



Introducing a Public Option or Capped Provider Payment Rates into Private Insurance Markets

Updated Estimates

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This brief updates a previous report on the impacts of a public option or capped provider payment rate health reform proposals published in March 2020 (Blumberg et al. 2020). In this update, we provide estimates for 2022, using a revised current-law baseline in the Health Insurance Policy Simulation Model (HIPSM) that reflects changes in economic conditions resulting from the COVID-19 pandemic. In this and two accompanying papers (Holahan and Simpson 2021a, 2021b), we analyze public option and capped provider payment rate proposals that apply to the nongroup health insurance market only and some that would apply both in the nongroup and employer health insurance markets. We show the anticipated impacts on premiums in both the nongroup and employer markets, the number of people uninsured, and spending by employers, households, and the federal government. We also show the effect on national health expenditures.

We first consider a public option and capped provider payment rates introduced in the nongroup market alone. This is the most frequently proposed approach for such reforms (Blumberg et al. 2019, 2020; Blumberg, Simpson, and Buettgens 2019). However, other proposals would also extend a public option to the employer market.¹ Because the number of people enrolled in employer coverage is more than nine times that in nongroup coverage and employer-based plans tend to pay health care providers higher rates than do nongroup insurers, introducing the public option or capping provider payment rates in both markets will have much greater effects than if the policies are introduced in the nongroup market alone.

What Is a Public Option?

A public option is a government-sponsored insurance plan that pays providers (doctors, hospitals, prescription drug manufacturers) according to a defined payment schedule and set of benefits. As an insurer, the federal government ultimately bears the risk associated with the plan. Payment rates under a public option are generally assumed to be lower than those typical of commercial insurers, with the federal government using its purchasing and/or negotiating power to lower health care spending for enrollees. A public option could be available in nongroup or employer markets or both, and one or multiple public options could be offered in a particular market, with multiple plans offering different actuarial values or cost-sharing structures. Here, we simply discuss a single public option.

A public option could be made available either nationally or in particular geographic areas. It could be implemented alone or in conjunction with regulated limits on rates paid by competing private insurers in the same markets (hereafter called “capped provider payment rates”). Combined, the approaches would be similar to the Medicare program’s structure, or more specifically, the offering of private Medicare Advantage plans that compete with the traditional Medicare fee-for-service plan (a type of public option). Taking advantage of a public option introduced alone would require consumers (e.g., households and/or employer groups) to enroll in a newly established insurance plan. However, depending on how the public option’s provider payment schedule is set relative to that for commercial plans in a given market, competition from the public option may result in more aggressive negotiation between private insurers and providers for lower rates, possibly lowering private insurance premiums as well. But, if private insurers cannot maintain sufficient market share because of (1) an inability to negotiate lower payment rates with providers or (2) other consumer preferences for a public option, competition from a public option may reduce the number of private insurers competing in at least some areas.

How Would Capping Provider Payment Rates Work?

Capping provider payment rates for all private insurers in particular markets or nationwide has been proposed as an alternative to a public option (or, as noted above, in conjunction with one).² This approach would limit the payment rates insurers could pay health care providers in the applicable markets. Generally, payment rates would be capped at lower levels than those typical of private insurers today, or the growth rate of such caps would be constrained to lower premiums and health care spending over time. The capped rates could apply to insurers in nongroup or employer markets or both. A central advantage of capped provider payment rates over a public option is that consumers could obtain the full benefit of lower provider payment rates while being enrolled with their preferred insurer. In addition, capped provider payment rates likely result in more private insurers entering or staying in markets, compared with a public option implemented alone. Under capped payment rates, insurers would not need large numbers of enrollees to leverage and achieve competitive payment rates with providers.

Policy Approaches Modeled

The updated analyses presented here rely on the same methodology as our earlier work (Blumberg et al. 2020); estimates are produced for 2022, using the Urban Institute’s Health Insurance Policy Simulation Model (Buettgens and Banthin 2020).

We first look at public option proposals implemented only in the nongroup market. As noted, this would be a new, qualified health plan that would compete with private insurance plans already in these markets. It would follow the same rules applied to private plans in those markets, including participating in risk adjustment. The public option would likely become the lowest-priced silver plan or the benchmark plan (the second-lowest-premium silver plan) in many rating regions, particularly if it pays providers Medicare-like rates.³ However, it may not become either low-priced offering if its provider payment rates are set above Medicare levels. If the nongroup public option becomes the lowest-priced silver option or second-lowest-priced option, the benchmark premium will drop, thereby reducing the cost of federal premium subsidies and costs for some households.

Next, we analyze approaches that would extend the public option or capped provider payment rates to employer insurance markets, too. To take advantage of potential savings from a public option, an employer would have to switch coverage for the firm’s workers into that new plan. Consistent with our earlier work, we assume a firm’s decision to switch into the public option varies by its wages and size; the lower the average wage and the smaller the firm, the more likely they will switch from their current insurance to the public option. Large and high-wage firms would be more likely to remain with their current coverage, because they could vary benefit packages, cost sharing, and out-of-pocket limits. Some may view paying somewhat higher provider payment rates as worthwhile, because it allows them to tailor benefits and provider networks to employees’ needs or wishes. We also assume employers would have to save at least 20 percent in premiums to make switching sufficiently attractive.

We analyze several levels of provider payment rates. The following reforms are modeled in nongroup markets alone:

- Public option 1 sets provider payment rates at Medicare levels.
- Public option 2 sets provider payment rates at Medicare levels plus 10 percent for professionals and plus 25 percent for hospitals.
- Public option 3 sets provider payment rates at Medicare levels plus 15 percent for professionals and plus 60 percent for hospitals.

In the next two simulations, a public option is introduced into employer markets in addition to nongroup markets. All simulations including the employer markets assume provider payment rates above Medicare levels, because the impact on health care providers would be much larger, and we assume using Medicare rates would be too disruptive to the health care system, at least in the near term.

- Public option 4 sets provider payment rates at Medicare levels plus 10 percent for professionals and plus 25 percent for hospitals.
- Public option 5 sets provider payment rates at Medicare levels plus 15 percent for professionals and plus 60 percent for hospitals.

The next two reforms simulated introduce capped provider payment rates into both the nongroup and employer markets:

- Capped rates 1 sets provider payment rates at Medicare levels plus 10 percent for professionals and plus 25 percent for hospitals.
- Capped rates 2 sets provider payment rates at Medicare levels plus 15 percent for professionals and 60 percent for hospitals.

In each reform, we also assume federal implementation of prescription drug reforms that would require prescription drug manufacturers to provide the public option or private insurers operating under regulated payment limits rebates halfway between those currently provided to the Medicare and Medicaid programs. This health-care-cost-containment policy and its rebate levels would be set nationally, because drugs are sold in a national market. We estimate these increased rebates would reduce average current prescription drug prices facing commercial insurers by approximately 30 percent (Hwang and Kesselheim 2020).

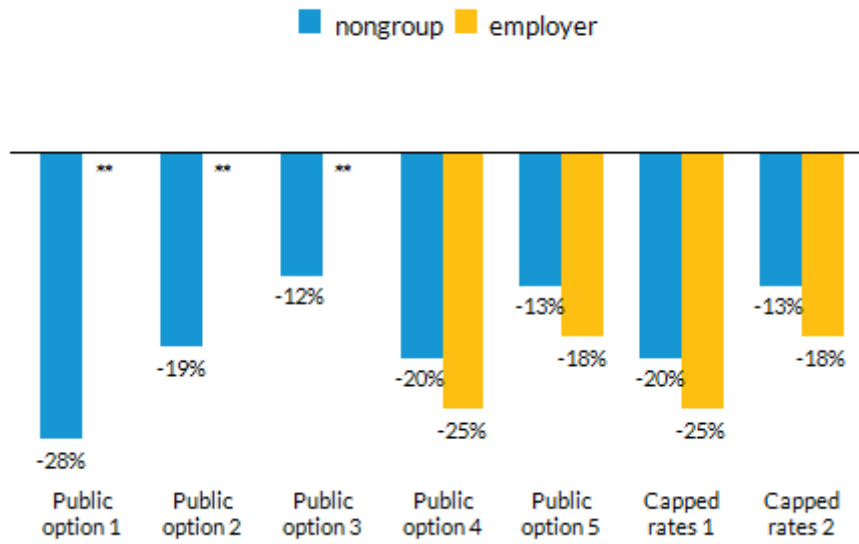
Highlights of Findings

Table 1 and figure 1 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.

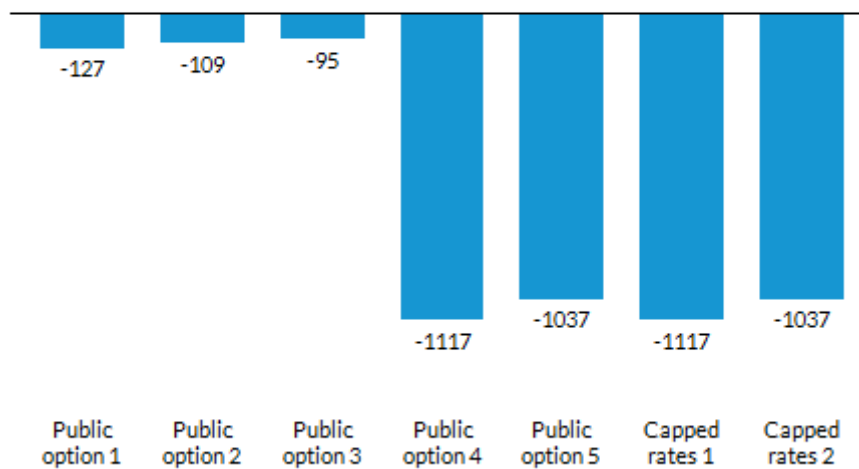
FIGURE 1

Summary of Effects of Reform Options, 2022

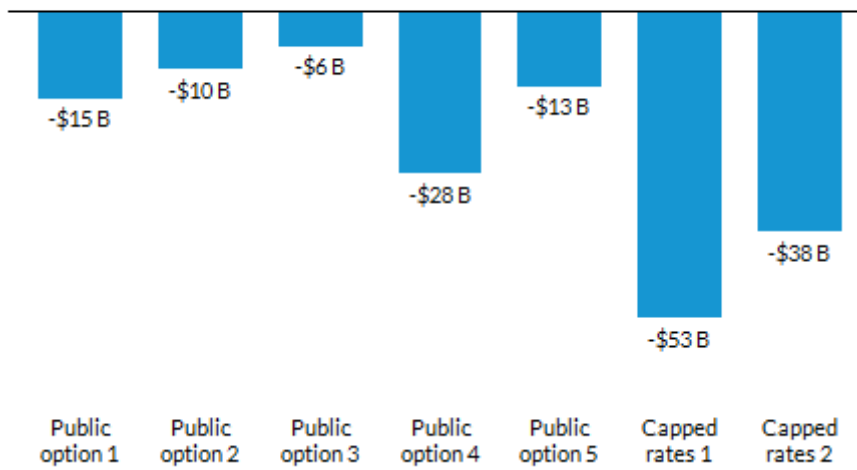
On median premiums



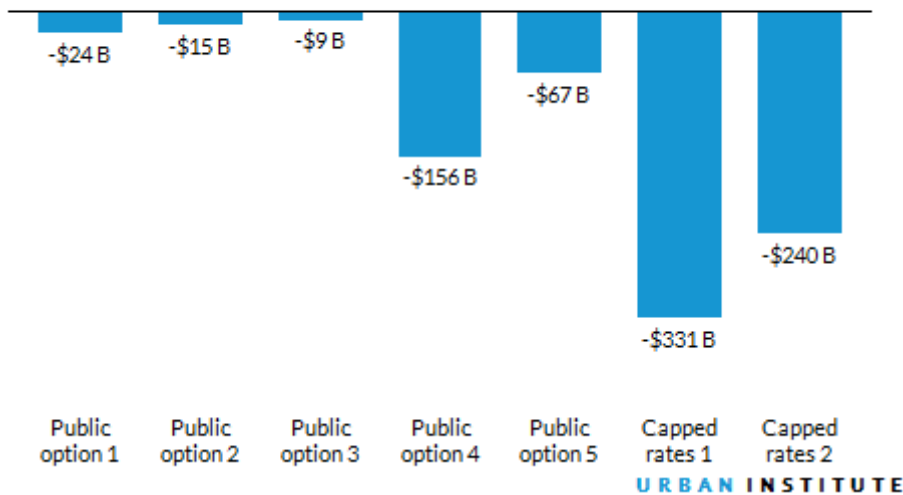
On thousands of people uninsured



On the federal deficit



On health system spending



Source: Health Insurance Policy Simulation Model, 2021.

Notes: B = billion. Reform simulated as fully phased in and in equilibrium in 2022. 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 +/- 0.5%.

- Bottom-line effects.** First, private and government savings are greater the more provider payment rates are reduced relative to current law. Second, extending reforms to both the nongroup and employer markets has greater effects on the outcomes measured here than

does limiting the reforms to the nongroup market. Third, capped provider payment rates have more significant impacts than public options.

- **Premiums and coverage in the nongroup market.** We estimate a nongroup public option using the specified provider payment rates could lower premiums by 12 to 28 percent. The greatest reduction in premiums occurs under reforms that reduce provider payment rates the most. We estimate the effects on insurance coverage to be very small. Policies that enhance and expand subsidies are needed to significantly increase insurance coverage, but we do not consider them here.⁴
- **Federal, household, and employer health spending in the nongroup market.** Because nongroup premiums are lower, federal spending on premium tax credits declines by \$6 to \$15 billion. Household spending falls by \$3 to \$8 billion, about 1 percent of household spending; the effects are, however, fully concentrated among nongroup enrollees, so their savings are larger. Employer spending is virtually unaffected. National health spending declines slightly.
- **Premiums and coverage in the employer market.** A public option or capped provider payment rates tend to lower premiums more in employer markets than nongroup markets, because provider payment rates in employer markets tend to be higher today. When the public option is extended to employer markets using the payment rates analyzed, we estimate premiums for participating employers fall by 18 to 25 percent. Nongroup premiums in these same simulations fall by 13 to 20 percent. Reductions in premiums are larger for options with greater reductions in provider payment rates, which we assume are directly related. We estimate offering the public option or capped provider payment rates in the employer market could reduce the number of people uninsured by more than 1 million. Far more people in employer markets would be affected by capped provider rates than by the public options, because we estimate many employers would choose not to participate in the public option.
- **Employer and household spending in the employer market.** Extending the public option or capped rates to the employer market significantly affects spending. Employers save \$32 to \$86 billion under public option-only reforms, but their savings under capped rates range from \$145 to \$202 billion. Household spending falls by \$27 to \$58 billion under public options reforms but by \$87 to \$118 billion under capped rates.
- **Federal spending and income tax revenue in the employer market.** As employers spend less on premiums, economic research indicates they convert the savings into higher wages for their workers. Because those higher wages are taxable, the federal deficit decreases. The federal deficit falls by \$13 to \$28 billion when a public option is introduced into the employer market but declines by \$38 to \$53 billion under capped rates.
- **National health spending.** National health spending on the nonelderly falls by less than 1 percent under the public option reforms limited to the nongroup market. If a public option is available in the nongroup and employer markets, total health spending falls by as much as 7 percent, depending on the payment rates used. Under the capped rate reforms, national health spending could fall by as much as 16 percent.

TABLE 1

Public Option and Capped Provider Payment Rate Reform Options in All Markets, 2022

Reform	Availability of public option	Payment policy ^a	Change						
			In median nongroup premiums	In median employer premiums ^b	In number of uninsured	In the federal deficit ^c	In employer spending	In household spending	In health system spending
Public option 1	Nongroup insurance markets	Medicare rates	-28%	NA	-127,000	-\$15 B	*	-\$8 B (-1%)	-\$24 B (-1%)
Public option 2	Nongroup insurance markets	Medicare rates plus 10% for professionals and plus 25% for hospitals	-19%	NA	-109,000	-\$10 B	*	-\$5 B (-1%)	-\$15 B (-1%)
Public option 3	Nongroup insurance markets	Medicare rates plus 15% for professionals and plus 60% for hospitals	-12%	NA	-95,000	-\$6 B	*	-\$3 B (-1%)	-\$9 B (**)
Public option 4	Nongroup and employer markets; subset of firms choose public option	Medicare rates plus 10% for professionals and plus 25% for hospitals	-20%	-25%	-1,117,000	-\$28 B	-\$86 B (-11%)	-\$58 B (-10%)	-\$156 B (-7%)
Public option 5	Nongroup and employer markets; subset of firms choose public option	Medicare rates plus 15% for professionals and plus 60% for hospitals	-13%	-18%	-1,037,000	-\$13 B	-\$32 B (-4%)	-\$27 B (-5%)	-\$67 B (-3%)
Capped rates 1	Nongroup and employer markets; all employers pay lower rates	Medicare rates plus 10% for professionals and plus 25% for hospitals	-20%	-25%	-1,117,000	-\$53 B	-\$202 B (-25%)	-\$118 B (-20%)	-\$331 B (-16%)
Capped rates 2	Nongroup and employer markets; all employers pay lower rates	Medicare rates plus 15% for professionals and plus 60% for hospitals	-13%	-18%	-1,037,000	-\$38 B	-\$145 B (-18%)	-\$87 B (-15%)	-\$240 B (-11%)

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 markets.

^b This column shows the change in median premiums in all 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 all markets.

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

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

Projected Impacts of Public Option and Capped Provider Payment Rate Proposals

In this section, we present our detailed estimates of each of the seven reforms modeled. We include estimates of changes in median nongroup and employer premiums, health insurance coverage, and health care spending by households, employers, and the federal government. For federal spending effects, we show the impact on the federal deficit, which is a combination of the direct reduction in federal government spending on health care programs (primarily from lower spending on Marketplace premium tax credits) and the increased income tax revenue from lower employer spending on nontaxable health insurance benefits.

All estimates assume the reforms are fully phased in and in equilibrium in 2022. This means the supply of services is assumed to expand to meet any increased demand for services. In reality, it is more likely the reforms would require a multiyear phase-in, over which payment rates would decrease toward target levels. How long the phase-in would take would determine the underlying savings to households, employers, and the federal government. The slower the pace of payment rate reductions, the less potentially disruptive to the health system and the more politically feasible a reform will likely be. But, the resulting savings will be lower as well.

Public Option 1: Medicare Rates in Nongroup Markets

- public option in all private nongroup insurance markets nationally
- pays Medicare rates for hospitals and professionals
- prescription drug prices set halfway between Medicare and Medicaid prices in all markets

Premium and coverage effects. The median benchmark premium in the nongroup market falls by 28 percent. The number of people uninsured falls by 127,000, a small effect because only households facing full, unsubsidized nongroup premiums are affected.

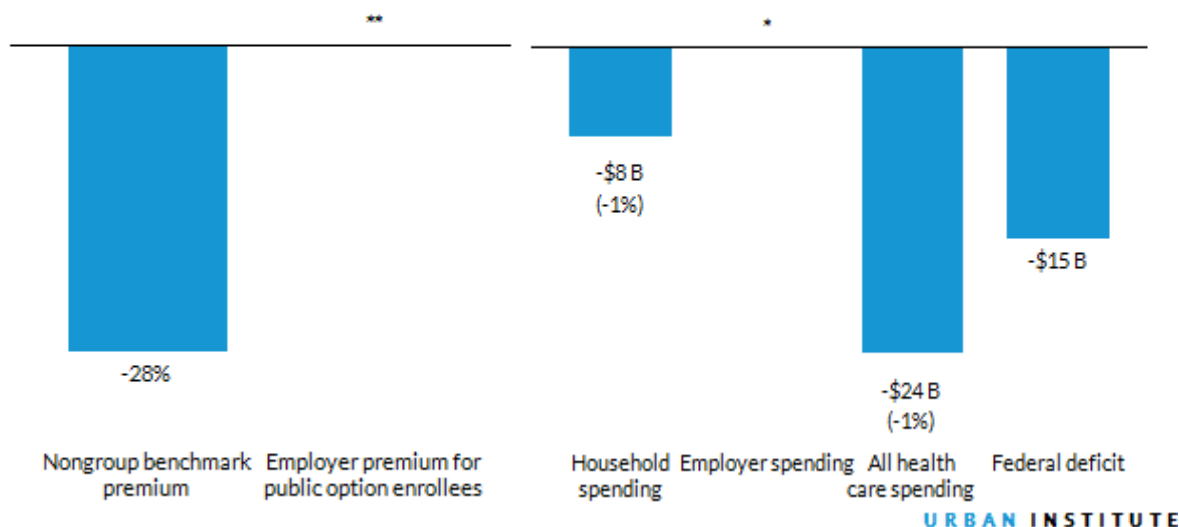
Health care spending. Because tax credits are tied to premiums, tax credits fall as benchmark nongroup premiums fall. Federal health spending, and thus the federal deficit, falls by \$15 billion. Household spending falls by \$8 billion, or 1 percent. Employer spending is essentially unaffected. Overall health spending falls by \$24 billion, or 1 percent.

FIGURE 2

Effects of Public Option 1

On median premiums

On health spending and the federal deficit



Source: Health Insurance Policy Simulation Model, 2021.

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

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

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

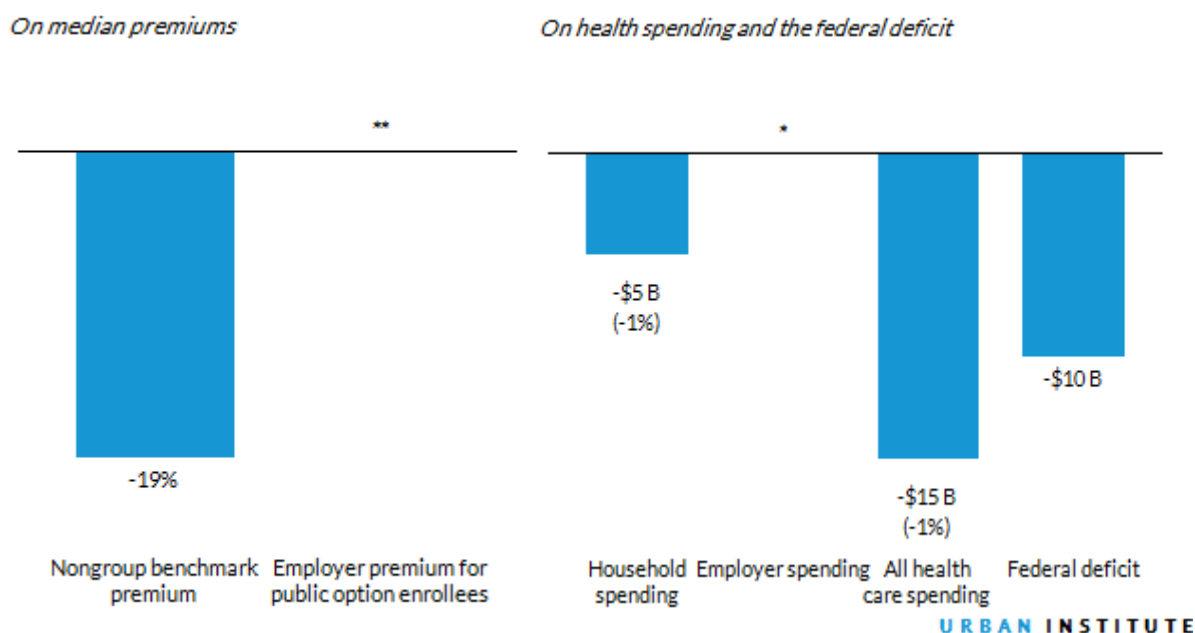
- public option introduced in all nongroup markets nationally
- pays Medicare rates plus 10 percent for professionals and plus 25 percent for hospitals
- prescription drug prices set halfway between Medicare and Medicaid prices in all markets

Premium and coverage effects. This reform decreases the median benchmark premium less than public option 1 (19 percent versus 28 percent) because it uses higher provider payment rates. It also has a modestly smaller effect on the uninsured population, which decreases by 109,000 people.

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

FIGURE 3

Effects of Public Option 2



Source: Health Insurance Policy Simulation Model, 2021.

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

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

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

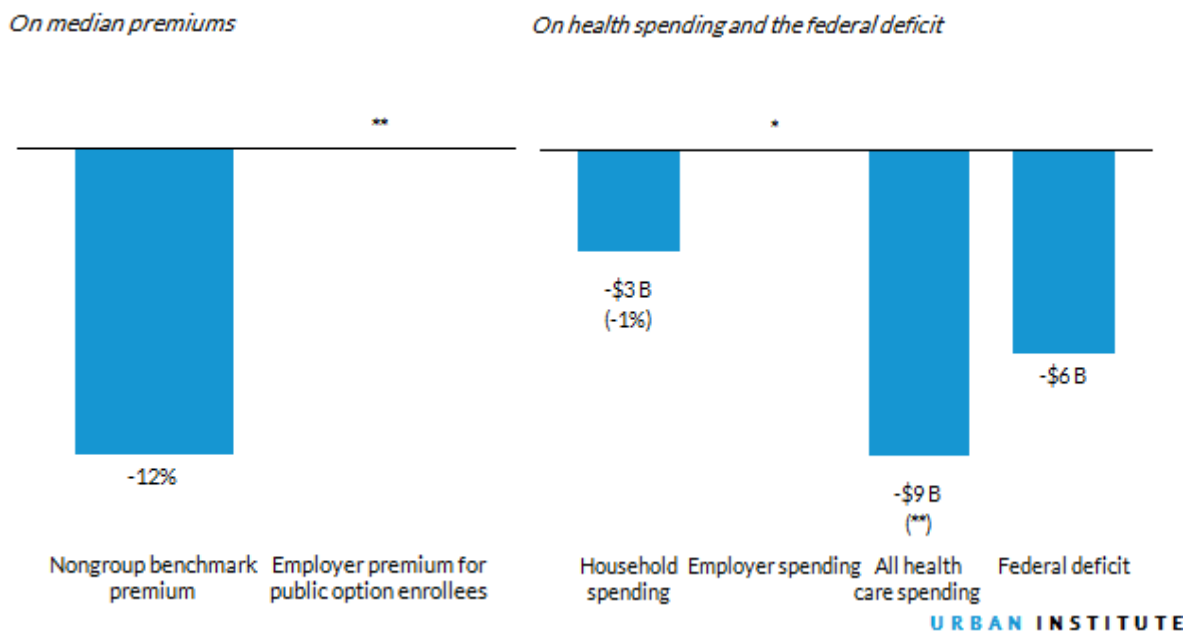
- public option in all private nongroup insurance markets nationally
- pays Medicare rates plus 15 percent for professionals and plus 60 percent for hospitals
- prescription drug prices set halfway between Medicare and Medicaid prices in all markets

Premium and coverage effects. The median benchmark premium falls by 12 percent, a smaller effect than under the first two reforms because of the higher provider payment rates. The number of people uninsured falls by 95,000, again a smaller effect than under the first two reforms because the smaller reduction in premiums attracts fewer new enrollees.

Health care spending. Federal health spending falls by \$6 billion, because smaller reductions in premiums mean lower premium tax credit savings than under public options 1 and 2. Household spending falls by \$3 billion, or 1 percent. Employer spending is again unaffected. Overall spending falls by \$9 billion, or less than 0.5 percent.

FIGURE 4

Effects of Public Option 3



Source: Health Insurance Policy Simulation Model, 2021.

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

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

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

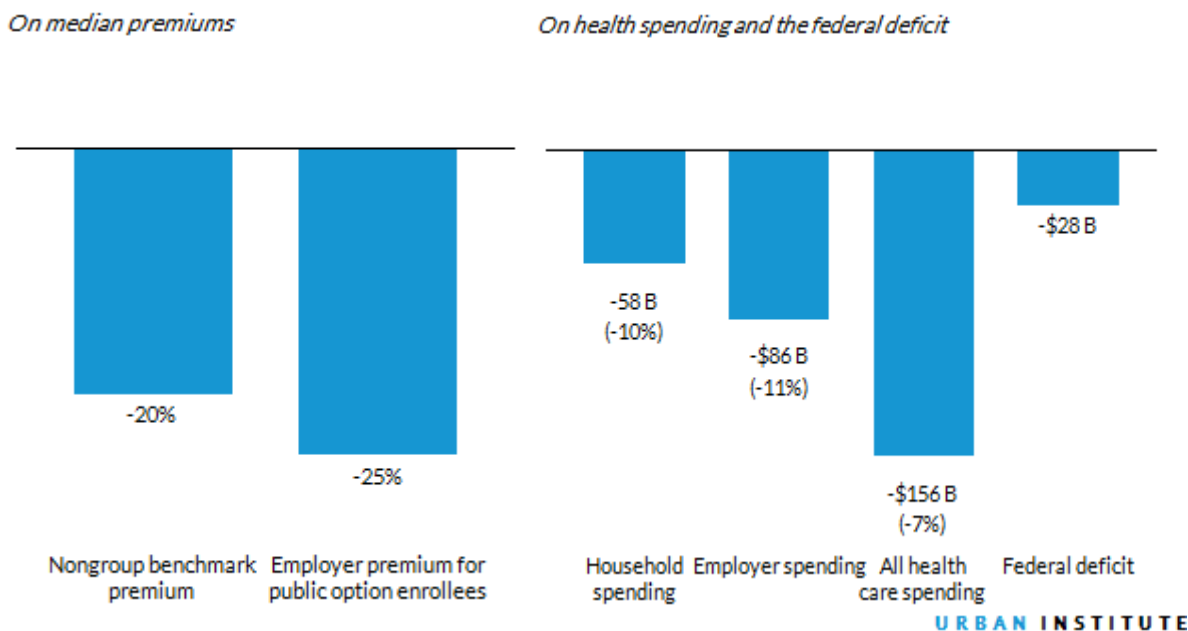
- public option available to all employer and nongroup insurance markets nationally
- pays Medicare rates plus 10 percent for professionals and plus 25 percent for hospitals
- prescription drug prices set halfway between Medicare and Medicaid prices in all markets

Premium and coverage effects. Median benchmark premiums fall by 20 percent in nongroup markets and by 25 percent for employers choosing the public option. Employer coverage increases by 1.3 million people (not shown), and the number of people uninsured falls by 1.1 million.

Health care spending. Federal spending, primarily on premium tax credits, declines by \$12 billion, or 2.5 percent. Household spending falls by \$58 billion, or 10 percent. Employer premium spending falls by \$86 billion, or 11 percent. Lower employer spending on health care results in higher employee wages and, in turn, increases federal tax payments, generating \$17 billion in new tax revenue; the net effect on the federal deficit is a \$28 billion reduction. Overall spending declines by \$156 billion, or 7 percent.

FIGURE 5

Effects of Public Option 4



Source: Health Insurance Policy Simulation Model, 2021.

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

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

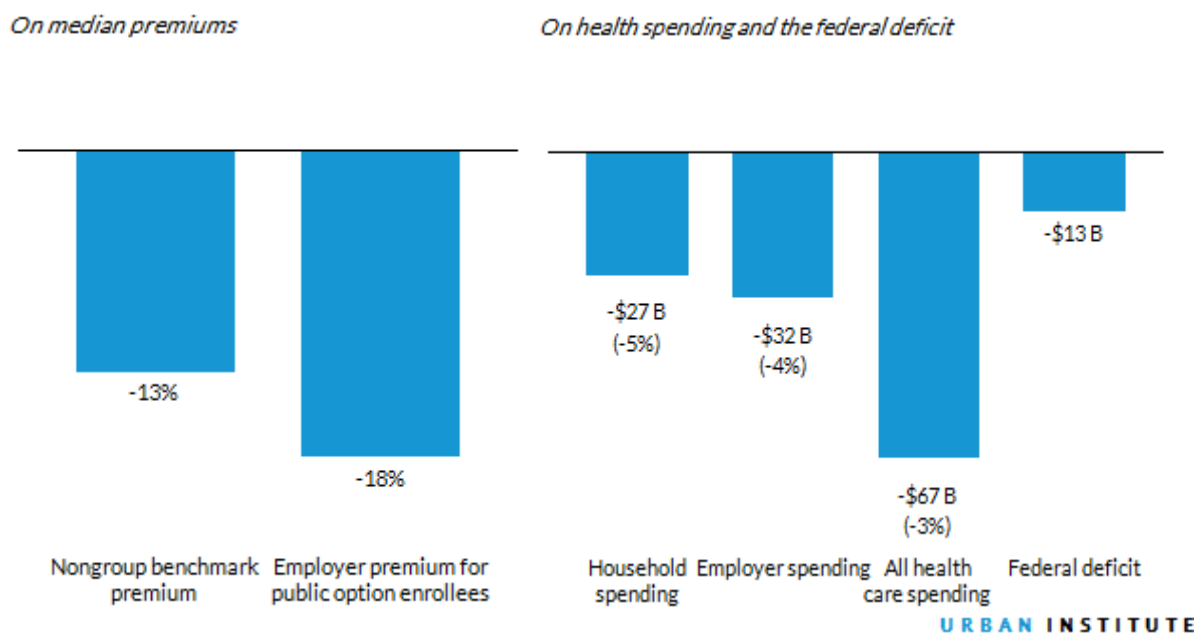
- public option available to all employer and nongroup insurance markets nationally
- pays Medicare rates plus 15 percent for professionals and plus 60 percent for hospitals
- prescription drug prices set halfway between Medicare and Medicaid prices in all markets

Premium and coverage effects. Because this reform uses higher payment rates than public option 4, median benchmark premiums fall by 13 percent in the nongroup market and by 18 percent among employers choosing the public option. Introducing the public option, a new and less expensive insurance option, into the employer market increases employer coverage by 1.2 million people and reduces the number of people uninsured by 1.0 million.

Health care spending. Federal government spending falls by \$8 billion, less than under public option 4 because the higher provider payment rates reduce the reform's impact on premiums. Households save \$27 billion, or 5 percent. Employers save \$32 billion in premiums, or 4 percent. Employer savings translate to increased taxable wages, thereby generating about \$5 billion in new federal revenues. The federal deficit declines by \$13 billion. Overall spending decreases by \$67 billion, or 3 percent.

FIGURE 6

Effects of Public Option 5



Source: Health Insurance Policy Simulation Model, 2021.

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

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

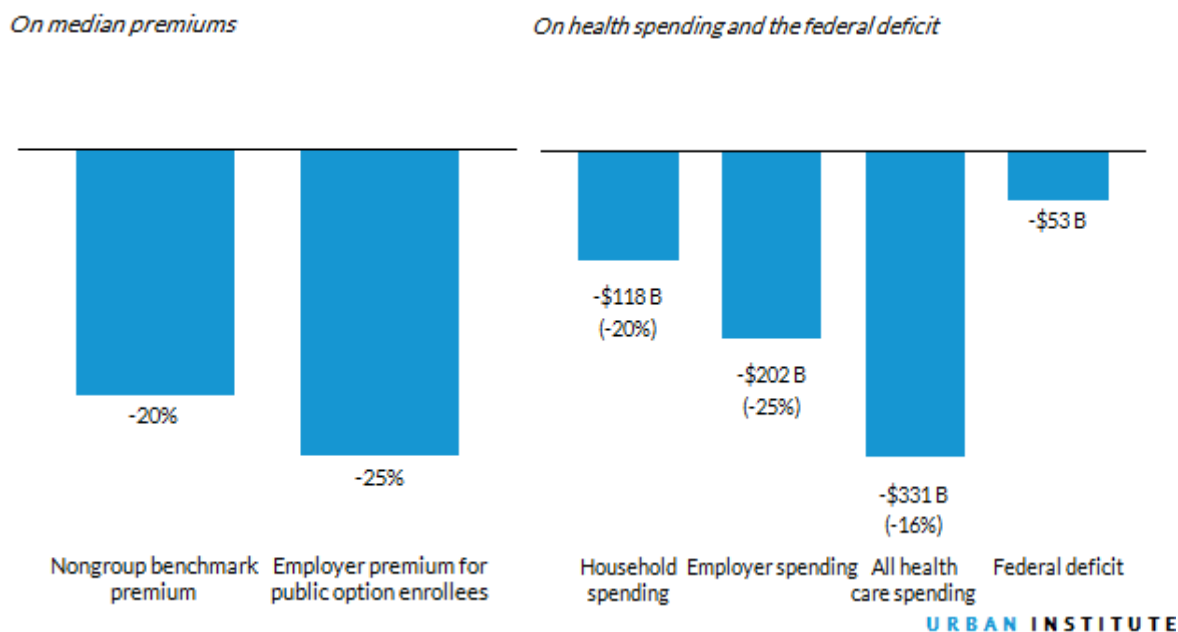
- payment rates capped for all insurers in all employer and nongroup insurance markets
- rates capped at Medicare levels plus 10 percent for professionals and plus 25 percent for hospitals
- prescription drug prices set halfway between Medicare and Medicaid prices in all markets

Premium and coverage effects. Median benchmark premiums fall by 20 percent in nongroup markets and by 25 percent in employer markets. Employer coverage increases by 1.3 million people, and the number of people uninsured falls by 1.1 million.

Health care spending. Capped provider payment rates have greater effects on health care spending than do public option-only reforms, because almost all enrollees in all insurance plans benefit from capped payment rates. Federal spending falls by \$12 billion, or 2.5 percent, almost completely from lower premium tax credits in the nongroup market. Household spending falls by \$118 billion, or 20 percent. Employer premium spending falls by \$202 billion, or 25 percent. As employers pass savings on to workers via higher wages, tax payments increase by \$41 billion and the federal deficit decreases by \$53 billion. Overall health spending falls by \$331 billion, or 16 percent.

FIGURE 7

Effects of Capped Rates 1



Source: Health Insurance Policy Simulation Model, 2021.

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

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

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

Premium and coverage effects. Median benchmark premiums fall by 13 percent in nongroup markets and by 18 percent in employer markets. The number of people uninsured falls by 1.0 million.

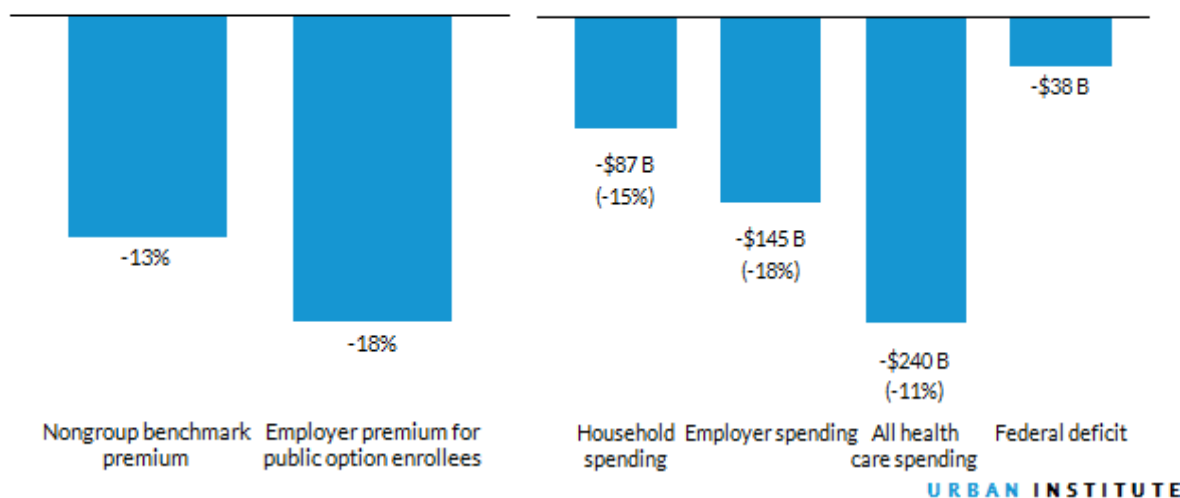
Health care spending. Savings under this reform are smaller than under capped rates 1 because the provider payment rates are higher. Household savings are \$87 billion, or 15 percent. Employers save \$145 billion in premiums, or 18 percent. Federal spending on subsidies falls by almost \$8 billion. Increased tax revenues from higher wages total almost \$30 billion. Thus, the net effect on the deficit is a \$38 billion reduction.

FIGURE 8

Effects of Capped Rates 2

On median premiums

On health spending and the federal deficit



Source: Health Insurance Policy Simulation Model, 2021.

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

Discussion

This analysis shows health reforms that reduce prices insurers pay to hospitals, physicians, and other professionals to rates similar to those used by the Medicare program and reduce prescription drug prices below Medicare prices could significantly reduce insurance premiums and government, employer, and household spending. A public option and capped provider payment rates can also reduce the number of people uninsured while increasing cash wages and federal income tax revenues.

The magnitude of these reforms' effects depends on the amount by which provider payment rates are reduced. For example, reducing payment rates to Medicare levels in the nongroup market would reduce median benchmark premiums by 28 percent, the number of people uninsured by 127,000, the federal deficit by \$16 billion, and overall health care spending by \$24 billion. In contrast, setting provider payment rates at Medicare levels plus 15 percent for professionals and plus 60 percent for hospitals reduces median benchmark premiums by 12 percent, the number of people uninsured by 95,000, the federal deficit by \$6 billion, and total national health care spending by \$9 billion. Extending the reforms modeled to the employer market as well results in similar differences in premiums and spending.

We also show extending the public option to both employer and nongroup markets has significant implications. Median premiums for employers choosing the public option fall by 18 to 25 percent. The number of people uninsured falls by between 1.0 and 1.1 million, far more than under a policy limited to the nongroup market but still a small relative increase in the number of people enrolled in employer-based coverage. Savings to the federal government are considerably higher under reforms extended to the employer market for two reasons: (1) spending on Marketplace premium tax credits declines, and (2) federal tax revenues increase as employers switch to the public option and pass the savings on premiums to their workers via higher wages. Finally, the impact on national health spending is greater because the scope of the policy is much greater; the health care system would save \$67 to \$156 billion under a public option but \$240 to \$331 billion under capped rates. When implemented in nongroup markets alone, such reforms result in savings ranging from \$9 to \$24 billion.

Lastly, we show capping provider payment rates has significantly greater effects than a public option alone. With the public option, employers can drop their current coverage and enroll workers in the public option. We assume not all employers would do so: Many smaller, lower-wage firms would find it attractive to purchase coverage in the public option. Larger, higher-wage firms may be more likely to prefer providing benefits independently, allowing them to tailor benefit packages, cost sharing, and provider networks to meet their workers' needs. Some employers would not find it prohibitively costly to pay higher premiums for insurance plans using higher provider payment rates. Capped rates apply to all insurers; thus, most employers would benefit regardless of the insurance plan in which their workers were enrolled.

Public option-only reforms and capped provider payment rate reforms would have very different effects on the federal deficit, even if both policies impact both nongroup and employer markets and set provider payment rates at Medicare levels plus 10 percent for professionals and plus 25 percent

for hospitals. Subsidy costs and new tax revenues would reduce the deficit by \$28 billion under the public option and by \$53 billion under capped rates. Reductions in national health spending would also differ markedly, at \$156 billion under a public option versus \$331 billion under capped rates.

However, options that reduce health care spending the most would also significantly reduce provider revenues, potentially leading to disruptions in the health care delivery system, at least in the near term. This partially depends on how fast payment rates are reduced. Policies that provide the greatest savings to the federal government and health care system overall may be the least politically feasible. Provider payment rates could be lower if public option policies were limited to the nongroup market. But if such reforms are extended further to the employer market, provider payment rates would likely have to be set higher. Future research should explore where the caps could be set and how to govern their growth over time without significantly disrupting the health care system.

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 2021.⁵ 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 rate reforms. Each reform affects professional and hospital payment rates and prescription drug prices in all regions. The different simulations vary by the assumed provider payment rates (all expressed relative to Medicare's payment rates) and the insurance markets (nongroup, employers) 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 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 and the share of spending for each service type within the region.

Our approach differs for people with employer-sponsored insurance. We obtained estimates of the ratio of commercial insurer payment rates to Medicare rates from FAIR Health for specific procedures by region and provider type. We then used those ratios to estimate costs for people with employer-based insurance entering the public option or having provider payments capped. For all public option or capped payment rate reforms, 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 all 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 capping provider payment rates for several reasons: a lack of data on commercial payment rates in the nongroup market, the relevance of claims data to estimate the ratio of commercial payment rates to Medicare rates in the employer market, the need to estimate households' and firms' decisions to participate in the public option, and the need to make assumptions about the savings from regulating prescription drug prices. For each factor, different data can be used and assumptions made. Thus, our results may differ from actual results or those projected in other analyses.

- For the nongroup reform estimates, we lack actual payment rate data. We estimate Medicare payment rates using regression analyses. We assume markets with a large number of insurers and low hospital concentration have payment rates that approximate Medicare prices and thus premiums. Markets without these characteristics tend 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 household spending in 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. Further, though the data include plans covering 75 percent of the privately insured population in the United States, they include some Medicare Advantage plans and plans participating 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 ratio 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; our estimates include all inpatient services provided in the state, but lacking this information could lead to some error at the substate level.
- We have made assumptions about employer take-up of the public option by firm size, wages, and expected savings. Take-up of the public option is assumed to be higher for small, low-wage firms, and we assume a firm chooses the public option only when the resulting savings exceed 20 percent. Our assumptions are somewhat arbitrary, and different assumptions would have different results. Our capped rate simulations estimate the extreme case of all employers choosing the public option.
- Employers may gravitate to the public option over time. Our analysis assumes the policy is fully phased in and in equilibrium and therefore accounts for all long-term employer behavior.
- In our estimates of prescription drug savings, we assume drug pricing rebates from various private payers are the same across the country. If the mix of drugs consumed varies geographically, our rebates may be estimated with error. 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 rebates for the public option would lead to prescription drug prices halfway between Medicaid and Medicare 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. Any differences or errors in our savings estimates would be tempered by the fact that prescription drug spending accounts for only 23 percent of the premium dollar nationwide.

Supplementary Tables

TABLE 2

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

Percent change from current-law premiums

	Public option 1	Public option 2	Public option 3	Public option 4	Public option 5	Capped rates 1	Capped rates 2
Nongroup^a							
Percentile							
10th	-43	-34	-27	-36	-28	-36	-28
25th	-40	-32	-21	-33	-23	-33	-23
50th (median)	-28	-19	-12	-20	-13	-20	-13
75th	-17	-7	-5	-9	-5	-9	-5
90th	-12	-4	**	-5	-1	-5	-1
All employers							
Percentile							
10th	NA	NA	NA	-14	-7	-28	-21
25th	NA	NA	NA	-13	-6	-28	-21
50th (median)	NA	NA	NA	-12	-5	-26	-19
75th	NA	NA	NA	-11	-4	-25	-18
90th	NA	NA	NA	-10	-3	-24	-17
Employers offering public option^b							
Percentile							
10th	NA	NA	NA	-27	-22	-27	-20
25th	NA	NA	NA	-26	-20	-26	-19
50th (median)	NA	NA	NA	-25	-18	-25	-18
75th	NA	NA	NA	-24	-17	-24	-17
90th	NA	NA	NA	-22	-13	-23	-15

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 markets.

^a These rows show the change in the median nongroup benchmark premium.

^b These rows show the change in the median premiums 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.

** = less than +/- 0.5%.

TABLE 3

Health Insurance Coverage of the Nonelderly Population under Current Law and Nongroup and Employer Reforms, 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	244,240	244,222	244,208	245,230	245,150	245,230	245,150
Employer	149,325	149,258	149,262	149,264	150,649	150,573	150,649	150,573
Traditional	149,325	149,258	149,262	149,264	75,847	107,989	0	0
Public option	0	0	0	0	74,802	42,584	150,649	150,573
Private nongroup	14,960	15,056	15,044	15,034	14,664	14,667	14,664	14,667
Medicaid/CHIP	71,162	71,261	71,251	71,245	71,251	71,245	71,251	71,245
Other public	8,665	8,665	8,665	8,665	8,665	8,665	8,665	8,665
Uninsured (no MEC)^a	33,333	33,206	33,224	33,239	32,216	32,297	32,216	32,297
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)	—	127	109	95	1,117	1,037	1,117	1,037
Employer	—	-67	-64	-61	1,324	1,248	1,324	1,248
Traditional	—	-67	-64	-61	-73,479	-41,336	-149,325	-149,325
Public option	—	0	0	0	74,802	42,584	150,649	150,573
Private nongroup	—	95	83	73	-296	-294	-296	-294
Medicaid/CHIP	—	99	90	83	90	83	90	83
Other public	—	0	0	0	0	0	0	0
Uninsured (no MEC)^a	—	-127	-109	-95	-1,117	-1,037	-1,117	-1,037
Total	—	0	0	0	0	0	0	0

Change from current law (%)

Insured (MEC)	—	0.1	**	**	0.5	0.4	0.5	0.4
Employer	—	**	**	**	0.9	0.8	0.9	0.8
Traditional	—	0.0	0.0	0.0	-49.2	-27.7	-100.0	-100.0
Public option	—	NA	NA	NA	NA	NA	NA	NA
Private nongroup	—	0.6	0.6	0.5	-2.0	-2.0	-2.0	-2.0
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	—	-0.4	-0.3	-0.3	-3.4	-3.1	-3.4	-3.1
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 4

Health Spending for the Nonelderly Population under Current Law and under Nongroup and Employer Reforms, 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	579,765	582,780	584,651	529,653	560,801	470,327	500,445
Federal government	467,105	451,742	457,572	461,267	455,432	459,108	455,432	459,108
State government	220,370	220,386	220,400	220,395	220,271	220,318	220,271	220,318
Employers	800,116	799,992	799,996	800,000	714,200	767,957	598,424	655,417
Providers	27,475	27,371	27,381	27,380	27,218	27,289	27,218	27,289
Total, all payers	2,102,923	2,079,257	2,088,128	2,093,692	1,946,774	2,035,473	1,771,672	1,862,576
<i>Change from current law (millions of dollars)</i>								
Household	—	-8,092	-5,077	-3,205	-58,203	-27,055	-117,529	-87,412
Federal government	—	-15,362	-9,533	-5,838	-11,673	-7,997	-11,673	-7,997
State government	—	16	30	25	-99	-52	-99	-52
Employers	—	-124	-120	-116	-85,916	-32,159	-201,692	-144,699
Providers	—	-104	-94	-96	-257	-187	-257	-187
Total, all payers	—	-23,666	-14,795	-9,230	-156,148	-67,450	-331,250	-240,346
Federal tax offset from ESI change	—	NA	NA	NA	16,715	5,242	41,223	29,633
<i>Change from current law (%)</i>								
Household	—	-1.4	-0.9	-0.5	-9.9	-4.6	-20.0	-14.9
Federal government	—	-3.3	-2.0	-1.2	-2.5	-1.7	-2.5	-1.7
State government	—	**	**	**	**	**	**	**
Employers	—	**	**	**	-10.7	-4.0	-25.2	-18.1
Providers	—	-0.4	-0.3	-0.3	-0.9	-0.7	-0.9	-0.7
Total, all payers	—	-1.1	-0.7	-0.4	-7.4	-3.2	-15.8	-11.4

Source: Health Insurance Policy Simulation Model, 2021.

Notes: 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 [Choose Medicare Act](#), S. 1261, 116th Cong. (2019).
- ² See, for example, see [Blumberg and colleagues \(2019\)](#).
- ³ Under current law, Marketplace premium tax credits are tied to the benchmark plan premium in each geographic premium rating area. Subsidized enrollees can enroll in the benchmark plan without paying more than the applicable percentage-of-income cap. Subsidized enrollees choosing higher-premium options must pay the difference between the benchmark premium and their chosen plan's premium; those choosing a plan with a lower premium pay less than their percentage-of-income cap.
- ⁴ For estimates of the effects of reforms that include enhanced nongroup market subsidies combined with a public option, see [Blumberg and colleagues \(2019\)](#).
- ⁵ Norris Cochran (acting secretary, US Department of Health and Human Services), letter to governors regarding extension of COVID-19 public health emergency, January 22, 2021, <https://ccf.georgetown.edu/wp-content/uploads/2021/01/Public-Health-Emergency-Message-to-Governors.pdf>.

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