

Blumberg received her PhD in economics from the University of Michigan.

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