Public Option and Capped Provider Payment Rate Proposals That Exempt Rural Areas

John Holahan and Michael Simpson

March 2021

In recent years, we have completed extensive analyses of proposals that would introduce a public health insurance option or cap provider payment rates for all insurers, as in Medicare Advantage (Blumberg et al. 2019, 2020; Blumberg, Simpson, and Buettgens 2019). In this and two accompanying papers (Holahan and Simpson 2021a, 2021b), we analyze such reforms that apply to the nongroup health insurance market only and some that would apply both in the nongroup and employer health insurance markets. Here, we explore the coverage and cost impacts of introducing these reforms in urban areas only, leaving rural areas' insurance markets unchanged. This reform is motivated by concern that providers in rural areas, both physicians and hospitals, are under considerable financial stress. It is often difficult to attract physicians to rural areas, and a large number of rural hospitals face threats of closure or shrinkage. Constraints on payment rates could exacerbate these problems. On the other hand, exempting rural areas from payment constraints would mean rural residents and employers pay more for coverage.

We show exempting rural areas in these reforms would not significantly affect aggregate household and employer spending, federal government spending, or overall spending. This is because the number of people living in areas we characterize as rural is relatively small. Rural providers are, by design, better off if exempted from the reforms we examine. However, more rural residents would be uninsured and household and employer spending would generally be higher. Moreover, more federal dollars will flow to rural areas if they are exempted from the reforms.

As noted, we examine public option and capped provider payment rate proposals that would be introduced solely in the nongroup market as well as in both the nongroup and employer markets. The public option would be a government-developed insurance plan that pays professionals (doctors and other health providers), hospitals, and prescription drug manufacturers according to a fee schedule that uses lower rates than those typical of commercial insurers. Discussions of a public option typically center around provider payment rates, specifically, whether they should be set at Medicare rates or some multiple thereof. Savings are greatest when Medicare rates (or lower rates) are used, but that may limit provider participation. Conversely, setting rates too far above Medicare levels could result in very little savings. But providers would be more likely to participate and would see little reduction in revenue.

The public option would require consumers (households and/or employers) to enroll in a new insurance plan to take full advantage of savings. The competition from a public option could result in more aggressive negotiations between private insurers and providers for lower rates, possibly lowering private plan premiums as well. Private insurers that cannot successfully negotiate lower provider payment rates may end up leaving insurance markets.

We also examine reforms that cap provider payment rates for all insurers, as is done in Medicare Advantage. Providers would be required to accept payment rates no higher than established amounts for both in- and out-of-network services. Presumably, the payment rates would be set below those typical of commercial insurers in most markets. Like a public option, capped provider payment rates could also be used in the nongroup market alone or in both nongroup and employer markets. Capping provider payment rates does not exclude the possibility of also having a public option, similar to the way private insurers with capped provider payment rates compete with traditional Medicare in the Medicare Advantage market. Capping rates would allow consumers to reap the full cost savings while enrolling with any insurer, not just the public option. With a capped rate policy, more private insurers are likely to enter and stay in insurance markets because large market share is not needed as leverage for negotiating payment rates with providers.

In this paper, we examine three reforms that would be implemented in just the nongroup market in urban areas. Public option 1 would pay providers at Medicare rates. This option has the deepest cut in payment rates and results in the greatest savings. Public option 2 would pay Medicare rates plus 10 percent for professionals (physicians and other providers) and plus 25 percent for hospitals (or current rates, if the proposed Medicare-like rates would exceed current rates).[1] Public option 3 would pay Medicare rates plus 15 percent for professionals and plus 60 percent for hospitals. Of the three nongroup market–only reforms, public option 3 provides the least savings but would be the most acceptable to providers.

We also examine four reforms that would extend the public option or capped rates to both the employer and nongroup markets in urban areas, potentially covering many more lives. Because more people would be affected and payment rates are higher in the employer market than the nongroup market, using Medicare rates could dramatically affect provider revenues (Blumberg et al. 2020). Thus, we assume rates are set somewhat above Medicare levels. In public option 4, payment rates in the

nongroup and employer markets would be set at Medicare levels plus 10 percent for professionals and plus 25 percent for hospitals. Public option 5 would also introduce the public option into both the nongroup and employer markets, paying Medicare rates plus 15 percent for professionals and plus 60 percent for hospitals. The final two reforms would cap provider payment rates for all insurers. Capped rates 1 would pay Medicare rates plus 10 percent for professionals and plus 25 percent for hospitals. Capped rates 2 would pay Medicare rates plus 15 percent for professionals and plus 60 percent for hospitals.

In each policy option, we assume prescription drug savings would apply in both urban and rural markets. We assume legislation establishing a public option would establish rebates halfway between those for Medicare and Medicaid and would be in effect nationally. Markets for prescription drugs differ from those for hospitals and professionals, and the arguments for exempting rural areas do not apply; under the reforms examined, access to prescription drugs is unlikely to be affected, because drugs are priced nationally. We estimate elsewhere these savings approximate a 30 percent cut relative to commercial payments (Hwang and Kesselheim 2020).

Characteristics of Urban or Rural Areas

Table 1 shows the differences in characteristics of urban and rural rating regions. Rural regions have considerably smaller population size, and many fewer people live in rural areas than urban areas. Thus, policies that exempt rural areas will have smaller effects on federal spending relative to policies that include them. Rural populations are slightly older, less likely to have employer-sponsored insurance, more likely to be covered by Medicaid, and more likely to have considerably lower per capita incomes. In addition, almost all rural areas have concentrated hospital systems, and most have concentrated nongroup insurance markets. Policies that would exempt rural areas would therefore exempt markets with high hospital or insurer concentration, which tend to have higher prices for hospital and professional services than less concentrated markets.

TABLE 1

Characteristics of Rural and Urban Regions, 2022

	Rural	Urban
Population		
Millions under age 65	53	224
Average population of an ACA rating region (thousands)	317	866
Average age	40.8	39.0
Average age of people younger than 65	32.2	31.9
Health insurance coverage among people under 65		
Employer	51%	55%
ACA-compliant nongroup	5%	5%
Medicaid/CHIP	28%	25%
Other public	4%	3%
Uninsured	11%	11%
Short-term, limited duration plan	1%	1%
Average family income among people under 65		
Thousands of dollars	60.3	76.7
As a share of FPL	307%	388%
Hospital/nongroup market concentration		
Share of people under 65 living in concentrated hospital markets[a]	93%	30%
Share of people under 65 living in concentrated hospital and/or ACA nongroup insurance markets[b]	94%	46%

Source: Health Insurance Policy Simulation Model, 2021.

Notes: ACA = Affordable Care Act. CHIP = Children's Health Insurance Program. FPL = federal poverty level.

[a] Concentrated markets have HHI > 5,000.

[b] Concentrated markets have HHI > 5,000 and/or two of fewer insurers in the ACA nongroup market.

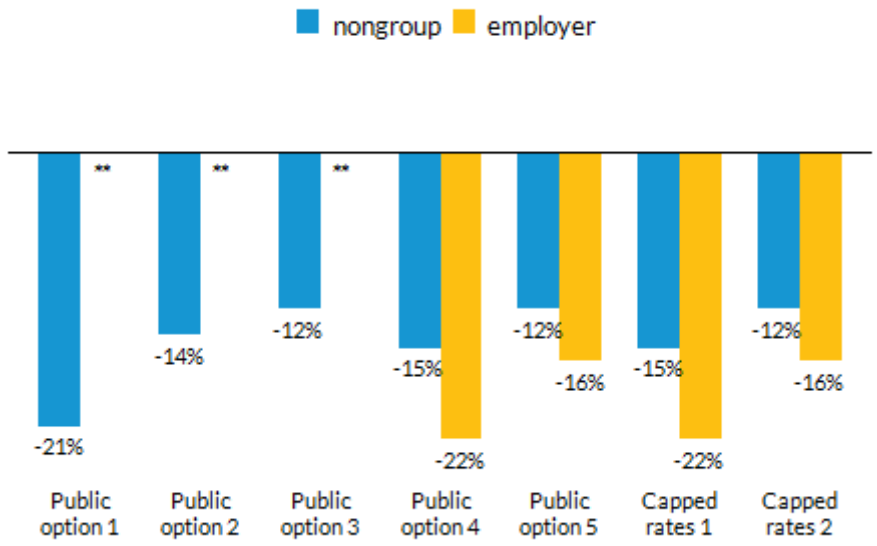
Highlights of Findings

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

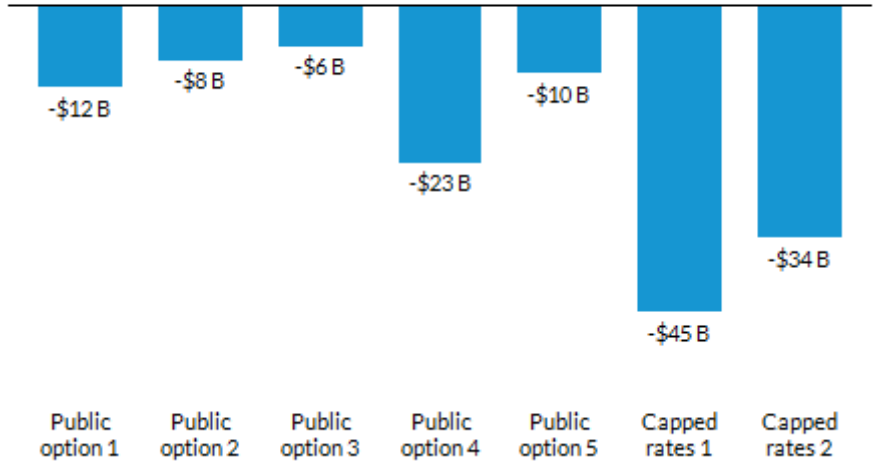
FIGURE 1

Summary of Effects of Reform Options for Urban Areas, 2022

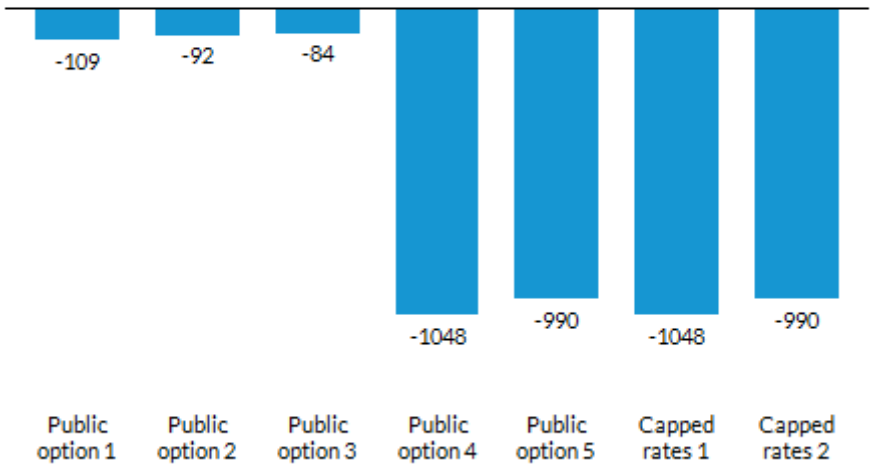
On median premiums



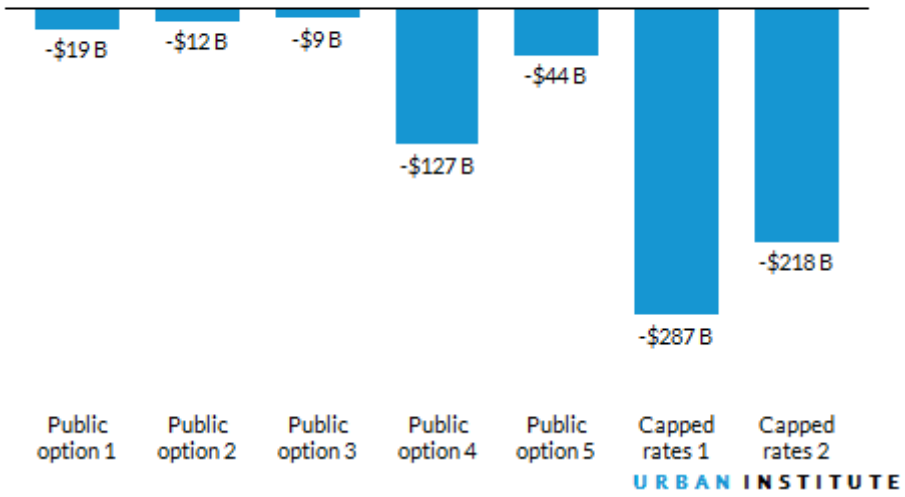
On the federal deficit



On thousands of people uninsured



On health system spending



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

- **Premium and coverage in the nongroup market.** We estimate a public option in only the nongroup market would lower median premiums by 12 to 21 percent in urban areas. Urban markets tend to be more competitive than rural markets, so premium reductions would be lower than in rural areas, if rural areas were included. The greatest reductions in premiums occur under reforms that have the greatest impact on provider payment rates. We estimate

premiums in rural areas would fall by 7 percent, because we apply increases in prescription drug rebates to rural areas. The coverage effects of public option policies in the nongroup market are very small, because most people in the Marketplace have subsidies. Thus, changes in overall premiums mostly change the subsidy amount, not the premium paid by the household, which is limited to a specified percentage of income. In this paper, we do not consider policies that would expand subsidies to improve coverage.

- **Federal, household, and employer health spending in the nongroup market.** The lower nongroup premiums in the reforms modeled decrease federal spending, primarily on premium tax credits, by $6 to $12 billion. Household and employer spending is largely unaffected. Effects on spending are small because the nongroup market is small.
- **Premiums and coverage in the employer market**. A public option or capped provider payment rates tend to lower premiums more in the employer market than in the nongroup market, because employer markets are generally less competitive and pay higher rates to providers. Under reforms that extend a public option to the employer market, we estimate median premiums for participating employers fall by 16 to 22 percent. Reductions in premiums are larger for reforms with greater reductions in provider payment rates. Offering the public option or capped payment rates in the employer market could reduce the number of people uninsured by about 1 million.
- **Employer and household spending**. Extending the public option or capped rates to the employer market has significant effects on employer and aggregate household spending. When the public option is extended to employer markets, employer spending falls by between $18 and $69 billion. Employers save more under capped rates in the employer market, from $130 to $173 billion. With a public option alone in the employer market, household spending falls by $19 to $48 billion; under capped rates in the employer market, household spending falls by $80 to $104 billion.
- **The federal deficit.** Federal spending on premium subsidies continues to fall in the nongroup market, but increases in federal tax revenues are much more important. As employers spend less on premiums, economic research indicates they convert the savings into higher wages for their workers. Higher wages are taxable, thus helping reduce the federal deficit. When the reforms are introduced into the employer market, the federal deficit falls by $10 to $23 billion under a public option and by between $34 and $45 billion under capped rates.
- **National health spending**. National health spending on the nonelderly falls by less than 1 percent if the public option is limited to the nongroup market. If a public option is available to employers as well, spending by all payers could fall by as much as 6 percent, depending on the payment rates used. With capped payment rates, spending by all payers could fall by as much as 14 percent.

TABLE 2

Public Option and Capped Provider Payment Rate Reforms for Urban Areas, 2022

Reform	Availability of public option	Payment policy[a]	Change						
			In median nongroup premiums[b]	In median employer premiums[c]	In number of uninsured	In the federal deficit[d]	In employer spending	In household spending	In health system spending
Public option 1	Nongroup urban markets	Medicare rates	-21%	NA	-109,000	-$12 B	*	-$6 B (-1%)	-$19 B (-1%)
Public option 2	Nongroup urban markets	Medicare rates plus 10% for professionals and plus 25% for hospitals	-14%	NA	-92,000	-$8 B	*	-$4 B (-1%)	-$12 B (-1%)
Public option 3	Nongroup urban markets	Medicare rates plus 15% for professionals and plus 60% for hospitals	-12%	NA	-84,000	-$6 B	*	-$3 B (-1%)	-$9 B (**)
Public option 4	Nongroup and employer markets in urban areas; subset of firms choose public option	Medicare rates plus 10% for professionals and plus 25% for hospitals	-15%	-22%	-1,048,000	-$23 B	-$69 B (-9%)	-$48 B (-8%)	-$127 B (-6%)
Public option 5	Nongroup and employer markets in urban areas; subset of firms choose public option	Medicare rates plus 15% for professionals and plus 60% for hospitals	-12%	-16%	-990,000	-$10 B	-$18 B (-2%)	-$19 B (-3%)	-$44 B (-2%)
Capped rates 1	Nongroup and employer markets in urban areas; all employers pay lower rates	Medicare rates plus 10% for professionals and plus 25% for hospitals	-15%	-22%	-1,048,000	-$45 B	-$173 B (-22%)	-$104 B (-18%)	-$287 B (-14%)
Capped rates 2	Nongroup and employer markets in urban areas; all employers pay lower rates	Medicare rates plus 15% for professionals and plus 60% for hospitals	-12%	-16%	-990,000	-$34 B	-$130 B (-16%)	-$80 B (-14%)	-$218 B (-10%)

Source: Health Insurance Policy Simulation Model, 2021.
Notes: B = billion. NA = not applicable. Reforms simulated as fully phased in and in equilibrium in 2022. Data are limited to health care spending among people below age 65 not enrolled in Medicare. Federal deficit effects are the sum of the change in federal spending on health care and the increase in federal income tax revenue.
[a] Prescription drug prices in each reform scenario are assumed to be halfway between Medicare and Medicaid prices in all (urban and rural) markets.
[b] This column shows the change in the median nongroup benchmark premium in urban and mostly urban markets.
[c] This column shows the change in median premiums in urban and mostly urban markets among employers providing the public option to their workers in public options 4 and 5. In capped rates 1 and 2, this column shows the change in median premiums for all employers in urban and mostly urban markets.
[d] Estimates in this column equal the change in federal spending on Medicaid/the Children's Health Insurance Program acute care for the nonelderly and Marketplace premiums minus the estimated increase in income tax revenue, which results from turning savings in untaxed health care premiums into taxable worker wages.
* = less than +/- $500 million. ** = less than +/- 0.5%.

Projected Impacts of a Public Option and Capped Provider Payment Rates Limited to Urban Markets

In the results below, we present estimated changes in median nongroup and employer premiums, health insurance coverage, and health care spending by households, employers, and the federal government in urban areas under the reforms modeled. All estimates are generated using the Health Insurance Policy Simulation Model (HIPSM; Buettgens and Banthin 2020). We also show the estimated increase in federal income tax revenue that results from employers achieving savings in health insurance costs and passing them on to workers via higher wages, which results in higher tax payments. In addition, we show the impact on the federal deficit, which is a combination of the reduction in federal government spending, primarily from lower spending on Marketplace premium tax credits, and, when reforms include employer-sponsored insurance, the increased income tax revenue.

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

Public Option 1: Medicare Rates in Nongroup Markets

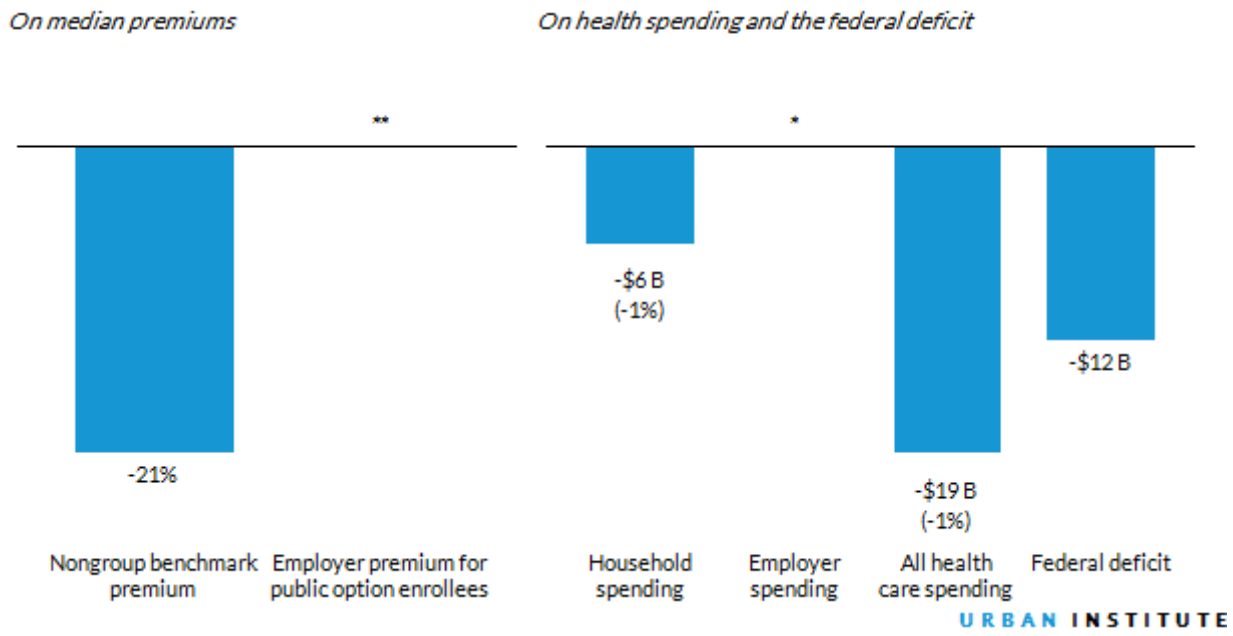
- public option in the private nongroup market in urban areas
- pays Medicare rates for hospitals and professionals in urban areas
- prescription drug prices set halfway between Medicare and Medicaid prices in all markets

Premium and coverage effects. The median benchmark premium falls by 21 percent in urban areas because of the lower Medicare payment rates. The number of people uninsured decreases by 109,000, a small effect because only households facing full, unsubsidized nongroup premiums are affected.

Health care spending. Because benchmark nongroup premiums fall in urban markets, Marketplace tax credits also fall, because the credits are tied to those premiums. Federal health spending, primarily on premium tax credits, falls by $12 billion.[2] Employer spending is essentially unchanged. Aggregate household spending decreases by $6 billion, or 1 percent. Because the policy only affects the nongroup market, it affects a small share of the population. Overall spending on the nonelderly falls by $19 billion, or about 1 percent.

FIGURE 2

Effects of Public Option 1



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

Public Option 2: Medicare Rates with Modest Upward Adjustments

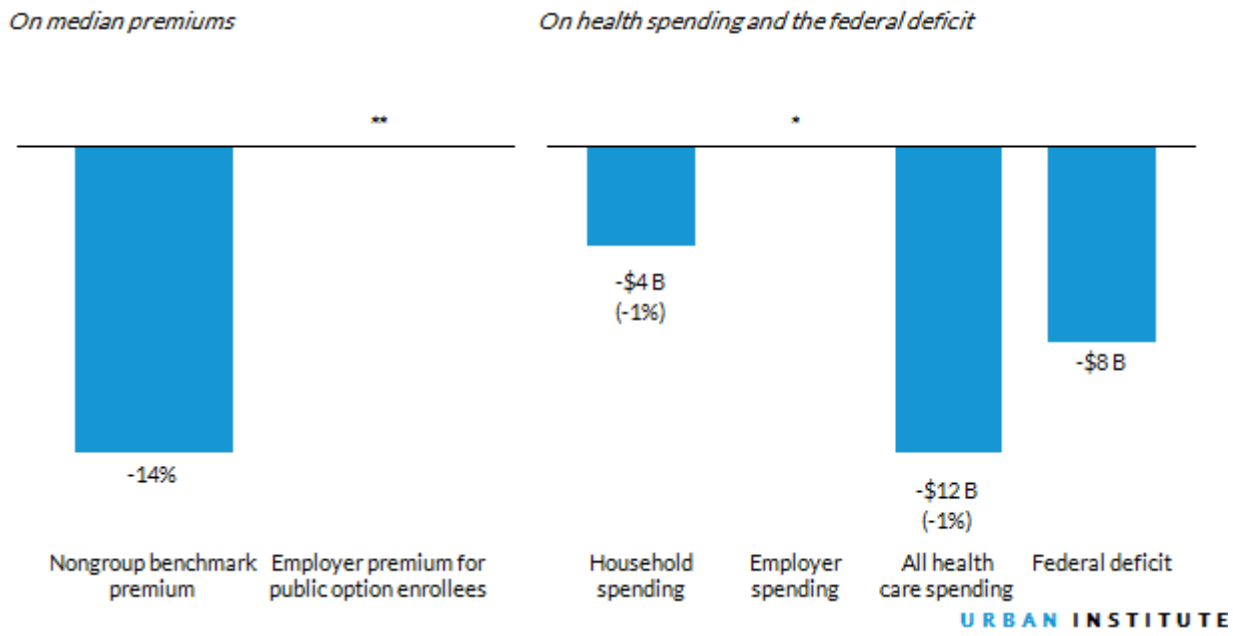
- public option introduced in nongroup markets in urban areas
- pays Medicare rates plus 10 percent for professionals and plus 25 percent for hospitals in urban areas
- prescription drug prices set halfway between Medicare and Medicaid prices in all markets

Premium and coverage effects. Median household premiums fall by 14 percent because hospital and physician payment rates are higher than under public option 1. Because premium savings are smaller, the impact on the uninsured population is also smaller; the number of people uninsured declines by 92,000.

Health care spending. Federal spending declines by only $8 billion, almost all because of the reduction in Marketplace subsidies. Aggregate household spending falls by $4 billion, or around 1 percent. Employer spending declines very slightly. Overall health care spending falls by $12 billion, or slightly less than 1 percent.

FIGURE 3

Effects of Public Option 2



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

Public Option 3: Medicare Rates with Large Upward Adjustments

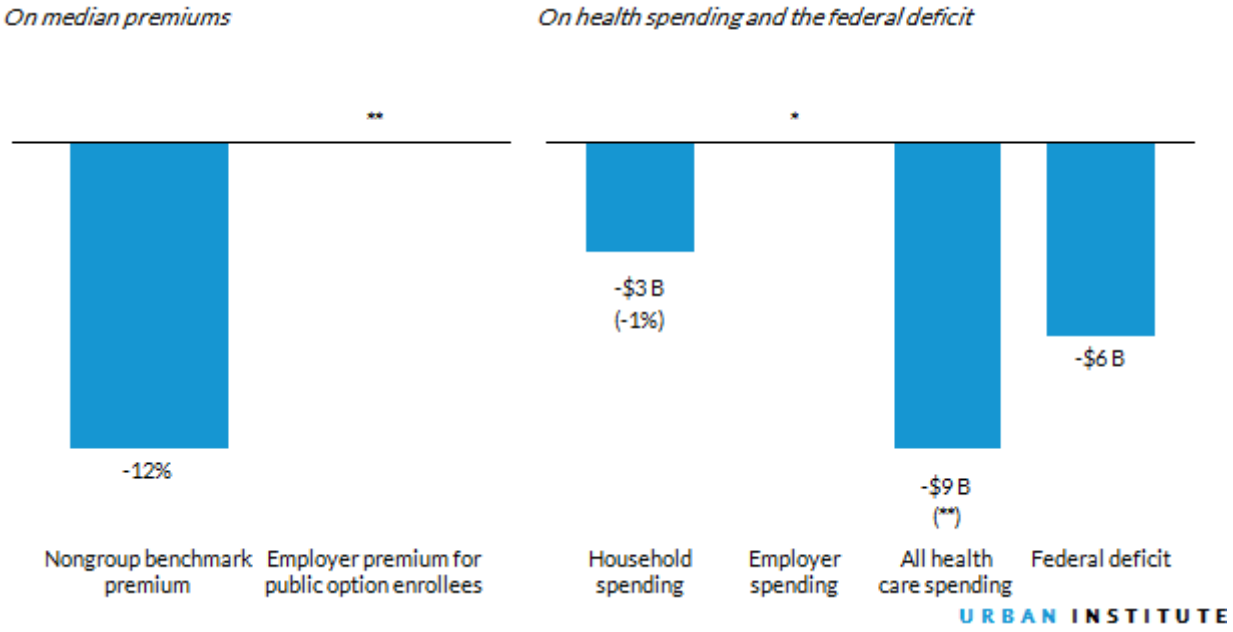
- public option in private nongroup insurance markets in urban areas
- pays Medicare rates plus 15 percent for professionals and plus 60 percent for hospitals in urban areas
- prescription drug prices set halfway between Medicare and Medicaid prices in all markets

Premium and coverage effects. Median benchmark premiums in the nongroup market fall by 12 percent, because the higher payment rates reduce available savings. The number of people uninsured falls by 84,000, less than under public option 2 because of the smaller reduction in premiums.

Health care spending. Federal health care spending falls by $6 billion, or slightly more than 1 percent, because of lower premium tax credits. Aggregate household spending falls by only $3 billion, whereas employer spending declines very slightly, because of a small decrease in employer coverage. Overall health care spending falls by $9 billion, less than 0.5 percent. Setting caps on physician and hospital payments at relatively high rates yields little savings to households, employers, or the federal government. This illustrates that a public option's effects on health care costs depends on how payment rates are set.

FIGURE 4

Effects of Public Option 3



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

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

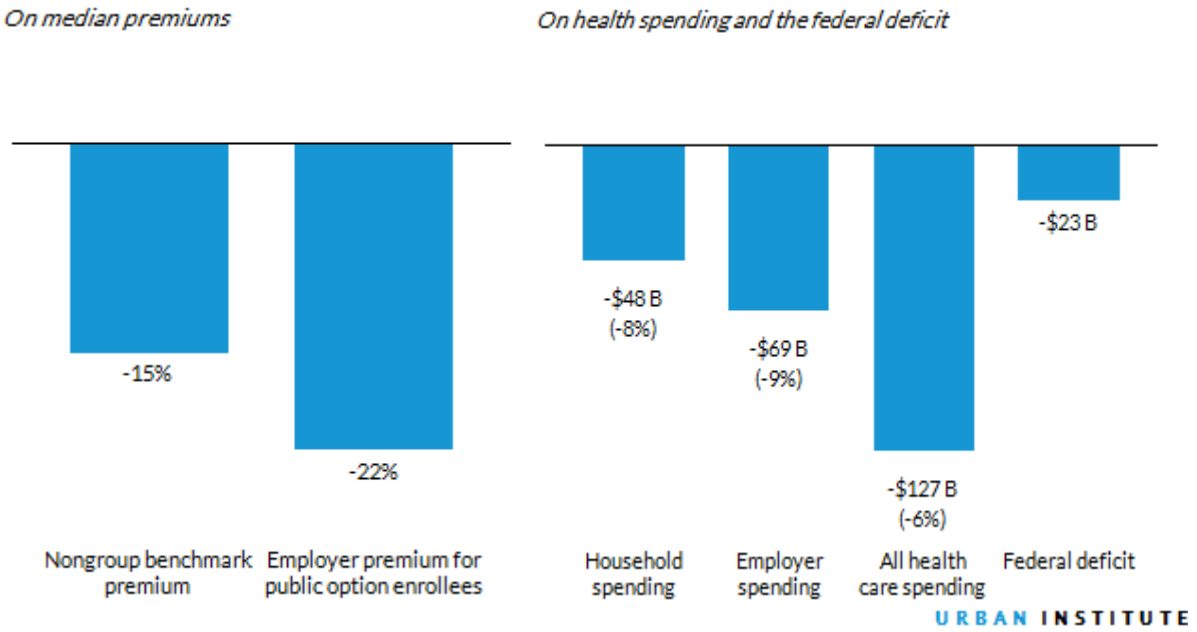
- public option available in the employer and nongroup markets in urban areas; a subset of employers choose the public option
- public option pays Medicare rates plus 10 percent for professionals and plus 25 percent for hospitals in urban areas
- prescription drug prices set halfway between Medicare and Medicaid prices in all markets

Premium and coverage effects. The median premium for employers choosing the public option falls by 22 percent, whereas the median nongroup premium falls by 15 percent. Premium reductions are larger in the employer market than nongroup market because employer insurance markets tend to be less competitive, and nongroup markets tend to be very competitive in most urban markets. This option reduces the number of people uninsured by 1 million, because almost 1.3 million people gain employer coverage.

Health care spending. Extending the public option to the employer market has dramatically larger effects than limiting it to the nongroup market. Aggregate household spending falls by $48 billion, or 8 percent. Employer spending falls by $69 billion, or 9 percent. Spending by the federal government, primarily on premium tax credits, falls by $10 billion, or 2 percent. Reduced employer spending leads to a $13 billion increase in tax revenues. The net effect on the federal deficit is $23 billion reduction. Overall health system spending falls by $127 billion, or 6 percent.

FIGURE 5

Effects of Public Option 4



Source: Health Insurance Policy Simulation Model, 2021.

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

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

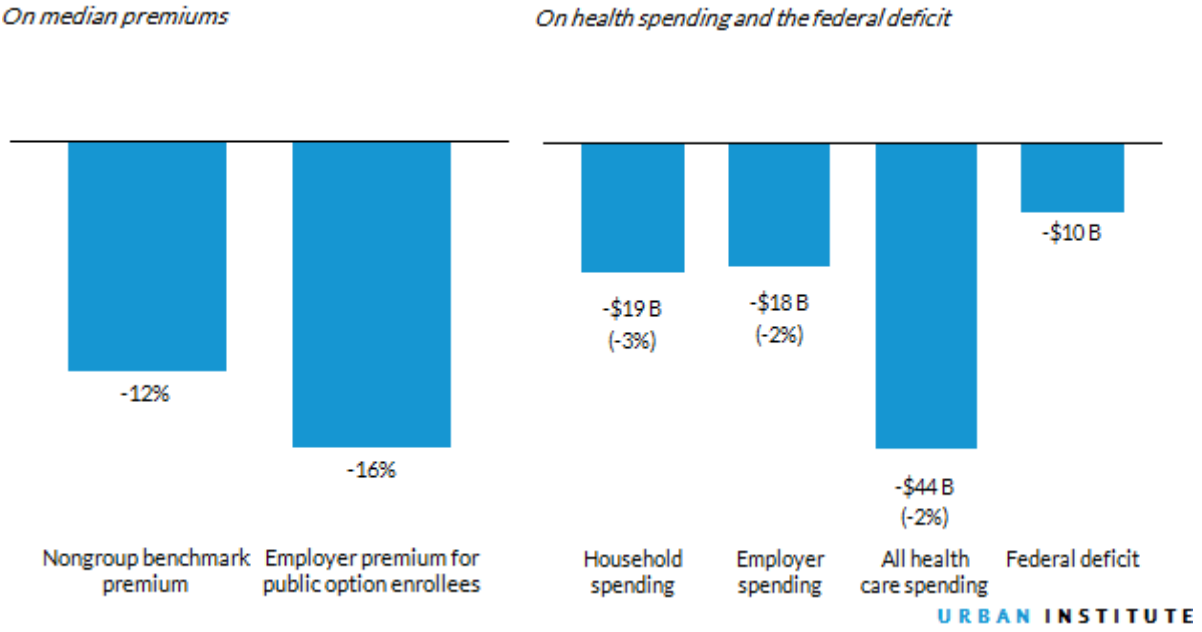
- public option available in the employer and nongroup markets in urban areas; a subset of employers choose the public option
- public option pays Medicare rates plus 15 percent for professionals and plus 60 percent for hospitals in urban areas
- prescription drug prices set halfway between Medicare and Medicaid prices in all markets

Premium and coverage effects. The median employer premium falls by 16 percent, whereas the benchmark nongroup premium falls by 12 percent. The number of people uninsured falls by 1 million, or 3 percent, because 1.2 million people gain employer coverage. This results from employers expanding offers of coverage in response to the availability of the lower-premium public option.

Health care spending. This reform primarily affects employer and household spending. Aggregate household spending falls by $19 billion, or 3 percent. Employer spending falls by $18 billion, or 2 percent. Federal spending declines by $8 billion, or 2 percent, because of reduced premiums in the nongroup market. Federal tax revenues increase by $2 billion, thereby decreasing the federal deficit by $10 billion. Overall health system spending falls by $44 billion, or 2 percent.

FIGURE 6

Effects of Public Option 5



Source: Health Insurance Policy Simulation Model, 2021.

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

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

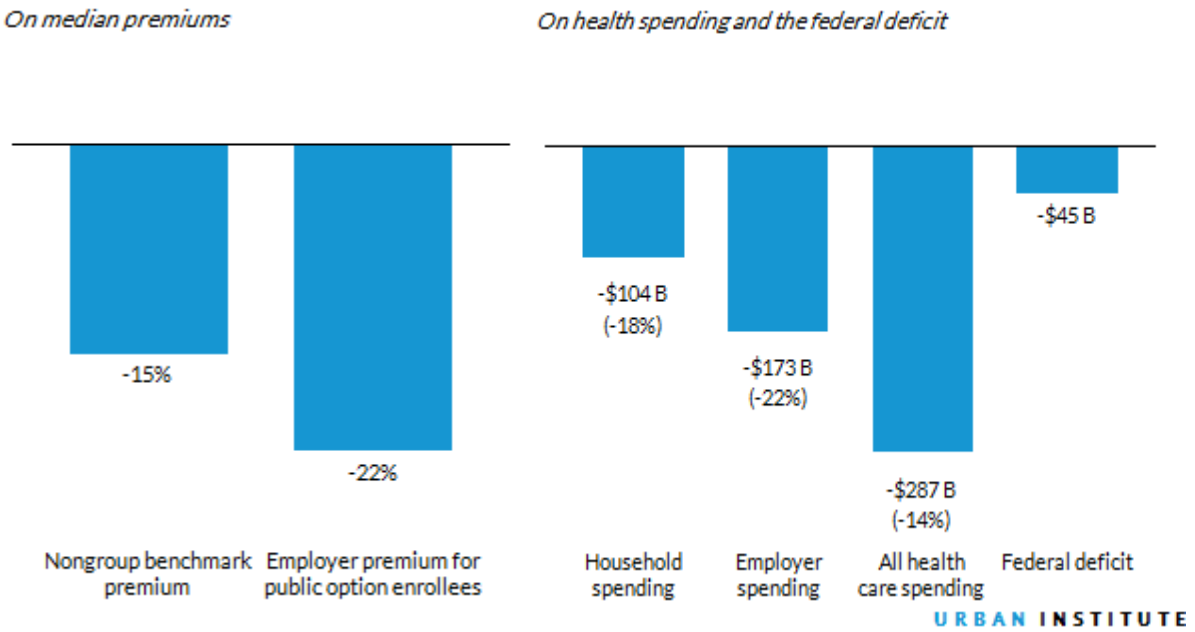
- payment rates capped for all insurers in employer and nongroup markets in urban areas
- rates set at Medicare levels plus 10 percent for professionals and plus 25 percent for hospitals in urban areas
- prescription drug prices set halfway between Medicare and Medicaid prices in all markets

Premium and coverage effects. The medium employer premium falls by 22 percent, and the benchmark nongroup premium falls by 15 percent. The number of people uninsured falls by 1 million, or 3 percent, because almost 1.3 million people gain employer coverage.

Health care spending. Spending effects are much larger under capped rates because all insurers are affected. Aggregate household spending falls by $104 billion, or 18 percent. Employer spending falls by $173 billion, or 22 percent. Federal spending, primarily on tax credits, declines by $10 billion. Federal tax revenues increase by $36 billion, thereby reducing the federal deficit by $45 billion. Overall, health care spending falls by $287 billion, or 14 percent.

FIGURE 7

Effects of Capped Rates 1



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

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

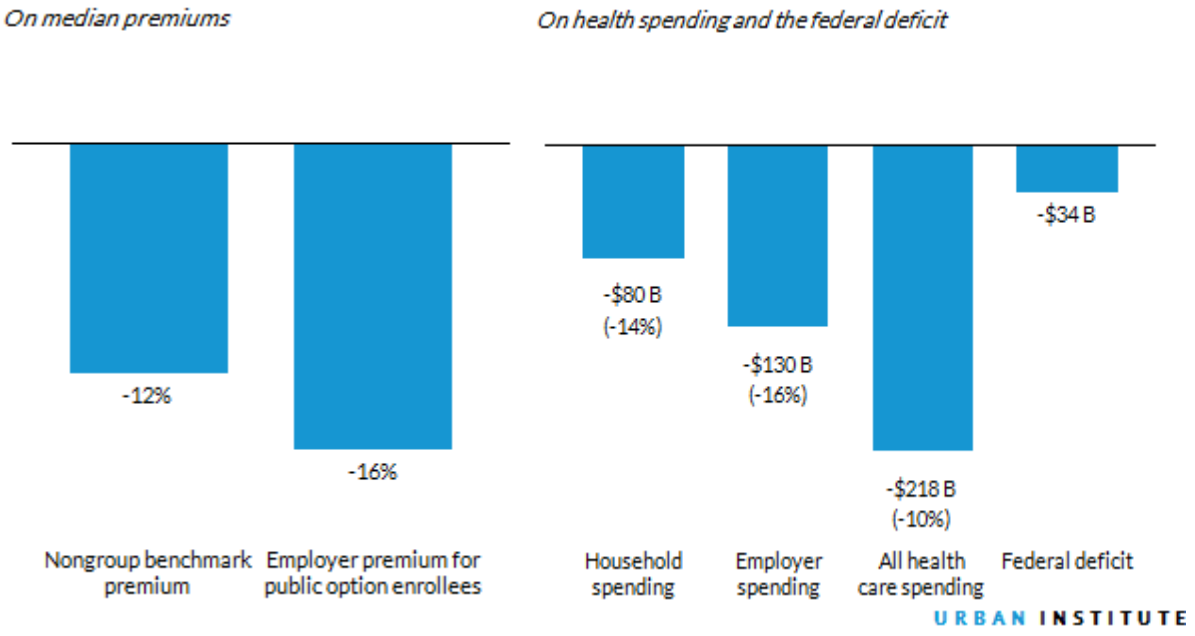
- payment rates capped for all insurers in employer and nongroup markets in urban areas
- rates set at Medicare levels plus 15 percent for professionals and plus 60 percent for hospitals in urban areas
- prescription drug prices set halfway between Medicare and Medicaid prices in all markets

Premium and coverage effects. The median premium falls by 16 percent in the employer market and by 12 percent in the nongroup market. The number of people uninsured falls by 1 million, or 3 percent. Again, this results from the large increase in employer coverage, because all insurers can lower premiums because of lower provider payment rates.

Health care spending. Health care spending falls by less than under capped rates 1 because payment rates, and thus premiums, are higher. Aggregate household spending falls by $80 billion, or 14 percent. Employer spending declines by $130 billion, or 16 percent. Federal government spending falls by $8 billion, or slightly less than 2 percent. Because of higher wages, federal tax revenues increase by $27 billion; thus, the federal deficit falls by $34 billion. Overall health care spending falls by $218 billion, or more than 10 percent.

FIGURE 8

Effects of Capped Rates 2



Source: Health Insurance Policy Simulation Model, 2021.

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

Impact of Exempting Rural Areas

We estimate the impact of rural exemption from the reforms modeled on rural areas by extending three of our policy options to all regions, instead of limiting them to urban areas, and computing the difference in rural areas. The three reforms, public options 2 and 4 and capped rates 1, would each pay Medicare rates plus 10 percent for professionals and plus 25 percent for hospitals. Through these reforms, we examine the impact on rural areas of exempting them from a public option in the nongroup market (public option 2), a public option in the nongroup and employer markets (public option 4), and capped rates in the nongroup and employer markets (capped rates 2).

TABLE 3

Impacts on Rural Areas of Exempting Rural Areas from Select Reforms

	Public option 2	Public option 4	Capped rates 1
Household spending			
Billions of dollars	1	5	8
Percent of current spending	1	5	7
Employer spending			
Billions of dollars	*	5	8
Percent of current spending	**	3	6
Federal spending			
Billions of dollars	3	3	3
Percent of current spending	2	2	2
State sending (including demand for uncompensated care)			
Billions of dollars	*	*	*
Percent of current spending	**	**	**
Provider spending			
Billions of dollars	*	*	*
Percent of current spending	1	1	1
Total spending, all payers			
Billions of dollars	4	13	19
Percent of current spending	1	3	4
Number of people uninsured[a]			
Thousands	18	55	55
Percent difference	**	1	1

Source: Health Insurance Policy Simulation Model, 2021.

Notes: Reforms simulated as fully phased in and in equilibrium in 2022. Federal, state, and provider spending include demand for uncompensated care. Data in this analysis are limited to health care spending among people below 65 not enrolled in Medicare.

[a] Includes those without insurance and those with short-term limited-duration plans.

* = less than $500 million. ** = less than 0.5%.

Under public option 2, aggregate household spending in the nongroup market is $1 billion higher when rural areas are exempted. Employers are largely unaffected, federal spending is 2 percent higher in rural areas, and overall spending is $4 billion, or 1 percent, higher than if rural areas were included in this reform. In other words, under rural exemption, households spend more, but more federal dollars enter rural markets. Uninsurance is slightly higher in rural areas because of the exemption as well; with rural areas excluded from the reforms, about 18,000 more people are uninsured.

Under public option 4, which extends the public option to both the nongroup and employer markets, spending by households, employers, and the federal government is higher because of rural exemption; the increases are $5 billion (5 percent), $5 billion (3 percent), and $3 billion (2 percent), respectively. Under rural exemption, overall spending in rural areas under this reform is $13 billion, or 3 percent, higher. When including rural areas in the reform, about 55,000 more people are uninsured than if such areas are exempted.

Under capped rates 1, spending increases by $8 billion (7 percent) for households, by $8 billion (6 percent) for employers, and by $3 billion (2 percent) for the federal government when rural areas are included in the reform. Overall, under capped rates 1, eliminating the rural exemption increases spending in rural areas by $19 billion, or 4 percent, and about 55,000 more people are uninsured.

Comparing the data in tables 2 and 3 shows rural exemption adds relatively little to federal or overall spending and reduces uninsurance only slightly. Urban areas are simply much larger and account for most spending. Therefore, rural providers could be protected from payment cuts without significantly changing the coverage and spending effects of a public option or capped provider payment rates.

Discussion

In this analysis, we examine seven public option or capped provider payment rate proposals that would apply only to urban areas, meaning they exempt rural areas from cuts in hospital and professional payment rates. (Rural areas would still benefit from reductions in prescription drug prices.) The reforms examined vary by whether they are limited to the nongroup market, whether the public option is extended to the employer market, or whether reductions in provider payment rates apply to all insurers in the nongroup and employer markets. The reforms' impacts depend on how payment rates are established, specifically, whether they are set at Medicare levels, a relatively small multiple above Medicare rates, or a larger multiple thereof. Exempting rural areas from the reforms is intended to assure rural residents' access to physicians and hospitals and protect rural providers' financial health. At the same time, we show fewer people would have insurance coverage because of the exemption, and households and employers would spend more than if the policies shown did not exempt rural areas.

We estimate public option policies limited to the nongroup market affect coverage very little. They also provide modest savings to the federal government, employers, and households. This is primarily because the nongroup market is relatively small, a large number of urban markets are very competitive, and urban premiums are already fairly low.

Extending the public option to employers reduces the uninsured population by about 1 million and provides more savings to the federal government. Employers would see substantial savings in premiums and, in response, would increase wages. Tax revenues would increase, contributing to a $10 to $23 billion reduction in the federal deficit.

The largest spending and coverage effects occur when provider payment rates are capped for all insurers, as under capped rates 1 and 2. All employers benefit, and, in turn, workers' wages increase, thereby increasing federal tax revenues. Consequently, we estimate the federal deficit falls by $34 to $45 billion under these reforms.

The effects of the reforms modeled are greater the more payment rates are reduced. Thus, the largest savings come from introducing a public option that pays Medicare rates in the nongroup market, under public option 1. But such severe payment rate cuts may not be politically feasible, especially if they extend to both the nongroup and employer markets. A public option that pays higher rates (e.g., Medicare levels plus 15 percent for professionals and plus 60 percent for hospitals as under public options 3 and 5) may be more feasible. But, such a public option in the employer market would have less of an effect on premiums and thus on federal, household, and employer spending. Capping payment rates to all providers by all insurers in the employer market, even at Medicare plus 15 percent for professionals and plus 60 percent for hospitals as under capped rates 2, would significantly affect government, household, and employer spending on health care, because the policy extends to payments by all insurers.

We also show the effect on rural areas of being exempted from the public option or capped provider payment rates. Because of the exemption, more federal dollars flow into rural areas. On the other hand, the number of people uninsured is slightly higher, as are household and employer spending. The reforms' effects on rural areas vary by their policy designs. Federal spending is higher if rural areas are exempt from the reforms, but how much depends on the policy. But because most federal spending is in urban areas, exempting rural areas only minimally affects the reach of the reforms examined here. And rural areas benefit from less disruption to their health systems.

Methods

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

We begin each simulation with a current-law baseline in 2022 that includes the estimated effects of and a partial recovery from the COVID-19 recession. For this analysis, we assume the Medicaid enhanced federal medical assistance percentage and maintenance-of-effort provisions in the Families First Coronavirus Response Act would have expired before 2022. However, in a letter to governors sent in late January 2021, the acting secretary of the US Department of Health and Human Services indicated the department planned to extend its public health emergency declaration through calendar year 2021.[3] This means the maintenance-of-effort requirement, which prohibits states from disenrolling Medicaid enrollees unless they request it, will last through January 2022, and the enhanced federal medical assistance percentage will be available through March 2022. Consequently, Medicaid enrollment will be notably higher in early 2022 than indicated in our estimates, but it will decline to the levels we show later in the year. Also, the federal government will pay a higher share of Medicaid costs in the first quarter of 2022 than we indicate.

We then estimate the effects of implementing each of the seven public option or capped provider payment rate reforms. Each reform affects prescription drug prices in all regions but affects professional

and hospital payment rates in urban rating regions only. The simulations vary by the assumed provider payment rates (all expressed relative to Medicare's payment rates) and the insurance markets (nongroup, employer) in which the public option and/or capped provider payment rates are available. All estimates assume reforms are fully phased in and in equilibrium in 2022.

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

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

Savings in the nongroup market apply to all enrollees under either a public option or capped provider payment rates. The model implicitly assumes all enrollees are affected by the public option, because we assume the Marketplace benchmark premium would decrease by the percent difference between the public option and baseline premiums. For people with employer-sponsored insurance, only those in firms opting in to the public option see savings. We assume firms that are small, pay lower average wages, and expect significant savings are more likely to choose the public option than large firms, those paying higher wages, and those expecting small savings from the switch. Capped rates 1 and 2 limit all provider payments in urban areas, reducing payments for everyone with employer-sponsored coverage. We discuss additional methodological issues in our earlier report (Blumberg et al. 2020).

Limitations

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

- For the nongroup reform estimates, we lack actual payment rate data. We estimate Medicare payment rates using regression analyses that estimate the impact on premiums of the number of insurers and measures of hospital concentration. We assume markets with a large number of insurers and low hospital concentration have payment rates that approximate Medicare prices and

thus premiums. Markets lacking these characteristics have been shown to have higher premiums. We estimate high premiums in markets with high insurer and hospital concentration will decrease to the levels seen in more competitive markets. But the high premiums we observe in noncompetitive regions could owe to factors other than higher provider payment rates.

- We assume the public option is the benchmark plan. We cannot estimate how many people choose plans that have higher premiums than the benchmark. To the extent individuals enroll in more expensive plans, we may underestimate aggregate household spending in our nongroup reform estimates.
- We use data from FAIR Health, which collects data from a large number of firms. However, the data do not contain all private plans in a state or substate area. Thus, the contributing insurers may not be entirely representative, despite their very large amount of data.
- We use FAIR Health data to represent the distribution of commercial payment levels. FAIR Health data cover plans for 75 percent of the privately insured population in the United States, but they include some Medicare Advantage plans and plans that participate in the nongroup market.
- FAIR Health provided us with data on payments for professional and outpatient facilities representing 47 percent of total professional spending and 42 percent of total outpatient facility spending. However, the services may not fully represent the average ratios of commercial insurer payment rates to Medicare rates. More importantly, FAIR Health does not release substate data on commercial payment rates for inpatient hospital services. Though our estimates include all inpatient services provided in the state, lacking substate information on inpatient care could lead to some error at the substate level.
- We have made assumptions about employer take-up of the public option by firm size, wages, and expected savings. Take-up of the public option is assumed to be higher for small, low-wage firms, and we assume a firm only chooses the public option when resulting savings exceed 20 percent. Our assumptions are somewhat arbitrary and different assumptions would have different results. Our capped rate simulations provide estimates of the extreme case of all employers choosing the public option.
- In our estimates of prescription drug savings, we assume drug pricing rebates from various private payers are the same across the country. If the mix of drugs consumed varies geographically, our rebates may be estimated with error. Medicare's pharmacy benefit manufacturers differ by geography, with some getting better rebates from manufacturers than others. Thus, Medicare rebates could differ across states, but we do not account for this.
- We estimate prescription drug rebates for the reforms modeled would lead to prices halfway between Medicare and Medicaid prices, or 30 percent below commercial insurance prices. These prices seem reasonable because they are less than those currently achieved in Medicaid and considerably less than in other western nations. We may also have underestimated the savings a public option could achieve. However, it has been politically difficult in the US to achieve lower drug prices, so we are cautious in our estimates. The differences or any errors in our savings estimates would be tempered by the fact that prescription drug spending accounts for only 23 percent of the premium dollar nationwide.

- We assume services provided for the currently insured will be unaffected and care demanded by the newly insured will be provided. We exclude rural areas from the reforms out of concern for access to care in those areas. However, providers in urban areas might therefore cut back on services in response to the payment cuts (Clemens and Gottlieb 2014; White and Yee 2013). If providers reduce services, premium cuts and reductions in spending will be larger than presented here, and issues of care might need to be addressed.
- We designate Affordable Care Act rating regions as urban or rural based on the share of urban counties in the region.[4] However, HIPSM assigns lower provider reimbursements by public-use microdata areas (PUMAs). Rating regions' and PUMAs' borders often, but not always, align. When a PUMA falls into more than one rating region, we assign it a population-weighted average of the reimbursement savings of the rating regions. PUMAs, whole or fractional (by population), are combined when computing reform effects by rating regions. Because of these assignments, some regions are not fully urban or rural. For presentation, we consider regions that are fully or mostly rural (by population) to be rural, and we consider those fully or mostly urban as urban.

Supplementary Tables

TABLE 4

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

Percent change from current-law premiums

	Public option 1	Public option 2	Public option 3	Public option 4	Public option 5	Capped rates 1	Capped rates 2
Nongroup[a]							
Percentile							
10th	-41	-35	-30	-36	-31	-36	-31
25th	-32	-27	-23	-28	-25	-28	-25
50th (median)	-21	-14	-12	-15	-12	-15	-12
75th	-14	-8	-6	-10	-7	-10	-7
90th	-11	-5	-2	-6	-4	-6	-4
All employers[b]							
Percentile							
10th	NA	NA	NA	-12	-5	-25	-20
25th	NA	NA	NA	-11	-4	-24	-19
50th (median)	NA	NA	NA	-10	-3	-23	-17
75th	NA	NA	NA	-9	-3	-22	-16
90th	NA	NA	NA	-8	-2	-20	-15
Employers offering public option[b]							
Percentile							
10th	NA	NA	NA	-24	-21	-23	-18
25th	NA	NA	NA	-23	-19	-23	-17
50th (median)	NA	NA	NA	-22	-16	-22	-16
75th	NA	NA	NA	-21	-14	-20	-15
90th	NA	NA	NA	-19	-10	-19	-14

Source: Health Insurance Policy Simulation Model, 2021.

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

[a] These rows show the change in the median nongroup benchmark premium in urban and mostly urban areas.

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

TABLE 5

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

Coverage (thousands of people)

	Current law	Public option 1	Public option 2	Public option 3	Public option 4	Public option 5	Capped rates 1	Capped rates 2
Insured (MEC)	**244,113**	**244,222**	**244,205**	**244,197**	**245,161**	**245,103**	**245,161**	**245,103**
Employer	149,325	149,270	149,272	149,273	150,591	150,531	150,591	150,531
Traditional	149,325	149,270	149,272	149,273	81,800	121,138	0	0
Public option	0	0	0	0	68,791	29,393	150,591	150,531
Private nongroup	14,960	15,046	15,036	15,029	14,673	14,678	14,673	14,678
Medicaid/CHIP	71,162	71,240	71,233	71,229	71,233	71,229	71,233	71,229
Other public	8,665	8,665	8,665	8,665	8,665	8,665	8,665	8,665
Uninsured (no MEC)[a]	**33,333**	**33,225**	**33,241**	**33,250**	**32,285**	**32,343**	**32,285**	**32,343**
Total	**277,446**	**277,446**	**277,446**	**277,446**	**277,446**	**277,446**	**277,446**	**277,446**
Change from current law (thousands of people)								
Insured (MEC)	**—**	**109**	**92**	**84**	**1,048**	**990**	**1,048**	**990**
Employer	—	-55	-54	-52	1,265	1,205	1,265	1,205
Traditional	—	-55	-54	-52	-67,525	-28,187	-149,325	-149,325
Public option	—	*0*	*0*	*0*	*68,791*	*29,393*	*150,591*	*150,531*
Private nongroup	—	85	75	69	-288	-282	-288	-282
Medicaid/CHIP	—	78	71	67	71	67	71	67
Other public	—	0	0	0	0	0	0	0
Uninsured (no MEC)[a]	**—**	**-109**	**-92**	**-84**	**-1,048**	**-990**	**-1,048**	**-990**
Total	**—**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Change from current law (%)								
Insured (MEC)	**—**	**	**	**	**0.4**	**0.4**	**0.4**	**0.4**
Employer	—	**	**	**	0.8	0.8	0.8	0.8
Traditional	—	0.0	0.0	0.0	-45.2	-18.9	-100.0	-100.0
Public option	—	NA	NA	NA	NA	NA	NA	NA
Private nongroup	—	0.6	0.5	0.5	-1.9	-1.9	-1.9	-1.9
Medicaid/CHIP	—	0.1	0.1	0.1	0.1	0.1	0.1	0.1
Other public	—	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Uninsured (no MEC)[a]	**—**	**-0.3**	**-0.3**	**-0.3**	**-3.1**	**-3.0**	**-3.1**	**-3.0**
Total	**—**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Source: Health Insurance Policy Simulation Model, 2021.

Notes: MEC = minimum essential coverage. CHIP = Children's Health Insurance Program. NA = not applicable. Dashes indicate the column heading does not apply. Reforms simulated as fully phased in and in equilibrium in 2022. Prescription drug prices in each reform scenario are assumed to be set halfway between Medicare and Medicaid prices in all markets.

[a] Includes those without insurance and those with short-term, limited-duration plans.

** = less than +/- 0.05%.

TABLE 6

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

Health spending (millions of dollars)

Reform	Current law	Public option 1	Public option 2	Public option 3	Public option 4	Public option 5	Capped rates 1	Capped rates 2
Household	587,856	581,432	583,517	584,611	539,661	569,182	484,126	507,376
Federal government	467,105	454,978	459,187	461,414	457,268	459,494	457,268	459,494
State government	220,370	220,374	220,398	220,407	220,312	220,356	220,312	220,356
Employers	800,116	800,019	800,011	800,009	731,095	782,269	626,753	670,582
Providers	27,475	27,395	27,419	27,441	27,316	27,386	27,316	27,386
Total, all payers	**2,102,923**	**2,084,197**	**2,090,532**	**2,093,882**	**1,975,652**	**2,058,687**	**1,815,774**	**1,885,195**
Change from current law (millions of dollars)								
Household	—	-6,425	-4,339	-3,245	-48,195	-18,675	-103,730	-80,480
Federal government	—	-12,127	-7,918	-5,691	-9,837	-7,610	-9,837	-7,610
State government	—	4	27	37	-58	-14	-58	-14
Employers	—	-97	-105	-107	-69,021	-17,847	-173,363	-129,534
Providers	—	-80	-56	-34	-160	-90	-160	-90
Total, all payers	**—**	**-18,725**	**-12,391**	**-9,041**	**-127,271**	**-44,236**	**-287,149**	**-217,728**
Federal tax offset from ESI change	**—**	**NA**	**NA**	**NA**	**13,206**	**2,330**	**35,540**	**26,548**
Change from current law (%)								
Household	—	-1.1	-0.7	-0.6	-8.2	-3.2	-17.6	-13.7
Federal government	—	-2.6	-1.7	-1.2	-2.1	-1.6	-2.1	-1.6
State government	—	**	**	**	**	**	**	**
Employers	—	**	**	**	-8.6	-2.2	-21.7	-16.2
Providers	—	-0.3	-0.2	-0.1	-0.6	-0.3	-0.6	-0.3
Total, all payers	**—**	**-0.9**	**-0.6**	**-0.4**	**-6.1**	**-2.1**	**-13.7**	**-10.4**

Source: Health Insurance Policy Simulation Model, 2021.

Notes: ESI = employer-sponsored insurance. Dashes indicate the column heading does not apply. NA = not applicable. Reforms simulated as fully phased in and in equilibrium in 2022. Data are limited to health care spending by people below age 65 not enrolled in Medicare. Prescription drug prices in each reform scenario are assumed to be set halfway between Medicare and Medicaid prices in all markets.

** = less than +/- 0.05%.

Notes

[1] Rates are capped at current rates in all reforms considered.

[2] In reforms limited to the nongroup market, the change in federal spending equals the change in the federal deficit.

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

[4] Counties are designated urban or rural using data from the University of Iowa's RUPRI Center for Rural Health Policy Analysis, available at https://rupri.public-health.uiowa.edu/publications/policybriefs/2014/premiums/.

References

Blumberg, Linda J., John Holahan, Matthew Buettgens, Anuj Gangopadhyaya, Bowen Garrett, Adele Shartzer, Michael Simpson, Robin Wang, Melissa M. Favreault, and Diane Arnos. 2019. *From Incremental to Comprehensive Health Reform: How Various Reform Options Compare on Coverage and Costs*. Washington, DC: Urban Institute.

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

Blumberg, Linda J. Michael Simpson, and Matthew Buettgens. 2019. "A Targeted Affordability Improvement Proposal: The Potential Effects of Two Nongroup Insurance Reforms Designed to Increase Affordability and Reduce Costs." Washington, DC: Urban Institute.

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

Clemens, Jeffrey, and Joshua D. Gottlieb. 2014. "Do Physicians' Financial Incentives Affect Medical Treatment and Patient Health?" *American Economic Review* 104 (4): 1320–49. https://doi.org/10.1257/aer.104.4.1320.

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

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

Hwang, Thomas, and Aaron Kesselheim. 2020. *Reducing Prescription Drug Costs: Policy Options for Public Plans*. PORTAL report for the Urban Institute. Washington, DC: Urban Institute.

White, Chapin, and Tracy Yee. 2013. "When Medicare Cuts Hospital Prices, Seniors Use Less Inpatient Care." *Health Affairs* 32 (10): 1789–95. https://doi.org/10.1377/hlthaff.2013.0163.

About the Authors

John Holahan is an Institute fellow in the Health Policy Center at the Urban Institute, where he previously served as center director for over 30 years. His recent work focuses on health reform, the uninsured, and health expenditure growth, developing proposals for health system reform most recently in Massachusetts. He examines the coverage, costs, and economic impact of the Affordable Care Act (ACA), including the costs of Medicaid expansion as well as the macroeconomic effects of the law. He has also analyzed the health status of Medicaid and exchange enrollees, and the implications for costs and exchange premiums. Holahan has written on competition in insurer and provider markets and implications for premiums and government subsidy costs as well as on the cost-containment provisions of the ACA. Holahan has conducted significant work on Medicaid and Medicare reform, including analyses on the recent growth in Medicaid expenditures, implications of block grants and swap proposals on states and the federal government, and the effect of state decisions to expand Medicaid in the ACA on federal and state spending. Recent work on Medicare includes a paper on reforms that could both reduce budgetary impacts and improve the structure of the program. His work on the uninsured explores reasons for the growth in the uninsured over time and the effects of proposals to expand health insurance coverage on the number of uninsured and the cost to federal and state governments.

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

Acknowledgments

This brief 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 authors 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.

The authors are grateful for comments and suggestions from Jessica Banthin and for editorial assistance from Rachel Kenney.

500 L'Enfant Plaza SW
Washington, DC 20024

www.urban.org

ABOUT THE URBAN INSTITUTE

The nonprofit Urban Institute is a leading research organization dedicated to developing evidence-based insights that improve people's lives and strengthen communities. For 50 years, Urban has been the trusted source for rigorous analysis of complex social and economic issues; strategic advice to policymakers, philanthropists, and practitioners; and new, promising ideas that expand opportunities for all. Our work inspires effective decisions that advance fairness and enhance the well-being of people and places.