

## The Public Plan: A New Type of Competitor

### SUMMARY

One of the most contentious issues in the health reform debate is whether or not the proposed health insurance exchange should feature a “public insurance plan” – a new coverage option operated in the public interest that competes with private insurance options. Consumers Union believes a public plan option is critical for reducing premiums and overall costs, and improving the quality of services for all Americans, including those who enroll in other types of insurance plans. We support this reform as one part of a comprehensive package of healthcare reforms. (Please see *Health Care – Our Prescription for Change* for a discussion of the overarching set of reforms.)

### What is the Public Insurance Plan Option?

A public plan would be another health insurance option – a new choice in the market – for consumers who are seeking stable, affordable coverage. The federal government would sponsor the plan, and, like private health plans today, the plan would enroll policyholders, set and collect premiums, and pay doctors and hospitals for medical care.

The public plan would exist alongside private insurance options in the proposed health insurance exchange.<sup>1</sup> It would compete with private insurers by offering quality, comprehensive coverage at affordable premiums for consumers who choose it.

### Why Do We Need A Public Plan?

The most significant way that the public plan option would differ from private health insurance plans is that it would be set up to serve the public interest, similar to public utilities like municipal water commissions.<sup>2</sup> This means:

- The public plan would be founded with a public mission and be accountable to the public.

- The plan would be set up as a non-profit, and it would not build profits or high executive salaries into its premiums.
- The plan would be tasked with holding down premiums and administrative costs. This means working with providers to develop innovative measures that improve the quality of care and eliminate waste.
- The plan would conduct its operations in an open and transparent fashion. For example, the methodology for determining premiums and annual premium increases would be publicly available, regulatory filings would be made on a timely and accurate basis.
- The plan would be tasked with maintaining the highest standard of patient and provider satisfaction, by being responsive to its policyholders and minimizing the hassles of insurance reimbursement.

In playing these roles, the public plan would serve as a “benchmark” plan that consumers and regulators can use to evaluate other insurance options in the market. Competition from this new type of competitor (the public plan), would spur private health plans to do better. The end result is an improved health care system where everybody wins: a uniquely American solution bringing our rapidly rising healthcare costs under control and expanding healthcare access to those who need it.

## The Public Plan is a Necessary Component of Health Reform

Fixing our broken system will require a comprehensive set of reforms.<sup>3</sup> Among other things, these reforms would require insurers to accept all applicants (so you can't be denied), set minimum coverage standards (so you don't find yourself with inadequate coverage), and limit variation in premium prices (so the sick aren't priced out of the system). Subsidies would be available to help lower income families afford coverage and people would be required to purchase coverage if a high quality, affordable option was available to them.

All these changes must be part of healthcare reform but they are not enough. We cannot introduce rules to govern every instance of insurer behavior, nor can we fully anticipate how commercial insurers will respond to new rules.<sup>4</sup> Congressional testimony from a former insurance industry official illustrated this point:

[M]embers of Congress and the public have good reason to question the honesty and trustworthiness of the insurance industry. Insurers make promises they have no intention of keeping, they flout regulations designed to protect consumers, and they make it nearly impossible to understand -- or even to obtain -- information we need.<sup>5</sup>

Adding *a new type of health insurance competitor* is key to reducing health care cost growth and improving the quality of health plans. But not just any new competitor will bring about this result – it must be a competitor charged with serving the public interest.

## Health Insurance Markets Lack Competition

Current healthcare market conditions provide insufficient incentives for insurance companies and providers (doctors, hospitals, outpatient centers, nursing homes, etc.) to deliver affordable, comprehensive healthcare, hold down costs, and respond to the concerns of patients. As a result, Americans have extremely expensive healthcare with uneven quality.

One reason for our expensive system is we do not have well-functioning, competitive health insurance markets. Many of our local markets are dominated by one or two large insurers who can raise premiums with impunity.<sup>6</sup> In at least 21 states, one insurance carrier controls more than half the market. In 39 states, two carriers control over half the market.

Studies have shown that in the face of rising medical costs, health insurers have passed these increases onto consumers through higher premiums instead of working to hold back cost escalation.<sup>7</sup> Employers and consumers are stuck with these high prices because they have few meaningful options to turn to for affordable quality coverage.<sup>8</sup>

Adding another health insurance competitor to this mix is key to restraining the growth of premiums and providing a new choice in these concentrated markets. But not just any new competitor will bring about this result – it must be a competitor operating with the right incentives.

The new competitor must have sufficient market clout to compete against sophisticated, deeply entrenched private insurers and strong hospital interests. The competitor must be specifically tasked with containing costs without lowering quality of services for its members. Finally, the competitor must operate in the public interest so that the cost savings benefit policyholders and are not funneled back to shareholders or into high executive salaries.

## The Public Plan Would Initiate Payment Innovations and Reduce Cost Growth

A public plan would help reduce the rapid growth in healthcare costs by implementing innovative new payment strategies that will reward providers for quality care, not for high volume.<sup>9</sup> Such strategies include “bundling” of payments, paying for episodes of illness, increasing rates for primary care doctors, and rewarding providers for quality outcomes and coordinated

preventive care. These are all innovations that have been discussed in the private and public insurance sectors but have seen little action to date.

The public plan should not be tasked with simply charging Medicare rates or even emulating private insurer rates.<sup>10</sup> Instead, the public plan must pay providers the “right” rates – rates that promote efficient, coordinated, quality care and that are high enough to attract physicians into the public plan network and limit any potential cost-shifting.<sup>11</sup>

The public plan would use its large-scale bargaining power to negotiate with providers to get as close to the “correct” price as possible. Sufficient market clout is important. In many areas around the country, hospitals (and some large physician groups) have considerable negotiating power. Cost containment success will require a strong negotiator at the other end. Sufficient market clout is also needed to ensure that the patient volume is high enough that providers see value in switching over to this new way of doing things.

## Private Insurers Can Not Lead Cost Containment Efforts

Private insurers have little incentive to take the lead in cost containment. For one, lack of a strong competitor makes it easy to simply pass cost increases through to policyholders. Moreover, developing new payment models is risky. A pilot of new payment systems, representing a small volume of patients would not be welcomed by providers. Private insurers are in the business of carefully controlling their business risk – not serving as the leading market innovator.

On the other hand, private insurers are quite willing to emulate innovations once they have been vetted in other settings. For example, Medicare’s DRG system for paying hospitals has been widely adopted by private insurers. Many insurers also peg their reimbursement for physicians to the rates paid by Medicare.

Perhaps the most compelling argument is that the private insurers have failed to strong, cost control measures on their own. Competition from a new type of insurer is needed.

## What the Public Plan is Not

Many oppose the public plan, particularly private health insurers. But most of their claims are designed to instill fear rather than put forth reasoned argument. Here are three that have been put forward.

## PUBLIC PLAN IS GOVERNMENT CONTROLLED HEALTH CARE

Some critics paint frightening scenarios of Washington bureaucrats overriding doctors' treatment recommendations and Americans waiting months to see a doctor. They contend that any expanded role for government in health care inevitably leads to poor customer service, limits on consumer choice, treatment delays, or poor quality of care by doctors who are paid too little. The critics don't mention that private insurers can cause these problems, and often do.

The public health insurance plan is a new *insurance* alternative. It is not a system like the one used in Britain where the government controls the doctors and hospitals and sets prices.

More importantly, enrollment in the public plan is voluntary. Participation by doctors and hospitals is voluntary. If the public plan provides poor customer service, treatment delays and the rest, it will not be able to attract enrollees.

## PUBLIC PLAN WILL DRIVE PRIVATE INSURERS OUT OF BUSINESS

Taking the opposite tack, some opponents of a public plan option have asserted that the public plan will be *too attractive* and put private plans out of business.

In fact, none of the proposed reforms before Congress would overturn the dominant role of private insurance and private providers in America's healthcare system. One widely-cited study modeled the impact of a comprehensive set of reforms. The study found that *if* public plan premiums were 20 percent less than the premiums of private insurers, many people would move from private coverage today into a new public plan option.<sup>12</sup> Even with this premium advantage, however, the study found that *the majority of Americans remained in private coverage.*<sup>13</sup>

As envisioned, the public plan and private plans will operate on a "level playing field" meaning they face the same regulations and must compete for customers.<sup>14</sup> A level playing field is essential if quality and cost innovations are to be diffused through out the system. Only if the public and private plans are able to emulate each others' innovations will our country realize the system-wide improvement we need. On this level playing field, it seems unlikely that the public plan could sustain a lower premium that would allow it to capture the entire market.

## PUBLIC PLAN WILL BURDEN TAXPAYERS

Critics have also charged that the public insurance plan will burden taxpayers. In reality, the public plan would have minimal public financing.<sup>15</sup> As envisioned, medical costs would be covered by premiums; just as private insurers' costs are covered by premiums—a condition known as being "actuarially sound."

The reform measures being debated do call for publicly-financed subsidies for those who could not otherwise afford coverage. But these proposed *subsidies are for both public and private insurance coverage options*.<sup>16</sup> The public plan would be no more or less publicly financed than the private insurance options, putting aside the startup costs.

This proposed system of public subsidies is a tremendous boon for private insurers. Taxpayers would be justified to ask what private insurers are giving up in return.

## In Conclusion

Faced with a public insurance plan option, private insurers are likely to increase administrative efficiency and negotiate with providers for better prices, made possible by less costly, more effective delivery of medical care. Quite simply, the public plan, paired with the other reforms envisioned for American, will provide the best *market-based* solution to the problem of rising premiums and lack of insurer competition.

---

*This Policy Brief was written by Lynn Quincy and Sondra Roberto.*

---

## ConsumersUnion®

NONPROFIT PUBLISHER OF CONSUMER REPORTS

Consumers Union has a long history of advocating for improvements in the consumer marketplace. Since our creation in 1936, we have worked for safer, more affordable, and better quality products and services at both the state and federal levels. We are a non-profit, non-partisan organization with an overarching mission to test, inform and protect.

[WWW.CONSUMERSUNION.ORG](http://WWW.CONSUMERSUNION.ORG)

### HEADQUARTERS

101 Truman Avenue, Yonkers, NY 10703  
Phone: (914) 378-2000 Fax: (914) 378-2928

### WASHINGTON DC OFFICE

1101 17th Street NW, Suite 500, Washington, DC 20036  
Phone: (202) 462-6262 Fax: (202) 265-9548

### SOUTHWEST OFFICE

506 West 14th St., Suite A, Austin, Texas 78701  
Phone: (512) 477-4431 Fax: (512) 477-8934

### WEST COAST OFFICE

1535 Mission Street, San Francisco, CA 94103  
Phone: (415) 431-6747 Fax: (415) 431-0906

## ENDNOTES

- <sup>1</sup> See our policy brief *Health Care – A Prescription for Change*, September 2009.
- <sup>2</sup> The argument for public utilities is that they often are “natural monopolies.” Given the amount of infrastructure needed to construct a municipal water system (for example), it isn’t a good use of our nation’s resources to have more than one company make that investment. Because the resulting company has no competitors, careful regulation is needed to ensure that the company operates in the public’s interest and not the top executives, owners or shareholders. Health insurance firms are not “natural monopolies” but they serve a meet a key public need: they essentially broker access to expensive health care. There is a growing consensus in this country that all citizens deserve access to health care that they can afford. Hence, the provision of health insurance and the provision of potable water have a key characteristic in common – they both provide a service essential for well-being and should in some sense, be regulated so they are serving the public interest.
- <sup>3</sup> Please see our policy brief *Health Care – A Prescription for Change* for more information on the full spectrum of possible reforms.
- <sup>4</sup> “How Cherry Picking Could Hurt Obama’s Health Care Plan,” *Forbes Magazine*, July 13, 2009 and GAO Testimony, “Control Over Fraud and Abuse Remains Elusive,” June 26, 1997.
- <sup>5</sup> Wendell Potter, Testimony Before the U.S. Senate Committee on Commerce, Science and Transportation, June 24, 2009.
- <sup>6</sup> American Medical Association, *Competition in Health Insurance: A Comprehensive Study of U.S. Markets: 2007 Update*.
- <sup>7</sup> James C Robinson. “Consolidation and the Transformation of Competition in Health Insurance,” *Health Affairs*, November /December 2004.
- <sup>8</sup> Deborah Chollet, Ph.D., Su Liu, Ph.D., and Gilbert Gimm, Ph.D. Concentration Of Health Insurance Markets: Implications For Insurance Prices And State Health Policy, unpublished study from Mathematica Policy Research.
- <sup>9</sup> In most cases, public insurers, such as Medicare and Medicaid, and private insurers pay providers in a “fee-for-service” manner – meaning they are paid separately for each consult, procedure, test, drug, or other service administered. In this system, providers have a financial incentive to increase the volume of services, whether patients need them or not. See
- <sup>10</sup> One of the proposals, the House’s Affordable Health Choices Act, would have the public plan use Medicare providers rates (plus an increment) temporarily while the plan developed new payment methodologies.
- <sup>11</sup> “Cost-shifting” refers to the phenomenon where certain insurers (or patients) pay less than the cost of providing a medical service, so doctors and hospitals charge other insurers and self-pay patients more to ensure that their costs are covered across all their entire mix of patients. Opponents of a public insurance plan option argue that the plan might pay too little, causing providers to raise their rates for private insurers, who ultimately would pass those increases on to their policyholders. But the public plan could avoid cost-shifting by paying appropriate levels and through payment structures that promote efficiency. Moreover, MedPAC’s detailed analysis of Medicare’s hospital payment found that Medicare’s payment rates cover the costs of the most efficient hospitals. Further, MedPAC found that when hospitals are under financial pressure (because they receive low rates from private payers), they find ways to deliver care more efficiently so that they make money at Medicare payment rates. In contrast, hospitals with the highest levels of private payments (and hence under less financial pressure to operate efficiently) do not typically make money on their Medicare patients.
- <sup>12</sup> The Lewin Group. *The Cost and Coverage Impacts of a Public Plan*, Testimony before the Ways and Means Committee, April 29, 2009.
- <sup>13</sup> Commission on a High Performance Health System. *The Path to a High Performance U.S. Health System: A 2020 Vision and the Policies to Pave the Way* (exhibit 28), The Commonwealth Fund, February 2009.
- <sup>14</sup> An important component of this “playing field” will be new “risk adjustment” mechanisms so that private insurers have less incentive to “cherry pick” only the healthiest applicants. If this mechanism were omitted, we should be prepared for the public plan to find itself with the least healthy applicants.

- <sup>15</sup> Initial start up monies may be provided by the federal government. For example, the plan might be “loaned” an initial reserve fund until premium collections allow the plan to build up sufficient reserves.
- <sup>16</sup> Subject to income requirements, the subsidies would be generally available for coverage that meets certain conditions. For example, these subsidies may be restricted to insurance purchased through the new health insurance exchanges and they may be restricted to coverage that meets certain standards for quality and comprehensiveness.