



Competitive Health Care

A Public Health Insurance Plan that Delivers Market Discipline

By Peter Harbage and Karen Davenport | March 2009

Introduction and summary

Doctors and patients, employees and employers, the insured and the uninsured, and hospitals and taxpayers are all stakeholders in the health care reform debate now beginning in Washington. They may disagree on any number of reform measures, but they all agree on one basic fact—the U.S. health insurance market is broken. Lack of competition in this critical marketplace means poor transparency and accountability, resulting in costly health care that harms our national health, bleeds our personal finances and the federal budget, and hinders our economic competitiveness. None of this is acceptable amid the worst slide in economic growth in 60 years.

Fortunately, our nation's health insurance market can be fixed with a big dose of what fixes most sectors of our economy—healthy, well-supervised competition. One of the best ways to introduce this much-needed competition is for the federal government to offer a public health insurance plan that can compete with private insurers within an insurance “exchange” that ensures public and private health insurance plans compete equally and transparently in the public marketplace.

There's no question a public plan within a public exchange is necessary. A recent American Medical Association survey found that a single private health insurance company controlled more than half the market for insurance in 16 states and a third of the market in 38 states. Within our broken market, insurance companies “compete” by reducing their exposure to policyholders' pre-existing conditions, focusing on risk reduction instead of affordable, quality, patient-focused health care.

This is why it's time to introduce what we at the Center for American Progress Action Fund call Public Plan Choice, which combines a public health insurance plan and a health insurance exchange to deliver real competition and real choice to all Americans. Public Plan Choice can bring doctors and patients, employees and employers, the insured and

the uninsured, and hospitals and taxpayers together in support of a reformed, competitive health insurance marketplace through the creation of a health insurance exchange that includes a public health insurance plan. Public Plan Choice would create a functional health care marketplace to replace the current broken system by:

- **Increasing meaningful choice.** In the face of tremendous consolidation in the health insurance market, employers and individuals have a shrinking set of health insurance options. Private insurers have used this market power to boost their profits. By including a public health insurance plan as another insurance option and creating a health insurance exchange that delivers transparency and accountability to the market, we can assure both viable competitors and real competition.
- **Promoting effective competition.** Public Plan Choice will establish a new health care framework that makes sure insurers provide the best value at the best price rather than one focused on avoiding risk. Public Plan Choice can play a supportive role in effective risk management both as a “safety valve” to assure everyone gets access to needed care and as a champion of a transparent health insurance exchange. To ensure effective competition, all private and public health insurance plans would compete on a level financial and regulatory field.
- **Creating a publicly accountable innovation leader.** Public Plan Choice will create incentives for effective performance just as today’s Medicare program promotes quality care alongside cost containment. Witness steps such as Medicare’s refusal to pay medical care providers for “never events” where a patient suffers a knowable and catastrophic mistake such as having the wrong limb removed. This is something other major insurers are now adopting. Public Plan Choice has the potential to do even more to promote effective use of purchasing power to drive improvements in the health care system through improved accountability and transparency.

Some opponents of a public health insurance plan and a transparent insurance market exchange argue that better insurance regulation could do just as much to increase consumer protections and make transparent, affordable, comprehensive health insurance available. Yet the marketplace would still remain an oligopoly driven by risk segmentation. History teaches us that health insurers will simply act in their own self-interest, absent some regulatory or market-driven limitation.

A U.S. health care system without a public health insurance plan and exchange also would remain overly dependent on government enforcement to achieve the goals of health reform—goals such as wellness programs and rules to ensure coverage for all. Public Plan Choice means market competition would be the driving force for change. Without Public Plan Choice, there is every reason to believe that market consolidation will continue, and that insurers will continue to miss opportunities to have the same innovation.

In the pages that follow, we will demonstrate how the choice of a public health insurance plan and health insurance exchange will create new market-driven incentives for private insurance plans to innovate in ways regulatory enforcement will not. First we will present our Public Plan Choice program in detail, then demonstrate how it can generate genuine competition, and finally how it can ensure continual accountability and transparency in our health insurance markets. In the end, we believe all stakeholders involved in receiving or providing health care realize this new health insurance marketplace we envision is a goal well worth pursuing.

Public Plan Choice defined

Promoting choice among health insurance plans to reform a dysfunctional health insurance market is an idea that has been around for decades. The Heritage Foundation has long advocated health reform modeled on the choices in the Federal Employees Health Benefit Program, which provides health insurance to federal employees.¹ Stanford University public policy professor Alain Enthoven has been advocating a similar, though structured, health purchasing arrangement for almost as long through “managed competition.”²

The concept gained new life and bipartisan support in Massachusetts in 2006 when that state introduced health reform in an effort to cover all those under the age of 64 (when Medicare coverage kicks in). The Massachusetts plan relies on a so-called “connector” that connects consumers to a choice of health plans to help create a more rational marketplace for the purchase of health insurance.

Then, in the 2008 presidential contest, competing health reform plans among the Democratic candidates, beginning with former North Carolina Senator John Edwards, were thoroughly debated. These plans—building on work done by academics such as University of California professors Jacob Hacker and Helen Halpin (who worked separately) and at the Urban Institute³—proposed to add a public health plan option as a competitor in a new health insurance exchange. This idea has been part of President Barack Obama’s ideas to improve health care coverage in our country, revive our economy, rein in health care costs, and boost innovation.

Key to the Massachusetts reform and President Obama’s health reform proposal is the establishment of a connector (Massachusetts) or exchange (Obama’s campaign plan) that offers a range of health plans side-by-side and that meet standards about who they must serve, what services they must cover, and how much they can charge. Put simply, the rules will specify the benefits that insurers must offer and require insurers to accept everyone who applies at a similar premium, regardless of an applicant’s health status. The operational features of this public health insurance plan and exchange would include:

- A health insurance exchange that offers private insurance plans and a public health insurance plan—all of them competing on a level playing field.
- A public insurance plan operated by public employees separate from existing public and private plans.
- Comprehensive and affordable coverage, with guaranteed access to health insurance and other consumer protections offered by all plans in the exchange.
- A service delivery model that provides choice among insurance providers, better care coordination, and fair and efficient payment processes for patients and physicians alike.
- A health care system that promotes innovation rather than risk segmentation.
- An option for individuals to keep the coverage they have today if they so choose.

Public Plan Choice—the combination of the exchange and a public health insurance plan offering within it—offers an opportunity to create both competition and a new competitor in the health insurance marketplace, strengthening the exchange’s incentives for all health insurers to be more efficient and responsive to individuals. Through fair competition on a level playing field, the insurance marketplace is made more functional.

Public Plan Choice means competition

Today’s health insurance industry oligopoly is profoundly costly and inefficient for individuals, families, employers, employees, physicians, hospitals, and other health care providers. As the number of competitors shrinks in the marketplace, choice becomes limited, prices rise, and innovation is stifled, to the detriment of customers and vendors.⁴ Consider that:

- **Among companies that offer insurance, most offer no health plan choice.** Just 1 percent of companies that offer employee health insurance benefits give their employees a choice of three or more plan types (such as a PPO, HMO, or conventional plan), and only 14 percent offer two plan types. That leaves 85 percent of companies offering their employees just one health plan type.⁵
- **Most small companies are not able to offer insurance at all.** Faced with high administrative costs and small employee pools, most small businesses are much less likely to offer insurance than larger businesses. In 2008, just 49 percent of companies with three to nine employees offered insurance, compared to 90 percent of companies with 25 to 49 workers.⁶ The National Federation of Independent Business, a major small business association, notes that America’s small businesses are “especially vulnerable to the weaknesses of our current system.”⁷
- **Individuals cannot obtain insurance on their own.** Many Americans seeking coverage in the so-called individual market for themselves or their families almost never find the insurance coverage they need or can afford, leaving them mostly uninsured. A 2005 survey by the Commonwealth Fund found that of those seeking coverage in the individual

market, 89 percent never ended up purchasing health insurance.⁸

- **Insurance industry consolidation has led to higher costs.** A 2007 survey conducted by the American Medical Association found that in more than 95 percent of insurance markets, one commercial carrier controlled at least 30 percent of the market.⁹ A single commercial carrier controls more than half the market in 16 states, and a third of the market in 38 states.¹⁰ In these concentrated markets, insurer revenue has grown even faster than health inflation—a sign that insurers are using their market power to pass on health care costs to purchasers and protect profitability.¹¹

Public Plan Choice would inject new market competition into this dysfunctional health care system by offering choice where it does not exist today. A functional health care market would set the rules of play on an active exchange to ensure fair and vigorous competition, which in turn would lead the public health insurance plan and its private-sector competitors to develop efficiencies based on price and value. Through an exchange and the transparency it makes possible, Public Plan Choice will also offer individuals better information and greater support to identify the health plan that best fits their needs—whereas today, comparison shopping for health insurance is a near impossibility given the lack of transparency.

In addition, by fostering true competition in the market, Public Plan Choice offers a real choice to families and individuals: a public health insurance plan or a range of private insurance plans. If the public health insurance plan in Public Plan Choice cannot compete on the market as some conservatives believe, then no one will choose the plan—and it will wither.

A level playing field

Some conservatives argue that a public health insurance plan will put private plans at a disadvantage in competition because the government will be both “player and umpire.”¹² That’s simply not true. Today, state governments (all of which regulate insurance companies) operate public Medicaid programs, purchase insurance for thousands of public employees, and regulate insurers. In fact, many states successfully offer their employees and retirees private health insurance plans side-by-side with these states’ self-funded health insurance plans.

This has led health policy experts, such as Len Nichols of the New America Foundation, to conclude that by separating the management of a public plan from the regulators of all health plans—public and private—along with other steps to promote competition, the Public Plan Choice is feasible.¹³

Policymakers can—and must—take steps to help ensure fair competition. That means the

public health insurance plan in Public Plan Choice has no unfair advantage in the marketplace over private plans, and every insurer plays by the same rules. Under our Public Plan Choice proposal, the public health insurance plan would be subject to the same or stricter oversight rules and regulations as private plans, such as solvency standards and administrative rules. And Public Plan Choice would follow the current model in states where those who operate a plan are separate and different from those who regulate it. All of the individuals in public or private plans should have the same access to government subsidies for the purchase of insurance, thereby further reducing the possibility of skewing enrollment toward one plan or another.

Efficiency and service instead of risk segmentation

Public Plan Choice will help significantly reduce the risk selection that defines the current health insurance market. In the current marketplace, any private insurance company that takes on more risk than its competitors by enrolling individuals who on average incur greater health care expenses will be forced to raise its health insurance premiums. This in turn hurts the competitiveness of that insurer compared to its rivals. Market “discipline” in the current marketplace, then, dictates that the way to boost profits is to reduce risk.

With 20 percent of patients responsible for generating 80 percent of health care spending every year, insurers have powerful incentives to directly or indirectly exclude those with high risk or to charge them higher premiums.¹⁴ This leads insurers to deny coverage, limit benefits, or increase charges to those individuals with “pre-existing conditions.” On the individual market, it also leads to high administrative costs by incentivizing insurers to exclude persons with a history of even the most minor illness from coverage through their health insurance underwriting process, and to target their marketing campaigns at healthy groups of people over those more likely to need insurance coverage because of their medical condition.

Under Public Plan Choice, the health insurance market would spread risk more widely instead of trying to mitigate the cost of risk, sharing the risk burden more fairly. This would help strengthen the system as a whole and benefit all the stakeholders in our health care system. Anyone purchasing insurance (individuals or employers) would have greater choice at lower costs. Health care providers (doctors and hospitals) would reap the same benefits because the uncompensated cost to them of providing uninsured health care would be greatly reduced. And the health insurers themselves would compete on a level playing field in terms of risk, allowing them to compete where they should—on price, quality of care, and customer service.

Public Plan Choice achieves these precise changes by promoting a new—and more desirable—form of insurance competition. Consumers considering a set of health insurance plans with common benefits and common terms of access can make choices based

on true value for the dollar, selecting plans that deliver high quality care at the lowest cost and with the lowest premiums. The exchange will need to be able to offer coverage at different price points within a definition of affordable and comprehensive. Instead of focusing on risk, insurers would compete on customer service, ease of use, and other quality improvements.

Of course, Public Plan Choice cannot eliminate all incentives for risk selection. Less healthy individuals may gravitate on their own to a plan—including the public health insurance plan—if that plan offers significantly stronger benefits at a lower cost relative to the rest of the market. New health care rules governing the health insurance exchange must allow for higher payments based on risk adjustment so that plans attracting a disproportionate share of expensive members are compensated adequately.

To date, risk adjustment has been hard to design and hard to implement, both technically and politically, as we've seen in Medicare. That means any new rules will likely always fall short of fully protecting insurers that offer particularly good care to particularly expensive patients at the onset of the implementation of Public Plan Choice. Yet Public Plan Choice can create a safety valve for imperfect rules aimed at managing risk by its ability to take on high-risk patients who choose the option. At the same time, though, a public health insurance plan within a health insurance exchange cannot be allowed to become a “dumping ground” for high-cost patients.

Still, the very availability of Public Plan Choice will help spread risk among plans, just as existing public coverage efforts such as Medicare and Medicaid do today. Case in point: Medicaid takes responsibility for certain low-income patients with special needs that would not ever be offered affordable health insurance on the individual market—if they were offered insurance at all.

Public Plan Choice: A publicly accountable leader

Public Plan Choice is about appropriately aligning the right incentives in the marketplace by creating a publicly accountable leader as a competitor in that marketplace. Properly designed and managed, Public Plan Choice means greater innovation in promoting quality, reducing paperwork for health care providers and consumers, promoting wellness programs and disease prevention, and addressing disparities in health care coverage. Each of these benefits is worth a quick examination.

Promoting quality

Public programs such as the Veterans Health Administration¹⁵ and Medicare are leaders today in improving health system quality. The VHA, for example, now boasts an innovative system of electronic health records, an integrated system of coordinated

care delivery, and a series of measures to expand the use of preventive care and disease management techniques.¹⁶

Medicare's quality care initiatives have been less extensive because the more fragmented nature of Medicare's fee-for-service approach has been copied by private insurers. Medicare, for example, has instituted improvements in its provider-payments systems and is investing in measuring and reporting quality care indicators, two things that private insurers are now following the Medicare lead in doing.¹⁷

Public Plan Choice could be an example for those in private industry to follow for those not in the VA system or in Medicare. For instance, the public health care plan in tandem with the health insurance exchange would promote transparency in health care innovations as public and private insurers compete for customers. In contrast, to the extent private plans are innovating they are for the most part not sharing these innovations publicly. Nor are these innovations replicable and thus able to drive improvements in the health care system. Public Plan Choice would change those dynamics.

Reducing provider paperwork

In the current marketplace, paperwork often serves to delay or avoid the payment of insurance claims to doctors, hospitals, and patients. To fulfill insurance plan requirements, health care providers spend more and more time on paperwork and less and less time on providing care. All this paperwork also means patients sometimes may not get needed care or that they may pay too much for it because of administrative barriers created by insurers. Patients frequently have to haggle with insurers after their physicians are finished, further burdening the system.

Public Plan Choice would focus on delivering needed care, not avoiding it. Specifically, Public Plan Choice could reduce pre-authorization requirements, which today limit care. And it could eliminate unnecessary documentation requirements and other administrative barriers to payments destined for patients and health care providers, which are required now only as a hurdle to deny payment.

There is even reason to believe this approach may lower administrative costs without increasing unnecessary care utilization, as one study in the *New England Journal of Medicine* has shown with regard to opening access to specialist in health plans.¹⁸

Promoting prevention and disease management

Because people change jobs with increasing frequency—and therefore insurance companies—health plans do not always have the incentive to provide preventative and disease management services to patients. Such programs often require up-front costs and may

only show a long-term return on investment to a specific insurer. Yet for the system as a whole, wellness and preventative programs do provide significant benefits to patients, and may benefit the system as a whole over time.

Public Plan Choice takes the long view and will focus on improving public health. Specifically, it will embrace the philosophy that the system will benefit over the long run from prevention and will make that investment.

Addressing health care disparities

Even among people who have health insurance, minorities and low-income individuals are more likely to have chronic and other medical conditions and less likely to receive the care they need.¹⁹ For example, chronic illness is a challenge for minority populations. African Americans are more likely than any other ethnic group to die from cardiovascular disease and HIV/AIDS.²⁰ Native Americans and Hispanics are more likely to die from diabetes than other ethnic groups.²¹

The public health insurance plan can lead in providing culturally and linguistically appropriate care and services, thereby creating competition among insurers for communities who have insurance and are seeking such services.

Working collaboratively with health care providers

Opponents of a public health insurance plan often focus closely on the possibility of lower incomes for health care providers, whether doctors or hospitals. Indeed, there are anecdotal reports of providers exiting Medicare due to low payments²²—with low provider participation rates being a problem that has daunted state Medicaid programs for years.²³ This is a problem Public Plan Choice must face squarely. If payments by the public health insurance plan are significantly lower than the rest of the market, then that could translate into a smaller health care provider network—something enrollees may be unlikely to tolerate. Because enrollees could choose another plan, the public health insurance plan will not have the same leverage as Medicare enjoys today as the health plan for all those 65 and over.

To be competitive in the market, all plans offered on the health insurance exchange (private plans and the public health insurance plan) will need to pay providers fairly. At the same time, it is reasonable to assume that the public health insurance plan will be easier for providers to work with than existing private plans. If providers were sure that the public health insurance plan in Public Plan Choice would make timely adequate payments absent the paperwork gimmicks (such as pre-authorization) used by insurers

today, and without undue coercion to participate, then Public Plan Choice could be seen as a major benefit to health care providers.

Ensuring accountability to patients

Perhaps most broadly, creating a public health insurance plan and a health insurance exchange would promote accountability to patients. Today, insurers face two conflicting fiduciary responsibilities: one to their shareholders and another to their policyholders. The resulting tension is all too frequently resolved in favor of profit to the detriment of the patient and the ire of the public. The incentives are so broken that even nonprofit health plans typically behave no differently than for-profit plans.

To protect the public, states regulate insurers. But under state control, the rules vary widely. By redirecting the focus of competition, Public Plan Choice can promote even greater responsiveness to patients. Public Plan Choice is an opportunity to build transparency into insurance from the inside out.

All plans in the health insurance exchange will have to meet certain standards for data and patient privacy in maintaining accountability to both the public and policyholders. The new exchange also will make it possible to develop tools that allow for the comparison of plans on critical information points. The public health insurance plan can be charged with promoting the health of its members, meaning there will be different incentives to measure the success of the public health insurance plan than those often used in the private market, such as loss ratios over quality health outcomes.

This change in incentives could promote more rapid adoption of quality innovations such as chronic disease management to offer more coordinated care to those who need ongoing services or better patient engagement in decision making. As part of this, policymakers should consider a range of system delivery and payment options, such as a capitated managed care payment approach for the public health insurance plan or a primary care case management model to help promote better chronic care in a fee-for-service system.

Conclusion

The U.S. health insurance system today is dominated by a few private insurers in most states. These insurers wield oligopoly power with misaligned health care incentives that create barriers for patients to secure the care they need and yet also push health care costs higher and higher. Public Plan Choice is an opportunity for policymakers to create a new approach to health insurance that makes sense for patients, providers, and the system as a whole.

Regardless of their ideological perspective, all the stakeholders in the health reform debate

largely agree on the need for a functioning health insurance market with transparency and accountability. In contrast, “the one principle conservatives [in Congress] seem to agree on is a willingness to fight the Democrats’ push to create a public plan,” according to Politico.²⁴ The general public, however, is ready for change. Americans are very interested in health care reform, with one key survey finding that 73 percent of voters—and a majority of those from each political party—saying that people should have a choice of public and private insurance.²⁵

If the coming health care debate focuses only on the public health insurance plan itself, then stakeholders will immediately go to their ideological corners. And a debate solely focused on payment rates in the public health insurance plan will have the same polarizing effect as these same stakeholders get bogged down in fights over possible winners and losers of health reform. Instead, conservatives, moderates, progressives, and liberals all should be able to support the types of changes to our health care system that Public Plan Choice can offer: expanded choices for individuals and employers, a competitive marketplace through a new health insurance exchange, and a publicly accountable innovation leader.

Above all, while any person who likes the insurance they have today will be able to keep it, Public Plan Choice will give American families the power to choose the type of health care they want from a variety of private plans and a public plan—knowing that the rules of the health insurance exchange will deliver transparency and accountability to the new health insurance marketplace. We in turn can help our government reduce its health-related fiscal imbalances and help our economy compete more effectively.

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