Urban Institute
Health Policy Center
Independent research for better health policy and better health

Getting to a Public Option that Contains Costs: Negotiations, Opt-Outs and Triggers

November 2009

Robert Berenson, John Holahan and Stephen Zuckerman

SUMMARY

The debate over a public option has essentially become a debate over the size and role of government in the health care system. The central argument, as we see it, should be one of fiscal conservatism—that a public option should play a role in addressing the very serious problem of health care cost containment. The current debate between the left and the right on this issue is obscuring the fact that consolidation in both the insurance and provider markets is propelling a higher rate of growth in health care costs. The consolidation of power, particularly in provider markets, makes it extremely difficult for insurers to negotiate rates for their services and contributes to rapid growth in health care costs. A strong public option is one that ties provider rates in some way to Medicare rates (though set at likely higher levels), and that is open to any individual or firm regardless of firm size. It would thus provide countervailing power to providers and help control cost growth.

We argue that a strong version is necessary because there is little else in health reform that can be counted on to contribute significantly to cost containment in the short term. Capping tax-exempt employer contributions to health insurance has great support among many analysts (including us), but it faces considerable political opposition. Proposals such as comparative effectiveness research, new payment approaches, medical homes and accountable care organizations, all offer promise but could take years to provide savings. Thus, the use of a strong public option to reduce government subsidy costs and as a cost containment device should be an essential part of the health reform debate.

We recognize that there is opposition to a strong public option. Both the House and Senate proposals are considering relatively weak versions to make the public option more acceptable. Both proposals would have the public option negotiate rates with physicians and hospitals. We see two problems with this. One is that negotiating rates is not simple and it raises difficult implementation issues; for example, with whom would the government negotiate? Further, negotiations are most likely to be unsuccessful with providers who have substantial market power. Since this is at the heart of the cost problem, a strategy of negotiations seems unlikely to be effective, as has been affirmed by cost estimates from the Congressional Budget Office.

The Senate has proposed a public option with an opt-out provision. This has the advantage of recognizing regional diversity in political philosophy by allowing states to pass legislation to keep it from being offered in their states. A disadvantage of this proposal is that it would exclude many who would potentially benefit from a public option. The states likely to opt out are likely to be those with high shares of low-income people and many uninsured.

The other alternative is to establish a strong public option but not implement it unless a triggering event occurred. The goal would be to allow the private insurance system to prove that it can control costs with a new set of insurance rules and state exchanges. The triggering events could be the level of premiums exceeding a certain percentage of family incomes or the growth in health care spending exceeding certain benchmarks. Since the public option would only be triggered because of excessive costs, however measured, we assume that a relatively strong version of a public option would come into play.

We recognize that taking a strong public option off the table may be necessary to enact reform legislation. But this will mean, at a minimum, higher government subsidy costs by not permitting a payer with substantial market power to bring cost containment pressure on the system. The outcome is likely to be that costs will continue to spiral upward. In effect, the nation would be relying on the range of promising pilot approaches to cost containment that would take some time to be successful. If they are not, we may be left with increasingly regulatory approaches, such as rate setting or utilization controls that apply to all payers. This would mean much more government involvement than giving people a choice of a low-cost public option that would be required to compete with private insurers.

What is the Debate About?

The debate over whether a public option should be part of health reform has become a lighting rod for ideological and political disagreement that threatens the passage of legislation. Public opinion polls show large majorities of Americans support some form of a public option.[1] The House of Representatives has included a public option as part of the legislation it passed. The Senate however seems likely to have difficulty getting 60 votes to support one in their bill; consequently, leaders are considering alternative versions. After the Senate and the House pass legislation, both bills would go to a conference committee. At that point the public option debate could further intensify, with conferees battling over what form of a public option, if any, would survive.

The issue of the public option has been widely misunderstood and mischaracterized. For some on the left, the public option is a strategy to discipline insurance markets, eliminating objectionable insurer practices. However, insurance reforms along with health insurance exchanges would change insurer practices by requiring guaranteed issue and renewal, ending preexisting condition exclusions, eliminating rescission of coverage and limiting the permissible forms of premium rating. The public option is not needed to address these problems, though it could be a useful safety valve for the sickest and poorest if insurance reforms are not as effective as intended.

The central argument for including a public option should be to restrain health care spending growth—it is an argument for fiscal conservatism. Depending on how it is implemented, it could do so by introducing needed competition into health insurance and health provider markets (Holahan and Blumberg 2008, 2009). Too often, health insurance markets as well as provider markets, particularly hospital markets, are simply not competitive. Much of the argument advocates make for the public option is that there are too few insurers in most health insurance markets. But the problem is more complicated than the number of insurers.

The issue of the public option has been widely misunderstood and mischaracterized…The central argument for including a public option should be to restrain health care spending growth -- it is an argument for fiscal conservatism.

The more important problem is the increasing market power that providers, particularly hospitals, have acquired, thereby weakening insurers' ability to negotiate over prices. Adding more insurers—even a public plan—with little leverage would not solve this problem. Indeed, the concentration in the hospital sector that has taken place over the past several years has been a major contributor to the fact that health care costs grow significantly faster than the rest of the economy (Vogt and Town 2006). A strong public option can provide much needed countervailing power on the demand side and contribute to cost containment.

A strong public option can contribute significantly to reducing subsidy costs and to system wide cost containment. A weak public option would likely not serve that role. A public option that begins with a small market share and would be required to negotiate prices with providers, often from a position of weakness, would do little to contain health care costs. In the absence of enough political support to pass a strong public option at this time, a "trigger" for a strong public option should be considered for inclusion in health reform legislation whether or not a weak public option is included as a political compromise. Even the threat of such a plan being triggered offers the potential to affect market dynamics between insurers and providers.

The more important problem that needs policy attention is that of the increasing market power that providers, particularly hospitals, have acquired, thereby weakening insurers' ability to negotiate over prices.

Although a strong public option could lower provider payment rates, even a strong public option is not likely to drive out private plans. Private insurers with some leverage over providers and innovative management practices will survive and be successful alongside a public option. Well-managed plans can selectively contract with providers to channel patients to those who demonstrate higher quality and greater efficiency; they can flexibly adopt medical and disease management approaches to influence provider and patient behavior; and they can alter benefit offerings, such as by varying patient cost-sharing to modify spending. These "managed care tools" are less common in public plans like Medicare and Medicaid. Private insurers would have greater incentive to use these approaches when faced with competition from a public plan. Moreover, providers should be more willing to negotiate with private plans given concern that individuals and firms would gravitate toward the public plan.

The likely outcome of competition between even a strong public option and private plans would be much like the competition between private and public universities and between the U.S. postal service and more expensive private competitors. People make choices on quality and service as well as price. The competition forces both public and private institutions to perform better to try to attract applicants and customers.

Many who oppose the public option fail to recognize that if the competition between private plans and a potentially weak public option does not successfully

moderate health care spending, or if there is no public plan at all, the likely result would be ever-increasing costs driving the country to government regulation of private-sector prices, if not in fact an explosion of support for some form of a single payer system. Indeed, a strong public option competing on a level playing field with private plans paradoxically might be the best "last chance" for competition to work.

We recognize the political opposition that a strong public option faces and we would support reform without a public option if, in the end, that was necessary. The purpose of this paper is to explain why a strong public option is needed, what it is, how it would function, and which questions need to be addressed before a public option can be designed and implemented. We also consider compromises that have been discussed that could overcome enough of the opposition to allow some form of a public option to be enacted.

A Public Option to Offset Provider Market Power

There has been a substantial increase in concentration among health insurers and providers in recent years. In 2008, 48 states and 314 metropolitan statistical areas (MSAs) had a high degree of insurer consolidation. According to Department of Justice and Federal Trade Commission standards, 94 percent of the MSAs were considered highly concentrated. In 89 percent of these 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 2009). 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 6.7 percent.[2] The fact that insurance revenues have been increasing faster than medical costs for so long indicates that insurers have developed significant market power (Robinson 2004; Dafny, Duggan, and Ramanarayanan 2009).

The larger problem, in our view, is increasing concentration and market power in provider markets. In response to insurer consolidation and the success of managed care, hospital markets (and to some extent other provider markets) have become increasingly concentrated (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; FTC and DOJ 2004). There is considerable evidence that hospital rates are higher in more highly concentrated markets, by as much as 40 percent (Cueller and Gertler 2005; Capps, Dranove and Satterthwaite 2003; Capps and Dranove 2004; Dafny 2005; Keeler, Melnick and Zwanziger 1999; Dafny 2005). Hospitals with considerable market power, often teaching hospitals, simply have too strong a market presence to be excluded from insurer networks; this strength allows them to have significant influence over the payment rates they require from insurers.

In addition to consolidating within markets, hospitals and, to a growing extent, physicians have used other strategies that increasingly have given them the upper hand in their negotiations with insurers. These strategies include forming integrated delivery systems, multispecialty group practices, and independent practice associations (Berenson, Ginsburg, and Kemper forthcoming). Although these new entities were not necessarily created to increase providers' market power, they have effectively done so. In fact, the strategies providers have adopted have not necessarily resulted in enhanced market concentration, yet they have resulted in provider price increases that far exceed current inflation rates.[3]

Thus, we conclude that insurer markets and provider markets, particularly hospitals, do not meet the conditions of competitive markets. Consolidation has meant there are limited numbers of insurers and provider systems in many markets. The insurer consolidation has not led to the ability or willingness of insurers to consistently use this power to negotiate with hospitals (though more so with physicians). Hospitals with extensive market power often use high levels of revenue either to accumulate reserves or to adopt new and expensive technologies and procedures, creating a "medical arms race" in which hospitals and physicians compete over the newest technologies and amenities, but not over prices (Robinson and Luft 1987). The problem is the lack of countervailing power; thus, in our view, the need for a strong public option.

What Is a Public Option?

Before considering how a public option would be designed, it is critical to understand some basic parameters of the policy. First, the public option would be one of several plans available to individuals through the health insurance exchange. No one would be required to choose the public option. Government subsidies would be available to modest-income individuals and families purchasing health insurance through the exchange, and could be applied to the purchase of a private plan or the public option. The subsidies are structured as limits on the share of income that households would have to pay for their coverage. The percentage of income required of individuals and families to contribute toward their premium increases as family income increases. Subsidy amounts are calculated based upon a benchmark, or reference, premium computed as an average of the three lowest-cost plans offered within the exchange.[4] The same subsidy amount, computed in this way, would be available to income-eligible people

… the public option would be one of several plans available to individuals through the health insurance exchange.

regardless of whether they enroll in a private or a public plan through the exchange. A low-cost public option would produce savings primarily to the government, with smaller savings for individuals and families. For plans that were more costly than the benchmark, individuals would have to pay the full marginal cost.

Second, a public option would not be funded with federal tax dollars. It would participate as a national plan in the exchange but would be legally and administratively separate from the exchange itself. Rather than the public option receiving direct financial support, the plan would be sustained by contributions from enrolling individuals, families, and employers along with subsidies provided to low-income people—exactly the same terms as an exchange-participating private plan. In other words, it is the subsidies that drive government costs, not the public option. The public option would have startup costs, but these would have to be built into its rates, with the startup cost fully paid back over time. The plan should not be able to return to Congress to obtain additional government support if costs exceed premiums; rather, premiums would increase and the market share of the public plan would fall.

… a public option would not be funded with federal tax dollars…it is the subsidies that drive government costs, not the public option.

Third, the public option would have to follow the same insurance rules established for all plans participating inside and outside exchanges. The benefit packages and cost sharing offered by the public option would have to meet the standards established for all plans. All exchange-participating plans, public and private, would participate in a risk adjustment system. To the extent that any plan, public or private, enrolled a disproportionate share of high-cost persons, the exchange would redistribute a portion of total collected premiums to offset differences in risk and ensure that no plan serving a higher-need population was placed at a competitive disadvantage.

What Are the Advantages of a Public Option?

The public option could have lower premiums than private plans, with savings resulting from two sources: plan administration and provider payment rates. First, the public option would have lower administrative costs than private plans. While some analyses have argued the administrative cost savings from public options would be huge, these are generally not apples-to-apples comparisons. Studies that control for differences in populations served by current-law public and private plans and that recognize the various administrative functions even a public option would need to carry out within exchanges conclude that savings are positive but modest, probably on the order of 5 percent (Matthews 2006; CBO 2006).

... the public option would have to follow the same insurance rules established for all plans participating inside and outside exchanges.

Second, the public option should be able to establish average provider payment rates at lower levels than private payers are able or willing to establish today. Currently, commercial rates are 30 percent higher than Medicare for hospitals and 25 percent higher for physicians, on average (American Hospital Association 2008; MedPac 2008a,b; Fox-Pickering 2008). The public option could make use of Medicare payment systems (though not necessarily Medicare's rate levels) for hospital inpatient and outpatient care, skilled nursing facilities, home health care, and the physician fee schedule. Some modifications would likely be appropriate, particularly to deal with specialties not relevant to the elderly population, such as pediatrics and obstetrics. Offsetting these potential cost advantages for a public option is the fact that private insurance plans have employed many more tools to reduce unnecessary services that drive up health spending.

A concern with lower provider-payment rates in a public option is that "underpayments" would result in providers increasing charges to private paying patients. This in turn raises insurance premiums paid by businesses and others. The cost-shifting argument presupposes that provider costs are unalterable and that efficiencies cannot be achieved in the face of financial pressure. While cost shifting is likely by some providers in some markets, it is also likely that hospitals would adjust to financial constraints by becoming more efficient and lowering costs. MedPac (2009) recently showed that in areas where insurers have more market power over hospitals, there is more financial pressure and hospital costs are lower. They also found that where hospitals have strong market power relative to insurers, private payments are higher and hospital costs are higher. Hospitals under financial pressure tend to control their costs, while those with little financial pressure have higher costs, but have the market power to raise prices and obtain higher revenues. MedPac concluded that the cost-shifting occurs where there are weak payers and strong providers. Thus, the problem is not that the public plans pay less, but that the weakness of private payers in their negotiations with hospitals allows costs to be passed on rather than forcing greater efficiency and lower costs.

Designing a Public Option

There are three major decisions that will define the strength or "robustness" of any public option. As written, none of the current legislative proposals include any of these elements of a strong public option. The first decision is whether providers who participate in Medicare would be required to participate in the new public option. This seems an essential requirement, at least at the outset. Without a

By setting payment rates above those provided by Medicare's rates but still below current average private rates, substantial savings could be obtained while still encouraging providers currently participating in Medicare to see patients participating in the new public plan.

participation requirement, it may be difficult to launch a new public option with a credible network of providers. Although requiring participation for Medicare providers at the outset will be essential, it is still important that rates be set at levels that could encourage rather than compel providers to participate. This would enhance the long-run sustainability of a public option. By setting payment rates above those provided by Medicare's rates but still below current average private rates, substantial savings could be obtained without discouraging providers currently participating in Medicare from participating in the new public plan.

The second and related decision is whether rates paid by the public option should be set by the government or negotiated with providers. Negotiations have the advantage that they appear to be less heavy-handed and seem to ensure that the buying power of the government would not be abused. However, negotiations raise several issues, the first of which is how they would work. For example, with whom does the public option negotiate? Would negotiations be at the national or local level, with state medical societies and state hospital associations, with local preferred provider organizations or individual physician practices and hospitals? The more separate negotiations required, the more administratively difficult implementation becomes.

The success of negotiations as a strategy is likely to vary across markets. Negotiations in markets where insurers have considerable power vis-à-vis the provider system could lead to reasonable control over rates. However, in markets where insurers have little power relative to providers, negotiations would likely be relatively ineffective. Because the latter situation—where insurers have little power relative to providers—seems to be increasingly common, relying upon negotiations, even if the implementation issues can be overcome, will substantially decrease a public option's cost containment potential. The Congressional Budget Office (CBO) has already concluded that a public option relying on negotiated rates would be less likely to result in savings than one that uses Medicare payment systems.[5]

Relying on rate setting instead of negotiations has raised concerns that the public option could shortchange providers (e.g., rural hospitals) in some areas relative to their costs; negotiated rates are less likely to do so. However, even using administered prices, the threat of beneficiaries rejecting a public option if access to providers were limited would necessarily lead to increasing provider payment rates. Currently, Medicare is raising fees to primary care physicians partly out of concern about primary care physicians dropping out of the program. Nevertheless, given the debate over the adequacy of payments in Medicare and, potentially, in a public option, it seems prudent to conduct the proposed Institute of Medicine study on geographic adjustment factors under Medicare and make any needed corrections.

The third decision is to define the segment of the population that will have access to the public option. In the current House and Senate bills, both proposals would limit access to the public option to those who would be eligible to purchase coverage in the exchange, namely those without access to employer-sponsored insurance and those working in firms below a certain size (e.g., 100 workers). Limiting access to the public option reduces the competitive threat to the private insurance market but also severely limits the use of the public option as a force for system-wide cost control. To the extent that the public option lowers premiums relative to private alternatives and induces its private exchange-based competitors to be more efficient, it would reduce subsidy costs and private costs for those who had access to it. But it would provide no benefits as a competitor in the rest of the insurance market.

If the public option were open to all firms, it would dramatically change the way all private insurers behave. No doubt, there would be fewer private insurers, but those that remained would be stronger and more effective in both negotiating with providers as well as managing utilization.

If the public option were open to all firms, it would dramatically change the way all private insurers behave. No doubt, there would be fewer private insurers, but those that remained would be stronger and more effective in both negotiating with providers as well as managing utilization. Of course, even with access to the public option being limited, the public could always demand that the exchange be opened more broadly if health care costs were not controlled.

Prognosis for a Public Option

It seems that the public option with the greatest potential to save money and control health care spending would be one that required providers participating in Medicare to participate, that tied rates in some way to Medicare rates (though likely higher) rather than negotiating rates with providers, and that was open to any individual or firm regardless of firm size. But each of these decision points has been controversial, and the current proposals moving through Congress do not establish a strong public option.

The bill passed by the House would consider physicians and hospitals that participated in Medicare as participants in the public option unless they opted out, but there would be no participation requirement, even at the outset. The Senate and House proposals would require payment rates to be set via negotiations with providers, although they are vague on how these negotiations would be conducted. Both proposals would limit enrollment to individuals without access to an employer plan and those in small firms. Although neither proposal contains a strong public option, there may not be enough bicameral support even to enact a weak public option—one required to negotiate rates, be independent of Medicare participation, and have limited scope of enrollment. As a result, policymakers are weighing various compromises, such as introducing greater state flexibility, developing alternatives that would not be publically administered, and establishing a trigger mechanism to control when implementation of a public option would occur.

Opt-Out and Opt-In Proposals

The Senate bill that was scored by CBO would have a national public option but would allow states objecting to it to opt out of providing it to their residents as a coverage option in the exchange. The intent of the opt-out provision is to reduce political opposition. An alternative version is an opt-in which would allow states to choose to join the national public option. These are essentially equivalent, but requiring legislative action to opt-in would probably decrease the likelihood of state participation relative to the opting-out. The opt-out or opt-in approaches seem to offer all of the advantages of the national plan for those states that participate. Their effectiveness depends again on how the plan is structured. A major criticism of the opt-out proposal is that those who might benefit the most—the sick and the poorest—would not have access to the public option if the state chose to opt out. For example, if states in the South and West were most likely to opt out, that would exclude states with the largest low-income and uninsured populations.

A final problem with the opt-out provision is that the federal government would be potentially vulnerable to high subsidies in states that have opted out if the private insurers within the opt-out states failed to control health care costs. Since the federal government would pay the difference between benchmark plans and the subsidized percentage of income, the cost of subsidies in an opt-out state could potentially exceed what they would have been had the public option been implemented. While in principle opt-out states could be on the hook for any higher subsidy costs that occur without a public plan, this would be almost impossible to implement.

Co-ops and Other State Options

Some politicians have proposed that states could establish nonprofit plans as an alternative to the public option. The Conrad proposal (Senator Kent Conrad, North Dakota) calls for the creation of not-for-profit cooperatives to develop a health insurance plan. These co-ops would both serve as the insurer for the enrollees and be responsible for contracting with providers and negotiating prices. They would operate under the same rules that apply to private insurers within exchanges and be controlled by an elected board as opposed to state governments. For those who think the problem being addressed is the absence of an option of a nonprofit insurer, co-ops would fill this void.

A major criticism of the opt-out proposal is that those who might benefit the most—the sick and the poorest—would not have access to the public option if the state chose to opt out. For example, if states in the South and West were most likely to opt out, that would exclude states with the largest low-income and uninsured populations.

Co-ops, however, would face some serious problems. They would take considerable time to set up and require substantial government seed money. Co-op premiums are only likely to be attractive if the co-ops have very low administrative costs and can negotiate low rates with providers. Even though their nonprofit status would contribute to keeping premiums lower, their overall administrative costs would not likely be low because co-ops would have to build new systems from the ground up. But the biggest concern is that they also are likely to have little power in negotiating provider rates. With limited market share and little ability to deliver enrollees, providers will have little incentive to offer low rates to the co-ops. Without low provider rates relative to well established insurers, the co-ops would be limited in their ability to attract enrollees, which would in turn limit their ability to drive provider rates down over time. The decision to avoid the tie to Medicare dooms co-ops to be a weak alternative to a strong public option.

Co-ops are not the only options that states could develop. States could establish the equivalent of public options within an exchange. Some states have self-insured plans that they make available to state employees. The public option could, in principle, work in concert with such state employee plans and have enough market share to negotiate rates effectively. But if states do not have self-funded plans or if they are not effective in restraining costs, they would have to start from scratch. They would have to establish new provider networks, negotiate payment rates and enroll beneficiaries. It is hard to see how they could develop into effective competitors, certainly not as effective as plans that are linked to Medicare. State co-ops and other state based options do not seem likely to be as effective as a national plan with an opt-out or opt-in provision.

Triggering a Public Option

Another alternative that has been discussed, given the controversy over implementing a strong public option, is the use of a trigger mechanism that would effectuate a public option only if certain conditions of performance were not met. This proposed concept, associated primarily with Senator Olympia Snowe of Maine, would allow private insurers the opportunity to show that they can provide affordable coverage under the new health reform rules, particularly to those eligible for subsidized care. Many proponents of a strong public option oppose a compromise relying on triggers because they believe that triggers would never be pulled or could be easily circumvented or ignored. While triggers do raise some challenging issues (discussed below) they would keep the systems' costs under constant scrutiny.

In the discussion below, we review previous experiences with triggers in both health and non health contexts and consider alternative approaches to establishing a trigger. Given that affordability and spending growth are the essential rationales for triggering a public option, it follows that a strong public option should be the outcome. This suggests that a triggered option should have rates based on the Medicare payment systems (though likely with rates set somewhat higher than Medicare).

The Evidence on Previous Triggers

Triggers can result in a "hard" or "soft" response. A hard or automatic response is defined in legislation and would occur unless Congress and the president act to override or alter it. Alternatively, a trigger can require a soft response, such as a report on the causes of failing to meet the criteria that pulled the trigger, development of a plan to address the problem, or forcing a new explicit and formal decision to accept or reject a proposed action or increase (GAO 2006).

The Gramm-Rudman-Hollings law of 1985 (GRH) included a hard trigger that specified a declining path for the budget deficit that was to culminate with a balanced budget (Penner and Steuerle 2007). If the deficit target was not achieved, government spending was supposed to be cut or sequestered according to a complex formula. In fact, the experience with GRH was that the hard trigger was never pulled—or more precisely, the deficit targets had to be increased and subsequently abandoned by Congressional action—because deficits worsen in bad economic times. Pulling a trigger that would have reduced spending or increased taxes to balance the budget would have had a deleterious impact on the economy (and in the process worsened the deficit).

The Medicare program contains three triggers: two hard and one soft. One hard trigger adjusts physician fees so that physician spending follows a sustainable growth rate (SGR).[6] With the exception of 2002, Congress has always disabled the trigger before the prescribed action, a reduction in physician fees, occurred. Although the SGR trigger was "hard," its automatic nature was preempted by specific legislative action because the consequences—significant reductions to physician fees (a 21 percent reduction could take place on January 1, 2010)—have been considered too harsh. However, although the legislatively prescribed trigger was only pulled in 2002, congressional action to override the effect of the trigger has surely

While triggers do raise some challenging issues they would keep the systems' costs under constant scrutiny.

resulted in fee schedule increases less than otherwise would have occurred if the SGR mechanism had not been in place. That is, because Congress has had to "pay for" not reducing physician fees under "pay-go" rules, it has had to moderate fee increases and find savings elsewhere.

In the Medicare Modernization Act of 2003, Congress specified that if Medicare's trustees projected, in two successive years, that general revenue financing would cover more than 45 percent of total costs for any of the following seven years, the trustees would have to issue a "funding warning," which in turn would trigger a requirement that the President propose cost-saving measures in the following budget. These recommendations would then have to be considered on an expedited basis by Congress. For three consecutive years, beginning in 2007, a Medicare funding warning was triggered. In the first two years, the Bush administration proposed spending reduction actions that were ignored by the Democratic Congress. This year, the Obama administration did not suggest legislative action; early in 2009, the House approved a resolution suspending the application of the Funding Warning Provision contained in the Medicare Prescription Drug, Improvement and Modernization Act of 2003 for the remainder of the 111th Congress. In short, this soft trigger has been ignored by Congress and may be repealed as part of health reform.

Medicare does have one hard trigger that has worked well for over a decade. Under this trigger, Medicare part B premiums are automatically adjusted to cover 25 percent of total Part B costs, under a rule made permanent in 1997. This trigger was put in place in order to stop the erosion of the share of private contributions relative to government contributions to the program.

Based on these recent experiences, the lesson is that a trigger needs to be hard, thereby producing an automatic and clear-cut action. The event that forces pulling the trigger needs to be based on transparent criteria and should be closely tied to the objective being sought, such as affordability of health insurance or constraining the growth in health care spending. There should be little ambiguity about the reasons for missing the targeted expectations; and the automatic actions being triggered need to directly address the reasons for failure. In the case of GRH, the prescribed action to be triggered (reduced government spending) would have made the problem (growing budget deficits) even worse and had to be abandoned.

Trigger Design: A Trigger Based on Affordable Premiums

The first approach we consider is to establish a hard trigger based on affordability of premiums within exchanges. That is, if the exchange benchmark premium exceeded a specific percentage of income for a specified percentage of the exchange population, this would trigger the introduction of a strong national public option into the local exchange. For example Senator Snowe proposed an amendment that would trigger the public option (which she calls a "safety net" plan) "in any state in which affordable coverage was not available in the Exchange to at least 95 percent of state residents."[7] The amendment proposed by Senator Snowe is silent on the characteristics of the public option that would be triggered. Current data suggest that less than 4 percent of the nonelderly population would have access to unaffordable coverage under this amendment, meaning that this affordability trigger, on average, would be unlikely to be pulled.

An alternative to the Snowe affordability trigger could be derived from other provisions in the Senate draft legislation. That draft proposal would require people to buy "affordable coverage," defined as coverage that requires no

Based on these recent experiences, the lesson is that a trigger needs to be hard, thereby producing an automatic and clear-cut action. The event that forces pulling the trigger needs to be based on objective and transparent criteria and should be closely tied to the objective being sought, such as affordability of health insurance or constraining the growth in health care spending.

more than 8 percent of modified gross income to be spent on premiums. In still another section of the bill, people with an offer of employer coverage that requires contributions in excess of 9.8 percent of modified gross income would be allowed to purchase coverage through the exchange and be eligible for subsidies. Taken together, these two provisions suggest that a trigger for a strong public option could be based on the share of income that would have to be spent on premiums by a person eligible to buy coverage through the exchange. This approach would be consistent with Senator Snowe's intent of using affordability as the trigger mechanism and also would be internally consistent with other provisions in the bill. For example, after taking subsidies into account, if 5 percent of families had to spend more than 8 to 10 percent of their incomes on the lowest cost plan, then a strong public option would be triggered. This trigger would be computed and implemented on a state-by-state basis when premiums were deemed too high compared to incomes.[8]

This approach would establish a single number (e.g., percent of income) as the basis for the trigger, with assessments on a state by state basis. However, it would not be without some controversies and questions. One concern about using affordability as the trigger is that the lack of affordability as defined can be affected by factors other than the lack of health spending control. For example, affordability would be affected by who comes into the risk pool and how the costs for those individuals

This approach would be consistent with Senator Snowe's intent of using affordability as the trigger mechanism...For example, after taking subsidies into account, if 5 percent of families had to spend more than 8 to 10 percent of their incomes on the lowest cost plan, then a strong public option would be triggered.

are spread. If penalties for not purchasing insurance, as called for in an individual mandate provision, are not sufficiently large, many relatively healthy individuals might "opt out," leaving an actuarially more expensive risk pool that increases the percentage of the population for whom coverage is "unaffordable." Further, difficulties with affordability could be the result of inadequate subsidies for low-income individuals. Opponents of a public option could argue to override the trigger by claiming that factors other than health plans' inability to manage spending caused the lack of affordability. In short, a triggering event tied to affordability could subject the public option to the same controversy as now, with opponents arguing that other policies should be adopted instead of a public option and increasing the likelihood of congressional pre-emption of the trigger.

A Trigger Based on the Rate of Spending Growth Targets

An alternative to using a trigger based on affordability of health insurance in the exchange is to use one based on the overall growth in national health spending. Most discussions of "bending the curve" refer to national health spending growth in relation to growth in gross domestic product (GDP). An advantage of using growth in national health expenditures (NHE) is that the data are regularly and consistently reported and are directly related to the purpose of a public option—to create competition with private insurers to reduce health spending growth. Because of annual variations, the trajectory of NHE might be constructed on a rolling-average, perhaps three year basis.

Earlier this year, stakeholder groups—representing drugmakers, health insurers, hospitals, labor representatives, medical device makers and physicians—sent a letter to President Obama promising to reduce the growth in health care spending by 1.5 percent, a 20 percent reduction in the growth rate. The letter pointed toward

An advantage of using growth in national health expenditures (NHE) is that the data are regularly and consistently reported and are directly related to the purpose of a public option—to create competition with private insurers to reduce health spending growth.

lowering administrative costs, reducing hospitalization rates, improving management of chronic diseases, increasing hospital efficiency, and expanding the use of health information technology as methods of reducing health care spending.[9]

These stakeholders were committing to holding down the growth of health spending without the imposition of additional government action. Failure of these stakeholders to voluntarily achieve their objective could be used as a metric for triggering the public option since the clear-cut purpose of having a strong public option is to provide competition to private insurers to restrain spending increases. This provides a strong rationale for tying the triggering event to failure to meet a criterion based on the growth in national health care spending per capita.

This would-be trigger is also not without problems. First, the share of the population with health insurance will increase and this will increase the level of national health expenditures per capita, likely requiring some adjustment to the target. Second, there is a year lag in obtaining National Health Expenditure data, so the triggering action would not be based on current spending data. That concern would be heightened by reliance on a three-year rolling average of spending growth. However, the rolling average would start at some point prior to the passage of the legislation, meaning that a public option could be triggered as soon as 2014. In addition, combined with a 12 month lag in data, failure to meet the established spending target would partly reflect system spending performance from four years earlier. Nevertheless, there is a strong rationale for using a multiyear rolling average of spending growth: to have greater confidence in the data, to permit cost containment activities with a longer lead time to achieve fruition, and to permit providers, plans and vendors to assess, in mid-course, whether additional actions are needed to avoid the triggering event of missing spending growth targets.

Another limitation of using growth in National Health Expenditures as the basis for a trigger of a public option is that it could not be applied at a state level, as some would prefer. It would still be possible, but not logical, under this approach to permit a state opt-out if the public plan is triggered.

Other Issues

In summary, it is possible to design a trigger that, if pulled, would initiate a public option as an offering in the exchange, subject to whatever rules and limitations the Congress defines in the initial legislation. A trigger policy could even include a state-opt out provision. To actually overrule an automatic trigger, Congress should be required to explicitly debate the merits of overriding the trigger. In addition, a Congress choosing to overrule the trigger should be required to vote on a decision that would be scored for budget purposes as a choice of that Congress as has been the case with the SGR. Such a decision should not be treated as a choice from the past for which current members can dodge responsibility (Penner and Steuerle 2007).

To have the best chance that the public option would actually come into place based on failure of private plans to control health spending or provide affordable coverage, it would be best for the legislation to establish a specific start date for a public option, with the trigger set to postpone that start date if the desired targets of spending or affordability were achieved. In this way, the Congress would have to take an affirmative action to override the initiation of the public option. Of course this would be more politically difficult to do in the current environment, as it would likely be perceived as legislation that explicitly included a public option as of a future date.

Conclusion

The debate over a public option has essentially become a debate over the size and role of government. This debate, as we see it, fails to recognize the consolidation in both the insurance and provider markets that are propelling a higher rate of growth in health care costs. The consolidation of power, particularly in provider markets, makes it extremely difficult for insurers to negotiate rates and contributes to health care costs growing faster than the growth in the economy. A strong public option—one that uses Medicare rates plus an increment, would require provider participation for those participating in Medicare, and could potentially be a choice for all Americans—would provide countervailing power and help to control the cost growth.

We believe that there is little else in health reform that can be counted on to contribute significantly to cost containment in the short term. Capping tax-exempt employer contributions to health insurance has great support among economists (Elmendorf 2009), but it faces considerable political opposition. There are many proposals that offer promise, including comparative effectiveness research, new payment approaches, development of medical homes and accountable care organizations, and improvements in chronic care management. There is broad consensus that we need to move in this direction, but these policies would likely provide savings only after a considerable time period. Thus, the use of a strong public option (which could incorporate these policies) to reduce government subsidy costs and serve as a system wide cost containment device seems to us an essential part of the health reform debate. However, we recognize that the strength of opposition to a strong public option is formidable.

There are two main alternative proposals that are under consideration. Both have some merit. Some in the Senate, including the majority leader, have proposed legislating a public option with an opt-out provision. This would allow states that are ideologically opposed to a government health insurance plan to keep it from being offered. The disadvantages of this proposal are that the public option that is being put forward would create inequities across states and potentially limit cost containment. Moreover, the states that are likely to opt out are likely to be those with high shares of low-income and uninsured people.

A separate weakness of the Senate's public option with an opt-out provision is that it would be required to negotiate rates with providers. We discussed two problems with this approach. One is that negotiating rates is not simple and raises questions of with whom would the government negotiate. Further, negotiations are most likely to be unsuccessful with most providers, especially with those who have accumulated substantial market power. The public option would have the same experience as private insurers have had today. Since this is at the root of the cost problem, a strategy of negotiations seems unlikely to be effective as has been affirmed by budget estimates from the Congressional Budget Office.[10]

The other alternative is to agree to a strong public option but not implement it unless a triggering event occurred.[10] This would allow the private insurance system to prove that it can control costs within a new set of insurance rules and state exchanges. The trigger could be based on the availability of insurance plans with premiums that were below certain targets, a specified percentage of the population had access to plans that were less than 8 to10 percent of income. Alternatively, the trigger could be based on control over the growth in health care spending.

Although one of the major reasons for implementing health reform is to control health care spending, there are few strong provisions in any of the proposals as they now stand that would accomplish this. The range of cost-related proposals—that is, taxing "Cadillac" health plans or adopting various forms of payment and system redesign—offer hope but little in the way of proven results. Many cost containment options being considered would not produce cost savings for several years. Taking a strong public option off the table may be necessary to enact reform legislation. But it will, at a minimum, increase government costs. In addition, it will eliminate the potential payer with the largest market power from exerting cost containment pressure on providers. The outcome of narrowing the options for controlling health care spending is that costs will continue to spiral upward. In the end, health care spending could have to be controlled through regulatory approaches such as rate setting or utilization controls that apply to all payers. These approaches would mean much more government involvement than giving people a choice of a low-cost public option that could compete effectively with private insurers, providing strong incentives for the private sector to become more efficient and reduce costs as well.

Notes

[1]Marjorie Connelly, "Polls and the Public Option," *New York Times,* October 28, 2009, http://prescriptions.blogs.nytimes.com/2009/10/28/polls-and-the-public-option/.

[2]Centers for Medicare and Medicaid Services, "Personal Health Care Expenditures Aggregate, Per Capita Amounts, and Percent Distribution, by Source of Funds: Selected Calendar Years 1970–2007," National Health Expenditure Data, Table 6, http://www.cms.hhs.gov/NationalHealthExpendData/downloads/tables.pdf

The Henry J. Kaiser Family Foundation and Health Research & Educational Trust, "Exhibit 1: Average Annual Premiums for Single and Family Coverage, 1999–2008," *Survey of Employer-Sponsored Health Benefits 2008*, September 24, 2008, http://ehbs.kff.org/images/abstract/7814.pdf.

[3]For example, a hospital system with member hospitals in several markets can negotiate from strength as a system without having excessive concentration in any individual market.

[4]A number of different plan levels would be offered within the exchange. While all would cover the same services, they would vary in the cost-sharing required of enrollees. Lower-income individuals and families would be subsidized for plans requiring lower cost-sharing than those with higher incomes. The reference premium for subsidy determination would be computed based upon the three lowest cost plans with the appropriate level of cost-sharing, given the income of the enrollees.

[5]Douglas W. Elmendorf, "Preliminary Analysis of the Affordable Health Care for America Act," Letter to the Honorable Charles B. Rangel, Congressional Budget Office, October 29, 2009, http://www.cbo.gov/ftpdocs/106xx/doc10688/hr3962Rangel.pdf.

[6]The Sustainable Growth Rate (SGR) is a statutory formula which is part of an overall system used to determine annual Medicare physician fee updates. The SGR is designed to limit aggregate Medicare spending on physician services by aligning spending with specific expenditure targets that prospectively reduce fees whenever aggregate spending exceeds those targets due to service volume growth.

[7] Senate Finance Committee, "Amendments Relating to Expanding Health Care Coverage," 2009 page 207, (http://finance.senate.gov/sitepages/leg/LEG percent202009/091909 percent20AHFA percent20Coverage percent20Amendments.pdf).

The share of income under Senator Snowe's amendment would be computed net of employer premium contributions and government subsidies provided through the exchange to those with low and moderate incomes. This share would be viewed as affordable under Snowe's amendment if it was between 3 percent of income at 133 percent of the FPL (the proposed Medicaid eligibility cutoff at the time the amendment was drafted) and 13 percent of income at 300 percent of the FPL and higher. Since the Senate bill's subsidy schedule would limit premium contributions by households up to 400 percent of the FPL to a share of income lower than the Snowe trigger schedule, only people with incomes above 400 percent of the FPL who purchased coverage through the exchange could be counted toward Senator Snowe's affordability trigger. As the exchanges are currently envisioned, only people without access to affordable employer-based coverage or who obtain coverage through a small employer would be eligible to purchase coverage in the exchange. Only a small share of those purchasing coverage independently have incomes above 400 percent of the FPL and very few workers with employer contributions to their coverage would have out-of-pocket premium responsibilities that exceed the Snowe trigger schedule. In states with incomes that are low relative to premiums or in which employer contributions are not generous, this trigger would be more likely to initiate a public option offering. And if premiums grow substantially faster than incomes, the triggers could potentially come to be pulled in several states.

[8] Although payments to plans in the exchange might be risk-adjusted to reflect who actually enrolls in each plan, an affordability trigger would only have to reflect the premiums payments required from each family.

[9] Robert Pear, "Industry Pledges to Control Health Care Costs," *New York Times*, May 11, 2009, http://www.nytimes.com/2009/05/11/health/policy/11drug.html

[10] Congressional discussion around the idea of a trigger has not explicitly described the type of public option that might come into being.

References

American Medical Association. 2009. "Competition in Health Insurance: A Comprehensive Study of U.S. Markets." American Medical Association Division of Economic and Health Policy Research.

American Hospital Association. 2008. "Underpayment by Medicare and Medicaid Fact Sheet." Chicago, IL: American Hospital Association.

Berenson, Robert A., Thomas Bodenheimer, and Hoangmai H. Pham. 2006. "Specialty-Service Lines: Salvos in the New Medical Arms Race." *Health Affairs* web exclusive, July 25.

Berenson Robert A., Paul B. Ginsburg, and Nicole M. Kemper. "Unchecked Hospital-Physician Market Power in California Foreshadows Challenges for National Health Reform." *Health Affairs,* forthcoming.

Capps, Cory, David Dranove, and Mark Satterthwaite. 2003. "Competition and Market Power in Option Demand Markets." *RAND Journal of Economics* 34(4): 737-763.

Capps, Cory, and David Dranove. 2004. "Hospital Consolidation and Negotiated PPO Prices." *Health Affairs* 23(2): 175–181.

Congressional Budget Office. 2006. *Designing a Premium Support System for Medicare*. Washington, D.C.: Congressional Budget Office, December.

Cueller, Alison E., and Paul J. Gertler. 2005. "How the Expansion of Hospital Systems Has Affected Consumers." *Health Affairs* 24(1): 213–219.

Dafny, Leemore S. 2005. "Estimation and Identification of Merger Effects: An Application to Hospital Mergers." National Bureau of Economic Research Working Paper No.11673. Cambridge, MA: National Bureau of Economic Research.

Dafny, Leemore S., Mark Duggan, and Subramaniam Ramanarayanan. 2009. "Paying a Premium on Your Premium? Consolidation in the U.S. Health Insurance Industry." National Bureau of Economic Research Working Paper

No.15434. Cambridge, MA: National Bureau of Economic Research.

Elmendorf, Douglas W., 2009. "Options for Expanding Health Insurance Coverage and Controlling Costs." Congressional Testimony. Washington, D.C.: Congressional Budget Office, Feb. 25.

Federal Trade Commission and Department of Justice. 2004. *Improving Health Care: A Dose of Competition*. Washington, D.C.: FTC and DoJ. http://www.usdoj.gov/atr/public/health_care/204694.htm.

Fox, Will, and John Pickering. 2008. "Hospital and Physician Cost Shift: Payment Level Comparison of Medicare, Medicaid, and Commercial Payers." Seattle, WA: Milliman. http://www.milliman.com/expertise/healthcare/publications/rr/pdfs/hospital-physician-cost-shift-RR12-01-08.pdf

General Accountability Office (GAO). 2006. *Mandatory Spending: Using Budget Triggers to Constrain Growth.* Washington, D.C.: GAO-06-276, Jan. 31.

Holahan John, and Linda J. Blumberg. 2008. "Can a Public Insurance Plan Increase Competition and Lower the Costs of Health Reform?" Washington, D.C.: The Urban Institute. http://www.urban.org/url.cfm?ID=411762

—. 2009. "Is the Public Plan Option a Necessary Part of Health Reform?" Washington D.C.: The Urban Institute. http://www.urban.org/url.cfm?ID=411915

Keeler, Emmett B., Glenn Melnick, and Jack Zwanziger. 1999. "The Changing Effects of Competition on Non-Profit and For-Profit Hospital Pricing Behavior." *Journal of Health Economics* 18(1): 69-86.

Matthews, Merrill. 2006. "Medicare's Hidden Administrative Costs: A Comparison of Medicare in the Private Sector." Alexandria, VA: Council for Affordable Health Insurance.

Medicare Payment Advisory Commission. 2008a. "Report to Congress: Medicare Payment Policy, Hospital Inpatient and Outpatient Services." Washington, D.C.: MedPAC.

—. 2008b. "Report to Congress: Medicare Payment Policy, Physician Services." Washington, D.C.: MedPAC.

—. 2009. "Report to the Congress: Medicare Payment Policy." Washington, D.C.: MedPAC. http://www.medpac.gov/documents/Mar09_March percent20report percent20testimony_WM percent20FINAL.pdf.

Penner, Rudolph G., and Eugene C. Steuerle. 2005. "A Radical Proposal for Escaping the Budget Vise." Washington D.C.: The Urban Institute. *National Budget Issues* Policy Brief No.3.

—. 2007. *Stabilizing Future Fiscal Policy: It's Time to Pull the Trigger*. Washington D.C.: The Urban Institute Press.

Robinson, James C. 2004. "Consolidation and the Transformation of Competition in Health Insurance." *Health Affairs* 23 (6): 11–24.

Robinson, James C., and H.S. Luft. 1987. "Competition and the Cost of Health Care, 1972-1982." *Journal of the American Medical Association* 257(23):3241-3245.

Vogt, William B., and Robert Town. 2006. "How Has Hospital Consolidation Affected the Price and Quality of Hospital Care?" Research Synthesis Report 9. Princeton, NJ: Robert Wood Johnson Foundation.

About the Authors and Acknowledgements

Robert Berenson. M.D., is an institute fellow, John Holahan, Ph.D., is center director and Stephen Zuckerman, Ph.D., is a senior fellow at the Health Policy Center of the Urban Institute. The authors appreciate the helpful advice and suggestions of Linda Blumberg , Paul Ginsburg and Len Nichols.

The Urban Institute is a nonprofit, nonpartisan policy research and educational organization that examines the social, economic, and governance problems facing the nation. The views expressed are those of the authors and should not be attributed to any campaign, the Urban Institute, its trustees, or its funders.