

COULD A PUBLIC HEALTH INSURANCE OPTION LEAD TO MORE COMPETITIVE MARKETS?

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Calls for the establishment of a “public option,” which emerged during the debate on the Affordable Care Act, have re-emerged in this election season. Some proposals base the public option on Medicare, while others on Medicaid. In this article, Wharton professor and LDI Senior Fellow Mark Pauly discusses the likely effects of a public option on private markets, using experience in Medicare Advantage as a guide. Will the public option become the preferred one, sweeping away the private market? Or can the public and private options peacefully coexist?

INTRODUCTION

Even though the proportion of uninsured people in the U.S. has fallen to 8%, there are still calls for ways to make more lower priced plans with serious financial protection available, both to close the coverage gap and to avoid sliding back into uninsurance by customers who feel that current premiums are unaffordable (Winfield 2018; Mangan 2016; Kasumov 2018). One frequently discussed policy is to make a public option available alongside the private options in individual insurance markets and the job-based private insurance most people get (BidenPresident.com 2019; Bradner and Luhby, 2019). The assumption is that, sometimes, this option may be less costly and/or more attractive than the private plans available to individuals or at the job. To date this discussion has largely proceeded on ideological grounds. Progressives give the public option the benefit of the doubt in terms of its ability to offer a superior product (Rovner 2019), and conservatives are concerned that government officials may set up a process that favors the plans supplied by their sponsor (Book 2009; Hoff 2009; Torrey 2019; Yglesias 2019). The public option might either be a plan brought to you by the people who manage original Medicare, or it might be the plan each state’s Medicaid program offers to low-income people (Andrews 2019; Sanger-Katz 2019).

The most obvious benefit in a market (as opposed to a political) setting of adding an option is that it expands the list of choices available to the relevant populations; indeed, “choice” is included in the title of many of the Medicare or Medicaid option bills. While some critics think that consumers already face too many coverage options in some markets (Becker’s Hospital Review 2014; Schwartz 2016; Zolkefli 2017), given their hypothesized inability to make rational decisions, others favor the proposed expansion for several reasons:

- Some consumers may trust government-affiliated plans more than private plans and may therefore choose to obtain or retain coverage.
- Increased competition in local markets where existing private plans are near monopolies may lower premium markups or improve coverage.
- Public plans may be more successful in bargaining over prices for medical goods (drugs) and services (doctor visits) where sellers have some market power.
- If the public option is sufficiently popular and displaces a large share of private insurance, it will be politically and administratively easier to move to a single payer public plan than at present, when hundreds of millions would have to abandon the coverage they now have (Partnership for America’s Health Care Future, 2019).

The competitive hope is that these new public plans will be more likely to say “no” to overpriced sellers or to low-value services than commercial insurers historically have been. The political hope is that the public option may use the tool of a competitive voluntary market ultimately to wipe out the need for competitive markets. However, for the latter process to occur, there must first be a reasonable expectation that a public option will become the preferred choice for nearly everyone.

I have recently completed a study of the role of competitive markets in health insurance and health care that argues for possible positive effects from more competition (Pauly 2019). How strong is this argument in favor of a public option and what outcomes are possible or likely?

MEDICARE AS A PUBLIC OPTION

One proposal envisions that the Medicare program, somehow defined, might be made available to some or all people currently buying private insurance, but with modest or no subsidies, compared to the 90% subsidy rate available to people over 65. Today’s Medicare plan consists of two classes of options—“Original Medicare,” a largely fee for service (FFS) plan for hospital and doctor services (with an Accountable Care Organization sometimes available), or private Medicare Advantage (MA) plans offering at a minimum the same benefits as Original Medicare at the same premium with zero additional charge.

Medicare Advantage has been gaining market share at the expense of both original Medicare FFS and the public managed care ACO. Its share of total enrollment is about 35% (Richman 2018). Here we have an example of competition between public and private options in which the private option is displacing the public one. Neither the ACO innovation nor attempts to link FFS physician payments to quality have thus far been able to stem the tide.

While we cannot know how the shares might change over the next five years, it is reasonable to guess that original Medicare will still be a majority, the ACO by a small minority, but MA by an increasing number of newer beneficiaries. Probably those who choose each option will prefer that option – so if any option gets significant take-up, that will be (after the fact) evidence that having the option was a good policy. Particularly if different options are chosen by different

people with similar income and wealth (as seems to be the case), that suggests that a uniform single payer policy would not meet the desires of a heterogeneous population as well as offering choices does. If the version of Medicare that offers both Original Medicare and private alternatives were to be made available to more of the population, what could we conclude?

If original Medicare retains a sizeable share, that will be evidence for the value of a public option. If private insurance also obtains much of the market, that will be evidence both of preferences by many for a private alternative, and evidence that the terms of tradeoff between the options are not biased in favor of one or the other. Finally, the increasing share of MA is strong evidence that a public option does not dominate the market (even when it started out with first mover advantages). Thus, there is no reason to believe that offering a public option in other markets will lead that option to become the plan “for all.” A more likely scenario is that public and private options will coexist, as in today’s Medicare, with insurance buyers choosing based on the relative value a plan delivers. Most importantly, there is no evidence to support the presumption that the public plan will deliver better value. Below we will discuss why not.

The current process for setting the terms of choice between public and private plans in Medicare is complex. A simple version would be



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one in which a dollar amount of the plan subsidy is set in some way and then private plans could price above or below, returning any saved premiums in cash in the latter case. Medicare uses a quasi-bidding process to set its contribution and limit benefits and refunds – but probably the system makes little difference to the final market share.

The primary arguments for the eventual dominance of a public option are (a) the public option will have lower administrative cost and (b) the public plan will have more bargaining power. In Medicare data, the administrative cost of original Medicare as a percentage of claims is lower than for private insurance in general. Some of that difference is

artificial: the Medicare population has higher average claims than the under 65 population, but the administrative cost per person covered is not very different. And there is additional administrative cost associated with Medigap coverage because the Original Medicare plan is not a good fit with what most seniors want. More substantively, however, even with more going to administration (about twice as large a percentage) the MA plans are able to offer more attractive benefits (some of which are only possible because of the administrative expense). Some of the administrative cost goes toward managing care, which Original Medicare as an FFS plan does not do, and some goes to designing better coverage. The key point is that here as elsewhere consumers do not choose the lowest-overhead, most frugal insurance seller but rather the one that has a product model and price combination they find attractive—even if this skims off a little more in profit.

The argument that original Medicare has pricing power because of its largeish market share (relative to any one MA plan) and because of its ability to deploy political pressure seems correct. Original Medicare does pay substantially less per unit of physician or hospital service than commercial firms in the under 65 market. However, private MA firms have been able to get physicians to provide services by paying roughly the Original Medicare price for doctor services (and less for some other things like medical equipment) (Chen, Hicks, Chernew 2018).

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We do not really know why this process of piggybacking on Original Medicare’s price deals works, or what would happen if Original Medicare cut its physician fees yet further. Right now about 25% of primary care doctors refuse to take new Original Medicare patients. In Medicaid with lower prices the percentage taking patients is even lower. There must eventually be a serious tradeoff between “negotiating” lower prices and access to care that limits negotiating strategy.

At present, however, whatever Original Medicare does fails to convey an advantage to it relative to private plans. Any price bargaining power may have gone as far as it can go; even a larger share for some original Medicare plus Medicare buy-in probably will not add much to Medicare’s ability to hold down reimbursement if it wants to continue to assure the same supply of and access to providers. Maybe not—physicians especially have little alternative to taking whatever Medicare offers if there is no other big game in town. Hospitals can and surely will threaten to go broke if payments are held down more strictly for more of their customers, and for many of them that will be a credible threat. Drug pricing is harder to understand, since getting discounts requires restricting the choice of options (e.g., to something like the VA formulary), which may not be especially appealing in a public option. For breakthrough drugs with no close substitutes (the most overpriced drugs, according to critics) the bargaining power of Medicare or any large buyer is very limited because there is no credible threat to walk away.

The conclusion so far is that a neutral and unsubsidized extension of the option to buy into Medicare at what the care will cost to insure probably will not sweep the field, or even dominate the voluntary insurance market—if recent experience with Medicare Advantage is any guide.

MEDICAID

Others have proposed a buy-in to state Medicaid programs as a way of offering a public option (Wikelius and O’Toole 2018). The Medicaid insurance program traditionally offered coverage with zero premiums, near zero cost-sharing, but much below-market levels of provider reimbursement. Many physician practices will not accept Medicaid patients (or new Medicaid patients), thus creating a de facto “preferred” provider network among those who do—preferred because they are willing to work for less. In contrast, virtually all hospitals are still willing to accept Medicaid patients even with low reimbursement. So would offering a Medicaid buy-in appeal to people who currently choose private insurance?

Lower estimated premiums in Medicaid buy-in plans (relative to commercial insurance) have to come from hypothetically lower provider payment negotiated by the state Medicaid bureaucracy or its contractors, compared to what private plans can currently do.

Why should anyone expect Medicaid to be able to get providers to take less than commercial rates for their new non-poor customers? Clearly Medicaid or any other insurer can set its reimbursement rates—so the real question is the level of provider supply or acceptance it can get at those low fees.

There is an analytical challenge to determining the relationship between reimbursement level of individual insurance for the non-poor (or any other insurance) and the number of providers willing to

large base of poor enrollees (say, by threatening to withdraw their business unless the provider accepts the same low price for its new non-poor plans). It may be possible for a plan to exert more public relations pressure, especially on hospitals, if they should refuse the public's plan (in what is purely a commercial dispute).

The literature on the relationship between Medicaid reimbursement rates for original Medicaid is almost entirely correlational and somewhat old. Using cross-sectional research on payment levels (relative to Medicare), studies invariably find a positive correlation between the reimbursement rate a state chooses and the proportion of primary care physicians accepting Medicaid patients or new Medicaid patients. Currently, about 70 percent of physicians accept new Medicaid patients at the average payment rate set by states,

(Masterson 2019; Holgash and Heberlein 2019; Paradise 2017; King 2019), but about half of physicians report that their Medicaid patient share is 10 per cent or less (Gillis 2017).

What does this experience tell us about the ability of Medicaid plans or contractors to extract lower payments than private firms? The significant interpretation is that lower payments will be met with less willingness to take

people with such insurance. Lower payments create a de facto provider network (of those providers willing to accept patients at the low payment). Premiums will therefore be lower but coverage will not be so attractive, thus limiting the market share of the public option.

Will a new Medicaid-for-all plan that sets a low level of reimbursement ever be able to achieve greater provider participation than a private plan that did the same thing? The answer is probably not.

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supply care for a given (low) fee. On the one hand, if the insurer has a large captive population (e.g., because a state has a 'high' low-income population), it will be able to threaten providers with loss of business unless they accept low fees. But on the other hand, providing fees below some “equilibrium” level will cause providers to reject the insurance and feel no great loss if the business goes away. So there could either be an inverse relationship between fee levels and provider participation, driven by varying determinants of market share, or a positive relationship between fee and participation, driven by (possibly mistaken) valuations in fee levels an insurer tries out for its given population.

One way to think about this is to imagine that, conditional on potential market share, there will be a positive relationship between fees and provider supply, but that variations in exogenous market share shift this relationship, evoking more supply at a given low fee level if an insurer has a large share.

Would the new Medicaid-for-all option be endowed with a tradeoff that is more favorable than that faced by its commercial competitors? One hypothesis is that it can somehow “leverage” its already existing

AN UNBIASED CAMEL'S NOSE

My conclusion so far is that offering a public option in an unbiased or neutral way would probably be desirable as an addition to competition, one that some buyers would like better or trust more than commercial plans, and that would put pressure on commercial premiums. It might even permit less strict state regulation of private plans because consumers could be advised to choose the public plan if they wanted to be safe from profiteering and fine print.

But many market advocates are nervous precisely because they feel that a public option would be the camel's nose into the under-65, non-poor insurance market tent (Atlas 2019). Are there features of proposals for public options that would tip the scales in favor of government?

There is the possibility of obvious bias through taxation, premium regulation, or coverage limits. Probably the public plan will cover the same essential services (and zero copayment for some) as private plans on the exchange. The more obvious biases should be able to be prevented but there may be more subtle ones.

The second possibility is if subsidies favor the public plan. The current calculation of subsidies is benchmarked against the premium of the second cheapest silver plan and that could be the public plan. Risk adjustment is also another possibility for bias given its inherent imprecision. There have been some attempts to reduce payments to MA plans by changing risk adjustment. Probably the most important point is that thus far, superior private plans have been able to override new biases against them in Medicare.

The most serious source of bias, raised by the proposal of Vice President Biden, is that the public option that initially has no enrollees will be able to propose a premium based on the Medicare FFS schedule, which seriously undercuts private payments. This self-fulfilling prophecy can then lead to a large market share for the lower-premium public option. However, as noted above, private MA plans have been able to match Original Medicare discounted pricing. One question is whether that could happen in the private under 65 individual market (it does not happen now) without greater limits on access than the 20% or so already experienced by Original Medicare. It will be difficult to answer this question a priori, and proposals for private plans for people under 65 to match the public option will lead to provider complaints.

Could any private plans compete in the market with a low pay, high pressure public option? I think it is plausible that there would be success but some prior planning and analysis of this issue is obviously needed. Other attempts to pressure private sellers of medical services or drugs to give lower prices to Medicaid have generally not panned out, so the leverage over doctors who have agreed to accept Medicare's fee schedule may not matter much but will need monitoring.

CONCLUSION

Supporters of private markets in health insurance that include both for-profit and public plans might consider tentative if watchful support for the idea of a public option. It would be a way to display the courage of their convictions in the superiority of private firms, and might also be a way to fix up some deficiencies in the extent of competition in some individual markets after Obamacare. I doubt that in this round of Exchange competition, as in the previous one, that group insurance

will lose much ground to the individual market, most especially if the tax exclusion for the former remains in place. There is still a good case for fixing the current help-the-high-income value of the exclusion (Committee for a Responsible Federal Budget 2015).

What kind of health care delivery system will be linked with a

public option has gotten very little discussion. The usual assumption is that it will look like Medicare FFS or whatever the private contractors for a state's Medicaid program have come up with, but perhaps some innovative ideas will emerge among private competitors. The size of subsidies offered to different population groups for insurances of all types need to be examined and rationalized since they are at best ad hoc and often unfair. But markets probably have little to fear from a neutral public option.

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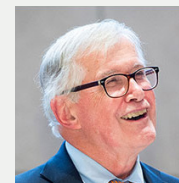
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