Public Plan Option: Fair Competition or a Recipe for Crowd-Out?

Panelist Responses to Written Questions
May, 2009

In April 2009, the Alliance for Health Reform, with support from the Commonwealth Fund, held a Capitol Hill briefing to examine a public plan option in the context of health reform. Panelists were **Karen Davis**, The Commonwealth Fund; **Karen Ignagni**, America's Health Insurance Plans; **John Holahan**, Urban Institute; and **Stuart Butler**, The Heritage Foundation.

Following the panel presentations, many participants submitted written questions. Though several questions were addressed on site, there was not sufficient time to answer all. The Alliance asked the panelists to respond in writing to any or all of the remaining questions. Following are their responses.

Questions for Karen Davis:

Cost Containment

One questioner would like specifics on how a public plan would save money

(KD) A public health insurance option within the context of a national health insurance exchange has the potential to bend the health care cost curve by reducing administrative costs, increasing competition and driving private sector innovation, and creating a broad base to apply delivery system innovations and improvements such as payment reform, utilization of comparative effectiveness research, and steps to coordinate care. The degree to which a public health insurance option is able to slow the rate of cost growth depends on how it is structured, who is allowed to enroll and on the policies applied through this option. An estimate by the Lewin group found that if we implemented all of the policies presented in the *Path to a High Performance Health System* report together and opened the insurance exchange (with a public plan option) to all employers within five years, we could save $3 trillion over eleven years from 2010 to 2020. However, if the exchange did not include a public health insurance option at all, these policies would yield only about $800 billion over eleven years.

How does Commonwealth's estimate of cost benefits of a public plan incorporate the $40 trillion unfunded liability of the current Medicare Program – and if not incorporated, can that provide a fair comparison to private plans?

(KD) Neither private plans nor the public health insurance plan pre-fund future years of coverage; rather premiums are set to cover expected outlays in the upcoming year including a reserve for unanticipated high expenses. A public health insurance option could incorporate and streamline subsidies to make

coverage affordable for poor and near-poor families but would not be largely funded by the federal government the way the Medicare program is. Like private plans, a public health insurance plan can be financially self-sustaining, with premiums set to cover projected medical outlays and administrative overhead.

Questions for Karen Ignagni:

Guarantee Issue

The Lewin Group estimates that, if a reform plan like the one it modeled were fully implemented, there would still be 20 million people uninsured. If that were true, would insurance plans still be willing to ignore health status in issuing and setting premiums?

(KI) For guarantee-issue to work, it is necessary for everyone to be brought into the system and participate in obtaining coverage. Achieving this objective will require specific attention to the mechanisms for enforcing the personal coverage responsibility. In the example offered, 20 million people constitute over 6% of the U.S. population. Our goal is to bring everyone into the system, which will allow a guarantee issue environment – where health insurance plans issue coverage regardless of health status – to be sustainable over the long-term.

Rates

You noted there would be little left of the private market with a public option that paid Medicare rates. What would be the effect, and downside, if the public plan option used "private payment rates?"

(KI) Requiring a government-run public option to use "private payment rates" would mean that the government-run plan would need to compensate doctors and hospitals based upon market rates for their services. To pay "private rates" the government-run public plan would have to negotiate with providers, and conform to rules such as those for network adequacy, and move away from a model based on administered pricing. It would similarly mean that the government-run public plan could not leverage other public programs like Medicare to require that providers work with them. However, serious consideration would need to be given to whether a government-run public option, even if it initially paid "private payment rates," would likely fall into the government pattern of paying sub-market rates to providers as Congress pressures the government-run plan to restrain costs.

Competition

Looking at FEHBP, the greatest enrollment is in the most expensive plan. If private plans have more tools and provide extra value, why wouldn't consumers choose private plans over a public option? Wouldn't this be fair competition?

(KI) Some consumers would gravitate to private health insurance plans that deliver disease management services, high-quality provider networks, and wellness and prevention benefits. But these programs, while they may produce savings down the road, cost money up front. If a government-run public option mirrored Medicare by not including these programs and underpaying doctors and hospitals, the public option may be a cheaper product – especially for low-income families and small businesses that struggle to offer health coverage for their workers. Projections from the Lewin Group indicate that health insurance coverage for up to 120 million people would be disrupted as those people are funneled into the government-run health plan.

Transparency

Will private insurers make their contracts with providers publicly available so that consumers can know payment and other terms when choosing among private plans?

(KI) Consumers and purchasers need accurate information to make more informed health care decisions. At the same time, the disclosure of this information should comport with antitrust guidelines to ensure that vigorous competition continues to thrive in the marketplace. To achieve this objective, ranges – such as the 25th percentile and 75th percentile of payments to hospitals which are disclosed by Medicare – should be the model for disclosing price information. This information would assist consumers in selecting a health plan based upon the ranges of rates paid to providers.

For enrollees of a health plan, information should be made available to permit accurate comparisons of physicians, hospitals and other practitioners. Information should be disclosed and displayed in a format that is easily accessible and understandable and consumers should be educated on how to use that information.

Questions for All Panelists:

Are there lessons from other countries regarding government steering function of private insurance companies?

(SB) Yes, countries like Switzerland suggest that we can have the government involved in setting up the architecture of an FEHBP-like system – without having to have a public plan.

(KI) Two countries, the Netherlands and Switzerland, offer examples of governments regulating a health insurance market while maintaining private delivery of health insurance. The Dutch and Swiss health care systems require health insurance plans to guarantee issue coverage to all applicants and prohibit plans from varying premiums based upon the health status of the patient. In both countries, these reforms are successful because all residents are responsible for

purchasing health insurance and maintaining coverage, thereby achieving universal coverage.

(KD) As the other panelists have mentioned, governments in Switzerland and the Netherlands play an important role regulating competition among health insurance companies and ensuring that markets work in the public interest. Private insurance administrative overhead in both countries is only five percent of premiums. In both countries the government plays a significant role in setting or negotiating provider payment. The principal lesson is perhaps the importance of a comprehensive approach – both the Dutch and the Swiss combine individual mandates, standardized basic benefits packages, tightly regulated markets with open enrollment and community rating, risk equalization, and funding mechanisms to ensure that coverage is affordable for low- and middle-income families.

Would legislation to create a public plan be subject to the "Byrd rule" under a reconciliation order? If not, how is it scored in the budget and under what assumptions?

(SB) I would think it would be subject to the Byrd rule, since it is not strictly budget related.

(KI) AHIP is committed to helping pass health care reform legislation this year with bipartisan support. Comprehensive reform of 16% of our national economy requires collaboration across party lines. Such reform must also be amenable to the vast majority of the public and their representatives in Congress. A government-run plan that increases federal spending may be subject to the Byrd rule if the proposal makes changes to the social security system; however, we believe that a resolution to the problems in our health care system is best achieved outside of the reconciliation process.

(KD) Bipartisan action under regular order is obviously preferable, but the overriding goal is affordable health insurance for all and bending the health care cost curve by enhancing value and improving quality.

Those opposed to a public plan argue that the private market can provide the quality and access to care necessary. However, the private system has failed – leaving 45 million uninsured. Why hasn't the private market made changes that would make a public plan less attractive?

(SB) We all agree that the private market is badly structured, both because of the inherent problem of risk rating and because the vast majority of working people are effectively denied choice because of the tax penalties associated with going outside the place of work for coverage. Setting up an exchange with equivalent tax treatment for plans outside the place of employment (like the tax rules in Massachusetts and the FEHBP) and with risk adjustment would solve the

problems currently limiting the private market. A public plan is not necessary (and there is not one in the FEHBP)

(KI) There are many reasons why there are over 45 million uninsured persons, why health care costs are high, and why parts of our system are delivering less than high quality health care. All segments of the health care system share in the responsibility to address the 45 million people who are uninsured and must come together to solve this problem and enhance value and improve quality.

Many of the concerns associated with the functioning of today's markets relate back to the root cause: that having coverage today is optional and not everybody chooses to be in the system. The problem with this approach is that if people put off getting coverage until after a medical problem has developed it drives up coverage costs for everyone already in the system.

To address this dual challenge, health plans have proposed comprehensive insurance market reforms that combine guarantee issue coverage and rating reforms with a personal coverage requirement, along with targeted financial assistance to low and moderate income individuals and families to help them purchase coverage and ensure that everybody is brought into the system.

(KD) Under the Commonwealth Fund Commission's "Path" proposals, many coverage and payment initiatives are phased in over time to allow private insurers ample opportunity to adapt and innovate. The choice of a public health insurance option would encourage private plans to compete on value rather than on price and on avoiding risk. Ensuring a "level playing field" for plans is important but the patients need to be at the center of the equation so that we do not lose sight of the central goal of health reform – covering the uninsured in the most affordable way possible in order to provide access to high quality, affordable care. By having the choice of a public health insurance option available along side private plans, we are incorporating the best of what each has to offer and facilitating competition that returns value to households, businesses, and government.

What lessons can we learn from the experience with the Medicare prescription drug plan, Part D? Aren't the private plans – with no public option – holding costs down well below what CBO predicted?

(SB) Correct.

(KI) The Part D program relies upon competitive market forces to keep Part D premiums low for beneficiaries. Experience in the Part D program has demonstrated these competitive forces in action. The estimated actual average monthly premium for 2009 of roughly $28 for basic coverage is far below the original estimates for 2009 of $43 – nearly 35% lower than originally projected. In 2008, the Centers for Medicare & Medicaid Services (CMS) announced that

current estimates of the cost of the Part D benefit to taxpayers now are almost $250 billion less than original projections.

(KD) Medicare Part D is an important and successful addition to the Medicare program. What hasn't been established is whether the initial premium estimates were too high, or whether competition among private plans lowered premiums. We do know that pharmaceutical spending peaked just before enactment of legislation, and estimates based on trends prior to enactment would have overestimated costs. There is evidence that Part D does not work well for some individuals, especially dual eligible beneficiaries transitioning from Medicaid to Medicare drug coverage. Fund-sponsored work has also shown that the program fails to generate accurate, easy-to-use information about options and procedures for navigating the plans. This can cause dangerous disruptions and delays in getting needed medication. With respect to costs, although the Part D expenditures are well below what CBO predicted, private plans have not been able to negotiate rates as low as Medicaid. The plans have also been unsuccessful negotiating rates for biologics. Much greater transparency on actual drug prices, pharmaceutical expenditures, and premiums will be required to reach a thoughtful conclusion.

As an insurance concept, how is a public plan for health insurance similar and/or different than state insurance plans for automobile insurance in states where individuals are mandated to have insurance?

(KI) State insurance plans for automobile insurance, such as the California Low Cost Automobile Insurance Program (CLCA), are quite different from the proposed government-run public health plan. The CLCA program offers liability only automobile insurance – the bare minimum necessary to comply with California's insurance requirement – to low-income individuals and families. The government-run health plan would most likely include a comprehensive benefit package, similar to private health insurance products currently available on the market, but may be less flexible and innovative. The CLCA program also selects against high risk drivers. Eligible individuals must be low-income *and* have a good driving record. A government-run public plan would most likely be unable to refuse coverage to applicants because of their high risk, preexisting conditions. This scenario would make the management of risk much more complicated under the government-run plan than under the CLCA program.

What are the implications of a public plan option for healthcare providers?

(SB) Very simple. Payment rates will go down sharply. For a public plan to have a significant impact on long-term costs, its lower payment rates must "migrate" to the rest of the health system. Many proponents of the public plan want to encourage that. If enrollees in all plans receive a subsidy that limits their out of pocket costs, it is fairly obvious that to restrain spending Congress will

eventually limit payment rates. That will mean virtually all doctors and hospitals will have to mirror the public plan rates.

(KI) The Medicare and Medicaid programs currently shift costs to consumers covered under private health insurance plans by underpaying hospitals and physicians. A report produced by Milliman Inc. found that annual health care spending for an average family of four is $1,788 higher than it would be if Medicare, Medicaid and private employers paid hospitals and physicians similar rates. A government-run health plan that pays health care providers at Medicare rates would further challenge the financial viability of the health care delivery system. The Lewin Group projected that hospitals would lose up to $36 billion and physicians up to $33 billion under a government-run plan. Providers would provide more health care for more patients and receive less revenue.

(KD) Under the Commission's "Path" proposal, which includes a public health insurance plan paying at Medicare rates, hospitals, physicians, and other providers' revenues experience sustained and substantial grow through 2020. In earlier years, revenues are raised as the uninsured are covered and bad debts and charity care reduced. Revenues continue to increase due to medical advances and an aging population. In addition, when a public health insurance plan is incorporated into larger reform efforts that adopt innovative provider payment methods with opportunities for shared savings as efficiency and value is improved, ample opportunities for revenue growth exist for efficient and innovative insurers and providers.

Can state employee health benefits programs serve as models for a federal public health insurance plan option?

(SB) The state plans are nothing like the public plan envisioned in the current discussion. They are actually operated by private insurance firms such as Blue Cross and few would call such plans "public" in any meaningful sense. Most states, such as California, don't even identify them as public and so evidently don't see the need to suggest they are somehow safer than other plans. They are public only in the sense that the state is responsible for plan financing, and the state does so on a pay-as-you-go basis.

(KI) Some have suggested that state employee benefits programs where states maintain a self-funded offering for its employees can serve as a model for a federal government-run health insurance option. At least two key points are worth noting, however, in response to this view. First, when a state decides to self-fund their health benefits program for their employees, it is acting like many large employers by choosing to self-fund a health benefits option. As part of this arrangement a state typically hires a private-sector administrator to help run the plan, with the administrator serving as the state's vendor – not as a competing insurer or health plan. In some cases states will offer a few self-funded options from which its employees can choose. Second, in a number of cases where states

have chosen to offer a self-funded option they have systematically reduced the number of fully-insured private offerings in which their employees may enroll. For these reasons, it is difficult to see that state employee programs provide a model for a federal, government-run plan that preserves the availability of private insurance coverage options. Moreover, with respect to broader level-playing field concerns state self-funded employee plans again do not provide a model for a federal, government-run option as state self-funded plans do not necessarily have to comply with the myriad number of regulatory and financial requirements that fully-insured private plans face.

(KD) It makes sense for state governments to offer their own self-insured product just as large employers offer their own ERISA coverage. The federal employees health benefits program standard option Blue Cross Blue Shield plan is really a self-insured product with the Blues paid an administrative fee for administering claims and reserves held by the federal government. Similarly, it makes sense for a new health insurance exchange to build on these models and offer a self-insured product. With a large group, it is unnecessary to pay a private insurer for pooling risk as most large employers have learned.

In a public plan, who/what entity would determine benefits?

(SB) Congress – or a federal board not subject to congressional control. In either case not families.

(KI) AHIP supports the development of an 'essential benefits plan' that is available nationwide, provides coverage for prevention and wellness, and covers acute and chronic care. To maintain affordability, the essential benefits plan should not be subject to varying and conflicting state benefit mandates. The coverage under the essential benefits plan should allow to vary by actuarial equivalence to ensure that any package can evolve naturally based upon new innovations in benefit design and the latest clinical evidence. Moreover, any package should be informed by clinically appropriate and evidence-based care and not subject to micromanagement by Congress or any political body.

(KD) A quasi-public entity charged with establishing and operating a national health insurance exchange should set benefit standards. This could include two or three tiers for those wanting different levels of comprehensive benefits. It is also important to ensure adequate financial protection for enrollees and facilitate comparison of plans in the insurance exchange. This group could remain entirely independent of the government agency providing the public health insurance plan (e.g., the Centers for Medicare and Medicaid Services or a new agency within the U.S. Department of Health and Human Services), and be distinct from the public or quasi-public entity that sets the rules and runs the national insurance exchange.

How would a public plan option deal with state differences in mandated benefits?

(SB) Presumably the congressionally mandated (or board mandated) benefits would pre-empt state mandated benefits.

(KI) See previous question.

(KD) Although there is some variation in state differences in mandated benefits, the vast majority of such benefits are already included in a widely recognized standard plan—the Blue Cross Blue Shield "Standard Option" plan offered through FEHBP. A public health insurance plan could be modeled after this type of standard plan and would include the majority of benefits mandated by individual states.