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Designing a Mixed Public and Private System for the Health Insurance Market

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This paper considers some design features of a health care reform proposal that would make a government-run health insurance plan available to all. The details of any health care reform proposal are important, and the details of this proposal still are under development. However, some details are available and discussed here.

The analysis begins with a description of problems in markets for health insurance that reforms might address. It then considers a specific reform proposal: offering a public plan and competing private plans in a government-run purchasing pool. The Medicare program provides an important precedent for such a system, and offers a practical guide to the problems and opportunities offered by such a mixed public and private system. The analysis then turns to application of the mixed public and private system to the commercial insurance market, discussing the likely problems and ways to resolve them.

An important assumption underlying this analysis is that public and private plans have inherent advantages and disadvantages, and neither type of plan needs to be favored with special subsidies or regulations. Both plans can be offered on a relatively level playing field. The best judges of the advantages, disadvantages and economic value of each plan are not politicians, bureaucrats, or policy analysts, but consumers supported by good data systems.

In this analysis, "the commercial health insurance market" means the market for health insurance faced by people who are not currently enrolled in Medicare, Medicaid, government-subsidized high-risk pools or other public insurance program. For example, the non-elderly disabled population that is enrolled in Medicare would not be part of the commercial insurance market as discussed here; nor would the low-income individuals enrolled in Medicaid; nor would the aged-entitled Medicare-enrolled population, even though many Medicare beneficiaries are enrolled in private health plans (the Medicare Advantage [MA] program, private supplementary policies, or private Part D drug coverage plans).

Problems in the Commercial Insurance Market

Economists distinguish between problems of efficiency and problems of fairness. The purpose of the division is to understand the steps that are necessary to address the problem. There is not a one-to-one mapping from problems to the categories of efficiency and fairness. A single problem can raise issues both efficiency and fairness.

A good example is the most prominent problem in U.S. health insurance: the uninsured. Forty-seven million Americans did not have any type of health insurance coverage during 2006 (U.S. Census Bureau 2007). Lack of insurance is, in part, attributable to, and results in, inefficiencies and also represents a problem of fairness.

Advocates of "consumer-directed" health plans with large deductibles have argued that traditional health insurance policies are poorly designed, encouraging inefficient consumption of health care services that leads to inefficiently high health insurance premiums, increasing the proportion of the population with inadequate coverage. Other analysts cite the relatively higher administrative costs of private health plans compared to public fee-for-service Medicare as a form of inefficiency. Inefficiently high administrative costs would lead to higher premiums, making insurance unaffordable for more individuals. Advocates of single payer reform believe it would be more efficient for federal government to exercise its massive purchasing power to extract deeper price discounts from the health care industry, including physicians, hospitals and drug companies.

There also is concern that the lack of truly portable universal health insurance coverage can lead to "job lock," that is, individuals remaining in a sub-optimal job simply to maintain health insurance coverage for themselves or their family members. "Sub-optimal" in this case means that the individual's utility, determined in part by his marginal revenue product (the effect of an additional hour of labor on output times the market price of one unit of the output), would be higher in another job. The job with

the higher marginal revenue product might not offer health insurance, and if not, even the higher wages that accompany the individual's increased earning power in the new job might not be enough to cover the cost of similar coverage obtained in the *non-group* insurance market. An additional problem is that transition to the small-group or non-group market could entail a reassessment of the individual's risk (or the risk of an insured family member), or greater risk of reassessment if the individual's or family member's health status changes.

These problems impact both efficiency and fairness. The *efficiency* problems could be summarized as follows: An inefficiently high number of people have an inefficiently low level of insurance, including no insurance. This problem is accompanied, and in part caused, by inefficient production of health insurance coverage, both in administration and product design. Friction in transitions in the health insurance market may lead to some inefficiency in the allocation of people to jobs (job lock).

The *fairness* dimension of the problem definition suggests: Some individuals, including children, lack health insurance for reasons beyond their control, and those individuals do not have the same ability to realize their full potential, holding other factors constant, as insured individuals. This situation violates both process fairness and equal treatment of equals.

A Proposal for a Mixed Public and Private Insurance System for the Commercial Health Insurance Market

Although this analysis addresses a generic proposal to add a universally available, government-run health insurance plan to the commercial health insurance market, a specific proposal to that effect currently is being circulated. The proposal is by Jacob Hacker (2007) of Yale University, whose work on the proposal was sponsored by the Economic Policy Institute.

The primary problem identified in the proposal is the lack of "health security," which Hacker defines as (1) periods of uninsurance that affect a significant proportion of Americans and (2) the high cost of health care. Hacker also mentions the adverse impact of high health care cost on businesses and the costs of uncompensated care borne by people with insurance. The proposal has the following general features:

1. "Every legal resident of the United States who lacks access to Medicare or good workplace coverage would be able to buy into[1] the "Health Care for America Plan (HCAP), a new public insurance pool[2] modeled after Medicare. Every enrollee would have access to either an affordable Medicare-like plan with free choice of providers or to a selection of comprehensive private plans."
2. "A requirement that employers (and the self-employed) either purchase coverage comparable to HCAP for all their workers or pay a relatively modest payroll contribution (6% of payroll) to fund HCAP coverage for all their employees;"[3] and
3. "A requirement that Americans who remain without insurance take responsibility for their and their families' health by purchasing private coverage or buying into the HCAP."

The proposal thus includes mandates for both employers and individuals. Specific features of HCAP include:

1. Coverage of physical and mental health services as well as prescription drugs.
2. Point-of-purchase cost-sharing and "strict limits on out-of-pocket spending."
3. "For those enrolled in the plan at their place of work, anyone whose income was below 200% of the poverty level would pay no additional premiums. (The poverty line in 2006 was

[1] In fact, they would be *mandated* to enroll in HCAP.
[2] In the Hacker proposal, the term HCAP appears to be used to refer to both a government-run health plan (like FFS Medicare) and a government-run pool that would feature both the HCAP plan and a selection of private health plans.
[3] Employers would have to choose between offering their own health plan (or set of health plans) to their employees or offering the HCAP pool, which would include both the government-run plan and a selection of private plans.

roughly $10,000 for an individual and $20,000 for a family of four.) The maximum monthly premium —phased in between 200% and 300% of the poverty level—would be $70 for an individual, $140 for a couple, $130 for a single-parent family, and $200 for all other families." Premiums would not vary with age, region, or health status.

4. Out-of-pocket premiums for private plans and for HCAP would be treated as under current tax law.
5. The remainder of the premium would be paid "by employers," who would be "eligible for transitional subsidies that would ensure that no firm faced a substantial new burden."
6. Employers could offer supplements to HCAP benefits.
7. Enrollment in HCAP would be open to any legal U.S. resident without good workplace coverage.

Estimated *total* savings from the plan (as opposed to savings only for employers, insured individuals, the government, etc.) come from several sources, including:

1. "Concentrated purchasing power" in the large HCAP.

2. Lower administrative costs in HCAP relative to private insurers.

3. " … improvements in the quality and cost-effectiveness of medical care."

Hacker rests his argument on "the time-tested idea of social insurance, the notion that major financial risks should be pooled as widely as possible across rich and poor, healthy and sick, young and old." But there is no general agreement on the characteristics of social insurance.

Mixed Public and Private Health Insurance – Lessons from Medicare

Advocates for a health care system based on private plans and a universally-available

government-run plan often appeal to the Medicare program as a successful basis for their proposal. A brief review will help put the discussion of design issues into perspective.

A Brief History of Private Plans in Medicare

Medicare is the most prominent U.S. example of a mixed system of public and private health plans. Three types of private health plans are associated with the Medicare program. The first is private supplementary or "Medigap" policies that cover services and cost-sharing not covered by the Medicare entitlement. The second is Medicare Advantage (MA) plans that replace the government-administered fee-for-service (FFS) Medicare plan with private coverage. The third is stand-alone Part D drug coverage plans that offer optional coverage of outpatient prescription drugs to Medicare beneficiaries.

The history of private plans in Medicare begins in the earliest days of the program with private plans paid on a fee-for-service basis (Dowd, Feldman, and Christianson 1996). Beginning in the 1970s, advocates of health maintenance organizations (HMOs) were arguing in favor of competitive markets for private health plans, and in some cases, extension of those systems to Medicare. The more recent history of private plans in Medicare usually is dated from 1982 to 1985, which marked the introduction of capitated private plans on a wide scale under the Medicare Competition Demonstration. Congress incorporated capitated private plans into the program before the evaluation of the demonstration was complete, which may have contributed to a number of design flaws that have proved difficult to correct.

During the late 1980s and early 1990s, private plans were providing generous supplementary benefits including free prescription drug coverage to beneficiaries in areas with high FFS Medicare costs. However, there was general dissatisfaction with the payment system for private plans, including inadequate risk adjustment and wide variations in payment levels even in contiguous counties.

Both Private Plans and FFS Medicare Have Advantages

Dowd, Feldman and Coulam (2005-2006) have argued that FFS Medicare and private MA plans have advantages, but they need to be carefully scrutinized. FFS Medicare guarantees the availability of *health insurance coverage* nationwide, but not necessarily access to *providers* willing to treat Medicare patients (although about 90 percent of doctors and almost all hospitals participate). FFS Medicare has considerable market power in negotiating prices with health care providers[4] and, depending on how they are counted, lower administrative costs as a percent of total claims expense.

FFS Medicare also has a demonstrated track record of provider payment initiatives, such as diagnosis-related groups (DRGs) for inpatient services and the resource-based relative value scale (RBRVS) for physician services, that have been adopted by many private health plans. Studies of care for chronically ill beneficiaries generally favor FFS Medicare over private health plans.

Private MA plans enjoy more freedom in their contracts with providers. The importance of this freedom has been demonstrated recently when both courts and Congress have prevented the Centers for Medicare & Medicaid Services (CMS) from competitively bidding its contracts for durable medical equipment (DME) and clinical laboratory services. Even though private plans' provider fees often are higher than Medicare's (MedPAC 2004), private plans are free to pursue competitive contracting that is more likely to produce efficient price levels than government-administered prices.

MA plans are less constrained in their ability to initiate care management interventions. Unfettered by distinctions between Parts A, B, and to a large extent D, they coordinate care easily across a continuum of treatment sites and modalities. Although Hacker appears to believe that the HCAP public plan would deliver more cost-effective health care than private health plans, there is not a great

[4] While its large market share has allowed Medicare to extract significant price discounts from providers, that advantage must be considered in light of the fact that monopsony can be inefficient. That point might be easier for advocates of bulk purchasing power to grasp if we change "FFS Medicare" to "United Health Care." FFS Medicare's payments to providers need careful monitoring because FFS Medicare is large enough to affect market-wide supply behavior (Dowd, et al., 2006-07).

deal of evidence from Medicare to support that belief. Studies of the provision of preventive care, for example, favor private MA plans over FFS Medicare. FFS Medicare recently began experimenting with disease management strategies, whereas Welch, et al. (2002) reported that 99 percent of private plans had employed some type of disease management programs in 2000. Recent demonstrations of disease management in Medicare have been so unsuccessful that CMS is contemplating ending the demonstration (Abelson 2008).

The relative advantages of either FFS Medicare or MA at any point in time may be temporary. For example, regional PPOs in Medicare have resulted in private health plans being at least nominally available throughout the country, and in addition to disease management and competitive bidding for some types of services, FFS Medicare is experimenting with pay-for-performance systems similar to those used by private plans.

Lack of a Level Playing Field in Medicare

The Medicare program does *not* feature a level playing field between private health plans and FFS Medicare. Under current law, FFS Medicare must offer free choice of providers, whereas MA plans are able to practice selective contracting, and can require a referral to see a specialist. In addition, FFS Medicare must: (a) be offered in all locations; (b) accept all enrollees at any time they apply; (c) and cover only services listed in the entitlement, which might preclude covering some cost-effective preventive care. FFS Medicare is prohibited from offering a "one-stop shopping" product that includes basic Medicare coverage and (optional at extra cost) supplementary coverage and Part D coverage all administered and financed by the federal government. FFS Medicare also reports detailed claims data, while MA plans do not .

Private plans also face some legislatively-imposed cost disadvantages relative to FFS Medicare. To level the effect of those constraints, FFS Medicare would have to: (a) abide by all administrative reporting requirements imposed on MA plans, including submission of adjusted community rate reports; (b) abide by the same quality reporting requirements, including Health Effectiveness and Data Information Set (HEDIS) measures; (c) be subjected to the same penalties imposed on private plans for submitting incorrect data; and (d) declare "service areas" for FFS Medicare (presumably encompassing the entire U.S.) and ensure adequate access to providers in those service areas.

There are three policy options regarding these disparities. First, some restrictions could be removed. For example, free choice of provider could be removed from the Medicare entitlement, allowing FFS Medicare to use the same contracting approaches as private plans, perhaps as plan options within FFS Medicare. Alternatively, premiums for disadvantaged plans could be subsidized to neutralize their legislatively-imposed cost disadvantages. Finally, the disparities could continue to be ignored, and consumers could be left to decide which plans will survive and which will not.

Paying Private Plans in Medicare

One of the most difficult areas in the Medicare program has been designing a payment system for private health plans. In the early 1980s, private plans began to receive capitation payments for Medicare beneficiaries. Despite good advice to the contrary (Dowd, Feldman and Christianson 1996), those capitation payments were set as a function of average expenditures in FFS Medicare in the beneficiary's county of residence. The extraordinary variation in average FFS spending across counties (even in the same general market area) led to significant variations in private plan capitation rates. Private plans' costs did not vary as much as FFS costs, and thus private plans in high payment areas had significant amounts of surplus revenue. Private plans could return the surplus revenue to the

government, or possibly hide it in inflated cost estimates, but competition among private plans forced them to convert the surplus revenue into supplementary benefits, which varied in direct proportion to their payments (McBride 1998). Because massive reviews of the literature found the quality of care in FFS Medicare and private plans to be roughly equal (Miller and Luft 1997, 2002), the policy concern in the 1990s was that FFS Medicare was being protected from direct price competition with private plans, leading to wasted government expenditures.

The arbitrary benchmark of FFS spending was replaced in the 1997 Balanced Budget Act legislation with an arbitrary cap of two percent payment increases per year, which led to the withdrawal of private plans from markets where restricted payments were not sufficient to maintain their competitive position in the market. Further administrative tinkering with payments in the early 2000s led to the establishment of "floor" counties with minimum payment levels that were higher than FFS spending levels. The concept of floor counties was extended in the 2003 Medicare Modernization Act legislation to the point that overpayment of private plans became the dominant policy concern.[5]

The Medicare Payment Advisory Commission (MedPAC) has recommended a return to the pre-BBA payment policy—setting private plan payments equal to FFS spending in each county. That would restore the differentials in private plan payments across counties, as well as the differentials in supplementary benefits offered by private plans. An important difference, however, is the ease with which private plans now can offer Part B premium rebates as part of their supplementary benefits. The expected result is that beneficiaries in areas with high FFS spending now receive not only more generous coverage from private plans than beneficiaries in high payment areas, but also cash payments. It is difficult to see how this approach addresses the problem of wasted government spending.

[5] Interestingly, analysts who object to the overpayment of private plans express no concern regarding overpayments to FFS Medicare in areas where FFS Medicare's costs are substantially higher than those of private plans.

Dowd, Feldman and Christianson (1996) recommended a payment approach that eliminates government waste and bickering over whether private or public plans are being unfairly subsidized. The approach is to have private plans and FFS Medicare submit capitation bids, and then set the government's contribution to health plan premiums for Medicare beneficiaries equal to the lowest bid submitted by a qualified health plan in each county. Demonstrations of this "competitive pricing" or "premium support" approach to plan payment first were mandated then stopped by Congress in the late 1990s (Dowd, Coulam and Feldman 2000). Another demonstration has been mandated for 2010.

Designing and Running a Mixed Public and Private Health Insurance System in the Commercial Insurance Sector

Why Offer a Government-run Health Plan in the Commercial Insurance Market?

The purpose of offering a government-run health plan in the commercial insurance market must be stated carefully because it will become the operational equivalent of the entitlement restrictions in the Medicare program, and the entitlement restrictions will determine the rules governing public and private health plans in the mixed system. Presumably the purpose of any health care reform proposal is to address the problems of market failure and fairness identified earlier in this analysis (or new ones that might be identified by different analysts). This analysis assumes that the purpose of the proposed reform is to offer individuals in the non-group insurance market the opportunity to purchase group-like health insurance coverage that would have the following features.

1. Protection against having one's health risk reassessed after an illness or injury. One of the most valuable features of large-group employment-based health insurance is the guarantee that employees will have access to health insurance premiums that protect against higher premiums due to the onset of

serious illness or injury as long as they remain on the job. Large employers are able to provide an insurance product (either one plan or multiple plans) that offer their employees not only community-rated premiums (and thus protection against risk-redefinition) but also the opportunity to switch among community-rated health plans during open enrollment periods.

Protection is very limited, however, and can be withdrawn if the employee changes employers. The Health Insurance Portability and Accountability Act (HIPAA) has helped in that situation, as long as the employee maintains continuous coverage and moves to another firm that offers community-rated health plans. But HIPAA carries no guarantee that employment-based coverage will be universally available or that the premiums will not increase if the person changes jobs or is unable to work.

The absence of long-term protection against risk reassessment is a topic of legitimate concern and if understood correctly, might provide the most stable pillar of a proposal for a new type of government activity in the commercial health insurance market. The problem applies primarily to individuals who lose, or are threatened with loss of their group insurance policies.

2. An iron-clad guarantee of portability of coverage and a community-rated premium from one job to another (or from employment to unemployment). "Portability of coverage," in this analysis, means that the consumer is guaranteed continuous coverage at a premium that reflects average health expenditures in their pool if they move their residence to any part of the U.S. It does not mean that premiums will be invariant with respect to the *average* level of health care spending in the pool of which they are a member, nor invariant with respect to average levels of health care spending in one part of the country versus another, nor does portability imply continuous enrollment in exactly the same health plan or even the same *type* of health plan. In its loosest form, portability might not even imply premiums that are constant across age groups since aging is a foreseeable risk, and it might allow for premiums that vary with income, as well.

3. *Lower marketing and underwriting costs than in the individual health insurance market, presumably resulting in more affordable premiums.* Although there is some controversy regarding the ability of the non-group market to offer guaranteed protection against having one's risk reassessed in the event of serious illness or injury ((Pauly and Nichols 2002), it is not controversial to assert that marketing and underwriting costs are higher in the individual market than the group market. If it were possible to offer group-like coverage to individuals through some mechanism, the cost of any given level of coverage could be reduced.

4. Other possible but controversial purposes. Beyond these simple, but important purposes, there are other secondary purposes that might be proposed. Is the purpose of the government-run plan to ensure the availability of a health plan that features unfettered access to all providers, as in FFS Medicare? Is unfettered access to providers an essential feature of a health plan or an amenity for which some consumers are willing to pay, while others choose lower cost plans with restrictions on provider access? Said another way, if unfettered access to providers increases the cost of the public plan in HCAP, should HCAP receive public subsidies to neutralize that additional cost from the consumer's perspective?

In the Medicare program, FFS Medicare with a supplementary policy is the domain of higher income beneficiaries, while MA plans with limited provider access have enrolled a plurality of lower income and minority beneficiaries who are not eligible for Medicaid (Dowd, et al. 1994; Thorpe and Atherly 2002). Unfettered choice of provider thus appears to be treated as an amenity in the Medicare program. This analysis takes the same perspective, assuming that group and staff-model HMOs and preferred provider plans are as valid care-delivery models as open access plans.

Is the purpose of the government-run plan to amass enough individuals in a health plan so that larger price discounts can be extracted from health care providers? Although advocates of government-

run plans tout the advantages of bulk purchasing power, monopsony purchasing can be inefficient. FFS Medicare's pricing power does allow it to ignore local market pathologies such as provider pricing power where those pathologies exist (Dowd *et al.* 2006-2007; Berenson 2008) and thus in some concentrated provider markets, FFS Medicare may offer the efficiency advantage of bilateral monopoly. However, a better approach would be local enforcement of antitrust laws.

If the purpose of a government-run health plan is to deliver a more efficient mix of health care services to the population than private health plans, then evidence from FFS Medicare in the areas of preventive care and disease management is not encouraging.

These secondary objectives are worthy of additional empirical research. Because they are more controversial, however, they are not the focus of this analysis.

Specific Design Features

What health plan characteristics would be necessary to achieve the goals of a mixed public and private system? Which characteristics should be required of all health plans, and which should remain flexible? As noted earlier, this analysis is based on the premise that both public and private health plans have some intrinsic advantages and disadvantages, and neither type of plan needs to be favored with special subsidies or regulations. However, public and private plans may face different challenges in implementing different design features, and ultimately both types of plans will be disciplined by the intersection of their own ideas regarding plan design with their cost structures and the consumers and providers with whom they contract.

1. *Government pool or government health plan?* In theory, the objectives of universally available coverage and premium stability that covers transitions between the individual and group health insurance markets, *per se,* could be accomplished without introducing a new government-run health

plan. Both objectives could be achieved by introducing only an insurance pool, most likely run by the government, that offered multiple community-rated private health plans to enrollees with annual open enrollment periods that allowed plan switching without reassessment of health risk.

The multiple health plan pool is a model has worked well for large employers for decades and the problems of risk adjustment appear largely to have been sorted out. From the consumer's perspective, the plan would appear similar to the Federal Employees Health Benefits Program. The choice of health plans would vary depending on the region of the country, but every area would have at least one plan available. Premium stability would require consumers to abide by the rule that stabilizes group-insurance pools: continuous participation. Another key difference between employer-sponsored and non-group insurance is that the former provides the individual with guaranteed issue, while the latter is individually experience-rated (i.e., "medically underwritten").

2. *Standardization of the benefit package*. Any system that promotes competition among health plans must wrestle the question of the benefit package. Is it best to have a standardized package of benefits on which all plans base their prices, or should plans be able to offer any benefits they like? Even among advocates of health plan competition, opinion is divided on this issue. Some analysts believe that a standardized benefit package makes it easier for consumers to compare health plans, and reduces the temptation for plans to use benefit packages to attract good risks. Others note that not all consumers have the same preferences, and forced uniformity of benefits reduces consumer welfare.

Certainly precise standardization has the potential to limit competition. For example, requiring staff model health maintenance organizations (HMOs) to charge coinsurance rather than copayments created difficulties in the past, because physicians in staff model HMOs often were salaried, and no fee schedules existed. Medicare has approached the problem by allowing private plans' benefit packages to be actuarially equivalent to FFS Medicare benefits. But what about larger differences in benefit

packages, for example, consumer directed health plans with large deductibles? Hacker would require employers to offer a benefit package "as good as" HCAP, thus ruling out large deductible plans. An operational definition of "as good as" that is realistic, much less efficiency-enhancing can prove elusive, however. Even the strictest interpretation of "standardized benefits" fails to include some of the most important features that distinguish one health plan from another, such as the size of the provider networks, inclusion of specific providers such as specialty or tertiary hospitals, and the location of clinics. Erring on the side of maximum consumer choice, with contingency plans to deal with any problems arising from variation in plan benefit levels, would seem to be prudent course of action. Two areas requiring further thought are risk segmentation and rules for setting employer or government contributions to premiums, as discussed below.

Equal treatment of plans with varying levels of consumer cost-sharing requires equalization of the tax treatment of premiums and out-of-pocket spending at the point-of-purchase (e.g., coinsurance, copayments, and deductibles). One approach that has advantages for fairness and efficiency, would be to replace the current tax deduction of "employer-paid" health insurance premiums with a refundable, advanceable, tax credit used to pay either premiums or qualified out-of-pocket health expenditures.

A related issue is whether public and private plans would have to abide by the same rules regarding approval of new medical technology. Pauly (2005) believes that any serious attempt to make health care more affordable must incorporate some approach to the adoption of costly new technology. He is not optimistic that competition among plans can produce an efficient rate of growth in the adoption of new technology in the current market environment, though the mid-1990s may have provided some evidence that it is technically feasible. Pauly cites legal obstacles as one of several constraints that may prevent health plans from making efficient allocation decisions. Health plans may be unwilling to make even efficient allocation decisions if they run the risk of being portrayed

unilaterally as cost-driven rationers of technology. While *requiring* all health plans to adhere to the same payment rules for new technology could inhibit what little innovation might take place, *allowing* all plans in a market area to adopt the same payment policy regarding a new technology (though not necessarily the same *prices*) without fear of antitrust action might provide a way to avoid the risks of unilateral decisions by individual plans.

The approach to benefit standardization in Medicare has been to specify a basic minimum benefit package, but to allow beneficiaries to purchase different types of additional coverage, either through supplementary policies, MA plans, or Part D coverage. One of the lessons learned from that experience is that the basic benefit package, once specified, is difficult to change, making an allowance for supplementary coverage even more important. Even so, FFS Medicare is disadvantaged relative to MA plans by not being able to offer one-stop shopping – a single product that covers the basic entitlement benefit package, supplementary coverage and outpatient prescription drug coverage. Hacker's proposal would allow private plans to offer coverage that was more (but not less) generous than HCAP.

Hacker's proposal also would allow employers to offer supplementary coverage to to HCAP. Although this feature addresses the problem of diverse consumer preferences, there is a well-known problem with supplementary coverage in Medicare. Because Medigap policies often reduce the point-of-purchase cost-sharing for services covered by Medicare, care becomes cheaper, and demand for care increases. Medicare pays approximately 80 percent of the increased cost due to Medigap coverage, but beneficiaries' premiums reflect only the 20 percent covered by Medigap. The result is a spillover cost from privately financed Medigap policies to tax-financed Medicare.

It is unclear whether supplementary insurance for HCAP would reduce the point-of-purchase price of health care services in the same way as Medigap insurance. If so, and HCAP premiums were paid entirely by enrollee premiums, the spillover problem would be reduced, since the increased cost of

HCAP attributable to supplementary insurance would be borne "internally" by HCAP enrollees. However, HCAP premiums for low income enrollees are publicly subsidized, presumably from tax revenue. Thus, there would be both an increased income transfer from non-HCAP enrollees to HCAP enrollees who purchase supplementary insurance, and from HCAP enrollees without supplementary insurance to HCAP enrollees with supplementary insurance. These transfers could be addressed by taxing HCAP (or supplementary insurance) premiums.

3. *Advertising and consumer information*. Standardized benefits are one approach to improved consumer information, but not the only approach. There has been remarkable progress in the availability of consumer information about varying types of health plans and health care providers in recent years. At the simplest level, employers nationwide have developed clear, concise summaries of health plan information that are distributed to employees at open enrollment. These summaries minimally contain information about coverage, provider networks and premiums, but in some cases have results from surveys of provider quality and consumer satisfaction, as well. But there are limits to this information. As the *Guide to Health Plans for Federal Employees* points out, "We cannot deal with every single coverage nuance or difference … Nor can we assure that all plans will make identical medical necessity decisions in close cases" (Francis 2007).

At the national level, the production of similar information for Medicare and the growing availability of consumer information about the quality of providers are encouraging developments. CMS' detailed information on the Part D plans, including formularies, pharmacy locations, and estimated savings by plan, all produced in an 18 month timeframe stands as one of the remarkable technological achievements in the history of consumer health care information.

Even if only a small portion of consumers access information about plans and providers, it might be enough to discipline the market. Health plans also can incorporate information about the quality of

providers into the provider network decisions. The widespread availability of quality information also can engender a response by providers even if the effect on consumer choice is ambiguous.

A level playing field implies that the same consumer information should be available for both public and private health plans. That information should be tailored and relevant to the consumer's local market area even if some of the plans, e.g., the public plan in HCAP, are available nationwide.

Consumer information should take two forms: standardized information of the type made available by large employers to their employees, and plan-generated advertising. Both public and private plans should be allowed to advertise. Other government agencies who find themselves in competition with the private sector are allowed to advertise, and many have large advertising budgets (e.g., the U.S. Postal Service). Advertising must, of course, be truthful, and the iron-clad rule regarding advertising of the government-run health plan is that the entire cost of advertising must be built into the government plan's premiums. If marketing pathologies are suspected, such as marketing designed to encourage the enrollment of low-risk individuals, those practices first should be analyzed to determine why the enrollment of low-risk individuals is profitable—e.g., a flaw in the risk adjustment system—before simply prohibiting them.

4. Risk selection and risk adjustment. The objective of risk adjustment is to have out-of-pocket premiums of competing health plans faced by consumers reflect the efficiency with which care is delivered, rather than a component of enrollee health status that is not attributable to membership in the health plan.[6] A second objective is to reduce the health plan's incentive to expend resources on efforts to attract only good risks.

The relationship between plan design and risk selection is not a new topic. Concerns over risk selection were rampant in the 1980s and 1990s. One analyst during that period referred to risk selection

[6] This topic is more complex than most analyses recognize. For example, most analysts would agree that a health plan should not be held responsible for the diabetes of a new enrollee, but what about an enrollee who has been in the plan for 30 years and develops diabetes?

as the Achilles heel of all competitive approaches to health insurance markets (Robinson, et al., 1991). Risk adjustment appears to elicit less concern today. It is possible that the potential problems of biased selection simply were overemphasized in a population of working adults with plan switching limited to annual open enrollment periods. The technology of risk adjustment has also improved considerably. As Ginsburg (2008, 683) writes, "Indeed, with the state of risk adjustment having progressed, risk selection that occurs when differences in benefit design are offered would not be as large a problem."

In the Medicare program, private plans were concerned that the risk-adjusters of the 1990s were triggered by utilization data, particularly hospital admission data, and they felt their efforts to reduce unnecessary hospitalizations were being penalized. The problem seems largely to have been resolved when CMS allowed the health plans to have a stronger hand in the design of the risk-adjustment system, resulting in triggers that did not rely as heavily on traditional sources of utilization data.

Currently, concerns about risk selection seem confined to situations in which health plans are dramatically different, as in the case of large-deductible plans versus traditional full-coverage plans. Hacker emphasizes this point in his proposal, ruling out the health savings accounts that accompany large deductible plans and "threaten to further fragment the health insurance market."

5. The choice environment. Working from the premise that both public and private health plans have intrinsic advantages and neither requires artificial advantages in the market, then any restriction on consumer choice between the two types of plans needs careful justification. Although Hacker's proposal allows choice between HCAP (either the HCAP health plan or the HCAP multiple health plan pool) and employer-sponsored insurance (ESI) at the employer level, the HCAP health plan and other employer-chosen plans would not be offered alongside each other to employees.

There are several possible justifications for prohibiting the side-by-side offering of the HCAP health plan and employer-sponsored private plans in the same firm, though none of them necessarily are

convincing. The first involves the calculation of the HCAP premium. Should there be one HCAP premium for the entire country, as in the Hacker proposal, or should the premium reflect geographic differences in health care costs, or the expected health care expenditures of other specific subgroups of enrollees? Part B FFS Medicare premiums are constant for beneficiaries nationwide, which means that beneficiaries and other taxpayers in (relatively low-cost) Minnesota subsidize the premiums of beneficiaries in (relatively high cost) Miami. I know of no efficiency or fairness based defense of those subsidies, yet they are retained and expanded to the commercial health insurance market in Hacker's proposal.

Should the HCAP premium vary by industry? For example, the expected health expenditures for employees in the logging industry might be quite different than for employees in the banking industry. Setting HCAP premiums equal for everyone establishes a system of subsidies across firms whose employees might have very different levels of risk. Are those subisidies desirable or do they mitigate the economic incentives for risky industries to improve the working conditions of their employees? What private plans will be offered in the HCAP pool? Will they be limited to plans that can serve the entire country, or will local private plans be allowed in the HCAP pool? Health care costs vary substantially across the country. If the public HCAP health plan were s offered alongside local private plans, either in the HCAP pool or alongside plans offered by the employer, and the HCAP plan was required to charge only one premium averaged across the entire country, then it seems unlikely that anyone would join the HCAP health plan in areas with lower than average costs.

A good reason to subject the public HCAP health plan to competition with private plans is that the market could help determine the efficient set of benefits for the HCAP plan. Do most consumers really want unfettered access to physicians (comprehensive provider panels and no referrals needed for specialists) if such access results in a substantial increase in premiums? Do they want first dollar

coverage at higher premiums, or some level of point-of-purchase cost-sharing? One way to answer these questions, of course, is to look at the choices that consumers have made in the current commercial health insurance market (albeit often under the effect of prices distorted by the tax deductibility of premiums and out-of-pocket spending). Another way to answer the questions is to test various designs of HCAP against each other and against the designs of private plans in a level playing field choice environment with no special subsidies for the HCAP plan.

In the HCAP multiple health plan insurance pool, should the government limit the number of competing private plans? Although the notion of having two tiers of competition, one for health plans to gain entry to the government-run pool and one for the enrollment of individual consumers, may be intuitively appealing, I know of no evidence that two-tier competition produces lower premiums than open competition and one study to the contrary (Vistnes, Cooper and Vistnes 2001). The long-run equilibrium in the Part D market will be very instructive in this regard. Will the market continue to support fifty different plans in a market area, or will the equilibrium number of plans with any significant enrollment be much smaller?

6. Mandatory participation and default enrollment. An interesting question is whether purchase of health insurance should be mandated, as in Massachusetts. Mandatory coverage solves the problem of adverse selection (consumers waiting until they are sick to purchase insurance), although medical underwriting already makes the adverse selection strategy difficult to implement. Mandatory coverage has the additional advantage of forcing irresponsible uninsured consumers who are able to pay for health care services to do so, but collection agencies hired by health care providers serve a similar purpose. Mannheim and Court (2008) warn that legislative mandates requiring individuals to purchase insurance from private health plans with no "escape clause" (e.g., the option not to drive if one wants to

avoid the mandate for automobile insurance) might be unconstitutional, whereas a mandate to purchase insurance from a public health plan would not.

Proposed mandates often apply to employers as well as employees. In the Hacker proposal, for example, employers would have the option of offering private health plans or contributing to the cost of HCAP for their employees. As long as costs are the same under the two systems it is likely that the results will be similar, since the cost of the employer's mandated contribution to premiums (whether towards a plan offered by the employer or HCAP) would come out of the employee's total compensation. It also is likely that the effect of the mandate on low-wage employees would be the same, inducing the substitution of capital for labor. Whether employer and employee mandates have similar economic consequences for employees depends on the tax treatment of premiums.

One effective way to detect non-compliance with a mandate is to require proof of insurance any time a person visits a health care provider. Uninsured individuals then can be assigned to a health plan. Mandatory assignment can become a contentious issue, depending on the likely health status of non-compliers. It might be the case that non-compliers are young healthy individuals who believe that they don't need health insurance or low income individuals in poor health for whom the premium subsidy is inadequate. In a multiple health plan pool, it would be possible to assign non-compliers randomly to one of the participating health plans.

7. The "employer's contribution" to premiums. The employer's contribution to premiums, though a misnomer, is an important topic because the structure of the employer contribution can alter the total cost of health insurance in the firm. The reason that "employer contribution" to premiums is a misnomer in economic theory is that the employee's total compensation is determined by her marginal revenue product. Competition in the market for the output of the firm prevents the employer from paying the employee more than her marginal revenue product, and competition in the market for labor

prevents the employer from paying less. Total compensation can take the form of either taxable wages or (generally tax-exempt) fringe benefits like health insurance, but more of one type of compensation must be offset by less of another type. This is the reason why economists often are not concerned that rising health care costs will put U.S. firms at a disadvantage relative to foreign competitors. An increase in the cost of health insurance will lead to a decrease in wages or other fringe benefits, but not to an overall increase in the cost of production.

However, this theoretical result does not preclude employer interest in finding cheaper ways to provide the health insurance benefit. In order to retain employees, the employer must maintain the market equilibrium level of employee happiness or utility. Suppose that employee happiness is a function of taxable wages and the characteristics of the health insurance policy (or policies) offered by the firm. Characteristics in this case refers to level of coverage, quality of care obtained from participating providers, and other similar characteristics, but not the *cost* of the insurance product. If the employer (and employees) can find a way to offer a new health insurance product that maintains the same level of employee happiness as a previous product but at lower cost, then that firm will be able to offer higher wages and thus gain an advantage in the market for labor. So employers do care about the cost of health insurance products, even though they don't actually pay the cost of insurance.

Vistnes, Cooper and Vistnes (2001) reviewed several different strategies of offering multiple health plans to employees, including a single health plan and multiple plans with different methods of employer premium contributions. They found that total costs were minimized when the employer offered multiple health plans and set a level dollar contribution to premiums.

It is possible, of course, for employers to structure premium contributions so that employee enrollment choices *do* affect employer costs. Suppose that employers set their contribution to premiums at an equal percentage of the premium for each plan, *and do not adjust wages or other fringe benefits*

when employees choose more expensive plans. In that case, the employer's labor costs will rise when employees choose more expensive plans. If HCAP and employer-sponsored private plans were offered side-by-side, it would be important to consider the employer's incentives regarding employee choice of plan. If the employer's costs were reduced by enrolling high-risk employees in HCAP, for example, then the employer's incentive would be to structure the contribution to premiums to encourage enrollment of high risks in HCAP. One way to neutralize the employer's incentives is to require the employer to make the same risk-adjusted contribution to premiums for both HCAP and private health plans.

A practical question regarding the employer premium contribution arises when benefit levels are very different from one plan to the next. This problem becomes especially acute when large-deductible health plans are mixed with traditional health insurance products. The way in which the problem is resolved can have the effect of distinguishing health plan features that are considered essential versus those that are considered amenities. If the employer sets a contribution to premiums based on the lowest cost plan in the choice set, regardless of its features, then the cost-increasing features of more expensive plans that are not shared by the least expensive plan implicitly are deemed amenities, rather than essentials, and employees must purchase those plan features with out-of-pocket dollars.

8. The employee's contribution to premiums—tax effects. The tax treatment of employer and employee premiums is an important part of any health insurance proposal. Presumably, any employer contributions to health insurance costs would be deductible from corporate income taxes as a cost of doing business, and under Hacker's proposal employer contributions to health plan premiums would continue to be exempt from the employee's personal income and FICA taxes.

Employee-paid premium contributions to HCAP would be taxed as other employee-paid premiums under current law. This strategy almost certainly would ensure, holding other factors constant,

that the wealthy would remain in private plans while the poor would join HCAP. Hacker acknowledges, "Thus, enrollees in the Health Care for America Plan would mostly be current beneficiaries of Medicaid and S-CHIP, low-wage employees, and the working uninsured, as well as early retirees, contingent workers, and the self-employed" (Hacker 2007, 5).

9. Setting provider payment rates in the government-run health plan. The controversy over provider fee discounts obtained by a large payer with price-setting ability has been mentioned at several points. As in the case of administrative costs, the goal of provider fees is not to minimize them but to find the efficient level. The efficient level is the point that equalizes the supply of, and demand for, the services of health care providers. As discussed by Nyman . (2003), one difficulty is that in markets with insurance, the level of demand for an insured service is likely to include a component of inefficient moral hazard. Should provider fees be set to supply that inefficient level of demand?

Another problem is that pricing decisions by a large payer can affect the supply of services to enrollees in smaller health plans in complex and often non-intuitive ways. For example, if the large price-setting plan reduces its provider fee levels, it might seem obvious that providers would raise their prices to other health plans. However, if the large plan lowers its fees, providers should want to see *more* patients from the smaller health plans, and the way to do that is for them to *lower*, not *raise* their prices to patients in those smaller plans. Analysts who believe the opposite should ask themselves if they believe that providers would *lower* their prices to smaller plans if the larger plan *raised* its fees.

Are smaller health plans placed at a disadvantage in the market for provider services relative to Medicare? Should providers be required to serve enrollees of private health plans for the same fees as FFS Medicare (or the public plan in HCAP)? If FFS Medicare's fee discounts are cost-justified because FFS Medicare patients are cheaper for providers to treat than the patients of smaller health plans, then inefficiency in FFS Medicare price discounts would be limited to any inefficiency associated with

incomplete risk adjustment. If FFS Medicare's discounts are the result of monopsony pricing power, then extending that pricing power to private plans would increase the level of inefficiency.

Taking FFS Medicare as an example, we could ask what it would mean to require providers to serve private plans' enrollees for the same fees as FFS Medicare's beneficiaries? As in other markets, private plans are free to demand any level of discounts they like from providers, and providers are free to accept or reject the offer. Presumably, mandating FFS Medicare fee levels for private plans would mean the provider who failed to grant FFS Medicare discounts to private plans would become ineligible to serve FFS Medicare beneficiaries. In areas where such a mandate had any teeth, the result would be *de facto* price controls, and there is no guarantee FFS Medicare's fee levels are efficient (Dowd, et al., 2006-07). The same concern extends to all forms of price controls, including all-payer fee schedules determined administratively rather than by the market.

FFS Medicare fees vary only by the geographic practice cost indicator (GPCI) and that adjuster takes only the price of inputs to the practice of medicine into account, not market conditions like variations in demand or supply of health care services. FFS Medicare fees might be inefficiently high in some markets and inefficiently low in others. Pricing by private health plans provides an independent check on efficiency of FFS fees. Lack of responsiveness of FFS Medicare fees to local market conditions as well as the lack of any well-specified process for monitoring the effect of FFS Medicare fees on provider access by Medicare, Medicaid, or commercially insured patients does not provide support for the concept of efficient price setting by the government. On the other hand, greater flexibility in Medicare fee-setting could open up the process to greater political manipulation.

10. Who should run the new system? There are two levels of administration to consider in any mixed public and private insurance system: (1) who should run the public health plan (if there is one); and (2) who should set the rules for the overall system?

If a new government-run plan were established, it would be necessary to consider exactly what "government-run" means. Although policies for FFS Medicare are set by Congress and CMS, claims payments and many quality assurance tasks are administered by private or quasi-private firms. In theory, there is no reason why many of the administrative tasks of the government-run health plan could not be subcontracted to the private sector, including disease management, utilization review, marketing, and provider contracting. Although CMS would be an obvious candidate to administer a government-run plan, particularly if many of the costs of administration were fixed costs already incurred in the administration of the FFS Medicare, it might be difficult for CMS to adapt to, or incorporate, a new system that relied much less heavily on government administration. Otherwise, there might be some advantage to establishing a new independent agency free to innovate and whose performance could be compared to that of CMS.

Assigning administrative responsibility for the entire mixed public-private system is a much more difficult question, and one with a long history, even in the purely private sector. When fully-insured HMOs first were offered by employers alongside the employer's self-insured plan, there was concern that employers were establishing premium contribution rules to favor selection of the self-insured plan by good risks.

Throughout the history of private plans in the Medicare program, there have been charges that portions of Congress and CMS were hostile to private plans, and the design of the TEFRA-risk and Medicare+Choice systems with their restrictions on premium rebates, their uneven reporting requirements for private plans versus FFS Medicare, and the insistence on an HMO-only competitive pricing demonstration in the 1990s gave those charges some credibility. Periodically, there are proposals to establish a relatively free-standing entity, modeled after the Securities and Exchange Commission or the Federal Reserve Board, to administer a mixed public and private health insurance

system in Medicare. Today, in contrast, some claim that CMS is favoring private plans over traditional Medicare (Berenson and Goldstein 2007). Advocates of managed competition often hold up the Federal Employees Health Benefits Program as a successful example of a quasi-private system in which multiple health plan choices are offered to employees. Although the employer is the federal government, the health plans in FEHBP are private, and unlike FFS Medicare, which is micro-managed by the Congress, FEHBP is managed in a relatively autonomous manner by the Office of Personnel Management. However, the stakes would be much higher in a mixed public-private system for the entire commercial insurance sector, and it seems unlikely that such a system could avoid the political micromanagement that has plagued the Medicare program.

Conclusion

The position that public and private plans each have some intrinsic advantages that do not require artificial support leads to the recommendation that they be offered on the same terms to consumers. Difficulties arise when analysts attempt to impose asymmetric constraints on either set of plans, or plan designs that have not been vetted by the market. Requiring the public plan to contract with all willing providers in a market area or to offer unrestricted access to specialists are examples. If the cost increases associated with such restrictions are worth less to consumers than their cost, then advocates of those restrictions will find that they have to impose further restrictions to keep the public plan from being rejected by consumers. The result is an endless array of adjustments designed to favor either public or private plans.

A simpler approach would be to equalize all rules and all subsidies (e.g., premium subsidies for low income consumers) across public and private plans. Undoubtedly, the result will some level of inefficiency and some features that will be considered unfair. But the alternative is the somewhat

tortured history of private plans in the Medicare program which cycles from one set of restrictions and overpayments to another.

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