



## Public Health Insurance Plan/"Public Option" Position Paper August 2016

### ISSUE SUMMARY:

Proposals are currently being considered to implement a public health insurance plan, also known as a public option, that would provide coverage to Americans through state or federal marketplaces that would compete alongside private insurance plans. Studies suggest that as many as 119 million Americans could obtain coverage through this plan. NAHU strongly opposes the creation of a public option as it would never compete fairly with the private market, could exacerbate the worst elements of existing public health programs including inefficiencies, high costs and bureaucracy, would be financially infeasible in the long run, and could potentially devastate existing private market coverage.

### BACKGROUND:

A public option is intended to address the perceived market failure where many consumers have been faced with only one or two health insurers offering coverage in their area. By having a public plan to compete with these insurers, proponents claim that the effective monopoly from some of these insurers would be eliminated, as the private and public plans would have to compete with each other for consumers. Variations of the public-option proposal would limit the plan's availability to only those counties with little existing competition or where one insurer was the dominant player in the market.

Leading proposals for a public option would make it available to consumers purchasing coverage through the state or federal marketplaces. The plan would comply with requirements related to other state or federal marketplace plans and offer various plan option levels. Premiums would be established according to state or federal marketplace rules. As a public plan, it could have the power to dictate prices, provider networks and provider reimbursements. A public plan could also potentially indemnify itself for unexpected costs, allowing it to offer insurance at below-market costs, and may have an unfair advantage calculating its medical loss ratio (MLR), as administrative costs could be assumed by other sections of the government where private insurers would have no similar offset.

NAHU strongly opposes the creation of government-run plans to compete with the private insurance market. A public plan could create an unequal field and potentially devastate private-market coverage due to persistent adverse selection. As a public plan could set provider reimbursement rates similar to existing public programs like Medicare and Medicaid, it could significantly undercut the rates of private insurers. A 2009 [study](#) by Lewin Group found that if a public plan used Medicare or Medicaid reimbursement rates, premiums could be up to 30% lower and as many as 119 million people could leave private insurance for the public plan.

One of our most serious concerns about the public option is its potential to further exacerbate the cost-shift that already drives up healthcare spending. Cost-shifting is a hidden tax on private payers that occurs when government payment rates are too low and providers shift costs to the privately insured to make up the difference. The public reimbursement rates result in these costs being shifted onto private insurers and plan enrollees. A 2008 [study](#) by the actuarial firm Milliman found that annual healthcare spending for an average family of four was \$1,788 higher than it would be if Medicare, Medicaid and private employers paid hospitals and physicians similar rates. A government-run plan reimbursing at these rates could result in a net \$70 billion decrease in provider reimbursements, with at least some of those costs shifted directly onto those already privately insured, while drawing consumers away from private coverage and leading to a potential death spiral and the collapse of the private market.



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We are also concerned about the coverage adequacy a public plan would be able to offer to Americans. Existing public plans may provide less coverage and restrict provider access more than the average employer-sponsored plan, with the Congressional Budget Office estimating that the benefit package for Medicare is 15% below the average employer-sponsored plan. Under Medicaid, specialists are often inaccessible without long waits. Under a public option, Americans could find it increasingly difficult to make appointments with physicians and other healthcare providers. This is because lower payments would make it increasingly unaffordable for providers to see patients—particularly with additional patients becoming covered under the public option.

### **HISTORY OF PUBLIC OPTION PROPOSALS:**

The public option was originally included in several of the legislative proposals offered by Democrats in the lead-up to the passage of the Affordable Care Act (ACA) in 2009-10. In addition to the public option, various alternatives were offered to provide additional competition in the insurance market. Leading proposals included a plan by then-Senator Olympia Snowe (R-ME) to create a corporation to offer health insurance in any states where fewer than 95% of the residents had access to affordable coverage, a proposal by several Democrats to allow older Americans under age 65 to buy into Medicare, creation of a single national exchange through the Federal Office of Personnel Management to be administered similarly to the existing Federal Employees Health Benefits Program, and an employee free choice voucher proposed by Senator Ron Wyden (D-OR), which would require employers to give a voucher to their lower-income employees to use on the marketplace or outside market instead of participating in their employer-provided plan. The Free Choice Voucher was passed as part of the ACA, but was repealed in 2011 before ever taking effect.

Initial support for a public option in 2009 was driven by President Obama, Speaker of the House Nancy Pelosi (D-CA) and Senate Majority Leader Harry Reid (D-NV). At the time, Democrats controlled a 60-vote supermajority in the Senate and held a 76-seat margin over Republicans in the House (255-179). Despite these large majorities in each chamber, only roughly a third of each chamber’s Democrats vocally supported a variation of a public option, and with it barely passing the House by a vote of 220-215 in November 2009 with 39 Democrats voting against it, there was never enough support to include this proposal in its final package. Numerous leading Democrats, including Senators Max Baucus (D-MT), Ben Nelson (D-NE), Kent Conrad (D-ND), Joe Lieberman (I-CT) and Blanche Lincoln (D-AR), stated that they would never support any public option, joining all Republicans who likewise would never support a public option. Even at its zenith of support, there have never been enough votes or political viability for a public option to become law.

### **PUBLIC OPTION ALTERNATIVES IN THE FINAL ACA PACKAGE:**

Two public option alternatives ultimately were implemented from the final ACA package that was signed into law: Consumer Operated and Oriented Plans (CO-OPs) and a Basic Health Program (BHP). The CO-OPs were proposed by Senator Kent Conrad (D-ND), then chairman of the Budget Committee, to create publicly funded state and regionally based non-profit health plans to compete alongside private insurers by negotiating directly with healthcare providers for low-cost rates. At its start, 23 CO-OPs were established with federal funding before Congress ultimately eliminated any further funding for new entrants in early 2013. The BHP was proposed by Senator Maria Cantwell (D-WA) to create a public-sponsored option for non-Medicaid-eligible people with family incomes between 133% and 200% of the federal poverty level. The BHP is funded by the federal government, which pays 95% of what BHP enrollees would have received in marketplace subsidies. Minnesota and New York are the only states to implement a BHP to date.



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The CO-OP program has largely failed its objectives, with just seven of the 23 original CO-OPs remaining as of July 2016, and serves as a poor indication for the viability of federally funded plans. Designed to generate market-based competition within the newly created marketplaces, many co-ops were encouraged to compete largely on price, thus attracting a higher share of sicker consumers. They were hit especially hard by lower-than-anticipated risk-corridor payments made available to insurers and CO-OPs that were designed to provide plans protection from unexpectedly large claims due to sicker enrollees. CO-OPs with the lowest pricing strategy to attract higher volume were hit hardest by the low risk-corridor payments, given their comparably higher share of risk to other marketplace carriers. While the risk-corridor payments were favorable to the CO-OPs in their first year, providing \$2.9 billion in payments, in 2015 all insurers combined received only \$362 million, or 12.6%, of expected payments, largely due to funding cuts made by Congress.

The program was initially funded with \$6 billion in federal funds, but that was reduced to \$2.6 billion in low-interest loans after the program's funding was reduced from multiple rescissions made by Congress (\$2.2 billion in 2011, \$1.4 billion in 2012 and \$13 million in 2013). Much of this federal funding has been lost due to the insolvency of failed CO-OPs and is unrecoverable. Given these failures, the potential for a new government-run public health insurance plan is significantly less viable.

### **NAHU POSITION:**

With the latest calls for a public option, NAHU strongly opposes any legislative proposal to create a public option to compete with private insurers. The current political control of Congress suggests a low viability for future legislation to pass, as a public option was not viable even with Democratic supermajorities in both chambers, and the failures of the CO-OP program suggest low practical viability of a program to be successfully implemented. Nevertheless, given ongoing market characteristics of low insurer competition and high prices for private-market coverage, there could be interest in another public option alternative, particularly if it were to have the support of private insurers. Therefore, while its political and practical viability is significantly lower than other threats to private-market coverage and the employer-based healthcare system, such as proposals to eliminate or cap the employer exclusion and state-based single-payer efforts, we are deeply concerned about the damaging impact that a public option could have on private-market coverage and strongly oppose any efforts to create such a program.