



Health Policy Brief

June 19, 2009

A Public Health Insurance Plan: Should Americans be able to enroll in a newly created, publicly administered health insurance option as the nation works to expand health coverage?

What's the issue?

A key issue in the health reform debate is how best to provide affordable, high-quality health insurance for roughly 50 million uninsured Americans and another 250 million who have coverage. One of the most contentious options is endorsed by President Barack Obama and many congressional Democrats: creating a new, public health insurance plan or plans as an alternative to private health coverage.

As of the publication date of this brief, there is no detailed proposal for such a plan. Particulars are likely to emerge as health reform legislation is hammered out in coming weeks. Still, the concept of a public plan has elicited both support and concern.

In general, supporters believe that a public plan would be more reliable than private insurance and more affordable because administrative expenses would be lower and there would be no need to generate returns for shareholders. A public option also could cost less if it paid doctors, hospitals, and other health care providers the same rates that Medicare pays, as these are generally lower than what private insurers will pay. Dollars spent on health coverage would stretch further, covering more people, offering better benefits, or both.

Supporters argue that a public plan supported entirely by premiums and no government subsidies would be a useful benchmark against which to judge the performance of private insurers.

Opposition to the notion of a public plan comes from health insurers' leading trade association, America's Health Insurance Plans (AHIP), as well as from some conservative Democrats and many Republicans. Other groups, like the American Medical Association and American Hospital Association, are very concerned about the public-plan option and want to see details fleshed out.

A broad-based concern is that a public plan would further expand the role of government in health insurance. There is also worry that the public plan would be advantaged over private insurers for a number of reasons and would drive private plans out of business. There's concern that, even if initially designed to finance itself entirely through premiums, a public plan or plans would eventually be subsidized by taxpayers at a time when future Medicare and Medicaid expenditures already appear to be unsustainable. Doctors and hospitals, meanwhile, worry that a public plan would pay them relatively low rates comparable to Medicare's — and, potentially, for a far bigger population than is now enrolled in the Medicare program. There's also worry that many

people with private insurance would transfer into a more attractive publicly funded health plan — a phenomenon known as “crowd-out.” As private plans then disappeared, that could lead to what opponents fear most: a “single payer” health care system in which government pays all the bills for health care.

This issue brief discusses broad outlines of public insurance plan proposals and probes the general concerns of supporters and opponents. Future Health Policy Briefs will examine more detailed proposals as they emerge.

What's the background?

The idea of a public health insurance plan is not new; in fact, the United States has several publicly financed health insurance programs. Medicare currently covers about 45 million people who are age 65 and older and disabled people; it is funded by the federal government and individual contributions (for premiums, copayments, and coinsurance). Almost 61 million low-income beneficiaries are enrolled in Medicaid, which is paid for by a combination of federal and state money. Both programs were created in 1965. Enrollment in the Children's Health Insurance Program (CHIP), which began in 1997, covers roughly 7 million children whose families' incomes are too high for them to qualify for Medicaid. Public insurance programs at the federal, state, and local levels pay for 46 percent of all health care delivered in this country.

In all of these programs, government serves as the conduit, collecting taxpayer funds and funneling them to mainly private-sector health care providers. The government doesn't actually deliver the health care through government-owned and -operated health systems, as is the case in the United Kingdom — or, for example, through the U.S. Department of Veterans Affairs (VA), which operates hospitals and clinics and employs doctors, pharmacists, and other health care providers.

In the run-up to the 2008 presidential election campaigns, several Democratic candidates proposed ways to help the growing numbers of uninsured and underinsured people. Some candidates suggested creating a national health insurance exchange, which would offer individuals choices among a menu of private health insurance plans. This purchasing-pool idea was partially based on the Massachusetts Health Connector Authority, through which individuals can shop for standard-

ized benefit plans from various health insurance companies.

John Edwards, the former North Carolina senator then campaigning for the Democratic presidential nomination, was the first candidate to propose adding a public-plan option to the mix of offerings through a national health insurance exchange's menu. He often observed that he would like to recommend adoption of a single-payer system, but that Americans were divided over this option — with many favoring it but perhaps equal numbers opposing it. A fallback position, he said, was to create a public-plan option that would be available for those who wanted it.

Other presidential candidates, including Barack Obama and Hillary Clinton, later adopted the public insurance plan option as part of their health reform proposals as well. Sometimes the public plan was described as “Medicare-like” and as if it would be open to all Americans. At other times, candidates suggested that it would be available only to those who did not have coverage through their employers or through programs like Medicare and Medicaid. In a June 2, 2009, letter to Democratic senators, President Obama repeated his desire to see a public-plan option in health care reform legislation. As still another alternative, Democratic Senator Kent Conrad of North Dakota, who chairs the Senate Budget Committee, has proposed creation of nonprofit health insurance “cooperatives” that would compete on a level playing field with private insurers. These could sell a form of private coverage as an alternative to other private plans. They could be a coordinated care organization built around a community health center or could function as an integrated system that combines insurance coverage with care delivery.

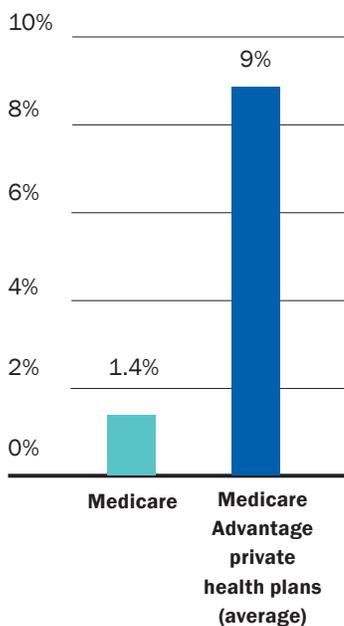
What's the argument?

In favor of a public insurance plan: Supporters believe that a public insurance plan or plans would lead to more affordable coverage and buy the most health care for the dollar. A key reason, they say, is that administrative expenses — what companies spend on such activities as marketing, advertising, and personnel — would be lower in a public plan than for private insurers.

For example, the administrative costs of the public Medicare program were 1.4 percent of total program costs in 2008, according to the U.S. Centers for Medicare and Medicaid Services. By

EXHIBIT 1

Administrative Costs in Medicare and Medicare Advantage Private Health Plans, 2008



Source: U.S. Centers for Medicare and Medicaid Services.

contrast, administrative expenses of Medicare Advantage plans, which are administered by private insurers, averaged 9 percent in 2008, or a total of 13 percent when profit margins are included, according to Medicare actuaries. Supporters say that a public plan would not have to generate returns for investors, as is the case for private insurers whose shares are traded on stock exchanges.

Cost comparisons between Medicaid and private coverage offer more evidence that a public plan could save money, supporters say. A 2008 study published in *Health Affairs* compared the cost of Medicaid coverage to that of private insurance for adults (after taking into account health condition, age, sex, race, education, and other factors). If an average low-income adult with Medicaid switched to private health insurance for one year, coverage would cost 26 percent, or \$1,455, more per person, and out-of-pocket expenses would be roughly 6.5 times, or \$1,096, more (including deductibles, copayments, and medical services not covered by private insurance). The difference is due to several factors, including higher out-of-pocket expenses in private plans and lower payment rates to providers in Medicaid.

A public insurance plan or plans could generate savings in other ways, advocates say. A large public plan could have greater bargaining power with doctors and hospitals, as well as the ability to pay these providers at Medicare payment rates that are generally lower than what private insurance pays. Medicare's average payment for physician services in 2007 was 80 percent of what two large national private insurers paid, with little variation over the past decade, according to the Medicare Payment Advisory Commission. However, some proposals for public plans specify that they must pay providers Medicare rates plus 10 percent, or rates comparable to those of private insurance, to create a "level playing field" between the public and private plans.

Jacob Hacker, a political science professor at the University of California, Berkeley, who is credited with developing the public-plan idea, has written that the public plan could also exert positive pressure on the private insurance market. It could promote competition and demonstrate to commercial insurers "how to provide good coverage at a reasonable cost with transparency and stability."

Finally, many consumers might prefer public over private coverage. A recent consumer survey

by the Commonwealth Fund found that just 8 percent of Medicare beneficiaries rated their coverage as "fair or poor," compared to 18 percent in employer-based plans. Medicare beneficiaries reported easier access to physicians and fewer billing problems.

Against a public insurance plan: A top concern of opponents is that a public plan could be entirely or partially funded by taxpayers, as opposed to being entirely financed by premiums and other fees collected from those covered by the plan. They fear that the public plan would operate much like Medicare and Medicaid, funded partly by payments from the insured populations but very largely paid for by taxpayers. These two programs "are already on a path to fiscal insolvency," wrote nine Republican members of the U.S. Senate Finance Committee in a June 5, 2009, response to President Obama's call for a public insurance plan. "Creating a brand new government program will not only worsen our long term financial outlook but also negatively impact American families who enjoy the private coverage of their choice," the senators continued.

Critics point to the 2009 Medicare trustees' report, which notes that Medicare's Hospital Insurance Trust Fund already spends more money than it receives from payroll taxes. Under a set of so-called intermediate assumptions, the trust fund is then expected to be exhausted in 2017. And in the next two decades, some 80 million Americans will become eligible for Medicare coverage. Long-term costs for the entire program are now projected to be about \$35 trillion in what economists call "present value" terms.

To address these concerns about America's worsening fiscal picture and the pressures of health spending, some proposals for a public plan specifically require that the plan be "actuarially sound" and self-sustaining. In other words, the public plan would have to charge enough in premiums to cover all medical outlays and all of its administrative costs, and thus would require no subsidies from the government. Yet opponents are skeptical that a public plan could really pay its own way. They believe that there would be ongoing pressures to supplement premiums paid by covered populations with public subsidies.

If a government-run insurance plan paid providers Medicare rates, which are less than what private plans pay, and if its administrative costs were lower, private plans could have great diffi-

culty competing, opponents say. They also worry that relatively lower payments for doctors, hospitals, and other providers could jeopardize the quality of care. Unless compelled by law to participate in the program, some providers could refuse to treat patients covered by the public plan, as Jeff Goldsmith described in a May 15, 2009, *Health Affairs* Blog post.

Another concern voiced by opponents is that if a public plan hewed not only to Medicare's rates but to Medicare's fee-for-service payment system, it might do little if anything to help foster needed changes in health care delivery.

Depending on exactly how it was designed, a public plan that cost less than a private plan but also had better benefits could compel people to switch from private insurance to the public plan. This is a phenomenon known as "crowding out" private coverage. The evidence suggests that in certain circumstances, the phenomenon is real. In 2007 the Congressional Budget Office (CBO) studied what happened after Congress created CHIP in 1997. The CBO found that enrollment of children in private health insurance plans declined, as parents chose instead to enroll their children in CHIP. The CBO concluded that for every 100 children who joined the public insurance program, 25–50 children disenrolled from a private plan.

Jonathan Gruber, an economist at the Massachusetts Institute of Technology, found the crowd-out phenomenon to be even bigger. In his 2007 study of the program, he found that for every 100 individuals newly enrolled, 60 had disenrolled from private coverage. However, Gruber cautions against assuming that this scenario would necessarily apply in the case of a public plan.

Gruber explains the situation this way. In the case of CHIP, the government made health coverage available for free or at low cost to people who previously had to pay for coverage, because that coverage was heavily subsidized by government. If the same were true of a public plan, "crowd-out" might occur. However, if the public plan option wasn't free but was only somewhat cheaper than private insurance, middle- and higher-income individuals with employer-provided insurance may have little reason to switch from their private coverage to the public option. It might be that only those who today have costly individual insurance coverage would be inclined to switch. In that case, it's unlikely any substantial degree of

"crowd-out" would occur.

A study released in April 2009 by the Lewin Group illustrates just how much the degree of "crowd-out" could differ depending on how a public plan was designed. Lewin, which is owned by UnitedHealth Group, examined the prospects under various scenarios. Depending on various design elements of a public plan, the study predicted, anywhere from as few as 10 million to as many as 119 million privately insured individuals — out of a total pool of 170 million with private coverage — might drop that coverage in favor of the public option.

Finally, opponents are concerned that the increasing bargaining powers of a large government plan could destabilize the marketplace, controlling prices and choking competition. Economists call the phenomenon a "public monopsony." As private plans were driven out of business, government could become the predominant payer. And if pressures mounted to subsidize public coverage, in effect the government might come to finance all health insurance — leading to what in effect would be a single-payer system.

What's next?

Two committees in the Senate and three in the House of Representatives are working on health reform legislation. On June 9, 2009, the House committees released details of a health reform proposal with a public-plan option that would be self-sustaining and that would be offered along with private plans through a new national health insurance exchange. States could set up their own exchanges in place of the national exchange. Legislation under consideration in the Senate Health, Education, and Labor Committee includes a government-sponsored, self-sustaining health plan that would make payments to health care providers at Medicare rates plus 10 percent.

Other proposals have emerged as well. Sen. Charles Schumer, Democrat of New York, has sketched a set of ideas that he says would "level the playing field" between a new public plan and private health insurance plans. Similar to a proposal put forward by Len Nichols and John Bertko, the public plan Schumer envisions would have to pay its own way and would receive no taxpayer subsidies. It would have to comply with the same national and state regulations that private insurers must follow, including requirements to

Details still to come:

How would a public or government-administered health insurance plan actually work?

How would one alternative, a health insurance cooperative, work?

Would a new public plan be subsidized by taxpayers, or would it pay its own way through premium dollars collected from policyholders?

Who would be eligible to become enrolled in a public plan or cooperative?

Would it be only for people without insurance coverage through employers or other public programs like Medicaid?

What would the basic benefit package be, and who would determine that?

maintain financial reserves and offer certain types of benefits. A variation on this theme has been proposed by Democratic Senators Jay Rockefeller of West Virginia and Sherrod Brown of Ohio, who propose a public plan that would be offered through a national health insurance exchange, pay Medicare rates for the first two years only, and pay its own way.

Sen. Max Baucus, Democrat of Montana and chairman of the Senate Finance Committee, has said that there are many ways to structure a public plan, and he is working to include one that can achieve bipartisan support. The committee outlined several options including a public plan in a May 14, 2009, policy paper, and Senator Baucus was preparing to unveil a particular version in health reform legislation as this policy brief was published.

On June 11, 2009, Senator Baucus said that he was leaning toward the proposal put forward by Senator Conrad for “consumer health cooperatives.” “I am inclined, and I think the committee is inclined, toward a co-op,” Senator Baucus said. “It’s not going to be public, we won’t call it public, but it will be tough enough to keep insurance companies’ feet to the fire.” These cooperatives could be operated at the national, regional, or state level. They would be in lieu of a public plan and would sell private health insurance, collect premiums, negotiate rates with providers, or even employ those providers. They would be independent of government and would receive no govern-

ment support other than start-up funding.

Fallback? Some lawmakers have recommended a that public plan could be a “fallback” option if, for example, certain targets or triggers for covering the uninsured are not reached. The latter idea would be similar to a provision in the Medicare Modernization Act of 2003, which would have created a backup government-administered prescription drug plan in states without two or more private prescription drug plans. As it turned out, the federal “fallback” plan was never created because dozens of private drug plans were introduced in most states.

Others have argued that a public plan should be a matter decided by the states, so if a state wanted one, it could create one. In fact, Massachusetts has created a variation of the concept for its low-income populations, who obtain coverage from private managed care organizations that is heavily subsidized by the state and federal governments.

As this policy brief is published, details of a public-plan option are still being developed. Senate leaders and President Obama have expressed a commitment to bipartisanship, hoping to write a bill that can gather the most votes from both Democrats and Republicans across the political spectrum. That support, they say, will be essential to the success of the new program. Exactly what role any form of public plan will play in any legislative compromise remains to be seen.

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Resources

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