



ADVANCING NATIONAL HEALTH REFORM

POLICY BRIEF
APRIL 2009

HEALTHY COMPETITION: How to Structure Public Health Insurance Plan Choice to Ensure Risk-Sharing, Cost Control, and Quality Improvement

By Jacob S. Hacker, Ph.D.

UC Berkeley Department of Political Science and
UC Berkeley School of Law

Prepared with the joint support of the Berkeley Center on Health,
Economic & Family Security, UC Berkeley School of Law, and the
Institute for America's Future in Washington, DC.

BerkeleyLaw
UNIVERSITY OF CALIFORNIA

Berkeley Center on Health,
Economic & Family Security

INSTITUTE FOR AMERICA'S FUTURE
ourfuture.org

This brief was funded in part by a
grant from The California Endowment

 The
California
Endowment

EXECUTIVE SUMMARY

The debate over health care reform has increasingly centered on the issue of “public plan choice”—whether Americans younger than 65 who lack employment-based coverage should have the choice of enrolling in a new public health insurance plan modeled after Medicare. The central argument for public plan choice is that such a plan, offered as a choice within a new national insurance “exchange,” provides an essential set of security guarantees, ensuring that Americans without insurance from their place of work can find a plan that offers them quality, affordable health care through a broad choice of providers in all parts of the country.

For public plan choice to provide such guarantees, however, the public plan must be properly structured, compete on a truly “level playing field” with private plans, and have the authority to use its bargaining power as one of many tools to encourage greater value in health care delivery. The most effective and easily implemented model for the new public plan is a “Medicare-like” plan that builds on Medicare’s administrative infrastructure and basic framework of coverage but is separate from Medicare’s risk pool and departs from Medicare in a number of key respects regarding payment and benefits.

To create a level playing field requires attention to the “three R’s” of workable public-private competition: *rules* that are the same for both the public plan and private plans, *risk adjustment* that protects plans from being competitively disadvantaged if they enroll a less healthy group of people, and *regional pricing* that allows private plans and the public plan to compete within regions on the same terms, rather than having the public plan compete on a national basis with regionally based private plans (whose premiums may be lower or higher in any given region).

Finally, giving the public plan the authority to bargain for reasonable rates is an essential item on the menu of cost control—and one that the Congressional Budget Office (CBO) and other budget watchdogs are likely to “score” as producing savings (in contrast with many other currently favored cost-control strategies). Nonetheless, there are reasonable concerns about how the new public plan will use its bargaining power—concerns reflected in current proposals for a price-taking (rather than price-making) public plan that would have limited ability to secure fair rates. However, a watered-down public plan would be a grave mistake. Instead, the public plan should include safeguards designed to ensure that providers are fairly represented and that bargaining for lower prices does not negatively affect patients’ access to care or shift costs onto private insurers. Indeed, a better alternative to a public plan without price-setting authority would be allowing private fee-for-service-style plans to piggyback on the public plan in setting their own prices.

Public plan choice is rooted in existing precedents that have shown themselves to work, rather than speculative convictions about how a delicately balanced new system will operate. It must be part of any successful reform package. Without public plan choice, Americans without workplace insurance will be put in jeopardy, private insurers will lack an effective check on their actions, and the opportunity to place our crumbling framework of health financing on a secure foundation will be lost.

ACKNOWLEDGEMENTS

This brief was prepared with the joint support of the Berkeley Center on Health, Economic & Family Security, UC Berkeley School of Law, and the Institute for America's Future in Washington, D.C. At the Center, Ann O'Leary, Melissa Rodgers, and Rachel Pepper provided invaluable assistance at every stage of the process. At the Institute, Roger Hickey and Diane Archer also offered extensive encouragement and help from beginning to end. Alex Lawson and Justin Berrier provided research assistance. Laura Vichinsky created the graphs. Jenifer MacGillvary designed the cover. The media teams at both Berkeley and the Institute for America's Future, including Toby Chaudhuri, Janet Gilmore, Susan Gluss, and Elizabeth Wu, provided impressive support for the release of this brief. In addition, extremely helpful comments on a previous draft were provided by Linda Bergthold, Phillip Cryan, Daniel Callahan, Debbie Curtis, David Cutler, Will Dow, Annette Gardner, Atul Gawande, Jon Gruber, Peter Harbage, Ken Jacobs, Maggie Mahar, Len Nichols, Harold Pollack, John Rother, Steve Shortell, Steve Sugarman, and participants in a workshop organized by Michael Reich of the UC Berkeley Institute for Research on Labor and Employment. All of these experts' assistance greatly improved the brief, but in no way makes them responsible for its content or claims.

In recent months, the burgeoning national debate over health care reform has increasingly centered on the issue of “public plan choice”—whether Americans younger than 65 who lack employment-based coverage should have the choice of enrolling in a new public health insurance plan modeled after Medicare. The idea was largely ignored in 2008 when it was endorsed by leading political figures, including then presidential candidate Barack Obama and Senate Finance Committee Chair Max Baucus.¹ Since the election, President Obama and his nominee for Secretary of Health and Human Services, Kathleen Sebelius, have publicly argued for public insurance choice. In recent months it has moved from the periphery to the center of political discussion, and the debate over it has grown more polarized.

The aim of this brief is to clarify what the debate is about and show how public plan choice can be made to work in a way that is effective, enduring, and acceptable to a wide range of stakeholders in American health care. Elements of public plan choice are indeed controversial, but that is true of all of the core aspects of the broad vision that President Obama and other leading reformers have embraced, including new requirements on employers and the need for new public financing. Indeed, controversy over public plan choice mostly reflects the fact that such choice, like employer requirements and adequate financing, is vital to the overriding goal of reform: quality, affordable care for all Americans. Those who have doubts about the feasibility or desirability of this goal will not find much to like in public plan choice either.

However, one reason for the dispute over public plan choice is that even the general outlines of how it would work remain unclear, allowing both supporters and opponents to project their greatest hopes and fears onto the idea. This report aims to make more transparent and understandable both the reasons for public plan choice and how it would operate in practice. Far from radical or unprecedented, public plan choice is simple, essential, based on established programs and models both here and abroad, and should be embraced by a broad range of reform-minded groups and politicians. Certainly, public plan choice is popular with the American people—the most important stakeholders in American health care.²

This brief proceeds in three parts. The first restates the argument for public plan choice, building on a companion report released last year entitled “The Case for Public Plan Choice.” The central argument is that a new public health insurance plan for the nonelderly—offered as a choice within a new national insurance “exchange” that allows people without workplace insurance to obtain group coverage—provides an essential set of security guarantees, ensuring that Americans without insurance from their place of work can find a plan that offers them quality affordable care through a broad choice of providers in all parts of the country. Long-term health security can only be provided if we restrain the rate of increase in health costs, and public health insurance is a proven approach to controlling costs while maintaining broad access and investing in improved quality.³ Moreover, a public health insurance plan provides a source of coverage that is much more stable and predictable than private plans. Even in a greatly reformed market, private health plans will have incentives to engage in practices—such as selecting healthier enrollees or shifting costs onto patients—that undermine health security. A public health insurance plan will not, and thus

can provide an essential source of competitive pressure on private plans to encourage better practices and more effective cost restraint.

The second part of the brief walks through the three key design issues raised by public plan choice: (1) how the public plan should be structured (for example, who should run the public health insurance plan and the exchange of which it is part), (2) how to create a “level playing field” for competition between the public plan and private plans, and (3) whether and to what extent the public plan should use its bargaining power to restrain spending.

The message of this brief, in short, is one of bold pragmatism. Yes, reformers must build on existing structures if they are to have a real chance of finally achieving affordable quality care for all Americans. But there are good ways to build on existing institutions and faulty ones. Public plan choice is rooted in existing precedents that have shown themselves to work, rather than speculative convictions about how a delicately balanced new system will operate. Its greatest virtue is that it creates a strong guarantee that reform will be successful and sustained. Without public plan choice, private health insurers, regardless of the degree of regulation, will still be able to game the system to maximize their profits while failing to provide health security over the long run—the same “heads, I win; tails, you lose” deal we have seen in our financial sector. Without public plan choice, we put Americans without workplace insurance, and especially those most in need of care, in jeopardy. Without public plan choice, in sum, we risk forfeiting the opportunity to place our crumbling framework of health financing on a secure long-term foundation.

THE CASE FOR PUBLIC PLAN CHOICE RESTATED

The goal of public plan choice is healthy competition—that is, competition to make Americans better cared for and more secure. Currently American health care is characterized mostly by unhealthy competition. Health plans compete by attracting healthier patients and aggressively weeding out or charging higher rates to those who need more care. Plans also compete by writing thousands of contracts with individual doctors and other providers, who then spend endless hours fighting with billing agents to get payment, often discounted, for the care they deliver. Competition today takes place on a restricted terrain, with each plan cutting its own deal and costs shifted back and forth across plans and providers. Patients—the ultimate “consumers” of care—generally do not have much choice of health plans and, in many cases, even of providers, and they are often left to go it alone in dealing with the complicated and sometimes harmful practices of other players in the system. No one can defend current arrangements as healthy competition.

Why Public Plan Choice Promotes Healthy Competition

Healthy competition requires not an endless array of choices—indeed, the evidence suggests that too many choices can impair consumer judgment.⁴ Rather, it requires a reasonable number of *meaningfully different* choices. One of the key reasons for public plan choice is that public plans can offer a set of valued features that private plans are generally either unable or unwilling to provide. Stability, wide pooling of risks, transparency, affordability of premiums, broad provider access, the capacity to collect and use patient information on a large scale to

improve care—these are all hallmarks of public health insurance that private plans have inherent difficulties providing. On the other hand, private plans are generally more flexible, and they have, at times, moved into new areas of care management in advance of the public sector. The bottom line, then, is that both public and private plans have unique strengths and weaknesses, and all Americans, not just the elderly or the poor, should have access to the distinctive strengths of a public health insurance plan, as well as the strengths of private plans.

No less important, if public and private plans are competing on a level playing field, the choice of enrollees between the two will place a crucial check on both, encouraging them to remedy their inherent weaknesses. If the public plan becomes too rigid, for example, more Americans will opt for private plans. If private plans engage in practices that obstruct access to needed care and undermine health security, then the public plan will offer a ready release valve to those dissatisfied with their private plans. New rules for private insurance like those outlined later in this brief will go some way toward encouraging private insurance plans to focus on providing value. But without a public health insurance plan as a benchmark and check on their behavior, key problems in the private insurance market will remain.

The Centrality of Cost Control

Perhaps the most pressing of these problems that will not be addressed by even the most stringent of regulations is cost control. The cost control that comes from having a public plan concerns both the level of the public plan's premiums and out-of-pocket costs and the long-term ability of the plan to restrain costs. With regard to the *level* of spending, public health insurance has much lower administrative costs than private plans and obtains much larger volume discounts in paying for care because of its broad reach. Public insurance also does not have to earn profits as many private plans do. The evidence is overwhelming that these features of public health insurance allow it to offer lower premiums—on the order of a 20 to 30 percent premium advantage over private plans.⁵

In addition, these lower premiums are accompanied by a better ability to control costs over time. As the aforementioned companion brief, “The Case for Public Plan Choice,” shows at length, the guiding model for a new public health insurance plan—Medicare—has a substantially better track record than private health plans in controlling costs while maintaining broad access to care, especially over the last fifteen years.⁶ That a broad public plan can better restrain cost increases than private plans is also shown by the experiences of other advanced industrial democracies. All these nations rely much more on public health insurance than the United States does, and all have lower health costs per person—on average around 50 percent lower.⁷ Taken as a whole, these nations have also seen their costs rise more slowly, even as they have maintained better overall health outcomes and much stronger health security for all their citizens.

The cost control advantages of public health insurance are not trivial ones. The long-term viability of any reform package depends on keeping coverage affordable over time; otherwise even the best-laid reform package will end up gradually shifting costs onto those covered, or dropping people from coverage altogether. Not only the sustained expansion of coverage, but also our federal budget's long-term health depends on cost control. As Office

of Management and Budget Director Peter Orszag has emphasized, “The principal driver of our long-term deficits is rising health care costs.... Rising costs for Medicare and Medicaid, in turn, reflect rising health care costs across the public and private sectors. Therefore, we need to be thinking about ways to slow overall health care cost growth, rather than just reducing the rate of growth in Medicare and Medicaid.”⁸

The great virtue of public plan choice as a means of cost control is that it proposes relatively minimal disruption to existing arrangements compared with other comprehensive reform proposals. It only says that a public health insurance plan will be offered alongside private plans as a coverage option for those without insurance through their employer. It is the competition between private plans and public health insurance, with its distinctive cost-control advantages, that presses both public and private plans to provide more for less and ensures that the goal of affordable quality coverage can be maintained over time at a price the nation can bear.

Public Plan Choice to Spur Improved Quality

Improved cost control is a proven advantage of public health insurance. It is shown by the historical record of existing programs both here and abroad, as well as by a number of credible independent forecasts of the effects of public-private competition, including my 2007 proposals for affordable quality care for all, “Health Care for America.”⁹ A second advantage has been less fully realized by existing programs: improved quality. Compared with the Veterans Healthcare System, a model of integrated care delivery in the public sector, Medicare has been slow to adopt quality innovations—though generally quicker than private health plans.

However, a new public health insurance plan for the nonelderly (and Medicare, through its association with the new plan) can and should be centrally involved in obtaining better information to improve physician and patient decisions, as well as insurer decisions about coverage, pricing, and benefit structure. Because of its broad and national reach, the stability of its enrollment, and the unparalleled opportunity for data collection and use, the new public health insurance plan is the player in the system that will have the largest incentives to make these investments.

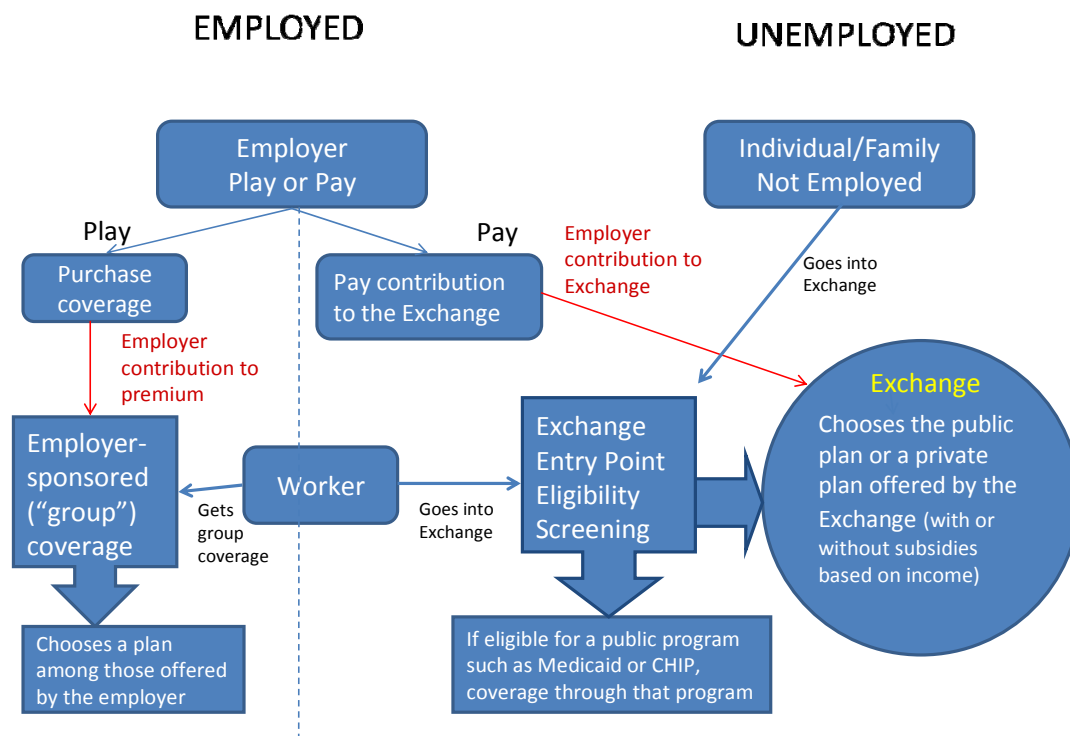
Public Plan Choice and the Future of Medicare

This leads to the final argument for public plan choice: safeguarding and improving the Medicare model. Now more than ever, we need a vision for Medicare reform that involves upgrading, rather than dismantling, the program. If we take the route of having just private plans for all but the poor and elderly, the implication for Medicare reform is that we should replace the program with a system of competing private plans. Moreover, we will lose the ability to improve both Medicare and the new public health insurance plan over time, as well as the potential to use the greater bargaining power and scope for quality improvement inherent in two complementary but distinct programs. A new public health insurance plan that embodies the basic principles of Medicare—inclusive, affordable, transparent coverage with a broad choice of providers—can not only light the way toward universal health security, but also help Medicare find the path toward improved care delivery and cost containment in the twenty-first century.

HOW TO STRUCTURE PUBLIC PLAN CHOICE

To understand the key design issues in public plan choice requires first grasping where the idea fits into the overall vision embraced by leading reformers who have endorsed a new public health insurance plan—a vision that embraces a “hybrid” model that builds on the best elements of existing public programs and private benefits while ensuring the health security that our current health financing arrangements fail to provide.¹⁰ Figure 1 provides a simple picture of that vision and where public plan choice comes in.

Figure 1: How Americans Obtain Coverage



Where Public Plan Choice Fits Into “Hybrid” Health Reform

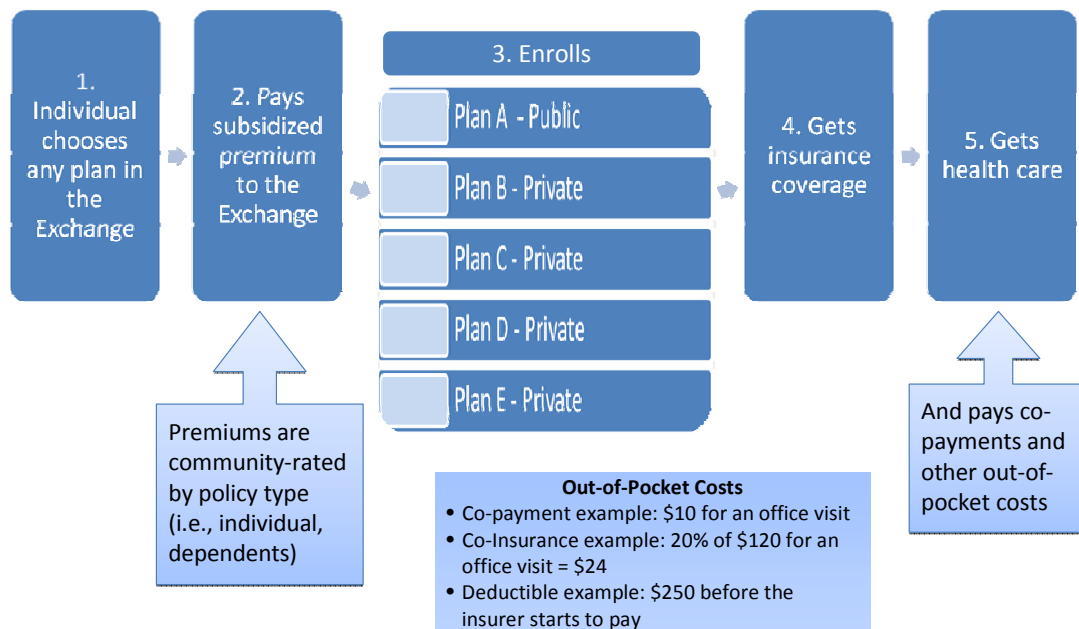
As the figure shows, for those who are employed, coverage comes either through their employer or, if their employer chooses not to provide coverage, through the new national insurance exchange. In either case, employers contribute some amount to the cost of coverage—in the former scenario (employment-based insurance) by helping pay the premium for privately purchased employment-based coverage, and in the latter scenario (no employment-based insurance) by contributing to the cost of coverage through the national insurance exchange. Those without direct or family ties to an employer would enroll directly in the exchange, rather than through their employer. If Medicaid and CHIP were retained as distinct programs, there would also have to be some means of distinguishing those who have

access to these programs from those who need to obtain coverage through the exchange—a process that would presumably occur as an individual or family entered the exchange.

Once in the exchange, public plan choice would become relevant. Those in the exchange would be given a menu of standardized health plan choices that would include private options for that region and the new public plan. At least for those whose coverage was not fully paid for by the government, the premiums individuals or families would pay would vary with the plan they chose, public or private. Thus, as Figure 2 illustrates, the public plan would simply be another item on the menu of health plan choices for those obtaining coverage through the exchange.

Figure 2: Inside the Exchange: Individual View

Individual chooses a plan and pays premium to the Exchange → Exchange pays plan



These figures embody two crucial assumptions: first, that anyone who is eligible to be in the exchange should be able to choose the public health insurance plan; and, second, that everyone younger than 65 who is not receiving insurance from an employer (or from Medicaid and CHIP if these programs remain) should be able to enroll in group health plans through a national insurance pool offering both regulated private plans and the new public plan. Put another way, the exchange should provide insurance on the same terms to everyone receiving coverage through it. Neither the exchange nor the public plan should be restricted to a special category of those without workplace insurance. Instead, all those who do not obtain group coverage through the workplace (or an existing public program) should obtain coverage through the exchange. The individual insurance market provides costly, incomplete protection that—absent cream-skimming of the healthiest patients—is patently

inferior to what group insurance plans now provide, and especially to what a new public health insurance plan could provide.¹¹

Though simple in broad conception, public plan choice raises a number of thorny issues of design, as do all reform ideas. The three most crucial are (1) how the public plan should be structured, (2) how to create a “level playing field” for competition between the public plan and private plans, and (3) whether and to what extent the public plan should use its bargaining power to restrain spending. These are presented not in order of importance but in order of logical priority. The basic design of the system must be set before it is possible to know what a level playing field entails, and a level playing field is linked to but distinct from the question of whether and to what extent the public plan should use its bargaining power.

Who Should Run the Public Plan and What Should It Look Like?

In most discussions of the public plan, the phrase “Medicare-like” is used to describe the new plan. It helps, therefore, to know what Medicare is like. Even today, many commentators forget that Medicare consists of two broad parts: the traditional public program in which most beneficiaries are enrolled, and private plans that operate under contracts with Medicare’s administration to provide benefits to enrollees who opt out of the traditional program and into private plans. Thus, Medicare itself embodies a form of public plan choice—though one flawed in several key ways, as will become clear. When people say “Medicare-like,” however, they are referring to the traditional portion of Medicare that directly pays doctors and hospitals for care delivered to elderly and disabled Americans. A “Medicare-like” plan is a public health insurance plan that pays providers to deliver care, rather than a government contract with private plans to provide insurance.

More specifically, the new public plan should be *national* (with the same basic terms nationwide for patients and providers), *governmental* (a true public health insurance plan, not, say, a nonprofit insurer operating under federal charter), *comprehensive* (providing defined benefits on the same basic administrative platform), and *built on Medicare’s infrastructure*. As the next section of this brief discusses, plan offerings and pricing can and should differ regionally, but the public health insurance plan should be a single national plan with its own risk pool separate from Medicare’s that is available with the same benefits and coverage terms in all parts of the nation. This will make enrollment easier, ensure continued enrollment across state lines, facilitate interactions with multi-state employers, and build on the administrative structure that already exists for Medicare.

To build on Medicare’s infrastructure does not mean allowing nonelderly people to buy into the existing Medicare program (though this has independent merit for people near retirement without employment, health coverage, or both). Rather it means that the new public plan would use the basic overall structure of Medicare as a foundation for its operations, including, for example, existing regional and national public administrative bodies and the services of insurers who currently act as “carriers” for the program by processing payments.

This has several benefits: It makes the new public plan more familiar, since most people know of and generally like Medicare. It also lowers the set-up costs of the program,

since the Medicare infrastructure is already in place. To be sure, substantial investments will be needed to create a new public health insurance plan (in part because Medicare's administration is stretched thin as it is). Nonetheless, building on the existing Medicare model will lower the scale of those investments and facilitate the rapid creation of the new public plan. It will also create a greater chance that the innovations adopted by the new public plan will spill over into Medicare going forward.

All this said, the new public plan should not *be* Medicare. First, the benefits offered by the new public health insurance plan must be broader than Medicare's, including comprehensive mental health, maternal and child health services, and prescription drug coverage. Second, the new public health insurance plan should have a wholly separate risk pool from Medicare. Third, it should not, as Medicare does, manage contracts with private plans. Rather, as the next section discusses in more depth, private plans and the new public health insurance plan should both be offered through a new national insurance exchange distinct from either Medicare or the new public plan.

Finally, while the new public plan should build on Medicare's infrastructure, it should also seek to improve on Medicare's strategy for paying providers. Although the current Medicare system for paying hospitals works quite well, payments for physicians require more substantial reforms. In particular, payments for primary care must be upgraded relative to subspecialty care and advanced imaging, and the new public health insurance plan should move away from Medicare's heavy reliance on fee-for-service payment—for example, by “bundling” payments for hospitals, physicians, and providers of post-acute services so all the care provided for an episode of illness, regardless of setting, are within a single payment rather than paid for on a fee-for-service basis.¹²

One model of primary-care payment that would make sense for the new public plan is incorporated in proposals for giving patients a “medical home.” This would entail providing an up-front payment to physicians who agree to serve as care coordinators for patients. Patients who wish to have their care coordinated would be able, in return, to get reduced cost-sharing, a broader set of benefits, or both. Over time, this will allow for greater coordination and management of care, especially for those with chronic conditions who are attracted to the Medicare model but not always well served by it because of the fragmentation of their care. The public plan could adopt this and other payment innovations.

PUBLIC-PRIVATE COMPETITION ON A LEVEL PLAYING FIELD

Public-private competition is not a radical or new idea. It has a long intellectual and practical lineage, and is embodied today in well-functioning programs both here and abroad.¹³ Within Medicare, for example, people can choose private plans to pay for their care (though, as discussed shortly, these plans are excessively subsidized). In Australia and several continental European countries, including Germany, public and private plans compete side-by-side within a framework of rules that encourages long-term health security rather than the cream-skimming of healthy patients or the shifting of costs from one payer to another.¹⁴ For public-private competition to work, however, it must take place on a level playing field,

rather than one tilted in favor of the public plan or private insurers, so that competition is fair to all competitors and focused on value.

Contrasting Visions of a “Level Playing Field”

People on both sides of the debate over public plan choice say they are for a level playing field. Yet what most critics of public plan choice really mean is that they do not want a new public health insurance plan to have *any* inherent advantages. But that is at odds with true competition, which does not require competitors be equal but that they have an equal chance to succeed *if* they are equally good at doing what consumers want. It is also at odds with the basic goal of public plan choice—to push the public plan and private plans to maximize their strengths while minimizing their weaknesses. A public plan that did not create competitive pressures on private plans to improve their ability to control costs and provide secure coverage would be no more useful than a set of private plans that did not create competitive pressures on the public plan to provide the flexibility, responsiveness, and consumer service that the best private plans can offer.

Public plan choice occupies a middle ground in the health care debate between proposals to create “Medicare for all” and proposals that would rely only on regulated private plans and existing public programs to expand coverage. Perhaps not surprisingly, therefore, it has provoked criticism from both sides. Advocates of Medicare for all worry that the public plan will be disadvantaged relative to private plans because it will be more attractive to less healthy enrollees (the problem of “adverse selection”).¹⁵ Advocates of a private-plan-only strategy fear that the public plan will have *too much* of an advantage relative to private plans, in part because of its greater bargaining power.¹⁶

It would be glib to argue that these very different forecasts simply cancel each other out. Nonetheless, they do point to offsetting factors that will help ensure that a public plan on a level playing field will neither “wither on the vine” (as Newt Gingrich famously predicted would occur if Medicare were made to compete with private plans) nor overwhelm private plans with its superior pricing and cost control.¹⁷ The public plan will have some inherent advantages—notably the lack of the need to pay profits, low administrative overhead, and the ability to gain volume discounts. But so too will private plans, including the basic reluctance that Americans may feel to enroll in a public plan and the enormous marketing power of the private plans. And while every effort should be made to create a level playing field, it is likely that the public plan will indeed be more attractive to higher-cost patients. That, after all, is a major reason to have it. With appropriate safeguards, however, this adverse selection should be modest and not a threat to the public plan’s success.

The Public Plan and the Exchange Should Be Administered Separately

What should those safeguards be? To begin with, the administrator of the public plan should be separate from the administrative body that runs the health insurance exchange. In other words, unlike what occurs in the current Medicare program, the administrator of the exchange that manages contracts with private plans should be a distinct body from the administrator of the public plan, which would contract with the exchange on the same basic terms as other plans. The referee should not have a player in the game.

Beyond that, a level playing field requires a set of safeguards that are easily remembered as the “three R’s”: rules, risk adjustment, and regional pricing.

Rules to Create a Level Playing Field

First and foremost, the same *rules* must apply to both public and private plans. This means, for starters, that any and all public subsidies for coverage are available to any plan within the exchange at the same level. This point can be best explicated in the upcoming discussion of regional pricing, but is worth emphasizing at the outset. From the standpoint of enrollees, the basic assistance that they receive with their premium costs should not hinge on whether they enroll in the public plan or a private plan.

Both the public and private plans should also have to abide by the same fundamental rules, the main purpose of which is to prevent plans from profiting by selecting healthy people rather than delivering value. These rules include:

1. **Community rating** – All plans must charge the same rates to all subscribers.
2. **Guaranteed issue** – All plans are required to take everyone who wants to be in them during a specified enrollment period and provide insurance for a fixed term.
3. **Limits on marketing** – People should choose among plans based on objective information provided by the administrator of the exchange.
4. **Standardized and defined benefits** – At a minimum, all plans should be required to offer a benefit package that meets at least some basic actuarial standard, covers the same full range of benefits, and has the same maximum limits on out-of-pocket spending. Insurers should also be constrained from offering many, slightly different plans, since this sort of tailoring is usually done to select risk rather than deliver value.
5. **Reserve requirements** – Private plans must have adequate reserves. While the same requirement would not make sense for the public health insurance plan, which has the full faith and credit of the federal government behind it, it should have a modest premium stabilization fund to keep premiums from excessively fluctuating over time and it should be prevented from independently dipping into general revenues to pay for care. Like private plans, it should receive payments from the exchange based on the income and health status of enrollees. Though these payments may be funded out of general revenues, they should be available on equal terms to all plans.
6. **Transparency** – All plans should have to clearly state their terms and open their books for basic review of their spending and revenues.

Risk Adjustment

In addition to rules, there is also a need for *risk adjustment*.¹⁸ That is, plans should be paid different amounts by the exchange based on the expected and realized risk of their enrollees. Enrollees and plans should not be penalized when a plan attracts less healthy enrollees. Otherwise, plans will try to avoid enrolling the small proportion of the population that

accounts for the bulk of health costs in any given year, rather than focus on providing this group with high-quality care.

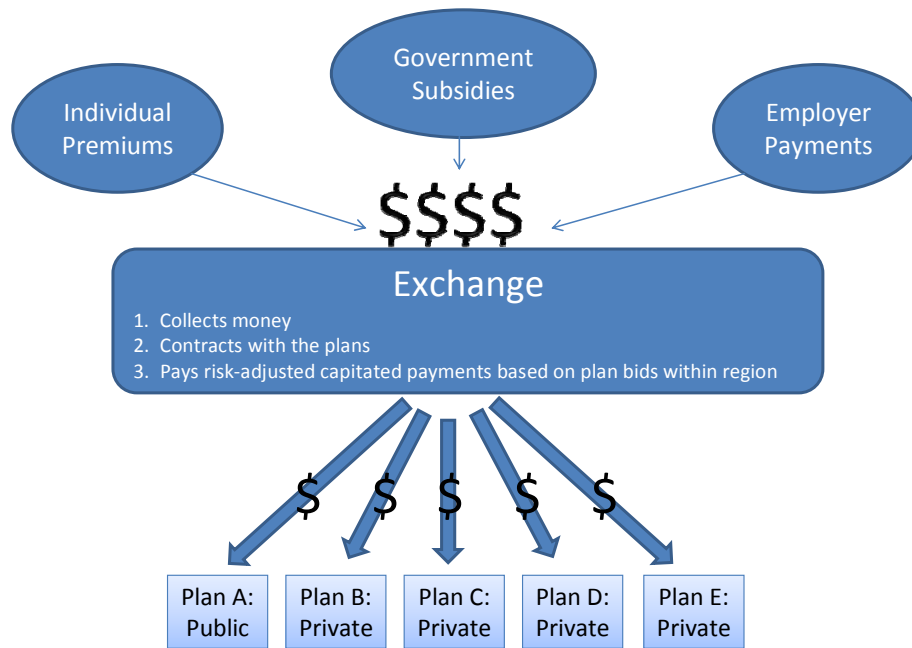
While prospective risk adjustment technologies have come a long way, they are still imperfect. Thus any risk-adjustment system should mix prospective risk adjustment with a retrospective risk-adjustment process at the end of the year that redistributes funds among the plans to ensure that those with very unfavorable mixes of risk are protected. Of course, the public health insurance plan must be part of this arrangement.

Regional Pricing of the Public Plan and Competing Private Plans

Finally, a level playing field requires a system for pricing the private plans and the new public health insurance plan that ensures that (a) they compete fairly with each other within geographic regions and (b) relative disparities in plan costs are reflected in the premiums that enrollees pay. This is perhaps the hardest technical challenge in designing a system of public plan choice, but the basic parameters of a solution are relatively easy to outline.¹⁹

Before outlining those parameters, however, it is worth pausing to emphasize a distinction that is easily lost in the complex discussion of plan pricing. This is the distinction between the *amount that plans are paid by the exchange* and the *premium that enrollees in the plan pay*. It might seem at first that these two amounts are identical, that people in the exchange just pay a premium (through the exchange) to the plan they enroll in. But, as Figure 3 shows, the exchange's payments to plans and individual premiums are not the same.

Figure 3: Inside the Exchange



For one, under a system of risk adjustment, the exchange calibrates the amount it pays each plan based on the health characteristics of those who enroll in it. Enrollees pay a premium that is either wholly or mostly community-rated, but private plans receive payments that reflect the health risk of enrollees.

For another, the premiums that individuals pay will be reduced by whatever subsidies are provided for coverage through the exchange. How these subsidies are set and how individual premiums will be established more generally constitute two of the most important design issues raised by any system of regulated plan choice, whether or not a public plan is in the competitive mix.

The Need for (Regionally Based) Competitive Bidding

There is a growing consensus that *the amount that plans are paid* by the exchange should be determined by a process of competitive bidding, akin to the process being proposed for the reform of Medicare's system of contracting with private plans.²⁰ Currently, Medicare pays private plans through a complicated process that bases payments on the historical per-capita cost of the traditional Medicare program in a particular area. Because of this formula and because of specific subsidies in the law, Medicare ends up grossly overpaying private plans. This process virtually ensures that the private plans do not compete with the traditional Medicare program on the basis of cost, and it creates perverse incentives for insurers to offer plans only in areas where historical average costs are high. Public plan choice would be hobbled by such a process.

Rather than base what private plans receive on the costs of the public health insurance plan (the current Medicare practice), both private plans and the public health insurance plan should submit bids to provide standardized benefits. (Benefits actually provided should be allowed to vary modestly to encourage plan diversity, but there must be a common baseline for comparing bids.)

Importantly, the bids made by both the public plan and private plans should be made on a regional basis. In other words, although the exchange should be nationally administered, the bids should be regionally specific. Many private plans will only wish to provide benefits in certain regions where they operate. The public health insurance plan will of course be truly national. Without regional bidding, the public plan will be disadvantaged in areas where private premiums are low and advantaged where they are high. Neither is conducive to a truly level playing field.

Setting the Premiums Paid by Enrollees

The more difficult issues arise when bids by the plans are translated into premiums paid by enrollees. Two such issues are most pressing: (1) whether the federal contribution to the cost of coverage (i.e., the subsidy) should be based on the lowest-cost plan in the region or on the weighted average of the premiums of all the plans in the region; and (2) to what extent enrollees in high-cost regions should be required to pay higher premiums than individuals in low-cost regions—in other words, how much of the regional variation in plan premiums should be borne by enrollees.

A strong argument can be made for the federal government setting subsidies on the basis of the average weighted premium of plans, as opposed to the cost of the least expensive plan.²¹ First, this would reduce the chance that lower-income enrollees would feel pressured by costs to enroll in the least expensive plan. Second, it would at least crudely adjust subsidies to reflect the *variance* of plan premiums as well as the *level*. In areas where the range of plan premiums is larger, subsidies based on the average will much better protect enrollees against premium costs than subsidies based on the lowest-cost plan. For these two reasons, the weighted-average-premium approach is preferable to the lowest-cost-plan approach for setting subsidies, and the graphics that follow focus on showing how this approach would work. However, either approach would create the necessary incentive for enrollees to prefer less expensive plans.

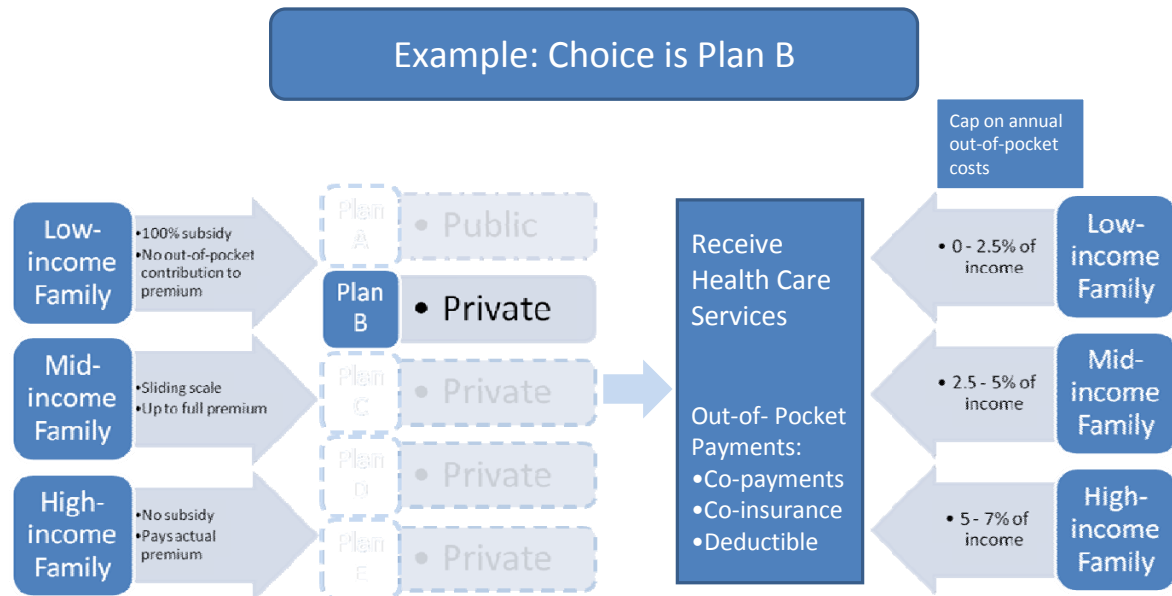
To provide a sense of how these two approaches would work, Table 1 shows how the choice of plan and the premium paid looks to someone enrolling in health insurance through the exchange using these two calculations.

Table 1: Subsidy Calculation: Two Approaches

PLAN CHOICES AND ANNUAL PREMIUMS	Weighted Average Approach Subsidy calculated at 80% of weighted average of plan premiums (assuming equal enrollment in each plan)		Benchmark Approach Subsidy calculated at 80% of lowest-cost plan premium	
	Individual Contribution	Government Subsidy	Individual Contribution	Government Subsidy
Plan A: \$4,000	\$640	\$3,360	\$800	\$3,200
Plan B: \$4,200	\$840	\$3,360	\$1,000	\$3,200
Plan C: \$4,400	\$1,040	\$3,360	\$1,200	\$3,200

In practice, as shown in Figure 4, the subsidy could vary with the income of the enrollee. Low-income enrollees would certainly receive even greater assistance, as well as help with cost-sharing. Because most enrollees through the exchange will be workers whose employers have contributed on their behalf, and because coverage should be kept affordable, the subsidies should cover a good portion of the premium for all enrollees. Since the average employer/employee split of health premiums is roughly 80/20 in the private market today, 80 percent seems a reasonable baseline contribution. Nonetheless, the 80 percent level shown here is meant to be illustrative, not definitive.

Figure 4: Subsidized Premiums and Other Out-of-Pocket Costs for Families



How Should Regional Variation in Premiums be Dealt With?

Regional variation in premiums presents an even tougher set of choices—in part because the treatment of different regions is inherently and deeply political. As Figure 5 shows, the potential approaches to regional premium variation range from ignoring it altogether and offering the same level of subsidies across the nation (**Option 1** in the graphic, which would mean imposing much greater costs on people in high-premium regions) to basing subsidies for enrollees in each region on the weighted average of plan premiums within that region (**Option 2**) to approaches that ensure even greater subsidies for high-cost regions (for example, standardizing the amount that enrollees pay for the least expensive plan in their region, regardless of the level of that plan's premium (**Option 3**)).

Perhaps the most straightforward approach would be to set subsidies on the basis of the weighted average of plan premiums (or the least expensive plan) within a region. For example, to continue the example outlined in the earlier graphic, for a middle-class family the subsidies might equal 80 percent of the average weighted premium within a region. This would mean that the percentage of the premium paid by middle-class families would be the same across the nation (20 percent), but in areas where premium levels were high, such families would end up paying more for health coverage, because the uncovered portion of the premium would represent a larger dollar amount. This seems a reasonable way to accommodate regional price variations while also limiting the degree to which taxpayers and enrollees in low-cost regions are subsidizing enrollees in high-cost regions.

Figure 5: Regional Variations in Subsidy Levels for Plans: Three Options

Premium		Subsidies and Premiums in High-Cost Region *Government Subsidy is 80% of weighted average of plan premiums						
PLAN CHOICES	National Average	Regional Variation	Option 1 No accommodation for regional variation Subsidy based on national average		Option 2 Partial accommodation for regional variation Subsidy based on regional average		Option 3 Greater accommodation for regional variation Subsidy ensures same contribution for lowest-cost plan across regions	
			Individual Contribution	Government Subsidy*	Individual Contribution	Government Subsidy*	Individual Contribution	Government Subsidy*
Plan A	\$4,000	\$5,000	\$1,640	\$3,360	\$800	\$4,200	\$640	\$4,360
Plan B	\$4,200	\$5,250	\$1,890	\$3,360	\$1,050	\$4,200	\$890	\$4,360
Plan C	\$4,400	\$5,513	\$2,153	\$3,360	\$1,313	\$4,200	\$1,153	\$4,360

The Case for Default Enrollment in the Public Plan

One question not answered so far is what happens if enrollees in the exchange fail to enroll in a specific plan. There is a strong argument for making the public health insurance plan the default source of coverage for enrollees who do not specify another option. Automatic enrollment in the public plan for those not choosing a specific plan would help the public plan to obtain a broad mix of risk, which may be difficult otherwise, because of the tendency for less healthy enrollees to enroll in the public plan. In addition, it would help ensure continuity of care and coverage for those who did not choose a plan, because the public plan would almost certainly have the broadest selection of providers in a region. Random assignment of those who do not select a plan across the full range of plans is administratively complex, it would be difficult if not impossible for people to move seamlessly into a new private plan, and it would likely undermine continuity of care. A better alternative would be to make the public plan the default, but institute an enrollment process that increases the likelihood that people in the exchange will affirmatively elect a plan of their choice, and also allow those who were enrolled by default to change plans on the first of the following month if they wanted to do so.

WHY BARGAINING IS VITAL AND HOW IT SHOULD WORK

The comparative and historical evidence is strong that bargaining for better rates is a critical way in which U.S. public programs and other national health systems have controlled costs,

with little or no evidence that this cost control has reduced access or impaired health.²² A public plan with the authority to bargain for fair rates is an essential item on the menu of cost control—and one that the Congressional Budget Office (CBO) and other budget watchdogs are likely to “score” as producing savings. (On the other hand, the CBO has expressed great skepticism about the short- to medium-term prospects for savings from such currently favored forms of cost control as pay-for-performance, comparative-effectiveness research, and health information technology.)²³

Why Countervailing Bargaining Power Is Needed

About one conclusion there can be no question: Our current private-insurance system fails to create effective countervailing power in the market for medical services. Private insurers can often save more by selecting healthy people than by bargaining with providers, and in some highly concentrated insurance markets, private insurers are effectively acting as oligopolies, keeping premiums high rather than driving hard bargains with providers, drug companies, or device manufacturers. The consolidation of the private insurance market over the last two decades was widely expected to bring down costs. (In 16 states, the dominant carrier accounts for at least 50 percent of private enrollment; in 36 states, the top three carriers account for at least 65 percent of the market.²⁴) Yet it obviously has not. Instead, private plans are passing on rising costs to subscribers while increasing their profitability. The reasons for this are multiple, and they go to the heart of the argument for a public plan alongside private plans.

First, the hospital market has grown increasingly concentrated, giving providers considerable market power of their own in negotiations with insurers. In areas where hospital concentration has proceeded farthest, hospital prices and profitability are higher without commensurate increases in service quality.²⁵ Second, private insurers appear to have largely acquiesced to these price increases. As John Holahan and Linda Blumberg explain, “Dominant insurers do not seem to use their market power to drive hard bargains with providers....Competition in insurance markets is often about getting the lowest risk enrollees as opposed to competing on price and the efficient delivery of care.”²⁶ Both of these trends provide strong reason for doubting that private insurance payments are the appropriate standard for public payments.

Is Medicare Bargaining Unfair?

Critics of Medicare prices respond that public plan bargaining is at odds with market pricing and simply unfair. The first charge—that Medicare prices are administered rather than set in the market—is true, but irrelevant. All health plans, public and private, use administered prices. A free market for health services is unrealistic, requiring that people shop around for individual treatments and pay the full cost themselves. In a world of insurance, administered prices are inevitable. Indeed, price bargaining is exactly what HMOs and other big health plans were supposed to do—only Medicare appears to do it better.

As for the unfairness of Medicare pricing, the evidence that Medicare underpays providers is much weaker than commonly believed. Exaggerated charges of cost shifting made by groups representing providers and insurers are based on the faulty assumption that any payment differentials between Medicare and private plans represent cost shifting.²⁷ In effect, these accusations presume that all payers should pay the same rates and that the total

level of payments to providers is appropriate. The whole point of bargaining, however, is to gain volume discounts and restrain total spending—insofar as doing so is consistent with ensuring good access to providers and high-quality care. So far, there is little evidence that Medicare bargaining has undermined access or quality.

Cost-Shifting Confusion

Within the academic literature, the general conclusion is that there is some cost shifting from Medicare to private insurers, albeit a much smaller amount than suggested by critics of Medicare pricing.²⁸ A careful 2006 study of hospital cost shifting from Medicare concludes that “a 1 percent relative decrease in the average Medicare price is associated with a 0.17 percent increase in the corresponding price paid by privately insured patients”—meaning that around 17 cents of every dollar in relative reductions in public Medicare plan payments to private hospitals are shifted onto private patients.²⁹ If this estimate is correct, then cost shifting from the public Medicare plan amounted to less than 10 percent of the overall increase in hospital prices to private payers between 1997 and 2001—the period under study.

Recently, the Medicare Payment Advisory Commission (MedPAC)—the independent, nonpartisan body charged with reviewing Medicare payment policies—has issued a devastating analysis of hospital industry claims of cost shifting.³⁰ As MedPAC notes, claims of extensive cost shifting imply that hospital costs are largely fixed and that it is hospitals in the worst financial shape that will have the greatest need and incentive to shift costs onto private payers due to low Medicare payments. MedPAC finds, however, that costs vary greatly across hospitals, even within the same markets, and it is the most financially pressured hospitals that are most efficient and thus most capable of earning money on Medicare patients. In other words, high payments from private insurers do not result from low payments for Medicare patients. Rather, these high payments permit hospitals to have higher costs, which in turn reduce their margins on Medicare patients. Based on this analysis, MedPAC concludes that “[i]ncreasing Medicare payments is not a long-term solution to the problem of rising private insurance premiums and rising health care costs. In the end, affordable health care will require incentives for health care providers to reduce their rates of cost growth and volume growth.”³¹

The Real Access Picture

Nor do access and participation measures suggest that Medicare is increasingly shortchanging providers: Most data show relatively stable access and participation, and none shows the dire picture sometimes painted. MedPAC is required to review carefully the adequacy of the public Medicare plan’s payments. Its most recent report (March 2009) concludes with regard to hospitals that “[m]ost indicators of payment adequacy for hospital services are positive. Access to hospital services continues to be good, with more hospitals opening than closing. In fact, the overall level of hospital construction was at a record high in 2007. Looking across service lines, many hospitals are expanding both the low-technology (e.g., palliative care) and high-technology (e.g., imaging) services they offer their communities. Despite increasing competition from independent diagnostic testing facilities and ambulatory surgical centers, the volume of hospital outpatient services per Medicare beneficiary has grown, indicating that access is strong. Another positive indicator is that quality-of-care measures are generally improving.”³²

A similar story can be told with regard to the public Medicare plan's physician payments. Medicare's fee schedule clearly requires reform for a variety of reasons. But it has not resulted in a physician exodus from the program, as critics suggest. In its most recent databook, MedPAC reports that 97 percent of physicians were accepting some new public Medicare plan patients—virtually the same rate as are accepting private PPO patients—with 80 percent reporting they accepted all or most patients.³³ And despite the aging of the population, the number of physicians participating in the public Medicare plan has more than kept pace with the growth of enrollees.³⁴

A MedPAC-sponsored survey of beneficiaries conducted in the fall of 2008 indicates “that beneficiary access to physicians is generally good and in several measures better than that reported by privately insured patients age 50 to 64.”³⁵ For example, Medicare beneficiaries were a third less likely than their privately insured counterparts to say that they should have seen a doctor for a medical problem in the past year but did not. According to MedPAC's survey and other recent surveys, people with Medicare are more likely to say they never have to wait for doctors' appointments than those aged 50 to 64 with private insurance, and 9 out of 10 said they had “no problem” finding a doctor or a specialist to treat them.³⁶ And Medicare's negotiated rates do not appear to have dented patient satisfaction with the program. AARP has found that 80 percent of people with Medicare are either “extremely” or “very satisfied” with their health care and access to physicians, a higher rate than for 50 to 64 year olds with private insurance.³⁷

In short, the survey evidence shows generally stable access to primary care physicians and specialists over the last few years, although there has been an increase in the share of the elderly who report having a “big problem” finding a new primary care physician.³⁸ Media stories have highlighted the difficulty that some Medicare beneficiaries have recently had in finding a primary-care doctor, and these stories are indeed distressing.³⁹ However, it is important to keep in mind that the share of elderly Americans who reported a “big problem” finding a primary-care doctor was only 1 percent of the total Medicare population (18 percent of the 6 percent looking for a new primary care physician). More important, the same problems have equally affected *privately* insured Americans. The 2008 MedPAC survey “found no statistical difference between Medicare and privately insured individuals in problems finding a primary care physician.” MedPAC also “conducted research in selected local areas suspected of having access problems but, in general, did not find evidence of major access problems.”⁴⁰

The Inherent Constraints on Public Plan Bargaining

To listen to critics of public plan choice, a new public plan would arbitrarily set prices at a level that would cause providers to refuse to provide services or that would bankrupt hospitals and doctors. Yet this is precisely the fear that is addressed by having a public plan competing alongside private plans on a level playing field. As former Medicare official Robert Berenson of the Urban Institute, recently testified before Congress, the concern that the public plan would indiscriminately cut payments

ignores the reality that the public plan in competition with private plans has built-in restraints that limit action to push down prices too low...As in Medicare, the public plan would have to balance spending-growth restraint with the duty to preserve access

to needed care and the quality of that care. If the public plan would aggressively move too strongly on the cost containment side, individuals would be able to select from among the private plan options. Further, the public plan, as with Medicare, as a strong buyer, would become responsible for the health and stability of the delivery system. If it would limit payments too strictly, it would face the risk of causing hospital closures, slowing down the introduction of desirable new treatments, and, for some specialties, reducing the availability of physician services.⁴¹

Providers do have legitimate complaints, but they mostly concern other aspects of American health insurance: *Medicaid* does grievously underpay providers in many states, and providers who deliver care to uninsured patients often collect just pennies on the dollar. This argues for upgrading Medicaid rates and broadening insurance coverage—not giving up on public-sector bargaining. Any national reform proposal that includes public plan choice will involve a major expansion of insurance coverage. (Many reform proposals would also upgrade Medicaid payment rates to bring them closer to Medicare and private payments.) This expanded coverage would mean that providers would be paid for a much higher share of the services they delivered.⁴² In the context of these reforms, providers should be much more willing to accept a new public health insurance plan that had some bargaining leverage.

Safeguards

Bargaining for better rates is an essential means of cost control. But it is also a controversial means, and any new public health insurance plan will have to include some safeguards to ensure that the public plan's bargaining power is used appropriately.

What might those safeguards look like?

1. **A better payment system than currently exists in Medicare.** The current fee-for-service structure for physician payments inevitably focuses attention on the blunt instrument of cutting service prices when the goal should be greater efficiency. One reason that Medicare's hospital payment system (which reimburses hospitals on the basis of diagnosis rather than services delivered) is less criticized than the physician payment system, even though it is arguably stricter and more austere, is that it is focused on efficiency, rather than price alone.
2. **An expanded Medicare Payment Advisory Commission.** There should be much more and much better information collected about the adequacy of provider payments.
3. **A new stakeholder advisory group.** Doctors and hospitals should have a regular seat at the table in the discussion of payments. In other countries, negotiation is regularized between providers and national policy administrators, and this creates both greater transparency and greater scope for over-time tradeoffs.
4. **Soft and hard triggers.** The new data collected by the expanded advisory commission should create automatic review procedures and eventually force action when provider participation, payment

adequacy, or care quality measures indicate that payment restraint is harming patient's care or access.

A Modest, Flawed Proposal

An alternative way of addressing provider and insurer concerns has recently been floated by Len Nichols and John M. Bertko of the New America Foundation.⁴³ Their “Modest Proposal for a Competing Public Plan” would have the “public plan” consist of a plan akin to existing state self-insured health plans. These plans, which have been established in many states, are often handled by private third-party administrators, who in turn establish contracts with providers. Because Nichols and Bertko’s proposal envisions the self-insured plans differing from region to region, perhaps the best way to describe their approach is one of “competing public *plans*.” These plans would not look like Medicare, nor would they use rates or payment methods that necessarily bear resemblance to Medicare’s. Indeed, Nichols and Bertko suggest that in some areas the public plan could take the form of a publicly chartered HMO, and they insist that these public plans should have no ability to use Medicare’s leverage to establish fair provider rates.

Nichols and Bertko are to be commended for clarifying the debate. They show that there is broad agreement among reformers about the need for consistent rules, comprehensive risk-adjustment, and equal subsidies across plans to ensure a level playing field. Where they depart from the “Medicare-like” vision of the public plan articulated in this brief (and embraced by many leading reformers) is with regard to the *form* that the public plan itself should take (or, in their case, the public *plans*). Candidly stating that the sticking point for them is price bargaining, they acknowledge that “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... 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.”

However, embracing this “modest proposal” would be a serious mistake. First, it envisions building a new set of regional plans largely from scratch, which would mean forfeiting the administrative and political advantages of building on the Medicare infrastructure and model. Second, it would also mean forfeiting a major advantage of the Medicare model: the ability to provide enrollees with a broad choice of providers. Private plans are perfectly capable of putting together tightly managed HMOs. The distinctive value that a public health insurance plan provides is more inclusive coverage, a value that most Americans hold in very high regard. Roughly half of federal employees covered by the Federal Employees Health Benefit Program, for example, choose the standard Blue Cross/Blue Shield plan, with its broad choice of primary care doctors and specialists.

Third, and most important, the prospect for substantial cost restraint under Nichols and Bertko’s modest proposal would be limited—particularly in the short to medium term—putting the broader goals of reform at risk. To be fair to Nichols and Bertko, the purpose of their paper is to make the case for a more modest public plan with weaker bargaining power, not lay out how they would control costs without a more robust public plan. Nonetheless, independent experts like those at the CBO have expressed substantial skepticism about the

ability of the system-wide initiatives to produce major savings in the near term. Meanwhile, the consolidation of private providers over the last fifteen years has heightened the need for a strong countervailing power in the health care market to make sure that prices are appropriate, emphasize primary and preventive care, and are restrained over time. In the face of these trends, state self-insured plans have not had a particularly impressive record of cost-restraint—certainly when compared with Medicare.

Moreover, as Bob Berenson notes, “to limit arbitrarily the public payer from using pricing...and having payers rely only on more intrusive approaches, such as prior authorization..., does not make good policy sense.” The public plan should be able to use the best tools it has while private plans should be able to use the best tools they have. The alternative, Berenson points out, is self defeating: “Differentiating ‘price controls’ from all the other tools a value-based purchaser—public or private—would use is both arbitrary and unworkable because, in practice, pricing services is inextricably linked to the other approaches recommended....Without a public plan option as a predictable approach to limiting health care spending, the promise of universal coverage is likely to be unrealized under the continuing pressure of rising health care spending.”⁴⁴

The All-Payer Alternative

A better alternative to a public plan without pricing authority, as Joseph White of Case Western Reserve has trenchantly argued, is to allow private plans that pay providers on a more or less fee-for-service basis to piggyback on the public plan in setting their own prices.⁴⁵ This idea has echoes in the operation of the private fee-for-service plans that operate alongside Medicare today (though, as discussed, these plans are unfairly favored by a system for paying private plans that excessively subsidizes them). It is also similar to the all-payer rate setting that occurs in other rich nations. Its logic is simple, and well put by White: “If the main problem, from the private insurers’ perspective, is the superior market power of the public plan, that should be addressed by *sharing the market power among all payers*, through all-payer rate-setting.”⁴⁶

In practice, all-payer rate setting of this sort would mean that private fee-for-service plans within the exchange would use the same fee schedule that the public plan did. This would not stop private plans from offering alternatives to fee-for-service coverage, such as integrated HMOs—they would simply use their own payment methods. Nor would it stop the public plan from improving its own payment methods; it would only require that those innovations be shared with other plans that used similar pricing methods.

All-payer rate setting of this sort would broaden price bargaining so that providers and insurers (including the public plan) could shape the whole pie rather than their own small slices of it, reducing the incentives for cost shifting. It would therefore require that providers and insurers (including the public plan) engage in regularized negotiation over provider rates, rather than the one-on-one turf wars that usually occur today. By putting the public plan and insurers “on the same side,” so to speak, it would reassure private plans that they would have the ability to compete with the public plan, allowing them to focus on innovations in care management, quality assurance, and customer service.

A less obvious but no less important effect of all-payer rate setting would be substantially reduced administrative costs. Although it is well known that administrative costs are much higher in the United States than other nations, it is less well known that a major portion of this difference arises because of the diverse and conflicting billing and reimbursement practices of providers and private insurers. A pathbreaking study of administrative costs in California by Jim Kahn and his colleagues found, for instance, that roughly 20 to 22 percent of spending on physician and hospital services in California that are paid for through privately insured arrangements is used for billing and insurance-related functions.⁴⁷ Standardized billing and payments for a large part of the provider market would not only reduce administrative expenses, it would also facilitate the monitoring of care and of physician practice patterns—both of which are now shrouded in the fog of competing billing and reimbursement practices.

Allowing private plans that use fee-for-service payment to piggyback on the public plan's rate thus would have broader benefits than simply reducing the opposition of private insurers to the idea of a public plan. It would make cost control more effective, encourage administrative simplification and care improvement, and increase the degree of coordination in American health financing. Yet, whatever its merits, this approach cannot take the place of a new public plan for the nonelderly. The new public plan would have to spearhead the development of payment schedules and improved payment methods for the nonelderly, it would be needed to invest in public information and the development of strategies to improve the quality of care that could be disseminated system-wide, and it would serve as a crucial continuing check on private insurers, as well as a backstop plan for those patients most in need of care. As White argues, "Combining a Medicare-like public plan with competition from private insurers within a system of coordinated payment rates would have many advantages." But for those advantages to be realized, a public plan is essential.⁴⁸

CONCLUSION

This brief has shown how a true public health insurance plan, built on Medicare's infrastructure but separate from the Medicare program, can be offered within an independent exchange in a manner that allows it to compete effectively with private health plans—neither unduly disadvantaged by its inherent attractiveness to higher-risk enrollees nor unduly advantaged by the greater bargaining power it will likely enjoy.

The goal is a system in which private insurance and public insurance are encouraged to compete side by side to attract enrollees on a level playing field that rewards plans that deliver better value and health to their enrollees. Public insurance can be a benchmark for private plans and a source of stability for enrollees, especially those with substantial health needs. Private plans can provide an alternative for those who feel that public insurance does not serve their needs and a source of continuing pressure for innovation in benefit design and care management. And both should have a chance to prove their strengths and improve their weaknesses in a competitive partnership.

A key message of this memo is that the evident need for the improvement of Medicare and other public programs should not be taken as an argument against allowing

nonelderly Americans without secure workplace coverage to have the same choice that America's seniors and people with disabilities do: enrolling in a public or private plan. Public plan choice is an essential means of guaranteeing quality, affordable care, while setting a high standard that private plans must compete to meet. It can also show the way toward a better Medicare program that serves the elderly and disabled Americans more effectively.

Perhaps that is why Americans are strongly supportive of public plan choice. A recent poll commissioned by Health Care for America Now! shows that the overwhelming majority of Americans, Republicans as well as Democrats, believe that a choice of public and private plans is preferable to either a public-only or private-only strategy.⁴⁹ The poll finds, moreover, that Americans believe strongly that such competition will ensure lower costs and better access to care—even when they are presented with some of the arguments that have been made against public plan choice.

Allowing public insurance and private plans to compete on a level playing field is the key to cost control and quality coverage. It is also, as this brief has shown, eminently practical. If we fail to let Americans without secure workplace coverage have the choice of a public health insurance plan, it will not be because the goal defies our capacity to achieve it, nor will it be because the value of a competing public plan to the cause of health security has been left unclear. It will be because fear has won out over hope, blinding us to the sensible middle ground that lies before us.

REFERENCES

- ¹ Obama '08, "Barack Obama's Plan for a Healthy America." Accessed April 7, 2009, <http://www.barackobama.com/pdf/issues/HealthCareFullPlan.pdf>; Sen. Max Baucus, Chairman, Senate Finance Committee, "Call to Action: Health Reform 2009." Accessed April 7, 2009, <http://finance.senate.gov/healthreform2009/finalwhitepaper.pdf>; Edwards '08, "Universal Health Care Through Shared Responsibility." Accessed April 7, 2009, <http://johnedwards.com/about/issues/health-care-overview.pdf>; Clinton '08, "American Health Choices Plan Quality, Affordable Health Care for Every American." Accessed April 7, 2009, <http://www.hillaryclintonquarterly.com/americanhealthchoicesplan.pdf>; Tom Daschle; Scott S. Greenberger; Jeanne M. Lambrew, *Critical: What We Can Do About the Health-Care Crisis*, (New York: Thomas Dunne Books, 2008). For additional background on public plan choice, see Peter Harbage and Karen Davenport, "Competitive Health Care: A Public Health Insurance Plan that Delivers Market Discipline," Center for American Progress Action Fund, March 25, 2009. Accessed April 7, 2009, http://www.americanprogressaction.org/issues/2009/03/pdf/competitive_health.pdf; Jacob Hacker, "The Case for Public Plan Choice," Institute for America's Future and Berkeley Center for Health, Economic & Family Security, UC Berkeley School of Law, 2008. Accessed April 7, 2009, http://institute.ourfuture.org/files/Jacob_Hacker_Public_Plan_Choice.pdf; Hacker, "Health Care for America," Economic Policy Institute, January 2007. Accessed April 7, 2009, <http://www.sharedprosperity.org/bp180.html>; Hacker "Medicare Plus" *Covering America: Real Remedies for the Uninsured, Volume 1* (Washington, D.C. Economic and Social Research Institute, June 2001); Mark Schlesinger and Jacob S. Hacker, "Secret Weapon: The 'New' Medicare as a Route to Health Security," *Journal of Health Politics, Policy and Law* 2007. Accessed April 7, 2009, <http://jhppl.dukejournals.org/cgi/content/abstract/32/2/247>; Helen Halpin, "The CHOICE Option," University of California at Berkley, March 31, 2002. Accessed April 7, 2009, <http://www.health-access.org/expanding/hcop.htm#calchoice>, expanded into a national proposal in the 2003 compendium of proposals, *Covering America: Real Remedies for the Uninsured, Volume 3* (Washington, D.C. Economic and Social Research Institute, December 2003), and the reform approach that John Holahan, Linda Blumberg, and Len Nichols outlined in 2001 to expand coverage through a combination of existing public programs and the creation of state purchasing pools that would include a state-run managed fee-for-service plan, *Covering America: Real Remedies for the Uninsured, Volume 1* (Washington, D.C. Economic and Social Research Institute, June 2001).
- ² See the discussion of public opinion at end of this brief.
- ³ Hacker, "The Case for Public Plan Choice."
- ⁴ Barry Schwartz, *The Paradox of Choice: Why More is Less* (New York: HarperCollins, 2004).
- ⁵ The Lewin Group, "Cost Impact Analysis for the 'Health Care For America' Proposal," February 15, 2008. Accessed April 7, 2009, <http://www.sharedprosperity.org/hcfa/lewin.pdf>; Karen Davis, "Public Programs: Critical Building Blocks in Health Reform," Testimony before the Senate Finance Committee, June 16, 2008. Accessed April 7, 2009, <http://finance.senate.gov/healthsummit2008/Statements/Karen%20Davis%20Testimony.pdf>.
- ⁶ Hacker, "The Case for Public Plan Choice."
- ⁷ Chapin White, "Health Care Spending Growth: How Different Is The United States From The Rest Of The OECD?" *Health Affairs*, Vol. 26 Issue 1, January/February 2007; Gerard Anderson, et al., "It's The Prices, Stupid: Why The United States Is So Different From Other Countries," *Health Affairs*, Vol. 22 Issue 3, May/June 2003.
- ⁸ Peter Orszag, "Questions from Chairman Conrad for Peter Orszag, Nominee to be Director, Office of Management and Budget," Senate Budget Committee, 2009. Accessed April 7, 2009, <http://budget.senate.gov/democratic/documents/2009/QAsConradOrszag.pdf>
- ⁹ The Lewin Group "Cost Impact Analysis for the 'Health Care For America' Proposal."
- ¹⁰ Hybrids are "organizational arrangements that use resources and/or governance structures from more than one existing organization." Bryan Borys and David B. Jemison, "Hybrid Arrangements as Strategic Alliances: Theoretical Issues in Organizational Combinations," *Academy of Management Review*, Vol. 14, No. 2, April, 1989, 235. In health insurance, a public-private hybrid would build on the best elements of the present system: large group plans in the public and private sectors. At the same time, it would involve putting in place a new means of allowing Americans without access to secure workplace coverage to choose among insurance plans that provide strong guarantees of quality affordable coverage, with these guarantees including a guarantee of effective cost control—the central prerequisite of health security over the long run. See Mark Schlesinger; Hacker and Schlesinger, "Secret Weapon."

- ¹¹ Peter Harbage, "The Inefficient Individual Market," Center for American Progress Action Fund, March 23, 2009. Accessed April 7, 2009, http://www.americanprogressaction.org/issues/2009/03/pdf/administrative_costs.pdf; Karen Pollitz, "Statement before Committee on Energy and Commerce Subcommittee on Health," March 17, 2009. Accessed April 7, 2009, http://republicans.energycommerce.house.gov/Media/file/Hearings/Health/031709_Health_Affordable_Coverage_Hearing/031709_Pollitz_Health_Affordable_Coverage.pdf. For this reason, it would be a mistake to place heavy restrictions on *which* firms should be allowed to enroll their workers in the exchange. Both large and small employers and both low-wage and high-wage firms should be able to enroll their workers in the pool by making a contribution on their workers' behalf. (Note that what is under discussion here is enrollment in the exchange, rather than the public health insurance plan. Whether to enroll in a public or private plan is the choice of the worker if his or her employer does not provide insurance.)
- ¹² Glenn Hackbarth, "Achieving Payment Reform in Medicare," *Modern Healthcare*: Vol. 38 Issue 44, November 3, 2008. Accessed April 7, 2009, <http://www.commonwealthfund.org/Content/Publications/Commentaries/2008/Nov/Achieving-Payment-Reform-in-Medicare.aspx>.
- ¹³ While a prominent feature of many current reform proposals, public plan choice has been on the political agenda before and for many of the same reasons it is today: a desire to ensure broad access and cost containment as well as to provide a choice of providers and of a secure, simple insurance product. During the debate over the Clinton health plan in the early 1990s, for example, House Majority Leader Richard Gephardt amended the Clinton plan to include a new "Medicare Part C" program for the nonelderly that would compete with private health plans. Meanwhile, in his capacity as Chair of the Health Subcommittee of the House Ways and Means Committee, Representative Pete Stark proposed allowing the nonelderly to enroll in a new expanded Medicare program or in a private health insurance plan. And of course, Medicare has its own framework for public-plan choice, which expanded from Medicare demonstration projects with HMOs in the 1980s into the Medicare+Choice program in the 1990s and, finally, the Medicare Advantage Program in the 2000s. Despite the common description of it as a "single payer," Medicare allows beneficiaries to choose between a public fee-for-service plan and various private plans. In short, there is nothing radical or unprecedented about allowing public and private insurance to compete side by side on a level playing field to attract enrollees, provide value, and improve health.
- ¹⁴ Timothy Jost, "Working Draft-Comparative Experience With Public/Private Competition," Washington and Lee University School of Law, 2009, jostT@wlu.edu.
- ¹⁵ David Himmelstein; Steffie Woolhandler, "Public Plan Option in a Market of Private Plans," Physicians For A National Health Program, March 26, 2009. Accessed April 7, 2009, <http://www.pnhp.org/blog/2009/03/26/himmelstein-and-woolhandler-on-a-public-plan-option>.
- ¹⁶ Robert Moffit, "How a Public Health Plan Will Erode Private Care," The Heritage Foundation, December 2008. Accessed April 7, 2009, <http://www.heritage.org/research/healthcare/bg2224.cfm>.
- ¹⁷ Newt Gingrich, "POLITICS; Gingrich on Medicare," *New York Times*, July 20, 1996. Accessed April 7, 2009, <http://www.nytimes.com/1996/07/20/us/politics-gingrich-on-medicare.html?sec=health>.
- ¹⁸ William Dow, "Economic Considerations in Reforming California's Non-Group Insurance Market," University of California- Berkeley. Accessed April 7, 2009, [http://www.law.berkeley.edu/files/Dowreinsurance-RA2007-11-02\(1\).pdf](http://www.law.berkeley.edu/files/Dowreinsurance-RA2007-11-02(1).pdf); Wynand van de Ven; Randall Ellis, "Risk Adjustment In Competitive Health Plan Markets," Chapter 17, Handbook of Health Economics (eds. A.J. Culyer and J.P. Newhouse March 31, 1999). Accessed April 7, 2009, <http://bbs.cenet.org.cn/uploadimages/20043423334827860.pdf>.
- ¹⁹ Robert A. Berenson; Bryan E. Dowd, "Medicare Advantage Plans At A Crossroads--Yet Again," *Health Affairs*, Web Exclusive, November 24, 2008.
- ²⁰ Medicare Payment Advisory Commission, "Report to the Congress: Medicare Payment Policy," March 2008, 87. Accessed April 7, 2009, http://www.medpac.gov/documents/Mar08_EntireReport.pdf; Ibid, 238; Peter R. Orszag, "The Medicare Advantage Program: Enrollment Trends and Budgetary Effects," Statement before the Committee on Finance, United States Senate, April 11, 2007. Accessed April 7, 2009, <http://www.cbo.gov/ftpdocs/79xx/doc7994/04-11-MedicareAdvantage.pdf>; Office of Management and Budget, "A New Era of Responsibility: Budget of the United States Government Fiscal Year 2010." Accessed April 7, 2009, <http://www.whitehouse.gov/omb/budget>.
- ²¹ Congressional Budget Office, "Designing a Premium Support System for Medicare," December 2006. Accessed April 7, 2009, <http://www.cbo.gov/ftpdocs/76xx/doc7697/12-08-Medicare.pdf>.

- ²² Jacob Hacker, Hacker, "The Case for Public Plan Choice;" Gerard Anderson, et al., "It's The Prices, Stupid: Why The United States Is So Different From Other Countries."
- ²³ Douglas W. Elmendorf, "Options for Controlling the Cost and Increasing the Efficiency of Health Care," statement before the Subcommittee on Health, Committee on Energy and Commerce, U.S. House of Representatives, March 10, 2009. Accessed April 7, 2009, http://www.cbo.gov/ftpdocs/100xx/doc10016/03-10-Health_Care.pdf.
- ²⁴ James C. Robinson, "Consolidation and the Transformation of Competition in Health Insurance," *Health Affairs*, Volume 23, No. 6, November/December 2004, Exhibit 1.
- ²⁵ John Holahan; Linda Blumberg, "Can a Public Insurance Plan Increase Competition and Lower the Costs of Health Reform?" Urban Institute Health Policy Center, 2008, 3. Accessed April 7, 2009, http://www.urban.org/UploadedPDF/411762_public_insurance.pdf.
- ²⁶ Ibid, 3.
- ²⁷ Milliman, "Hospital & Physician Cost Shift: Payment Level Comparison of Medicare, Medicaid, and Commercial Payers," a report prepared for America's Health Insurance Plans, the American Hospital Association, the Blue Cross Blue Shield Association, and Premier Blue Cross, December 2008. Accessed April 7, 2009, <http://www.bcbs.com/news/bluetvradio/cost-shift-study-2008/us-cost-shift-20081208.pdf>.
- ²⁸ See, for example, Jan Clement, "Dynamic Cost Shifting in Hospitals: Evidence from the 1980s and 1990s," *Inquiry*, Vol. 34 Issue 4, Winter 1997/98: 340–350; Jason S. Lee, et al., "Medicare Payment Policy: Does Cost Shifting Matter?" *Health Affairs*, Web Exclusive, October 8, 2003; and Michael A. Morrissey, "Cost Shifting: New Myths, Old Confusion, and Enduring Reality," *Health Affairs*, Web Exclusive, October 8, 2003.
- ²⁹ Jack Zwanziger and Anil Bamezai, "Evidence Of Cost Shifting In California Hospitals," *Health Affairs*, Vol. 25 Issue 1, January/February 2006.
- ³⁰ Medicare Payment Advisory Commission, "Report to the Congress: Medicare Payment Policy," March 2009. Accessed April 7, 2009, http://www.medpac.gov/documents/Mar09_EntireReport.pdf.
- ³¹ Ibid, 11.
- ³² Ibid, 45.
- ³³ Medicare Payment Advisory Commission, "A Data Book: Healthcare Spending and the Medicare Program; Section 5: Access to Care in the Medicare Program," June 2008, Chart 5-3, 55.
- ³⁴ Medicare Payment Advisory Commission, "Report to the Congress: Medicare Payment Policy," March 2009, 95.
- ³⁵ Ibid, 78.
- ³⁶ Teresa A. Keenan, "Access to Physicians Survey,," AARP, February 2007, 2-3. Accessed April 7, 2009, http://www.aarp.org/research/health/carequality/physician_access.html.
- ³⁷ Ibid, 3.
- ³⁸ Medicare Payment Advisory Commission, "A Report to Congress: Medicare Payment Policy," March 2008, 84; Medicare Payment Advisory Commission, "A Report to Congress: Medicare Payment Policy," March 2007, 102. Accessed April 7, 2009, http://www.medpac.gov/documents/Mar07_EntireReport.pdf.
- ³⁹ Julie Connelly, "Doctors Are Opting Out of Medicare," *New York Times*, April 1, 2009. Accessed April 7, 2009, <http://www.nytimes.com/2009/04/02/business/retirementspecial/02health.html>.
- ⁴⁰ Medicare Payment Advisory Commission, "Report to the Congress: Medicare Payment Policy," March 2009, pg. 78.
- ⁴¹ Robert A. Berenson MD, "Health Reform in the 21st Century: Reforming the Health Care Delivery System," Testimony before The United States House Committee on Ways and Means, April 1, 2009. Accessed April 7, 2009 http://www.urban.org/uploadedpdf/901244_testimony_healthreform.pdf.
- ⁴² Families USA "Paying a Premium: The Added Cost of Care for the Uninsured," June 2005. Accessed April 7, 2009, http://www.familiesusa.org/assets/pdfs/Paying_a_Premium731e.pdf.
- ⁴³ Len M. Nichols; John M. Bertko, "A Modest Proposal for a Competing Public Health Plan," New America Foundation. Accessed April 7, 2009, <http://www.newamerica.net/files/CompetingPublicHealthPlan.pdf>.
- ⁴⁴ Robert A. Berenson MD, "Health Reform in the 21st Century: Reforming the Health Care Delivery System," Testimony before the United States House Committee on Ways and Means, April 1, 2009. Accessed April 7, 2009 http://www.urban.org/uploadedpdf/901244_testimony_healthreform.pdf.
- ⁴⁵ Joseph White, "Health Care Reform With Credible Cost Control: The Case for All-Payer Regulation," Case Western Reserve University, White Paper, 2009, jxw87@case.edu.
- ⁴⁶ Ibid, 6.

⁴⁷ James G. Kahn,; Richard Kronick; Mary Kreger; David N. Gans, "The Cost Of Health Insurance Administration In California: Estimates For Insurers, Physicians, And Hospitals," *Health Affairs*, Volume 24, No. 6, November/December, 2005.

⁴⁸ Joseph White, "Health Care Reform with Credible Cost Control: The Case for All-Payer Regulation," 6.

⁴⁹ Health Care for America Now, "Public Rejects Insurance Industry's Misleading Claims: New Poll Shows." Accessed April 7, 2009

http://healthcareforamericanow.org/site/content/public_rejects_insurance_industrys_misleading_claims_new_poll_shows.; see also Robert Blendon and John Benson, "Americans' Views on Health Policy: A Fifty-Year Historical Perspective," *Health Affairs*, Vol. 20 Issue 2 (March/April 2001.); Mark Schlesinger; Jacob S. Hacker, "Secret Weapon: The 'New' Medicare as a Route to Health Security."

University of California, Berkeley
School of Law
2440 Bancroft Way, Suite 300
Berkeley, CA 94704
510.643.2335
www.law.berkeley.edu/chefs.htm



Berkeley Center on Health, Economic & Family Security

The Berkeley Center on Health, Economic & Family Security (Berkeley CHEFS) is a research and policy center at the University of California, Berkeley, School of Law and the first of its kind to develop integrated and interdisciplinary policy solutions to problems faced by American workers and families. Berkeley CHEFS works on increasing access to health care, improving protections for workers on leave from their jobs, supporting workers in flexible workplaces, and ensuring that seniors are secure during retirement.

1825 K Street NW
Suite 400
Washington, DC 20006
202.955.5665
<http://institute.ourfuture.org>



Institute for America's Future

The Institute for America's Future is a center of non-partisan research and education. Drawing on a network of scholars, activists and leaders across the country, IAF develops policy ideas, educational materials and outreach programs. The Institute's efforts help shape a compelling progressive agenda primarily focusing on kitchen-table concerns such as affordable health care, accessible higher education, retirement security, living wages, healthy workplaces, strong infrastructures, safe food, fair trade and clean energy.



Jacob S. Hacker is Professor of Political Science at UC Berkeley and Co-Director of the Berkeley Center on Health, Economic & Family Security at UC Berkeley School of Law.