AN FTI CONSULTING REPORT – PUBLISHED AUGUST 2020

The Public Option in the 2020 Economic Environment

EXPERTS WITH IMPACT™

FTI CONSULTING

As the global COVID-19 pandemic rages, the U.S. health care system remains under intense pressure. As Americans seek health care, they find the pandemic has exacerbated longstanding financial and access challenges. Lower-income and minority communities are disproportionately impacted by the concomitant economic and public health crises, exposing disparities in access to health care services. And yet, the crisis has shown us the resilience of the American health care system, as providers crisscross the country to meet the needs of patients in communities overwhelmed by outbreaks, and private insurance plans waive out-of-pocket costs to ensure continued access to medical services. Meanwhile, Medicaid, COBRA and the individual insurance marketplaces have functioned as a critical backstop for furloughed and laid-off Americans, who lost their employer-sponsored coverage.

Policymakers continue to examine the ways in which the U.S. health care system could be improved to meet the health care needs of all Americans and to prevent future catastrophe during the next public health emergency. One policy proposal under consideration is a national public option, which would allow individuals to purchase a public, government-sponsored, insurance plan on the individual marketplace. Supporters argue that such a system could have mitigated some of the challenges the country is experiencing today. Given the extreme economic and health consequences of the current crisis, FTI sought to understand how the system would have fared had a public option been in place when the crisis hit.

KEY FINDINGS

- Compared to commercial payers, a public option would reimburse significantly less for hospital in-patient services, which would exacerbate the financial pressure on providers during a public health crisis. Payment rates for pneumonia and respiratory illnesses under Medicare fee-for-service average between one-third to one-half of commercial rates.
- Under the current system, hospitals are projected to lose $49.6 billion in revenues nationwide in 2020. Under a public option scenario, those losses would exceed $79.2 billion in total. That financial hit to providers would come on top of losses incurred solely as a result of implementation of the public option.
- Due to the pandemic, losses in hospitals' commercial revenues are drastic. For example, rural hospitals are projected to lose $14 billion in commercial revenues and will recoup less than half that amount through increased payments from Medicaid. Under a public option, losses of commercial insurance revenues would be even greater, amounting to $20 billion for rural hospitals. For providers operating with tight margins – particularly those in rural and underserved communities – such losses could lead to the elimination of critical service lines or even facility closures.
- Any changes in service offerings or in the number of hospitals that remain operational could create access challenges for patients, especially those insured under the public option, living in rural areas or both. Many of these individuals may already have difficulty finding in-network providers or health care facilities close to home. Rural areas could be disproportionately impacted given that patients living there are more likely to be older, sicker and to rely on public health insurance.[1,2]
- States deemed COVID-19 "hot spots" including California, Texas, Florida, Georgia, and Arizona will experience significant financial consequences as a result of the pandemic. Losses from commercial insurance revenues from these five states are estimated to range from $1.4 billion to nearly $11.6 billion. Under a public option scenario, these losses would be even more devastating, ranging from $1.8 billion to $15.6 billion, depriving state and local governments of revenues needed to fund public health efforts to the contain outbreaks.
- The economic downturn will push hospital operating margins to devastating lows – a 60.3 percent reduction in 2020 relative to 2018. Under our system today, 43 percent of hospitals will see negative margins in 2020. If a public option were in effect in 2020, the share of hospitals with negative margins would increase to over 53 percent.
- Reductions in operating margins under a public option scenario could have serious implications for preparedness efforts. Under the current system, health care providers have invested millions into surge preparations and capacity building. With a public option in place, diminished margins would limit the resources available to expand intensive care units (ICUs), procure supplies and enhance staffing. Such measures are essential to containing the spread of disease in health care settings and ensuring access to high-quality critical care.
- Rather than serving as a backstop during the pandemic-related economic downturn, the public option would draw more Americans away from private plans. This, in turn, would further diminish the private market and ultimately reduce the number of plan options available to consumers.

Introduction

In 2010, Congress passed the Affordable Care Act (ACA), which transformed much of the health care system as we know it. Ten years later, the uninsured rate in the U.S. has decreased significantly, premiums have stabilized and are even declining in some markets, and more insurers are re-entering the marketplaces, which gives consumers more choice.[3,4] Today, states continue to expand or consider expanding Medicaid, which will decrease uninsured rates. The benefits of expanding health insurance coverage extend to providers, but the effects vary geographically and based on payer mix. In general, individuals in wealthier, urban and suburban areas are more likely to be covered by private plans, while those in rural areas are more likely to have public insurance coverage.[5] This dynamic creates unique challenges for provider finances and patient access to care. Any health system reforms that impact payer mix could have widespread financial consequences.

Prior to the declaration of the pandemic in the U.S., a majority (55 percent) of Americans were covered by private, commercial plans, typically offered through their employers, and most Americans reported satisfaction with their health insurance coverage.[6,7] While the current system has faced challenges in responding to the pandemic, our analysis suggests that a public option would only exacerbate stresses on the health system. Instead of improving access to care and supporting health system capacity, the public option could instead leave many Americans worse off than under the current system today – with similar rates of unemployment but a two-tier system of care characterized by fewer providers and more limited health care resources. Though a public option could help reduce the uninsured rate among minority populations, the disparities between the public and private systems would continue to create access barriers, leaving many to grapple with the unintended effects of systemic transformation.[8]

Methodology

In this report, FTI Consulting compared the current health care system ("current system") to a hypothetical U.S. health care system with a fully implemented and mature public option ("public option") in order to determine how each would fare in the present economic and health care environment. Our previous analysis of the impact of a public option found that this policy proposal would have serious implications for the private insurance market, raising private insurance premiums while diminishing the number of available private plans until they are eventually eliminated.[9]

According to that analysis, six years after the public option would be introduced, 20 percent of state marketplaces would no longer offer a single private insurance option. When the public option comes close to full maturity, that figure would likely reach nearly 70 percent (33 states), representing nearly a quarter of marketplace enrollees. Insurance markets in rural areas, home to some of the country's most vulnerable communities, would be particularly hit hard by the public option. Even in the minority of states where one or more insurers remain in the marketplace alongside a mature public option, consumers outside of the states' population centers may find few, if any, options for private insurance in the marketplaces.[10]

Over time, fewer privately insured individuals will cost providers as they grapple with more individuals insured by public plans that reimburse at lower rates. Ultimately, by the time the public option has reached its full take up, Americans could be living under a "two-tier" health system where employer-based insurance, which generally offers higher reimbursement rates to providers, conveys access to a different set of hospitals or services that could be accessed through the public option. This puts providers in a dilemma: continue to see patients who are increasingly insured by public plans with lower reimbursement rates and whom providers may need to take losses on? Or, participate in more selective networks which limit the number of patients in public plans but help providers maintain positive operating margins?[11] Our analysis envisions a hypothetical scenario in which a public option system is in place during an economic downturn comparable to the current crisis and examines how this system would fare compared to the American health care system today.

Public Option Assumptions

- A public option is a government insurance plan available for purchase on the individual insurance marketplace. The plan directly competes against private marketplace insurance plans.
- Unlike private plans, the public option employs rate-setting, resulting in decreased premiums for consumers at the expense of lower reimbursements for health care providers.
- Premiums for the public option are expected to be set approximately 25 percent below market value for comparable private insurance plans.
- Reimbursement rates for the public plan are assumed to be set at Medicare rates plus 5 percent.
- Eligibility for coverage and subsidies in the public option remain consistent with existing marketplace rules.
- The model assumes a mature public option, in which significant discrepancies in premiums have already squeezed out most private competition in the individual market, leaving the employer market as the primary source of private coverage.

Given the fluid nature of the debate over federal stimulus packages, federal relief efforts were not factored into this analysis. To date, congress has appropriated $175 billion through CARES Act funding intended to relieve some of the financial stress caused by the pandemic.[12] Projections of the total cost of government spending vary based on assumptions about infection and hospitalization rates. An analysis by the Brookings Institute and USC Schaeffer found that government spending by Medicare, Medicaid and the Children's Health Insurance Program (CHIP) could amount to between $6.3 billion and $167 billion.[13] Under a public option, more individuals would have public insurance coverage and government spending would increase. As a result, the amount of provider relief funds required in such a crisis may also need to increase given that providers would already be experiencing additional financial strains associated with lower reimbursement rates in the public option and changes in payer mix that are more heavily weighted towards public payers than they are today.

2020 ECONOMY: IMPACTS ON CURRENT SYSTEM VS. SYSTEM WITH PUBLIC OPTION

Impacts on Health Insurance Coverage

Health insurance coverage during a pandemic is critical, especially given the time and costs associated with hospitalization for an emerging infectious disease like COVID-19. The average hospital stay for patients who survive is 10.7 days, but almost a quarter of COVID-19 patients spend over two weeks (16 days) in the hospital.[14] While scientists are working diligently to contain the public health crisis and to treat COVID-19 patients, clinicians and researchers have already begun warning of possible longer-term effects. Based on these initial findings, robust health insurance coverage will still be necessary for those who have recovered from the virus, well after they have left the hospital. Some studies indicate that those who survive COVID-19 will experience lingering lung issues, heart damage or acute kidney injury, which requires dialysis.[15,16,17] However, under a public option scenario, an economic crisis would accelerate the loss of private coverage, further diminishing the private insurance market and ultimately reducing the number of plan options available to consumers as they recover financially from the pandemic.

Health Care Coverage and Provider Finances Strained Due to Global Pandemic and the Related Economic Downturn

This public health crisis hit the U.S. hard. As of early August 2020, the U.S. recorded over five million confirmed COVID-19 cases and over 165,500 deaths.[18] The virus and the related national response have also plunged the economy into recession. As states nationwide were forced to shut down, thousands were either laid off from work or furloughed, leading to over 44 million unemployment claims filed by early June 2020.[19]

Given that a majority of Americans have private coverage typically tied to their employers, and others (even with government subsidies) partially or fully self-finance their coverage in the individual market, the unemployment rate affects Americans' ability to retain private health care coverage. The Congressional Budget Office (CBO) estimates that unemployment will jump to 11.6 percent in 2020 because of the pandemic. The unemployment rate could take several years to return back to the 2019 level of 3.6 percent.[20] The U.S. economy is linked inextricably to the American health care system. As such, as providers continue to treat infected patients and as global economic recovery lags, the distribution of patients with private, public, or no insurance will shift, straining provider finances.

Current System

As the economy sinks further into recession and unemployment remains high, Americans will continue to lose their private health insurance coverage. Using economic projections into 2020 and beyond, FTI economists estimated changes in insurance coverage as a result of the unemployment impacts of the public health crisis. Our modeling shows that more than 15 million privately insured individuals will lose their insurance in 2020, decreasing the total number of privately insured individuals by 10.3 percent from 2019. The increase in unemployment alone is estimated to drive the uninsured population up by 11.1 percent or nearly 15.7 million. Meanwhile, the recession will increase the Medicaid population by approximately 22.5 percent, or 15.7 million people.[21] Notably, as of July 2020, it does not appear that the economic crisis is driving enrollment in the individual market, but rather is discouraging people from seeking coverage.

It is also important to recognize that these projected losses could be mitigated by policy decisions at the federal and state levels, including through stimulus legislation. Some policymakers have proposed short-term solutions such as COBRA subsidies to help recently unemployed individuals maintain their employer-sponsored insurance. Others have pushed for special enrollment periods to allow for Americans to purchase insurance coverage during the public health crisis.[22] Ultimately, these types of policy changes could help provide greater flexibility, ensuring Americans have the coverage necessary to weather the economic storm without undermining the health care system.

Table 1: Projected Percentage Change in Coverage, 2018-2021

Insurance Source	2020 Change
Employer Sponsored	-15,585,274
Direct Purchase	-5,310,442
Medicaid	+15,666,530
Uninsured	+7,401,646

Source: Current Population Survey Annual Social and Economic Supplement (2000-2018)

Public Option

Under a public option scenario, a pandemic would also lead to losses of private insurance coverage, though the total number would be smaller given that the baseline of individuals with private insurance would be lower at the outset. However, it is important to note that, by the time the public option is near maturity, upwards of two million marketplace enrollees could have already experienced a loss of their private coverage.[23] Rather than serving as a backstop during the pandemic-related economic downturn, the public option would draw more Americans away from private plans. This, in turn, would further diminish the private market and ultimately reduce the number of plan options available to consumers.

Long-Term Sustainability

Changes in coverage do not affect patients solely – they also affect the providers who care for those patients. As job losses lead more patients to become uninsured, they may have fewer resources to see their doctor. And, as more patients switch to public programs, providers will receive lower reimbursements for the same types of care. State-wide shutdowns and the cancellation of elective procedures have already depressed provider revenues. In May, following the first COVID-19 peak in the U.S., a survey of primary care practices found that 14 percent were temporarily closed and that 56 percent of practices experienced significant decreases in patient volume.[24] Hospitals were also hit hard; hospitals lost an average of $1.4 billion per day between March 1 and April 15, 2020 as a result of fewer inpatient hospitalizations.[25]

A public option would reimburse significantly below commercial rates for in-patient hospital services, which would exacerbate the financial pressure on providers in the midst of a public health crisis. FTI compared rates between Medicare and commercial insurance for respiratory diagnoses, pneumonia and other respiratory illness-related treatments (such as oxygen therapy), and found that Medicare fee-for-service reimbursements are significantly lower than commercial rates (see Appendix). Reimbursements that fall below commercial rates, as is the case across most government plans, are insufficient to cover the full cost of care. Hospitals frequently lose money when they treat Medicare patients. According to a 2020 MedPAC report, hospital Medicare profit margins remain deeply negative.[26] Given that a public option would also reimburse below commercial rates, providers are likely to lose money by treating public option patients, exacerbating the financial pressure on providers amid a public health crisis.

For all that they do, our nation's health care system and providers need to be standing strong at the end of a pandemic. To account for lower public payment rates, providers generally rely upon a mix of patients, including those with both public and private insurance, to sustain operations. Private payments often make up for low payment rates from public payers, keeping providers afloat. The present economic crisis is tipping the usual balance, and, under a public option scenario, these challenges would grow. An influx of patients with public option coverage is likely to force providers to shift costs to those with private insurance, resulting in increased premiums and out-of-pocket costs for individuals with private plans.[27]

Effect of Economic Downturn on Hospital Financial Strength

To understand the effects of the public health crisis and related economic downturn on providers, FTI studied hospital finances to understand the big picture impact on hospital revenues nationwide, in rural and urban areas and in COVID-19 "hot spots." We found many hospitals on shaky ground. In 2019, a record 47 hospitals shut their doors. As of July 2020, 42 hospitals and health systems have already either closed or declared bankruptcy.[28] Our analysis finds that the economic downturn could be ruinous to hospital finances nationwide, squeezing hospital operating margins to devasting lows and putting hospitals at risk of closure. By many measures, a public option would further exacerbate anticipated declines. As a result, patients in rural areas or those with public option insurance would be forced to travel further to find care, or face greater difficulty finding in-network providers.

The bad economy continues to impact provider operating margins. In 2018, approximately a third of hospitals had negative margins. FTI's analysis projects that in 2020, there will be a 60.3 percent reduction hospital operating margins nationwide relative to 2018. This means that under the current system, over 43 percent of hospitals will see negative margins in 2020. Under a public option, even more hospitals would suffer from financial difficulties. If a public option had been in effect in 2020, the share of hospitals with negative margins would increase to over 53 percent.

Between March 1, 2020 and June 30, 2020, the pandemic cost hospitals approximately $50 billion a month, according

to the American Hospital Association.[29] To capture losses across the entire year, FTI used 2018 hospital financial data to estimate the change in revenues under the current system for various payers as a result of the projected changes in health insurance coverage during the public health crisis.[30] Under the current system, hospitals are projected to lose $38.4 billion in revenues nationwide. Under a public option scenario, hospitals would lose $68.1 billion in revenues (see Table 2).[31] This would be on top of already significant revenue losses incurred before the public health emergency, as a result of implementing the public option. As most hospitals generate the majority of their revenue from commercial reimbursements, this projected loss could devastate hospitals' long-term financial well-being. A report in the Journal of the American Medical Association (Khullar, et al) estimated that the median hospital had only 53.4 days cash on hand and 49.2 days in net accounts receivable, which puts numerous hospitals at risk of failure should the financial strain of the weakened economy persists longer than a few months.[32]

Table 2: Change in Revenues for Current System vs. Full Public Option

	Change Revenues (Current System)	Change Revenues (Assuming Full PO)
Private Insurance	- $69.0 B	- $98.6 B
Medicaid	+ $25.0 B	+ $25.0 B
Uninsured (Charity Care)	- $5.6 B	- $5.6 B
Total	**- $49.6 B**	**- $79.2 B**

Source: CMS Medicare Cost Report (2018). 2020 estimates presented in 2018 USD.

Experience of Rural vs. Urban Areas

While the public health crisis poses financial challenges for providers across the country, rural and urban hospitals endure lost hospital revenues differently. Urban areas will experience significant declines in commercial revenue. Residents of urban areas have greater rates of private insurance coverage compared to people living in rural areas. Because urban areas have higher population density, it is understandable that, collectively, hospitals in urban areas will experience larger total dollar decreases in commercial revenue compared to rural areas.[33] Our model projects that urban hospitals will lose $55 billion as a result of the pandemic (see table 3). Under a public option, urban hospitals experience additional revenue declines of over $20 billion, or $78.6 billion in total lost commercial revenue.

Urban and rural areas alike are experiencing devasting financial strain as a result of the public health and economic crises. Yet, rural hospitals had been closing for years prior to the national pandemic. Approximately 35 percent of American hospitals are located rural areas. In the first half of 2020, 12 rural hospital have closed.[34,35] The public health emergency and resulting economic downturn will continue

Table 3: Change in Revenues for Rural vs. Urban Hospitals

	Difference in Rural Hospitals	Difference in Urban Hospitals
Commercial Insurance	- $14.0 B	-$55.0 B
Commercial Insurance (with fully implement Public Option)	- $20.0 B	- $78.6 B
Medicaid	$5.4 B	$19.6 B
Uninsured (Charity Care)	- $715 M	- $4.8 B

Source: CMS Medicare Cost Report (2018). 2020 estimates presented in 2018 USD.

smaller dollar losses but, due to their limited budgets, the financial pressure creates a larger impact compared to urban hospitals, which may be more liquid. Our model projects that under the current system, rural hospitals will lose $14 billion in commercial revenue in 2020.

Under a public option scenario, losses of commercial revenues would be even greater, amounting to $20 billion for rural hospitals alone. Rural hospitals are at especially high risk of closure – 21 percent of rural hospitals have been found to be financially unstable.[36] When studying impacts nationwide, FTI found that certain states will be at disproportionate risk. States with large rural areas such as Alaska, West Virginia and Wyoming will experience decreased commercial revenues in excess of 15 percent under the current system and would face even greater reductions under a public option scenario.

COVID-19 "Hot Spots"

Particular states and cities are experiencing a rapid increase of COVID-19 cases, resulting in "hot spots" around the country. Within these areas, we can further see how a public option would place additional strain on limited financial resources to fight the pandemic. As of July 2020, the top five "hot spot" states were California, Texas, Florida, Arizona and Georgia.[37] Under the current system, hospital losses from commercial revenues are estimated to range from between $1.4 billion in Arizona to nearly $11.6 billion in California (see table 4). In California, the public option would increase losses from commercial coverage by an additional $4 billion.

While providers in "hot spots" might be expected to make up lost revenues from the increased volume of infected patients, we found that, under a public option scenario, reimbursements for those services by public programs

Table 4: Difference in Revenues from Private Coverage in Hot Spot States

	Difference in Revenues from Commercial Coverage	Difference with a Fully Implemented Public Option
California	- $11.6 B	- $15.6 B
Texas	- $5.2 B	- $7.3 B
Florida	- $3.1 B	- $4.8 B
Georgia	- $2.2 B	- $3.1 B
Arizona	- $1.4 B	- $1.8 B

Source: CMS Medicare Cost Report (2018). 2020 estimates presented in 2018 USD.

Table 5: Change in Commercial Revenue in Hot Spot Cities

Hot spot cities	Change in Commercial Revenue	With Fully Implemented Public Option
Los Angeles, CA	-11.1%	-13.7%
Miami, FL	-7.3%	-14.9%
New York, NY	-9.4%	-11.3%
Phoenix, AZ	-11.1%	-14.9%

Source: CMS Medicare Cost Report (2018). 2020 estimates presented in 2018 USD. Hot Spot cities assessed at Metropolitan Service Area (MSA) level.

would likely be insufficient to cover hospitals' costs. As elective procedures are reduced or cancelled in a pandemic, reimbursement for treatment of COVID-19-related services becomes important to providers' bottom lines. To determine how hospitals would fare under a public option scenario in which rates for such services would be comparable to Medicare, FTI calculated the differential in reimbursements for services associated with the treatment of COVID-19 and found:

- Commercial reimbursements for pneumonia treatments ranged from $9,999 to $20,950 – more than double Medicare fee-for-service.
- Commercial reimbursements for respiratory treatments ranged from $37,743 to $117,726, while Medicare fee-for-service payments for the same services ranged between $12,089 and $48,271.
- On average, commercial reimbursements for COVID-19 procedures totaled $49,677, while the Medicare fee-for-services paid just $13,306.[38]

As the public health crisis shocks the health care system financially, a public option could worsen financial challenges for both providers and these state and local governments. In general, states that eased restrictions and lockdowns have seen rising numbers of cases, which resulted in several massive spikes by early July. Consequently, many states have reevaluated their opening policies, which will likely lead to prolonged economic strain for many individuals and businesses, particularly small businesses.

While the effects of the pandemic on commercial insurance revenue vary, in general, cities in hot spot states are the most negatively impacted. For example, in California, where total commercial revenue losses are the highest, Los Angeles will also bear the brunt of these financial consequences through commercial revenue losses upwards of 11 percent (see table 5). These losses would be even more significant under a public option scenario, resulting in a relative reduction in funds available to cities and states to invest in disease prevention and containment efforts.

Navigating a Two-Tier System During a Pandemic

Over the course of 2020, the public health crisis will have a sustained, negative impact on provider finances. Under a public option scenario, further reductions in operating margins could undermine pandemic readiness. Patients insured under a public option would navigate a cash-strapped system with insurance that pays significantly below commercial rates. To prepare for surges in acutely ill patients, hospitals have invested millions of dollars to acquire supplies, intensive care unit (ICU) beds, infrastructure, additional staff and more. Such measures are essential to containing the spread of disease in health care settings and ensuring access to high-quality critical care. Under a public option, these investments may not have been possible given that hospitals would have more publicly insured patients leading to revenue declines as a result of lower reimbursements, ultimately limiting hospitals' ability to invest in preparedness and increased capacity.

According to a report by Kaiser Health News, over 50 percent of counties in the United States have no ICU beds.[39] At the onset of the pandemic, hospitals sought to expand ICU capacity by building new units, or converting traditional beds into ICU beds. In 2015, the average price of an ICU bed was between $25,000-$30,000, compared to $5,000-$10,000 for regular surgical beds.[40] According to the Chief Operating Officer of Cedars-Sinai Medical center in California, the cost of equipment to convert a regular hospital bed into an ICU bed is around $45,000.[41] But hospitals don't just need ICU beds; they also need additional floor space to accommodate negative pressure rooms and critical equipment like ventilators.

Under a public option scenario, investments difficult to make today would become nearly impossible, especially for rural hospitals in peril today (40 states have at least one rural hospital at risk of closure under financial pressures).[42] In addition to physical investments, hospitals also must invest in additional staff for expanded units, which further compounds the cost of readiness. Beyond having fewer resources to invest in pandemic preparedness, under a public option scenario, years of low reimbursement rates from public insurers could have already led to a reduction in health care services or facilities nationwide. Consequentially, health care infrastructure across the country would be insufficient to meet the needs of all patients.

A System with Resources to be Nimble

The U.S. health care system needs to serve our national interests, which include efficient resource distribution – especially during a pandemic, to serve patients' interest – so they may access to the care they need, and to serve providers' interests – so they remain viable. Throughout the present crisis, private payers have supported patients and providers. Both private payers and the federal government (through the CARES Act) accelerated payments to providers so they could remain financially stable and open while patient volumes plummeted.[43] These payments served as a critical lifeline, especially considering diminished patient volumes by over 50 percent between March 1 and April 15.[44] Insurers also intervened early to waive copays for COVID-19 treatment before federal legislation mandated it.[45]

Beyond COVID-19-specific support, payers have also made changes to ensure that patients and providers were supported in their typical day-to-day health care needs during the economic and public health crises. Payers eased provider reporting requirements, such as prior authorization, to allow for increased flexibility.[46] Even more significantly, private payers helped accelerate the transition to telehealth by announcing payment parity between telehealth and in-person visits.[47] These changes helped patients maintain lifesaving access to their doctors despite the physical restrictions imposed by stay-at-home orders.

Events of recent months demonstrate how private insurers remain valuable to the American health care system. Much of the problem solving to meet patient and provider needs during the public health crisis originated from private payers who made changes to their policies and who have invested in their local communities. Private payers also remain vital partners as the country emerges from the pandemic. A survey by Optum found that 61 percent of employers regard private insurers as a "key partner" to help return employees to work.[48] If the current health care system were radically transformed, as it would be under a public option, private payers would have fewer financial resources and less flexibility to respond to a crisis. When the government is responsible for more lives and private insurance is undercut, sources of private sector support would be limited, and the federal government would bear the brunt of the burden to help keep communities and the health system intact.

Conclusion

While the American health care system has struggled in the face of an unprecedented health and financial crisis, it has demonstrated its adaptability and resilience. Public and private payers have helped mitigate the crisis for providers and ensured that patients can continue to access care. Under a public option scenario, the response to the pandemic would be hampered as providers would face steeper revenue losses and would have fewer resources prepare for surges in sick patients. The public option and the resulting "two-tier" system of health coverage would offer Americans fewer choices and limit their access to vital health care in a public health crisis. While there is room for improvement under the current system, the public option would drain provider resources, contract networks and lead to closures, costing Americans, especially rural individuals and minority populations. As policymakers consider new health care reforms, they should take care to understand the present system's strengths, and the possible ramifications of major reforms, which could inadvertently yet foreseeably limit competition and consumer choice. COVID-19 and the economic recession offer a stark reminder that the next pandemic or economic downturn could be imminent, and any future health care system could fare very differently than ours today.

Appendix

EFFECT ON COMMERCIAL AND MEDICARE REIMBURSEMENTS

Estimating Payments using Pneumonia and Respiratory Diagnosis

In a recent study, Kaiser Family Foundation (KFF) compared private payer and Medicare rates for select inpatient hospital services, including respiratory services that are similar to COVID-19 treatments.[49] The study found that private insurance paid more than twice of what Medicare paid for these respiratory diagnoses. In another study, Peterson-KFF examined the potential costs of COVID-19 treatments by looking at commercial claims for pneumonia and respiratory patients.[50] According to their findings, the average payment (employer plan combined with employee's out-of-pocket costs) for a pneumonia admission was $20,292, indicating that the total payment for an inpatient admission for COVID-19 could be over $20,000. In FTI's analysis using this approach, the commercial payment for a pneumonia admission ranged from $9,999 to $20,950 in 2018.[51] The Medicare payment ranged from $4,645 to $8,536. Commercial payments were between 2 and 2.5 times higher than Medicare rates for these DRGs. Similarly, commercial payments for respiratory diagnoses were between 2.5 and 3 times higher than Medicare rates. Commercial and Medicare payments ranged from $37,743 to $117,726 and $12,089 to $48,271 respectively. Payments for COVID-19 treatments similar to pneumonia and respiratory services could go up to $117,000.

Estimating Payments using COVID-19 Hospital Procedures

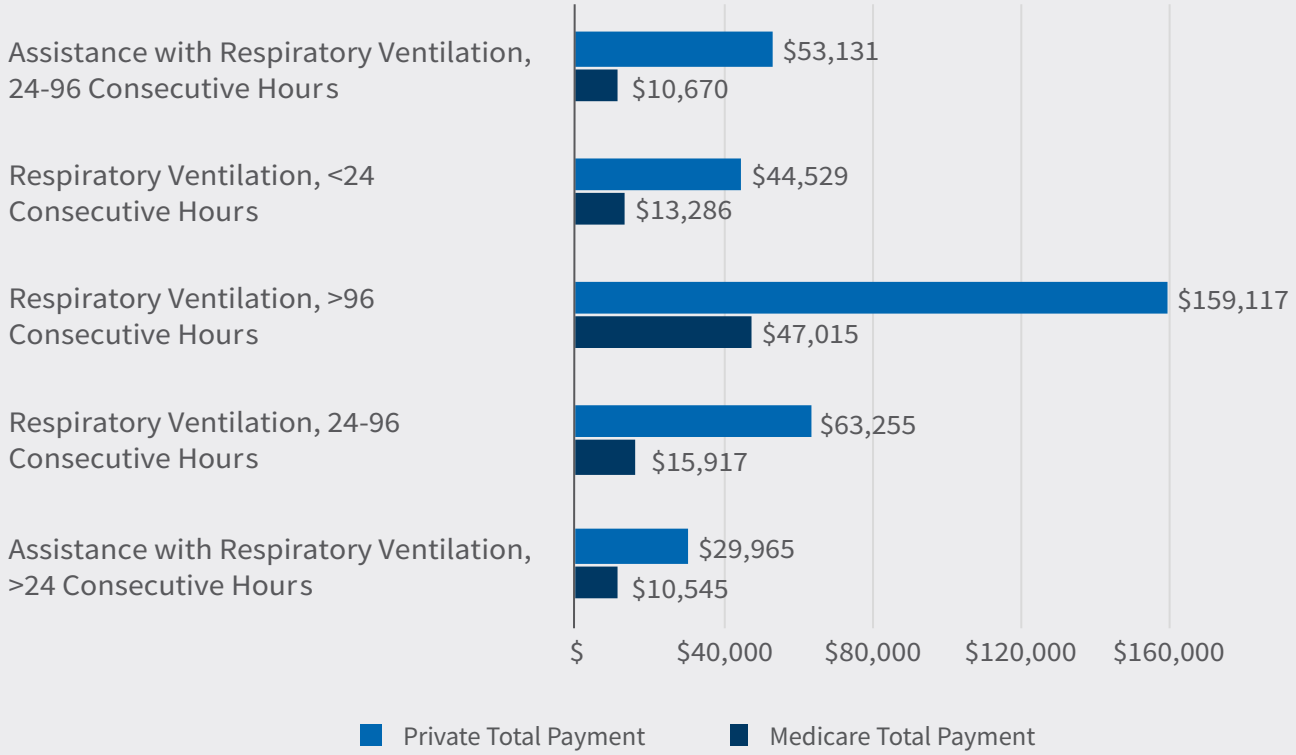
The most common procedures for COVID-19 patients who are hospitalized included oxygen therapy, intubation, ventilation, and admission to the ICU, depending on the severity of illness. Other tests included chest x-ray or CT Scan. FTI estimated the average payment for these hospital procedures using MarketScan commercial claims data and Medicare claims data from 2018. Overall, commercial payments were more than 3 times higher than Medicare payments. As the elderly are more likely to be admitted to a hospital, Medicare utilization was more than 20 times greater than commercial.

The average commercial payment for COVID-19 procedures was $49,677, while the Medicare payment was $13,306. Respiratory ventilation procedures were the top five most utilized services for both commercial and Medicare patients. As presented, Medicare payments ranged from $10,545 to $47,015. Commercial payments ranged from $29,965 to $159,117, up to five times higher in comparison.

DRG	Description	Medicare		Commercial	
		Visits	Total Payment	Visits	Total Payment
117	Respiratory Infections & Inflammations W Mcc	83,113	**$12,089**	1,944	**$37,743**
193	Simple Pneumonia & Pleurisy W Mcc	175,804	**$8,536**	5,649	**$20,950**
194	Simple Pneumonia & Pleurisy W Cc	143,149	**$5,924**	5,509	**$14,044**
195	Simple Pneumonia & Pleurisy W/O Cc/Mcc	42,791	**$4,645**	2,759	**$9,999**
207	Respiratory System Diagnosis W Ventilator Support > 96 Hours	31,560	**$48,271**	1,122	**$117,726**
208	Respiratory System Diagnosis W Ventilator Support < = 96 Hours	58,615	**$16,269**	2,501	**$42,202**

Source: MarketScan Commercial Claims Data 2018, Medicare Claims Data 2018

Private Payment and Medicare Payment Comparison for Top 5 COVID Procedures



Source: MarketScan Commercial Claims Data 2018, Medicare Claims Data 2018

CITATIONS

1. About Rural Health. Centers for Disease Control and Prevention. https://www.cdc.gov/ruralhealth/about.html. Published August 2, 2017. Accessed August 7, 2020.
2. Mueller KJ, Alfero C, Coburn AF, Lundbland JP, MacKinney AC, McBride TC, Barker A. Insuring Rural America: Health Insurance Challenges and Opportunities. Rural Policy Research Institute; 2018:1-18.
3. Collins SR, Gunja MZ. What Do Americans Think About Their Health Coverage Ahead of the 2020 Election? The Commonwealth Fund. https://www.commonwealthfund.org/publications/issue-briefs/2019/sep/what-do-americans-think-health-coverage-2020-election. Published September 26, 2019. Accessed August 7, 2020.
4. Premiums for HealthCare.gov Plans are Down 4 Percent But Remain Unaffordable to Non-subsidized Consumers. Centers for Medicare and Medicaid Services. https://www.cms.gov/newsroom/press-releases/premiums-healthcaregov-plans-are-down-4-percent-remain-unaffordable-non-subsidized-consumers. Published October 22, 2019. Accessed August 7, 2020.
5. Kirby JB, Muhuri P. Statistical Brief #512 Insurance and Access to Care in Urban and Rural Areas, 2014-2015. Agency for Healthcare Research and Quality; 2018:1-7
6. Health Insurance Coverage of the Total Population. Kaiser Family Foundation. https://www.kff.org/other/state-indicator/total-population/?currentTimeframe=0&selectedDistributions=employer--non-group&sortModel=%7B%22colId%22%3A%22Location%22%2C%22sort%22%3A%22asc%22%7D. Published April 23, 2020. Accessed August 7, 2020.
7. McCarthy J. Most Americans Still Rate Their Healthcare Quite Positively. Gallup. https://news.gallup.com/poll/245195/americans-rate-healthcare-quite-positively.aspx. Published December 7, 2018. Accessed August 7, 2020.
8. Health Equity Considerations and Racial and Ethnic Minority Groups. Centers for Disease Control and Prevention. https://www.cdc.gov/coronavirus/2019-ncov/community/health-equity/race-ethnicity.html#fn2. Published July 24, 2020. Accessed August 7, 2020.
9. Assessing the Impact of a Public Option on Market Stability and Consumer Choice. FTI Consulting. https://www.fticonsulting.com/insights/reports/impact-public-option-market-stability-consumer-choice. Published November 19, 2019. Accessed August 7, 2020.
10. Ibid
11. Ibid
12. CARES Act Provider Relief Fund. U.S. Department of Health and Human Services. https://www.hhs.gov/coronavirus/cares-act-provider-relief-fund/index.html#:~:text=Provider%20Relief%20Fund-,CARES%20Act%20Provider%20Relief%20Fund,lines%20of%20the%20coronavirus%20response. Published 2020. Accessed August 7, 2020.
13. Fiedler M, Song Z. Estimating Potential Spending on COVID-19 Care. The Brookings Institution. https://www.brookings.edu/research/estimating-potential-spending-on-covid-19-care/. Published May 7, 2020. Accessed August 7, 2020.
14. Manke K. Long Hospital Stays, High Rates of ICU Admission for U.S. COVID-19 Patients. UC Berkeley. https://news.berkeley.edu/2020/05/26/long-hospital-stays-high-rates-of-icu-admission-for-u-s-covid-19-patients/. Published May 30, 2020. Accessed August 7, 2020.
15. Spagnolo P, Balestro E, Aliberti S, et al. Pulmonary fibrosis secondary to COVID-19: a call to arms? The Lancet Respiratory Medicine. 2020;8(8):750-752. doi: 10.1016/S2213-2600(20)30222-8
16. Batlle D, Soler MJ, Sparks MA, et al. Acute Kidney Injury in COVID-19: Emerging Evidence of a Distinct Pathophysiology. Journal of the American Society of Nephrology. 2020;31(7):1380-1383. doi: 10.1681/ASN.2020040419
17. Shi S, Qin M, Shen B, Cai Y, Liu T. Association of Cardiac Injury With Mortality in Hospitalized Patients With COVID-19 in Wuhan, China. Journal of the American Medical Association Cardiology. 2020;5(7):802-810. doi:10.1001/jamacardio.2020.0950
18. Home. Johns Hopkins Coronavirus Resource Center. https://coronavirus.jhu.edu/map.html. Published 2020. Accessed August 12, 2020.
19. Unemployment Insurance Weekly Claims. U.S. Department of Labor. https://www.dol.gov/ui/data.pdf. Published August 6, 2020. Accessed August 7, 2020.
20. Swagel P. CBO's Current Projections of Output, Employment, and Interest Rates and a Preliminary Look at Federal Deficits for 2020 and 2021. Congressional Budget Office. https://www.cbo.gov/publication/56335. Published April 24, 2020. Accessed August 7, 2020.
21. Projections were generating using Census' Current Population Survey (CPS) Annual Social and Economic Supplement (ASEC) from 2000-2018 to estimate population and health insurance coverage. Model estimated an unemployment rate of approximately 11.6% in 2020 and 10.3% in 2021. The rate is expected to reach equilibrium of approximately 6% by 2022. We assume that the unemployment rate holds steady from 2022 through 2050 when projecting coverage estimates.
22. The Heroes Act.; 2020. https://www.congress.gov/bill/116th-congress/house-bill/6800.

23. Assessing the Impact of a Public Option on Market Stability and Consumer Choice.
24. Quick COVID-19 Primary Care Survey. The Larry A. Green Center, Primary Care Collaborative. https://static1.squarespace.com/static/5d7ff8184cf0e01e4566cb02/t/5ecea10bebe58e1aea04692a/1590599948613/C19+Series+11+National+Executive+Summary+with+comments.pdf. Published May 2020. Accessed August 7, 2020.
25. Hospital Volumes Hit Unprecedented Lows. Crowe. https://www.crowe.com/-/media/Crowe/LLP/Widen-Media-Files-Folder/h/Hospital-volumes-hit-unprecedented-lows-HC2003-044A.pdf?la=en-US&modified=20200430214218&hash=B7FA8AF457E36ED70EFDFA031D56BC224D7BE110. Published May 2020. Accessed August 7, 2020.
26. Report to the Congress: Medicare Payment Policy. Medicare Payment Advisory Commission; 2020. http://medpac.gov/docs/default-source/reports/mar20_entirereport_sec.pdf?sfvrsn=0. Published March 2020. Accessed August 7, 2020..
27. Risk to Colorado's Health System by State Option. FTI Consulting. https://www.fticonsulting.com/insights/reports/evaluating-risk-colorados-health-system-state-government-option. Published March 20, 2020. Accessed August 7, 2020.
28. Ellison A. 42 Hospitals Closed, Filed for Bankruptcy This Year. Becker's Hospital Review. https://www.beckershospitalreview.com/finance/42-hospitals-closed-filed-for-bankruptcy-this-year.html. Published June 22, 2020. Accessed August 7, 2020.
29. Report: Nation's Hospitals Losing About $50B a Month Fighting Pandemic. American Hospital Association. https://www.aha.org/news/headline/2020-05-05-report-nations-hospitals-losing-about-50b-month-fighting-pandemic. Published May 5, 2020. Accessed August 7, 2020.
30. Estimates were derived from 2018 Medicare Cost Reports.
31. These are conservative estimates, as they only reflect losses stemming from changes in insurance coverage. They do not reflect the impact of state restrictions on elective procedures or reduced service volumes.
32. Khullar D, Bond AM, Schpero WL. COVID-19 and the Financial Health of US Hospitals. Journal of the American Medicine Association. 2020;323(21):2127-2128. doi:10.1001/jama.2020.6269
33. Access in Brief: Rural and Urban Health Care. Medicaid and CHIP Payment Access Commission. https://www.macpac.gov/wp-content/uploads/2018/10/Rural-Access-In-Brief.pdf. Published October 2018. Accessed August 7, 2020.
34. Fast Facts on U.S. Hospitals, 2020. American Hospital Association. https://www.aha.org/statistics/fast-facts-us-hospitals. Published March 27, 2020. Accessed August 7, 2020.
35. 172 Rural Hospital Closures: January 2005 – Present (130 since 2010). University of North Carolina Cecil G. Sheps Center for Health Services Research. https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/. Accessed August 7, 2020.
36. Diaz A, Chhabra KR, Scott JW. The COVID-19 Pandemic and Rural Hospitals-Adding Insult to Injury. Health Affairs. https://www.healthaffairs.org/do/10.1377/hblog20200429.583513/full/. Published May 3, 2020. Accessed August 7, 2020.
37. United States COVID-19 Cases and Deaths by State: Cases in Last 7 Days. Centers for Disease Control and Prevention. https://www.cdc.gov/covid-data-tracker/#cases. Published 2020. Accessed July 27, 2020.
38. See Appendix for additional estimates.
39. Schulte F, Lucas E, Rau J, Szabo L, Hancock J. Millions of Older Americans Live in Counties with No ICU Beds as Pandemic Intensifies. Kaiser Health News. https://khn.org/news/as-coronavirus-spreads-widely-millions-of-older-americans-live-in-counties-with-no-icu-beds/. Published March 2, 2020.
40. Rubenfire A. Hospitals Paying More for Electric Beds. Modern Healthcare. https://www.modernhealthcare.com/article/20150427/NEWS/150429935/hospitals-paying-more-for-electric-beds. Published April 27, 2015.
41. Neighmond P. Growing Costs and Shrinking Revenues Squeeze Hospitals as They Brace for Coronavirus. NPR. https://www.npr.org/sections/health-shots/2020/04/06/828108255/growing-costs-and-shrinking-revenues-squeeze-hospitals-as-they-brace-for-coronav. Published April 6, 2020. Accessed August 7, 2020.
42. 2020 Rural Hospital Sustainability Index. Guidehouse; 2020: 1-10.
43. LaPointe J. Public, Private Payers Offer Upfront Reimbursement Amid COVID-19. Health Payer Intelligence. https://healthpayerintelligence.com/news/public-private-payers-offer-upfront-reimbursement-amid-covid-19. Published April 9, 2020.
44. Hospital Volumes Hit Unprecedented Lows.

45. Simmons-Duffin S. Some Insurers Waive Patients' Share of Costs for COVID-19 Treatment. NPR. https://www.npr.org/sections/health-shots/2020/03/30/824075753/good-news-with-caveats-some-insurers-waive-costs-to-patients-for-covid-19-treatm. Published March 30, 2020.

46. Ibid.

47. Health Insurance Providers Respond to Coronavirus (COVID-19). America's Health Insurance Plans. https://www.ahip.org/health-insurance-providers-respond-to-coronavirus-covid-19/. Published August 7, 2020.

48. Serxner S, Kichlu R, Ratelis E. Employer Insight Survey: Returning to the Worksite Transition – Strategies and Approaches. Optum. https://www.optum.com/content/dam/optum3/optum/en/resources/PDFs/employer-insight-survey-overall-results.pdf. Published 2020.

49. Lopez E, Claxton G, Schwartz K, et al. Comparing Private Payer and Medicare Payment Rates for Select Inpatient Hospital Services. Kaiser Family Foundation. https://www.kff.org/medicare/issue-brief/comparing-private-payer-and-medicare-payment-rates-for-select-inpatient-hospital-services/. Published July 7, 2020. Accessed August 7, 2020.

50. Rae M, Claxton G, Krani N, et al. Potential costs of COVID-19 treatment for people with employer coverage. https://www.healthsystemtracker.org/brief/potential-costs-of-coronavirus-treatment-for-people-with-employer-coverage/. Published March 12, 2020. Accessed August 7, 2020.

51. A study on health costs of COVID found similar results.
Cox C, Rudowitx R, Neuman T, et al. How health costs might change with COVID-19. https://www.healthsystemtracker.org/brief/how-health-costs-might-change-with-covid-19/.Published April 15, 2020. Accessed August 7, 2020.

Acknowledgments: This work was supported by the Partnership for America's Health Care Future.