The Impacts of Public Option and Capped Rate Proposals on Households and Employers

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This paper examines the impact of two public option proposals and a capped rate policy on household and employer health care spending. The first policy would introduce a public option in the nongroup market, the second policy would extend the public option to the nongroup and the employer markets, and the third policy would cap payment rates for all insurers. We assume provider payment rates would be set at Medicare rates plus 10 percent for health professionals and plus 25 percent for hospitals. We show the policies' effects on households and employers overall and their effects on only the employers participating in and individuals affected by the policies.

We find overall savings to households would be small under a public option limited to the nongroup market. Under a public option in the nongroup and employer markets, however, households overall would save about 10 percent on health spending, and they would save about 20 percent under a capped rate policy in both the nongroup and employer markets. Employers would spend about 11 percent less on health insurance under a public option extended to the employer market; a capped rate policy would reduce overall employer health spending further, by about 25 percent.

Focusing only on households affected by the reforms and employers participating in the reforms, people with incomes below 400 percent of the federal poverty level (FPL) would save 4 to 5 percent under a public option in the nongroup market. This income group largely already benefits from limits on premiums set at a specified percentage of income. In contrast, people in affected households with incomes above 400 percent of FPL would save about 9 percent under a public option in the nongroup market. Under a public option extended to the employer market as well, however, affected individuals would save about 19 percent on health care spending, and those with incomes below 200 percent of

FPL would have slightly lower savings. Affected individuals would save about 21 percent under a capped rate policy. A public option introduced into the nongroup market only would not lower health spending for employers, but a public option or capped rate policy in the employer market would reduce participating employers' spending on premiums by about 25 percent per insured person.

Introduction

In March 2021, we published aggregate results of the effects of several public option and capped rate proposals on premiums in both the nongroup and employer markets, the number of people uninsured, employers' and households' spending, the federal government deficit, and national health expenditures (Holahan and Simpson 2021). In this paper, we provide detailed estimates of the effects on households and employers of three of those public option and capped rate proposals:

- **Public option 1.** This reform would introduce a public option solely in the nongroup market.
- **Public option 2.** This reform would extend the public option to include both the nongroup market and employers that choose to participate.
- **Capped rates.** This reform would cap provider payment rates paid by all insurers for all enrollees in both the nongroup and employer markets.

A public option is a government-sponsored health insurance plan that would pay providers (doctors, hospitals, and prescription drug manufacturers) according to a payment schedule. The federal government would ultimately bear the risk associated with the plan. A public option could be available in the nongroup or employer markets or both. Payment rates would generally be lower than those typical of commercial insurers, because the federal government could use its negotiating power to lower health spending.

The public option would likely become the lowest-priced or second-lowest-priced silver plan, or the benchmark plan, in many rating regions, particularly if it pays providers Medicare-like rates. However, a public option may not become the benchmark plan if provider payment rates are set well above Medicare levels. If the public option becomes the lowest- or second-lowest-priced option, the benchmark premium will drop, thereby reducing the costs of federal premium subsidies for many households.

An alternative to a public option is capping provider payment rates paid by all private insurers nationwide or in particular markets. This would limit the payment rates all insurers could pay health care providers in the applicable markets. Unlike a public option, capped rates would not require establishing a new insurance option; instead, payment rates would be capped below the rates typical of private insurers today. Capped rates could apply to insurers in the nongroup or employer markets or both. An advantage of capped provider payment rates over a public option is that consumers could obtain the full benefit of lower provider payment rates without having to change their insurer. Capped rates might also result in more private insurers entering or staying in markets; in contrast, the public

option could discourage insurers from participating. By regulating payment rates, insurers do not need large numbers of enrollees to successfully negotiate with providers.[1]

Payment rates can be set at various levels, and many reform proposals set them at Medicare rates or multiples thereof. In our past work, we looked at alternatives ranging from Medicare rates to rates well above Medicare's. In this paper, we assume health professionals (including physicians and other health professionals) will be paid at Medicare rates plus 10 percent and hospitals will be paid at Medicare rates plus 25 percent. We also assume the prices of prescription drugs will be set halfway between Medicare and Medicaid prices, which represents about a 30 percent cut from current prices.

When we extend the public option to employer insurance markets, we must make assumptions about whether an employer would choose to enroll their workers into the new plan. Consistent with our earlier work (Blumberg et al. 2020), we assume a firm's decision to choose the public option varies by its wages and firm size; the lower the average wage and the smaller the firm, the more likely a firm will switch from its current insurance to the public option. Large and high-wage firms would be more likely to remain with their current coverage because they can vary benefit packages, cost sharing, and out-of-pocket limits; such firms would view paying higher provider payment rates as worthwhile, because that allows them to structure 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 to the public option sufficiently attractive. These issues do not appear in the capped rates analyses because the lower payment rates apply to all employers.

Prior Results

The key results in the prior paper are summarized in table 1 (Holahan and Simpson 2021).[2] Under public option 1, which applies only in the nongroup market, premiums would fall by 19 percent. We estimate that 109,000 people would gain coverage compared with a pre–American Rescue Plan Act (ARPA) policy baseline. Coverage impacts would be small because most nongroup enrollees' premiums are already limited to a percentage of their income. Most savings from the public option would be reflected in lower federal subsidy payments; the federal deficit would fall by $10 billion because of the lower cost of Marketplace subsidies resulting from lower premiums. The effect on employer spending would be negligible. Household spending would fall by $5 billion, or about 1 percent. Overall health spending would fall by $15 billion, or 1 percent.

TABLE 1

Characteristics of Public Option and Capped Provider Payment Rate Reform Options and Changes from Pre-ARPA Law, 2022

			Change from Pre-ARPA Law						
Reform	**Availability of reform**	**Payment policy[a]**	**In median nongroup premiums**	**In median employer premiums[b]**	**In number of uninsured**	**In federal deficit[c]**	**In employer health spending**	**In household health spending**	**In health system spending**
Public option 1	Nongroup in concentrated hospital or insurer markets	Medicare plus 10% for professionals and plus 25% for hospitals	-19%	n/a	-109,000	-$10B	*	-$5B (-1%)	-$15B (-1%)
Public option 2	Nongroup and employer markets, concentrated hospital markets; subset of firms choose public option	Medicare plus 10% for professionals and plus 25% for hospitals	-20%	-25%	-1,117,000	-$28B	-$86B (-11%)	-$58B (-10%)	-$156B (-7%)
Capped rates	Nongroup and employer markets, concentrated hospital markets; all employers pay lower rates	Medicare plus 10% for professionals and plus 25% for hospitals	-20%	-25%	-1,117,000	-$53B	-$202B (-25%)	-$118B (-20%)	-$331B (-16%)

Sources: Health Insurance Policy Simulation Model, 2021, and John Holahan and Michael Simpson, "Introducing a Public Option or Capped Provider Payment Rates into Private Insurance Markets: Updated Estimates" (Washington, DC: Urban Institute, 2021).

Notes: ARPA = American Rescue Plan Act. B = billion. n/a = 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.

[a] Prescription drug prices under each reform are assumed to be halfway between Medicare and Medicaid prices in all markets.

[b] This column shows the change in median premiums among (1) employers providing the public option to their workers under public option 2 and (2) all employers in all markets under capped rates. Public option 1 is not available in the employer market.

[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.

The impact of public option 2, a public option in both the nongroup and employer markets, would be significantly greater than the impact of public option 1 because of the large size of the employer market. Premiums would fall by 20 percent in the nongroup market and by 25 percent in the employer market. The number of people uninsured would decline by 1.1 million. Again, coverage effects would be relatively small given the large size of the employer market; most firms already offer insurance to their workers and take-up rates are high, leaving little room for increases in coverage. The federal deficit would fall by $28 billion; this is a combination of the lower costs of subsidies and new tax revenues from lower employer spending resulting in higher taxable wages. We estimate that employer spending on health insurance would fall by $86 billion, or 11 percent. However, employers would not save on the total compensation they pay their workers. A substantial body of economic research indicates reductions in employers' spending on health care are eventually passed back to their workers via higher wages (Gruber 2000); we assume all savings on premiums go to worker wages. Household health spending would fall by $58 billion, or 10 percent. National health spending would fall by $156 billion, or 7 percent.

Capping provider rates at the same levels for all enrollees in both the nongroup and employer markets would have an even greater impact. Again, the decrease in premiums would be 20 percent in the nongroup market and 25 percent in the employer market. But because all people who purchase insurance would benefit from the lower payment rates, the policy's reach is more extensive. Again, 1.1 million fewer people would be uninsured. The federal deficit would fall by $53 billion, again because of lower Marketplace subsidies and increased tax revenues due to higher wages resulting from employers' reduced spending on health. Employer spending on health insurance would fall by $202 billion, or 25 percent. Household health spending would fall by $118 billion, or 20 percent. National health spending would fall by $331 billion, or 16 percent. These estimated savings would be greater if provider payment rates were set at Medicare levels and lower if they were set at higher rates than those used here (Medicare plus 10 percent for professionals and plus 25 percent for hospitals).

In the next section, we examine the three policy options' impacts on employer and household health care spending in greater detail. We estimate the impact on household spending by income group, baseline insurance status (employer-sponsored or nongroup), and type of spending (premiums for employer or nongroup coverage and out-of-pocket spending). We then estimate the impacts on employers' spending on insurance premiums by firm size and average wage. In a later section, we examine these results among only the employers participating in and individuals affected by the reforms.

Aggregate Health Spending Impacts among All Households and Employers

In this section, we provide data on aggregate health spending for households and employers. We include all households and employers, regardless of whether they are affected by the policy.

Household Spending Impacts by Selected Subgroups

Table 2 shows changes in aggregate health spending for households by income, coverage type, and spending type.[3] Under a public option only in the nongroup market (public option 1), households' health spending for the nonelderly would fall by about 1 percent relative to the pre-ARPA baseline. More than half of the spending reductions would go to families with incomes above 400 percent of FPL, because premiums for families with nongroup coverage and incomes below 400 percent of FPL are generally already limited to a percentage of income under the Affordable Care Act; most of the savings on spending among people with subsidized coverage would accrue to the federal government. Families with incomes above 400 percent of FPL, who pay the full premium, would see larger savings, but they make up a small fraction of the nongroup market. Overall savings to households would be small for this reason and because of the small size of the nongroup market overall.

TABLE 2

Spending on Health Care for the Nonelderly Population by Households under Pre-ARPA Law and Public Option and Capped Rate Reforms, 2022

	Pre-ARPA law	Public option 1	Public option 2	Capped rates
Under pre-ARPA law and reforms ($millions)				
All households	*587,856*	*582,780*	*529,653*	*470,327*
By household income				
Below 200% of FPL	90,133	89,165	81,785	73,857
200–400% of FPL	184,878	183,724	165,277	146,786
Above 400% of FPL	312,846	309,891	282,591	249,684
By coverage type				
Employer-sponsored	483,311	483,202	433,708	374,382
Nongroup	73,688	68,912	66,572	66,572
Uninsured (no MEC)	30,857	30,665	29,374	29,374
By spending type				
ESI premiums	255,319	255,278	227,735	191,502
Nongroup premiums	41,418	38,686	37,266	37,266
Other	291,119	288,816	264,652	241,558
Change from pre-ARPA law ($millions)				
All households		*-5,077*	*-58,203*	*-117,529*
By household income				
Below 200% of FPL		-968	-8,348	-16,276
200–400% of FPL		-1,154	-19,601	-38,092
Above 400% of FPL		-2,954	-30,254	-63,161
By coverage type				

	Pre-ARPA law	Public option 1	Public option 2	Capped rates
Employer-sponsored		-109	-49,603	-108,929
Nongroup		-4,776	-7,117	-7,117
Uninsured (no MEC)		-191	-1,483	-1,483
By spending type				
ESI premiums		-41	-27,584	-63,817
Nongroup premiums		-2,732	-4,152	-4,152
Other		-2,303	-26,467	-49,561
Percent change from pre-ARPA law				
All households		*-1*	*-10*	*-20*
By household income				
Below 200% of FPL		-1	-9	-18
200–400% of FPL		-1	-11	-21
Above 400% of FPL		-1	-10	-20
By coverage type				
Employer-sponsored		*	-10	-23
Nongroup		-6	-10	-10
Uninsured (no MEC)		-1	-5	-5
By spending type				
ESI premiums		*	-11	-25
Nongroup premiums		-7	-10	-10
Other		-1	-9	-17

Source: Health Insurance Policy Simulation Model, 2021.

Notes: FPL = federal poverty level. MEC = minimum essential coverage. ESI = employer-sponsored insurance. Other household spending includes premiums for people with Affordable Care Act–noncompliant nongroup coverage (short-term limited-duration policies). Reforms simulated as fully phased in and in equilibrium in 2022. In all reforms, provider payment rates are set at Medicare rates plus 10 percent for professionals and plus 25 percent for hospitals, and prescription drug prices are assumed to be halfway between Medicare and Medicaid prices in all markets.

* = less than +/- 0.5 percent.

Under a public option only in the nongroup market (public option 1), almost all of the savings to households ($4.8 billion) would go to those who had nongroup coverage before the reform. These people would save 6 percent on health care spending, because they benefit from the lower premiums and lower out-of-pocket costs resulting from lower provider payment rates. But these effects overall are small because nongroup coverage is a small fraction of total coverage.

Extending the public option to the employer market as well (public option 2) would increase household savings considerably, to about 10 percent of baseline spending. The percent savings would vary little across income groups. Once again, more than half of the savings would accrue to those with incomes above 400 percent of FPL; people in this income range make up half of those with employer or nongroup insurance, and they are more likely to have employer-sponsored insurance (ESI) than those with lower incomes. Each income group would benefit from lower premiums in firms choosing the public option. Out-of-pocket costs would also be lower because of lower provider payment rates.

Under public option 2, most savings would go to those with ESI ($49.6 billion), mainly because the employer market is a far larger market to begin with. The reduction in spending on those who had nongroup coverage would be slightly larger ($7.1 billion) than under a public option in the nongroup

market alone, because some people would drop nongroup coverage because of the increased affordability of ESI. The small reduction in the number of people uninsured would translate into savings among the previously uninsured ($1.5 billion). The largest savings would be in ESI premiums ($27.6 billion). Nongroup premiums would also fall ($4.2 billion), but the dollar savings would be smaller, largely because the nongroup market is smaller. Other household spending on health (i.e., out-of-pocket spending) would decline substantially ($26.5 billion).

A capped rate policy in both the nongroup and employer markets would result in substantially greater savings to households than those resulting from public options 1 and 2. This would occur because all employers providing insurance would participate. Under public option 2, firms would have to choose whether to participate in the public option; as noted, this is assumed to vary with firm size, average wages, and the potential savings available from choosing the public option. This is not the case with a capped rate policy; all firms would benefit from lower provider payment rates. Household savings would approach 20 percent, and this would not vary substantially by income.

Those who had ESI before the reform would see the largest spending reductions under capped rates, about 23 percent relative to baseline spending. Savings to those who had nongroup coverage before the reform would remain the same as under option 2, about 10 percent relative to the baseline. Overall, previously uninsured people would save about 5 percent relative to the baseline after gaining coverage. By type of spending, the largest savings would be in ESI premiums, which would fall by an average of 25 percent. Nongroup premiums would fall by 10 percent, and other household spending would fall by 17 percent.

Employer Spending by Firm Characteristics

The top panel of table 3 shows large firms spend more than small and medium firms combined under pre-ARPA law. Firms with average wages between the 25th and 75th percentiles account for more than half of employers' spending on health insurance.

A public option in the nongroup market alone would have trivial effects on employers. A public option in both the nongroup and employer markets would result in reduced employer spending on premiums. The largest reductions in spending would go to large firms, because, as noted above, these firms account for more than half of employer spending. Similarly, more than half of the reductions in spending would go to firms with average wages between the 25th and 75th percentiles.

TABLE 3

Spending on Health Insurance for the Nonelderly Population by Employers under Pre-ARPA Law and Public Option and Capped Rate Reforms, 2022

	Pre-ARPA law	Public option 1	Public option 2	Capped rates
Under pre-ARPA law and reforms ($millions)				
All employers	*800,116*	*799,996*	*714,200*	*598,424*
By firm size				
Small	184,030	183,993	167,296	138,839
Medium	138,477	138,450	121,938	103,842
Large	477,608	477,553	424,966	355,743
By firm's average wage				
Lowest 25 percent	213,856	213,785	184,225	158,694
25th–50th percentiles	423,877	423,846	378,570	316,955
Highest 25 percent	162,383	162,364	151,405	122,775
Change from pre-ARPA law ($millions)				
All employers		*-120*	*-85,916*	*-201,692*
By firm size				
Small		-37	-16,735	-45,191
Medium		-28	-16,539	-34,636
Large		-55	-52,642	-121,865
By firm's average wage				
Lowest 25 percent		-71	-29,631	-55,162
25th–50th percentile		-31	-45,307	-106,922
Highest 25 percent		-18	-10,978	-39,608
Percent change from pre-ARPA law				
All employers		*	*-11*	*-25*
By firm size				
Small		*	-9	-25
Medium		*	-12	-25
Large		*	-11	-26
By firm's average wage				
Lowest 25 percent		*	-14	-26
25th–50th percentiles		*	-11	-25
Highest 25 percent		*	-7	-24

Source: Health Insurance Policy Simulation Model, 2021.

Notes: ARPA = American Rescue Plan Act. FPL = federal poverty level. Reforms simulated as fully phased in and in equilibrium in 2022. In all reforms, provider payment rates are set at Medicare rates plus 10 percent for professionals and plus 25 percent for hospitals, and prescription drug prices are assumed to be halfway between Medicare and Medicaid prices in all markets.

* = less than +/- 0.5 percent.

In percentage terms, spending reductions under public option 2 would vary little by firm size; for all firm sizes, savings would be between 9 and 12 percent relative to baseline spending. These savings are similar because of two offsetting factors. We assume small firms would be more likely to choose the public option and see savings. Larger firms would be less likely to choose the public option, largely because administrative costs are lower for large firms and they are more likely to self-insure. On the other hand, our assumption that firms will need to see savings of at least 20 percent to move to a public

option favors large firms' participation in the public option. Small firms generally have employees in one region; if that region does not achieve sufficient savings from the public option, firms in that region will not participate with the public option. Large firms usually have employees in multiple regions, and lower costs in regions with significant savings mean most large firms would reach the assumed savings threshold to attract their participation in the public option.

As noted, public option participation differs by firms' average wages. In our modelling, we assume firms with low average wages would be more likely to participate in the public option than high-wage firms. This reflects high-wage firms being less concerned with costs and more willing to tailor health insurance to employees' preferences. Because of their greater participation in the public option, we estimate firms with the lowest average wages would experience savings of 14 percent from public option participation, whereas the highest-wage firms would save 7 percent. The 20 percent savings threshold affects firms at all wage levels, and thus differences in average wages dominate employers' decisions about whether to participate in the public option.

Employers would see much larger savings under capped rates, because all employers would benefit from the lower provider payment rates. The bulk of the savings would go to large firms because of their high baseline spending. Medium-wage firms would also receive more than half of the savings. In percentage terms, employers' savings would vary little by firm size or average wage; across firm sizes and average wages, savings would be about 25 percent. The reduction in employer spending on health insurance should result in increases in employee wages and salaries. Because employee wages are taxable, whereas health insurance premiums generally are not, this change is reflected in the changes to the federal deficit in table 1.

Per Capita Savings to Employers Participating in and Households Affected by Reforms

Whereas the previous section discussed aggregate spending for all households and employers, regardless of whether they are affected by the policy, this section examines effects on per capita spending among employers participating in and individuals affected by the introduction of a public option or capped rate policy. This includes everyone with nongroup coverage under each policy. People with ESI would be affected under public option 2 if the employer through whom they receive insurance were to choose the public option. All people with ESI would be affected under capped rates.

Savings to Affected Households

Table 4 shows that under public option 1, people with incomes below 200 percent of FPL would save $125 per capita, or 5 percent. People with incomes between 200 and 400 percent of FPL would save $237 per capita, or 4 percent, whereas those with incomes above 400 percent of FPL would save $794 per capita, or 9 percent. Those in the first two income categories would save less because they already benefit from the percentage-of-income caps on premium contributions; that is, they are not typically

affected by a premium reduction. Those with incomes above 400 percent of FPL would save more, both in dollar and percentage terms, because they do not benefit from the cap on premiums under pre-ARPA policy. Nongroup market enrollees would see savings of $324 per capita, or 7 percent, reflecting savings of 7 percent on both nongroup premiums and other household spending.

TABLE 4

Per Capita Spending on Health for the Nonelderly Population by Households Affected by Public Option and Capped Rate Reforms, 2022

	People Affected by Public Option 1		People Affected by Public Option 2		People Affected by Capped Rates	
	Before reform	Under reform	Before reform	Under reform	Before reform	Under reform
All households ($)	**4,905**	**4,581**	**3,234**	**2,629**	**3,362**	**2,667**
By household income						
Below 200% of FPL	2,492	2,367	2,605	2,170	2,720	2,170
200–400% of FPL	5,290	5,052	3,142	2,555	3,202	2,530
Above 400% of FPL	8,806	8,013	3,543	2,860	3,689	2,929
By coverage type						
Employer-sponsored	n/a	n/a	2,909	2,254	3,214	2,485
Nongroup	4,905	4,581	4,887	4,540	4,887	4,540
By spending type						
ESI premiums	n/a	n/a	1,435	1,078	1,691	1,271
Nongroup premiums	2,755	2,572	2,745	2,541	2,745	2,541
Other	2,150	2,009	1,584	1,311	1,578	1,284

	Change Due to Public Option 1		Change Due to Public Option 2		Change Due to Capped Rates	
	$	%	$	%	$	%
All households	**-324**	**-7**	**-605**	**-19**	**-695**	**-21**
By household income						
Below 200% of FPL	-125	-5	-435	-17	-550	-20
200–400% of FPL	-237	-4	-587	-19	-672	-21
Above 400% of FPL	-794	-9	-683	-19	-760	-21
By coverage type						
Employer-sponsored	n/a	n/a	-655	-23	-729	-23
Nongroup	-324	-7	-347	-7	-347	-7
By spending type						
ESI premiums	n/a	n/a	-357	-25	-419	-25
Nongroup premiums	-183	-7	-204	-7	-204	-7
Other	-141	-7	-273	-17	-295	-19

Source: Health Insurance Policy Simulation Model, 2021.

Notes: ARPA = American Rescue Plan Act. FPL = federal poverty level. n/a = not applicable. ESI = employer-sponsored insurance. Reforms simulated as fully phased in and in equilibrium in 2022. In all reforms, provider payment rates are set at Medicare rates plus 10 percent for professionals and plus 25 percent for hospitals, and prescription drug prices are assumed to be halfway between Medicare and Medicaid prices in all markets.

Under public option 2, savings would be substantially greater. People with incomes below 200 percent of FPL would save $435 per capita, or 17 percent. People with incomes between 200 and 400

percent of FPL would save $587 per capita, or 19 percent, and people with incomes above 400 percent of FPL would save $683 per capita, or 19 percent. Because the public option would reduce premiums for many firms, employees would benefit from lower premium contributions and lower cost sharing. Those with ESI would save $655 per capita, or 23 percent, and those with nongroup coverage would save $347 per capita, or 7 percent. Spending on ESI premium contributions would fall by 25 percent, spending on nongroup premiums would fall by 7 percent, and other household spending would fall by 17 percent.

Under capped rates, household savings would be even higher than under public options 1 and 2. People with incomes below 200 percent of FPL would save $550 per capita, or 20 percent. Those with incomes between 200 and 400 percent of FPL would save $672 per capita, or 21 percent, and those with incomes above 400 percent of FPL would save $760 per capita, or 21 percent. Those with ESI would save 23 percent, whereas those with nongroup coverage would save 7 percent. Spending on ESI premiums would fall by 25 percent, spending on nongroup premiums would fall by 7 percent, and other household spending would fall by 19 percent.

Premium Savings for Participating Employers

Employers would not see noticeable savings if the public option were to apply only in the nongroup market. However, introducing a public option into the employer market as well (public option 2) would result in substantial savings to employers. Because of the availability of a public option, small firms would see reductions of $1,204 per insured person (workers plus dependents), or 24 percent, medium firms would save $1,244 per insured person, or 25 percent, and large firms would save $977 per insured person, or 25 percent. Examining employers' savings by average wage shows employers in the lowest quartile of average wages would spend $880 less per insured person, or 25 percent. Employers in the middle two quartiles would spend $1,232 less per insured person, or 24 percent, and those in the highest quartile would save $1,098 per insured person, or 23 percent.

Under capped rates, employer savings would be somewhat higher than under public options 1 and 2. Small firms would spend $1,276 less per insured person, or 24 percent, medium firms would spend $1,326 less per insured person, or 24 percent, and large firms would spend $1,285 less per insured person, or 25 percent. Across the average-wage groups examined here, firms would receive savings of about 24 to 25 percent. Again, as noted, we expect reductions in employer spending would result in higher worker wages and thus higher household incomes. However, we do not measure this beyond the effect on the deficit (table 1). Percent savings would be similar across public option 2 and capped rates because only firms participating in the reform (all firms under capped rates) are represented.

TABLE 5

Per Beneficiary Spending on Health for the Nonelderly Population by Employers Participating in Public Option 2 and All Employers under Capped Rates

	Spending on People with Insurance from an Employer Participating in Public Option 2		Spending on People with Insurance from an Employer under Capped Rates	
	Before reform	Under reform	Before reform	Under reform
All employers ($)	**4,339**	**3,276**	**5,262**	**3,972**
By firm size				
Small	5,067	3,863	5,236	3,960
Medium	5,069	3,825	5,447	4,121
Large	3,944	2,967	5,221	3,936
By average wage in firm				
Lowest 25 percent	3,468	2,589	4,278	3,199
25th–50th percentiles	5,091	3,859	5,804	4,387
Highest 25 percent	4,677	3,578	5,598	4,263

	Change Due to Public Option 2		Change Due to Capped Rates	
	$	%	$	%
All employers	**-1,063**	**-25**	**-1,290**	**-25**
By firm size				
Small	-1,204	-24	-1,276	-24
Medium	-1,244	-25	-1,326	-24
Large	-977	-25	-1,285	-25
By average wage in firm				
Lowest 25 percent	-880	-25	-1,078	-25
25th–50th percentiles	-1,232	-24	-1,417	-24
Highest 25 percent	-1,098	-23	-1,335	-24

Source: Health Insurance Policy Simulation Model, 2021.

Notes: Reforms simulated as fully phased in and in equilibrium in 2022. In all reforms, provider payment rates are set at Medicare rates plus 10 percent for professionals and plus 25 percent for hospitals, and prescription drug prices are assumed to be halfway between Medicare and Medicaid prices in all markets.

Discussion

In recent years, interest in developing and implementing a public option in the nongroup and employer markets has grown. Another alternative of interest is to cap all provider payment rates paid by insurers in both markets. The latter would extend limits on provider payment rates to all insurers, and a larger number of enrollers would benefit than under a public option. In previous work (Holahan and Simpson 2021), we focused on the impact of these policies on insurer premiums, federal spending and new tax revenues, and national health expenditures. In this paper, we show that households and employers would also benefit significantly.

In this paper, we analyze a public option in the nongroup market, a public option in both the nongroup and employer markets, and a policy that caps payment rates paid by all insurers; each policy sets payment rates at Medicare plus 10 percent for professionals and plus 25 percent for hospitals. We show that a policy limited to the nongroup market would have relatively small effects. Aggregate

savings to households would be about 1 percent of baseline spending. People affected by the policy would save more: about 4 to 5 percent per capita for those with incomes below 400 percent of FPL and about 9 percent per capita for those with incomes at or above 400 percent of FPL. The difference is that people with incomes below 400 percent of FPL already benefit from percentage-of-income caps on premium contributions. Thus, people with lower incomes already have some protection against high premiums, and they would benefit less if the benchmark premium were reduced by the introduction of a public option. Employers would also not be affected if the public option were limited to the nongroup market.

If the public option were extended to the employer market as well, overall household savings would be about 10 percent. Affected households would save 19 percent per person, and such savings would be slightly lower for people with lower incomes. Employer spending on insurance premiums would fall by about 11 percent if the public option were introduced into the employer and nongroup markets. Though we did not find differences in savings by firm size, we do find savings would be greater for low-wage firms than high-wage firms. Reductions in premium costs among employers participating in the reform would be about 25 percent per insured person.

Under capped rates, overall household savings would be about 20 percent. Savings among those affected by the reform would be about the same. Employers would spend 25 percent less on premiums in aggregate and per capita under either a public option in the employer market or a capped rate policy.

In summary, this study shows that a public option or capped rate policy can generate substantial savings not only for the federal government but for households and employers, particularly if the policy is extended to the employer market. Savings to households and employers would be greater under a policy that employs Medicare rates, but health care system disruption and political opposition would be greater. If higher payment rates were employed, the policy may be more acceptable to providers but savings would be smaller.

Notes

[1] More information on issues involved in capped rate and public option policies is available in Blumberg (2021).

[2] In this and the previous work, the baseline and reforms are based on pre-ARPA law. "Baseline" therefore refers to pre-ARPA policy, and the public option and capped rate reforms are based on pre-ARPA law with specified provider payment rate cuts. Under current law, subsidies will return to the pre-ARPA policy after 2022.

[3] All spending shown is for acute health care for the nonelderly population (ages 65 and younger).

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

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

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