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Is the Public Plan Option a Necessary Part of Health Reform?

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Unfortunately, the debate over whether to provide a public health insurance option as a competitor to private plans under comprehensive health care reform seems to have become an ideological litmus test. Conservatives are fervently aligned against the option while liberals are as strongly in favor it.[2] Those who oppose it fear that the public plan will have so many inherent advantages that private plans will be unable to compete, eventually leaving the system entirely in government hands by destroying a competitive insurance market. Supporters believe that a public plan is a critical fallback option in a universal system that would cover many high-need and low-income groups.

The arguments around the public plan too often ignore what we believe is the central reason for including a public plan as a component of reform: that health insurance markets today, by and large, are simply not competitive. And as such, these markets are not providing the benefits one would expect from competition, including efficient operations and consequent control over health care costs. We believe that the concentration in the insurance and hospital industries that has taken place over the past several years has been a significant contributor to this problem. The role of the government plan is to counter the adverse impacts of market concentration and, in doing so, slow the growth in health care costs.

In this paper, we first describe problems with competition in current insurer and provider markets, in particular focusing on the implications of consolidation in both markets. We then discuss how a public plan could help address these problems. Next, we examine how a public plan might be structured and how much money a plan might save. We address how large the public plan would be and what impact it would have on the current private insurance industry. We then examine the most common arguments against the public plan. We conclude by arguing that private insurance plans would survive but be more efficient and more effective controlling health care spending.

Competition in Insurance and Hospital Markets

Economic theory offers a clear description of the characteristics of competitive markets. These include the following:

- Many buyers and sellers participate in the market for a particular good.
- Buyers must be able to make comparisons on price and characteristics of the goods that are offered by the various sellers. Sellers should be able to freely enter or exit the market.
- Economic profits are driven to zero in equilibrium (i.e., all income is devoted to paying for the inputs used in the process of production.
- Each buyer and seller takes the market price as the outcome of competition; in other words, they cannot determine prices.

Health insurance markets very often lack these characteristics. First, in recent years, there has been a great deal of consolidation among health insurers. Robinson (2004) found that in 36 of the 50 states, three or fewer insurers accounted for 65 percent of the commercial market in 2003. Thirty-four states had values of the Herfindahl-Hirschman Index

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(a measure of market concentration) that exceeded federal guidelines that deem industries of anti-trust concern (Holahan and Blumberg 2008). According to a 2008 analysis in 42 states and 314 metropolitan statistical areas (MSAs) done for the American Medical Association, consolidation among insurers continues. Ninety-four percent of the MSAs studied were highly concentrated according to Department of Justice/Federal Trade Commission standards. In 89 percent of MSAs, one health insurer had at least 30 percent of the commercial health insurance market, while one insurer had at least 50 percent of the insurance market in 15 entire states (American Medical Association 2008).

Second, there is considerable variation in health insurance products sold, and consumers have great difficulty in making price and quality comparisons. This is especially true in the private nongroup insurance market, but is increasingly true in commercial group insurance as well. Covered services and cost-sharing requirements vary not only across insurance firms but across products sold within a single firm. In most nongroup insurance markets, the products a firm is willing to sell will even vary with the characteristics of the purchaser, with those with current or past health issues often offered plans with fewer covered benefits. Plans may vary considerably in provider networks as well. While reform would ideally prohibit insurers from offering less comprehensive products to individuals with worse health status, how much uniformity in benefit packages and cost-sharing will be required is unclear, and provider networks will certainly continue to vary across plans. Where there is variation, such as benefit limits and which services count toward out-of-pocket maximums, consumers may not understand the implications until they become ill. As a consequence, making comparisons across sellers is extremely difficult and may remain so.

Third, entry into health insurance markets is quite difficult. In order to gain market share with a network model plan, insurers must be able to negotiate discounts with providers (and group/staff model plans are in decline). However, providers are often unwilling to negotiate such discounts for carriers with small enrollment. As a consequence, entering a market is very difficult, or doing so requires operating at a loss for some time.

Fourth, insurance industry profits have continued to grow over time, another indication of noncompetitive markets. The analysis by Robinson (2004) found that between 2000 and 2003, private insurance revenue increased even faster than medical costs, indicating that insurer market power allowed the firms to not only pass on rising health care costs to purchasers but to also increase profits at the same time.[3] Between 2000 and 2007, annual increases in single and family premiums were 8.9 and 9.5 percent, respectively, while health care spending by the privately insured increased by 6.7 percent.[4] Analysts at Health Care for America Now (2009) researched Security and Exchange filings and reported large increases in insurance company profits over the same period. And finally, it is very apparent that insurers have considerable flexibility in setting premium rates in the vast majority of markets. As a consequence, those shopping for coverage may be offered different prices for similar products with different carriers, and competition is not driving them to comparable levels. For example, an analysis of how individuals in less-than-perfect health fare in the individual health insurance market found that premium offers for the same individual in the same insurance market could vary across carriers by a factor of 2 to 1 or more (Pollitz 2001).

Compounding the health care cost impact of generally noncompetitive health insurance markets is that many of the same problems exist in provider markets. Provider markets, particularly hospital markets, have also become increasingly concentrated in recent years (Berenson, Bodenheimer, and Pham 2006). Eighty-eight percent of large metropolitan areas were considered to have highly concentrated hospital markets, according to a 2006 study (Vogt and Town 2006; see also FTC and DoJ 2004). And a

number of studies have shown that hospital rates are higher in more highly concentrated markets (Cueller and Gertler 2005; Capps and Dranove 2003, 2004; Keeler, Melnick, and Zwanziger 1999; Krishan 2001). One study found that mergers between close competitors increased prices by as much as 40 percent for both the merged hospitals and their rivals in those markets (Dafny 2005). High hospital rates are probably a better indicator of noncompetitive behavior in hospital markets than are profits, as many hospitals are nonprofits that are able to negotiate high rates and then reinvest their increased revenue back into hospital operations.

As is the case with insurers, it is very costly for hospitals to enter a market. Further, there is great variation in payment rates to different hospitals even by the same insurer; in other words, prices are not set by the market but by hospitals with different degrees of market power.[5] For example, the New Jersey Commission on Rationalizing Health Care Resources reported payments to hospitals per colonoscopy that ranged from $716 to $3,717, made to different hospitals for the same procedure.[6] The range for normal delivery of a baby was $2,178 to $3,629 across six hospitals studied. Similarly, one California insurer paid five different hospitals anywhere from $1,800 to $13,700 for an appendectomy. This variation in payments across providers is also consistent with the data collected by the Boston Globe on payments by the largest insurer in Massachusetts to different provider networks.[7] Data on payment rates to providers are generally considered proprietary and are therefore usually difficult to obtain; however, available evidence clearly indicates that competition is not eliminating these large variations in prices. And while prices should be expected to vary with perceived quality, variations of this magnitude well exceed what should be expected.

The Consequences of the Lack of Competitive Markets

Both health insurance markets and provider markets, particularly hospitals, do not meet the conditions for competitive markets. Consolidation has meant there are limited numbers of insurers and providers in many markets. The products offered by sellers in insurance and hospital markets are complex and difficult to understand and evaluate. It is almost impossible to compare prices of either insurance products or services provided by hospitals and other health providers. The barriers to entry in both markets are great. Insurer consolidation means high levels of profitability. While much of the hospital sector is not-for-profit, lack of competition often means increased revenue devoted to the purchase and diffusion of new and expensive technologies and procedures.

The impact of consolidation on prices depends on conditions in particular markets. In markets where there is little concentration among insurers but a concentrated hospital market, there is no real ability for insurers to negotiate with hospitals. A dominant insurer can do better in obtaining discounts from hospitals but will still have little negotiating power with dominant hospital systems. 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. The problem is the lack of countervailing power, thus, in our view, the need for a public plan.

The following section delineates why we expect the introduction of a public health insurance plan will create more competitive health insurance markets. We then describe the features of our envisioned public plan, explain why we believe private insurers will survive competition with it, and respond to the

prominent arguments made against having one.

How Could a Public Plan Help?

There are at least two strong arguments for a competing public plan. The first reason is that there is a strong need for cost containment both to lower the growth in health care costs for all Americans and to lower the cost of providing government subsidies for the purchase of insurance to lower-income people. The public plan would have lower administrative costs than private plans and could establish or negotiate provider payment rates at lower levels than private payers are able or willing to do today. The second reason is that some private insurers have denied claims and delayed payments to individuals with high health care needs as a way to control costs. To achieve high rates of voluntary participation in insurance coverage and to create a sense that a mandate to obtain coverage is fair, all individuals, regardless of health status, should have an insurance option with which they feel comfortable. The public plan would play that role for a significant segment of the population. While reformed insurance markets will limit the current ability of private insurers to avoid the sick, in practice, oversight will not be perfect and thus regulations will not be perfectly enforced.

What Would the Public Plan Look Like?

We suggest that the public plan would look much like the traditional Medicare program but it would differ in certain important ways. We envision it as a national plan that would compete in local or regional exchanges, using local prices. The public plan would be legally and administratively separate from the exchanges. The policies employed by the public plan would be set at the national level but would be adjusted for local costs. We assume that national legislation would establish insurance market rules that would ensure guaranteed issue and modified community rating (e.g., limited age bands), and would prohibit preexisting condition exclusions and benefit riders. All plans, both private and public, would have to abide by these rules.

All of the plans participating within an exchange (and possibly those outside of it), including the public plan, would offer a limited set of insurance packages consistent with standard benefit guidelines determined at the federal level. While the plans would ideally cover the same set of services, they could vary in the levels of cost sharing required. While all plan levels would be open to all interested enrollees, the level of subsidy would be tied to the plan level deemed most appropriate for a particular income group. For example, the lowest-income population would be subsidized to the plan level with little to no cost-sharing requirement. As income increased, subsidies would be tied to plan levels with increasing cost-sharing requirements.[8]

The public plan's benefits and cost-sharing requirements would certainly be different than those of the traditional Medicare program, and enrollees would be kept in a separate risk rating pool than Medicare enrollees. The benefit package offered by the public plan to the nonelderly population would have to meet the standards established for all plans, and these benefit packages and cost sharing requirements are likely to look more like typical large-group private insurance plans than Medicare. Similarly, the risk pool for the new public plan would be completely distinct from the current Medicare program. Because the expected medical costs for the nonelderly are significantly lower than for the elderly, doing otherwise would increase the average premium in the exchange plans, making them less affordable for the nonelderly.

The public plan would have the same type of administrative structure as the traditional Medicare program does today. The Center for Medicare and Medicare Services might run the program, although this would not be a necessity. The public plan would have public rule-making and appeal processes similar to those already established for Medicare. Most importantly, it would use Medicare payment systems, that is, the prospective payment systems for hospital inpatient and outpatient care, skilled nursing facilities and home health care, and the physician fee schedule. Some

modifications would be likely, however, such as different payment levels, an increased focus on specialties not relevant for the elderly population (e.g., pediatrics and obstetrics), and reforms to encourage more physicians to specialize in primary care and to provide high value preventive care.

It will probably be necessary to require providers who participate in Medicare to participate in the public plan, at least at the outset. As described previously, health care cost growth in recent years has been exacerbated by the noncompetitive dynamic of the consolidated insurers and consolidated provider networks. These large provider systems can thwart insurers' efforts to lower payment rates by the threat of the provider not participating in the insurers' networks unless rates are maintained at high levels. Without access to the large flagship provider systems, plans are unlikely to be able to attract a critical number of enrollees. Cost containment therefore requires the leverage to induce broad-based provider participation under rates somewhat lower than many private plans pay today. Rates can be adjusted up or down over time based upon objective analysis of what levels are appropriate to ensure access to quality care, but without a change to the current dynamic between powerful insurers and powerful provider networks, the public plan would likely be as ineffective as private insurers have been in recent years at controlling costs. After a few years of experience and payment adjustments, a new equilibrium should be reached, and the participation link between the two programs could likely be released without significant ramifications.

Of course, a participation requirement is not the same as a requirement to take all patients who seek care, and some physicians may argue that they do not have the capacity to expand their patient loads. It is therefore critical that the program makes it economically worthwhile for them to take public plan enrollees. A program that pays higher rates than Medicare does today (see below) should result in providers participating voluntarily, particularly when higher rates are also paid on behalf of many of those who are now uninsured.

We believe that MedPAC should provide oversight over the payment policies of the new public plan as it now does for Medicare. Analysis of the impact of Medicare policies on the markets for hospitals, physicians, and other services is essential to the current effectiveness of the Medicare program. We believe it is critical for MedPAC to extend this role to the public plan, providing data and statistical analysis that support recommendations to Congress and allows Congress to make key decisions that will affect the programs' operation. These responsibilities could include an initial recommendation for payment levels for hospitals and physicians under the public plan.

We would expect the public plan to be a managed fee-for-service program but have more focus on active care management efforts than Medicare. That is, the public plan's mission should include development of medical homes and improved management of the care of the chronically ill. Further, the plan should be required to establish policies that would encourage the use of electronic health information. To the extent that it could adopt reforms including bundled payments and partial capitation arrangements, it could pave the way toward broader system reform.

The Source of Savings: Administrative Costs and Payment Rates

The public plan would most likely have lower administrative costs than private plans, particularly compared to those in the individual and small group market. A number of studies have found rather dramatic differences between private and government insurance, but estimates often overstate the differences because some assessments of government costs exclude certain administrative roles from their calculations (Matthews 2006). In addition, because the average medical claims cost for the elderly are higher than for the nonelderly, any calculation of fixed administrative costs relative to average

Medicare claims will be lower than the same calculation for the non-Medicare population. For example, CBO analyses that compared the administrative costs of Medicare advantage plans to those of the traditional Medicare program concluded that administrative costs of private plans were about 11 percent, compared with 2 percent in the Medicare fee for service program (CBO 2006).

A public plan offering insurance to the nonelderly population within local exchanges would probably not have administrative savings of this magnitude. The administrative costs of health insurance plans include claims processing, utilization review, disease and chronic care management, marketing, underwriting, collecting premiums, and profits. Several of these functions would all be required of any public plan. Private plans would probably have lower marketing costs within an exchange and underwriting costs would probably be eliminated. Private plans would still have some marketing costs and the need to attract capital. The bottom line is that the administrative costs of private plans within a purchasing exchange would be lower than we see today and public administrative costs higher than seen in Medicare. But nonetheless, we believe some differences would still exist, probably on the order of 5 percent.

While the greatest cost savings could be achieved by the public plan paying providers Medicare rates, it would be more prudent to instead pay rates somewhere between Medicare and private rates. Based on data from MedPAC and other sources, we estimate that commercial insurers, on average, pay about 30 percent higher rates to providers (35 percent for hospitals and 23 percent for physicians) than does Medicare (American Hospital Association 2008; MedPAC 2008a, b; Fox and Pickering 2008). There is no need to reduce payment rates in the new plan to current Medicare rates to have a major impact on expenditures—there is considerable savings to be had *between* Medicare and current private rates. But more importantly, starting a public plan at Medicare rates would constitute a dramatic reduction in payment rates for a significant segment of the insured population. Such a change could lead to financial problems in the short run for hospitals and to problems accessing care for beneficiaries within the public plan. Setting rates for hospitals and physicians is a critically important policy decision. It requires considerable analysis of the impact of payment rates on access and quality of care, hospital access to capital markets, and other concerns. As a consequence, these decisions should be the outcome of comprehensive analysis conducted by MedPAC with the resulting information provided to the Congress.

How Big Would the Public Plan Be?

An issue of concern to many is the potential size of the public plan. The advantage of a larger public plan is that it would bring more bargaining power in confronting concentrated provider markets. But the concern is that it would eventually eliminate the private insurance market. The Lewin Group provided an analysis that showed that if all Americans were eligible to join the public plan and if the public plan paid current Medicare rates, 131 million people would join the public plan (Shiels and Haught 2009). Of these 131 million enrollees, 119 million would have moved from having prior private insurance. This result has received enormous attention. But the Lewin study also showed that if rates were set halfway between Medicare and private plans and only small firms, self-employed, and individuals were allowed to join the plan, only 31.5 million would be in the public plan with 21.5 million of those having prior private coverage.

The Lewin report also did not assume that there would be a response on the part of private payers. Private insurers would clearly respond to the presence of a public plan competitor by negotiating more aggressively with providers. Providers in turn would most likely find it in their interest to negotiate lower rates with insurers; otherwise, they would risk the exit of private plans and have only the public plan with which to contract. As private plans bring down their costs, the difference in

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their premiums from those of the public plan would shrink as well, possibly attracting more enrollees.

Predicting the enrollment in a public plan is difficult because the choices individuals make depend upon

- subsidy generosity;
- specific plan characteristics that cannot be known a priori (e.g., provider network, service, benefits, premiums);
- eligibility rules for enrolling in coverage through an exchange (e.g., will it be restricted to individual purchasers, will small employers be able to purchase coverage, will low-income workers in large offering firms be eligible, will eligibles have non-exchange coverage options); and
- the public perception of the plan (e.g., will it be seen as primarily for the low-income population or will it be more broadly attractive).

As such, any enrollment prediction will require significant assumptions about individual behavior, and the resulting estimates will be subject to more than typical levels of uncertainty.

With these caveats in mind, we estimated the number of people who would join the public plan, the number who would retain private health insurance, and the potential savings from using a public plan; given the uncertainty about so many of the parameters, these should be considered "ballpark" estimates. The assumptions made are delineated in the methodology appendix to this paper. We assumed a comprehensive reform framework consistent with those being discussed in Congress. These include the following:

- An insurance exchange offering private plans and a public plan option to individual and small employer purchasers (fewer than 50 workers), where the exchange would be the exclusive market for these purchasers. The public plan would be offered only in the exchange;
- Income-related subsidies for families up to 400 percent of the federal poverty level obtaining coverage through exchange plans (either public or private).[9] Cost-sharing requirements would increase with income as well, with those at 300 percent of the federal poverty level subsidized to the average level of coverage in the employer market today. For those with incomes below 400 percent of the poverty level, the government pays the difference between the premium and a specified percent of family income.[10] *Consequently, strategies that would lower the premiums will reduce the cost of government subsidies.*
- Subsidies would be tied to the cost of a benchmark plan, most likely the average of the three lowest-cost plans in an area; thus those eligible for subsidies would have a choice of at least two private plans without additional premiums. The lower the average cost of these three plans, the lower the subsidy cost to the government.
- A Medicaid expansion to all those with incomes less than 100 percent of the federal poverty level; those currently on Medicaid and CHIP with higher incomes would obtain coverage in the exchange;
- An individual mandate for all individuals to obtain health insurance coverage;
- Low-income workers offered employer coverage by large firms not included in the exchange could enter the exchange if they chose in order to take advantage of available subsidies. However, to opt into exchange coverage, the employers of these workers must make the same contribution to the exchange as the employer makes to health insurance coverage for the other workers in the firm;
- The average premium in the base case with only private plans available in the exchange is $4,330 for single, $8,660 for couple, and $11,970 for family coverage in 2009; this assumes a benefit package slightly less generous than the typical employer-sponsored plan today. Subsidized

premiums for the low-income population would be higher, as they include lower levels of cost-sharing to ensure affordability of necessary medical care.

Enrollment in Coverage through the Exchange.

All estimates provided here exclude the population below 100 percent of the FPL from the base, since that income group would be enrolled in Medicaid coverage. Given the design contours of the reform, almost all individuals and families who are self employed or working in firms with fewer than 50 workers as well as those who have nongroup coverage can be expected to enroll in coverage through the exchange. We assume that about a third of low-income people who work in larger firms (50 or more workers) would enroll in the exchange as well, with the share choosing exchange coverage decreasing as incomes increase. This occurs because some low-income workers in large firms could find that the subsidies available in the exchange are greater than the employer contribution to their coverage, but this becomes less likely as incomes increase. For those above 400 percent of the poverty level, there is significantly less reason to join the exchange, and we anticipate less than 20 percent of higher-income workers in larger firms would end up in the exchange because their employer no longer offers coverage. The vast majority (90 percent) of low-income previously uninsured families will likely obtain coverage through the exchange. The share of the previously uninsured obtaining coverage through the exchange can be expected to fall somewhat as income increases, as the subsidies in the purchasing pool fall and employer-based insurance becomes increasingly attractive as income rises. We predict only about half of the higher-income (unsubsidized) previously uninsured will enroll in exchange-based coverage after reform. Still, we expect roughly three-quarters of the previously uninsured with incomes above the new Medicaid eligibility level to enroll in exchange-based coverage.

Based on these assumptions, we calculate that about 92 million Americans would purchase insurance through the exchange. The number purchasing through the exchange is relatively insensitive to the premiums of the public plan and its provider payment rates. Because those eligible for subsidies have their premiums capped as a percentage of income, lower public plan premiums do not benefit families, only the government. In other words, the choice to purchase through the exchange versus outside of it is affected by the availability of subsidies, not by the level of public plan premiums.

Enrollment in Public Plan Coverage.

We believe that, of those enrolled in exchange-based coverage, the public plan will be most attractive to the lowest-income enrollees. We predict that roughly 70 percent of the low-income exchange enrollees (those under 200 percent of the federal poverty level) would choose the public plan, with the likelihood of choosing the public plan falling as income increases, down to about a third of those with incomes of 400 percent of the poverty level and above. The implication of these estimates is that roughly half of the total exchange population would purchase private plans after weighing the somewhat higher premiums in most of the private plan offerings against other features—that is, access and service—and about 47 million would enroll in coverage through the public plan. The public plan would enroll many of the uninsured, about 13 million by our estimates,[11] and a disproportionate share of those who would receive income-related subsidies.

Private plans would continue to serve about 161 million Americans (including private administration of self-funded plans for large employers), including about 45 million who would purchase private coverage through local or regional exchanges. Today, 177 million people have private coverage, enrolling either as individuals or through employers. Some of those who now have employer coverage and many with nongroup coverage would end up in the public plan, but many who are uninsured and some on Medicaid would end up in private plans, either inside or outside the exchange. As a consequence, after reform, we expect private

insurance to cover 91 percent of the total number of lives covered by private insurance today.

How Much Could the Public Plan Save?

We next estimated the savings to the federal government from providing a public plan option in the health insurance exchanges, assuming the same reform structure outlined above. All savings estimates are presented relative to the government cost of the same reform with only private plans offered within the insurance exchange and represent fully phased in reforms beginning in 2010. We estimated the government savings under two sets of assumptions. First, we assumed that the public plan would reduce costs by 15 percent relative to the base case (the rough equivalent of Medicare rates plus 20 percent, plus modest administrative savings relative to private plans) and that the private plans operating within the exchange would respond to competition by the public plan by reducing their costs by 5 percent (through reductions in rates and stronger utilization management). Second, we assumed greater savings potential (lower public plan payment rates), with the public plan costs 25 percent below the base case premium (the rough equivalent of Medicare rates plus 10 percent, and modest administrative savings relative to private plans) and the private exchange plans responding with 15 percent savings through rate reductions and stronger care management.

The approach to calculate the projected savings presented here are provided in the methodology appendix. However, in brief, baseline government costs (absent a public plan option) were computed using the CPS microdata with individuals assigned to exchange coverage as described previously. We used the delineated income-related subsidy schedule to simulate the government subsidy cost of exchange coverage, using exchange premiums based upon average employer-sponsored insurance premiums inflated for year and some modifications in benefits under reform. These costs were trended forward from 2010 to 2019 using the projected annual change in private health expenditures. Costs under reform that included a public plan were calculated by lowering the premiums for public versus private exchange coverage by the savings percentages laid out above, recomputing the subsidy costs using the microdata, and trending them forward annually.

The results are shown in table 1. Under the first set of savings assumptions and assuming a fully phased-in reform in 2010, we estimate that the public plan would save the federal government $17.4 billion in 2010 through reduced subsidy costs and approximately $224.1 billion over the first 10 years after reform. Under the more optimistic savings assumptions, we estimate that the presence of the public plan would save the federal government $31.0 billion in 2010, and $399.8 billion over the first 10 years after reform. Such savings could play an important part in reducing the government financing burden associated with comprehensive health care reform. If the public plan succeeds in slowing the rate of growth in costs over time, the savings would be greater than shown in table 1.

The Arguments against the Public Plan

Several arguments are being made in opposition to having a public plan option available to the nonelderly population.

Government Favoritism and the Level Playing Field.

The first is that the public plan will always be favored—that there is no way that Congress would let the public plan fail and would find ways to tilt the playing field in its favor, providing it with advantages not afforded private plans. However, experience with the Medicare program does not support this concern. Indications from the Medicare Advantage experience suggest that, if anything, private plans would most likely be favored over a public plan. For example,

Table 1. Estimated Savings from U.S. Public Plan under Two Scenarios

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2019
Subsidies, No Public Plan	**97.6**	**102.2**	**107.2**	**112.8**	**119.3**	**126.5**	**134.5**	**143.0**	**152.0**	**161.6**	**1256.6**
Government Subsidies for Health Insurance Exchange											
15% Savings on Public Plan, 5% Savings on Private Exchange Plans	**80.2**	**84.0**	**88.1**	**92.7**	**98.0**	**104.0**	**110.5**	**117.5**	**124.9**	**132.7**	**1032.5**
System Savings	32.0	33.5	35.2	37.0	39.1	41.5	44.1	46.9	49.8	53.0	412.0
Government Savings	17.4	18.2	19.1	20.1	21.3	22.6	24.0	25.5	27.1	28.8	224.1
Government Subsidies for Health Insurance Exchange											
25% Savings on Public Plan, 15% Savings on Private Exchange Plans	**66.5**	**69.7**	**73.1**	**76.9**	**81.3**	**86.3**	**91.7**	**97.5**	**103.6**	**110.2**	**856.8**
System Savings	61.2	64.1	67.2	70.8	74.8	79.3	84.3	89.7	95.3	101.3	788.0
Government Savings	31.0	32.5	34.1	35.9	37.9	40.3	42.8	45.5	48.4	51.4	399.8

Medicare Advantage plans are paid 14 percent more than Medicare fee-for-service in 2009 for the average beneficiary, clear evidence that traditional Medicare has not always been favored (MedPAC 2009). Moreover, there are administrative hassles associated with enrolling in the traditional Medicare program, since the vast majority of enrollees also must join three additional plans—Medicare Part B, a private prescription drug plan, and private Medigap/supplemental coverage—to obtain comprehensive protection. If one joins a Medicare Advantage plan, it is one stop shopping: hospital, physician, prescription drugs, and catastrophic coverage are all provided for one premium (Berenson 2008). Both examples suggest that the political process does not have a tendency to disadvantage private plan options.

This argument also presupposes that the federal government would use general revenues to prop up a public plan if it proved financially unsustainable. Private plans must maintain reserve funds, for example, and are subject to premium taxes. A public plan not subject to those requirements could have lower premiums, it is said, making it difficult for private carriers to effectively compete. Additionally, if the public plan was not run efficiently and had high costs after adjusting for risk, making it an unattractive option to purchasers, the argument suggests that the government would inject funds to hold premiums down and increase enrollment. We believe that the public plan will need initial start-up capital but then should be required to build enough of a cushion in its premiums to develop an adequate reserve fund and to repay the government for the start-up funds over time. It should not have the luxury of setting lower premiums and then turning to the Treasury for additional funds to cover its shortfalls. Plus, plans competing in exchanges could be exempt from premium taxes as are Federal Employee Health Benefit Program plans today.

Consumer incentives to purchase lower-cost plans to take best advantage of both subsidy and private dollars will be in place, as discussed earlier. Thus, any plan that costs significantly more than the benchmark would probably see little enrollment unless it offered sufficient value to warrant extra payments. If the public plan was more expensive than all the other plans within a market, its enrollment would be low.

The public plan would, however, have a significant disadvantage in that it might very well get a disproportionate share of higher-risk enrollees. This is the case because the low-income population obtaining coverage with subsidies may be more comfortable interacting with a public agency and the low income are more likely to have higher than average health care needs. In addition, some private insurers have tended to avoid those with high medical needs over the years since competitive advantage has been linked to enrolling lower risk populations. The practices utilized to deny coverage or claims have engendered some degree of mistrust over the years. Risk adjustment will be a necessity under reform in order to compensate any plan, public or private, that experiences adverse selection. But these adjustments,

while much improved in recent years, are imperfect, and it is likely that the public plan would not be fully compensated for having higher-cost enrollees.

Misuse of Government Power.

Some have argued that the public plan would misuse its market power, which would lead to underpayments to providers as well as access and quality problems. There are several reasons why this is very unlikely to occur. First, as we have suggested, MedPAC should be given responsibility to monitor and report on the impact of public plan policies in conjunction with those of Medicare and Medicaid; this should give Congress the information it needs to protect providers from the overuse of market power. Second, providers can, do, and will lobby if they believe the rates that they are paid are inadequate. They have been shown to have considerable political power in this regard. Finally, no one would be required to enroll in the public plan; if they believe that rates are low and as a result access is poor, they can join a competing private plan. This counterbalancing competitive pressure from the private plans would limit how low the provider payment levels would go in the public plan.

Administered Pricing versus Negotiations.

Another concern is that the public plan would use "administered" prices rather than negotiate with providers. While this is true, it ignores the fact that the setting of rates in Medicare is the outcome of a series of negotiations in which there is input from MedPAC to Congress and considerable provider lobbying before congressional decisions are made. In this sense, there is little practical distinction between administered and negotiated prices. The argument over administered prices also ignores the fundamental reality of the current marketplace. Negotiations in some markets where insurers have power vis-à-vis the provider system lead to one kind of outcome, that is, reasonable control over rates. In other markets where insurers have little power relative to providers, negotiations result in a very different outcome. For example, when one specialty group dominates the provision of a type of a care in a certain area or one hospital system dominates a market, insurers have little ability to control rates today.[12] There is nothing particularly advantageous about negotiations when there is an imbalance of power.

Cost Shifting.

The final argument often made against the public plan option relates to the so-called "cost shift" of public costs to private payers. The concern is that lower provider-payment rates from public insurance programs lead providers to "shift" unpaid costs for public beneficiaries onto the privately insured cases by requiring higher payment rates of private carriers. These higher rates, the argument goes, are then passed onto consumers in the form of higher private premiums. Thus, some would suggest that the public plans would buy care less expensively but at the cost of increases in private premiums. But this argument presupposes that providers' costs cannot be changed and that efficiencies cannot be achieved in the face of financial pressure. In reality, some cost shifting is likely in some markets and by some providers but, in many markets, hospitals adjust to financial constraints by becoming more efficient and lowering costs.

MedPAC recently conducted an analysis in which they found that, in areas where insurers have more market power over hospitals, there is more financial pressure and hospital costs are lower, leading to positive Medicare operating margins (MedPAC 2009). They found that where hospitals have strong market power relative to insurers, private payments are higher, hospital costs are higher, and thus Medicare margins are negative. Hospitals under financial pressure tend to control their costs, and, as a result, they profit from Medicare. Hospitals facing little financial pressure have the market power to raise prices and obtain higher revenues but they also have higher costs. As a

result, Medicare margins are negative because Medicare rates do not vary with regard to market power. They conclude that cost shifting occurs when there are weak payers and strong providers. The solution is not for public payers to pay more, but for the demand side of both private and public insurers to have greater power relative to hospitals. The result would be that hospitals would reduce costs because they would not be able to shift them back to insurers.

Will Private Insurance Plans Survive?

We believe it is highly unlikely that private insurance would be eradicated by competition from a public insurance plan. Some plans would not survive, but the strongest and most efficient would. First, the public plan would not use all of its potential market power for the reasons outlined above. Rates would be determined based on MedPAC analyses and recommendations. Moreover, providers would lobby over the adequacy of rates. Individuals would move from public plans to private plans if public plan rates were inadequate and led to poor access to providers of choice. Thus, there are significant constraints on the ability of a public plan to use all of its market power, driving down rates below reasonable levels.

Second, there is some evidence that private plans are more effective at managing utilization relative to Medicare fee for service. The private sector has developed wellness and disease management programs that have been widely adopted. The Association of Health Insurance Plans has presented data that suggest that private Medicare Advantage plans have had considerable success in reducing utilization.[13] In one study, they found a 34 percent reduction in hospital days and a 17 percent reduction in hospital readmissions. Another study found an 18 percent reduction in hospital days, a 41 percent reduction in readmissions, and a 32 percent reduction in emergency room visits (Association of Health Insurance Plans 2009).[14] MedPAC reports that HMOs' bids in Medicare Advantage for the average beneficiary were 98 percent of average fee-for-service expenditures, which suggests the ability to compete (MedPAC 2009).[15] Again, it is not that all private plans would survive; those that have profited through positive risk selection but cannot create incentives for the efficient management of health care will be unlikely to do well in a more competitive environment. However, those that manage care effectively and control utilization will survive, as will those that bargain effectively with providers for lower rates. Plans that provide better consumer service and better access to desired providers than the public plan would do well even with somewhat higher premiums. Private plans would also likely become more aggressive in provider negotiations because of the price competition catalyzed by the public plan.

Conclusion

A public plan would not destroy the private insurance market but would make it more competitive and lead to the benefits associated with competition. Many private plans would remain attractive because of their ability to be responsive to consumer demands and to be innovative in care management. Public plans are attractive because they can offer better access to necessary care for diverse populations, have lower administrative costs, and have strong negotiating power with providers. The presence of both types of plans should make each perform better in a reformed insurance marketplace. Most importantly, faced with competition from a public plan, private alternatives will become more efficient, leading to declines in their own costs. The net effect would be reduced growth in health care costs.

We estimate that the number of people with private coverage would fall from 177 million to 161million. Many will leave employer coverage, particularly those in small firms, and join the public plan as will many with nongroup coverage. But on the other hand, significant numbers of those who are now uninsured and some now on Medicaid would join private plans, either by taking up

coverage in large firms outside the exchange or choosing a private plan within the exchange.

We estimate that the public plan could provide substantial savings. Private payment rates by commercial insurers are about 30 percent above those rates paid by Medicare. We argue that it would be unnecessary and probably unwise for the public plan to pay Medicare rates. Under the two alternative assumptions we have made, that the public plan would pay Medicare rates plus 20 percent and plus 10 percent, we estimate that the cost of income-related subsidies needed to obtain universal coverage would save between $224.1 billion and $399.8 billion over 10 years. If the public plan can reduce the annual rate of growth, the savings would be still greater. We emphasize that MedPAC should play an important role in deciding on hospital and physician rates paid under the public plan, taking into consideration implications for access to care, physician incomes, and hospital financial well-being.

There are, however, many other structural changes required as part of a comprehensive cost-containment strategy. There is a need for more primary care doctors, medical homes, better management of the chronically ill, value-based reimbursement strategies, and expansion of the use of information technology. It may also be useful to take greater steps to increase the penetration of integrated health care systems. While all of these have merit, they are not likely to be sufficient. If as a nation, we are serious about cost containment, a competing public plan would seem to have a role; the alternatives, such as all-payer rate setting and global budgets, seem far more drastic measures.

Due to the controversial nature of the public plan option, policymakers are considering alternatives that could be considered as possible compromises between liberals and conservatives. These alternatives include reducing the market power or rate-setting power of the public plan or creating nongovernmental, nonprofit entities that could produce their own insurance plans with negotiated provider payment rates. While these options are likely to have political appeal, it is important to recognize that the cost-containment potential of a public plan rests fully in its ability to leverage the power of the federal government as health care purchaser to encourage provider participation and reduce prevailing payment rates. Without taking advantage of that strength, the cost-containment potential of the public plan option or an alternative would be tremendously weakened.

Endnotes

[1] John Holahan is the director of the Urban Institute's Health Policy Center. Linda Blumberg is a senior fellow at the Health Policy Center of the Urban Institute. The authors wish to thank Robert Berenson, Gary Claxton, Stan Dorn, Genevieve Kenney, and Stephen Zuckerman for helpful comments and suggestions. They also thank Aimee Williams and Allison Cook for their valuable research assistance.

[2]. See for example, Erica Werner, "Delays, Disputes Slow Progress of Health Care Bill," *The Associated Press*, June 18, 2009, http://www.washingtonpost.com/wp-dyn/content/article/2009/06/18/AR2009061800176.html; Carrie Budoff Brown, "Dems Hesitant on Kent Conrad's Proposal," *Politico*, June 16, 2009, http://www.politico.com/news/stories/0609/23755.html; Robert Pear, "Schumer Offers Middle Ground on Health Care," *New York Times* May 5, 2009, http://www.nytimes.com/2009/05/05/health/policy/05health.html?_r=1&scp=9&sq=public%20plan&st=cse.

[3]. The Federal Trade Commission and U.S. Department of Justice, Horizontal Merger Guidelines, issued April 2, 1992 and revised April 8, 1997, www.ftc.gov/bc/docs/hmg080617.pdf , (Accessed June 9, 2009). The Herfindahl-Hirschman Index is calculated by summing the squared market shares of each competitor in a given market.

[4]. Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group; U.S. Bureau of the Census, Table 6. Personal Health Care Expenditures Aggregate, Per Capita Amounts, and Percent Distribution, by Source of Funds: Selected Calendar Years 1970–2007, http://www.cms.hhs.gov/NationalHealthExpendData/downloads/tables.pdf; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999–2008, Exhibit 1. Average Annual Premiums for Single and Family Coverage, 1999–2008, http://ehbs.kff.org/images/abstract/7814.pdf.

[5]. See for example, Uwe E. Reinhardt, "Testimony Before the House Committee on Ways and Means," April 22, 2009.

[6]. http://www.nj.gov/health/rhc/finalreport/index.shtml.

[7]. Scott Allen and Marcella Bombardieri, "A Handshake that Made Healthcare History," *Boston Globe*, December 28, 2008, page A1. http://www.boston.com/news/local/massachusetts/articles/2008/12/28/a_handshake_that_made_healthcare_history/.

[8]. We assume that government subsidies would be tied to a mix of the lowest-cost plans at the appropriate cost-sharing level for each income group. For example, the benchmark plan could be established at the average cost of say the three lowest-cost plans in an area. To enroll in a plan more expensive than the benchmark plan in a particular cost-sharing category, even if the more expensive plan is the public plan, would require additional payments by beneficiaries.

[9]. Consistent with discussions in Congress, we assume that undocumented immigrants would not be eligible for insurance subsidies under the reform. This population is therefore not included in the figures presented here.

[10]. The subsidy schedule for coverage within the exchange would work as follows: those with incomes between 100 and 149 percent of the poverty level would be subsidized such that their premium would not exceed 1 percent of income; those between 150 and 199 percent of poverty 3, percent of income; those between 200 and 249 percent of poverty, 5 percent of income; those between 250 and 299 percent of poverty, 7 percent of income; 300 and 350 percent of poverty, 9 percent of income; and 350 and 399 percent of poverty, 11 percent of income. Those with incomes below 100 percent of the poverty level would obtain their coverage through Medicaid, at no cost to the individual or family.

[11]. Over 16 million of the estimated 45 million uninsured in 2009 are under 100 percent of the federal poverty level and would get coverage through Medicaid under this approach. Another 9 million would obtain private coverage through the exchange, 13 million would obtain coverage in the public plan, and the remaining 7 million would obtain private coverage through large employers outside of the exchange.

[12]. Scott Allen and Marcella Bombardieri, "A Handshake that Made Healthcare History," *Boston Globe*, December 28, 2008, page A1, http://www.boston.com/news/local/massachusetts/articles/2008/12/28/a_handshake_that_made_healthcare_history/.

[13]. Data presented by Karen Ignagni, President of the Association of Health Insurance Plans, at Alliance For Health Reform Briefing, April 27, 2009.

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Appendix
Methodological Approach

Estimating the Number of Individuals Enrolling in a Public Plan

Enrollment estimates were based upon the 2008 March supplement to the Current population survey, which provides data from 2007. An estimate of undocumented citizens, by income, was used to reduce the population totals; the aggregate estimate in 2007 was 10.4 million people. Population totals were aged to 2009 using Census Bureau projections.

Exchange Enrollment

The first step in estimating the number of people to enroll in a public plan option was to compute an expected number of individuals of different types enrolling in the health insurance exchange. We assume that the public plan would only be offered through the exchange, so public plan enrollment would necessarily be a subset of exchange enrollment. Individual exchange enrollment probabilities would vary by income, since income-related subsidies for non-Medicaid coverage would only be available through exchange plans, making the exchange most attractive to the low and moderate income. Exchange enrollment would also vary by source of coverage prior to reform, since larger employers would not be able to buy group coverage through the exchange as we have specified it, making the exchange more attractive to those with small firm coverage, the self-employed, those purchasing coverage individually, and the previously uninsured.

We assume that all those with family incomes below 100 percent of the federal poverty level (FPL) would obtain coverage through Medicaid, and consequently, none of them would enroll in the exchange. All of the calculations that follow therefore exclude that population. We deem 96 percent of the self-employed and 95 percent of those with pre-reform employer-based coverage through small employers (fewer than 50 workers) to obtain coverage post-reform through the exchange. While no new small group commercial coverage would be issued outside of the exchange under this design, a small share of small employers self-insure and may continue to do so, and a small fraction of the self-employed and those in small firms may change to large firm coverage through the spouse of an employer post-reform. These percentages are assumed to stay quite constant across the income distribution (those over 100 percent of the FPL).

Those receiving health insurance coverage through larger employers (50 workers or more) would not be eligible to obtain coverage as a group through the exchange. However, individuals wishing to opt out of their employer coverage could obtain insurance through the exchange as long as the employer made the same contribution to the exchange coverage as to the health insurance they purchase for their other workers outside of the exchange. Low-income workers would be eligible for subsidies toward the purchase of exchange plans on the portion of the premium not paid for by their employers. Under these limitations, we expect about 25 to 30 percent of workers between 100 and 299 percent of the FPL and about 18 percent of higher-income workers in large firms to enroll in exchange-based coverage.

We expect that states will reduce Medicaid eligibility for optional higher-income groups as a consequence of the expansion of Medicaid to all those below 100 percent of the federal poverty level and the presence of subsidized federal coverage through the exchange. While we expect states to continue to provide the vast majority of Medicaid/SCHIP coverage to those below 150 percent of the FPL (with roughly 15 percent obtaining coverage through the exchange after reform), we estimate that slightly more than half of prior Medicaid enrollees between 150 and 199 percent of the FPL and 90 percent of those with higher incomes reporting Medicaid prior to reform to get coverage through the exchange as well.

We assume that almost all (95 percent) of those purchasing nongroup coverage prior to reform and not qualifying for the expanded Medicaid program will obtain their coverage through the exchange. A small percentage may retain grandfathered plans or obtain their coverage through large employers via a spouse. With regard to those uninsured prior to reform, we assume that those with the lowest incomes are the most likely to enroll in exchange coverage as they would obtain the most benefit from the subsidized insurance

available there. We predict that about 90 percent of previously uninsured individuals with incomes between 100 and 149 percent of the FPL would obtain coverage through the exchange, with the probability falling as income increases, to about 50 percent of the previously uninsured with incomes at or above 400 percent of the FPL.

Taken together, these projections would lead to roughly 92 million individuals enrolled in exchange-based coverage, either through private plans or a public plan option.

Public Plan Enrollment

Of those enrolled in coverage through the exchange, we estimate roughly half to enroll in a public plan option if it is made available. We anticipate the public plan being most attractive to the lower-income population, with the likelihood of enrollment falling as income increases. If subsidies are tied to the lower cost plans within a particular benefit category (e.g., an average of the lowest cost three plans), there will be financial incentives for the subsidized population to choose among the most efficient options. Presuming that the public plan will be one of these options, we estimate that roughly 70 percent of exchange-enrolled individuals between 100 and 199 percent of the FPL to choose the public plan, with the likelihood of doing so falling to 35 percent of the exchange-enrolled population at or above 400 percent of the FPL.

Table A-1 summarizes the distribution of health insurance coverage after reform by coverage status prior to reform. As shown, many who begin with ESI keep it, but many purchase through the exchange and some enroll in the public plan. Of those who now have non-group coverage, the lowest income enroll in Medicaid and most of the remainder purchase through the exchange, about half in the public plan. Of the uninsured, many enroll in Medicaid, others sign up for their employers plan and the remainder purchase through the exchange, with a disproportionate share choosing the public plan.

Table A-1
Post-Reform Insurance Coverage Distribution by Coverage Status Prior to Reform

		Final Coverage					
Initial Coverage	*Total*	ESI	Medicaid	Tricare/ Other Fed	Private Non-group	Exchange Private	Exchange Public
ESI	*162,624,787*	109,244,568	0	0	0	28,394,050	24,986,169
Medicaid/CHIP	*29,533,687*	0	23,530,501	0	0	2,481,293	3,521,892
Tricare/Other Fed	*6,457,657*	0	0	6,161,802	0	133,975	161,880
Private non-group	*14,107,063*	0	2,559,065	0	597,805	5,555,482	5,394,711
Uninsured	*43,335,333*	6,515,963	15,791,062	0	0	8,420,297	12,608,012
TOTAL	*256,058,527*	*115,760,531*	*41,880,629*	*6,161,802*	*597,805*	*44,985,097*	*46,672,664*

Cost Estimates

Once individuals in the microdata were deemed to be exchange-enrolled or not, we assigned insurance premiums to each exchange-enrolled individual. Premiums were based upon average employer-based insurance coverage premiums in the 2006 Medical Expenditure Panel Survey – Insurance Component (MEPS-IC), the most recently available. These premiums were inflated to 2009 using projected per capita growth in private health insurance expenditures. Benefit package generosity within the exchange was assumed to be slightly less than today's average employer-based coverage, and thus we reduced this estimate by 10 percent. Because the reform proposal would subsidize lower-income individuals to benefit packages with lower cost-sharing requirements than is typical in employer-based coverage today, we increased premiums for those with incomes below 300 percent of the FPL to take this into account. Those with incomes below 150 percent of the FPL would have coverage with no cost sharing requirements for covered benefits in the exchange, those with incomes between 150 and 199 percent of the FPL would have cost-sharing requirements that would be 25 percent of the average ESI plan, those with incomes between 200 and 249 percent of the FPL would have cost

sharing requirements 50 percent of the average ESI plan, and those with incomes between 250 and 299 percent of the FPL would have cost requirements 75 percent of the average ESI plan.

Once all exchange enrollees were assigned the appropriate premium, government subsidies were calculated using the following subsidy schedule: those with incomes between 100 and 149 percent of the poverty level would be subsidized such that their premium would not exceed 1 percent of income; those between 150 and 199 percent of poverty, 3 percent of income; those between 200 and 249 percent of poverty, 5 percent of income; those between 250 and 299 percent of poverty, 7 percent of income; 300 and 350 percent of poverty, 9 percent of income; and 350 and 399 percent of poverty, 11 percent of income. Those with incomes below 100 percent of the poverty level would obtain their coverage through Medicaid, at no cost to the individual or family. Those individuals enrolling in exchange coverage but with baseline coverage through a large employer only qualified for a subsidy based upon the portion of the premium not paid for by their employer, as specified in the design of the reform.

Subsidy costs in the absence of a public plan option then were summed across all those enrolled in an exchange plan, and these costs were trended forward to 2019 using the projected annual change in national health expenditures. For simulations including a public plan option, exchange-coverage enrollees were divided between those in public and those in private exchange plans. Premiums for private and public coverage were lowered by the specified percentages in each scenario, and subsidies were recalculated. The two scenarios were as follows:

- Scenario 1: We assumed that the public plan would be able to reduce costs by 15 percent relative to the base case (the rough equivalent of Medicare rates plus 20 percent, plus modest administrative savings relative to private plans) and that the private plans operating within the exchange would respond to competition by the public plan by reducing their costs by 5 percent (through reductions in rates and stronger utilization management).
- Scenario 2: We assumed greater savings potential (lower public plan payment rates), with the public plan costs 25 percent below the base case premium (the rough equivalent of Medicare rates plus 10 percent, and modest administrative savings relative to private plans) and the private exchange plans responding with 15 percent savings through rate reductions and stronger care management.

These estimates were then trended forward to 2019 using the same growth rates. The savings from the presence of a public plan option are calculated as the difference between the subsidy costs with no public plan option and the subsidy costs with a public plan option available.