6. Public option

- What is a public option?
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- The public option's ability to lower costs

What is a public option?
Designed to fuel competition in the healthcare insurance marketplace and reduce costs, public option proposals option is a public plan that either 1) competes with private plans, such as in the ACA marketplaces, or 2) allows participation in/buy-in to Medicare or Medicaid by Americans who currently are ineligible for those programs. Public options are often associated with single payer health plan concepts. However, it should be noted that the public option is not the same as single payer healthcare, which is public but includes no other "options" or alternatives.
History:
The public option made its debut as a coverage alternative during healthcare reform negotiations leading up to passage of the Patient Protection and Affordable Care Act.
Several bills in the House of Representatives during the 2009-2010 healthcare debate included public option proposals:
- The Affordable Health Care Act for America Act (H.R. 3962) and its predecessor, the America's Affordable Health Choices Act of 2009 (H.R. 3200) had established this option as a qualified benefit plan that would compete with private insurers in a marketplace format; and
- The Public Option Act (H.R. 4789) would have enabled all citizens and permanent residents to participate in Medicare.

The idea never caught on in the Senate and the public option was eventually removed from the debate due to lack of political support. Instead, lawmakers pursued the idea of competitive state-based insurance marketplaces or exchanges to offer a variety of health insurance options to consumers.

Analysis of recent proposals to establish a public option in the U.S. healthcare system
Background Facts:
Lawmakers have made a number of attempts since ACA passage to introduce and approve a public option alternative.
2013: Rep. Janice Schakowsky (D-IL) introduced H.R. 261, the Public Option Deficit Reduction Act, which would have offered a government-run alternative on the federally run (?) ACA marketplace with premiums lower than private insurance offerings. Schakowsky in 2015 reintroduced the bill as H.R. 265, gaining 37 Democratic cosponsors.
Present Day: The public option has gained renewed momentum on Capitol Hill over the last year or so. Several proposals, mostly from Democrats, draw from current healthcare programs to expand coverage for Americans and offer more affordable coverage options:
- Sen. Brian Schatz (D-Hawaii) and Rep. Ben Ray Luján (D-N.M.) have a proposal to create a Medicaid-based option, which would be offered on the ACA state marketplaces. Under the State Public Option Act, any resident regardless of income could buy into a Medicaid

insurance plan. Sen. Bernie Sanders (I-VT) is a co-sponsor; but otherwise this is a Democrat-supported bill. States would have the option of adopting it—and may decline, so some experts question whether it would have much impact.

- Another proposal that would create a public option benefit on the state marketplaces is the "Medicare X" bill (S. 1970) sponsored by Sens. Tim Kaine (D-VA) and Michael Bennet (D-CO). Adopting the framework of the Medicare program, the bill would initially offer Medicare X in those exchanges with limited options. Eventually, it would be available throughout the individual market and in the Small Business Health Options Program (SHOP) Exchange.
    - The government would be able to negotiate drug prices under Part D, and providers would get reimbursed under Medicare rates, with some flexibility to increase reimbursement for rural providers. Seven other Democratic senators have signed on as cosponsors.
- A related but different effort is Sen. Sanders' Medicare for All Act bill (S. 1804), which seeks to provide universal, government-operated coverage through taxpayer support, reducing Medicare's eligibility age over a four-year transition period, until all U.S. residents are eligible by the fourth year. The government would also have the ability to negotiate drug prices. However, the bill has yet to establish bipartisan support—Sanders introduced it along with 16 other Democrats. This ultimately is a single-payer approach rather than a public option, but often is mislabeled as the latter.

Would a Medicaid or Medicare Buy-in Work?

Medicaid: Offering Medicaid on the state exchanges or marketplaces would be a very difficult concept to implement, mainly because Medicaid programs vary widely among the states and incorporate both fee-for-service and managed care. Whether a buy-in would save money and provide more choice for consumers would depend on their state of residence. It's doubtful that the 19 states that didn't opt to expand Medicaid would adopt a buy in. Given that many plans already participate in Medicaid, and Medicaid managed care plans represent some of the most successful plans in the insurance marketplaces, many observers say that adding a Medicaid buy-in wouldn't be that useful. Also, Medicaid usually pays providers at lower rates than do private insurers. It's not clear that there would be enough providers willing to accept those rates in all areas, which could mean delayed or reduced access for Medicaid beneficiaries. The formula for state and federal funding might need to be adjusted to allow for a buy-in. Still, a Medicaid buy-in option would be attractive to consumers because cost-sharing for Medicaid is much lower than for most other private and government payers.

Medicare: A Medicare buy-in could work in theory, but implementing it in practice would be very challenging, considering how complicated Medicare is. Parts A, B, and D all have different funding sources and contribution requirements. Provider reimbursement rates for Medicare are closer to those of private insurers (compared to Medicaid), but many providers still might balk at accepting those rates for an expanded population. Medicare has the advantage of being well-regarded nationally (unlike Medicaid, with has some stigma for being designed for poor Americans). The design of any buy-in option – i.e. what would be covered, how much new enrollees would be expected to contribute, and whether provider payment rates would mirror

current Medicare standards – would determine how attractive buy-in would be to consumers and its cost to the government.

Capping provider payments: Adapting Medicare Advantage's cap on provider payments may serve an alternative that Urban Institute analysts say would be more politically feasible and easier to implement than a public option. Applying such a policy to all ACA-regulated health plans in the individual or nongroup market means that providers couldn't demand payments any higher than Medicare rates. This would help control costs in areas of high premiums and break down monopolies that exist in certain markets, opening them up for more competition. The Medicare Advantage limit, which forbids "balance billing" by providers, even if they are out of network, provides precedent for this approach. The cap needn't be exactly at Medicare levels; it could be moderately higher, but still low enough to keep premiums down while providing enhanced competition in markets suffering from a lack of carriers.

Model Achieving Success in CA: As Washington lawmakers look to revive the public option, one plan in Los Angeles says it's achieved success with this model, at least on a regional level. L.A. Care Health Plan (whose CEO is Zetema member John Baackes), describes itself as "the nation's largest publicly operated plan." L.A. Care launched in 1997, initially contracting with seven established health plans to provide insurance to low-income populations. It offers coverage with MediCal and Medicare Advantage Special Needs plans, and competes with 5 private insurers on the Covered California ACA exchange to offer affordable options to consumers. Overall, it covers 2 million people in the Los Angeles County area. Experts have suggested that L.A. Care could serve as a model for a "State-Designated Regional Health Consortium" or SDRHC, a public, not-for-profit or cooperative that could be offered on the ACA marketplaces or outside of the exchanges.

The public option's ability to lower costs
Background Facts:
2009: During the ACA healthcare reform debate on Capitol Hill, the the Berkeley Center on Health, Economic & Family Security did an economic analysis on the costs and benefits of a public option. The report included estimates from the Urban Institute, which projected that the public option would save the government $47 billion per year or more than $400 billion over ten years, and overall save $79 billion per year or $800 billion over ten years. The Lewin Group and Congressional Budget Office (CBO) similarly projected that U.S. healthcare costs would decline under the public option, saving the federal government money.
2013: CBO estimated that Schakowsky's proposal to add a public option plan to the ACA marketplaces would reduce federal budget deficits by $158 billion over ten years. Premiums for the public plan would be between 7% and 8% lower, on average, during the 2016–2023 period than premiums for private plans offered in the exchanges—mainly because the public plan's payment rates for providers would generally be lower than those of private plans.
Today: CBO has yet to score any of the current public option proposals in Congress. However, a 2016 Urban Institute analysis of Sanders' single payer healthcare plan, a similar proposal to S. 1804, concluded that single payer would cover more people but increase national health care spending as well as federal government spending. Sanders' plan to automatically enroll all U.S.

residents in acute care coverage would reduce the number of uninsured by more than 28 million individuals in 2017 and by nearly 31 million in 2026. At the same time, the report estimates that national health care expenditures would rise by nearly $519 billion in 2017, reaching $6.6 trillion by 2026. Federal government spending would increase by about $2.5 trillion or 257.6% in 2017 and $32 trillion or 232.7% over ten years.

Analysis: Looking at these spending figures, it appears as if the single payer route would cost a great deal more than a public option approach. This could be because a public option seeks to contain costs by spurring competition with private insurers, a feature that single payer doesn't have. It's also possible that public option proposals would reimburse doctors at lower rates.

An Urban Institute analyst offers additional insights:
A single payer system would be much costlier than a public option because one is a full-blown overhaul of the healthcare system and the other is an incremental model that seeks to offer low-cost health insurance. A public option aims to reimburse providers at Medicare rates, which is lower than what's typically offered by commercial plans like Cigna or the Blues plans. This is what drives down costs, appealing to consumers looking for cheaper health insurance. Single payer by comparison takes everything that exists in the insurance market, and merges it into one government-run plan. These plans assume no cost-sharing, premiums, deductibles or copays—which means that the government is paying for everything instead of individuals. The government would also be absorbing costs previously paid by the states or employers. Costs would also rise due to consumers taking advantage of the free healthcare and using more services.

6.1 Public option: discussion questions

- Should federally managed ACA marketplaces include a public option?
- Should states be encouraged to allow Medicaid buy-in for their residents? If so, for which residents, and under what conditions?
- Should the federal government allow individuals to buy in to Medicare? If so, who should be eligible and what should they pay? Should there be both FFS and MA options?
- Under what circumstances would a public option be most likely to emerge?
- What are the key political issues for the public option on the national level? The state level?
- Can the L.A. Care model be replicated on other state-based exchanges? Should it be?
- Would a public option be more likely to accelerate movement toward a single-payer system, or to demonstrate the benefits of a competitive healthcare marketplace?
- Would the Urban Institute's suggestion of capping provider payments rein in costs and encourage competition without moving to a public option?
- Would a public plan spur more competitive pricing from private insurers in ACA marketplaces?
- Would a public plan be able to negotiate lower prices with providers in the same way that Medicare does?
- Should individuals eligible for group coverage be allowed to buy into a public option?

- Should the federal government offer a public plan that would compete with private insurers for group coverage?
- How might a public plan be funded at either the federal or state level?
- Which of the current public option proposals in Congress would be most likely to save money for the government while lowering health care costs?