

Economic Shocks and Probable Expansions to a Public Option

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Abstract

A politically realistic public option would have significant impacts on America's future fiscal condition. These impacts would be exacerbated by the kinds of economic shocks, such as recessions, that our country has seen on a fairly regular basis. In this paper, we focus on economic shocks that could directly affect the costs of a politically realistic public option or indirectly raise costs due to likely congressional responses. We consider three stylized examples. The first is a freeze on public option premiums in response to a recession. The second is a provision that would grant premium relief for the unemployed both during normal economic times and during recessions. The final example investigates the cost of the politically realistic public option if health care costs grow faster than projected, leading to higher per-enrollee subsidies. In each case, we find that a public option is likely to evolve from a deficit-neutral program into an expensive entitlement program that will increase the federal debt or require higher taxes. Ultimately, the inherent design of the public option makes it vulnerable to the same legislative expansions that nearly all federal entitlement programs have experienced. Our analysis casts doubt on the idea that future Congresses will have the political fortitude to maintain the promise of a budget-neutral public option, particularly amidst the shocks that are sure to impact America's economy in the coming decades.

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Introduction

From eligibility expansions to increased subsidies, entitlement programs regularly undergo significant legislative enhancements. Occasionally, unexpected economic or demographic challenges force lawmakers to reform their predecessors' work. More often, a program's initial design creates conditions that guarantee future Congresses will face strong political pressure to expand its eligibility or benefit levels. A public option is likely to create a similar political environment. While touted as a deficit-neutral method to reduce health insurance premiums, the design of the public option makes it unlikely that future Congresses could maintain the plan's low-cost promises.

Two key assumptions underpin the optimistic budget forecasts for public option proposals. First, the plan's budget neutrality requires enrollees to pay premiums that fully cover plan expenditures. Second, the promise of lower premiums is predicated on reimbursing physicians and hospitals at Medicare-level rates. In previous work, we examined how political pressure from public option enrollees and medical providers could eventually lead Congress to subsidize premiums and raise reimbursement rates. We estimated a politically realistic public option would evolve from a deficit-neutral program to one costing nearly \$800 billion in its first ten years. Over the long-term, the program's cost would increase the federal debt by 31 percent of GDP by 2050 or require significant middle-class tax increases.²

Enrollment in a politically realistic public option would quickly exceed 100 million Americans. As a consequence, relatively small economic or legislative changes could substantially increase the budgetary cost of a public option. In this paper, we focus on economic shocks that could directly affect the costs of a politically realistic public option or indirectly raise costs due to likely congressional responses.

We consider three stylized examples. The first is a freeze on public option premiums in response to a recession. The second is a provision that would grant premium relief for the unemployed both during normal economic times and during recessions. The final example investigates the cost of the politically realistic public option if health care costs grow faster than projected, leading to higher per-enrollee subsidies.

The examples provide further evidence that a public option is likely to evolve from a deficit-neutral program into an expensive entitlement program that will increase the federal debt or require higher taxes. We find that freezing premiums during a recession would increase the 2050 debt burden by 3.9 percent of GDP. To avoid this debt increase, Congress would need to raise taxes. We estimate that, if the public option were financed similarly to Medicare Part A, middle-income tax filers would see their taxes rise by an inflation-adjusted total of \$2,833 in 2050.

Similarly, providing premium relief for the unemployed would increase the cost of the public option by 18 percent over the first ten years, raising the plan's 10-year deficit effect to \$932 billion. This figure would grow substantially during future recessions.

² In Church, Heil, and Chen (2020), we estimated the fiscal effects of public option proposals under varying premium and reimbursement rate assumptions. In Chen, Church, and Heil (2020), we used new survey data to revise our earlier estimates for the politically realistic public option and considered various tax increases that could finance it.

Finally, relatively small changes in the health cost growth rate would substantially increase long-term deficits. We estimate a 0.9 percentage point increase in the average growth rate—about a 20 percent increase in the long-term growth rate—would increase the long-term deficits effects of the plan by 71 percent. To avoid a large increase in debt, the increased cost growth would require even higher taxes. If financed through a broad-based payroll tax, the typical family would see their 2050 tax bill rise by an additional \$1,618 (2020 dollars).

The paper is organized as follows. Section I summarizes the results of our previous work on the politically realistic public option. Section II explores how the public option would create interest groups and political incentives for Congress to expand the program. We then turn to our stylized examples. Section III considers the costs of a premium freeze during recessions. Section IV estimates the effects of premium relief for the unemployed. Section V considers the effect of unexpected increases in health care costs. Section VI concludes.

1. A Review of the Politically Realistic Public Option

While their details vary, federal public option proposals would generally create a government-run health insurance program where the government would collect premiums from enrollees and contract directly with hospitals and physicians. Most proposed plans would charge enrollees actuarially fair premiums that would cover all plan expenditures. Proponents expect these premiums to be lower than private insurance plans because the government would have lower administrative costs and be able to reimburse doctors and hospitals at rates close to Medicare levels.

In Church, Heil, and Chen (2020), we considered the likelihood that the public option would maintain actuarially fair premiums and Medicare-level reimbursement rates. We demonstrated that Congress has regularly grown and subsidized federal health care programs in order to lower costs for enrollees and increase payments for medical providers. The legislative history of Medicare Part B is particularly noteworthy. Part B premiums were initially set to cover 50 percent of the plan's costs, but Congress soon relaxed this requirement. Similarly, from 2003 to 2014, Congress enacted 17 "doc fixes" that overrode scheduled reimbursement rate cuts for doctors.³

We estimated the fiscal costs of a public option plan that follows a similar legislative path as other federal health care programs.⁴ This politically realistic public option would be available in the individual, small-group, and large-group markets.⁵ Employers would offer the public option alongside private options, and thus enrollees with employer-sponsored insurance (ESI) would receive the same tax-preferred treatment for public option premiums as they do for purchasing private plans. Initially, premiums and reimbursement rates would be set according to the standard design of most public option proposals. Premiums would be set to fully cover that plan's expenditures.⁶ Reimbursement rates for doctors and hospitals would be set at Medicare-level rates.⁷

3 CRS, 2015.

4 Here, we briefly summarize the politically realistic public option. For a complete overview see Church, Heil, and Chen (2020).

5 Importantly, we exclude Medicaid enrollees, the uninsured, and seniors from our analysis.

6 Average premiums would be actuarially fair, but individual premiums would follow the Affordable Care Act's community rating rules.

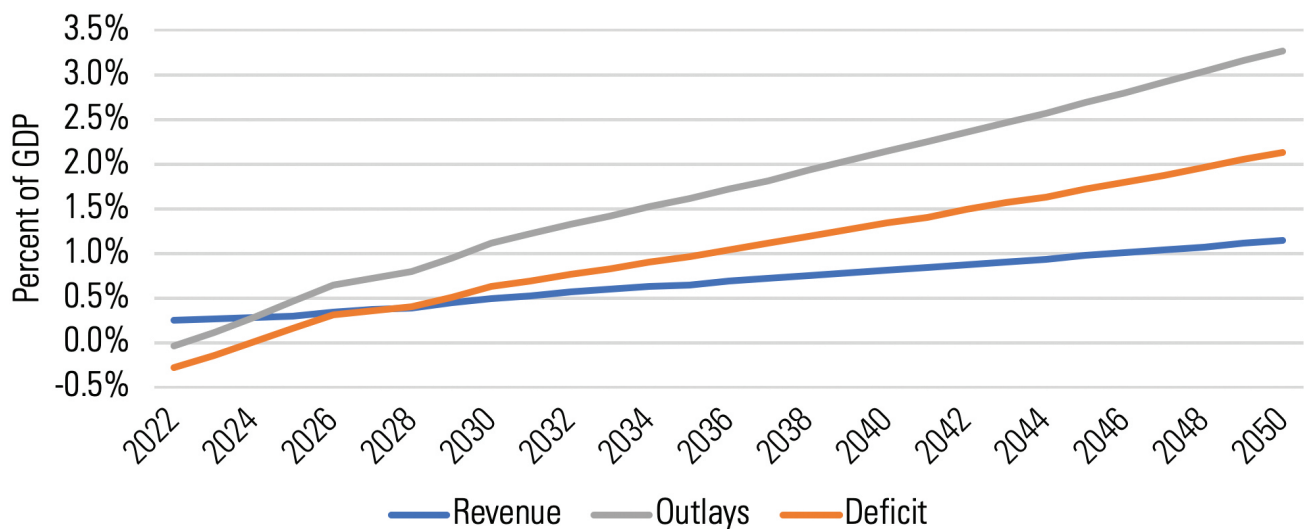
7 Physician services are set at 75 percent of private levels and inpatient hospital services at set at 62 percent. We assumed administrative costs would equal 8.5 percent of total plan costs, which is the midpoint between Medicare administrative costs and private insurers.

Reflecting the history of other federal programs, we assume the rules governing premiums and reimbursements would be quickly relaxed. Enrollee premium growth would be capped at the rate of price inflation. Reimbursement rates would rise from Medicare-level rates to private-level rates in five years.⁸ Relaxing these two assumptions would create a growing divide between public option expenditures and premiums. That difference, which we call the implicit subsidy, would be paid by the federal government.

The implicit subsidy would be partially offset by two factors. First, lower premiums paid by ESI individuals would increase taxable income and therefore raise tax revenue. Revenue would rise by the product of the ESI enrollee’s marginal tax rate and the difference between the private premium and public option premium. For example, if an enrollee’s marginal tax rate is 30 percent and the implicit subsidy is \$1,000, tax revenue would rise by \$300, and the net cost to the government would be \$700. Second, the lower premiums would reduce the costs of subsidies in the Affordable Care Act (ACA) Marketplace Exchanges. This would primarily affect federal outlays, but would also have a small effect on revenue for recipients who have a positive income tax liability after accounting for the premium tax credits.

In Chen, Church, and Heil (2020), we estimated the 10-year cost of a politically realistic public option that would begin in 2022. Total federal outlays would rise by \$1.8 trillion while revenue would grow by \$1 trillion. The 10-year deficit effect would be \$792 billion. Since the difference between the actuarially fair premium and price-indexed premiums would grow over time, the long-term fiscal effects would be far larger. By 2050, the public option would add \$737 billion in annual federal deficits (2020 dollars). Figure 1 shows the change in deficits, revenue, and spending as a percent of GDP. Public option outlays would reach 3.3 percent of GDP by 2050, larger than any other federal programs except Medicare and Social Security. If deficit financed, we estimate the public option would increase long-term deficits by 2.1 percent of GDP. Long-term federal debt would rise from 195.2 percent of GDP to 225.9 percent.⁹

Figure 1. Budget effects of a politically realistic public option



8 In Church, Heil, and Chen (2020) we considered several alternative assumptions for premiums and reimbursement rates. These changes affected the magnitude of the results but generally did not change the direction.

9 Throughout this paper, we rely on CBO’s September 2020 budget estimates, which do not include the budget effects of the Consolidated Appropriations Act of 2021.

Avoiding the increase in federal debt would require higher taxes. In Chen, Church, and Heil (2020), we explored several tax increase options that could finance the increased spending.¹⁰ Limiting the tax increase to the top three income tax brackets would require raising the top income tax rate to over 60 percent. Likewise, the corporate tax would need to be above 50 percent—far higher than corporate tax rates of other developed nations. Such high rates would lead to large changes in economic behavior and increase tax avoidance strategies, lowering projected revenue estimates and harming the economy. Thus, we concluded that the significant revenue demands of the public option would preclude such narrow tax increases; instead, a broad-based income tax or increase in Medicare HI payroll tax would likely be needed to finance the program. If financed through payroll taxes similar to Medicare’s HI tax, we estimated the typical middle-income family would see their 2050 tax burden rise by \$2,533 in inflation-adjusted dollars.¹¹

Below, we consider how various economic or legislative changes would affect these estimates. We assume that each change occurs with the politically realistic public option in place. As such, the budget effects discussed below are *in addition* to the costs discussed here.

2. The Political Environment after a Public Option

Before discussing our stylized examples, it is worthwhile to consider the political pressures that policymakers would experience after the enactment of a public option. These pressures reveal why Congress is likely to succumb to the demands of enrollees and medical providers to increase spending and subsidize the program.

The public option would be different from almost every federal entitlement program in the sense that most of its beneficiaries would write checks (directly or through one’s employer) to the government.¹² Under typical public option proposals, the government would have to behave like a private insurer. Premiums would have to rise annually on millions of voters to keep up with health care costs. Likewise, efforts to save money through increased cost-sharing provisions or narrow provider networks (which are already unpopular when put in place by private insurers) would affect public option enrollees, who will be the constituents of elected politicians. The federal government would likely have to cancel coverage for those who fail to pay, even if it were a consequence of layoffs or other economic shocks.

Meanwhile, low premiums would lead to significant enrollment in the public option. Figure 2 shows the estimated number of Americans that would choose the plan. By 2050, 58 percent of those under 65 would have coverage under the public option. This enrollment would dwarf the participation rates of all other federal programs. Further, since there would be no means-testing or eligibility requirements, the demographics of public option enrollees would largely reflect the U.S. as a whole.

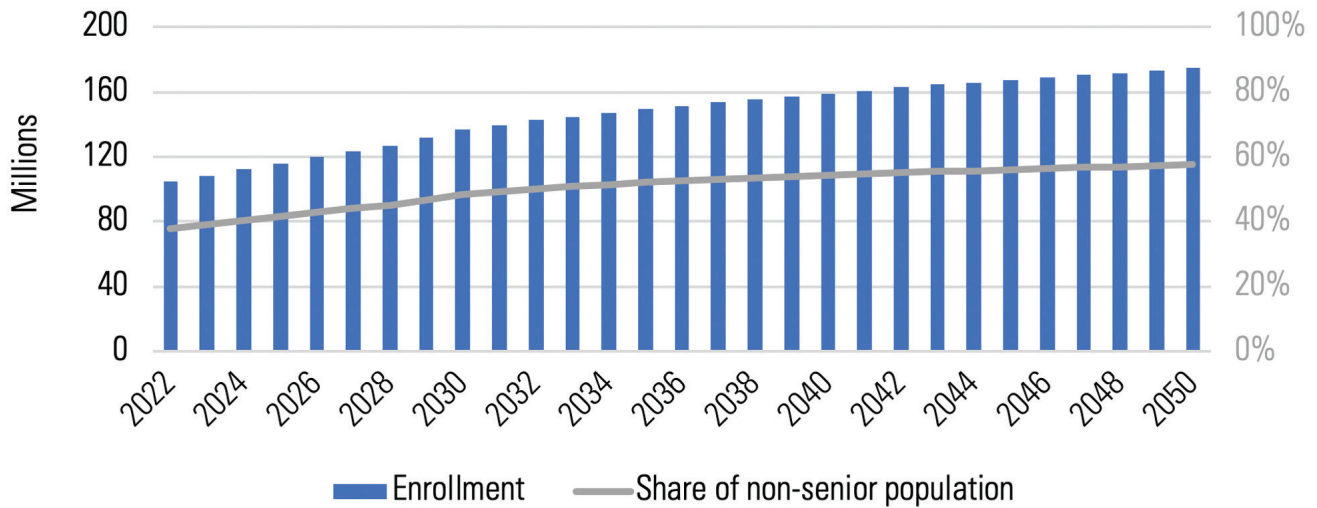
10 These tax increases included a corporate tax increase, an increase in the Additional Medicare Tax & the Net Investment Income Tax, an increase in the top three income tax rates, a broad-based income tax, and an increase in the Medicare HI payroll tax.

11 In Chen, Church, and Heil (2020) we also considered how much taxes would have to rise in order to keep long-term federal debt at 150 percent of GDP. Tax figures in this paper only estimate paying for the politically realistic public option and the stylized examples, thereby keeping long-term debt at CBO’s projection of 195 percent of GDP.

12 The closest analogue to this would be Medicare Part B, which requires enrollees to pay monthly premiums. Nevertheless, the vast majority of Medicare enrollees do not pay monthly premiums directly. Nearly 70 percent of Medicare enrollees have their premiums deducted from their Social Security checks and a significant share of remaining enrollees has their premiums paid fully or in part by Medicaid (CRS, 2020a).

Consequently, public option enrollees would constitute a powerful voting bloc. Their demands for premium relief, broad networks, and minimal cost-sharing would be hard to refuse. This would be particularly true if changes to these policies were finalized in October—when ACA exchanges rates are released—as that would fall weeks before federal elections in even-numbered years. Congress would face the irresistible urge to shield enrollees from premium increases, in order to curry political favor with them.¹³

Figure 2. Enrollment in a politically realistic public option



Public option enrollees would not be the only constituency with an incentive to lobby Congress for programmatic changes. In 2019, private health insurance covered 68 percent of the population, while Medicare, Medicaid, and other government programs covered 34 percent.¹⁴ By 2050, we estimate that 45 percent of the population would be enrolled in the politically realistic public option, while 42 percent would be enrolled in either Medicare or Medicaid. As a consequence, the vast majority of reimbursements received by doctors and hospitals would no longer come from private health insurance companies, but from the federal government.

This would dramatically increase the incentive for medical providers to advocate for increased reimbursement rates. As we have documented previously, physicians successfully lobbied Congress for higher Medicare reimbursement rates than required by the Sustainable Growth Rate (SGR) for over a decade and a half.¹⁵ That same political pressure would be magnified even further under a public option that would eventually enroll over twice as many people as Medicare.

As discussed in our earlier work, the political pressure would likely lead Congress to relax premium rules to shield enrollees from large increases, as well as increase reimbursement rates for health care providers. But even after premium growth is limited to inflation, these interest groups would likely apply significant political pressure to further enhance the program. In the sections below, we consider the budget effects of probable future program enhancements.

13 Congress has a long history of expanding entitlements to increase their chances at reelection. For example, Cogan (2018) notes that during the 1950s and early 1960s, five of the six Social Security expansions were implemented in the month before a congressional election (see page 162).

14 The totals sum to over 100 because there is considerable overlap between programs. U.S. Census Bureau, 2020.

15 For a full discussion, see Church, Heil, and Chen (2020).

3. Premium Freezes

Federal entitlement programs generally expand during economic downturns. This is partially a consequence of so-called automatic stabilizers found in many of these programs. As incomes fall during recessions, more individuals and families qualify for assistance, and current recipients see their benefit levels rise. As written, the typical public option proposals would not include automatic stabilizers.¹⁶ If an economic shock means public option enrollees can no longer afford their plans, plan administrators would be obligated to cancel their coverage. Likewise, if health expenditures were to rise faster than wage growth—as often happens during recessions—public option proposals would require commensurate increases in premiums.

While these rules may be codified in initial public option legislation, subsequent recessions might force Congress to overturn them. In fact, Congress would likely follow its historical behavior and provide premium relief to public option enrollees during economic downturns. In this section, we consider how Congress has used federal health care programs to provide economic relief during past recessions, and how it might do the same with the public option by freezing enrollee premiums during economic downturns.¹⁷

Congress regularly shields beneficiaries of federal health care programs from premium increases or other adverse changes to their health insurance during recessions. Most notably, during the last two recessions, Congress enacted legislation that increased subsidies for state Medicaid programs. Under the Medicaid program, states receive a federal matching grant to provide health care to low-income individuals. The size of this grant is determined by a state's Federal Matching Assistance Percentage (FMAP), which is determined by a state's per capita income. The percentage typically varies between 50 to 80 percent.

During and after the last three recessions, Congress increased state FMAPs. In 2003, the Jobs and Growth Tax Relief Reconciliation Act increased Medicaid FMAPs by 2.95 percentage points from April 2003 to October 2004. In 2009, the American Recovery and Reinvestment Act (ARRA) increased them by 6.2 percentage points in FY2009 and FY2010, before phasing out these increases in FY2011. ARRA also included a "recession adjustment period" that prevented FMAPs from falling in any state until FY2011. ARRA further increased FMAPs in states with high unemployment rates. Finally, the Families First Coronavirus Response Act of 2020 (FFCRA) increased FMAPs by 6.2 percentage points. This increase will remain until the end of the quarter when the COVID-19 public health emergency period officially ends.¹⁸

While these actions may be viewed as providing economic relief to states rather than individuals, the recent Congressional action shows these efforts are intended to protect Medicaid recipients during economic recessions. In the case of FFCRA, states that received enhanced FMAPs were prohibited from increasing premiums or tightening eligibility requirements. These prohibitions reflect Congress's desire to shield Medicaid enrollees from any adverse changes in their health plans during the recession.

¹⁶ For a recent legislative example of a federal public option proposal, see the Public Option Deficit Reduction Act (H.R. 1419).

¹⁷ In this section and the following two sections, we make separate budget calculations. While it may be tempting to sum the budget effects presented in each section, care should be exercised as there are interactions between the stylized examples.

¹⁸ CRS (2020b).

Medicare Part B’s “hold-harmless” provision also reflects Congress’s desire to protect enrollees. The government automatically deducts Part B premiums from Social Security checks. Individuals are “held harmless” if their Medicare Part B premiums would increase faster than their Social Security benefits year-to-year. Rather than reducing Social Security payments to retired seniors, the federal government does not increase Medicare premiums until Social Security COLAs rise.¹⁹ While the hold-harmless provision is not directly related to recessions, inflation during and immediately after recent recessions has been markedly low. Thus, following the Great Recession, hold-harmless provisions were triggered in 2010 and 2011.

Applying these historical examples to the public option suggests that Congress might consider freezing premiums for public option recipients during recessions and the ensuing labor market recoveries. As discussed in section II, the pressure to freeze premiums would be particularly strong given the large number of Americans that would be enrolled in the public option and therefore affected by any premium increases. Below, we consider the fiscal effects if policymakers were to freeze premiums during future recessions.

Similar to official government projections completed by the Congressional Budget Office (CBO), the long-term budget estimates presented in section I do not include the prospect of future recessions. Since 1982, the U.S. has experienced five recessions or approximately one every eight years.²⁰ Thus, it is reasonable to conclude that over the next 30 years, the U.S. will undergo at least two additional recessions. Given this possibility, we estimate the effects of recession-induced premium freezes with the assumption that two recessions will occur over the next 30 years. We assume they will begin in 2031 and 2041 and last for one year.²¹ We assume premiums are frozen in the year after a recession begins and that each freeze lasts for two years. That is, 2032 and 2033 premiums remain at their 2031 levels, while 2042 and 2043 premiums remain at 2041 levels. This is broadly similar to the ARRA’s Medicaid FMAP increases. The Great Recession began in the 2008 fiscal year (December 2007). Congress passed ARRA in the FY2009, and the provisions were scheduled to last for two years (although they were extended further into FY2011).

There is an important consideration in how to account for the fiscal cost of freezing public option premiums. The long-term cost of premium freezes varies depending on how premiums are allowed to grow after the freeze. We consider two methods for growing premiums once the freeze ends:

1. *Method 1: Returning to Pre-Recession Schedule.* Following the two-year freeze, this option returns premium levels to what they would have been without the recession. This will result in a larger-than-normal increase of public option premiums three years after a recession begins. In terms of fiscal costs, this method is accompanied by temporarily higher non-interest spending. Long-term spending may still be higher if the premium freezes are deficit-financed instead of paid for with dedicated taxes.
2. *Method 2: Returning to Pre-Recession Growth Rates.* After the freeze ends, premiums will grow at the same projected growth rate as prior to the recession. This will result in permanently higher federal spending since premiums will be lower in every year after the freeze, because the gap between actuarially fair premiums and the actual premiums paid by enrollees will now be wider.

19 Since Medicare Part B beneficiaries as a group are legislatively required to pay 25 percent of the program’s expenses, Congress raises premiums on four groups: New enrollees to Medicare who are unable to be held harmless; individuals with MAGIs above \$85,000 who pay an Income-Rated Monthly Adjustment Amount; enrollees who are on Medicare but do not receive Social Security benefits; and low-income “dual-eligible” beneficiaries who have their premiums paid for by their state (CRS, 2020a).

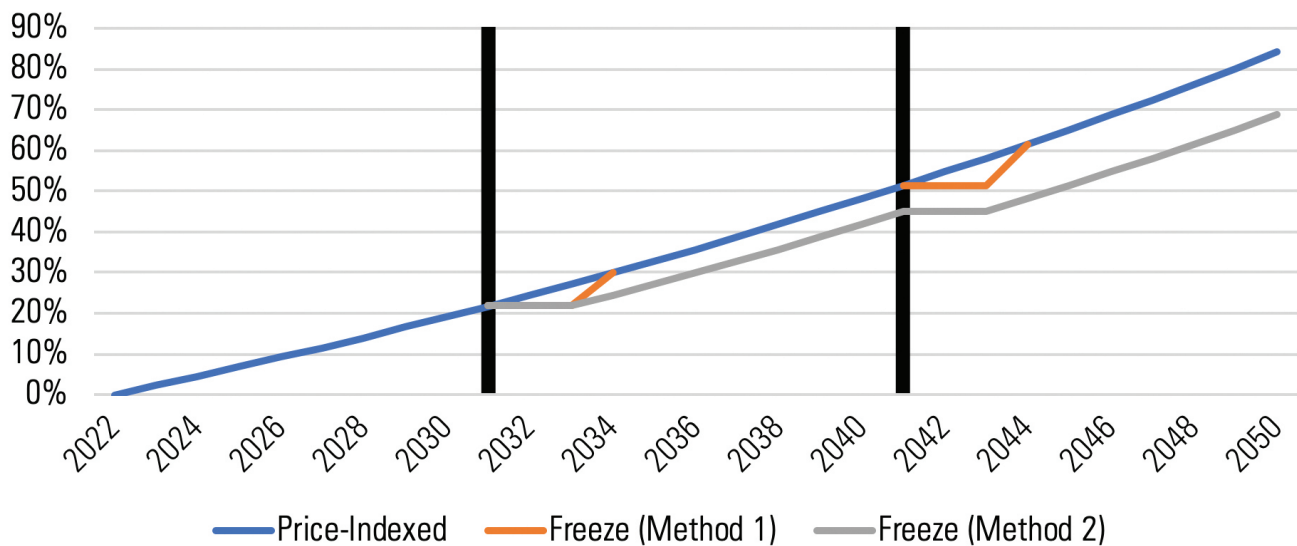
20 CY1981-1983, 1991, 2001, 2007-2009, and 2020.

21 We choose these years to avoid any effects on our 10-year budget estimates.

Figure 3 shows how premiums would grow over the next 30 years under three scenarios: (1) Without a recession (with price-indexed premiums), (2) with premium freezes where premiums return to pre-recession scheduled levels after the freeze (i.e., method 1), and (3) with premium freezes where premiums grow at the pre-recession growth rates (i.e., method 2). In 2050, premiums would be 18 percent lower if policymakers did not return premiums to pre-recession scheduled levels.

One could argue that higher fiscal costs associated with method 2 would make it likely that Congress would choose to quickly return premiums to their pre-recession scheduled levels. But doing so would require significant year-over-year premium increases on enrollees. For example, under method 1, premiums would have to rise by 8.2 percent from 2033 to 2034—5.5 percentage points faster than projected price inflation. In 2034, annual premiums for a 40-year-old would rise by \$508 under method 1 compared to \$166 under method 2. As such, the second option reflects the more likely response from Congress, especially considering the first method would require relatively rapid premium increases three years after a recession starts and just one year after it has concluded.

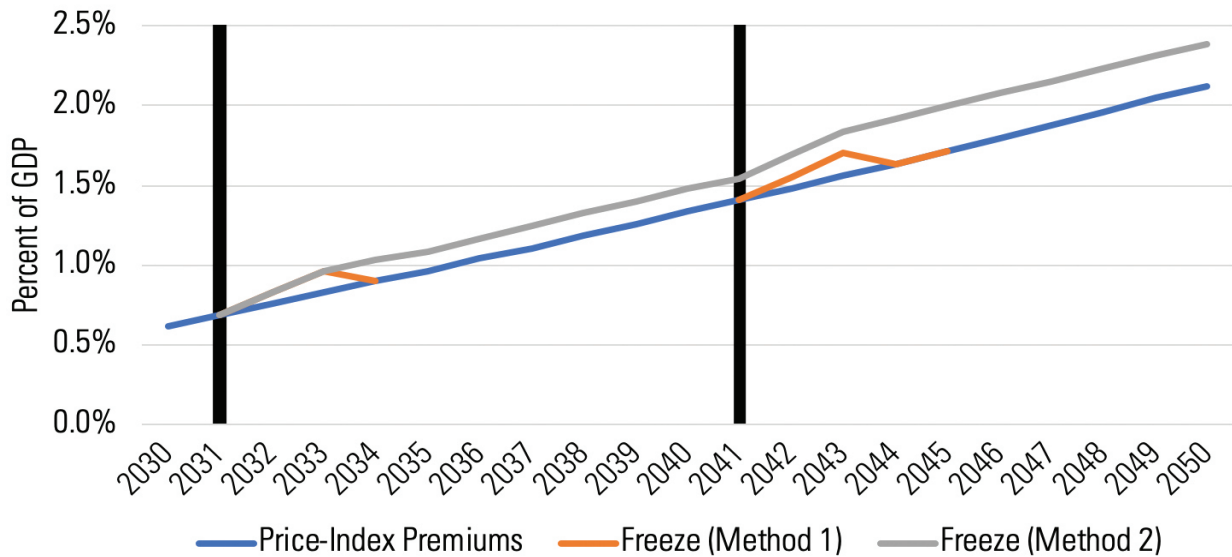
Figure 3. Nominal premium growth with premium freezes



Notes: Black bars indicate the year a recession begins. Method 1 assumes premiums return to pre-recession scheduled levels after freeze. Method 2 assumes premiums grow at pre-recession growth rates but from the lower base.

The long-term fiscal effects from the premium freezes depend on the method chosen for increasing premiums after the freeze ends. Figure 4 shows the non-interest deficits from 2030 to 2050 under the three scenarios. Method 2 would mean the public option’s long-term deficits would grow to 2.4 percent by 2050.

Figure 4. Federal deficits with premium freezes



Notes: Black bars indicate the year a recession begins. Method 1 assumes premiums return to pre-recession scheduled levels after freeze. Method 2 assumes premiums grow at pre-recession growth rates but from the lower base. We use CBO's estimate of nominal GDP for the calculation. Since the recession would lower GDP, the deficit effects would be higher during and immediately after the recessions than shown here.

Table 1 presents the deficit effects in 2020 dollars for selected years. During the stylized 2031 recession and two years after, the deficit effects of either method are identical. The two-year cost of a freeze would be \$51.8 billion in 2020 dollars. In comparison, the temporary increases in FMAPs in ARRA were estimated to cost \$86.6 billion in 2009 dollars.²² After the freeze ends, however, the larger fiscal cost of method 2 is evident in the figure above. By 2050, premium freezes that are not immediately followed by a return to pre-recession levels add 12 percent to the cost of the program.

Table 1. Non-interest deficits from freezes (billions 2020 dollars)

	Price-Indexed Premiums	Freeze (Method 1) ²³	Freeze (Method 2)
2032	\$201.9	+\$16.6	+\$16.6
2033	\$222.2	+\$35.2	+\$35.2
2034	\$245.8	+0.5	+\$34.6
2042	\$456.6	+\$22.5	+\$64.1
2043	\$487.7	+\$44.4	+\$87.2
2044	\$517.2	-\$1.1	+90.5
2050	\$736.9	+\$0.0	+\$92.0

Notes: Method 1 assumes premiums return to pre-recession scheduled levels after premiums are frozen. Method 2 assumes premiums grow at pre-recession growth rates but from a lower base.

²² Kaiser Family Foundation (2009).

²³ Method 1 does not return premiums precisely to their pre-recession trendline. Since the estimates are derived from our microsimulation model, the population that chooses to enroll in the public option is slightly different due to changes in the risk pool from the premium freeze.

Importantly, these estimates assume that the recessions do not produce other changes that would affect the cost of a public option. Specifically, we assume no changes in health cost growth or overall price inflation. In addition, we assume no change in the number of individuals covered by employer-sponsored insurance or enrolled in individual plans (on or off the ACA's Marketplace Exchanges).

By 2050, the premium freezes with method 2 would increase the federal debt by an additional 3.9 percent of GDP, or about \$1.4 trillion in 2020 dollars.²⁴ Including the entire effects of the public option, the 2050 federal debt would rise from 195.2 percent to 229.8 percent of GDP. To avoid this increase in the federal debt, Congress would need to increase taxes or cut spending. As noted in section I, the revenue required to fund the public option would likely require a broad-based tax increase, such as an increase in the Medicare HI payroll tax. We estimated that the politically realistic public option would require raising the HI tax on the typical middle-class family by an inflation-adjusted \$2,533 (2020 dollars) in 2050. The premium freeze would increase this total to \$2,833.

4. Premium Relief for the Unemployed

A public option would require enrollees (or their employers) to pay monthly premiums to the federal government. One question that has received little attention is how the public option would handle a failure to pay premiums. While private insurers may disenroll non-payers, such actions would be politically sensitive for the administrators of a public option.²⁵ This would be especially true for those who become unemployed and lose their ESI coverage.²⁶

Providing premium relief to unemployed public option recipients would be particularly likely during recessions. In recent years, Congress has already shown a willingness to subsidize premiums for the unemployed. For example, ARRA included a provision that paid for 65 percent of COBRA premiums for workers who were involuntarily terminated from their job. The subsidies were available to individuals with incomes below \$125,000 and families with incomes below \$250,000.²⁷ In May 2020, the House of Representatives passed the Health and Economic Recovery Omnibus Emergency Solutions (HEROES) Act. While it was not signed into law, it included a provision that would have fully subsidized COBRA premiums for terminated and furloughed workers until January 31, 2021.

Below, we estimate the cost of subsidizing public option premiums for the unemployed who were enrolled in the public option through their employer-sponsored coverage. We omit those with individual marketplace plans because many are eligible for ACA premium tax credits and would see their premium subsidies rise if they were to suffer income losses. We assume premium relief for the unemployed would occur for a maximum of 26 weeks or until the enrollee finds a new job. This is consistent with time limits for traditional state unemployment programs.

24 Except for the effects of the premium freezes, we do not attempt to account for how the stylized recession would affect long-term budget projections.

25 Typically, private plans on the ACA's Marketplace Exchanges may terminate benefits due to non-payment after a 90-day grace period (<https://www.healthcare.gov/apply-and-enroll/health-insurance-grace-period/>). Medicare Advantage plans must offer a two-month grace period (<https://www.cms.gov/Outreach-and-Education/Outreach/Partnerships/downloads/11338-P.pdf>).

26 The closest parallel to this issue is Medicare Part B, which may disenroll recipients who fail to pay. But, as explained in footnote 12 above, few Medicare recipients pay Medicare premiums directly. Medicare recipients who pay premiums directly and then suffer an economic shock can receive premium subsidies from Medicaid or may begin to collect Social Security benefits if they are eligible and have delayed retirement.

27 Kaiser Family Foundation (2009).

The size of the benefit per unemployed beneficiary is an important consideration. Under the politically realistic public option, the annual premium paid by a 40-year-old enrollee would be \$6,185 in 2022. Thus, an unemployed 40-year-old enrollee would receive a benefit of \$119 per week up to the 26-week maximum. This benefit would be in addition to the enrollee’s implicit subsidy from the politically realistic public option.

This benefit may affect an enrollee’s willingness to find new work because they would lose this premium benefit. While the magnitude of this effect is debatable, research on unemployment insurance programs finds unemployment assistance leads to longer periods of unemployment as recipients are less active in looking for employment and less willing to accept a job offer. These effects are weaker—although not zero—during periods of high unemployment.²⁸ In this case, the premium relief would come in addition to traditional unemployment insurance benefits, further increasing work disincentives.

Would these adverse work effects mean Congress would be leery to enact premium relief for the unemployed? Recent legislative efforts suggest otherwise. The Coronavirus Aid, Relief, and Economic Security (CARES) Act of 2020, for example, extended unemployment coverage to previously ineligible groups and provided a temporary increase in all benefits of \$600 per week. More recently, the Consolidated Appropriations Act of 2021 provided a \$300 increase in weekly unemployment benefits until March 14, 2021. Likewise, in 2009, Congress increased regular unemployment benefits by \$25 per week. The legislative changes also included extensions of unemployment coverage beyond the traditional 26 weeks, suggesting that our stylized 26-week maximum benefit may underestimate the period of premium relief during recessions.²⁹

To estimate the budget effects of the premium relief, we consider three scenarios:

1. *No recessions*: This assumes unemployment rates remain at levels projected in CBO’s most recent *Long-Term Budget Outlook*.
2. *Average recessions*: Recessions begin in 2031 and 2041, and the unemployment gap (the difference between actual unemployment and CBO’s estimate of full employment) matches the average gap of the last four recessions (not counting the 2020 COVID-19-related recession).³⁰
3. *Deep recessions*: Recessions begin in 2031 and 2041 and the unemployment gap matches the path of the 2007 recession.

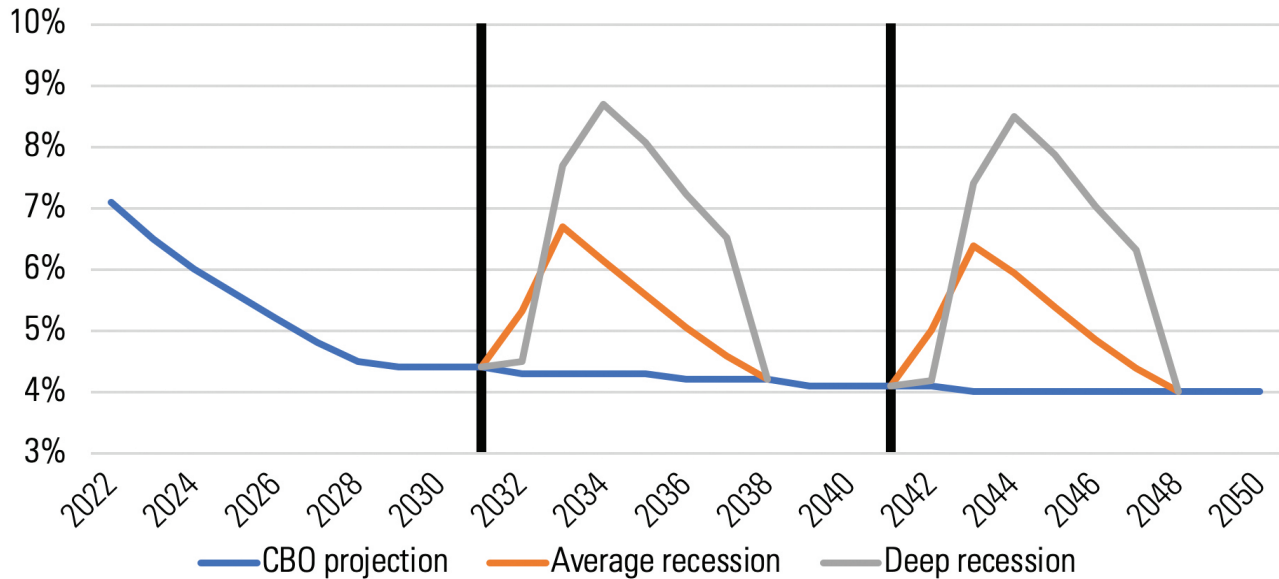
We assume the employment effects of either recession begin in the year following the start of a recession and end six years later. This period is slightly shorter than the time it took to recover from the Great Recession, but it is generally consistent with past recession recovery times. Figure 5 shows the projected unemployment rates under the three scenarios.

28 For a review of the literature see CBO (2012).

29 The Consolidated Appropriations Act of 2021, for example, extended unemployment benefit eligibility to 50 weeks.

30 We use CBO’s estimate for the unemployment gaps for previous recessions (CBO, February 2020). Projected full-unemployment rates are from CBO’s Long-Term Budget Outlook (CBO, September 2020).

Figure 5. Unemployment rates under various recession scenarios



Note: Black bars indicate start of stylized recession.

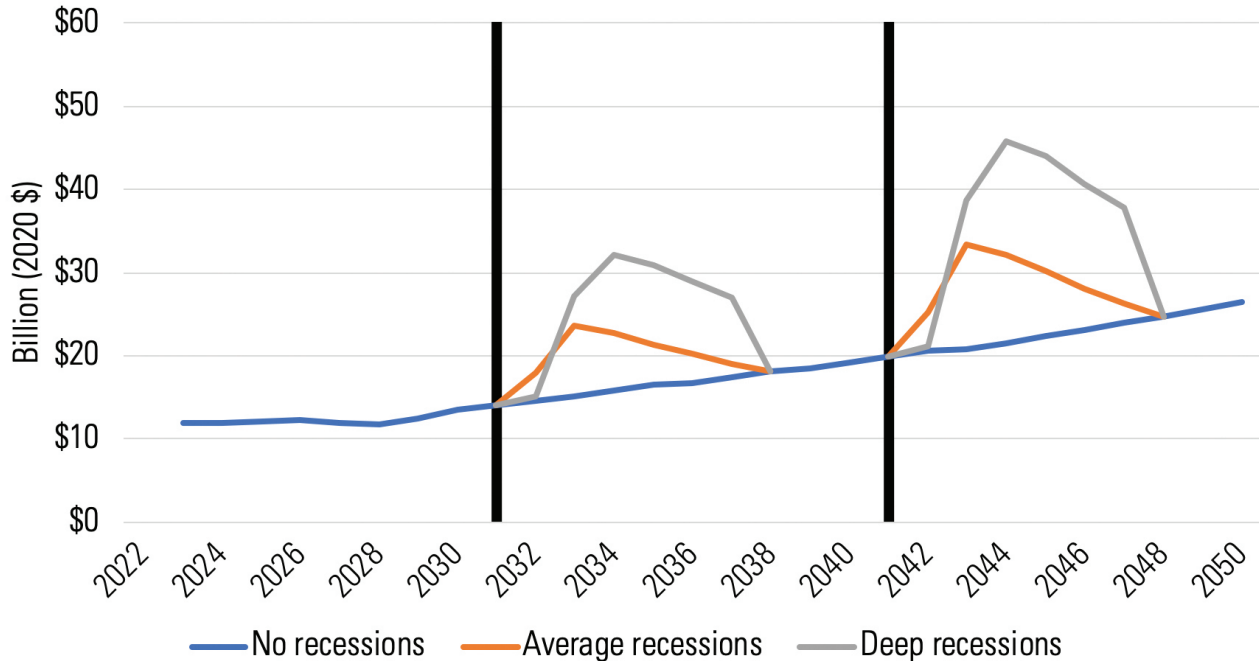
We estimate the budget effects with premium relief for the unemployed using a simulation that randomly assigns unemployment status conditional on several demographic and work variables that affect the likelihood of unemployment.³¹ We then randomly assign the length of unemployment.³² The deficit effects from each scenario are presented in Figure 6.³³

31 Unemployment status is determined by first estimating the probability that an individual will experience a period of unemployment. We impute the probability of unemployment using regression estimates from pooled data (2017 to 2019) from the Annual Social and Economic Supplement to Current Population Survey (CPS ASEC) data. Specifically, we run a probit regression that estimates the probability of experiencing a period of unemployment during the year. The covariates included in the recession are age, sex, marital status, race, education level, industry, and firm size. We then rescale the probability of unemployment by the ratio of projected unemployment in the particular year to the average unemployment over the pooled sample. We then assign unemployment status to individuals where the probability of being unemployed is larger than a randomly drawn variable from a uniform distribution.

32 The length of unemployment is randomly assigned but intended to match the distribution of the length of unemployment using pooled data (2017 to 2019) from the CPS ASEC.

33 The reported deficit effects are the median effects from our simulations. The 5th percentile for each scenario was between 3.4 to 5.3 percent lower and the 95th percentile was 3.4 to 5.3 percent higher.

Figure 6. Deficit effects from unemployment premium relief (2020 dollars)



Note: Black bars indicate start of stylized recession.

Without any recession, the annual fiscal cost of unemployment premium relief would initially cost \$12 billion and grow to \$26 billion by 2050 (using 2020 dollars). Over the first 10 years, the nominal deficit impact would be \$139 billion. This would be in addition to the 10-year deficit effects of \$792 billion for a politically realistic public option without any unemployment premium relief. The peak fiscal costs of recessions, where unemployment rates are consistent with the average of the last four recessions, would be 55 to 60 percent greater. A deep recession such as the 2007 recession would more than double the cost of premium relief in the peak year of unemployment. If the 2031 recession were an average recession, the premium relief would apply to about 6.3 million public option recipients in the peak year of unemployment (2033). The deeper recession would result in 8.3 million receiving premium relief in the peak year (2034).

Our figures do not account for any spending offsets that may occur if the premium relief reduces spending from other programs. For example, the relief could reduce demand for Medicaid or ACA subsidies. This omission is at least partially offset by our decision to include only individuals with ESI coverage. Instead, it seems likely that public option premium relief would be offered to unemployed individuals with individual (i.e., non-ESI) coverage. This is particularly true for those with annual family incomes in excess of the ACA income eligibility thresholds (generally, 400 percent of the poverty line).

The long-term budget effects from the premium relief program would be considerable. Under the deep recession scenario, the larger deficits would add 2.4 percent of GDP to the federal debt in 2050, or \$817 billion after adjusting for inflation. If instead the premium relief were paid for by increases in Medicare HI taxes, middle-income taxpayers would see their 2050 taxes rise by \$89. While this figure may seem small, it would be in addition to the \$2,533 tax increase necessary to finance the politically realistic public option.

5. Health Care Cost Growth Assumptions

The previous two sections have examined how Congress might alter public option premiums to provide economic relief to enrollees. Here we consider scenarios where health expenditure costs rise faster than projected.

In response to a large increase in health costs, Congress would have a few good options. First, they could follow the framework of typical public option proposals and raise premiums to cover the increased costs. Second, Congress could opt for other cost-cutting measures such as narrowing networks or increasing cost-sharing requirements. Third, Congress could cut reimbursement rates for doctors and hospitals. As discussed in our previous work and in the above sections, the political ramifications of any of these options seem to weigh heavily against them. Instead, the most likely option is that Congress would choose to further increase the implicit subsidy. We estimate the effects of this choice below.

Our current public option estimates rely on CBO's projections to determine the growth rate in private health care premiums and medical spending. Long-term cost estimates for other federal health care plans use these same projections. Over the long run, small changes in expected growth rates will have large effects on our cost estimates.³⁴

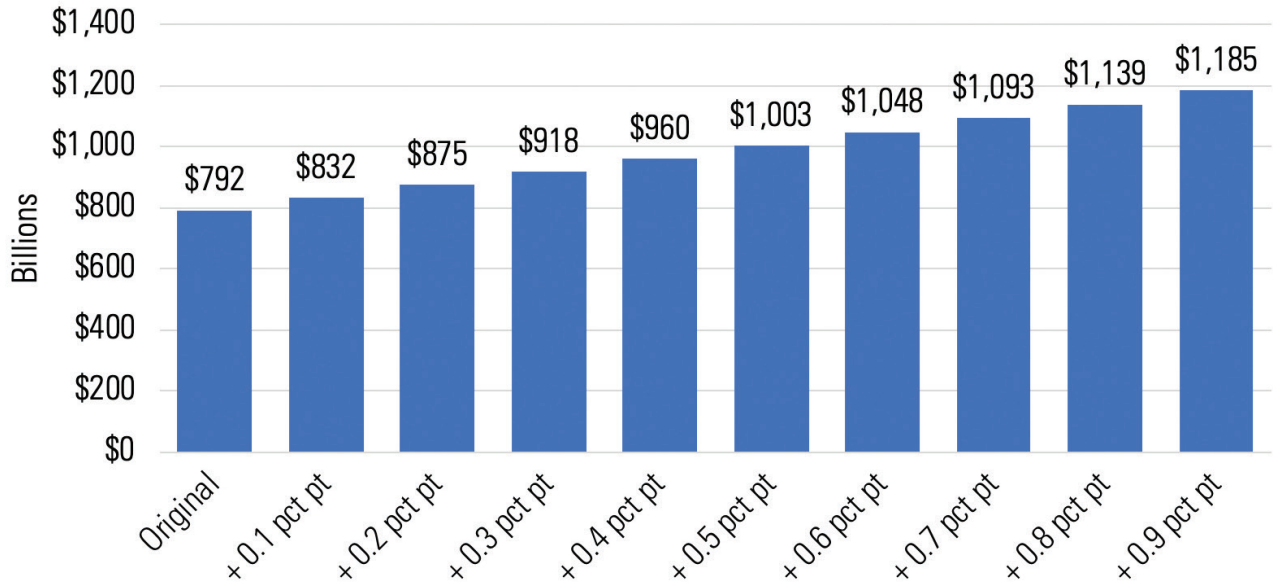
In 2031, CBO assumes private health care premiums and expenditures per enrollee will grow 1.49 percentage points faster than potential GDP per capita. CBO calls this "excess cost growth," and it is critical to long-term costs. This excess cost growth will fall linearly to 1.0 percentage points by 2050, averaging 1.2 percentage points over the 20-year period. As noted by CBO, this is 0.9 percentage points lower than the average rate from 1985 to 2017.³⁵ The average long-term growth rate is approximately 4.6 percent. Thus a 0.9 percentage point increases the growth rate by less than 20 percent.

If our health care cost growth assumptions for private health care prove to be too low, the costs from a politically realistic public option would be significantly higher. Figure 7 shows the 10-year budget effects under various growth rate increases. We estimate that if cost growth is 0.9 percentage points higher than projected in every year from 2022 to 2050, the public option's 10-year deficit effects (excluding interest) would rise from \$792 billion to \$1.19 trillion.

³⁴ Our analysis is not unique. CBO regularly considers how the long-term budget outlook would change if excess cost growth for Medicare and Medicaid were 1.0 percentage points higher or lower than their baseline estimate. For example, in 2019, CBO estimated that a 1.0 percentage point increase in the excess cost growth for Medicare and Medicaid would increase the 2049 federal debt by 54 percent of GDP (CBO, 2019, Box 1-1 in the supplementary data file).

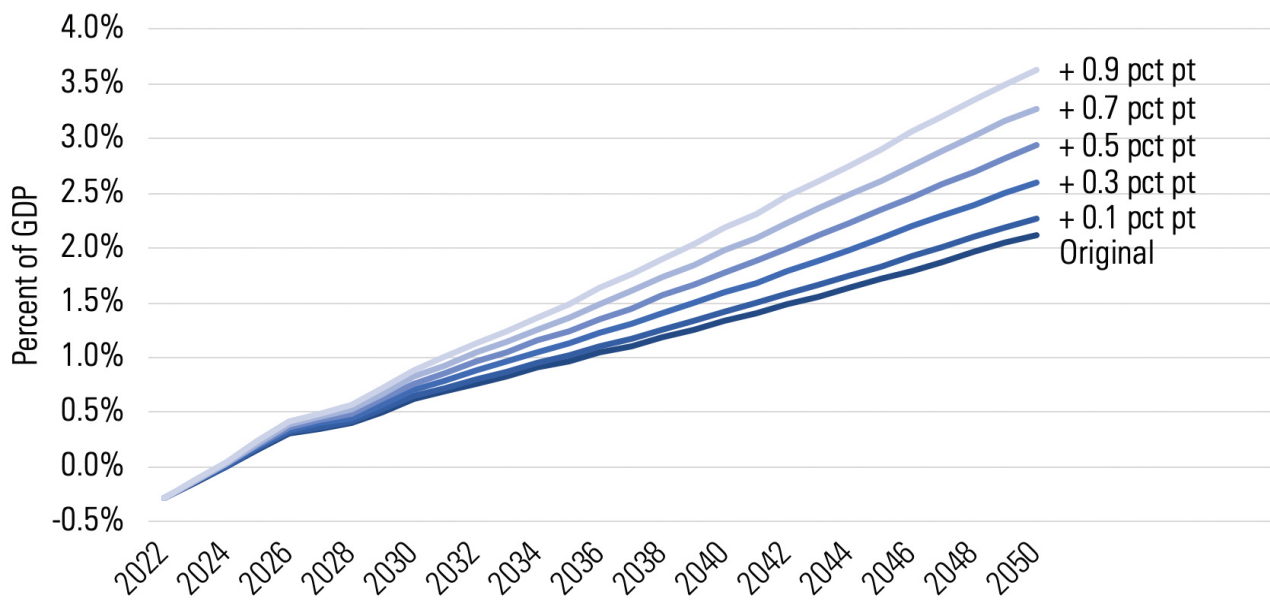
³⁵ CBO (September 2020), page 64.

Figure 7: Higher health care cost growth: 10-deficits (2022 to 2031)



Since the increased cost growth would be compounded over time, the long-term effects are far larger. Figure 8 shows the 30-year non-interest deficit effects of the public option under various cost growth rate increases. By 2050, a 0.9 percentage point increase in the growth rate would increase the non-interest deficit by 1.5 percent of GDP. This would be in addition to the 2.1 percent increase from the politically realistic public option with our standard growth projections.

Figure 8: Higher health care cost growth: 30-year non-interest deficits



Adding interest expenses would further increase the costs of the program. Under a deficit-financed public option, the 2050 federal debt would increase from 225.9 percent in the politically realistic public option with the baseline cost growth assumptions to 245.6 percent with the 0.9 percentage point increase in health care cost growth. This would increase the public option’s debt effects by 64 percent. Under the most extreme scenario, total federal deficits would reach 18.3 percent of GDP, an increase of about 45 percent relative to CBO’s 2020 projections.

Avoiding these debt increases would require substantially higher taxes. In Figure 9, we estimate the increase in the HI payroll tax necessary to prevent the public option from adding any increase in the debt. Under our baseline excess cost growth projection, the payroll tax would need to rise to 7.8 percent by 2050. If cost growth is 0.9 percentage points higher than expected, the rate would rise to 10.9 percent, nearly a four-fold increase from the current rate.

Figure 9. Medicare payroll tax rate under various cost growth assumptions

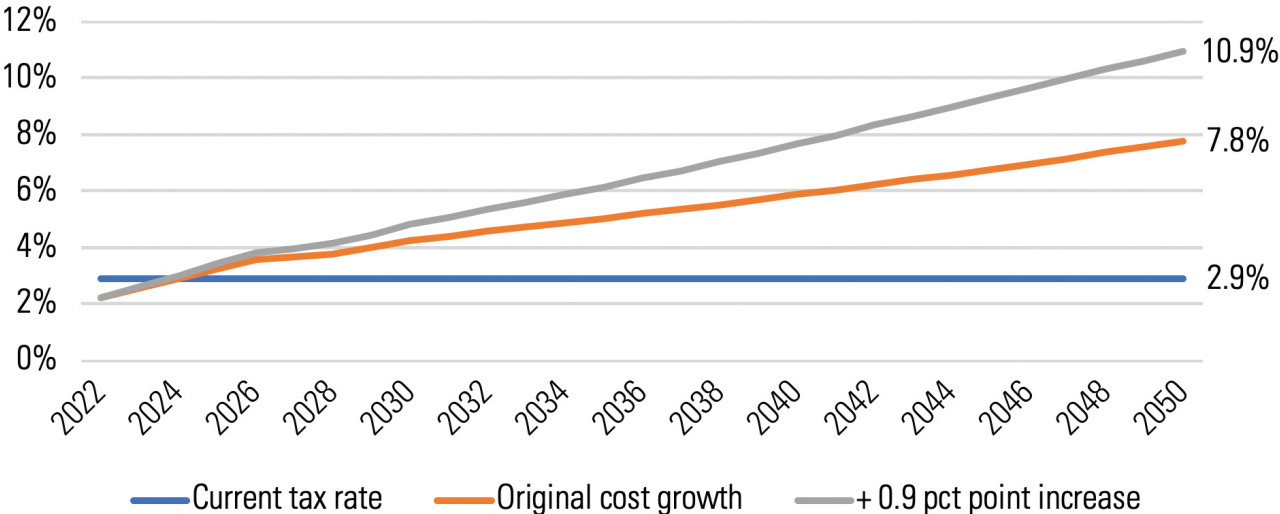


Table 2 illustrates how this new tax increase would affect future taxpayers. Recall, the middle-income tax increase needed to finance a politically realistic public option is \$2,533 (2020 dollars). If the excess cost growth is 0.9 percentage points higher than projected, the tax increase would rise by \$1,618 to \$4,152. Upper-income households would see even larger increases.

Table 2. Median tax increase by quintile under various assumptions (2020 dollars)					
	Lowest	Second	Middle	Fourth	Highest
Original Estimate	\$0	\$1,425	\$2,533	\$4,322	\$8,922
+ 0.9 pct point increase	\$0	+\$913	+\$1,618	+\$2,786	+\$5,603
Total new taxes	\$0	\$2,338	\$4,152	\$7,108	\$14,525

Note: The typical family in the first quintile doesn’t have wage income, thus the median tax increase is zero.

While our baseline cost growth estimates rely on CBO’s best guess of excess cost growth, the analysis above reveals a troubling reality: relatively minor adjustments to future health care costs growth rates would lead to rapidly growing federal deficits or require much higher taxes on working Americans.

6. Conclusion

Each of our stylized examples reflects a probable scenario that would further increase the cost of a public option. While it is unlikely that any of the scenarios perfectly reflect how future Congresses will behave, they each mirror the historical behavior of Congress to enhance entitlements, particularly during recessions. Each example casts doubt on the idea that future Congresses will have the political fortitude to maintain the promise of a budget-neutral public option. If Congress breaks this promise, taxpayers will find an expensive new government program that fuels higher debt levels or requires painful tax increases.

A likely objection to this analysis is that the predicted excess spending would occur whether or not a public option was enacted. In fact, one might argue that, insofar as our stylized examples prove prescient, the public option will provide Congress with a useful vehicle to support families during future economic downturns.

To be certain, in the last two recessions, Congress has shown an increased willingness to increase spending dramatically during recessions. The CARES Act, for example, added approximately \$2 trillion to the FY2020 deficit, and the Consolidated Appropriations Act of 2021 included \$900 billion in economic relief related to the COVID-19 pandemic. Nevertheless, the nature of the public option would likely increase the urge to spend. As we have shown, the public option represents a dramatic departure from most government programs. Not only would the plan's enrollment dwarf participation in any other program, but the plan is unique in that all enrollees would be writing checks to the government in exchange for coverage. This means that, rather than having to send checks to individuals, recession-related subsidies for the public option would only require Congress to suspend the collection of payments or delay premium increases. The fact that scheduled premium increases would likely coincide with federal elections every other year further increases the likelihood that in bad economic times, Congress would find the premium-relief measures irresistible.

Congress will undoubtedly have strong political reasons to use the public option to distribute economic relief, but there are reasons to question the efficacy of using the public option for this purpose. First, since a public option would not be means-tested, the fiscal relief would be poorly targeted. Any direct subsidy to premiums would benefit individuals across the income distribution. In fact, since Medicaid would continue to provide coverage for most low-income families, subsidizing the public option would largely benefit those above the poverty line.

Second, since not all Americans would be enrolled in the public option, the relief would be allotted randomly based on a pre-recession choice of health insurance.

Third, as shown in our examples, manipulating public option premiums would likely have long-term effects on the cost of the program and the insurance market more generally. Much of the increased deficits from our recession-related examples would occur in the years after a recession. As shown in section III, unless Congress is willing to dramatically increase premiums in the middle of a nascent recovery, the premium freezes would have long-lasting effects on the federal budget. Likewise, unemployment premium relief might be a temporary measure during recessions, but it seems probable that politicians would not be eager to disenroll laid-off individuals even during good economic times.

Public option proponents continue to sell the plan as a low-cost method for expanding access to and making health insurance more affordable. Ultimately, the inherent design of the program makes it vulnerable to the same legislative expansions that nearly all federal entitlement programs have experienced. The result may happen incrementally, but over time, the public option will likely evolve into a very expensive program that bears little resemblance to the plan its supporters claim to desire.

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