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Design of Public Option and Capped Provider Price Reforms

Important Interactions between Provider Prices and Other Program Features

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The 2020 presidential election brought discussions of introducing a public option into US health insurance markets back to the forefront of health policy debates. A public option would consist of a government-designed and administered (directly or via contract) health insurance plan or set of insurance plans that would be introduced in one or more health insurance markets. The federal government would determine payments made to providers (e.g., doctors, hospitals, pharmaceutical manufacturers) participating with a public option or negotiate prices with providers to attract them to participate; alternatively, state governments or a quasi-governmental or nonprofit entity could govern a public option. Conversations about public option plans have also prompted discussions about a related policy option, capping payments made to providers by commercial insurers. This strategy would require providers participating in particular insurance markets to accept prices from commercial insurers at or below a government-designated level. Thus, these capped prices would apply to providers participating in any private insurance plan offering coverage in the specified markets, whereas a public option would apply government-designated rates in new government-administered insurance plans alone.

About US Health Reform—Monitoring and Impact

With support from the Robert Wood Johnson Foundation, the Urban Institute is undertaking a comprehensive monitoring and tracking project to examine the implementation and effects of health reform. Through the US Health Reform—Monitoring and Impact project, which began in May 2011, Urban researchers are using microsimulation modeling to project the cost and coverage implications of proposed health reforms, documenting the implementation of national and state health reforms, and providing technical assistance to states. More information and publications can be found at www.rwjf.org and www.urban.org.

These two health reform approaches are related in that both seek to provide insurance options to consumers that would pay providers based upon payments determined (in the case of the public option) or limited (in the case of capped provider prices) by the federal government or its chosen agent. As noted, the public option would do so via a new insurance plan or set of insurance plans administered by the government, and the capped prices would do so via private insurers participating in the markets chosen. Depending on where these rates or rate limits are set, either approach could reduce premiums relative to current levels. Either policy could be used alone or in tandem with the other.

Though people broadly support the idea of a public option and/or lowering the costs of health care (Politico 2020),¹ implementing such policies requires numerous design decisions, can have significant unintended consequences, and is politically challenging. Design decisions profoundly affect such policies' abilities to meet their stated objectives, disruptions to the US health care system, and health care providers' finances. Many of these design decisions interact with one another, meaning they ought to be considered together. This is especially true of how the chosen schedule of provider prices interacts with other design choices. Here I delineate the major design choices that must be made for public option and/or capped provider price reforms and outline their trade-offs in government costs, household costs, impacts on providers, and access to care. I explicitly recognize that a public option and capped provider prices paid by commercial insurers can be implemented independently or simultaneously.

What follows is a summary and interpretation of an extended discussion in 2020 with a small group of health policy experts that included, in addition to me, Michael Chernew, Jack Ebeler, Matt Fiedler, Richard Frank, Sherry Glied, Tim Gronniger, John Holahan, Mark Miller, and Cori Uccello. No particular view presented below should be attributed to any particular participant or organization with which they are affiliated. The central conclusions of the discussion include the following:

- Advocates of public option and capped provider price reforms do not always agree on the reforms' intended objectives. Some see a public option primarily as a cost-containment mechanism, intended to lower public and private health care spending and thereby increase insurance coverage and access to care. Others view a public option as most importantly an

alternative to commercial insurance that could better serve the interests of consumers; these supporters may have little interest in designing a system to reduce the costs of care. Capped provider prices could reduce health care spending, increase coverage, and improve access to care as well but would not provide an alternative to commercial insurance.

- Both reforms could reduce health care spending, but the extent of savings depends on the prices the reforms rely on and the markets in which the reforms are introduced.
- In designing either reform, the interaction of the provider price schedule and the size of the markets included will have powerful implications for the magnitude of system-wide savings and effects on provider revenue. The lower the price schedule and the larger the markets to which they apply, the greater the potential for public and private savings. But greater, too, is the potential to disrupt health care provider markets.
- In either reform, the provider price schedule will directly affect providers' voluntary participation in the insurance plan networks. Lower price schedules will tend to decrease voluntary provider participation and thus make it more difficult to establish broad provider networks. However, prohibiting providers refusing to participate with the public option or commercial insurers relying on capped prices from participating with other insurers in the same market could increase participation.
- A public option reform requires many additional design decisions beyond those required of a capped provider price reform. These include whether state variation in essential health benefit requirements would be permitted, the actuarial value tiers in which a public option would be introduced, risk adjustment participation, applicability of premium taxes, reserve fund requirements, and financing of start-up and administrative costs.
- Setting capped provider prices at a relatively high point in the provider price distribution (e.g., the 75th or 80th percentile) would reduce the prices of the highest-priced insurance plans, and such a reform could be introduced into both employer group and nongroup markets with little anticipated health care delivery disruption. Introducing a public option in nongroup insurance markets would provide new competition in markets dominated by monopolistic providers and/or insurers and would constitute a new tool that could evolve into a valuable option for consumers dissatisfied with private insurance options.

Objectives: Cost Containment versus Availability of Noncommercial Broad Network Plans

Central to the effective design of any public policy is clarity in the policy's intended objectives. Advocates of a public option are not unanimous in their objectives, and design choices will determine which objectives are most likely to be met by the program ultimately introduced.

Some see a public option as a cost-containment mechanism. In many areas of the country, lack of competition among insurers and/or health care providers is associated with high premiums, generally

because of high provider prices.² Regardless of the source of high medical prices, many support lowering them to improve access to care and free up public and private funds for other priorities. A public option run by the federal government could make payments to health care providers that are lower than those paid by most commercial insurers. Doing so would mean public option plans could offer consumers actuarially fair premiums lower than many of those offered by commercial insurers. Lower premiums translate into household savings on out-of-pocket costs for people enrolled in the option, and lower premiums may put competitive pressure on private insurers in markets where the public option is introduced (Blumberg et al. 2019). A public option introduced in the employer market could provide a lower-premium insurance option for employers and their workers. Likewise, a public option offered in the private nongroup insurance market could offer a lower-premium option to nongroup enrollees, especially those with higher incomes that make them ineligible for federal financial assistance (Blumberg 2021). In addition, if a public option were to decrease the nongroup Marketplace benchmark premium (currently set at the second-lowest silver Marketplace premium in a person's area of residence), federal spending on premium tax credits would decrease as well, leading to government savings. Likewise, placing caps on provider prices for commercial insurers in all or some markets could generate both private and government savings.³ Depending on how it is administered, a public option could also operate with lower administrative costs than those typical of private insurers, another possible source of savings that could lower premiums.

Lower health care spending during the first year of the COVID-19 pandemic reduced the sense of urgency some felt in addressing rising health care spending via a public option or provider price caps. However, the drivers of increased health care spending in private markets that many were concerned about before the pandemic have not changed, meaning those concerns will return. Moreover, an ongoing focus has been placed on the extent to which Medicare and private insurers overspend on prescription drugs, and concerns remain about how Medicare Advantage plan pricing potentially increases health care costs. In addition, the Biden administration has already issued an executive order instructing federal agencies to work on addressing broad issues related to the economic consequences of market consolidation, including in the health care sector. This signals that health care cost containment strategies remain an important policy interest.

Others see a public option as an alternative insurance vehicle that would be more responsive to the interests of consumers than profit-motivated insurers. Some people are concerned with the narrow provider networks offered in many nongroup insurance market plans in particular, and they see a public option as a way to offer consumers broad provider networks at an affordable premium, not unlike the traditional Medicare program. Some people value a single insurance plan being available to everyone across the country, particularly one theoretically less likely to deny claims or limit important benefits. Some view a public option as a vehicle for providing subsidized coverage to populations currently without coverage options (e.g., those in the Medicaid eligibility gap),⁴ whereas others see it as a first step toward a Medicare for All program.

Capping provider prices for all commercial insurers could create public and private health care savings, as noted above, regardless of whether capped prices are implemented alongside a public

option. In fact, because most insurer premiums could be affected by the caps, depending on where they are set, the caps could lead to greater aggregate private savings than a public option alone. However, capping prices paid by commercial insurers cannot satisfy the desire for an alternative to insurers motivated by profit or other interests that benefit certain private entities (e.g., private nonprofit insurers), as the public option could do. Consequently, the primary purpose of capped provider prices is to reduce health care spending by reducing providers' and/or insurers' market power over prices while maintaining sufficient quality of and access to care. In addition, such an approach can improve equity in the markets by reducing the variation in prices paid across providers and markets.

These different objectives will often be in some tension with one another. Creating and maintaining broad provider networks, for example, generally requires paying providers higher prices to attract their participation. Higher provider prices, in turn, will generally translate into higher premiums and reduce the opportunities for private and public savings. Plans with lower rates of claims denials will also, however, tend to increase provider participation even at lower prices (Dunn et al. 2021), but they may lead to increased costs as well.⁵ Therefore, I refer to these somewhat competing objectives while presenting the advantages and disadvantages of specific design choices.

Private and public savings resulting from lowering payments to providers under either a public option or capped provider prices can increase health insurance coverage. Combined with current medical loss ratio restrictions, lower payments to providers per service should translate into lower premiums. In turn, lower premiums facing consumers can increase the number of people purchasing coverage in the nongroup market. For employers, lower premiums can translate into greater enrollment by workers and some current premium spending being transformed into higher taxable wages. Government savings from lower premium tax credits in the nongroup market and/or greater tax revenue from increased wages in the employer market make more dollars available to enhance financial assistance in the nongroup market (e.g., improved premium tax credits) or expand eligibility for public programs (e.g., filling in the Medicaid coverage gap).

Though related, the public option and caps on private insurers' provider prices will likely affect different insurance markets differently. Capped provider prices constrain the range of prices of participating insurers but otherwise leave the markets structured as they are today. The public option introduces a new and potentially lower-priced insurer into the market, but it does not explicitly constrain commercial insurers' pricing. Depending on the characteristics of particular insurance and provider markets, the resulting competitive responses could differ.

The Foundation for Developing Provider Price Schedules

Both a public option and capped provider prices for private insurers require delineating provider price schedules. With a public option, a schedule would determine the reimbursements for medical services provided to enrollees. With capped prices, a schedule would limit commercial insurers' provider payments to no more than specified levels. Schedules could be based on services for health care professional payments and per admission diagnostic related groups for hospital payments, for

example, as is the case for the Medicare program. Under either approach, payment schedules or limits on prices should reflect the intensity of services provided. The main foundations considered for creating such payment schedules are the traditional Medicare schedule and commercial insurer fees. Both have distinct advantages and disadvantages for public option and capped provider price policies.

The Medicare Fee Schedule

This schedule is an existing set of prices that accounts for geographic variation in the costs of providing care. Consequently, the Medicare schedule could be applied to new programs or plans quickly. A small number of services, particularly those for pediatric care, may need to be added to the existing schedule, but it already accounts for the vast majority of care. The Medicare fee schedule has also been developed with the intent to reimburse providers at levels relative to each other based on variations in input costs and the relative value of different services provided. Thus, price differences across the schedule have a rational basis. Depending on how high policymakers want prices to be, multiples of Medicare prices could be used, for example, 110 or 160 percent of Medicare prices. Different multiples could be used for hospital versus professional care. This would account for current commercial rates for professionals already being closer to Medicare rates than are hospital rates. And, institutionally, provider participation issues for public insurance programs have been a greater concern for physicians than for hospitals. More complexity could be introduced by varying the percent adjustments more finely, for example, by treating different types of hospitals differently (e.g., teaching hospitals, rural hospitals) or treating various physician specialties differently.

The Medicare fee schedule-based approach also has the advantage of containing a ready-made measure of provider volume. One risk of lowering provider prices is that some providers could respond to the ensuing reduction in revenue by increasing the volume of services they provide per patient on average. Medicare's relative value units and diagnostic related groups can be aggregated for each provider, as measures of each provider's volume. These can be used as a basis for further price adjustments should the average volume of services provided per patient increase significantly under reform.

The trade-off of using the Medicare payment schedule, however, is that it could complicate the general Medicare rate setting process and the process of establishing these rates (e.g., the recommendations of the Relative Value Scale Update Committee). If a public option or commercial provider price limits were to rely on the Medicare schedule, then any discussion or debate over modifications to Medicare rates (e.g., productivity adjustments, growth rates) would have implications for provider prices more generally. Lobbying around the Medicare schedule would become more complicated and fraught, and these pressures could push Medicare rates higher than they otherwise would be, because a larger share of provider revenues would be at stake, leading providers to lobby harder to keep prices up. However, the savings to government and consumers would be commensurately larger, potentially leading policymakers to pursue them more aggressively; consequently, the ultimate impact of a public option or capped provider prices on Medicare payment rates is uncertain.

Provider Prices Used by Commercial Insurers

These prices vary dramatically across insurers, providers, and even plans offered by the same insurers. A substantial part of the variation in commercial insurers' provider prices likely relates to geographic variation in provider and/or insurer competition. A schedule for a public option or capped prices could be developed using a specified percentile of the distribution of commercial provider prices, say the median, depending on the payment schedule desired. The advantages of relying on a payment schedule based in commercial rates are that the schedule (1) may be more politically palatable to health care providers and (2) would not interfere with negotiations between providers and the federal government over Medicare rates. However, that political appeal may fall appreciably if provider prices are set well below the median of current rates (e.g., at the 35th percentile).

If a schedule based on a low percentile of national commercial rates were chosen, the impact of consolidation and noncompetitive markets that have inflated prices in some areas would be less likely to affect the delineated schedule. For example, if the 20th percentile of the commercial rate distribution for each service were chosen as a benchmark, those rates could be multiplied by a factor greater than 1 to increase payment levels without having the relative prices for different services affected by existing monopolistic behavior. Geographic cost adjustments could be applied after the fact. In addition, the commercial rate approach does not require providers or insurers to change the definition of services they use to be consistent with Medicare definitions; however, commercial insurers' definitions of services likely vary, so some disruptions and system modifications would be required to standardize these definitions regardless.

The first disadvantage of the commercial benchmark is that determining the distribution for every existing medical service would be a significant data-collection undertaking. This information does not currently exist, so collecting it will take considerable time and resources. In addition, market forces, not relative value, determine commercial providers' prices, an important difference from the Medicare schedule, which explicitly accounts for relative value. Consequently, the current variation in commercial prices across the country is tremendous. Any particular point in the pricing distribution may not appear to make sense based on rational criteria, because the pricing distribution is the product of market distortions. Plus, many commercial insurers pay hospitals based on days instead of admissions, which tends to increase spending by private payers. Further, coding across private insurers is seldom comparable, which creates considerable complexity in comparing current prices across these insurers.

Regardless of which benchmark is used, the final payment schedule and annual update approach chosen will determine a reform's effect on the provider market (i.e., savings and access to care). Theoretically, using an upwardly adjusted Medicare schedule as a benchmark (e.g., 120 percent of Medicare rates) could achieve similar savings as using the distribution of commercial prices as a benchmark, depending on which percentile is chosen and whether any additional adjustments are applied. The same is true regarding the annual adjustment chosen. The closer rates remain to current ones, the lower the risk of disruption to the health care system, but the lower, too, are savings from the reform.

Managing a public option or capped prices, including the level and growth of prices, could be entrusted to an active administrator or possibly to a state department of insurance if national variation were permitted. In this way, the administrator could adjust prices (including for geographic variation) as a function of information collected on access to different types of care, provider participation, the quality of care provided, and aggregate spending. Such discretion would create some additional uncertainty about ultimate public and private savings, but the flexibility would provide the administrator with the nimbleness necessary to modify prices and correct for unintended consequences of over- or underpricing particular services. Limits on the flexibility provided to such an administrator would likely be needed, however. Otherwise, providers with market strength could effectively negotiate prices with the public option and drive prices higher than appropriate or desirable. In addition, the capabilities of different departments of insurance vary considerably across states. Thus, if they were to administer a public option or capped prices, they could define important economic parameters differently, which could lead to some positive and some negative outcomes.

Interaction of the Provider Price Schedule and the Size of Markets Included in a Reform

As analysts have shown (Holahan and Simpson 2021), introducing a public option or capped provider prices into nongroup insurance markets alone is unlikely to generate large aggregate savings. This is purely because the number of people buying coverage in those markets is small, an estimated 15 million people in 2022 (Banthin et al. 2020). The employer group market is roughly 10 times as large, an estimated 150 million people in 2022. Consequently, implementing these types of reforms in the employer group market creates more potential for private and public savings and disruption of the health care delivery system. Commercial insurers' payments to providers in many nongroup insurance markets are also likely already significantly lower than those paid in employer-sponsored insurance markets, an additional reason why these types of reforms have greater savings potential in the employer market than the nongroup market (Blumberg et al. 2020). For example, according to Urban Institute estimates, introducing a public option paying providers rates modestly above Medicare's (Medicare plus 10 percent for professionals and Medicare plus 25 percent for hospitals) in nongroup insurance markets alone would reduce health system spending (public and private combined) by \$15 billion in 2022 (Holahan and Simpson 2021). Introducing that same public option into both nongroup and employer markets would reduce health system spending by \$156 billion in 2022, more than a 10-fold difference. Capping provider prices across both markets at the same rates would reduce health system spending by more than double that amount, \$331 billion in 2022.

Lower prices applied to a smaller number of consumers will affect overall provider revenues less, and thus the risk of health care delivery system disruption is rather small. That means that reforms using provider prices well below commercial levels only for public option enrollees in the nongroup market would carry less risk of delivery system disruption than broad caps on provider prices for all insurers in both the employer group and nongroup insurance markets. But the former reform would also achieve smaller aggregate savings than would the latter.⁶ In addition, lower provider prices could

limit the number of providers willing to participate with these plans, especially if the enrollees constitute a small percentage of the providers' expected revenue.

A more limited public option or capped prices targeted solely to nongroup insurance consumers could also phase in lower prices more quickly without significantly disrupting health care delivery (Skopec and Holahan 2021). Conversely, the larger the share of health care consumers affected by lower prices, the longer it will likely take for health care providers to respond with the organizational changes necessary to preserve supply and quality.

One policy option that has been discussed is creating a public option solely to provide coverage for adults with low incomes caught in the Medicaid eligibility gap. In the 12 states that continue to refuse to expand Medicaid eligibility under the Affordable Care Act, more than 3 million uninsured people living in poverty are ineligible for any financial assistance to enroll in insurance coverage, because their incomes are too low to qualify for Marketplace subsidies but too high to be eligible for their states' traditional Medicaid programs (Simpson, Bantlin, and Buettgens 2021). Because the population in the eligibility gap in these states is largely uninsured today, providing them coverage through a federal public option, even one paying Medicare rates, would put additional revenue into the health care delivery system, not less. Consequently, such a narrow program should not risk significantly disrupting health care delivery.

Interaction of Provider Price Schedule and Network Breadth

In recent years, many nongroup insurers have built narrow provider networks to be able to offer price-competitive plan options to consumers (Wengle et al. 2020). Including only health care providers willing to take lower prices in a provider network translates into lower insurance premiums. Creating broader provider networks generally requires paying some providers at higher prices or having some other type of purchasing leverage that attracts more providers to participate.⁷

Consequently, ensuring voluntary participation of a broad network of providers is difficult if a public option pays providers substantially below typical commercial prices. Relying on voluntary provider participation will most likely lead to a trade-off between network breadth and premium savings. Requiring providers participating with the Medicare program (or the Medicaid program) to also participate in the public option may increase provider participation, even at relatively low payment levels. However, this could also risk some providers leaving the Medicare or Medicaid programs instead. In addition, physician participation is difficult to enforce. Thus, one option is to require hospitals to participate, say, as a requirement of participation in the Medicare program, but not requiring the same of physicians. Because all hospitals participate with the Medicare and Medicaid programs and those programs constitute a large share of hospital revenues, hospitals are far less likely to stop participating in those programs, even if public option participation is tied to them. The most challenging network breadth issue is related to physicians in this context. Failing to enforce

consequences for physicians declining to participate with the public option could lead to a significantly narrower provider network than envisioned, however.

Another option for increasing physician participation is prohibiting physicians who decline to participate with the public option from participating in other plans serving that same market.⁸ For example, if a public option were introduced into the nongroup market in a given area, a physician refusing to participate in the public option would be prohibited from participating with the private nongroup insurers offering coverage in that area. If physicians' decisions not to participate with the public option depend on their desires to protect their pricing leverage with private insurers, this approach could significantly increase physician participation. In addition, it would not risk a decrease in Medicare or Medicaid participation. The same approach could be used for hospitals as well.

Capping provider prices for commercial insurers at low levels raises similar concerns about physician participation. However, if providers are reticent to participate with the public option over concerns that doing so could jeopardize their pricing negotiation leverage with private insurers, capping prices for all insurers in a given market minimizes participation concerns. In general, though, the larger the number of insured people in the markets where the caps are implemented, the harder it is for physicians to avoid accepting those prices. For example, capping commercial prices in the nongroup market alone would affect physician revenues less than would capping them in the nongroup and employer group markets, because the employer insurance markets are so much larger. But at the same time, physicians can more easily refuse to participate with nongroup insurers than they can refuse to take patients with employer-based insurance, because the number of enrollees in the former is so much smaller than the number in the latter.

Provider Payment Schedules and the Interaction of a Public Option with Capped Prices for Commercial Insurers

At least theoretically, the reach of a public option is smaller than that of capped provider prices for commercial insurers. The primary effect of a public option would be on the people who choose to enroll in it, though some evidence shows that a public option could alter the dynamics of provider-insurer negotiations and lead to somewhat lower private insurer prices as well, particularly in highly concentrated markets (Blumberg et al. 2019). Capping commercial insurer prices, depending on where the rates are set, could affect all commercial insurance enrollees to some degree, thereby affecting a larger group of people and potentially to a greater extent. Consequently, the prices used for a public option could be set below capped prices for all commercial insurers. Either of these policies could be implemented alone or together, using different price schedules for the two strategies. With such an approach, the public option can provide broadly available insurance options designed by the government and not motivated by profit, whereas the capped prices play the central cost-containment role and somewhat improve equity of payments among providers and markets.

Additional Design Considerations for a Public Option

Though capping provider prices used by commercial insurers has various benefits, as noted earlier, it is primarily designed to lower insurance premiums. This is achieved by either reducing the most extreme prices, by setting capped prices at a higher point in the price distribution, or by reducing prices more broadly, by setting the capped prices at a lower point in the price distribution. Capped provider payments do not, however, provide an insurance product that is not subject to profit motives or other private entities' interests. To address the latter, a government-designed and administered plan, the public option, is needed. Because it would create a new public source of insurance, a public option would require additional design considerations beyond the prices the plan pays to providers.

State Variation in Essential Health Benefit Requirements

Although the 10 categories of essential health benefits defined in the Affordable Care Act must be covered in each state's nongroup and small-group markets, the rules surrounding benefit definitions and the quantity limits on some of these benefits vary (dollar limits on benefits are prohibited, however). Benefits covered by a public option could be made uniform nationally or could vary modestly by state to be consistent with the other qualified health plans sold in each state.

Though a public option offering a uniform set of benefits ensures everyone in the country has access to at least one plan, offering a public option plan (or plans) that differs from the other plans offered in the markets where the public option is sold carries significant risks. Benefit variations can make it more difficult for consumers to compare their options, but more importantly, they can lead to adverse selection either into the public option or private plans. To the extent that either the public option's or private plans' benefits in a state are more or less attractive to higher-risk enrollees, the risk-adjustment system may be unable to completely compensate for the difference. Consequently, if uncorrected adverse selection escalates premiums in the plan(s) selected against, the public option or the private health plans may be unable to compete for consumers in the long term.

Actuarial Value Tier Participation

Likewise, if no private insurers offer a particular actuarial tier of coverage (current law only requires insurers to offer silver and gold levels), introducing a public option in that tier could create selection problems. For example, a significant number of Marketplace rating areas currently lack an insurer offering a platinum (90 percent actuarial value) option, largely because these high-value plans are felt to attract enrollees with higher medical needs. If a platinum public option were introduced in these areas, all else staying the same, it could attract enrollees with higher-than-average health care costs. Given the imperfection of risk adjustment, this outcome could make it hard for the public option to compete with private insurers in the area.⁹

Level Playing Field Issues

The politics of the public option are also extremely challenging. Many consumer advocates' distaste for for-profit commercial insurance leaves them uninterested in designing a system that provides these insurers with the level playing field they feel they need to compete with a public option. In other words, some are happy to let an uneven playing field lead to a fully public system, like Medicare for All. Meanwhile, the private insurers with which a public option would compete are focused on any possible unfair advantages a government insurer would have over them in their markets. And, in truth, a large financial advantage that allows a public option to set its premiums well below those of private insurers could drive at least some current private options out of the markets—for better or for worse, depending on one's perspective. Beyond the core component of provider payments discussed above, at least four categories of expenses can affect the extent to which a public option competes with private insurers on a level playing field: risk adjustment, premium taxes, reserve funds, and start-up and management costs.

Risk adjustment. In nongroup insurance markets, risk adjustment reallocates a portion of insurers' premium revenues to compensate insurers that disproportionately enroll people with higher-than-average health care costs in a year. The objective of this strategy is to allow all insurers to set premiums in a manner that reflects the average risk of the entire pool of people enrolled in nongroup insurance in the state, enabling insurers with higher-cost enrollees to remain attractive and affordable to potential enrollees with various medical needs. Risk adjustment also undermines the incentives for insurers to attempt to enroll healthier people and to dissuade people with greater medical needs from enrolling in their plans.

Consequently, creating a level playing field within an insurance market that includes a public option would require that the public option participate in the risk-adjustment system. It is unclear *a priori* whether a public option would attract disproportionately healthy or sick enrollees, or neither. Therefore, excluding the public option from the system could help or hurt private insurers and similarly increase or decrease actuarially fair premiums associated with the public option based on the risk profile of those enrolled. In turn, this could make it difficult, if not impossible, for either the public option or private insurers to remain viable.

Likewise, including the public option in risk adjustment could result in the government plan making payments to some private insurers or vice versa. The Affordable Care Act's risk adjustment payments are calculated as a function of the differential risk of enrollees and the average premium in a state. As such, if a public option were to lower the average premium in a state, it would also lower the size of risk-adjustment payments between insurers. This could disadvantage some higher-priced private insurance plans should they be selected against, which would benefit plans enrolling healthier people.

Premium taxes. Almost every state and the District of Columbia imposes taxes on insurers' gross premium revenues. The most common tax rate is 2.5 percent, though such rates range as high as 4 percent (Grace, Sjoquist, and Wheeler 2007). Usually, these taxes take the place of corporate income taxes on insurers and are likely passed on to consumers purchasing insurance through higher

premiums.¹⁰ Consequently, private insurers would be at a direct pricing disadvantage if equivalent taxes were not imposed on a public option plan introduced in the state. Leveling the playing field to improve private insurers' abilities to compete would therefore require the public option to pay premium taxes as well.

Reserve funds. Typically, state laws require insurers to maintain reserve funds that ensure the company would be able to pay enrollee claims even if premium revenue for the year fell short of actual claims. States regulate the level of required surpluses, but they typically range from 15 to 25 percent of expected annual claims. Insurers cannot increase premiums in subsequent years to cover costs associated with underestimates in prior years; doing so could run afoul of medical loss ratio requirements, and insurers doing so would be placed at a competitive pricing disadvantage. Though the federal government could obviously use general revenues to cover any public option shortfalls in a given year, doing so would create, at minimum, a perception of an unfair competitive advantage from private insurers' perspectives. Including small premium add-ons to build up reserve funds for a public option may be unnecessary as a practical matter but could enhance private insurers' sense of competitive fairness.

Start-up and ongoing administrative costs. The administrative costs associated with starting a private insurance plan and supporting its ongoing operations are generally recouped by the administrative load added on to expected annual claims when computing premiums. These costs include such necessities as provider network development, data infrastructure development and maintenance, claims payment, and customer service. The instinct with a public option may be to build off the government's existing infrastructure for the Medicare and Medicaid programs in the Centers for Medicare & Medicaid Services, for example. Depending on one's perspective, using existing infrastructure could be considered good savings or an unfair advantage, however. Start-up costs could, for example, be amortized in the premium or absorbed via general revenues along with those for the other existing public insurance programs. Adding something small to the premiums to account for a reasonable level of such costs may be unnecessary but, again, could improve private insurers' perceptions of fairness.

Discussion

Public option advocates do not always share the same objectives for establishing such a program. However, the central design choices necessary to develop a public option are inextricably tied to the intended objectives. The level and growth of payments to providers are critical features of a public option, and these choices have tremendous implications for premium affordability and cost-savings potential, network breadth, and disruption to the health care delivery system. Sufficient political support for a public option will likely require greater agreement on such a program's objectives than is apparent today; some people currently focus on a public option's cost-savings potential, whereas others focus on the availability of a consumer-motivated, instead of profit-motivated, broad-network plan.

As research has indicated (Holahan and Simpson 2021), a public option alone has limited power to contain health care system costs broadly, particularly when only made available in the nongroup insurance market. It would, however, provide new competition in markets dominated by monopolistic providers and/or insurers. It would also be a new tool that could evolve into a valuable consumer-oriented, administratively efficient entity that serves as an alternative coverage option for those dissatisfied with their commercial insurance options.

Capping provider prices paid by commercial insurers is primarily a cost-containment tool that could be implemented with or without a public option. In the presence of a public option, capping commercial prices paid to providers may allow private insurers to lower their premiums and compete more effectively. Setting such caps at a relatively high point in the provider price distribution (e.g., at approximately the 75th or 80th percentile) would primarily reduce the prices of outlier plans, whereas setting the caps at a lower percentile would reduce costs more broadly.

Regardless of the presence of a public option, caps on provider prices would have the greatest effect when applied broadly to insurers in the group and nongroup markets, as opposed to nongroup markets alone. Caps could be set high initially, thereby lowering provider prices and associated premiums only in the highest-priced markets to start. Caps could then be lowered over time in conjunction with a significant data collection and monitoring effort that could be used to prevent provider price adjustments from significantly disrupting the health care delivery system, a particularly important consideration if the caps are implemented across all commercial insurers.

Notes

- ¹ Gaby Galvin, "About 7 in 10 Voters Favor a Public Health Insurance Option. Medicare for All Remains Polarizing," Morning Consult, March 24, 2021, <https://morningconsult.com/2021/03/24/medicare-for-all-public-option-polling/>.
- ² Though monopolistic (or otherwise strongly consolidated) insurers should have substantial leverage to reduce provider prices and thus reduce premiums, many areas with highly concentrated insurance markets also have highly concentrated provider markets. Even when that is not the case, dominant insurers do not face strong incentives to be tough negotiators with providers, and thus they seldom use that leverage to significantly reduce prices. For example, highly concentrated insurance markets are strongly correlated with high premiums in the nongroup market (Holahan, Banthin, and Wengle 2021).
- ³ The greatest savings resulting from lower nongroup Marketplace premiums accrue to people with incomes sufficiently high that they pay for full premiums independently, without federal premium subsidies. However, lower premiums can also generate savings for people eligible for premium subsidies who choose insurance options that are more expensive than the second-lowest silver (benchmark) premium available, since these consumers are liable for the full difference between premiums for the benchmark and the more expensive plan. In addition to government savings resulting from lower nongroup Marketplace benchmark premiums, lower commercial insurance premiums in the employer market can also generate government savings. Economic theory and empirical research suggest lower employer spending on health insurance premiums tends to translate into higher wages. Because wages are taxable as income but health insurance contributions are not, lower premiums in the employer market tend to increase government tax revenue.
- ⁴ Currently, 12 states continue to refuse to expand Medicaid eligibility to all lawfully present residents with incomes up to 138 percent of the federal poverty level (FPL). Because the Affordable Care Act was written assuming Medicaid expansion would be implemented in all states, its drafters only made people with incomes

above the FPL eligible for premium tax credits through the Marketplaces. Consequently, many people with incomes below the FPL are ineligible for any financial assistance obtaining health insurance in 11 of those states, because those states' traditional Medicaid eligibility rules exclude nonparents and are generally very limited for parents. For example, in Alabama, only parents with incomes up to 18 percent of FPL are eligible for Medicaid and nonparents are ineligible regardless of income. In Texas, parents with incomes up to 17 percent of FPL are eligible and all nonparents are ineligible. The one notable exception is Wisconsin, which has not expanded Medicaid eligibility under the Affordable Care Act but extended its traditional Medicaid program to all adults with incomes up to the FPL. In addition to people with incomes below the FPL in these states, others with incomes between 100 and 138 percent of FPL are excluded from Marketplace assistance if someone in their family is eligible for worker-only employer-based insurance deemed affordable to them.

- ⁵ Lower claims denial rates will generally mean higher total amounts of claims paid. Higher spending on claims payments translates into higher premiums.
- ⁶ If a public option or capped provider prices were available only in the nongroup market, these large price differences between the employer and nongroup markets could, at least theoretically, pressure more people to seek nongroup insurance coverage and decrease incentives for some employers to provide insurance. However, evidence shows the provider prices in nongroup insurance markets made competitive by Affordable Care Act reforms are considerably lower than prices in employer markets, yet employer-provided coverage has not decreased. The value of the tax subsidy provided for those with employer-based insurance, benefits tailored to worker preferences, frequently broader provider networks, and ease of enrollment seem to keep workers in their employer-provided policies.
- ⁷ For example, the traditional Medicare program offers enrollees a very broad network of providers, even though it pays providers at rates below those of commercial insurers, because few providers can turn down the large volume of Medicare enrollees and their high average use of medical services.
- ⁸ This approach is discussed in Fiedler (2020) and (2021).
- ⁹ If, however, the premium tax credit benchmark plan were changed to gold (instead of the current silver) under broader reforms, platinum plans could be much more attractive, leading more private insurers to offer them.
- ¹⁰ The precise incidence of premium taxes depends on elasticities of demand and supply, which may differ by market and geography.

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Linda Blumberg is an Institute fellow in the Health Policy Center at the Urban Institute. She is an expert on private health insurance (employer and nongroup), health care financing, and health system reform. Her recent work includes extensive research related to the Affordable Care Act (ACA); in particular, providing technical assistance to states, tracking policy decisionmaking and implementation at the state and federal levels, and interpreting and analyzing the implications of particular policies. Examples of her work include analyses of the implications of congressional proposals to repeal and replace the ACA, delineation of strategies to fix problems associated with the ACA, estimation of the cost and coverage potential of high-risk pools, analysis of the implications of the King v. Burwell case, and several studies of competition in ACA Marketplaces. In addition, Blumberg led the quantitative analysis supporting the development of a "Road Map to Universal Coverage" in Massachusetts, a project with her Urban colleagues that informed that state's comprehensive health reforms in 2006. Blumberg frequently testifies before Congress and is quoted in major media outlets on health reform topics. From 1993 through 1994, she was a health policy adviser to the Clinton administration during its health care reform effort, and she was a 1996 Ian Axford Fellow in Public Policy. Blumberg received her PhD in economics from the University of Michigan.

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