



Which Hospitals Could Be Financially Affected by a Public Option?

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Several current health reform policy proposals include the introduction of a public option health insurance plan that would compete with private health insurance plans.¹ Most of these proposals would only allow public option plans to compete with nongroup plans on the Affordable Care Act (ACA) Marketplace, though one prominent proposal would allow it to compete with both large-group employer and nongroup insurance markets.² Nearly all current proposals for a public option indicate these plans would reimburse for medical services at rates lower than those currently paid by private plans and perhaps comparable with those paid by traditional Medicare. By paying providers lower rates, public option plans could have lower premiums than private plans. In turn, private plans may have to negotiate lower provider payment rates to maintain competitiveness in the market for health insurance coverage. Thus, the introduction of a public option plan could have a cascading effect on both private payment rates to providers and premiums for beneficiaries (Blumberg et al. 2020). In fact, researchers have argued capping provider payment rates across all payers could achieve many of the policy goals of public option plans.³

Reductions in private health insurance payment rates would greatly affect hospital systems. In 2017, private payment rates for hospital services exceeded Medicare's rates for such services by an estimated 230 to 240 percent (Blumberg et al. 2020; Whaley et al. 2020). At the same time, hospital closures have steadily increased over the past decade, particularly in rural areas and primarily because

of consistently low profitability, patient volume, and staffing (Kaufman et al. 2016). If a public option were to reduce private payment rates, it could thereby reduce rates of staff hiring or equipment purchases, the volume of patients served, and hospital operating margins or profitability; thus, a public option could accelerate hospital closures or decrease the quality of inpatient care. Reductions in private payment rates may not present immediate threats of closure or lower care quality for hospital systems with larger financial reserves, but they could hinder such systems' abilities to access reserve funds during emergencies or delay plans for larger projects requiring significant financial commitments. Understanding what kinds of hospital systems currently dedicate larger shares of services and resources to patients with private insurance is critical to understanding which hospitals' finances would most likely be adversely affected by a public option.⁴

In this brief, we use 2017 hospital discharge data from the Agency for Healthcare Research and Quality's Healthcare Cost and Utilization Project to identify hospitals that had a greater share of total charges paid by private insurance coverage and therefore would face the greatest risks of losing revenue under a public option. To do so, we estimate the ratio of total patient charges to private insurance relative to charges to all payers in individual hospitals. Though hospital charges are not equivalent to payments received by hospitals, charges for hospital services or procedures are typically identical across payers within the same hospital and are good measures of the intensity of hospital services delivered to patients. Though we observe the intensity of services and therefore hospital resources dedicated to treating patients with different payers, we cannot observe final negotiated payments for hospital charges. Thus, we cannot determine the final payer mix for hospitals. This is a major limitation unaddressed in this analysis. We argue that, in fact, ratios of private to total charges likely *underestimate* the actual share of total hospital revenues paid by private payers. We find the following:

- In 2017, the average ratio of private to total inpatient charges ranged from 17 percent in New Mexico to 41 percent in Utah. We find no association between hospitals in states that expanded Medicaid under the ACA (Medicaid expansion states) and private-to-total hospital charge ratios. Though Medicaid expansion states had greater Medicaid charges as a share of total hospital charges, we find these increases are almost entirely offset by a decrease in the share of total charges to uninsured or self-paying patients.
- We find major teaching hospitals, nongovernmental nonprofit hospitals, and hospitals in metropolitan areas had significantly higher private payer charges as a share of total charges.
- Private payers accounted for just 17 percent of all charges in rural hospitals. Thus, rural hospitals, typically at greatest risk of closure, had the lowest shares of private payment charges and highest Medicare charges as shares of overall charges in 2017. Unless reductions in private payment rates have spillover effects on Medicare payment rates or payment rates for other public payers, reductions in private payment rates under a public option may have a lower relative effect on rural hospitals.
- Hospitals in the highest quartile of ratios of private to total charges, expected to be at greatest financial risk with a public option in place, admitted more children and non-Hispanic Asian or

Pacific Islander patients as a share of total admissions than did hospitals in the lowest quartile of such ratios.ⁱ

- Conversely, hospitals in the lowest quartile of ratios of private charges to total charges, least likely to be adversely affected by a public option plan, admitted significantly more elderly patients, Hispanic patients, Native American patients, patients with Medicare or Medicaid coverage, and uninsured patients as a share of total admissions than did hospitals in the highest quartile of such ratios.

Though we find rural hospitals had the lowest shares of total charges attributable to private payers, many of these hospitals may have slim (or negative) operating margins or reserve funds. Reductions in private payment rates may make it more difficult for rural hospitals to hire additional physicians or other health care professionals in areas already facing shortages of such workers.⁵ Thus, rural hospitals could be at risk of inadequate staffing or even closure when faced with any absolute reduction in revenues. On the other hand, the hospitals with the greatest exposure to private payers (i.e., teaching hospitals, nonprofit nongovernmental hospitals, and hospitals in metropolitan regions) are traditionally associated with lower closure risks. Thus, our findings highlight which hospitals could be at greatest relative risk of facing near-term revenue reductions following the introduction of a public option plan that applies downward pressure on private payment rates. However, it does not indicate which hospitals are at greatest risk for closure, because other relevant factors, such as hospital market or monopsony power, volume shifting toward patients of other payer types, and quality of care, could adjust instead.

Methods

We acquired 2017 hospital discharge data from the Agency for Healthcare Research and Quality's Healthcare Cost and Utilization Project inpatient databases for available states with primary payer information. These databases almost fully account for hospital discharge records for each hospital in a state and include patient demographics, such as age, race and ethnicity, primary expected payer, total hospital charges, patient diagnostic and procedure codes, and length of stay. We collected data for 25 states (AK, AR, AZ, CO, DC, DE, FL, GA, KS, KY, MA, MD, MI, MS, NC, NM, NV, OR, RI, SD, UT, VT, WA, WI, and WV). They represent states in each census region, states that did and did not expand Medicaid under the ACA by 2017, and various population sizes. However, our dataset excludes several of the largest states (e.g., CA, IL, NY, and TX).

For each hospital, we calculated the ratio of total private charges (i.e., the sum of all charges for patients identified as having a private payer) to all charges for all inpatient discharges in the year. Because differences in charges within hospitals reflect differences in service and resource intensity, this ratio measures the share of hospital resources dedicated to treating patients with private

ⁱ Throughout this brief, we use the racial and ethnic terms from our data source, the Agency for Healthcare Research and Quality's Healthcare Cost and Utilization Project. All racial groups are non-Hispanic. We recognize the limitations of these terms and remain committed to using respectful, inclusive language.

insurance coverage. However, charges within hospitals ultimately have different negotiated final payments for different payers. Typically, private payments for inpatient services are substantially greater than payments from traditional Medicare, and evidence shows this difference has grown over the past several decades but stabilized in recent years (Selden 2020; Selden et al. 2015). In 2017, private payments for hospital services exceeded Medicare payments for the same service by 231 percent (Whaley et al. 2020), and payments for patients covered by employer-sponsored insurance exceeded Medicare payments by 241 percent (White and Whaley 2019). Estimates from the Urban Institute (using 2017–18 FAIR Health data), Congressional Budget Office (using 2013–14 data from the Health Care Cost Institute), and RAND (using multiple data sources, including all-payer claims data and data for self-insured employers in 25 states) show inpatient services are priced roughly 1.9 to 2.0 times higher than Medicare fee-for-service payment rates (Blumberg et al. 2020; Maeda and Nelson 2017; Pelech 2018; White and Whaley 2019). Medicare and Medicaid payment rates for hospital services typically exceed final hospital payments rates paid by uninsured patients.

For any standard hospital charge for a specific inpatient service, final payments paid by private payers likely exceed payments made by public payers or uninsured patients. Thus, the ratio of private to total charges does not reflect the true share of total revenue from private payers; it likely underestimates the actual share. Consequently, though our analysis does not specify the exact payer share of hospital revenues, private-to-total charges ratios represent a lower bound of the true financial risk hospitals face under implementation of a public option.

Using hospital survey data from the American Hospital Association, we merge in characteristics on hospitals' teaching status, for-profit status, number of beds, and rurality. Six states (AK, GA, KS, MI, MN, and SD) and the District of Columbia do not permit linkage to the American Hospital Association survey and are excluded from analyses assessing differences in payment ratios by these hospital characteristics. We calculate ratios of private to total charges across states and hospital characteristics by taking an average of hospital ratios, weighted by the number of hospital discharges. In addition to these ratios, we calculate the share of total charges for each of the following payer types: Medicare; Medicaid; self-pay, uninsured, or other; and unknown payer.

We evaluate ratios of private to total hospital charges by state, state Medicaid expansion status, and hospital characteristics. We make explicit comparisons in private payer ratios by each characteristic and therefore use a weighted least squares regression analysis to identify whether differences in private payer ratios across these categories are statistically significant.

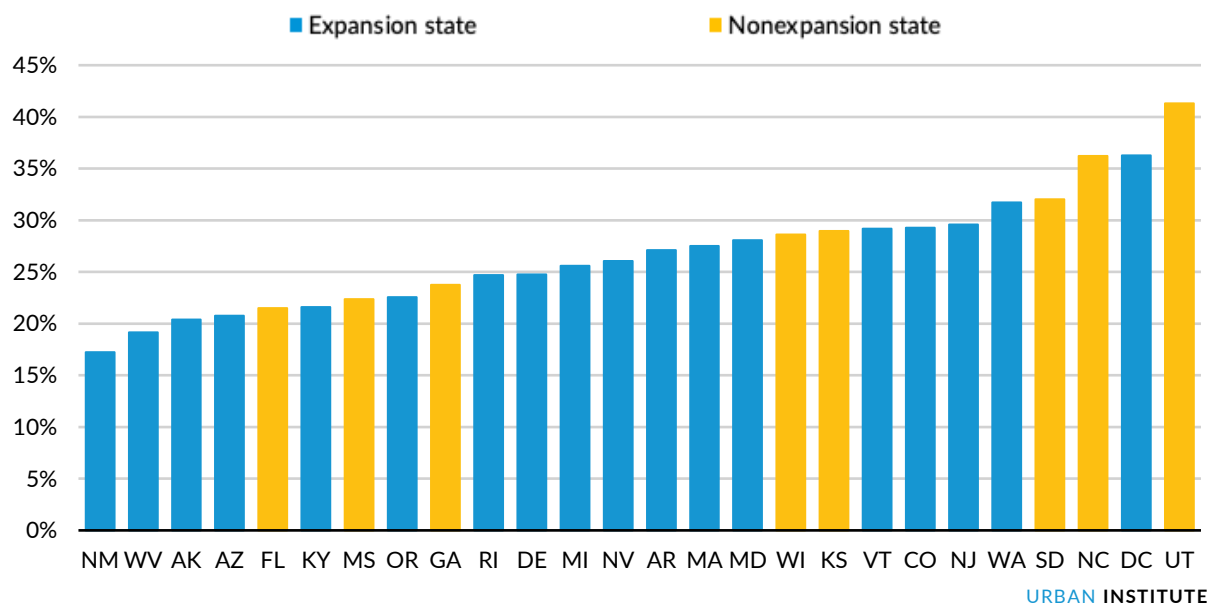
Finally, we investigate differences in patient characteristics in hospitals least and most likely at financial risk under a public option that leads to reductions in private payment rates. We do this by arranging hospitals from the lowest to the highest ratios of private to total charges and dividing them into quartiles. We then compare patient characteristics of hospitals in the first quartile (i.e., with the lowest ratios of private to total charges) to those in the fourth quartile (i.e., with the highest such ratios and potentially facing the largest relative reduction in revenues). We compare differences in patient age groups, races and ethnicities, and primary payer characteristics between hospitals in

quartiles 4 and 1, providing insight into the profiles of patients at hospitals facing high financial risk under a public option.

Results

We observe a wide distribution in ratios of private charges to total charges by geography. Figure 1 presents state average ratios of private charges to total charges, arranged from lowest to highest (i.e., from states with hospitals least to most likely to be financially disadvantaged by reduced private payment rates).

FIGURE 1
Ratios of Private Charges to Total Charges for Inpatient Hospital Services, by State and Medicaid Expansion Status, 2017



Source: 2017 State Inpatient Databases from the Agency for Healthcare Research and Quality's Healthcare Cost and Utilization Project.

Note: Ratios are the admission-weighted averages of hospitals' ratios of private to total charges.

States' ratios of private to total hospital charges ranged from 17 percent in New Mexico to 41 percent in Utah. Figure 1 also distinguishes states that had expanded Medicaid under the ACA by 2017 from those that had not. Though one may expect Medicaid expansion states to have lower private payer ratios, figure 1 shows no clear association between Medicaid expansion status and private payment ratios.

Table 1 shows ratios of each payer's charges to total charges. Ratios total to 100 percent across each row.

TABLE 1

Ratios of Payers' Charges to Total Charges for Inpatient Hospital Services, by State and Payer Type, 2017

Percent

State	Private	Medicare	Medicaid	Self-pay, uninsured, or other	Unknown payer
Alaska	20	35	33	12	0
Arkansas	27	50	15	8	0
Arizona	21	46	24	6	0
Colorado	29	45	21	5	0
District of Columbia	36	38	24	2	1
Delaware	25	51	21	3	1
Florida	22	53	15	9	1
Georgia	24	48	16	12	1
Kansas	29	53	10	7	1
Kentucky	22	52	23	3	0
Massachusetts	28	52	16	4	0
Maryland	28	48	20	4	0
Michigan	26	54	18	3	0
Mississippi	22	53	15	10	0
North Carolina	36	40	15	8	0
New Jersey	30	48	16	6	0
New Mexico	17	48	29	5	2
Nevada	26	44	22	8	1
Oregon	23	51	21	6	0
Rhode Island	25	44	24	7	0
South Dakota	32	50	12	7	0
Utah	41	38	13	7	1
Vermont	29	52	16	2	1
Washington	32	45	19	5	0
Wisconsin	29	52	16	3	0
West Virginia	19	55	22	4	0
By state Medicaid expansion status					
<i>Across all discharges</i>					
Expansion	26	49	20	5	0
Nonexpansion	26	49	15	9	1
<i>Among patients ages 19 to 64</i>					
Expansion	41	20	32	7	0
Nonexpansion	41	21	22	15	2

Source: 2017 State Inpatient Databases from the Agency for Healthcare Research and Quality's Healthcare Cost and Utilization Project.

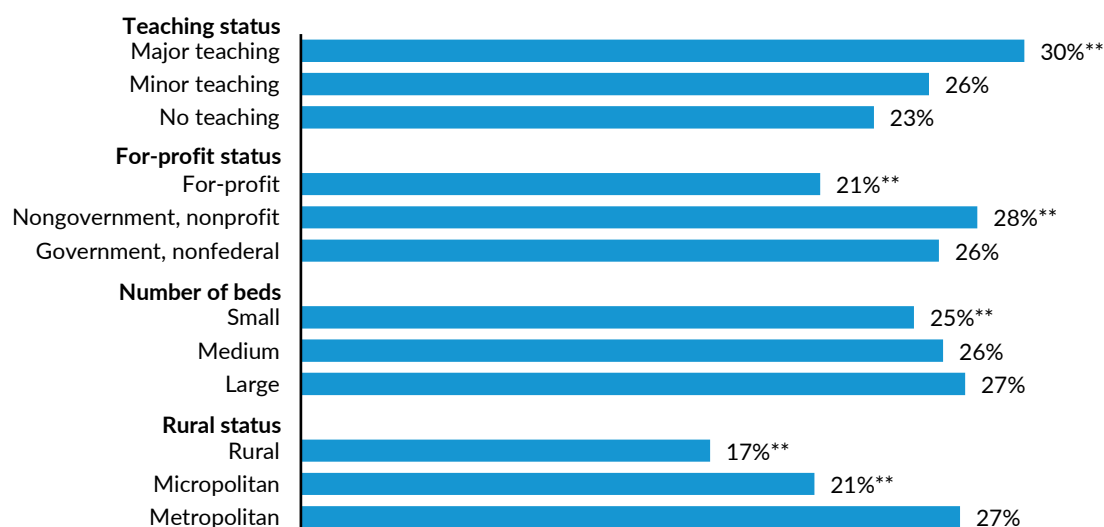
Note: Ratios are the admission-weighted averages of hospitals' ratios of private to total charges.

Medicare had the greatest share of hospital charges in all states, ranging from 35 percent of all charges in Alaska to 55 percent in West Virginia. Medicaid charge ratios were generally larger in Medicaid expansion states: the 15 states with the largest ratios of Medicaid charges to total hospital charges all expanded Medicaid under the ACA. Charges for self-paying, uninsured, and other patients remained large in some states in 2017, above 9 percent in Alaska, Florida, Georgia and Mississippi.

The bottom panel of table 1 also shows the average charge ratios for each payer type by state Medicaid expansion status. We present these averages for all patients then separately for patients ages 19 through 64, the age group directly affected by Medicaid expansion under the ACA. Though we find Medicaid expansion states had higher shares of Medicaid charges relative to nonexpansion states, these coincide with lower charges for uninsured, self-paying, or other patients. Private and Medicare payer shares were nearly identical in expansion and nonexpansion states, indicating state Medicaid expansion status has little association with hospitals' financial vulnerability under introduction of a public option that leads to reductions in private payment rates for inpatient services.

We investigate ratios of private to total charges by a hospital's teaching status, for-profit status, number of beds, and rurality in figure 2. Hospitals reporting any teaching instruction had higher ratios of private to total charges (30 percent of all charges for major teaching hospitals and 26 percent of all charges for minor teaching hospitals) than nonteaching hospitals (23 percent). Therefore, teaching hospitals may be more adversely affected by reductions in private insurer payments for inpatient services. Perhaps counterintuitively, nonprofit hospitals had significantly higher shares of total charges paid by private payers than did for-profit hospitals (28 percent versus 21 percent). We observe few differences in the ratio of private to total charges by a hospital's number of beds. However, hospitals with fewer beds had statistically lower private payment ratios. Finally, rural hospitals' private charges represented a smaller share of overall charges (17 percent) than did micropolitan hospitals' and metropolitan hospitals' private charges (21 percent and 27 percent).

FIGURE 2
Ratios of Private Charges to Total Charges for Inpatient Hospital Services, by Hospital Characteristics, 2017



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Sources: 2017 American Hospital Association annual survey and 2017 State Inpatient Databases from the Agency for Healthcare Research and Quality's Healthcare Cost and Utilization Project from the following states: AR, AZ, CO, DE, FL, KY, MA, MD, MS, NC, NM, NV, OR, RI, UT, VT, WA, WI, WV.

Notes: Ratios are admission-weighted averages of ratios of private to total hospital charges. Analysis of hospital characteristics excludes Alaska, Georgia, Kansas, Michigan, South Dakota, and Washington, DC, whose inpatient databases did not have American Hospital Association annual survey linkage. For each hospital characteristic, the following categories are assigned as reference groups: no teaching; government, nonfederal; large bed size; and metropolitan location (the third category for each grouping).

** The difference in private payment ratios relative to the reference group is statistically significant at the $p < 0.05$ level.

The payer mix across hospitals with different numbers of beds differed little in 2017 (table 2). Rural hospitals had larger Medicare charges as a share of total charges (61 percent) than did micropolitan and metropolitan hospitals (56 percent and 49 percent), which potentially highlights older age demographics in rural areas. This makes rural hospitals relatively less financially exposed to a reduction in private payment rates.

TABLE 2
Ratios of Payers' Charges to Total Charges for Inpatient Hospital Services,
by Hospital Characteristics, 2017

Percent

	Private	Medicare	Medicaid	Self-pay, uninsured, or other	Unknown payer
Teaching status					
Major	30	42	21	7	0
Minor	26	51	17	6	0
No teaching	23	54	15	6	1
For-profit status					
For-profit	21	53	16	8	1
Governmental, nonfederal	28	49	17	6	0
Nongovernmental, nonprofit	26	44	21	8	1
Number of beds					
Small	25	52	16	6	1
Medium	26	51	16	6	0
Large	27	46	19	7	0
Rural status					
Rural	17	61	17	5	0
Micropolitan	21	56	16	6	0
Metropolitan	27	49	18	6	0

Sources: 2017 American Hospital Association annual survey and 2017 State Inpatient Databases from the Agency for Healthcare Research and Quality's Healthcare Cost and Utilization Project from the following states: AR, AZ, CO, DE, FL, KY, MA, MD, MS, NC, NM, NV, OR, RI, UT, VT, WA, WI, WV.

Notes: Ratios are admission-weighted averages of the ratios of payers' charges to total hospital charges. Analysis of hospital characteristics excludes Alaska, Georgia, Kansas, Michigan, South Dakota, and Washington, DC, whose inpatient databases did not have American Hospital Association annual survey linkage.

Lastly, we investigate patient populations in hospitals with the lowest and greatest ratios of private to total charges (table 3). To do so, we first ranked hospitals by ratios of private to total charges and divided them into quartiles. Next, we compared patient age, race, and payer

characteristics (1) among all hospitals, (2) among hospitals in the first quartile of ratios of private to total hospital charges (i.e., with the lowest ratios and therefore at least financial risk from reduced private payment rates), and (3) in the fourth quartile of such ratios (i.e., with the highest ratios and most financial risk). We also present the differences in patient characteristics between the first and fourth quartiles of hospitals. The first row of table 3 presents the average ratio of private to total charges in each group, revealing wide variation; the average such ratios are 26 percent across all hospitals, 10 percent among hospitals in quartile 1, and 38 percent among hospitals in quartile 4.

Hospitals likely least affected by the introduction of a public option (quartile 1) served significantly fewer infants and children and significantly more elderly patients as a share of all patients than did hospitals potentially most affected by a public option (quartile 4). Fewer than 1 in 10 patients (9 percent) in quartile 1 hospitals were children under age 18, compared with about 1 in 5 patients (20 percent) in quartile 4 hospitals. Much of this difference owes to a larger share of births occurring in quartile 4 hospitals (12 percent of all discharges) than in quartile 1 hospitals (6 percent of all discharges), suggesting a larger share of resources in quartile 4 hospitals were dedicated to maternity services (data not shown).⁶ Notably, 70 percent of children served by quartile 1 hospitals had Medicaid, compared with 40 percent in quartile 4 hospitals (data not shown). Thus, though children represented a larger share of all patients in quartile 4 hospitals, a larger share of socioeconomically disadvantaged children were admitted into quartile 1 hospitals.

About 44 percent of patients in quartile 1 hospitals are ages 65 or older, whereas less than one-third of quartile 4 hospital patients are in this age range, a 25 percent difference. Hospitals with the lowest and highest ratios of private to total charges had nearly identical shares of patients ages 19 to 64. Hospitals in quartiles 1 and 4 also served similar shares of non-Hispanic white patients (69 percent) and non-Hispanic Black patients (16 percent); differences in these shares were insignificant between the two quartiles. But compared with quartile 1 hospitals, quartile 4 hospitals, expected to be most financially exposed by a public option's reduced private payment rates, served significantly fewer Hispanic patients (4.4 percentage-point difference) and Native American patients (1.7 percentage points) and significantly more non-Hispanic Asian or Pacific Islander patients (2.2 percentage-point difference).⁷

Unsurprisingly, a much larger share of patients in quartile 4 hospitals (most adversely affected financially by a public option) had a private payer than in quartile 1 hospitals (42 percent versus 12 percent of all patients). This difference is primarily offset by smaller shares of patients with public insurance coverage in quartile 4 hospitals than quartile 1 hospitals. About one-third of patients in quartile 4 hospitals had Medicare coverage, whereas about one-half of patients in quartile 1 hospitals did. Much of this difference owes to differences in patient age characteristics, particularly in the shares of elderly patients between the two hospital groups, as noted above. Quartile 4 hospitals also served fewer Medicaid patients than did quartile 1 hospitals (an 8 percentage-point difference). Moreover, quartile 4 hospitals served fewer self-paying, uninsured, and other patients than quartile 1 hospitals (a 4.3 percentage-point difference).

Altogether, table 3 indicates introducing a public option is unlikely to affect hospitals that serve more elderly, Hispanic, Native American patients, patients with Medicare or Medicaid coverage, and uninsured patients as shares of total patients. On the other hand, children represent a greater share of all patients in hospitals with the highest ratios of private to total charges among the states examined and could therefore be negatively affected by the introduction of a public option.

TABLE 3
Characteristics of Patients at Hospitals with the Lowest and Highest Shares of Private Payer Charges, 2017

	All hospitals	Quartile 1 of ratios of private to total hospital charges (lowest private payment shares)	Quartile 4 of ratios of private to total hospital charges (highest private payment shares)	Difference between quartiles 4 and 1 (percentage points)
Average ratio of private to total charges	26.3%	10.1%	37.8%	27.7*
Patient characteristics				
<i>Age</i>				
Infants	10.8%	6.5%	13.6%	7.1*
1 to 18	4.2%	2.8%	6.2%	3.4*
19 to 64	48.0%	47.2%	47.7%	0.6
65+	37.1%	43.6%	32.5%	-11.1*
<i>Race/ethnicity</i>				
White	68.5%	64.9%	69.0%	4.1
Black	16.5%	16.4%	15.9%	-0.6
Hispanic	9.9%	13.4%	9.0%	-4.4*
Asian or Pacific Islander	1.9%	0.8%	3.1%	2.2*
Native American	0.9%	2.2%	0.6%	-1.7*
<i>Primary expected payer</i>				
Private	29.0%	11.5%	41.6%	30.2*
Medicare	41.2%	50.7%	33.1%	-17.6*
Medicaid	22.0%	26.7%	19.0%	-7.7*
Self-pay/uninsured/other	7.2%	10.2%	6.0%	-4.3*
Unknown payer	0.6%	0.8%	0.3%	-0.6
Number of hospitals	2,336	584	584	NA

Source: 2017 State Inpatient Databases from the Agency for Healthcare Research and Quality's Healthcare Costs and Utilization Project for the following states: AK, AR, AZ, CO, DC, DE, FL, GA, KS, KY, MA, MD, MI, MS, NC, NM, NV, OR, RI, SD, UT, VT, WA, WI, WV.

Notes: NA indicates the column heading does not apply. All racial groups are non-Hispanic. Estimates for patients classified from "other" racial backgrounds are not reported separately. Hospital-level estimates are weighted by the number of admissions.

* The difference between quartiles 4 and 1 estimates is statistically significant at the $p < 0.05$ level.

Discussion

A hospital's ratio of private to total charges provides a reasonable measure of its exposure to the changes in private payment rates for hospital services that could occur under the introduction of a public option with Medicare-like payment rates. Such reduced private payment rates could, in turn, decrease premiums, increasing health care plan affordability beyond such progress made by the ACA.⁸ But whether providers and hospitals can withstand a major reduction in payment rates from private payers is unknown.

We find the ratio of private charges to total charges varies greatly across hospitals' geography and characteristics. However, we observe no systematic pattern between hospitals in Medicaid expansion and nonexpansion states in 2017. Predictably, hospitals in Medicaid expansion states had a greater share of Medicaid charges than nonexpansion states. However, this almost entirely owes to a reduction in the share of charges for uninsured, self-paying, or other patients.

Nonteaching, for-profit, and rural hospitals all have lower shares of total hospital charges paid by private payers. These hospitals are less financially threatened by reductions in private payments than their counterparts. Regardless, hospitals with narrow operating margins (often the case with rural hospitals) could still be at financial risk following any absolute decrease in payment rates. Teaching hospitals and metropolitan hospitals could face significant payment reductions under the introduction of a public option, because a large share of their overall charges are paid by private payers. If current revenue is used to help finance curriculum, faculty, research, or student support at teaching hospitals, a reduction in private payments under a public option could have a downstream effect on faculty salary/hiring, medical school tuition, and research output.

By comparing the characteristics of patients in hospitals with the highest ratios of private to total charges (expected to be most financially affected by the introduction of a public option that reduces private payment rates) with the characteristics of patients in hospitals with the lowest such ratios, we predict which patient populations could be most affected by a public option. We find hospitals with the highest shares of private charges served significantly more children but significantly fewer elderly, Hispanic, and Native American patients as a share of total patients than did hospitals with the lowest shares of private charges in 2017. Further, hospitals potentially most financially affected by a public option plan served fewer patients with Medicare coverage, patients with Medicaid coverage, or patients who self-pay or lack coverage. This suggests the characteristics of patients predicted to be most immediately affected by a reduction in private payment rates do not resemble those of vulnerable patient groups.

There are several ways in which reductions in private payment rates may affect patient populations served in hospitals that face greater financial risk under a public option. Reductions in private revenues may lead to hospital closure, in which case patients would be required to seek alternative, next-best options for hospital services. Alternatively, reductions in private payment rates could reduce the willingness for hospitals to serve private patients relative to patients with other coverage types. Past evidence has shown that increasing Medicaid payment rates for medical care

services is associated with increased physician willingness to accept new Medicaid patients (Alexander and Schnell 2020; Polsky et al. 2015). Thus, reductions in private payment rates could result in reduced admissions for private patients. Finally, reductions in overall hospital revenues or operating margins may reduce hospitals' abilities to provide quality care (Akinleye et al. 2019).

Our findings highlight which types of hospitals could be at greatest relative risk of facing a near-term reduction in revenues following the introduction of a public option. Hospitals facing a large revenue reduction may exit the market entirely, which could accelerate hospital closures, particularly in rural areas (Kaufman et al. 2016). And hospitals remaining in the market could adjust other factors in response, such as shifting volume toward patients of other payer types or decreasing the quality of care. In addition, hospitals may use private payments to help subsidize services for uninsured patients or patients with lower-reimbursement coverage types, meaning reduced private payments may alter the payer profile of hospital patients.

The extent to which a public option could threaten hospital finances depends on two factors. First, a public option could dramatically affect private payment rates if it is permitted to compete in the large-group employer markets, by far the most common type of insurance among the nonelderly population today (Garrett and Gangopadhyaya 2020). Alternatively, a public option that solely competes with existing nongroup plans may ultimately have little effect on overall private payment rates and thus hospital finances. Second, how much private payment rates decline depends on how much lower payment rates in the public option are set relative to the average payment rate of the private plans with which it competes.⁹ Currently, public option proposals vary significantly on both factors.

A public option is intended to further improve coverage affordability for the nonelderly beyond the accomplishments of the ACA. Though improved affordability could greatly benefit households, dramatic changes in provider reimbursement rates could have profound effects on the health care system and hospitals. A strategy for implementing a public option must account for the trade-offs between improved affordability and disrupted delivery of hospital services.

Notes

- ¹ Medicare-X Choice Act of 2019, S. 981, 116th Cong. (2019); Choose Medicare Act, S. 1261, 116th Cong. (2019); Keeping Health Insurance Affordable Act of 2019, S. 3, 116th Cong. (2019); Consumer Health Options and Insurance Competition Enhancement Act, S. 1033, 116th Cong. (2019); and President Biden's health care plan, available at <https://joebiden.com/healthcare/>.
- ² S. 981, S. 3, and S. 1033 would establish a public option plan on individual health insurance exchanges to compete with nongroup plans and permit ACA premium subsidies to apply to such plans. S. 1261 further allows employers to enroll in and contribute toward a public option plan for employees.
- ³ Linda J. Blumberg and John Holahan, "Capping Provider Payment: An Alternative to a Public Option," *American Prospect*, January 5, 2018, <https://prospect.org/health/capping-provider-payment-alternative-public-option/>.

- ⁴ Throughout this brief, we refer to any nonpublic and non-self-paying payer as a private payer or private plans. These plans have also been classified as commercial plans in other studies (e.g., Whaley et al. 2020; White and Whaley 2019).
- ⁵ Holahan and Simpson (2021) examines versions of public option and capped payment rate proposals that would exempt rural areas.
- ⁶ We identified hospital births by identifying any discharges that included an ICD-10 diagnostic code beginning with Z38.
- ⁷ As an extension to the analysis in table 3, we investigated differences in patient characteristics in quartiles 4 and 1 hospitals, after adjusting for state of residence. We found little change in differences between quartiles 4 and 1 patients' ages and payer characteristics when restricting comparisons between hospitals in the same state. Notably, adjusting for state of residence nearly eliminated differences in patients' racial/ethnic composition between quartiles 4 and 1 hospitals. This indicates the way patients of different races and ethnicities are potentially affected by a public option owes to state-level differences in ratios of private to total charges, as highlighted in figure 1 and table 1.
- ⁸ For analyses of the impact of various of public option and capped payment rate proposals on premium prices, uninsurance rates, health spending, and the federal deficit, see "What Are the Effects of Alternative Public Option Proposals?" Urban Institute, March 17, 2021, <https://www.urban.org/research/publication/what-are-effects-alternative-public-option-proposals>.
- ⁹ S. 981 does not specify exact provider reimbursement rates for the public option. However, the recently updated bill indicates the public option plan would reimburse providers at Medicare fee-for-service rates but would allow reimbursement up to 150% of Medicare rates in rural areas; more information is available at https://www.bennet.senate.gov/public/_cache/files/e/f/ef813732-2d0e-47c2-bc13-274bb3bac800/12C07C9B3C3056DA4515AEBB57BC1D9C.medicare-x-summary.pdf. S. 1261 indicates the public option's payment rates would not be lower than Medicare payment rates but would not be higher than the average rate paid by other insurers on the exchange. S. 3 sets public option payment rates equal to those paid by Medicare Parts A and B. S. 1033 allows the secretary of the US Department of Health and Human Services to negotiate a payment agreement with health care providers, but it sets the plan's payment rates at Medicare levels without such an agreement.

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