Rekindling Reform
Working to Achieve Quality Health Care for All
c/o Community Studies of New York ■ 155 W. 72nd St., Suite 402 ■ New York, NY 10023 ■ email@rekindlingreform.org ■ www.rekindlingreform.org

and

Center for Policy Analysis
Promoting the public's health in the U.S. and around the globe
Thoreau Center for Sustainability
P.O. Box 29586, San Francisco, CA 94129 415-922-6204

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Working Paper (2nd Ed.): A Public Plan Option and U.S. Health Care Reform

The Public Plan in a Nutshell

- Open enrollment; lasting coverage assured; the default choice
- Federally administered
- Comprehensive benefits, setting the standard for all plans
- Free choice of practitioners
- Affordable
- High quality – sets high standard for the competing plans
- Cost containment – sets high standard for competing plans
- Prospect for eventual merger with Medicare

INTRODUCTION: The Key Role of Public Plans

Opinion polls in the United States show overwhelming support for access to health care as a matter of simple justice. People want health care that is accessible and responsive to their needs without being burdensome economically, health care that is sure to be there when they need it and that therefore gives them peace of mind. The existing U.S. system falls sadly short. Government could guarantee such a human right to all through universal national (social) health insurance – a single payer system. However, it is clear that Congress is not disposed to pursue that course. That leaves one effective course open to Congress: to develop a new social insurance *option*.

Our perspective, however, is one of moving ultimately to a *single* public system. Accordingly, to that end, we are committed to restoring and strengthening Medicare – undoing the damage

wrought by the Medicare Modernization Act, securing Medicare's financial integrity, and filling in the serious gaps in its benefits.

A social insurance plan is a government managed arrangement requiring equitable contributions by participants. Social Security and Medicare are examples. Medicare, for its part, has proven the power and reliability of that model in its coverage of elderly people and people with disabilities. But for most people under 65 in the U.S., access to health coverage is dominated by commercial, investor-owned insurance companies. They treat health coverage as a market commodity and have little public accountability. To maximize profit, they market selectively and discriminate in pricing. They sell coverage that is neither reliable nor stable. They deny claims unpredictably and withdraw from markets they deem unprofitable. They profit from skyrocketing costs and have shown no capacity for or interest in containing them.

As a result, at least one-third of the nation is either uninsured or under-insured, and most are insecurely insured. Consequently, millions of people are forgoing necessary health care, even critically necessary care. Lack of access to timely, adequate health care imposes human and societal burdens of serious illness, prolonged disability, and premature death. Runaway health care costs are a severe economic burden not only on individuals and households (they are a leading cause of personal bankruptcies) but also on employers and government at all levels, most critically state governments. Our failure as a nation to deal better with health care costs has helped move some state governments to the brink of economic collapse.

The nation's leaders are under pressure to bring quality, affordable health care to all. As the nation considers new program choices, Rekindling Reform urges that, at a minimum, people be offered the choice of a public insurance option, similar to Medicare, that can effectively use the purchasing power and other tools that uniquely enable government programs to serve the public interest. To offer less would deprive the nation of a real, viable alternative to the current failed private insurance model.

A driving force in health care reform is the widespread recognition of the dangers posed by unrelenting growth in per capita health care expenditures, while the quality of much of American health care remains mediocre. We suggest that health care programs under public auspices are in the best position to tackle both cost control and quality assurance simultaneously, since they have no obligation to give priority to short-term profits for investors and inordinately large salaries to executives.

- A public plan could more readily begin **paying for quality of care rather than for the number of procedures** performed.
- It could use incentives to develop a **primary care based delivery system**, with medical homes for most beneficiaries, and group practices with physicians on salary, teamed with qualified non-physician practitioners and ancillary personnel. Thereby, a public plan could achieve effective **coordination of care**, with procedures for easy patient-practitioner communication.
- A public plan on a national scale more readily supports training in **best practices**.

Apart from its inherent administrative efficiency, a public plan can contribute uniquely to system-wide cost containment efforts. If the plan develops new operating efficiencies, these will soon become public knowledge; unlike commercial insurers, it would have no reason to treat them as proprietary secrets so as to divert savings to corporate profit or executive salaries.

Conflicting Approaches

In the nation's debate over how best to achieve health coverage for all, the proposal to introduce a so-called public plan option has become a major bone of contention. Partisans of the commercial insurance business and their allies in Congress strongly resist creation of a Public Health Insurance plan. They fear that its superior affordability, quality and fairness would constitute unfair competition and that, in practice, Public Health Insurance would win the public's favor. In an effort to shape a compromise that could win broader support in Congress, some strategists have recently proposed ideas that threaten to undermine real reform.

One such proposal would require the Public Health Insurance plan to resemble commercial insurance as much as possible. Typically, that would mean pretending to achieve affordability and widespread coverage by competing on premium price at the expense of adequately comprehensive benefits. It would give little or no help to the seriously under-insured, the largest class of victims of the current broken insurance system – most of us. Reform would be an empty promise, as thousands of Massachusetts residents are now experiencing.

The *defensible* way to "level the playing field" is by bringing up the bottom: establishing a public benchmark model and requiring private plans to conform. Rekindling Reform proposes that Congress create a Public Health Insurance plan with comprehensive benefits, then require commercial insurers to offer comparable benefits while competing on quality of care and on overall cost to beneficiaries.

It has also been suggested that the public and private health insurance plans should all be under a common regulatory agency. That fails to recognize the fundamental difference in the nature of public plans (social insurance) and private plans (mainly commercial insurance), and the regulatory implications of that critical difference.

The primary accountability of commercial plans, by law, is to their investors. Much of the need for regulation of private insurance plans stems from the inherent conflict between their obligations to investors and those to beneficiaries. There, regulation must strive for a measure of public accountability that would otherwise be entirely absent. However, a social insurance plan is free of such conflicting objectives. With such a system, a significant measure of public accountability is already built in. This asymmetry between commercial and public plans imposes a heavier and distinctly different regulatory burden on the commercial plans.

Below we offer: (A) guidelines for an effective new public plan, (B) a standard for benefits of all plans, and (C) guidelines that should apply to all plans and their interactions, in the interest of maintaining a level playing field.

SPECIFIC PROPOSALS

A. Public plans

We propose the following provisions 1-9 as primary, defining features of the new Public Health Insurance plan. (Point 3 will have important relevance for all plans.)

1. **Open enrollment:** The new Public Health Insurance plan should be required to accept anyone not enrolled in Medicare who applies, at any time, irrespective of age or pre-existing conditions (see also 11, 17.) and must **guarantee continuing coverage**. None of this should be construed as invalidating existing benefit arrangements under collectively bargained labor contracts, but employers must have the option of insuring their workers under the new Public Health Insurance Plan.
2. **Federally administered:** The Medicare-like Public Health Insurance plan should be administered by the federal government, as Medicare is. It should have the capacity to respond to local differences in costs. It should have the authority to engage in innovation to improve quality and limit costs. To take advantage of existing infrastructure, it should be administered by a new subdivision of the Center for Medicare and Medicaid Services (CMS), in parallel with Medicare. Coordination with Medicare should be explored, for example, in negotiation of prices and reimbursements and in considering cost containment strategies. Reforms on the Medicare side should include incentives to better contain costs.

3. **Comprehensive benefits:** Our ultimate goal is to put an end to basic under-insurance. The new Public Health Insurance plan should have comprehensive benefits – sufficiently comprehensive that beneficiaries would not feel pressed to buy supplementary coverage. For example, in addition to standard hospital and physician benefits, it should cover preventive services, mental health and substance abuse, maternal and child health, and dental services, prescription drugs, eyeglasses, long term care including home care and nursing home care, and rehabilitation services to improve as well as to maintain function. (See also 10.) Reforms on the Medicare side should aim to align benefits with those of the new Public Health Insurance Plan. Alignment of benefits, though not sufficient to enable merging the Public Health Insurance Plan with Medicare, would help movement toward a unitary public system.

4. **Choice:** Beneficiaries of the new Public Health Insurance plan should have portable access to the health care practitioners of their choice, who must be qualified by licensure, education or training to provide the covered services.

5. **Affordability:** We seek to prevent medical bankruptcy. Particularly if the new Public Health Insurance plan is to be funded in the first instance by premiums, the premiums must be affordable. **(**The simplest way to structure and administer a plan for predictable and affordable cost to beneficiaries is exclude copayments, coinsurance, and deductibles. In any case, essential preventive services should carry no out-of-pocket cost.) The affordability criterion may vary by region, depending on local health care and living costs. Beneficiaries whose incomes qualify them should get public subsidies. The subsidy would supplement an affordable sliding-scale, income-based contribution from the

beneficiary, a contribution of an amount based on realistic health care and living costs data (the self-sufficiency standard for the region). (See also 14.)

6. **Prices:** The Public Health Insurance plan should have **authority to negotiate** prices for the goods and services needed for its beneficiaries' health care.

7. **Effective and efficient services:** In the interest of both quality and cost containment, the Public Health Insurance plan should provide incentives that **enhance the role and capacity for primary care and team models** in the planning, coordination, and delivery of services.

8. **Appeals:** Beneficiaries of the Public Health Insurance plan should have access to a simple, user friendly appeals process that renders timely decisions. The appeals process should incorporate all current appeals and due-process protections available to Medicare beneficiaries. (See also 21.)

9. **Plan guidance:** To enable fair, democratic input, the CMS entity administering the Public Health Insurance plan should have an advisory unit to provide **guidance from beneficiaries, purchasers, and providers**. The entity should have an inspector general, who would report annually on cross-system comparative health outcomes, beneficiary satisfaction, service utilization levels, provider issues, and cost containment. The advisory unit should hold public hearings on the inspector general's report.

B. Benefits in private plans

10. **Benefits in commercial plans** should be at least as comprehensive as in the new Public Health Insurance plan, in terms of both specific benefits and overall actuarial value.

C. Provisions pertinent to all plans

11. Each plan offered in a region should be required to accept anyone in that region who wants to be in the plan. It should charge the same premiums to all of its subscribers and should have transparent terms and finances.

12. To facilitate people's informed choice among plans, an agency is needed to create and maintain a comprehensive. user friendly database as well as tools and staff sufficient to **enable people to compare plans** in detail and accurately. (This would not preclude marketing of/by individual plans.)

13. There should be significant, enforceable **penalties for deceptive or selective marketing** for the plans**.**

14. Many people, whether they choose a private plan or the Public Health Insurance plan, will be able to afford coverage only with the help of public subsidies. Therefore, a **subsidy –** essentially a voucher – should be available to every income-qualified beneficiary**.** Irrespective of the plan chosen, the subsidy should be the same as if the beneficiary had enrolled in the Public Health Insurance plan. (See also 5.)

15. Because, for many individuals and households, income expectation varies substantially during the course of a year, **adjustment of subsidies** to income changes could, for example, be combined with the personal income tax filing procedure. However, to minimize distress if the beneficiary's income falls significantly, premiums and subsidies should be adjustable promptly in such cases.

16. The degree of financial risk that an insurance plan assumes depends on such factors as the health and occupations of the beneficiaries. There should be retrospective **risk adjusting payments among plans** so that no plan is at a competitive handicap if the people it enrolls happen to be at greater risk of illness or injury.

17. An eligible **person who fails to choose a plan** should be enrolled by default in the Public Health Insurance plan.

18. In general, individuals should be able to **switch plans** within 60 days after first enrolling and during a 30 day period at the end of each year. They should also be able to switch plans quickly when they are faced with a change of employer health plans or when they experience a major change in family circumstances.

19. Health care practitioners and institutions should be **free to choose which plans they affiliate with**. Insurers should be barred from imposing rules or offering incentives to prevent or dissuade providers from affiliating with the Public Health Insurance plan.

20. HHS should have the authority and resources to promote adoption of evidence-based practices by the service providers under all plans.

21. There should be a **common final appeals agency** for beneficiaries of all plans. This would, in addition, be an important tool for monitoring enforcement of national standards for all plans, including ERISA plans (benefit plans established under the standards of the Employee Retirement Income Security Act).

22. In the first year, each plan should direct at least 85% of plan revenues to services delivered in licensed patient care facilities or patients' homes. Higher standards should be met in subsequent years.

~~23.~~ Functions that should be the responsibilities of one or more independent public agencies are: the plans information center (12), subsidy management (14, 15), risk adjustment (16), regulatory enforcement (11, 13, 19, 21), and final appeals (20). Also needed is a national registry that maintains up-to-date records identifying everyone's health insurance plan. It is not obvious that all of these functions are best assigned to a single agency; pros and cons need to be examined.