

# IN BRIEF: A MODEST PROPOSAL FOR A COMPETING PUBLIC HEALTH PLAN

The individual and small group health insurance markets do not work well today for many participants and potential participants alike. The cost of health care and the rate of health care cost growth make it difficult for many people to afford health insurance or essential care. Likewise, an increasing number of large employers are worried about cost trajectories.

Many comprehensive reform proposals reflect the fundamental need to control health care costs and create a marketplace wherein insurers compete on value and customer satisfaction, rather than risk selection and marketing. Several leading proposals promote competition between private health plans and a “public” health insurance option. Unfortunately, the debate over this issue has become polarized unnecessarily.

## Proof-of-Concept

More than 30 state governments offer their employees a choice between traditional private health insurance products and a plan self-insured by the state.

This experience combined with historic competition between public and private plans in both the Medicare program and California Public Employees Retirement System (CALPERS) serves as proof-of-concept: plans operating with politically appointed managers can compete with plans run by private managers if the rules of engagement are structured properly.

We believe a public plan can compete fairly with private plans if:

- the rules of the insurance marketplace (or exchange) apply to all plans, and
- the governance structure is designed to isolate the public plan from unfair advantages and perverse incentives

## Policy Spotlight: State Employee Health Plans

More than 30 state governments offer their employees a choice between traditional private health insurance products and a plan self-insured by the state. In the case of the self-insured product, the state or a third party administrator (TPA) negotiates provider contracts and performs administrative functions. While the state may pay a TPA (usually the resident “Blue” plan) to handle some tasks, the plan is publicly owned and financed. If claims outpace premiums in a given year, the state pays and is at risk for the difference. Likewise, if the TPA collects more premiums than it pays out in claims, the surplus dollars are usually allocated to a premium stabilization fund or remain with the state’s general revenues. The TPA never profits more than agreed upon in the administrative fee.

*This issue brief is a short summary of a paper by Len M. Nichols and John M. Bertko entitled: “A Modest Proposal for A Competing Public Health Plan,” New America Foundation, March 2009.*

## Conditions for Fair Competition

**The administrators of the public plan must be accountable to an entity other than the one identified to govern the marketplace.** In other words, the authority overseeing the marketplace (exchange) and enforcing its rules should not have an incentive to favor the public plan over private plans.

**The public plan cannot be Medicare.** Creating a marketplace where private insurance plans could compete fairly with Medicare for the under-65 population would be difficult and complex for a number of reasons. Therefore, we believe the public plan option cannot be Medicare.

**The new public plan must be actuarially sound.** This means it must charge premiums that cover its costs. The public plan may not be subsidized using additional government revenues.

**The public plan cannot leverage Medicare (or any other public program) to force providers to participate.** For example, the public plan cannot require providers to serve public plan patients as a condition of participating in the Medicare program.

**The public plan should not be required to use Medicare payment rates.** Instead it must offer rates that elicit voluntary participation, which means providers should have the same freedom to negotiate with the public plan as they do with other private carriers.

**The insurance market rules and regulations governing the public plan must be the same as those governing private plans.** These rules and regulations include: guaranteed issue, guaranteed renewal, modified community rating, flexibility to charge different rates on geography, risk adjustment, no pre-existing condition exclusions, marketing rules, open enrollment periods, limits or reporting requirements based on premiums to claims ratios, minimum benefit package.

**The public plan cannot be granted an unfair advantage in enrolling the uninsured or low-income individuals who will presumably be eligible for subsidies in the new marketplace.** This means individuals should be able to apply subsidies to the public or private plan of their choice.

**Public and private insurers should be required to adhere to the same rules regarding reserve funds.** All insurers operating in the exchange should be required to have reserve funds equaling their incurred but not reported (IBNR) claims. In lieu of solvency requirements (because a state or government cannot be insolvent), the public plan must also establish a Premium Stabilization Fund. This model is currently used by the Federal Employees Health Benefit Program (FEHBP).

**The public plan would also need to contribute to value-based initiatives that benefit all payers.** For example, if an assessment for funding comparative effectiveness research is levied, private plans and the new public plan must be required to contribute proportionately.

## A Note on Cost Containment

This model requires that we address cost growth containment systemically and avoid relying heavily on the public plan's potential market power. In turn, this will require a commitment on the part of policy makers to help build a health information infrastructure, develop and disseminate best practice information, and encourage re-aligned incentives that promote high-quality, efficient care for all.

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