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Ripple Effects:

Potential Impacts of a National Public Option on Provider Viability and Disparities in Access to Care

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The COVID-19 pandemic brought into sharp focus the severe inequities that plague the U.S. health care system. Today, as the country emerges from the grip of the pandemic, decisions about the future of health care policy in the U.S. must be considered through the prism of health equity, taking into account the direct and indirect consequences of health reforms on vulnerable populations. President Joe Biden and Congressional Democrats are exploring policy proposals to establish a public option, a government-run plan designed to compete with private plans on the marketplace. As policymakers seek to expand coverage through a new government insurance option, they should also consider how the program and its use of lower provider reimbursements could ultimately impact access to care for vulnerable Americans.

A previous analysis by economists at FTI Consulting found that under a public option, providers faced with a sudden influx of patients on government plans with lower reimbursement rates could experience new financial challenges. In this brief, we sought to further examine how these financial constraints could exacerbate existing access challenges among low-income and racial and ethnic minority communities. Our analysis revealed that more than half of the hospitals observed could lose revenue under a public option, a significant portion of which serve diverse – and often vulnerable – patient populations. Consequently, these hospitals could be forced to choose between reducing service lines to stay afloat or closure. Such disruptions to health care access in those communities has the potential to exacerbate existing health disparities.

KEY FINDINGS

- While the public option aims to expand health care coverage, our analysis finds that the coverage gains under the policy are likely to be limited, reducing the overall national uninsured rate by merely 0.7 percentage points.
  - Further, our analysis finds that over 1.5 million currently insured individuals will likely forgo private insurance under the proposal, shifting more of the US population into government coverage.
- By increasing the number of individuals with public coverage characterized by low reimbursement rates, a public option could lead to financial challenges for providers. Of the hospitals in our sample, approximately half would lose money due to the public option, totaling $1.3B annually. Ultimately, revenue losses under the policy could impact access to care for vulnerable communities across the country.
  - Over half of U.S. hospitals in our sample are likely to lose revenue as a result of a public option. More than 500 of these hospitals are already operating at a significant loss and would be at higher risk of financial distress under a public option scenario.
  - Together, these higher risk hospitals could lose revenues totaling over $175 million annually and could be forced to reduce service lines or make staffing changes to make up for lost revenue, thereby diminishing the availability of essential health care services.
- To remain financially stable and open for patients under a public option, providers may be forced to shorten appointment times, make staffing changes, or eliminate certain service lines to conserve resources. Such changes may disproportionately impact vulnerable populations, including racial and ethnic minorities, for whom barriers such as lack of reliable transportation[1] may limit access to alternative sources of care.
- Mounting financial pressure on our nation's health care providers could exacerbate health care access issues in vulnerable communities across the country. Almost one-third of the hospitals at higher risk under the Public Option serve populations in which racial and ethnic minority patients are overrepresented.
  - Hospitals that serve disproportionately diverse patient populations could lose a combined $45.8 million annually under a public option. Compounding the magnitude of this loss, approximately a quarter of these hospitals are the sole hospital in their county.
  - Black and Hispanic Americans experience worse health outcomes and more barriers to care compared to their white counterparts, meaning service line disruptions or hospital closures in racial and ethnic minority communities could be particularly catastrophic for these populations.
- Hospitals in large population centers in states like Illinois and New York could be disproportionately affected by the proposed public option. Fifty percent of hospitals in Kings County, New York- a geographical area coextensive with the borough of Brooklyn which counts fewer hospital beds than necessary to serve the population[2]– would be at higher risk under the public option. Similarly, community advocates in the South Side of Chicago warned that a hospital closure could further strain the community's already overburdened health system;[3] yet nearly one-third of hospitals in Cook County could be at risk under the plan.
- A public option could decrease access to care in rural communities by putting one in four rural hospitals at increased risk of financial distress. Of the higher risk rural hospitals in the sample, 90 percent were the only hospital in their county. Given that many rural, low-income areas have a limited number of health care providers, losing even one hospital could have a dire impact on access to care.
- Many of the hospitals at financial risk under the public option are located in the Southwest, home to disproportionately large Hispanic populations. Under a public option, hospitals in Arizona, Texas, and New Mexico would lose nearly $18.4 million per year in revenue combined.
  - In Texas alone, eight hospitals that are the sole source of hospital care in predominantly Hispanic communities would be at higher risk of closure under a public option. Additional financial constraints on any of these hospitals and nearby providers could have severe consequences for individual and population health in these communities.

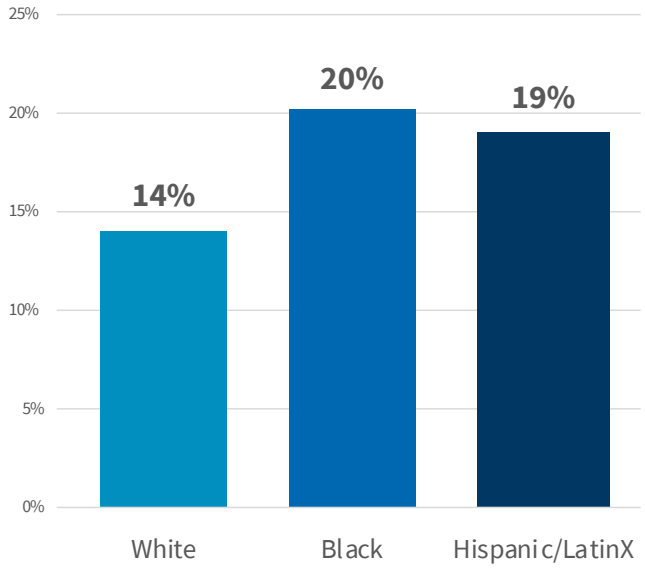
Background

Health Care Access Disparities in the U.S.

As the U.S. becomes increasingly diverse,[4] policymakers should consider that vulnerable Americans, including racial and ethnic minority groups and low-income patients, often face unique barriers to accessing health care providers and services. For instance, Black and Hispanic Americans are more likely to go without seeing a doctor each year and often report difficulties scheduling and securing preventive care (Figure 1).[5] Additionally, reports show that low-income areas are most likely to have a physician-to-patient ratio of fewer than five physicians per 10,000 residents,[6] impacting the availability of care.

Given existing access challenges, these populations sometimes rely on hospitals not only as a source of emergency care but also for non-emergent care that could otherwise be addressed in a primary care setting.[7] Barriers to securing primary care, such as a lack of transportation[8] or long travel times,[9] can exacerbate these conditions and make these populations more likely to turn to nearby hospitals for around-the-clock health care. In addition, these populations suffer from worse health outcomes compared to their white and higher-income counterparts,[10,11] increasing their need for inpatient and outpatient care at these hospitals.

Figure 1: Percent of Americans Reporting Trouble Securing an Appointment for Routine Care (2019)



Source: Agency for Health Research and Quality, 2019

A shift in payer mix may be especially detrimental to the financial viability of providers that serve vulnerable populations for whom Medicare and Medicaid are the dominant sources of coverage. A 2021 report by the Medicare Payment Advisory Commission (MedPAC) found that Medicare reimburses hospitals at less than 60 percent of commercial insurance rates.[12] With Medicare margins averaging -8.7 percent,[13] providers serving a disproportionate number of publicly insured patients often struggle to stay afloat, sometimes leading to service line shutdowns or closures. Increasing enrollment in public plans with payment rates that fail to cover operating costs may exacerbate these challenges in diverse and low-income communities.

Coverage and Health Equity

Expanding access to affordable coverage represents a critical first step on the road to addressing deep-seated inequalities in U.S. health care. While proponents of a public option argue that introducing another government-sponsored health program will move the country closer to the goal of achieving greater health equity, it is important to consider policies that have proven effective in beginning to close the coverage gap. The Affordable Care Act (ACA), for example, enabled 20 million previously uninsured Americans to gain free or subsidized coverage[14] via Medicaid and the exchanges, reducing disparities across geography, socioeconomic status, and racial and ethnic groups by making coverage substantially more affordable.[15,16]

Health equity gains under the ACA were not limited to coverage status. Research shows that the proportion of Black Americans declining care due to cost fell after 2013, thereby reducing the nationwide health care affordability gap between white and Black Americans.[17] A closer look shows that Medicaid expansion played a particularly large role in driving this progress by providing coverage and establishing managed care programs, which reduce health care expenses by preventing and managing chronic disease.[18]

The Public Option

In contrast with the market-based approach of strengthening the ACA, some Democrats are exploring policy proposals to establish a public option—a government-run plan designed to provide coverage for Americans in the coverage gap and to compete with private plans on the exchange. The public option would likely offer a premium-free plan for Americans in the coverage gap in non-

expansion states. However, the plan would also be available to all Americans through the marketplace, where it would compete with private plans.

Advocates for the policy argue the public option has the potential to address the "full scope of health disparities."[19] However, expansions of government health programs in other countries have not resulted in significant reductions in health disparities.[20] In the U.S., the significance of coverage status with respect to disparities in access to care varies by race and ethnicity. In fact, research shows that for Black patients, systemic racism, lack of trust in the medical system, and patient-provider communication may be equally important factors.[21]

Methodology

In this analysis, we sought to understand the specific impacts lower reimbursement rates under a public option may have on access to care for vulnerable populations and the financial stability of the providers who serve them. We set out to determine whether hospitals that are already operating with negative margins could see impactful revenue loss under the program, especially hospitals serving a large number of low-income or racial and ethnic minority patients. We assume that if these hospitals were faced with additional revenue losses, they might struggle to continue to provide certain services to patients, therefore reducing access to care for these populations. This analysis builds upon a previous report by FTI Consulting that found a public option that reimburses below commercial rates could upend the private insurance market and create financial challenges for providers who would suddenly face an influx of patients on government plans.[22]

To assess the impact of introducing a public option on access to care for vulnerable populations, we examined the financial implications for hospitals in diverse communities across the country. Based on existing public option proposals, we assumed the public option would be available for purchase in the individual marketplace for all Americans, including those with employer-sponsored insurance.

Specifically, we modeled the public option to assess how lower reimbursement rates coupled with an influx of patients on public insurance could impact hospital finances on a national scale. For this analysis, we assumed that premiums under the public option would be approximately 23 percent lower than the market value of comparable plans due to government rate setting for provider reimbursements.[23] In addition, we assumed reimbursement rates under the public option would be equivalent to Medicare rates. To estimate the number of uninsured Americans that may purchase the Public Option and the number of marketplace enrollees that might switch to the plan, we calculated the cost difference between the average ACA premium and the public option premium. We then assumed that a proportion of individuals for whom the cost of the public plan is lower than the available alternatives would move to the public option.

To determine the public option's financial impact on providers, we analyzed Medicare Cost Reports and commercial reimbursement data for more than 4,500 U.S. hospitals.[24] To estimate how much revenue these hospitals might gain or lose under the public option, we calculated per-person hospital payments using the plan's lower reimbursement rates and compared the new payments to current per-person payments. We also considered potential revenue gains due to the newly insured populations as well as potential losses resulting from privately insured individuals moving to the public program.

By identifying hospitals at "higher risk" of financial distress, meaning those that are already operating at a significant loss (over five percent in the most recent year), we determined which providers would be most vulnerable to closure or elimination of services lines (i.e., emergency room, maternity care). We then considered the demographic makeup of the communities most at risk under the policy, including those with large racial and ethnic minority populations (greater than the national average of 39.9 percent), as well as low-income communities.

Results

The analysis revealed that more than half of the hospitals observed could lose revenue under a public option. Consequently, these higher risk hospitals could be forced to choose between reducing service lines to stay afloat or closure. Both of these potential outcomes could exacerbate existing health disparities by reducing hospital access for low-income and racial and ethnic minority groups who rely on nearby hospitals as a source of care. Ultimately, this may render the public option inconsistent with lawmakers' objectives to reduce health disparities and improve access to care.

In total, we find that more than 2.3 million uninsured individuals could become newly insured under the public option plan—the same number of Americans that could be newly insured through full Medicaid expansion. Additionally, more than 1.5 million Americans would likely forgo their private insurance to move to a public option.

Due to low reimbursement rates under the public option, more than 2,000 of the nation's hospitals could lose revenue upon implementation of the plan. As the number of government-insured patients increases, these hospitals could lose a combined $453 million in revenue annually under the public option. In addition, more than 500 hospitals would be considered at higher risk for financial distress (Figure 2). Together, these higher risk hospitals could lose revenues totaling over $175 million nationwide every year.

Of the hospitals identified as higher risk, nearly one-third (159) are located in counties with racial and ethnic minority populations larger than the national average of about 40 percent. These hospitals, a quarter of which are the only hospitals in their respective counties, will lose a combined $45.8 million annually under the public option.

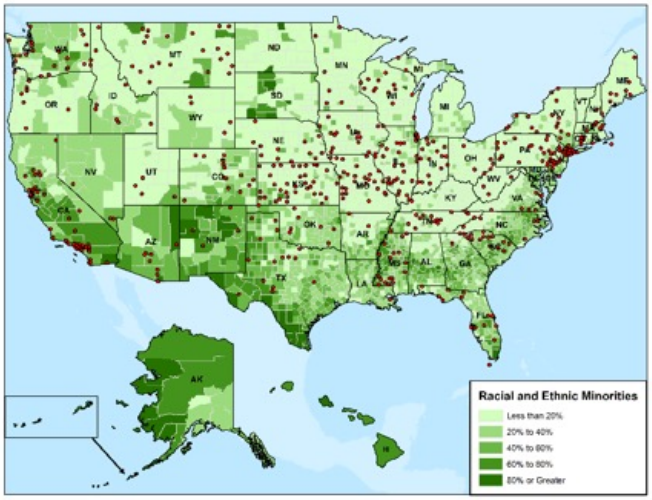
Impact on Hospitals and Vulnerable Americans in the Nation's Population Centers

Almost one-third of hospitals at higher risk under the public option serve larger than average minority populations, which already face barriers to access and rely on nearby hospitals as a source of care.[25]

These higher risk, diverse hospitals are scattered across the U.S., demonstrating the possible far-reaching financial impact of the public option. However, a closer look at the most impacted states reveals that many of the higher risk hospitals serving diverse populations are concentrated in the nation's population centers, many of which have large racial and ethnic minority populations and are already experiencing a shortage of hospital beds.[26,27]

Specifically, many hospitals serving diverse communities in New York, Illinois, and Arizona are located in some of the most populous counties in the country, including Cook County, Illinois – one of the largest counties in the U.S. as measured by population – and Kings County, New York—one of the most densely populated counties in the nation (Figure 4). In our sample, 50 percent of hospitals in Kings County, which is coextensive with the borough of Brooklyn, could be at higher risk of financial distress under the public option. Similarly, more than a quarter of hospitals in Cook

Figure 2: Hospitals at higher risk under the national public option



Note: Points represent general acute care and rural primary care hospitals at higher risk.

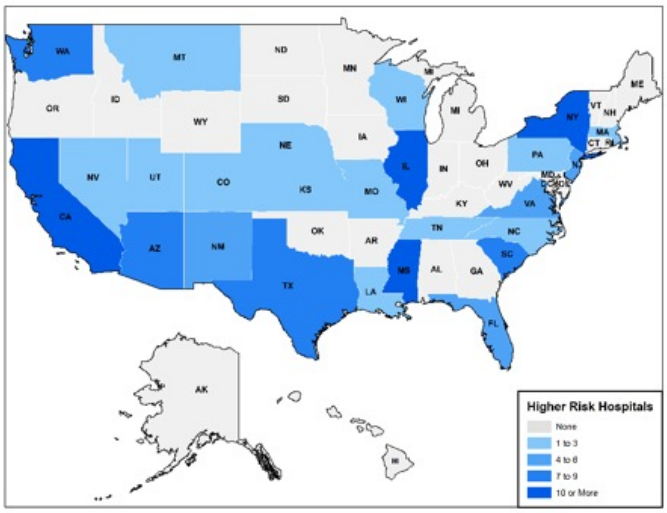
Source: Author's calculations using Medicare cost reports, hospital reimbursement rates, and American Community Survey (ACS).

County, Illinois—home to Chicago— would be at higher risk under the policy. Some of these hospitals are in the South Side of Chicago, where one hospital was recently in danger of shuttering, and others have shut down their inpatient services.[28] However, community leaders warn that closing a hospital in the South Side could have disastrous effects. According to local health experts, South Side residents rely on hospitals as a primary source of care because the local health system is stretched thin.[29]

Similarly, while these counties contain bustling city centers, many also contain multiple health professional shortage areas (HPSAs). For example, more than 40 percent of Arizona residents reside in an HPSA, lacking basic access to primary care.[30] In addition, Brooklyn (Kings County) is home to multiple medically underserved communities, counting two hospital beds for every 1,000 residents compared to more than six for every 1,000 residents in Manhattan.[31]

Hospital closures in these counties could worsen existing disparities in health outcomes for racial and ethnic minority residents. In most of these counties—as is the case for many other urban population centers across the U.S.—at least half of the residents are racial and ethnic minorities (Figure 4). Typically, low-income racial and ethnic minority populations living in urban population centers experience severe disparities in health outcomes and access compared to both their white counterparts and Americans living

Figure 3: States with greater than average ethnic residents and higher risk hospitals under the national public option



Source: Author's calculations using Medicare cost reports, hospital reimbursement rates, and American Community Survey (ACS).

in suburban areas. For instance, Black (70 percent) and Hispanic (56 percent) urban residents are less likely to have a usual source of health care compared to white residents (77 percent).[32]

Impact on Hospitals and Vulnerable Populations in Rural and Small Counties

Rural communities, particularly low-income rural residents, are often sicker and older than the average American[33] and face multiple barriers to wellness and care. While rural areas of the country tend to be less diverse overall, the health disparities experienced by people of color living in these communities are compounded by the access challenges associated with rural health care more broadly.

Of the 91 rural, higher risk hospitals in our sample, 88 are also located in low-income areas, and 84 are critical access hospitals,[34] many of which are concentrated in the Midwest and Rocky Mountains regions. Generally, rural areas account

Figure 4: Diverse Counties with More Than Three Higher Risk Hospitals

County	# of Higher Risk Hospitals	County Population	% Racial and Ethnic Minority
Los Angeles, CA	13	10,081,570	73.8%
Cook, IL	12	5,198,275	57.7%
Kings, NY	6	2,589,974	63.6%
San Francisco, CA	5	874,961	59.5%
Orange, CA	4	3,168,044	59.4%
Riverside, CA	4	2,411,439	64.7%
Nassau, NY	4	1,356,509	40%
San Diego, CA	4	3,316,073	54.4%
Maricopa, AZ	3	4,328,810	44.8%
King, WA	3	2,195,502	40.4%
Alameda, CA	3	1,656,754	68.6%

Source: Author's calculations using Medicare cost reports, hospital reimbursement rates, and American Community Survey (ACS).

for the majority of HPSAs in the country, counting 40 physicians for every 100,000 residents on average compared with 53 per 100,000 in cities.[35] As a result, hospitals are often the sole source of health care in rural counties, with many residents relying on hospitals for primary care in addition to inpatient services.[36] For instance, of the higher risk rural hospitals in our sample, 90 percent are the only hospital in their county. The remaining 10 percent are one of two hospitals in their counties. Under a public option, about 25 percent of the rural hospitals in our sample would be at higher risk of financial distress, which could worsen existing barriers to access for these residents.

Some rural hospitals that could lose revenue under the public option are also located in counties that are home to some of the largest racial and ethnic minority populations in the U.S. Our analysis revealed that apart from states with large population centers, Mississippi hospitals serving large racial and ethnic minority populations may also experience a significant impact under a public option. Mississippi has one of the largest numbers of higher-risk hospitals serving large racial and ethnic minority populations, many of which are in rural, low-income areas (Figure 5).

Financial Impacts on Hospitals in the Diverse Southwest

Similarly, many of the higher risk hospitals serving diverse populations are concentrated in Arizona, Texas, and New Mexico, which are home to significant Hispanic populations. Arizona, which ranks ninth in the nation for the number of HPSAs,[37] accounts for nine of these hospitals. The higher risk hospitals serving diverse populations are located across the state, but many are in small, low-income counties like Santa Cruz (85 percent minority), which is predominantly Hispanic. Under the public option, Santa Cruz County, a HPSA shortage area, could lose its only hospital. Similar impacts are seen in Texas, a state that did not expand Medicaid under the ACA, where Hispanic residents make up a disproportionate number of the state's uninsured population. In Texas, all of the diverse, higher-risk hospitals in our sample (eight) are also the only hospitals in their counties. Given that Hispanic Americans are also the least likely to access primary care,[38] losing access to hospital service could prove especially detrimental to health equity in those communities.

Figure 5: States with greater than average ethnic residents and higher risk hospitals under the national public option

States with > 3 Higher Risk Hospitals	# of Higher Risk Hospitals
CA	48
NY	17
IL	12
MS	**10**
AZ	9
SC	7
TX	8
WA	7
FL	5
NJ	6
NM	4
CO	3
VA	4

Source: Author's calculations using Medicare cost reports, hospital reimbursement rates, and American Community Survey (ACS).

Discussion: Public Option's Impact on Access to Care

As more Americans switch from private insurance to the public option, providers may have to make up for the influx of patients with plans that pay lower reimbursement rates. Research shows that U.S. physicians in high-minority practices that see a large proportion of patients enrolled in government programs like Medicaid face barriers to delivering the full continuum of quality care. To remain viable with limited resources, these providers are often forced to compensate for low-reimbursement rates by seeing a larger volume of patients, which could, in turn, impact the quality of care these patients receive.[39] For instance, to achieve larger volumes, some physicians report spending less time with individual patients.[40]

If increased patient volume does not offset losses under the public option, hospitals may be forced to cut staff, close service lines, or shutter entirely. Already, several hospitals in metropolitan areas have closed in recent years[41], and the American Hospital Association projects they will continue to close at a rate of 30 hospitals per year for the foreseeable future.[42] These closures and service cuts disproportionately impact the nation's most vulnerable populations. Hospital closures in metropolitan areas, like Chicago and Los Angeles County, are more likely to occur in areas that are racially segregated with a high concentration of low-income Black and Hispanic populations.[43] In addition, some hospitals that have recently closed served large minority populations that, due to lack of access to primary care providers, are more likely to rely on hospital emergency services as a source of primary care.[44] As these hospitals close, these residents may be forced to either forgo care or seek care at emergency rooms that could be overrun due to surrounding shortages.

Service cuts and closures could similarly impact racial and ethnic minorities and low-income residents in rural communities, which reported a record number of hospital closures in the last year. Many rural Americans already face long travel times to the nearest hospital[45] and barriers to primary care.[46] However, for racial and ethnic minorities in these counties, these disparities may become magnified. For instance, health care travel times for white Americans average 36 minutes compared to 45 minutes for Black Americans,[47] putting them at a higher risk of death from emergency health issues like cardiac arrest. Similarly, as COVID-19 continues to disproportionately impact racial and ethnic minorities and low-income Americans, research shows that hospital closures increase the risk of COVID-19 deaths among nearby residents.[48]

Conclusion

As policymakers discuss policy reforms, such as a public option, to expand access to care to all Americans, they must also evaluate how lower reimbursement rates under a new public plan could impact vulnerable populations. Our analysis reveals that small coverage gains under a public option may come with negative financial impacts on providers, and subsequent effects on access to care. Given that a growing number of U.S. hospitals are already struggling to keep their doors open, the introduction of another government health program with low reimbursement rates could trigger a wave of closures among hospitals that serve as primary sources of care for low-income and racial and ethnic minority populations. Policymakers should weigh the potential benefits of this policy against the possibility of undermining progress toward improved health equity. More targeted policies to address social determinants of health and build on the existing system may prove to be the least disruptive and most effective way to reduce the health disparities the nation faces.

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