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Healthy Competition — The Why and How of "Public-Plan Choice"

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The debate over health care reform has increasingly centered on the issue of "public-plan choice" — whether Americans younger than 65 who lack employment-based coverage should have the choice of enrolling in a new public health insurance plan that competes with regulated private plans. The idea — largely ignored in 2008 when it was endorsed by then-presidential-candidate Barack Obama — has come to dominate an increasingly polarized national debate.

This polarization is unfortunate, because public-plan choice can be made to work in a way that is effective, enduring, and acceptable to key stakeholders. Far from radical or unprecedented, it is based on established programs and models both here and abroad. And given that public-plan choice embodies values embraced by conservatives and liberals alike, it should not be a partisan deal breaker. Certainly, the concept is popular with the American people, many of whom believe — correctly, in my view — that competition between the public and private sectors will ensure lower costs and better access to care.[1,2]

The aim of public-plan choice is healthy competition that will ensure Americans are better cared for and more secure. Such competition does not require an endless array of choices but rather a reasonable number of meaningfully different choices. Indeed, the key reason for public-plan choice is that public health insurance offers a set of valued features that private plans are generally unable or unwilling to provide: stability, wide pooling of risks, transparency, affordable premiums, broad provider access, and the capacity to collect and use patient information on a large scale to improve care. Public health insurance emphasizes the broad sharing of risk, ensuring coverage that is affordable and of high quality for the small portion of the population that accounts for most health care spending. On the other hand, private plans are generally more flexible and more capable of building integrated provider networks, and they have at times moved into new areas of care management in advance of the public sector.

In short, public and private plans have unique strengths, and both should have an important role in a reformed system. (In fact, an independent analysis of my proposal, Health Care for America, indicates that more Americans would have private insurance

after reform than before — through either their employer or a private plan obtained through a proposed national insurance pool.[3]) Public-plan choice simply means that all Americans, not just the elderly or the poor, have access to the distinctive strengths of both types of plans. Such healthy competition has long been the stated rationale for encouraging the inclusion of private plans alongside the public program in Medicare, a rationale that applies at least as strongly to nonelderly Americans as to those covered by Medicare.

Healthy competition is about accountability. If public and private plans are competing on fair and equal terms, allowing enrollees to choose between the two will place a crucial check on each. If the public plan becomes too rigid, more Americans will opt for private plans. If private plans engage in practices that obstruct access to needed care and undermine health security, then the public plan will offer a release valve. New rules for private insurance could go some way toward encouraging private plans to focus on providing value. But without a public plan as a benchmark, backup, and check on private plans, key problems in the insurance market will remain.

Perhaps the most pressing of these problems is skyrocketing costs. Public health insurance has much lower administrative expenses than private plans, it obtains larger volume discounts because of its broad reach, and it does not have to earn a profit, as many private plans do. Furthermore, experience with Medicare suggests that public insurance is better equipped to control spending over time while maintaining broad access to care.[4] Nearly all other advanced industrial democracies rely much more on public health insurance than the United States does, and all have lower health care costs per person, have seen their costs rise more slowly, and yet have maintained better overall health outcomes and much stronger health security for all their citizens.[4]

To be sure, there are reasonable concerns about how the bargaining power of a new public plan will be used — concerns reflected in current proposals for alternative models that would fulfill some of the goals of a Medicare-like public plan but would have limited ability to secure lower rates and might be run by state governments[5] or even private insurers under public contract. Yet a watered-down public plan would be a grave mistake. Instead, the public plan should include safeguards designed to ensure that providers are fairly represented, that initial rates are reasonable, and that bargaining for lower prices does not negatively affect patients' access to care or shift costs onto private insurers.

Rather than a weak alternative, a new public plan should be Medicare-like — national, governmental, and built on Medicare's basic infrastructure. But it should not *be* Medicare. It needs to have a broader set of benefits. It must have a separate risk pool. It should improve on the way in which Medicare pays providers, particularly physicians. And, most important, it must compete on a level playing field with private insurance plans. This means, above all, that its administration should be separate from the agency that runs the new health insurance pool that contracts with and regulates private insurers. The referee should not have a player in the game.

Creating a level playing field requires attention to the three R's of workable public–private competition: rules that are the same for all plans, risk adjustment, and regional pricing. First, the new public health insurance plan and private plans should have to abide by the same fundamental rules. Within the insurance pool, any public subsidies for coverage should be available at the same level to any plan. Similarly, private plans must have adequate reserves, and the public plan should be prevented from independently dipping into general revenues to pay for care. All plans must also accept everyone who wants to enroll, and they must be willing to clearly state their terms and open their books for basic review of their spending and revenues.

Risk adjustment is also vital. To the fullest extent possible, enrollees and plans should not be penalized when a plan attracts less-healthy enrollees.

Finally, all plans must be able to set their premiums regionally. After all, many private plans will want to provide benefits only in certain geographic areas, whereas the public plan must be available throughout the country. If premiums are not set regionally, the public plan will be disadvantaged in areas where private premiums are low and advantaged in areas where they are high.

We can create a level playing field. We can make public-plan choice work. What stands between our current predicament and this vital element of reform is a constructive dialogue about how a new public plan would be structured and operate. If we fail to let Americans without secure employer coverage have the choice of a public health insurance plan, it will not be because the goal de-

fies our capacity to achieve it, or because the value of a competing public plan to the cause of health security has not been made clear. It will be because fear has won out over hope, blinding us to the sensible middle ground that lies before us.

Dr. Hacker reports receiving advisory-board fees from Pfizer and speaking fees from America's Health Insurance Plans, both of which he reports donating to charity. No other potential conflict of interest relevant to this article was reported.

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Public Health Care and Health Insurance Reform — Varied Preferences, Varied Options

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Health care and health insurance reform will surely require a mixture of public and private efforts for different population groups in different settings. One feature that might help with the choices Americans make as consumers, voters, and taxpayers is a menu of insurance plans managed by both public and private organizations for all population groups. People will end up with insurance they like better and that works better for them if they can select a plan from a large variety of options. Such an arrangement caters to the variability of consumers' preferences about insurance: how they want their insurer to limit or expand their choices of services, what level of financial protection they want, and how they want to interact with their insurance plan. Even now, some consumers select aggressive health maintenance organizations, others prefer mild preferred-provider organizations, while still others like high-deductible plans.

One aspect of health care that will have to be variable is the magnitude of public subsidies for insurance: families near the poverty line will be eligible for large subsidies, whereas the bulk of the population with moderate-to-high incomes will receive modest subsidies, primarily intended to help those who represent high risks. At present, these two groups face quite different insurance options: poor people may enroll in Medicaid or the State Children's Health Insurance Program, whereas most of the nonelderly population gets its insurance through employers, subsidized by the tax exclusion of compensation paid in the form of insurance premiums. The availability of options varies according to the employer's size: large firms usually offer the choice of a number of for-profit and nonprofit private plans, but no publicly administered plan; small firms almost always have only one private plan available. What reform should envision is the expansion of offerings for all groups: many more private options for the heavily subsidized and moderately more private- and public-plan options for others. Such a framing of reform might also help in winning bipartisan approval for expanding insurance options for all.

What is the value of offering such choices? Why not have the government choose a single cost-containing plan that will ensure that all Americans can meet their health care needs affordably, and then declare victory against uninsurance and inflation of health care costs? One answer is that there is no plan that's been proven to achieve all these goals. Instead, there will need to be tradeoffs among access, financial protection, and cost containment — and different Americans are willing to make different tradeoffs. Particularly among the modestly subsidized, who pay mostly with their own money (even if it is disguised as their employers'