

**PUBLIC PLAN CHOICE IN
CONGRESSIONAL HEALTH PLANS:**

THE GOOD, THE NOT-SO-GOOD, AND THE UGLY

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EXECUTIVE SUMMARY

The historic health reform bills passed out of three House committees and the Senate Health, Education, Labor, and Pensions committee all include a national public health insurance plan as a way to rein in costs, improve quality, and help make health care affordable. This new public plan would be available alongside regulated private plans within an insurance “exchange” open to those without employment-based insurance, promoting choice and competition in often highly concentrated local insurance markets. Yet crucial differences in the design and robustness of the public plan distinguish the bills passed out of committee. Meanwhile, the Senate Finance Committee, which has yet to produce a bill, has already taken the public health insurance option off the table.

This policy brief explores the various versions of public plan choice on the congressional agenda and shows how their best aspects can be combined to produce an effective public plan that will deliver on its promise—and why the cooperative “alternative” embraced by negotiators in the Senate Finance Committee does not merit consideration.

The competing provisions of the public health insurance plan that are currently in play fall into two groups: the “good” and the “not-so-good.” Good provisions are those that allow the public plan to create a provider network on its first day of operation, pay providers using a system that is established and transparent, operate as an effective competitor with private plans on a level playing field, and obtain drug price discounts—in short, that ensure that a public plan can deliver the most value to workers and their families, employers, and the economy overall. Not-so-good provisions, by contrast, compromise the public health insurance plan in important ways that reinforce the power of the private insurance industry and will make the public plan difficult or impossible to establish. These provisions—such as requiring the public plan to create a provider network from scratch and negotiate rates directly with providers across the nation, rather than building on Medicare’s existing network and payment methods—are likely to hinder the public plan from serving as a competitive benchmark for private plans or innovating in the payment and delivery of care.

The Senate Finance Committee’s cooperative model is not good, nor even not-so-good. It is “ugly.” Although few specifics about the model are available, there is absolutely no reason to think that cooperatives of any sort could achieve the three crucial goals that a competing public plan must accomplish—provide a *backup* option offering health and financial security to individuals without employer coverage, a cost and quality *benchmark*, and a cost-control *backstop* that drives payment and delivery system reform.

That all the bills currently moving toward debate in the House and Senate contain a public health insurance option is considerable cause for celebration. Nevertheless, there are good and not-so-good ways to structure a public health insurance plan, and the good ways must be chosen if the public plan is to have the best chance of achieving its critical goals. At the same time, federally promoted health cooperatives should be understood as an effort to kill the public plan and, with it, the prospect of an effective competitor to consolidated insurance companies that have too often failed to provide affordable health security.

The historic health reform bills passed out of four committees in the House and Senate all include a national public health insurance option as a way to rein in costs, improve quality, and help make health care affordable.¹ This new public plan would be offered as a choice alongside regulated private plans within an insurance “exchange” that is open to Americans without employment-based insurance.²

Yet crucial differences in the design and robustness of the public plan distinguish the versions passed out of committee. Moreover, the Senate Finance Committee, which has yet to produce a bill, has already taken the public health insurance option off the table.³ Instead, a group of six Republicans and Democrats who are negotiating the details of the bill (and who collectively represent less than three percent of the U.S. population) has substituted for the public plan the largely untested and symbolic idea of promoting consumer health care cooperatives—which cannot provide the choice for consumers, the competition for insurers, the cost controls, or the broad insurance and delivery innovations that a public plan can.⁴

This policy brief explores the various versions of public plan choice on the congressional agenda and shows how their best aspects can be combined to produce a workable and effective public plan that will deliver on its promise—and why the cooperative “alternative” does not merit consideration.

The competing provisions of the public health insurance plan currently in play fall into two groups: the “good” and “not-so-good.” Good provisions are those that allow the federal government to create a public plan with a broad provider network across the United States and that help ensure that this plan can act as an effective competitor with private plans on a level playing field, obtain drug price discounts, and innovate in the delivery and financing of care. Three crucial good provisions are (1) a “Medicare tie-in” that allows the public plan to develop a broad national provider network with competitive payment rates quickly, (2) the creation of a national exchange that can give a wide range of firms, as well as uninsured Americans, access to both the public plan and regulated private insurance options, and (3) providing the public plan with enough authority to reduce medical inflation through drug-price bargaining and innovations in the financing and delivery of care.

Not-so-good provisions, by contrast, compromise the public plan in ways that could reinforce the power of the private insurance industry at the expense of health care consumers. Such provisions are likely to hinder the public plan from getting established, from keeping premiums low, and from innovating in the payment and delivery of care, thus reducing its ability to serve as a competitive benchmark for private plans. Requiring the public plan to create a provider network from scratch and negotiate rates directly with providers across the nation is such a not-so-good provision. So too are provisions that would permanently restrict access to the exchange (and thereby the public plan) so that only the smallest firms could participate or prevent the public plan from having the authority to restrain costs and innovate over time.

Yet none of the not-so-good public plan provisions is as “ugly” as giving up on a national public health insurance plan altogether, as the Finance Committee negotiators have done.⁵ Cooperatives are not a public plan, and they are not a serious means of reliably achieving any of the public plan’s critical goals. To understand why requires first grasping what the public plan is and must do.

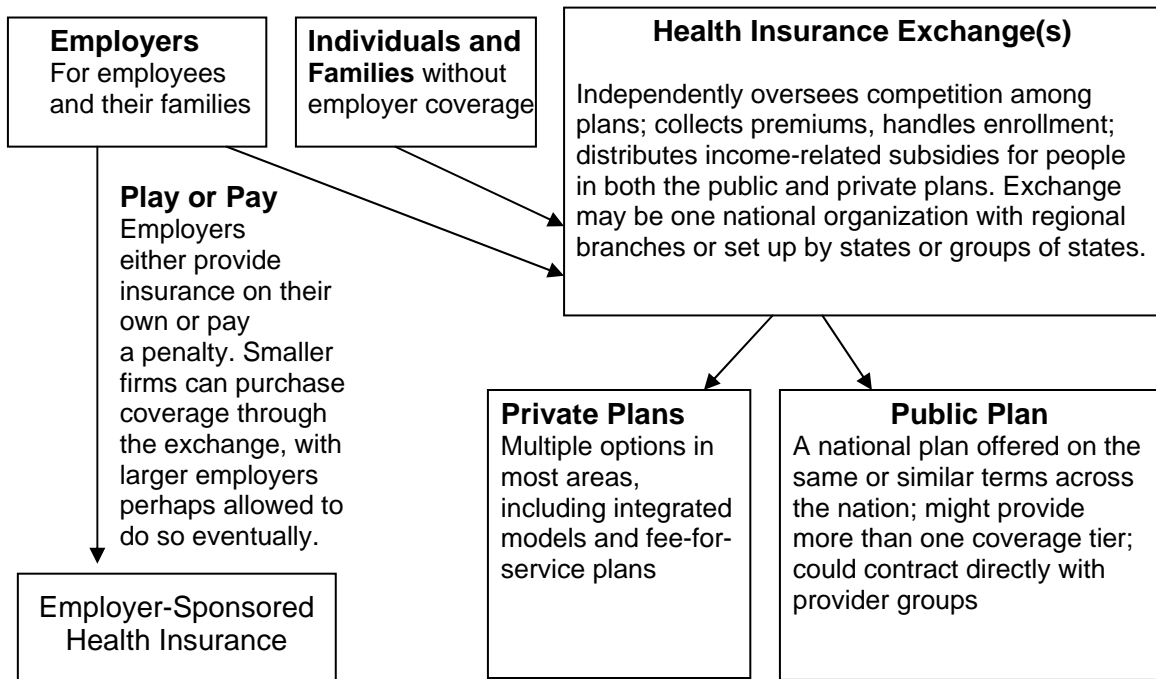
THE WHAT AND WHY OF A PUBLIC PLAN⁶

The bills and amendments passed out of House and Senate committees thus far envision a public health insurance plan that is national, comprehensive, and available on the first day that subsidized coverage is offered (rather than “triggered” down the line).⁷ This plan is called the “Public Health Insurance Option” in the House bill.⁸ It is called the “Community Health Insurance Option” in the bill passed out of the Senate Health, Education, Labor, and Pensions (HELP) Committee.⁹

In both the Senate and House bills, this plan

- is modeled after, but independent of, Medicare, fully bearing the risk of medical claims for its enrollees in a separate pool;
- derives its funding entirely from premiums, employer contributions, and government subsidy payments (that is, cannot draw on general revenues to support itself);
- is run by a government agency housed within the U.S. Department of Health and Human Services, whose activities would be coordinated with, but distinct from, those of the Center for Medicare and Medicaid Services (the HELP bill appears to leave open the possibility, however, that the public plan could be contracted out to private insurers or at least established on a state-by-state basis, two undesirable approaches that should be clearly ruled out in subsequent legislation);
- is available to anyone who lacks employer-provided health insurance—rich and poor alike, and whether working for a small or large employer, self-employed, or unemployed;
- allows doctors to participate independent of their decision to participate in Medicare;
- has authority to develop and implement delivery and payment reforms that promote value and quality;
- complies with the same set of rules and requirements as private plans, including benefit packages offered, risk adjustment, enrollment provisions, and data disclosure. These rules are set and enforced by a national insurance exchange (or “gateway” in the HELP Committee bill), which is wholly independent of the public plan.¹⁰

The figure on the next page provides a simple picture of the public health insurance plan’s place in a reformed system.



Three Vital Functions of Public Health Insurance Plan

The features just enumerated are essential if the public plan is to achieve its three vital goals. First, a public plan is needed as a *benchmark* on cost and quality for private insurance, pressing insurers to improve the value they deliver to their members and to bargain more aggressively in consolidated provider markets. Second, it is needed as a *backup* providing an option that offers financial and health security to all those without workplace coverage and small employers without access to good group health options. Finally, it is needed as a *backstop* to bring down costs over time through innovations in payments and the delivery of care, innovations that will be available to the private sector.

Most observers of health care know that the insurance market has become increasingly consolidated, with one or a small handful of insurers enrolling most of the privately insured in the vast majority of local markets and, in the process, driving up costs.¹¹ The American Medical Association (which endorsed the reform legislation in the House) estimates that out of 314 metropolitan areas across the nation, 94 percent can be defined as highly concentrated, with two companies or even a single insurer dominating the market.¹² This is a primary reason for a strong national public plan that can compete with private insurers on day one.

Less well known is that provider markets, and especially hospital markets, have also grown increasingly consolidated. The vast majority of major metropolitan areas—some 88 percent of large metropolitan areas, according to 2006 study—now feature hospital markets in which one or two major hospitals dominate the market.¹³ Many insurers pay flagship

systems and sole providers well above costs to ensure their participation—costs that independent analysts have determined are often themselves excessive because the hospitals in question are inefficient.¹⁴

These two problems—insurer and provider consolidation—are related. They have driven up premiums for employers and workers, and they have encouraged insurers to control costs by shifting expenses onto patients or weeding out high-cost patients, rather than bargaining for lower provider payments. As John Holahan and Linda Blumberg explain,

In some markets, dominant insurers have no incentive to be tough negotiators because they have no significant competitors and the demand for health insurance is not very sensitive to price. Small insurers lack bargaining power with providers and thus cannot compete with larger firms on premiums. And finally, there is no real competition in many hospital markets because smaller hospitals cannot challenge the dominant system on the range of available services (e.g., new technologies). The lack of effective competition and demand-side market power has contributed to the medical arms race and health care costs growing considerably faster than the economy.¹⁵

Only a strong national public plan can correct these problems. If, like smaller private insurers, the public plan does not have the strength to compete against the dominant insurers, private insurers will have no cost benchmark and costs will likely continue to rise. At the same time, provider groups will refuse to join the public plan network, crippling it in many areas. Without a substantial network of providers at the outset, in other words, the new public plan will face a classic “chicken-and-the-egg” problem. It will not be able to secure good provider rates without the bargaining leverage that comes from substantial enrollment, but without a guarantee of provider participation, it may not be able to attract broad initial enrollment.¹⁶

In short, to counteract the enormous leverage of the dominant insurers and provider systems in most local markets, the public plan needs an adequate amount of bargaining power at the outset to achieve its core goals. Otherwise, private insurers will threaten its viability, and it will not have the ability to keep costs in check.

ISSUE #1: A MEDICARE TIE-IN

This brings us to the first critical difference between the competing visions of the public plan that have been passed out of congressional committees—whether the bill has a “Medicare tie-in.”

Under a Medicare tie-in, providers participating in Medicare would automatically be considered participating providers in the new public plan (although, in the House bill, they would have the right to opt out) and payments to providers would be based on Medicare rates—for example, Medicare rates plus 5 percent. If the public plan is required instead to adopt the “not-so-good” approach of signing up providers and bargaining over payments directly with them, the public plan may have a very hard time building a network and

obtaining reasonable rates to act as a true competitor to private plans, given the barriers it will face in consolidated insurer and provider markets.

The versions of the House bill approved by the House Ways and Means Committee and House Education and Labor Committee contain a Medicare tie-in that has two crucial characteristics:

1. Providers participating in Medicare would automatically be considered participating providers in the new public plan, although they would have the right to opt out.
2. Initial payments to providers would be set at Medicare rates plus 5 percent. After three years, the Secretary of Health and Human Services could adjust rates. But during the crucial start-up period, the public plan would be able to piggyback on Medicare's payment methodology.¹⁷

These are good provisions. They would be even better if they included an explicit protection of providers' rights to join the public plan. Private plans (at least those that participate in the exchange) should be prohibited from setting as a condition of participation in their networks that providers not join the public plan.

By contrast, the House Energy and Commerce Committee approved the House bill with amendments that preserve only the first of these two elements.¹⁸ Providers participating in Medicare would be presumed to participate in the new public plan (but, again, allowed to opt out).¹⁹ However, rather than setting the rates the public plan would pay providers on the basis of Medicare rates, the Secretary of Health and Human Services would have to "negotiate" rates directly with providers.²⁰ These rates in the aggregate would have to be between Medicare rates and private rates, but no other details are given.²¹ This is a not-so-good provision that could drive up individual premiums and federal costs, burdening Americans as health care consumers and taxpayers alike. It threatens the viability of the public plan because it may require the government to pay providers higher rates than they would otherwise accept if the rates were set.

The HELP Committee bill has an even weaker guarantee that the public plan will be able to establish itself.²² Like the Energy and Commerce Committee bill, it states that the Secretary has to negotiate rates directly with providers.²³ But the legislation also lacks the presumption in the House bill that Medicare providers will participate (with an opt-out option), putting the public plan at a disadvantage against the private insurers with established networks.²⁴ This is also a not-so-good provision that should be changed to the House approach of presuming participation.

How would the Secretary effectively negotiate rates with providers as envisioned in the HELP and Energy and Commerce committees' bills? Both bills suggest that rates should not be higher, in the aggregate, than the average reimbursement rates paid by private health insurers.²⁵ But who would the Secretary negotiate with? All providers who might conceivably join? Those already accepting public payments? Would negotiations need to take place in every metropolitan area? How would the Secretary know what private rates are, given that we know almost nothing about private rates today? Would the public plan need to buy

provider networks from private plans? And how would all this further the cause of creating an alternative to existing private plans?

The logistics of such negotiation are daunting enough. But even more worrisome is their implications for the viability of the public plan. Given market consolidation, there are reasons to doubt that the small public plan projected by the Congressional Budget Office (CBO) under the House bills (which the CBO estimates would have 11-12 million enrollees) will succeed if it is not tied to Medicare's provider network and rates.²⁶ It will have a modest market share and face barriers to market entry that could be insurmountable, leaving it to the same fate that has befallen private insurers that have been kept from competing by dominant insurers. As Paul Ginsburg, President of the Center for Studying Health System Change, recently put it, "Having to negotiate rates with providers would be a major barrier to public plans...Actually, not only would negotiated prices be a barrier, but it would undermine one of the potential advantages of public plans—addressing provider leverage with private private plans."²⁷

Medicare Rates vs. "Negotiation"

While the HELP bill and Energy and Commerce amendments to the House bill speak of "negotiated" rates, presumably to distinguish them from the "administered" rates used by Medicare, this distinction is misleading. On one hand, private plans often "administer" rates in the sense of setting them internally. Indeed, many fee-for-service plans peg their own rates to Medicare. Although we know very little about private plan payments due to their proprietary nature, we do know that many large private insurers do not "negotiate" in the sense of bargaining directly with providers. They provide a price list to providers who have the option of accepting it or not.

On the other hand, all plans, including Medicare, "negotiate" rates in the sense that providers are allowed to decide whether they wish to accept rates or not, and rates have to be adjusted up or down to encourage a critical mass of providers to participate. Medicare, for example, uses underlying cost data to establish rates and monitors provider participation carefully to ensure that it is not adversely affected by rate changes.²⁸

And if "administered" rates mean simply rates that are transparent, written down, and the same for all providers with shared characteristics, then no one would argue against them for a new public plan—which should surely be required to abide by the same rules of transparency, clarity, and equal treatment of providers that Medicare does.

The difference between using "negotiated" and "administered" rates in the context of a new public plan is therefore best understood in terms of "higher" or "lower" rates. The real objection to using Medicare rates appears to be that they are deemed too low in certain areas and too high in others, not that they are administered. But if this is the objection, then, it would make more sense to improve the Medicare payment formula, rather than abandon it altogether.

In any event, the case for seeing Medicare rates as “too low” is weaker than believed. The overwhelming majority of providers accept Medicare rates, and people with Medicare coverage have better access to doctors than do the privately insured.²⁹ Moreover, it is worth remembering that providers would be free to opt out of the public plan envisioned in the House bill, which would pay more than Medicare rates.³⁰ Study after study—including analyses by the Congressional Budget Office, the Medicare Payment Advisory Commission (MedPAC), and the Government Accountability Office—all indicate that there is much less cost-shifting from Medicare to private insurers than generally supposed.³¹ MedPAC has shown, for example, that efficient hospitals make money on Medicare payments, and that the least efficient hospitals demand higher rates from private payers not because Medicare pays less but because they face insufficient pressure to bring down costs.³²

The long-term goal of cost control as well as the overarching goal of affordable insurance premiums requires more strenuous efforts to keep rates in check. If we are to be serious about “bending the curve” of long-term cost growth and thereby reducing the huge burden of medical costs on all Americans, then we have to use every tool in our toolkit, and Medicare’s payment system is an important tool. Medicare rates are transparent, rather than the proprietary information of specific plans. They are grounded in formulae that can be seen, debated, and challenged, encouraging accountability. The CBO can easily estimate the savings they will produce. And they have an obvious and necessary connection to the first component of the Medicare tie-in: that, by default, Medicare providers will participate in the new public plan. We should not abandon the Medicare payment system until we have something better to take its place.

ISSUE #2: WHICH EMPLOYERS HAVE ACCESS TO THE EXCHANGE?

A second crucial “good” provision concerns which employers are allowed to purchase coverage through the exchange.

In all the bills, the exchange would be open to people without qualified coverage from their employers (qualified coverage would have to meet standards designed to ensure it was affordable and available to all workers whose employers offered it). However, the bills differ with regard to what size of employers can “go into” the exchange—in effect, allowing their workers to choose from among the private plans and the new public plan.

In the House bill, firms with twenty or fewer workers would be able to go into the exchange. Their workers would then be able to choose among the plan options there. A House Education and Labor committee amendment to the bill expands access to the exchange to firms with 50 or fewer employees. The House bill also gives the Secretary the discretion to open up the exchange to larger firms in the future.

These are good provisions. Many firms that are larger than the very smallest businesses face serious problems finding good group health insurance. Frequently, these firms face the same severe barriers to coverage in the private market that the smallest firms do. They must pay significantly higher costs than very large firms, employees have fewer

plan options, and in many states, small businesses may be denied access to coverage altogether based on their employees' health status. A single incident can cause a small business's health premiums to rise dramatically for years to come, even if it has more than 50 workers.³³ A particularly salient example is provided by the health policy expert Joseph White:

When Lee Atwater, then chairman of the Republican National Committee, was stricken with a brain tumor, the committee's insurer, when the contract was up for renewal, proposed a 52 percent rate increase. The insurer was doing its job: protecting the firm's profitability. The RNC was just another unlucky, smallish firm. It shopped around and found alternative coverage for only 26 percent more than it had been paying. Some employees decided they could no longer afford family coverage at those rates.

At the time that Atwater was diagnosed, the RNC had well over 50 employees.

Larger firms that self-insure (that is, pay medical claims themselves) do not face these same barriers, but some of them, along with their employees, would also benefit from increased plan choice and reduced administrative costs through the exchange.

Opening up the exchange to medium and large businesses does raise three issues. The first is an issue of capacity. The House deals with this by restricting access in the first several years.³⁴ If the exchange works well at that point, there is no capacity reason why it could not slowly expand to include firms that are above the twenty-employee threshold.

The second issue is adverse selection—the concern that only firms with higher than average costs would go into the exchange. This is especially problematic if the exchange is community-rated (that is, if insurers are required to charge the same premiums to all enrollees, at least within broad age and family-type categories) and the outside group market is not. Fortunately (and appropriately), the House and HELP bills have community-rating for all sectors of the market, except self-insured health plans in which employers pay claims out of their own coffers.³⁵ These provisions reduce the chance of adverse selection caused by the entry into the exchange of firms in the individual and small group market with higher-risk workforces, since these firms will have access to community-rated coverage outside the exchange as well as within it.

This leaves the large group market, where firms would potentially have a choice between self-insuring and entering a community-rated exchange, which might cause the exchange to attract firms with less healthy workers. This could be addressed in a number of ways, assuming it proves to be an issue, and is the kind of detail that is rightfully left to the discretion of the Secretary, as in the House bill.

The third concern is that employers going into the pool will displace existing employment-based coverage. It is important to distinguish this concern from the fear that employers will “drop” coverage to allow their workers into the pool—that is, stop providing coverage altogether so that their workers can obtain subsidized coverage through the exchange. The best way to prevent the dropping of coverage is to ensure that all firms

contribute to the cost of coverage through some sort of “play-or-pay” requirement (provide coverage or pay a nontrivial amount) and to enact measures that bring health care costs down in the private market.³⁶

However, when a small firm decides to purchase coverage through the exchange, they are in effect buying group health insurance for their workers. If firms believe their workers would have access to better options through the exchange, why should they not be able to buy coverage for their workers through it? After all, employers who enrolled their workers in the exchange would have to pay the same share of the premium that they would have to pay if they purchased coverage outside the exchange, so the main attraction of going into the exchange for employers would be to obtain better value group health plans, including the public plan.³⁷

Going into the exchange is not the same as going into the public plan. Indeed, employers that choose to purchase coverage in the exchange do not get to decide what plans their employees choose. Their workers do, just like all other participants in the exchange. Estimates differ on what share of participants in the exchange would choose the public plan. But the CBO has concluded that roughly a third of those in the exchange would do so, or between 11 and 12 million enrollees.³⁸ The Urban Institute estimates that the share would be closer to half of those in the exchange, but either way, a large share of those obtaining coverage through the exchange are expected to choose private plans.³⁹

To be sure, the public plan is almost certain to be cheaper than private plans with similar features (such as broad choice of provider), and it will offer a set of valued features that private plans are generally 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, most people do not buy products and services simply because they are less costly. Product preference is also based on what people are familiar with. Private plans currently have approximately 171 million members, many of whom are happy with their coverage.⁴⁰ They have decades of experience, networks in place, name recognition, deep pockets for marketing and public relations, and the caché of being private. While people are familiar with and favorable toward Medicare, the new public plan will not have a proven track record, and it will not be marketed in the way private plans are. Finally, private plans are generally more flexible and more capable of building integrated provider networks, and they have at times moved into new areas of care management in advance of the public sector. In sum, there is at least as much reason to think that the public plan will be disadvantaged in a competitive system as to think it will be advantaged.⁴¹

The goal, in any case, is not to protect one plan or another. It is healthy competition in which all plans are pressed to improve their weaknesses and build on their strengths. If public and private plans are competing on fair and equal terms, the choice of enrollees between the two will place a crucial check on each. If the public plan becomes too rigid, more participants in the exchange 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 release valve. New rules for private insurance could go some way toward encouraging private plans to focus on providing value. But without a public plan as a benchmark, backup, and backstop, key problems in the insurance market will remain.

Concerns about the exchange becoming overwhelmed, or employers with high-risk workforces disproportionately going into the exchange, or the displacement of existing employment-based plans are legitimate. But this is why, in the House bill, the Secretary is given the discretion to open up the exchange, rather than required to do so.⁴² There is no reason why the Secretary could not study these issues and establish a careful review process for access to the exchange to address these concerns.

The HELP bill, by contrast, leaves the determination of which employers may go into the exchange unsettled.⁴³ In the HELP bill, states are encouraged to create their own exchanges (again, called “gateways”) and the states would determine which firms had access to them.⁴⁴ If a state did not create an exchange, then the Secretary would have the authority to do so.⁴⁵ In that case, the Secretary would have the discretion to open up the exchange to larger employers, although the default in the legislation is 50 or fewer employees—better than the House bill passed out of the Ways and Means and Energy and Commerce committees and the same level in the amended Education and Labor Committee bill.⁴⁶

For reasons of efficiency, it would be far preferable to simply have a national insurance exchange. (As in the House bill, states could be given the right to establish an exchange if the Secretary determined them qualified to do so.) The national insurance exchange should have a simple uniform standard for allowing employers to go into the pool and, as in the House bills, the Secretary should be granted discretion to consider and implement an opening up of the exchange to larger employers in the future.

ISSUE #3: GIVING THE PUBLIC PLAN (AND MEDICARE) ENOUGH AUTHORITY TO RESTRAIN COSTS AND INNOVATE

Major efforts are needed to improve the quality and cost-effectiveness of medical care. No sector is immune from these problems, and none is exempt from the challenge of addressing them. But a new public plan could help spearhead the improvements that are needed.

Medicare already shows unique quality advantages over private insurance when it comes to reliable patient access to affordable care—advantages that would carry over to a new public plan for the nonelderly. Elderly Americans with Medicare report that they have greater access to physicians for routine care and in cases of injury or illness than do the privately insured.⁴⁷ They are also half as likely as nonelderly Americans with employment-based insurance to report common access problems, such as skipping a medical test, treatment, or follow up, and failing to see a doctor when sick.⁴⁸

Over the last two decades, moreover, Medicare has increasingly emphasized improved payment methods and rigorous reviews of technology and treatment, and it has made increasing investments in quality monitoring and improvement. Revealingly, private

plans generally use Medicare's criteria for covering treatments as their standard of medical necessity, and they have adopted many of Medicare's innovations in payment methods.⁴⁹

Still, much more needs to be done. MedPAC, leading members of Congress, and others have made a host of recommendations for how to reform the Medicare system, many of which are underway or under development and could be quickly adopted by a new public plan.⁵⁰ These innovations could be made available to private payers, and, as they do today, many would likely follow the lead of the public sector.

The innovations include:

- Developing practice guidelines and quality measurements that will allow for value-based purchasing (a policy mechanism that links payment to performance).
- Requiring public reporting by providers of quality indicators to help purchasers and payers get maximum value.
- Testing the effectiveness of new technology.
- Developing a pay-for-performance system based on quality outcomes.
- Finding alternatives to the fee-for-service-based system for physician payment.
- Shifting payment methods and rates to better reward primary care providers and increase their supply, and to decrease the oversupply of specialty physicians, who are escalating costs without necessarily improving quality.
- Building a system based on coordinated care for those with chronic diseases, rather than maintaining our current fragmented care.

A new public plan, working with Medicare and private plans, could help lead reforms of this sort. Because of its relatively broad reach, transparency, and accountability, the public plan could test and evaluate potential delivery-system and payment reforms; collect, report, and use ongoing performance data; and streamline paperwork and administration in ways that would not be possible without a core role for public insurance for nonelderly Americans. It could also encourage the development of so-called accountable care organizations, integrated provider groups with which the public plan could contract.

The simple truth is that private insurance has few incentives to conduct quality research, and limited scope to influence the practices of providers and other insurers even when they do. Moreover, insurance companies are generally reluctant to share private information that will allow others to learn lessons about how best to contain costs and improve quality.⁵¹ As MedPAC has noted, "Because the [public dissemination of] information can benefit all users and is a public good, it is underproduced by the private sector."⁵²

Finally, participation in a public plan is likely to be more stable. Insurers move in and out of markets, change their benefits frequently, shift the providers with which they contract, and so on. Even in the Federal Employees Health Benefit Program (FEHBP) and Medicare's private plan options, there is a substantial amount of change over time in plan offerings and networks, and even the participation of particular plans. All of this churning is costly, undermines continuity of care, and is difficult for enrollees, particularly those who require coordinated care. By contrast, a public plan with a relatively stable enrollment base

would be better poised to make long-term investments in patients' health that deliver financial and social benefits down the road.

A public plan for those under 65 would be well positioned to help lead these efforts—*if* it were given the tools to collect and maintain outcomes data, test new methods of providing and paying for care, and use its market power to promote quality and cost effectiveness in both the public and private sectors. Both the Senate and the House bills give the public plan authority to change payment methods, and they all emphasize the fostering of funding of new outcomes and cost-effectiveness research by the federal government.⁵³ However, they differ in how explicit they are about the ability of the public plan to innovate.⁵⁴

The House legislation gives the Secretary of Health and Human Services authority in the very first year of the public plan (2013) to “utilize innovative payment mechanisms and policies to determine payments for items and services under the public health insurance option. The payment mechanisms and policies under this section may include patient-centered medical homes and other care management methods, accountable care organizations, value based purchasing, bundling of services, differential payment rates, performance or utilization based payments, partial capitation, and direct contracting with providers.”⁵⁵ Moreover, “the public health insurance option may modify cost sharing and payment rates to encourage the use of services that promote health and value.”⁵⁶ Finally, the Secretary is given the authority to “monitor and evaluate the progress of payment and delivery system reforms,” not just in the public plan, but also under Medicare, linking the improvement of the two programs over time.⁵⁷ Good provisions like these are crucial if the public plan is to adopt new payment methods and care delivery approaches going forward.

Such provisions are particularly important because federal cost-control efforts should not be solely focused on Medicare. While Medicare is in need of reform in its payment and delivery frameworks, older and disabled Americans covered by Medicare have unique needs that make it imperative to move slowly in shifting the circumstances of their care. Further, there is likely to be a backlash among people with Medicare if cost-control efforts are narrowly focused on them. Ensuring that the new public plan for the nonelderly is fully engaged in payment and delivery innovation will provide lessons that will be more applicable to the privately insured population in general, as well as reduce the chance that elderly and disabled Americans who rely on Medicare feel that the burden of cost control is solely on their shoulders.

Only the House bill, moreover, explicitly gives the public plan the ability to bargain directly for lower drug prices—a critical tool of cost control.⁵⁸ And only the House Energy and Commerce Committee amendments to the House bill allows such bargaining to also take place in Medicare, which would provide critical relief to older Americans and increase the ability of the federal government to bring costs down over time.⁵⁹

These are especially good provisions. If Medicare and the new public plan bargained directly for drug prices, there is no question they would receive better deals than currently offered to private payers. The CBO has found that drug prices under four federal programs—including the Veterans Health Administration (VHA) and Medicaid—are on average 49 percent below the average wholesale price of the drugs.⁶⁰ Another recent study found that the lowest prices available for the top 20 drugs prescribed to seniors were 58 percent cheaper under the VHA plan than under Medicare Part D.⁶¹ Medicare’s private plans negotiated drug manufacturer rebates of only 8.1 percent in 2007.⁶² Finally, a recent McKinsey study finds that branded drugs in the United States are 60 percent more expensive than in Canada, and that the top-selling drugs of leading drug companies are 2.3 times more expensive here than in other rich nations, where public-sector bargaining is prevalent.⁶³

ISSUE #4: THE COOPERATIVE COP-OUT

So far, I have emphasized that some public plan design ideas are good (a Medicare tie-in, an exchange open to larger employers over time, a public plan with the authority to innovate and bargain for lower drug prices), while others are not-so-good (requiring that the public plan construct a network from scratch and negotiate rates directly with providers, permanently walling off the exchange from all but the smallest of firms, preventing the public plan from innovating or bargaining with drug companies). The truly “ugly” idea, however, is to do away with the public plan altogether in favor of the untested, largely symbolic alternative of consumer cooperatives, as the Finance Committee negotiators have done.⁶⁴ However designed, cooperatives simply cannot achieve the goals of a true public plan.

So few specifics are available about what consumer health cooperatives would look like or how they would be chartered that a detailed critique is difficult. But that may be just as well, since there is absolutely no reason to think that cooperatives of any sort could do the three crucial things that a competing public plan must do—that is, provide a backup, benchmark, and backstop. Cooperatives might be able to provide some backup in some parts of the nation, but they are not going to have the ability to be a cost-control backstop, much less a benchmark for private plans, because—like private plans—they are not going to have the reach, authority, or desire to drive broadly implemented delivery and payment reforms or act as a strong public-spirited competitor that discourages private insurers from engaging in practices that undermine health security. As Senator Jay Rockefeller, a member of the Finance Committee, has concluded after extensive review of the issue: “What I have to worry about is, are co-ops going to be effective taking on these gigantic insurance companies? And from everything I know from people who represent them, the answer is a flat ‘no.’”⁶⁵

Consumer cooperatives would have several severe disadvantages. First, they would require building a new set of plans largely from scratch in markets often dominated by one or two powerful insurers. This would mean forfeiting the administrative, economic, and political advantages of building on the Medicare infrastructure to get a new alternative to private plans up and running quickly. Second, such models would also require forfeiting another major advantage of a Medicare-like public plan: the ability to provide enrollees with a broad choice of providers. The only two sizable examples of consumer health

cooperatives, Group Health Cooperative of Puget Sound and HealthPartners in Minnesota, are both health maintenance organizations (HMOs) with restricted provider networks.⁶⁶ And they have had decades to become established.⁶⁷ New cooperatives would face the same problems breaking into markets that smaller private competitors face in many markets today. Analysts at Oppenheimer, Carl McDonald and James Naklicki, report that “as the co-ops are currently described, we think they would be a big positive for the managed care group, but it seems to us that they would be destined to fail from the moment of creation.”⁶⁸

The history of health cooperatives backs up McDonald and Naklicki’s pessimism. Cooperatives of various sorts have been discussed and sometimes created to provide health care in the past. After the Great Depression, the Farm Security Administration encouraged the development of health cooperatives--which at one point had about 600,000 members, mostly in rural areas.⁶⁹ But the cooperatives crumbled in the face of physician resistance (including boycotts), the lack of financial wherewithal of the cooperatives themselves, and the eventual withdrawal of government support.⁷⁰

Even today’s remnants of the cooperative movement do not provide the most inspiring of lessons. The only survivor of the 1940s experiment is Group Health Cooperative of Puget Sound.⁷¹ It is a well-regarded HMO, paying doctors on a salaried basis but, unfortunately, is now little different from other nonprofit HMOs, with around a half million members in Idaho and Washington State.⁷² By contrast, WellPoint—the nation’s largest insurer and a major force behind the defeat of health care reform in another West Coast state, California—has more than 33 million members.⁷³

Finally, and most important, the prospect for cost restraint and quality improvement under these proposals would be limited. Medicare has increasingly out-performed private plans in restraining the rate of increase of health spending while maintaining broad access.⁷⁴ A new public plan could draw on Medicare’s experience, as well as the experience of the national VHA system, to improve its cost-control methods and enhance the quality of care. By contrast, cooperatives, if established after a potentially lengthy period of development, would be relatively small and scattered and therefore lack the means to restrain cost increases or drive delivery or payment reforms on a broad scale. As the editorial board of *USA Today* writes in a recent editorial on the cooperative idea:

The simplest public option is to let people without employer-provided health insurance to buy into Medicare, or a similar program, at cost. It would pay doctors and hospitals rates close to what Medicare pays, and it could be a powerful engine for holding down costs. Since it could build in part on the existing Medicare system, it could be up and running at the national level reasonably quickly ... [P]ress some co-op enthusiasts for details, and there's a lack of clarity about how they'd get started, how much the start-up would cost, how long it would take, how they'd grow big enough to compete with private insurers, how they'd significantly differ from the original state Blue Cross/Blue Shield organizations and, most importantly, how they could save serious money.⁷⁵

Cooperatives are not ready for prime time. They are certainly not a substitute for a public plan.⁷⁶

PUTTING THE PIECES TOGETHER

Amid the inevitably fierce legislative debate over health care reform, it is easy to lose sight of the enormous progress that has been made. For the first time in the history of comprehensive health reform for working-age Americans, a complete bill has been moved to the floor of the House of Representatives, and the Senate is poised to act, with a bill already reported out of the Senate HELP Committee.⁷⁷ These two bills, moreover, contain the three elements that should be in any reform proposal that builds on employment-based insurance while filling its gaps and improving the quality and cost-effectiveness of care: an exchange that offers a new public plan alongside private plans, a requirement on (all but the smallest of) employers to contribute to the cost of coverage, and a requirement that all Americans obtain coverage when it is made affordable and available.⁷⁸

The new public plan offered through an insurance exchange is a crucial linchpin of this approach. It will provide an affordable option to Americans without workplace insurance. It will bring competition to insurance markets that too often lack it. It will create the means for delivery and payment reforms that are necessary to provide affordable coverage over the long term. It will help provide the health security that Americans say they want, through a means—the choice of a public health insurance plan—that Americans overwhelmingly support.

Nonetheless, as this brief has shown, there are good and not-so-good ways to structure a competing public plan. The table on the next page summarizes the crucial areas of difference, and identifies the approach within each area that will ensure an effective national plan is up and running on the first day that an insurance exchange is established.

First, this plan should build on Medicare's provider network, signing up Medicare providers automatically but allowing them to opt out if they wish. Second, the new public plan should initially pay modified Medicare rates, rather than negotiate rates directly with providers across the nation. Third, the public plan should have authority to reduce medical inflation through innovations in the financing and delivery of care. And fourth, the public plan and Medicare should both be given authority to bargain directly for lower drug prices for enrollees. Taken alone, each of these four choices may seem small. But together they describe the difference between a public plan that is likely to work effectively and one that faces the risks of beginning with both hands tied behind its back. A compromised public plan will surely end up costing the federal government, taxpayers, and enrollees more. But the deeper issue is that it will not be able to deliver choice and competition within the insurance marketplace.

That the two bills under consideration in the House and Senate contain a public health insurance option is considerable cause for celebration. Yet it is no cause for complacency, because the Senate Finance Committee appears unlikely to produce a bill that contains a true public plan.⁷⁹ If, as expected, the Committee endorses federally promoted health cooperatives, they should be understood for what they are: an effort to kill the public plan and, with it, the prospect of an effective competitor to consolidated insurance companies that have too often failed to provide affordable health security.

Getting to Yes on the Key Issues Concerning a New Public Plan

	House Bill (Ways & Means/ Education & Labor)	House Energy & Commerce Amendments	Senate HELP Bill	Senate Finance Negotiations	The Right Approach
National public plan	Yes	Yes	Maybe*	No	Yes
Medicare providers presumed to participate in the public plan	Yes	Yes	No	No	Yes
Modified Medicare rates	Yes (Medicare plus 5%)	No	No	No	Yes
Option of allowing larger employers into exchange in the future	Yes	Yes	Yes, but not uniform	???	Yes
Incentives for innovation in the public plan	Yes	Yes	Yes, but could be stronger	No	Yes
Drug price bargaining in both the public plan and Medicare	No	Yes	No	No	Yes

* The HELP bill appears to leave open the possibility that the public plan could be contracted out to private insurers or at least established on a state-by-state basis, two undesirable approaches that should be clearly ruled out in subsequent legislation

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