



ADVANCING NATIONAL HEALTH REFORM

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THE COSTS AND BENEFITS OF A PUBLIC OPTION IN HEALTH CARE REFORM: An Economic Analysis

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EXECUTIVE SUMMARY

Congress is debating fundamental changes to the health care system in the United States, with the overarching aim of reducing health care costs while increasing health care coverage. Among the most contentious issues is whether change should include the option to purchase public health insurance.

Existing cost estimates from the Congressional Budget Office, the Lewin Group and the Urban Institute agree that a public option would reduce overall health care costs in the United States and save the federal government money. The Urban Institute projects savings of \$47 billion per year (more than \$400 billion over a decade) to the government and \$79 billion per year (\$800 billion over a decade) overall. The Lewin Group projects around \$40 billion per year in additional total savings from extending the public option from small firms to all firms. These economic projections most likely underestimate the benefits of a public option because they fail to consider the effect of a public option on competition in the health insurance market.

This report explains why the public option is likely to garner greater benefits and cost savings than previously projected. Previous estimates have suggested that costs would be shifted to private insurers and employers would drop private insurance in favor of a public option. While the public option would compete with private insurers, whose local monopoly power currently provides them advantages in many markets, there is no good empirical evidence that the public option's lower reimbursement rates would shift costs onto private insurers. Nor does the evidence suggest that employers who currently provide insurance would suddenly stop covering their employees in favor of the public option.

In the next several weeks, Congress will determine not only whether change will include a public option, but also how the public option will be constructed. This report details how a robust public option that is administratively streamlined with Medicare, builds on Medicare's pricing scheme, is national in scope, and is eventually available to all firms would most likely be able to substantially lower premiums, rein in health expenditures, and bring fiscal savings.

INTRODUCTION

Congress is debating fundamental changes to the health care system in the United States, with the overarching aim of reducing health care costs while increasing health care coverage. Among the most contentious issues is whether effective change—as measured by both cost reduction and coverage expansion—should include the option to purchase public health insurance.

Each of the health care bills under serious consideration dramatically expands health insurance coverage, leaving open the question of how to best reduce costs without compromising access or quality. The purpose of the public option is largely to inject greater competition in the health insurance market and thus reduce costs, both of total health expenditures as well as public sector costs of subsidizing health care. The *status quo* involves:

- ◆ Health care expenditures of \$2.2 trillion in 2007. The United States GDP in 2006 was \$13,195 trillion. This means that 16 cents of every dollar spent was spent on health care.¹
- ◆ The federal government subsidizing health care by allowing firms to purchase health insurance for their employees with pre-tax dollars, at a cost of \$246 billion in the year 2007.²

Overall reductions in health care costs, therefore, will not only affect individual and employer spending, but also dramatically increase tax revenues to the government. This in turn will improve fiscal balance in our economy.

Whether health care reform will reduce the growth in health care spending depends on what elements of the House, Senate HELP, and Senate Finance Committee bills survive the legislative process. Congressional proposals contemplate that with health care reform tens of thousands of uninsured Americans will gain access to health insurance. In addition to Medicaid expansions for the lowest-income Americans, current legislative proposals include subsidies for Americans between 133%³ and 400% of the federal poverty level who buy health insurance through a marketplace known as a health insurance “exchange.” Insurers who offer products in the exchange will then compete for the greatest market share of these new customers. Robust competition in the exchange is necessary to control costs. The two main visions for how to inject meaningful competition into the exchange are (1) through health insurance cooperatives as proposed by the Senate Finance Committee and (2) through an additional public option as set forth in the Senate HELP Committee bill and most clearly in the House bill.

Existing cost estimates from the Congressional Budget Office, the Lewin Group and the Urban Institute all agree that a public option would reduce overall health care costs in the United States and save the federal government money.

Debates about the merits of including a public option in health care reform have thus far focused on ideological policy preferences. This brief is designed to clarify the underlying assumptions behind existing cost estimates and make the models more accessible

to policy makers. This brief analyzes existing models of health insurance markets in general and the public option in particular. It points to flaws in modeling of the health insurance market presented in the existing models, which most likely lead to an overestimate of the costs and an underestimate of the benefits of the public option. The projections considered in this brief come from the Congressional Budget Office (CBO), the Lewin Group, Price Waterhouse Cooper, and the Urban Institute, all of which have developed economic models that have been used to estimate the net cost of implementing the various health care proposals being debated in Congress (see Figure 1). It is important to note that only the Urban Institute has explicitly looked at the costs and savings of the public option. It estimates that a public option would generate \$788 billion of savings over a ten year period, \$400 billion of which would accrue to the government. The Lewin group has modeled the additional savings that a widely-available public option would generate and finds similar fiscal savings levels of approximately \$48 billion per year or \$500 billion over ten years.

Figure 1

Estimates of Savings on Health Care Expenditures from a Public Option

Author	Congressional Budget Office	Lewin Group	Price Waterhouse Cooper	Urban Institute
Formal Cost Comparison With and Without a Public Option	No	Yes*	No	Yes
Fiscal Savings	Unspecified but large and positive	Not reported for fiscal savings	Unspecified but large and positive	Average of \$40 Billion per year over 10 years
Savings on Total Expenditures	Unspecified but large and positive	Average over \$47 Billion per year over 10 years	Unspecified but large and positive	Average of \$79 Billion per year over 10 years
Flaws in Analysis	Fails to fully model competitive effects of public option on private market	Fails to model competitive effects of public option; assumes large cost shifts	Fails to model competitive effects of public option; assumes large cost shifts	Fails to fully model competitive effects of public option on private market
Effect of Correcting	Lower premiums, more government savings	Lower premiums, more government savings	Lower premiums, more government savings	Lower premiums, more government savings

*See p. 4 for explanation of the Lewin Group cost comparison.

I. How the Public Option Would Generate Savings

Most of the savings from a public option come from either **subsidy reduction** or a **tax base increase**. Both mechanisms are explained here.

The government's low administrative costs and ability to negotiate provider reimbursement rates would reduce the price of health insurance. By offering insurance at lower prices, the public option would introduce greater competition into the exchange and thereby lower the premiums of private health insurers. Since the government would be subsidizing health insurance purchased in the exchange for those between 133% and 400% of the federal poverty level, lower overall premiums translate into lower overall governmental health expenditures. The July 2009 estimates from the Congressional Budget Office project that low-income health care subsidies in H.R. 3200 would amount to approximately \$160 billion per year by 2019.⁴ The mechanism for reducing fiscal expenditures, emphasized by the Urban Institute model, is what this brief calls the **subsidy reduction effect**.

The Lewin Group highlights another mechanism for generating savings. The Lewin Group projects costs for two different scenarios rather than focusing explicitly on the costs and savings that the public option would generate. Comparing two of the Lewin Group scenarios—one in which uninsured individuals and small businesses have access to a public option, the other in which large firms would have access to a public option as well—shows that the more broadly available public option would generate \$45 billion in extra savings in the year 2011 alone. The largest portion of these additional savings comes from additional income tax revenue: employers who purchase coverage through the public option spend substantially less on medical premiums and can therefore afford to pay their employees higher wages. Since wages are taxed but medical premiums are not, this would generate increased government revenue from income taxes. This brief refers to this effect as the **tax base increase effect**.

By contrast, health care cooperatives (“co-ops”) would be unlikely to generate either a subsidy reduction effect or a tax base increase effect. The CBO has not explicitly looked at the competitive impact the public option would have on health care costs, but it has considered the impact of co-ops. In its most recent assessment of the costs of the Senate Finance Committee bill, the CBO found that co-ops would have “very little effect on ... federal costs because, as they are described in the specifications, they seem unlikely to establish a significant market presence in many areas of the country or to noticeably affect federal subsidy payments.”⁵

The CBO recently analyzed a scenario with a public option in its cost projections of the House Tri-Committee bill.⁶ A robust public option that includes a Medicare tie-in would be more able to compete with private insurance due to its administrative cost advantages, its lesser need to earn profits, and its greater ability to bargain with local hospitals and doctors for lower provider prices.

For a public option to reduce exchange subsidies or increase the tax base, it must be structured so that it can compete with private insurers. To do so, it must appeal to enrollees and providers, each of which is necessary to attract the other. These twin requirements have design implications and demand a public option robust enough that a meaningful number of consumers and providers will want to participate in it, thereby leading to significant economic savings. A robust public option would provide competition in the exchange, decreasing the premiums of other insurers. The result would potentially look somewhat like the public-private hybrid model that exists in the American university system, in which competition from public universities keeps the prices of similar-caliber private universities lower than they otherwise would be, although unlike universities public health care would not receive a net government subsidy.

How the public option is structured will have immense economic and fiscal consequences. In particular, the public sector can save money from adopting the following design features:

- ◆ Administering the public option so that the public option and Medicare appear seamless to providers;
- ◆ Tying provider reimbursement rates in the public option to Medicare;
- ◆ Administering the public option at a national level;
- ◆ Mandating that Medicare providers accept public option enrollees, or at least creating strong incentives for providers to do so;
- ◆ Making provider enrollment in the public option the default;
- ◆ Making the public option available to all Americans rather than restricting it to those without the possibility of employment-based coverage and small businesses;
- ◆ Placing caps on the premium differentials that insurance companies can charge for the same plan to different groups of consumers; and
- ◆ Allowing individuals to purchase health insurance through the exchange with pre-tax dollars (or eliminating the employer tax subsidy for health insurance).

II. Savings from the Public Option: How Accurate Are the Existing Cost and Savings Estimates?

The Lewin Group and the Urban Institute models correctly predict that a public option will save the government money and reduce total health care costs. However, their quantitative cost estimates likely underestimate the benefits and overestimate the costs of a public option. This brief discusses some of the modeling flaws evident in existing estimates and their relevance to overall cost and benefit estimates for the public option. Existing models of the health insurance market exhibit two flaws, both of which lead to substantial underestimates of the cost savings a public option would generate:

1. Existing models do not fully model the competitiveness of health insurance markets; and
2. Some models (the Lewin Group and especially the Price Waterhouse Cooper model, in particular) incorrectly assume that reduced profits through the effect of a public option in the exchange will show up as higher premiums in other insurance markets.

The Competitive Effect of a Public Option

The main problem with the existing studies is the way in which they model competition among providers and the prices that providers set with insurance companies. All studies assume that the public option will pay providers at or near the Medicare reimbursement rate and will charge enrollees premiums to cover costs. But existing studies do not model the monopoly power that hospitals have to set high prices.⁷ Private insurers pay hospitals on average 30% more than Medicare. A public option that exerts pressure on hospitals to lower the prices they charge private insurers would lead to overall price declines. The Lewin Group and the CBO models do not account for these savings, and the Urban Institute model does so only to a limited extent.⁸ In existing models, the main benefit of the public option is therefore its lower administrative costs, which for private payers amount to at most 10% of health care costs on average, although effective administrative costs in the individual market are most likely substantially higher. Administrative savings from having a public option are projected at around 5%, which translates into significant savings, but less than the models would predict if they correctly accounted for the counter-effect of the public option on the price-setting power of hospitals.

Cost Shifting

In the Lewin Group and Price Waterhouse Cooper models, as the public option becomes more widely available, private insurance premiums rise. These cost estimates assume that the public option will cause “cost shifting.” In essence, the argument is that hospitals lose money on Medicare and will therefore lose money on the public option. Moreover, as the argument goes, hospitals make up their losses by charging private insurers higher prices, which in turn are passed on in the form of higher premiums. In fact, the Price Waterhouse Cooper report assumes such an extreme form of cost shifting that every dollar of decreased revenue from the public option shows up as increased premiums for private insurers. Both the Lewin Group and Price Waterhouse Cooper conclude that government

savings from lower premium prices for those who purchase the public option are partially offset by increases in private insurance premiums.

The cost shifting argument has some very problematic implications and little to no empirical support. Hospitals and insurance companies both set prices to maximize profits; hospitals charge private insurers the maximum amount possible, regardless of whether they also receive payments from Medicare. Lower prices from one payment source may affect a hospital's profit margin, but should not cause the hospital to increase the already profit-maximizing price it charges private insurers. The one exception to this would be if hospitals are operating near bankruptcy in order to keep prices as low as possible, in which case a decrease in one customer's payments would lead to an increase for another customer because the hospital had not been charging the second customer a profit maximizing price in the first place. Whereas this is theoretically possible, there has been no good empirical work documenting that it happens. In fact, the best research done on the behavior of non-profit hospitals suggests that non-profits behave identically to for-profit hospitals.⁹ There is, in sum, no good empirical evidence that the type of cost shifting modeled by the Lewin Group, in which 40% of the lost revenues are shifted into private insurance premiums, actually occurs. In other words, the Lewin Group model dramatically reduces the estimated fiscal savings from a public option, thereby underestimating its fiscal benefit. Adding back in the 40% cost shift, savings from the expansive public option would increase by \$37.8 billion in the year 2011 alone.

III. Policy Choices

As policy makers debate the merits of including a public option in health care reform, three issues merit special consideration because of their impact on government finances, private health insurance premiums, and the number of uninsured Americans.

1. How should the public option be administered?
2. Who should be allowed access to the public option through the exchange?
3. What limits should be put on premium prices in the exchange?

Administration of the Public Option

Administrative design of the public option hinges on four decisions, each with potentially important cost implications. First, the public option could pay providers at the Medicare rate (or at an amount pegged to Medicare), or pay private market rates. Second, the public option could use the same administrative apparatus as Medicare, or an entirely new apparatus. Third, Medicare providers could be required to also accept patients with the public option, or not. Fourth, provider participation in the public option could be set up as an opt-out, or as an opt-in. Each of these decision points will affect the magnitude of expected cost savings.

Public Option Pricing

The public option could pay providers at Medicare rates, or “Medicare plus” rates, such as those originally proposed by the House in H.R. 3200. Medicare provider rates are much lower than private insurance rates. Low premiums will make the public option popular with consumers. But low reimbursement rates, which together with lower administrative costs lie behind the lower premiums, will make it relatively unpopular with providers (doctors and hospitals). Only if patient volume is high enough will providers have an incentive to contract with the public option. Conversely, consumers will only be interested in the public option if it is able to attract and retain an adequate provider network. A public option must therefore balance cost controls with appropriate provider reimbursement.¹⁰

In fact, the net impact of lower rates on provider participation is hard to predict because it depends on the competitiveness of the market structure in which providers and private insurers operate, which—as discussed above—is not well studied. A public option with high individual and provider enrollment could provide substantial price pressure to the private market if it pays Medicare-like rates. A public option that charges only slightly-below market premiums and pays providers at private rates will fail to exert price pressure on the private market. Locally bargained rates, such as those now contemplated in the newly-released House bill, H.R. 3962, are likely to exert little competition on the private market.

Administrative Streamlining of Public Health Insurance Programs

One way to keep prices low and ensure provider participation is to create an administrative tie-in with Medicare, discussed in more detail below. Another way for the public option to attract providers despite its lower rates is by simplifying administrative costs to providers who use Medicare by building on the Medicare payment structure. The benefit of administrative simplification that comes from tying one reimbursement schedule to another commonly-used reimbursement schedule is very much understudied by economists and is therefore not incorporated into economic models. Nevertheless, policy makers should expect it to have an impact on providers’ willingness to contract with a public option.

Moreover, a national public option will be more cost-effective than a series of state or local plans. A Montana public option will be significantly more expensive than a national public option offered in Montana.

Tying Medicare Participation to Public Option Participation

A Medicare tie-in could encourage greater competition in more monopolistic local health care provider markets, especially hospitals. If the number of participants in the public option is small, then providers will not find it worthwhile to accept public option patients. This, in turn, will limit consumers from buying the public option. Most providers want to accept Medicare patients. Medicare has many patients and these patients use medical services frequently. If Medicare mandates that providers who accept Medicare patients must also accept public option patients, then many providers will offer the public option. This will make the public option attractive to consumers. As a result, insurance coverage will be higher and premiums will be lower. Additionally, this will reduce fiscal subsidies and increase the tax base.

Creating Default Network Participation

As discussed above, high rates of provider participation are key to the ability of the public option to exert competitive pressure and rein in costs. The approach taken in the House bill is default provider participation in the public option with an opt-out option. This policy design follows a large literature in behavioral economics.¹¹ For example, individuals are much more likely to participate in a program (such as a pension plan) if they are enrolled by default, even with a costless opt-out. The behavioral economics literature would certainly support enrolling individuals in the public option as the default if they fail to select a plan. But it also suggests that default provider network participation in the public option could have a positive impact.

Breadth of Public Option Availability

One of the most important design questions for the public option is who will be eligible to buy it. The House opens the exchange (and along with it the public option) to large employers over time. If one important purpose of the public option is to provide competitive pressure on otherwise monopolistic or near-monopolistic insurance markets, then policy makers must give Americans broad access to the public option. In the beginning, as the public option is limited to those who work in small firms and who do not have the option of purchasing private employment-based health insurance, the competitive pressure that the public option will exert on private insurance will be limited. Competition would largely come from employers dropping coverage, which is unlikely in the short run and less likely to occur if the employer contribution (“play-or-pay”) requirement is meaningful, as proposed in the House bill. Recent empirical evidence from San Francisco found that the City’s local public option has been taken up by many individuals and businesses. Enrollment in the program has not, however, been associated with reductions in private health insurance coverage.¹²

Making the public option more broadly available over time would most likely dramatically increase its take up. This would in turn reduce prices in the group and individual markets, due to a combination of reduced profits for insurers and lower provider prices. Over time, the gap between Medicare rates and private insurance rates would be expected to drop. As a result, the large switch (approximately 70%) from private to public coverage that the Lewin Group estimates would probably be substantially smaller.¹³ Instead, the private market would face competitive pressure to adjust prices. Even the competitive reaction of the private health insurance industry assumed by the Urban Institute report, a uniform fall in premiums of 5% in the private market, would be small compared to what would likely happen to private insurance premiums with a public option that was available to everyone through the insurance exchange. The cost savings to the government here will come from an increase in the tax base. Lower prices of health care will mean higher wages and therefore more taxable income.

Community Rating Differentials

Insurance companies make profits by “cream-skimming” through excluding those with pre-existing conditions and charging different rates to different risk pools. All Congressional bills currently eliminate pre-existing conditions exclusions for the small group and individual medical insurance markets. Instead, insurers would only be able to charge individuals different rates for the same insurance plan based upon age, family composition,

zip code, and possibly some life choices and behaviors (for example, smoking)—a practice known as “rate banding.” However, the different bills allow for very different ranges of rate banding for the same plan. In the House bill, no health plan could charge enrollees more than twice the lowest premium rate, whereas in the Senate Finance Committee bill the difference could be fourfold. In other words, if the lowest premium for a plan is \$200, some groups of people could be charged up to \$400 per month for the same plan under the House version, but up to \$800 per month under the Senate Finance version. The degree of rate banding permitted has important implications for the public option’s ability to hold down costs. In theory, the public option, which would be subject to the same rules as all other plans in the exchange, could charge its enrollees the rate differentials permitted by the rate banding rules in the exchange. But if the rate bands are too wide, the public option—in contrast to private plans in the exchange—would be unlikely to charge older enrollees many multiples of what its younger enrollees pay. This could cause older Americans to migrate to the public option, thereby increasing its costs. In turn, this would lower the public option’s competitiveness and thus reduce overall cost savings.

IV Impacts of the Public Option on Labor Force Participation

This brief has so far considered the economic impact of a public option on health care costs. One would also project broader economic effects, especially in the labor market. The public option could influence both the willingness of people to work (labor supply) as well as the willingness of firms to hire (labor demand). These labor effects could in turn have an impact on government revenues.

Evidence suggests that labor force participation increases when wages are high. This is especially true at the low end of the labor market and particularly for women.¹⁴ Current health policy counter-balances this labor effect. Single as well as married mothers who are not offered employment-based insurance coverage sometimes forego employment opportunities out of fear of losing Medicaid.¹⁵ If affordable health insurance were readily available to otherwise uninsured workers through a public option, this could increase labor force participation, especially at the low-wage end of the labor market. The degree to which this would occur depends on policy decisions regarding affordability and how highly private insurance would be subsidized as compared with a public option. Moreover, even if lower-cost health insurance did spur workforce participation among low-wage workers, this would have limited fiscal benefits. Low income workers do not pay taxes but instead receive work incentives through Earned Income Tax Credit (EITC) payments. The increased EITC payments would potentially displace welfare payments through the Temporary Assistance for Needy Families (TANF) program. However, the net savings to the public sector will most likely be small.

A public option could have a more significant impact on the demand for labor by firms. Providing jobs would become cheaper if the cost of providing health insurance were cheaper. Currently, the United States spends over sixteen cents of every dollar on health care. Certainly, if the price of health care dropped, firms would switch from spending on health care for their employees to paying a higher wage. However, a reduction in the cost of health care would also certainly make it cheaper for firms to hire, stimulating employment. This could have a decent-sized impact and thus be particularly relevant in a time when unemployment is hovering near 10%. Its impact might be lower during normal times.

CONCLUSION AND RECOMMENDATIONS

Including a public option in a health insurance exchange will most likely both expand coverage and reduce costs to employers, individuals, and the government, while having a positive effect on job creation. However, design choices regarding the structure and scope of the public option could have large effects on the cost of providing health care and on the public option's fiscal impact. In existing estimates the CBO underestimates savings due to its failure to include the competitive effects of the public option in its model. The cost savings in the Lewin Group and Urban Institute estimates—both around \$50 billion per year—could be multiplied if the exchange and the public option were made more broadly available than the models consider. However, even with limited access a well-crafted public option would nevertheless save the United States tens of billions of dollars per year.

Such a plan would include the following features:

A Medicare Tie-In

The public option should tie itself to Medicare (1) monetarily by building on Medicare's reimbursement rates for services, (2) administratively by using the same payment and documentation system for both programs, and (3) by creating incentives for all providers who accept Medicare to also accept the public option. These measures would increase provider participation, in turn increasing take up. Large take up will likely reduce system-wide costs of health insurance, increase government tax revenue (assuming insurance in the exchange is purchased with post-tax dollars), and lower prices for private health insurance in the exchange. Even without a Medicare tie-in, making the public option national in scope rather than state-based would increase its ability to attract providers and participants, and therefore to exert price pressure on the private sector. A possible additional way to encourage providers to join the public option network is make participation in the public option the default so that providers do not have to sign up in order to participate.

Broad Access

The exchange and its offerings, including the public option, should be made available to as broad a segment of the population as possible. Current Congressional proposals contemplate opening the exchange to the unemployed and small-firm or self-employed workers who lack workplace coverage. Even in a restricted market, a public option would exert some competitive pressure on private insurers for this new pool of customers. But a more restricted market for the public option—which unlike private insurers would not operate outside the exchange—will put less pressure on private insurance plans to lower prices than a universally-available public option would. Most of the models being used to predict policy outcomes do not take into account the competitive effect of a public option on private insurance. It is important to build models that do.

Community Rating

The exchange should limit how much insurance plans can differentially charge older and younger enrollees, because large rate bands will disproportionately push older, more costly consumers into the public option and increase its costs relative to other insurers. Depending on the strength of the individual mandate, allowing for large gaps between

maximum and minimum premiums would also lead to higher rates of uninsurance for older people. Limiting the ability of private insurers to charge different prices across demographic groups may also have the effect of either pushing younger people into the public option or causing them to opt out of coverage. Both outcomes would likely lower health care expenditures given that the cost of coverage in the public option is lower than in the private market; however, opt-outs would also slightly raise rates of uninsurance. True community rating combined with an individual mandate would reduce uninsurance and allow the public option to reduce costs.

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