ITUP Health Reform Newsletter

By Adam Dougherty, MPH

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The Spectrum of A Public Plan

The creation of a new public insurance plan option has proven to be one of the most contentious debates in current health reform efforts. The idea behind establishing a new public plan is that it would compete with private insurers in order to bring down costs through administrative savings and a focus on efficiency and quality; we often hear this as the "keeping insurers honest" strategy.

There are legitimate concerns as to how such a plan would operate and the consequences as a result of its creation in the market. Referring to the graphic below, the Medicare for All structure would operate as Medicare currently does by paying for services through a Fund collected by some combination of individual premiums and taxes. Though administratively simple, this structure may not be politically feasible with fears of an unfair advantage for the public plan and private market crowd out. A more realistic alternative is the Self-sufficient structure, where the public program would operate solely on the premiums collected plus tax credits; the private plans would have access to the same tax credits through the Exchange. Other issues are who can access the Exchange and what

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The ITUP Health Reform Newsletter Series will give our constituents a deeper look at the some of the major policy implications being considered over the coming months. The newsletter will analyze topics more comprehensively than the accompanying ITUP blog, and include useful resources for reference. It will also investigate the effects of potential legislation specifically towards California and its unique demographic and social landscape.

reimbursement rates are paid to the providers. The bill in the House (H.R. 3200) has a public plan option that allows the uninsured and very small employers to access the Exchange. Reimbursement rates are Medicare plus 5%.

The final two options put the brakes on federal government involvement, or at least delay its intervention. One possibility is the establishment of a trigger, where a public option would come into play if certain insurance market goals were not met along some timeline. These could include enrollment rates, premium reductions, administrative savings, and other market criteria. Another alternative that is receiving particular bipartisan attention is the formation of health cooperatives in order to compete with insurers and slow the growth of costs, and are being seriously considered in the Senate Finance Committee as a way to garner bipartisan support. Co-ops are structured as non-profit organizations that offer insurance plans and employ providers, and are entirely governed by the consumers within the system; Group Health Coop in Seattle, Washington is one example; Kaiser Permanente is another. (Timothy Jost, "Public Plan or Cooperative: Does it Make a Difference?", Washington and Lee University)

Health cooperatives emerged in the 1930s, though some did not last long due to insufficient size and physician opposition. Today, social insurance fund systems like the ones in Germany resemble successful member-driven cooperatives operating under strong national guidelines and leadership. Senator Kent Conrad (D-ND) has proposed a national network of regional cooperatives, but acknowledges that each would need upwards of 500,000 participants to work correctly. Such a system would need significant start-up funds and have proper risk-adjustment mechanisms in pooling. The proposal may be particularly viable for states such as California, where our Local Initiatives and County Operated Health Systems would act as building blocks to accelerate the effort at the regional level.

A recent NYT article highlighted the Washington-based Group Health Cooperative of Puget Sound, which has been seen as a possible prototype for a national model (Kevin Sack, *Health Co-op Offers Model for Overhaul*, NYT, July 6, 2009). Several elements of Group Health that are thought to improve care in the system while lowering costs include salaried doctors, quality incentives for providers, and a patient-focused strategy. Skeptics argue that forming sufficient pools at the national level would take far too long compared to alternatives.

The Role of the Health Insurance Exchange

The formation of a Health Insurance Exchange (HIE) is a consistent element of most reform proposals. To offer plans to a new market of enrollees, insurance companies in the exchange would have to abide by a set of standards while providing plan data to the exchange itself. The ultimate goal of an HIE is to provide the

consumer with a menu of competitive insurance options, while instituting a set of market guidelines and performing risk adjustment. The Exchange would be an efficient mechanism to carry out reform, and could be particularly influential in promoting innovative payment reforms, distributing premium subsidies and giving market power and information to individual and small employer purchasers.

Elliot Wicks recently described three HIE structures and two possible roles of the exchange (Administrative Solutions in Health Reform Panel Seminar, Urban Institute, July 20, 2009). In the Senate HELP bill, proposed HIEs are state-level "Gateways" where H.R. 3200 contains a national exchange.

Structures

1) A national entity with common guidelines
2) A network of state/regional exchanges with strong financial incentives to follow federal guidelines
3) A network of state/regional exchanges with substantial flexibility and incentives in exchange design to promote experimentation and innovation

Passive Role: A Clearinghouse

In this structure, the HIE would implement insurance plan standards such as guaranteed issue, medical loss ratios, and rating rules while also providing education materials, coverage information and plan performance results to consumers. The HIE would facilitate enrollment and perform risk adjustments, while coordinating with Medicaid and the IRS to determine eligibility and premium credits. While this structure would improve access to pricing and performance information, it would not take a direct role in bargaining or negotiating by utilizing its market buying power.

Active Role: Value Negotiator and Selective Contractor

This HIE role would perform all Clearinghouse activities, but would also use market share to bargain for lower prices within the Exchange. In the absence of a public plan, this HIE could also be designed to contain costs through selective contracting and bargaining. There must be specific mechanisms to avoid and risk adjust for adverse selection of higher risk populations into the Exchange and among plans within the Exchange. Wicks notes that plans will not offer a lower price in the exchange if they can get access to the same populations outside the exchange, and the HIE needs to be the sole location of new enrollment (the subsidized populations and individual market) for this approach to work.

ABOUT THE AUTHOR

Adam Dougherty is the Research Director at Insure the Uninsured Project. He is currently stationed in Washington, DC acting as the ITUP correspondent on federal health reform. In addition to this newsletter, Adam also maintains a daily blog with updates on reform efforts from the nation's capital and can be accessed at: www.itup.org/blog

By the Numbers

- Health care costs the typical household **$15,000 per year**, almost twice as much as two decades ago (David Leonhardt, *Challenge to Health Care: Selling Reform*, NYT, July 21, 2009)
- **44,230 Americans** lose their health insurance every week amounting to over **6.9 million newly uninsured** between 2008 and 2010 (The Clock is Ticking: More Americans Losing Health Coverage, Families USA)
- The Senate HELP Committee approved an amendment in their bill to protect makers of biologics (a pharmaceutical protein manufactured by living cells) for **12 years of exclusivity** before generic manufacturing can commence (Patrick Yoest, *US Senate Approves 12 Year Biologic Drug Exclusivity*, WSJ, July 13, 2009)
- Inclusion of a new public plan in the proposed insurance exchange would save an additional **$783 billion over 11 years** compared to an exchange without one (Fork in the Road: Alternative Paths to a High Performance U.S. Health System, Commonwealth Fund)

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