

**Subject:** qotd: Jacob Hacker provides details for public option  
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Berkeley Center on Health, Economic & Family Security  
&  
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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.

#### 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.

[http://www.ourfuture.org/files/Hacker\\_Healthy\\_Competition\\_FINAL.pdf](http://www.ourfuture.org/files/Hacker_Healthy_Competition_FINAL.pdf)

Comment: This is a very important paper because addresses one of the most controversial issues in the current health care reform debate: Should a Medicare-like plan be offered in competition with a market of private health plans? UC Berkeley Professor Jacob Hacker adds to his previous contributions on the private plan/public option model of reform by describing in detail what a properly-designed Medicare-like option would look like.

To understand this fairly complex model, you really need to read this 31 page report. But looking at just a few of the problems that he addresses can give you an idea of where this approach is headed.

How would the public option control costs?

From the report: "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."

DM: In the Medicare Advantage program we have already tested this concept, and the private plans required more money, not less, than the "competing" traditional Medicare program. With a single, universal public program, cost efficiencies would apply to our entire health care system.

How would this proposal spur improved quality?

From the report: "... 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."

DM: So the public program would bear the costs on research and data collection. Would those costs be allocated exclusively to the patients in the public program? Would the private insurers have a free ride? Since the mission and income needs of the private insurers are different from the public plan, would they even use the results of the research, especially if greater spending would ensue? Would the government even have access to the proprietary information of these plans competing in the private marketplace? Obviously a single, universal public program would have a more complete and accurate information database that could be applied to improve the quality of our entire health care delivery system, rather than allowing private plans to pick and choose based on bottom line issues rather than optimal quality.

What should the public plan look like?

From the report: "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."

DM: So a bona fide public program is proposed, but...

How could the public and private plans compete "on a level playing field"?

From the report: "... 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: "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: community rating, guaranteed issue, limits on marketing, standardized and defined benefits, reserve requirements, transparency..."

Risk adjustment: "...there is also a need for risk adjustment. 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. 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: "... 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."

DM: Merely to counter the attack that the government doesn't play on a level field, we would have to establish a set of administratively complex rules of competition with which the government must comply, include the difficult task of determining and adjusting for the relative risks in the public and private pools in spite of the private insurers proclivity to game these risks, and then require our national public program to bid in each region to provide fairness for the government program? This adds considerable administrative inefficiency to a government program that should be offering greater efficiency. A single, universal national health program would not require these extra rules, risk adjustments and health plan competitive bidding processes.

How would the premium for the public plan be established?

From the report: "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. 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."

DM: Instead of a complex process to determine a premium for a public program based on the actuarial value of the benefits provided, a single payer program would do away with premiums. The system would be financed with a simpler and much more equitable tax. Also, everyone who believes in health care justice should be deeply troubled by the statement that this approach "would create the necessary incentive for enrollees to prefer less expensive plans."

Since premiums would be unaffordable for the majority, how would subsidies be administered?

From the report: "... 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."

DM: The purpose of government subsidies is to transfer payment for health care from the wealthy to those who cannot afford to pay for their full, evenly-divided allocation of our national health care bill. That now includes middle-income Americans. A subsidy system requires a separate administrative task for everyone included within the system of health care coverage, with further adjustments depending on out-of-pocket expenses, and periodic reevaluation of eligibility requirements. These administrative excesses are made necessary only because we couple the payment of health care to the specific benefit package - the insurance plan. A single payer system eliminates this administrative nonsense by replacing premiums and cost-sharing with tax financing - again, a much simpler and more equitable approach.

What about the all-payer alternative?

From the report: "...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... 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. 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."

DM: Okay. So we combine the public and private payers into an all-payer program. Then why would any individual in his/her right mind, other than an insurance executive or shareholder, want to keep this worthless, wasteful, expensive industry in play?

PNHP has been under attack by our friends in the progressive community for being opposed to the public Medicare-like option. That is a misstatement of our position. We are opposed to a fragmented, dysfunctional health care financing system that is causing financial hardship, physical suffering, and, all too often, death. Adding a public option will have only a negligible impact on the fundamental flaws that are causing so much personal grief.

Our friends and our enemies know what would fix our system: a single payer national health program. We think we understand the position of our enemies - largely based on greed. Why else would they support such a cruel system?

But our friends? Why do they attack us as they retreat to a secure position within the ranks of the private insurance industry? Besides, just wait and see what the insurers and their purchased representatives in Congress will do with Jacob Hacker's "Healthy Competition" proposal. You'll have to look quick because the window of opportunity for reform will have slammed shut.

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