ELLIS HEALTH POLICY

MEMORANDUM

TO: Interested Parties

FROM: Philip Ellis, Ph.D.

DATE: April 12, 2021

SUBJECT: **Effects of a "Public Option" on Provider Revenues: A State-by-State Analysis**

Proposals to establish a "public option" were a feature of President Biden's campaign and are expected to figure prominently in the forthcoming debate about healthcare reform. But much uncertainty surrounds how a public option would actually work, particularly as regards the payment rates for providers that it would establish. Tradeoffs will arise between the costs of such proposals and the resulting reductions in revenues for doctors and hospitals. Those tradeoffs arise because commercial payment rates are generally much higher than the Medicare rates to which many proposals would tie the public option's payment rates.

Perhaps more importantly, those effects would vary widely by state, largely because states are now in very different places with respect to the ratio of Medicare payments to commercial rates. I examined several scenarios but focused on one in which the public option is available not just in the individual insurance market but also to employer plans – and eventually captures 50 percent of the commercial market – and pays Medicare rates plus 10 percent to doctors and Medicare rates plus 30 percent to hospitals.

In that scenario, provider revenues would fall by about $184 billion (using 2021 revenue estimates for ease of exposition), or by about 9 percent, nationwide. But in several key states, the effects would be larger: 9.6 percent in Georgia, 9.9 percent in West Virginia, 12.0 percent in Montana, and 15.8 percent in Wisconsin. Of course, effects would be smaller than average in many other states, including: 7.7 percent in Nevada, 7.0 percent in Arizona, and 4.5 percent in Michigan. These figures represent a reduction in revenues that is roughly twice as large on the roughly one half of providers' revenues that now come (on average) from private payments.

These estimates are obviously illustrative and much depends on the specifications of the proposal. But frankly, the debate about a public option should be informed by facts and not based on vague assertions about savings and efficiencies. In my own view, if high commercial prices for healthcare are the problem, then a more effective approach would be to regulate those prices directly – rather than going the circuitous route of regulating prices via a public option. The remainder of this memo explains the basis for my findings.

The Context

Let me stipulate that prices in the U.S. healthcare system are generally the highest in the world – not only for brand-name drugs but also for hospital services and specialty care from physicians. Despite of insurers' efforts to negotiate lower prices and manage the quantity and intensity of services provided, the levels of medical prices and spending and their growth rates have been too high for too long – such that the average *annual* premium of an employer-sponsored family policy is now over $21,000 or roughly the cost of a basic Honda Accord. While prices are generally lower in Medicare and Medicaid, commercial insurance covers about 170 million people or roughly half of the country and its payments account for about half of all revenues for providers. Policymakers understandably seek solutions for these problems.

Into the breach come proposals for a "public option." Proponents argue that adding such a government-run health plan into the individual market – and perhaps the employer market as well – will help reduce healthcare costs and provide families and businesses with a more affordable and stable way to obtain insurance. Proponents also seem to assume that the public option's payment rates for doctors and hospitals will be close to Medicare's rates, and that providers will accept those rates. Whether and how that would happen is not obvious, but one thing is clear to me: **a public option would substantially reduce healthcare prices, costs, and premiums only if it also reduced providers' revenues substantially**.[1]

To show the financial effects of a public option's payment rates to doctors and hospitals, relative to Medicare's rates, I examined several scenarios. I relied primarily on a recent study in Health Affairs by Michael Chernew and colleagues showing that Medicare's payment rates to hospitals are, on average, about 49 percent of commercial insurance rates and that Medicare's rates for doctors are about 63 percent of commercial rates, on average. Because Medicare's rates are relatively low, I also examined two options in which a public option would pay higher-than-Medicare rates. I combined those three payment levels with three different scenarios for the public option's share of the commercial market: 10 percent (about the share currently covered by individually purchased policies); 50 percent, an estimate from the Urban Institute of what would happen if employers were allowed to buy into the public option; and 100 percent, which is an implausible outcome but is included for illustrative purposes.

My Findings

The results of my analysis at a national level are shown in Table 1. Clearly, if the public option was available only in the individual market, then the effects on providers' revenues may be limited. But because of its lower payment rates, premiums for the public option would be substantially lower than commercial premiums – which would create strong incentives for

[1] Of course, there are other reasons for introducing a public option, particularly in the individual insurance market – for example, to increase choice and competition in that market, which is limited in many parts of the country.

employers and employees to gain access to it by any means necessary. And some proposals, including the Biden plan, would explicitly open the employer market to the public option. If the public option gained a 50 percent share of the commercial market, and paid 10 percent above Medicare to doctors and 30 percent above Medicare to hospitals, I estimate that the aggregate reduction in those providers' revenues would be about $184 billion (expressed in 2021 dollars) or 9 percent – reflecting a reduction in revenues of about 18 percent for half of their business.[2]

Table 1. Estimated Reductions in Providers' Revenues under Different Public Option Scenarios
(in $ Billions and Percentage Terms for 2021)

	PUBLIC OPTION COMMERCIAL MARKET SHARE		
PUBLIC OPTION PAYMENT RATES	10 Percent	50 Percent	100 Percent
Medicare Rates for Doctors & Hospitals	**$48.1** *2.4%*	**$240.3** *11.8%*	**$480.6** *23.7%*
Medicare + 10% for Doctors & Medicare + 30% for Hospitals	**$36.7** *1.8%*	**$183.6** *9.0%*	**$367.3** *18.1%*
Medicare + 20% for Doctors & Medicare + 60% for Hospitals	**$25.8** *1.3%*	**$129.1** *6.4%*	**$258.3** *12.7%*

Results at the state level are shown in Figure 1 for the scenario of a public option with 50 percent market share paying rates that are 10 percent above Medicare for doctors and 30 percent above Medicare for hospitals.[3] Not surprisingly, the effects of a public option would be smallest in Maryland, given its unique all-payer system. Other states lie along the continuum, as noted above. Table 2 shows the dollar figures involved (using 2021 levels for illustration); as would be expected, the effects are larger in states with larger populations.

[2] In my analysis, I did not account for changes in the volume or intensity of services provided. Views differ about whether medical providers respond to price cuts by reducing quantity (as textbook economics would indicate) or by increasing quantity to reduce the effects on their revenues (with a backward-bending labor supply curve). Note that changes in service volume would change providers' total costs as well as their revenues.

[3] For these state-level calculations, I used data from several sources and projected the figures forward to 2021: estimates from the Centers for Medicare & Medicaid Services (CMS) on healthcare spending at the state level (link); data from the American Hospital Directory on hospital revenues by state (link); and data from the Health Care Cost Institute (HCCI) on the split between inpatient and outpatient revenues by state (link).

Figure 1. Total Decrease in Providers' Revenue (%) by State

Public Option with 50% Market Share Paying Medicare +10% / +30%

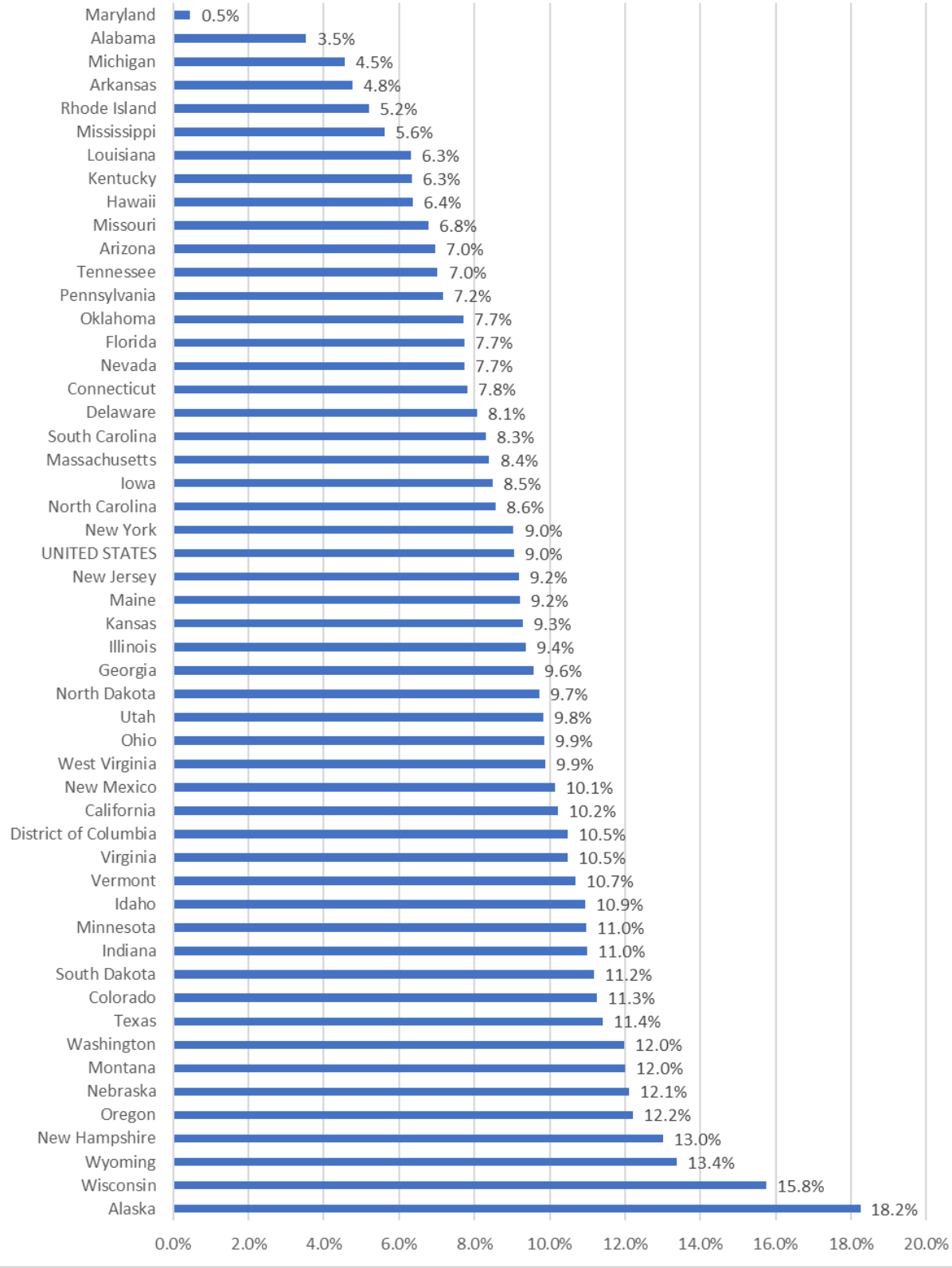

Table 2. Illustrative Effects of a Public Option on Providers' Revenues in 2021 ($Billions)
Public Option with 50% Market Share Paying Medicare + 10% to Doctors / + 30% to Hospitals

State	Total Revenues	Private Revenues	Estimated Reduction
Alabama	26.3	12.3	0.9
Alaska	7.3	4.8	1.3
Arizona	36.3	16.4	2.5
Arkansas	15.5	6.4	0.7
California	236.5	114.3	24.2
Colorado	31.0	17.1	3.5
Connecticut	25.2	12.8	2.0
Delaware	7.2	3.8	0.6
District of Columbia	10.7	6.5	1.1
Florida	125.3	60.0	9.7
Georgia	56.5	30.9	5.4
Hawaii	8.7	4.7	0.6
Idaho	8.5	4.7	0.9
Illinois	82.5	44.2	7.7
Indiana	46.2	25.7	5.1
Iowa	17.6	8.9	1.5
Kansas	17.3	9.7	1.6
Kentucky	27.8	12.5	1.8
Louisiana	28.6	13.4	1.8
Maine	9.3	4.7	0.9
Maryland	39.6	19.6	0.2
Massachusetts	56.4	30.1	4.7
Michigan	61.3	28.8	2.8
Minnesota	38.1	20.7	4.2
Mississippi	17.0	7.1	1.0
Missouri	40.8	20.5	2.8
Montana	6.9	4.0	0.8
Nebraska	13.2	8.0	1.6
Nevada	15.2	7.7	1.2
New Hampshire	9.9	6.1	1.3
New Jersey	55.7	27.6	5.1
New Mexico	11.6	5.0	1.2
New York	141.2	64.3	12.8
North Carolina	56.7	27.3	4.9
North Dakota	6.6	4.0	0.6
Ohio	85.2	47.1	8.4
Oklahoma	22.3	10.9	1.7
Oregon	24.7	12.1	3.0
Pennsylvania	91.4	47.4	6.5
Rhode Island	7.4	3.4	0.4
South Carolina	26.2	12.7	2.2
South Dakota	7.1	4.3	0.8
Tennessee	41.0	19.9	2.9
Texas	156.5	85.1	17.8
Utah	15.2	9.4	1.5
Vermont	4.4	2.2	0.5
Virginia	49.8	29.6	5.2
Washington	47.0	26.5	5.6
West Virginia	12.4	5.8	1.2
Wisconsin	42.0	24.7	6.6
Wyoming	3.3	2.0	0.4
TOTAL	**2,030.0**	**1,038.0**	**183.6**

Discussion

An assumption underlying those calculations is that most providers would accept the public option's rates and patients. If they were free to decline, however, many providers might do so – unless they expected the public option to have high enrollment, in which case it might be hard to forego those revenues (even at lower payment rates). But limited acceptance by providers could prevent the public option from gaining traction. Partly for that reason, some proposals would require providers to accept payments and patients from the public option as a condition of participation in Medicare. That linkage would make it much harder for providers to decline, but the outcome of that game of chicken is difficult to predict.

Other proposals envision having the public option simply negotiate rates with providers. The Biden plan was vague on this point, however, saying during the 2020 campaign that "*as in Medicare*, the Biden public option will reduce costs for patients by negotiating lower prices from hospitals and other health care providers." In fact, Medicare does not "negotiate" prices for doctors and hospitals in any meaningful sense, but rather sets them using statutory formulas. (Arguably, providers negotiate with Congress about the formulas.) If a public option truly negotiated its payment rates, the Congressional Budget Office (CBO) concluded in 2009 that those rates would "probably be comparable to the rates paid by private insurers participating in the [insurance] exchanges." Largely as a result, CBO concluded then that such a public option would "typically have premiums that are somewhat higher than the average premiums for the private plans in the exchanges."[4] (I was a leader of CBO's health team at that time.)

For many reasons, a great deal of uncertainty surrounds what effects a public option would have on health care spending, premiums, and providers' revenues. The lower its payment rates, the higher enrollment in the public option is likely to be – and those factors would combine to magnify the effects on providers; the inverse is also true. Trying to calibrate or phase in those effects will be difficult, because they depend on how providers, employers, enrollees, and insurers respond. Political pressure to raise Medicare or Medicaid rates could also arise, to help keep providers whole. Of course, CBO can always model different versions of a public option – as can others. But any such estimates must come with a very wide range of uncertainty around them, not to mention significant consequences that would accompany unexpected outcomes.

In light of those uncertainties, I would argue that proposals for more direct government action to constrain commercial payment rates deserve serious consideration. That approach

[4] A public option would probably have lower administrative costs – but would have new costs for advertising and billing that Medicare does not incur. And the percentage of premiums going to administrative costs would be higher than it is in Medicare simply because Medicare enrollees incur much higher health costs (which are in the denominator of that percentage). Also, a public option that did not use common methods to manage care – such as prior authorization or provider networks – might be attractive to patients but would have higher costs and higher premiums than private plans, all else held equal.

could provide a level playing field across insurers, and the constraints on price levels could be calibrated to local market conditions. For example, researchers at Harvard recently proposed price caps that would affect only the upper tail of the distribution of private prices in each area.

Of course, it must be acknowledged that modest limits on providers' payment rates would have correspondingly modest effects on healthcare spending and insurance premiums. But compared with a public option, such regulatory constraints can probably be phased in over time more easily to match providers' ability to gradually adapt. Constraining rates also has the advantage of getting at the problem of high payment rates directly, rather than taking the roundabout route of a public option. While the route of price regulation obviously raises its own substantial set of issues, controversies, and tradeoffs, constraining prices in that way could therefore have an advantage that doctors may appreciate: Compared with the public option, this treatment would be tailored much more closely to the underlying disease.

About the Author

Although I have consulting clients in the insurance and pharmaceutical industries, this work was conducted independently. More information about me is available here:

https://www.ellishealthpolicy.com/about-me