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A Modest Proposal for a Competing Public Health Plan

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Executive Summary

Many comprehensive reform proposals reflect the fundamental need to control health care costs and create a marketplace wherein insurers compete on value and customer satisfaction, rather than risk selection and marketing. Several leading proposals promote competition between private health plans and a "public" health insurance option. Unfortunately, the debate over this issue has become polarized unnecessarily.

It is possible to structure a new insurance marketplace so that public and private health plans compete on a level playing field. This will require separating the oversight of the public plan from that of the managers of the marketplace or exchange(s). It will also require that all rules of the marketplace – benefit package requirements, insurance regulations, and risk adjustment processes – apply to all plans equally, whether public or private. Finally, this model requires that we address cost growth containment systemically and avoid relying heavily on the public plan's potential market power. In turn, this will require a commitment on the part of policymakers to acquire a health information infrastructure, develop best practice information, and encourage re-aligned incentives that promote high-quality, efficient care for all.

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The individual and small group health insurance markets do not work well today for many participants and potential participants alike.[1] The cost of health care and the rate of health care cost growth make it difficult for many people to afford health insurance or essential care. Likewise, an increasing number of large employers are worried about cost trajectories. Many employers and employer groups are searching actively for ways to achieve more value for the money they spend on health care.[2]

Many comprehensive reform proposals reflect the fundamental need to control health care costs and create a marketplace wherein insurers compete on value and customer satisfaction, rather than risk selection and marketing.[3] Several leading proposals promote competition between private health plans and a "public" health insurance plan. This policy brief will articulate the motivations and reservations surrounding the public plan option and examine possible ways to address them within a framework that advances the debate. Specifically, we will identify the technical conditions under which a public plan could compete fairly with private plans, assuming ideology can be put aside.

Motivations and Reservations

Why do we need a public insurance plan?

Many analysts and policy proposals agree on the reforms necessary to make insurance markets work better for all, especially for those individuals who do not have large employers guaranteeing access and negotiating with providers and insurers on their behalf. These reforms include:

1. No penalties for health status
2. A minimum benefit package
3. Sliding scale subsidies
4. Risk adjustment
5. A requirement to purchase or enroll in coverage

Policy Spotlight: Insurance Market Reforms to Make Private Markets Work for All

- *No penalties for health status* to enable anyone to buy quality coverage regardless of their health history. Guaranteed issue,* guaranteed renewal, modified community rating,** and no pre-existing condition exclusions.
- *A minimum benefit package* to ensure quality coverage. This could be a particular package or an actuarial value minimum. Supplements may be offered but must be priced separately.
- *Sliding scale subsidies* to make high-value insurance package affordable for all.
- *Risk adjustment* across insurers based on objective *ex ante* data to reduce the financial risk of adverse selection for insurers.
- *A requirement to purchase* or enroll in coverage to balance the risk pool, reduce the risk of adverse selection, and ensure that "free riders" pay their fair share for health care.[4]

** insurers required to sell to everyone regardless of health status; **premiums cannot vary based on health status*

Some analysts, including the authors, think that a market comprised exclusively of private plans can achieve satisfactory performance with these reforms. We admit that there are few real-world examples that prove this kind of system would function as anticipated, though reforms in Massachusetts are making great strides.

More importantly, we acknowledge that many advocates and citizens are skeptical that regulations or contracts will ensure private insurers comply with all reforms for all people.

Documented examples of insurers refusing to authorize or pay for care that would benefit insured patients have reduced trust in all private insurers, even those that operate on a non-profit basis.[5] Some people remain skeptical that new insurance market rules will prevent private insurers from putting their own bottom line ahead of quality care and patient safety. Therefore, an overall distrust of private insurers is a central motivation for the public plan option.

Others argue that the insurance industry is hard to regulate because it suffers from a widespread lack of transparency. Key data about administrative costs and factors driving premiums are not publicly available. As a result, some assert the public plan would add value as a benchmark competitor from which consumers could gain information about the inherent reasonableness of premiums, provider networks, administrative costs, and the overall performance of private plans.[6] Teaching the public about the "black box" of administrative costs could be especially valuable. Insurance market reforms that end the profitability of marketing and underwriting and simplify administrative, billing, and incentive structures for providers could yield efficiencies.

Finally, and perhaps most controversially, some analysts believe that the public plan should capitalize on its potential buying power to reduce cost growth and improve value per dollar.[7] This power is necessary to counter local provider market power, which dominates many communities.[8] Under this scenario, the public plan would set prices by leveraging the buying power of Medicare to negotiate the lowest possible rates with providers. In turn, this could force competing insurers to be more aggressive with and demanding of providers. Indeed, supporters of this position believe that exploiting the power of a large public plan is necessary to make the delivery system as a whole more efficient and sustainable.

Why wouldn't everyone want a public plan?

Opposition to the idea of a public plan is equally strong. Concerns stem from the basic fear that a public plan will inevitably lead to a single payer system run by the government and therefore reduce choice and access to timely care.[9]

Two beliefs are at this view's core. First, some fear the federal government cannot be trusted and will favor the public plan in the application (or exemption) of some market rules. If the playing field is not level, then private plans will not be able to compete. This is particularly problematic because private plans per se are the *sine qua non* of many who hold this belief. Therefore, the public plan must not be allowed to exist. People who hold this view are trying to create a litmus test on this issue.

The second belief is that the public plan option can and will use the power of other public plans to pay providers lower rates than private insurers. More specifically, most providers could not afford to refuse to participate in Medicare because of its size. The public plan could capitalize on this and force providers to concede lower rates by leveraging their participation in Medicare. As a result, providers would shift costs to other private payers to make up for the underpayments by the public plan. Private insurers, providers, and self-insured employers share this view.[10]

Finally and most directly, some observers simply do not want the public share of the health care system to grow. Instead, they would prefer that public programs shrink. For these people, no form of a public plan is acceptable.

Can the Impasse Be Overcome?

Given the strength of conviction on both sides, it is not possible to construct a feasible alternative public plan that can satisfy everyone. However, we believe the type of public plan we describe can achieve many of the goals of public plan advocates, while preserving fair and effective market

competition, negating the risk of excess cost-shift, and avoiding an inevitable drift to a single payer health system.

The key to achieving fair competition is to set and enforce the rules of the insurance marketplace (or exchange) in such a way that they apply to all participants, public and private alike. All rules must apply to all plans. Holding public and private plans accountable to the same market conditions will make the public plan both effective and non-threatening to private insurers and providers. In addition, the governance structure must be designed to isolate the public plan from unfair advantages and perverse incentives.

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Before we specify the conditions in detail, however, three examples are worth noting. First, respected analysts believe that the competition between traditional fee-for-service Medicare (a public insurer with market power) and private health plans (e.g., Medicare Advantage) since the early 1980s shows that public-private competition, while never perfect, can be adjusted and managed reasonably well over time.[11]

Second, the California Public Employees Retirement System (CALPERS) allows private plans to compete with a PPO self-insured by the state quite successfully.[12] In addition, more than 30 state governments offer their employees a choice between traditional private health insurance products and a plan self-insured by the state.[13] This too serves as proof-of-concept: plans operating with politically-appointed managers can compete with plans run by private managers provided the "rules of engagement" are similar (or preferably identical).

Current experience also teaches us that health insurance products can be managed by private firms and still satisfy public policy purposes. In fact, about 77 percent of State Children's Health Insurance Program (SCHIP) enrollees and 64 percent of Medicaid beneficiaries are enrolled in private managed care plans.[14]

Conditions for Fair Competition

Governance

The administrators of the public plan must be accountable to an entity other than the one identified to govern the marketplace. In other words, the authority overseeing the marketplace (exchange) and enforcing its rules should not have an incentive to favor the public plan over private plans. For example, the public plan administrator could report to the Secretary of Health and Human Services, while the exchange (or exchanges) could be run by a non-profit, non-governmental entity that answers to an independent Board of Directors. The composition and balance of power among competing interests on the Board could be written into the enabling statute or non-profit charter, as the Medicare Payment Advisory Commission is today.[15]

Policy Spotlight: State Employee Health Plans

More than 30 state governments offer their employees a choice between traditional private health insurance products and a plan self-insured by the state. In the case of the self-insured product, the state or a third party administrator (TPA) negotiates provider contracts and performs administrative functions. While the state may pay a TPA (usually the resident "Blue" plan) to handle some tasks, the plan is publicly owned and financed. If claims outpace premiums in a given year, the state pays and is at risk for the difference. Likewise, if the TPA collects more premiums than it pays out in claims, the surplus dollars are usually allocated to a premium stabilization fund or remain with the state's general revenues. The TPA never profits more than agreed upon in the administrative fee.

Exchanges could be organized on national, state, or local levels. As a result, the Secretary (or state Governors) might appoint regional or local managers for each specific branch of the competing public insurance plan. Each manager could respond specifically to the market conditions and competitors in their area. Plan managers should not report to the CMS (Center for Medicare & Medicaid Services) Administrator because of CMS's authority over Medicare and Medicaid.

Under this design, the managers of the public plan will be evaluated by enrollee satisfaction and the overall quality and financial performance of the plan. Devising the governance structure in this way will prevent the managers of the public plan from having financial incentives to stint on the quantity and quality of care. This should reassure citizens who prefer a management structure that is accountable to political leaders over a corporate (or even non-profit) board of directors. The political purpose of a public plan is to create a haven for individuals who are skeptical of private health insurers at the outset of a newly reformed marketplace.

Structure of Public Plan

Some policy proposals suggest that the simplest way to invoke the public plan option is to give all Americans access to the Medicare program. Yet, creating a marketplace where private insurance plans could compete fairly with Medicare for the under-65 population would be difficult and complex for a number of reasons described below. Therefore, we believe the public plan option cannot be Medicare.

Premiums and Providers

The new public plan must be actuarially sound. This means it must charge premiums that cover its costs. The public plan may not be subsidized using additional government revenues (but low-income subsidies will likely be used by people choosing between the public and private plans). In addition, the public plan cannot leverage Medicare (or any other public program) to force providers to participate. For example, the public plan cannot require providers to serve public plan patients as a condition of participating in the Medicare program (sometimes called "cram-down").

Likewise, the plan should not be required to use Medicare payment rates. Instead it must offer rates that elicit voluntary participation, which means providers should have the same freedom to negotiate with the public plan as they do with other private carriers. As a result, the public plan's payment rates and its provider networks might differ from those of its competitors and from Medicare. We do not suggest using the public plan's pricing power to control costs. Therefore, we must deal with cost growth symmetrically across plans, instead of primarily through the public plan. We address the issue of cost containment later in this paper.

Rules of Operation

The rules and regulations governing the public plan must be the same as those governing private plans (see appendix for a complete list of specific conditions). For example, the public plan must sell to everyone regardless of health status (just like private plans). The public plan must also meet the

Limitations of Medicare as the Public Plan Option

Creating a marketplace where Medicare could compete fairly for the business of the non-elderly population would be difficult for a number of reasons. First and foremost, fee-for-service Medicare's market share is so large that private insurers would be skeptical of their ability to negotiate comparable provider price discounts in most markets. Health care providers would fear that Medicare's buying power would be extended to the under-65 market for the same reason. Two-thirds of hospitals have negative Medicare margins today.[16] Therefore, opposition to this possibility would be intense.

In addition, Medicare's benefit package is not as generous as most employer-based plans. As a result, there would be tremendous pressure to increase its comprehensiveness to meet the minimum standard benefit requirements of the exchange. This would unleash demand to increase its comprehensiveness for the already covered elderly and disabled populations, costing taxpayers as much as 15 to 20 percent more than under current law.

benefit standard identified by the authority governing the market. If market policy allows for actuarially equivalent plans to satisfy the minimum threshold, the public plan should have the freedom to offer actuarially equivalent packages accordingly. Likewise, the public plan should have the freedom to manage benefits. For example, the public plan could take shape as a PPO or HMO depending on what best meets local market competition.[17] Additionally, the public plan should have the choice to sell supplemental packages containing more comprehensive benefits priced separately.

Subsidies

The public plan cannot be granted an unfair advantage in enrolling the uninsured or low-income individuals who will presumably be eligible for subsidies in the new marketplace. This means individuals should be able to apply subsidies to the public or private plan of their choice. If automatic enrollment is in place, enrollees should be enrolled randomly in similarly low-cost plans and should not be defaulted exclusively into the public plan.

Financial Reserves

Public and private insurers should be required to adhere to the same rules regarding reserve funds. First, all insurers operating in the exchange should be required to have reserve funds equaling their incurred but not reported (IBNR) claims. This usually equals about 20 percent of their annual budgets. Insurers should be allowed to earn interest on these reserves.

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In lieu of solvency requirements (because a state or government cannot be insolvent), the public plan must also establish a Premium Stabilization Fund. The Fund would be used to capture possible surplus premium dollars and reduce premium increases from year to year as a result of higher-than-expected claims. This model is currently used by the Federal Employees Health Benefit Program (FEHBP), as administered by the Office of Personnel Management (OPM).

High-Value Insurance

We should keep in mind, however, that all health plans need initiatives like chronic care management and health information technology to deliver value. In the case of a self-insured product operated by a TPA, the costs of these high-value services would likely be spread across the TPA's clients. If the public plan chose not to contract with a private insurer, however, it would need to generate an operating margin to invest in these programs. The public plan would also need to contribute towards value-based initiatives that benefit all payers. For example, if an assessment for funding comparative effectiveness research were levied, private plans and the new public plan must be required to contribute proportionately.

If run effectively, the public plan could be a leader in quality and price and provide a trusted benchmark for consumers. In the spirit of competition, however, if the plan is managed poorly it will likely not garner trust, growing enrollment, or favorable ratings from its enrollees or the public.

A Note on Cost Containment

The disagreement over the potential uses of the public plan to rein in system costs could not be more profound. Our vision would not use the public plan's potential market power over provider payment. We know that opposition to this use of the public plan is intense. System-wide cost containment can be achieved in other ways. Let us be clear: we offer a compromise solution to the "public plan" debate not to downplay our overwhelming need to increase value per dollar and reduce cost growth per capita in the long run, but rather because we think both objectives are more likely to be sustainable over time if we use techniques less-reliant on price controls.

In addition, public plans that do capitalize on market share are not without cost-containment challenges. For example, recent experience with the sustainable growth rate (SGR) formula in Medicare indicates that behavioral responses to price setting can lead to inappropriate utilization because physicians respond to predictable downward price movements by increasing the number of services provided to "maintain income."[18] Managing costs by price alone is not easy.

Our approach to cost-containment would be more systemic and utilize combinations of information, incentives, and Medicare as a catalytic value-based purchaser. Health information technology, along with decision support tools and comparative effectiveness or best practice research, could provide each clinician-patient encounter with state-of-the-art options for most serious conditions within 5 years, as many integrated systems provide today. When coupled with new payment structures that bundle service payments and align interests across sites and providers, these information tools (and sensible malpractice reforms) could turbo-charge the pace of transformation toward increased efficiency and higher quality. Pockets of excellence exist today; however, their practice styles are not spreading fast enough because of poor system-wide incentives. Payers – public and private alike – will have to be vigilant and demanding to drive this change. To be sure, some provider resistance will be intense. Yet, covering the uninsured will allow providers to see a pathway to survival and will therefore go a long way toward delivery system changes. Stakeholder leadership and good policy, including transition support, can be helpful in clarifying these essential pathways to a better health care system.

Compared to price-control centered strategies, our approach to cost containment relies on a more market-oriented approach to value-based purchasing, which admittedly could take some time to materialize. Yet, this kind of policy is also more likely than the buying power of one public payer to find a politically sustainable balance between access, quality, and affordability over time. In addition, there is widespread agreement that the main source of health care cost growth in the long run is not provider price inflation, but rather inappropriate use of new technology. This fact suggests that the key to controlling health care cost growth over time is system-wide value-based purchasing, which is the most likely result of better aligned incentives between hospitals, physicians, payers, and patients. Thus, we think payment reform and best-practice information is more likely to enable sustainable cost growth reduction than price controls from public plan market power alone.

Conclusion

We were motivated to write this paper because we felt the debate over including a public plan in a reformed health insurance market was reaching a premature and unnecessary impasse. The real-world experiences of state and federal governments as well as the model of a competing public health insurance plan that we describe suggest that it is possible to structure a level playing field in which public and private health plans can compete fairly and effectively. This will require separating the oversight of the public plan from that of the managers of the marketplace or exchange(s). It will also require that all rules of the marketplace – benefit package requirements, insurance regulations, and risk adjustment processes – apply to all plans equally, whether public or private. Finally, this model requires that we address cost growth containment systemically and avoid relying heavily on the public plan's potential market power. In turn, this will require a commitment on the part of policymakers to acquire a health information infrastructure, develop best practice information, and encourage re-aligned incentives that promote high-quality, efficient care for all.

The real-world experiences of state and federal governments as well as the model of a competing public health insurance plan that we describe suggest that it is possible to structure a level playing field in which public and private health plans can compete fairly and effectively.

Appendix: Conditions for Fair Competition

The administrators of the public plan must be accountable to an entity other than the one identified to govern the marketplace. In other words, the authority overseeing the marketplace (exchange) and enforcing its rules should not have an incentive to favor the public plan over private plans.

The public plan cannot be Medicare. Creating a marketplace where private insurance plans could compete fairly with Medicare for the under-65 population would be difficult and complex for a number of reasons. Therefore, we believe the public plan option cannot be Medicare.

The new public plan must be actuarially sound. This means it must charge premiums that cover its costs. The public plan may not be subsidized using additional government revenues.

The public plan cannot leverage Medicare (or any other public program) to force providers to participate. For example, the public plan cannot require providers to serve public plan patients as a condition of participating in the Medicare program.

The public plan should not be required to use Medicare payment rates. Instead it must offer rates that elicit voluntary participation, which means providers should have the same freedom to negotiate with the public plan as they do with other private carriers.

The insurance market rules and regulations governing the public plan must be the same as those governing private plans. These rules and regulations include: guaranteed issue, guaranteed renewal, modified community rating, flexibility to charge different rates on geography, risk adjustment, no pre-existing condition exclusions, marketing rules, open enrollment periods, limits or reporting requirements based on premiums to claims ratios, minimum benefit package.

The public plan cannot be granted an unfair advantage in enrolling the uninsured or low-income individuals who will presumably be eligible for subsidies in the new marketplace. This means individuals should be able to apply subsidies to the public or private plan of their choice.

Public and private insurers should be required to adhere to the same rules regarding reserve funds. All insurers operating in the exchange should be required to have reserve funds equaling their incurred but not reported (IBNR) claims. In lieu of solvency requirements (because a state or government cannot be insolvent), the public plan must also establish a Premium Stabilization Fund. This model is currently used by the Federal Employees Health Benefit Program (FEHBP).

The public plan would also need to contribute to value-based initiatives that benefit all payers. For example, if an assessment for funding comparative effectiveness research is levied, private plans and the new public plan must be required to contribute proportionately.

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