

Health Policy Brief

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Public Health Insurance Plan: Should some uninsured Americans be able to enroll in a newly created, publicly administered health plan as the nation works to expand health insurance coverage?

What's the issue?

A key issue in the health reform debate is how best to provide affordable, high-quality health insurance for an estimated 36 million uninsured U.S. citizens. Reform legislation in the U.S. House of Representatives and Senate proposes to accomplish that through several means, including expansion of Medicaid, the federal-state program for poor and low-income people; opportunities to buy private health insurance coverage through new insurance exchanges; and the alternative option of enrolling in a new public health insurance plan or plans that would also be offered through the insurance exchange.

On November 7, 2009, the House adopted its version of health reform, the Affordable Health Care for America Act (HR 3962). An analysis by the Congressional Budget Office (CBO) suggests that 6 million Americans would ultimately meet the specific eligibility requirements laid out in the bill and would choose to enroll in the public plan. The Senate is still finalizing details of its proposal, but the sponsors say a key difference from the House bill is that the Senate version would

include a provision to allow states to “opt out” of offering a public plan.

In general, supporters believe that a public plan could bring new competition, choice, and accountability to the provision of health insurance. Administrative expenses could be lower than for private insurers, and there would be no need to generate returns for shareholders; as a result, dollars spent on health coverage would stretch further. The House version of the public plan would negotiate payment rates with doctors, hospitals, and other providers, and supporters hope those rates could be lower than those paid by private insurers. The public plan would also be required to develop innovative payment mechanisms that could ultimately hold down the rate of increase in health costs.

Role of government: Opponents of a public plan argue that it would present unfair competition to private health insurers. Some provider organizations worry that by driving down prices, a public plan would reduce their ability to provide high-quality care. Employer and insurer organizations add that in order to maintain their revenues, health care providers might “cost-shift” by raising

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charges to employer-based plans. A public plan is also opposed by those who are concerned that it could unduly expand the role of government in health insurance and health care. Finally, there are also growing questions, on the part of both supporters and opponents alike, about how viable or effective the latest redesigned version of the public plan is likely to be.

What’s the background?

The idea of a public health insurance plan is not new; in fact, the United States has several publicly financed health care or health insurance programs. In combination, they pay for 46 percent of all health care delivered in this country. These include Medicare, a federal government program, as well as Medicaid and the Children’s Health Insurance Program (CHIP), which are funded by both the federal and state governments. In all of these programs, government serves as the conduit, collecting taxpayer funds and funneling them to mainly private-sector health care providers. The government doesn’t actually deliver the health care through government-owned and -operated health systems, as is the case in the United Kingdom — or, for example, through the U.S. Department of Veterans Affairs (VA), which operates hospitals and clinics and employs doctors, pharmacists, and other health care providers.

All versions of key health reform legislation would expand the government’s role in financing health care, by expanding coverage for Medicaid and by creating new “affordability credits” to help low- and moderate-income individuals purchase health insurance. These are separate issues that have been taken up in earlier Health Policy Briefs (see [“Health Policy Brief: Key Issues in Health Reform,”](#) August 20, 2009). The idea of a public plan is a separate issue altogether, which foresees a new government role in organizing health insurance and, indirectly, affecting the provision of health care. This Health Policy Brief updates an earlier brief on the public plan concept published in June 2009, before any health reform legislation had been adopted by either branch of Congress.

History: The public plan option first gained attention in the run-up to the 2008 presidential election campaigns. To help expand coverage, then-Sen. Barack Obama and several other Democratic candidates proposed that a public insurance plan be added to the mix of insurance products

that people could select through a new national health insurance “exchange,” or purchasing pool. This government-administered plan would be run like any other insurance company, collecting premiums and paying out claims, but on a nonprofit basis. Jacob Hacker, a Yale University political science professor, is credited with developing the first version of this idea. As president, Obama has sent somewhat mixed signals on public-option proposals, endorsing and arguing for the concept, but also saying it was just one “means to an end” of expanding access to affordable health coverage.

House bills: In July 2009, three House committees approved health reform bills that included a public plan, although with somewhat different provisions. In October, House Speaker Nancy Pelosi unveiled a revised House bill that responded to criticisms of the public plan voiced by moderate and conservative Democrats. On November 7, this bill passed the House on a vote of 220–215, with only one Republican joining 219 Democrats in favor of passage, and 176 Republicans and 39 Democrats opposed.

Critical to passing this version of the public plan was an agreement among its sponsors that instead of paying the same rates to doctors, hospitals, and other providers that Medicare pays — rates that are frequently lower than what private insurers pay — the public plan administrators would have to negotiate those fees with providers. As this brief is published, the only restrictions on payments under the just-passed House bill are that payments must be no lower than Medicare rates and no higher than average private insurance rates. Implications of this provision are discussed below.

Senate bills: In the Senate, the Health, Education, Labor, and Pensions (HELP) Committee approved legislation in July 2009 containing a public plan option. In October 2009, the Senate Finance Committee approved a health care reform bill without one. Since then, Sen. Majority Leader Harry Reid has said a public plan option will be included in a newly crafted Senate bill that the Democratic majority will ultimately take to the floor of the Senate. It is expected that the new Senate bill will be unveiled sometime in November.

What’s proposed?

The House health reform legislation, HR 3962, would require the secretary of health and hu-

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man services (HHS) to establish a new health insurance plan run by the federal government. The new public plan would begin operations in 2013. The government would provide \$2 billion in federal funds for two purposes: to cover start-up costs for the plan, and to provide the plan with the resources to pay claims for the first 90 days of operation. This sum would be repaid over ten years. (Notably, under the legislation, the public plan would apparently not be provided with any surplus capital to protect itself against unexpectedly high payouts on claims, particularly in its first year of operation.)

With the exception of this \$2 billion, all other operations of the proposed public plan would be financed by premiums paid by beneficiaries. The federal government would be explicitly barred from providing any additional funding for the public plan should it run short of resources to fund operations or pay claims.

Eligibility and subsidies: The opportunity to enroll in the public plan would be available only for individuals eligible to buy health insurance through the proposed national health insurance exchange. This exchange would be a kind of one-stop marketplace that would allow uninsured people to easily comparison shop among somewhat standardized insurance policies. Some individuals and families who purchase coverage through the exchange could qualify for assistance to help pay for the insurance. Subsidies, in the form of “affordability credits,” would be available on a sliding scale, based on income and the price of the insurance, up to a family income of 400 percent of the federal poverty level (in 2009, \$43,420 for an individual and \$88,200 for a family of four).

In general, only individuals *not already covered* by a so-called qualified health plan that met federal standards could enroll in any plan sold through the exchange, including the public option. This is because, in principle, the public plan is mainly designed as a vehicle to help many of the uninsured gain coverage. However, there are a number of exceptions to this general rule that would allow others who currently have some form of coverage to switch to coverage from the public plan as well. Some of these exceptions include the following:

- **Veterans and active-duty military:** Veterans eligible for care through the Veterans Health Administration (VHA) could also enroll in a plan sold on the exchange, including the public plan. They would not be eligible for subsidies. Their non-VHA-eligible

spouses and dependents could also enroll in the public plan or any other exchange plan and could receive subsidies. Active-duty military personnel, spouses, and dependents in TRICARE could also enroll in any exchange plan but would not be eligible for subsidies.

- **Small businesses:** Many of these could also offer coverage to workers through the exchange, including a public plan. The workers could not get subsidies; instead, the business would have to contribute at least 72.5 percent of the costs of coverage for each worker, and at least 65 percent toward family coverage. In the first year, only small businesses with 25 or fewer employees would be allowed into the exchange; in the second year, firms with 50 or fewer workers; and, in the third year, firms with 100 or fewer workers.

- **Workers with employment-based coverage:** If premiums for their employer-sponsored coverage cost more than 12 percent of their income, workers could participate in the exchange and enroll in the public plan. Larger employers could also apply for permission from the exchange’s new federal supervisor, the Health Choices commissioner, to offer coverage through the exchange and enable workers to buy the public plan. The House bill would give the commissioner broad discretion to allow this — for example, if premiums for health insurance outside the exchange were growing faster than premiums for plans in the exchange.

Provider payments: Under the House bill, the public plan would negotiate its payment rates directly with providers, much as traditional private insurers do. (Some earlier versions of the House bill had the public plan paying either Medicare rates or Medicare rates plus an additional 5 percent, but those provisions were removed from the final version.) What’s more, under the revised bill, the public plan’s negotiated provider payments would have to be no lower than Medicare rates and no higher than average private insurance rates. Any provider participating in Medicare would be eligible to participate in the public plan but would also be free to decline.

Operations: The public plan would have to follow all laws and regulations that applied to private insurers. Under new federal law and rules, all policies sold in the exchange would have standardized benefits but could vary based on the level of cost sharing (deductibles and copayments). The public plan would also be subject to all other new laws and regulations set forth in the health reform legislation. (For a discussion of these, see

“The HHS secretary would be required to use the public plan as a platform for designing and implementing programs to achieve certain objectives . . . to improve the value of care and slow the rate of increase in health spending.”

[“Health Policy Brief: Health Insurance Reforms,”](#) October 21, 2009.)

Premiums for the public plan would be adjusted geographically, which means they would be likely to vary around the country. There would also be a new system of “risk adjustment” among all plans offered through the exchange, which means some plans with healthier, less expensive members would pay assessments that would in effect be transferred to plans with a sicker-than-average membership. In this way, insurers would not lose money simply because of what is called “adverse selection,” when some plans enroll more sick people than others do. This would mean that private insurers would in effect transfer funds to the public plan if the latter attracted more sick members, as many analysts think is possible. Conversely, if a private insurer attracted more sick enrollees than the public plan, the public plan would pay an assessment to the private insurer.

The HHS secretary would be required to use the public plan as a platform for designing and implementing programs to achieve certain objectives. These would include improving health outcomes, reducing health disparities (including any along racial or ethnic lines), providing efficient and affordable care, and preventing or managing chronic illness. The goal would be to improve the value of care obtained for the dollars invested and, ideally, to slow the rate of increase in health spending.

On November 6, 2009, the CBO released its analysis of the costs of the House bill’s proposed public plan, while noting that there were considerable uncertainties around its estimates. The CBO explained that from the public plan’s starting date of 2013 through 2019, it would collect a total of \$298 billion in premiums, exchange subsidies, and risk-adjustment payouts. Over the same period, the plan would incur a total of \$291 billion in benefit payouts and administrative costs. After paying back the startup funds of \$2 billion, the CBO analysis shows that the public plan would actually return \$5 billion to the federal budget through 2019.

Forthcoming Senate bill: Senate Majority Leader Harry Reid, a Nevada Democrat, has said that the Senate version of health reform legislation would also create a government-run insurance option. However, under his proposal, states would have until 2014 to choose not to participate. Other

details have not been released, although many are expected to be similar to the House bill. Further details of the Senate’s public plan option will be described in a forthcoming policy brief.

Other senators have proposed different approaches that may be offered as amendments to an eventual Senate bill. Sen. Olympia Snowe, a Maine Republican, has proposed a so-called trigger option. Under this option, a nonprofit government corporation would be created, through which a “safety net” plan might be offered to some states. However, this plan would be offered only in states in which “affordable coverage” was not available through an exchange to at least 95 percent of that state’s residents. An individual would be deemed to have “affordable” access if two or more plans were available at an annual premium cost, net of affordability credits, that did not exceed a specified percentage of that individual’s adjusted gross income (ranging from 3 percent for individuals just above the federal poverty level to 13 percent for moderate-income individuals).

What’s the argument?

In favor of a public insurance plan: Groups supporting the House bill and the public plan option include the AFL-CIO and other labor organizations, the American Academy of Family Physicians, and the American Nurses Association. These and other supporters have argued that a properly designed public plan would not only set a standard for best practices but would also apply pressure to competitors to control costs. Advocates believe that the public plan would reinforce the effects of the legislation’s market reforms, such as banning coverage denials due to pre-existing medical conditions, and would serve as a check on insurers to help keep them honest.

They also believe that a public insurance plan or plans would offer more affordable coverage for a series of reasons, as follows:

- The public plan would spend less on marketing and advertising than private insurance companies do.
- The public plan would pay its chief administrators far less than salaries and bonuses paid to senior managers and executives at top commercial insurance companies.
- Unlike private insurance companies whose shares are publicly traded on stock exchanges, the public plan would not have to pay profits to shareholders that could otherwise be spent on health care.

“How much leverage would the public plan have to squeeze providers’ fees, and how would providers respond as a result?”

- The public plan would be a platform for innovation, allowing the only avenue for the HHS secretary to try new payment methods or new organizational models of health care outside of the Medicare program.
- The public plan would negotiate more rigorously than private insurers to limit payments to health care providers.
- The public plan would take advantage of standard “utilization management” tools to help manage health costs. These utilization tools wouldn’t cost much to administer but could well succeed in driving down costs and lowering premiums. That would help attract more members and bolster the public plan’s bargaining power in negotiating with health care providers.
- The public plan would not have to pay any state taxes on the premiums it receives, while its competitors would.

Against a public insurance plan: Groups opposing the House bill’s public plan provision include the large health insurers’ trade association, America’s Health Insurance Plans, as well as business groups including the Business Roundtable, the Chamber of Commerce, and the National Business Group on Health. Their top concerns include the following:

- The public plan would expand the government’s role in financing health insurance. Even though both the House and Senate health bills prohibit the government from bailing out a public plan that became insolvent, it’s probable, opponents say, that the government would simply take on an open-ended financial commitment if the public plan ran into financial difficulty. This would be because the congressional sponsors who fought hard to create the public plan would be loath to let it fail, the argument goes.
- The public plan’s financial stability would be questionable. Under some scenarios, the public plan could attract more sick people than the private health plans do. In theory, risk-adjustment mechanisms could address that, and could funnel assessments from plans with healthier members back to the public plan. But that assumes that risk adjustment would work well enough to even out the health risk burden. The CBO, in fact, has concluded that risk adjustment would only partially offset the effects of adverse selection. Thus, the public plan would, over time, have to charge higher premiums to cover a greater outlay in claims, and therefore lose any price advantage it had relative to private insurance.

Additional questions: Aside from the views of supporters and opponents, there are also a number of unanswered questions about a public plan that could affect its operations and enrollment.

These include just how much lower a public plan’s administrative costs would be compared to those of private health plans; what effect a public plan’s administrative cost structure would have on its premiums; and how much impact a public plan would have on health insurance premiums and health costs generally.

Administrative costs: The question of the public plan’s administrative costs is particularly thorny. If the public plan genuinely had low administrative expenses, the CBO contends, that could actually put it at some disadvantage relative to private insurers in controlling health spending. Although the public plan would attract a less healthy pool of enrollees, it would have fewer resources with which to manage its members’ use of health care services. This diminished control over costs would necessitate higher premiums in the public plan. With all or nearly all of its price advantage gone — and with its premiums likely to be even higher than those available through private insurers — only about 6 million people would enroll in the public plan, the CBO concludes.

On the other hand, it’s also possible that the public plan’s administrative expenses would be higher than some proponents claim. As noted, the House bill would require the public plan to “prevent or manage chronic illness” and promote “care that is integrated, patient-centered, quality, and efficient.” That suggests to some analysts that the public plan’s administrative costs would be higher than Medicare’s 1.4 percent and closer to 8 percent — the share of administrative costs typically incurred by one existing nonprofit, member-governed health plan, Health Partners, based in Minneapolis, MN. These higher administrative costs would then have to be reflected in higher premiums.

Impact on health spending: There are also questions about how much of an impact the public plan would have on health spending. This comes down in large part to a question of how much real leverage the public plan would have to squeeze providers’ fees, and how providers would respond as a result.

Insurance executives say that enrollees’ underlying medical costs are far and away the main force driving up premiums. Competition among insurers through the exchange would not change this dynamic. In states such as California, where there is ample competition among health insur-

ers, some groups of providers still have significant market clout and have resisted insurers' efforts to restrain payment. It is still questionable whether or not adding a public plan to the mix would change this situation in any given market. In fact, the CBO analysis predicts that the public plan would, on average, pay providers about the same as private insurers and therefore have to charge higher premiums than many public plan proponents expected.

Cost shifting: At the same time, health care providers continue to voice concerns that a public plan would pay them less to provide care. Even though the House bill specifies that a public plan could not pay less than Medicare, the American Hospital Association worries that the public plan would ultimately end up paying Medicare rates. Hospitals would then try to charge private insurers more to make up for the shortfall — a phenomenon known as “cost shifting.” So while the public plan would pay lower rates to providers, private insurers would be forced to pay providers more and would have to raise their own premiums as a result.

Central to this debate is the question of how real is the phenomenon of “cost shifting.” An analysis by the Medicare Payment Advisory Commission (MedPAC), an independent group advising Congress, shows that “low” payment rates from Medicare don't always compel hospitals to try to shift costs to other payers. After all, hospital costs

aren't set in stone; if payers want to pay providers less, hospitals can frequently act to cut their costs. And, in fact, MedPAC found that in some efficient hospitals, Medicare payment rates, although low, not only cover these hospitals' costs, but are high enough that the hospitals can still run profitably.

What's next?

The public plan option is likely to continue as a flashpoint for controversy. Despite passage of the House bill, the fate of the Senate bill is uncertain. Any bill that emerges from the office of Senate Majority Leader Harry Reid can, and most likely will, be subjected to a number of amendments both before it comes to the floor of the Senate and as it is being debated. It is not clear what any of this portends for a public plan.

If a Senate bill is ultimately enacted, it and the House-passed bill would then go to a House-Senate conference committee. The conferees — most likely the chairs of key Senate and House committees, as well as the Speaker of the House and the Senate Majority Leader — would reconcile the differences between the bills and prepare a so-called conference report, or merged bill. Both bodies would then vote on the report; if it passed, a bill would go to the president for his signature.

At almost any point leading up to adoption of the conference report, the details of the public option discussed in this brief could change.

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Resources

Affordable Health Care for America Act, House Resolution 3962, U.S. House of Representatives, full text at http://docs.house.gov/rules/health/111_ahcaa.pdf, summary at http://energycommerce.house.gov/Press/111/health_care/hr3962_Section_by_Section.pdf

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