Public Option/Medicare or Medicaid Buy-in Position Paper

July 2021

ISSUE SUMMARY

Proposals are currently being considered to implement a public health insurance plan, also known as a public option, as well as proposals that allow a buy-in to Medicare or Medicaid. These programs would provide coverage to Americans through state or federal marketplaces that would compete alongside private insurance plans. Studies suggest that over 139 million Americans might obtain coverage through this plan by 2031 and grow to over 174 million by 2050.[1] As a result, this costly government program would increase federal non-interest outlays by more than $1 trillion in 2050.[2] NAHU strongly opposes the creation of a public option or a buy-in to a public program, as these programs would not compete fairly with the private market, could potentially devastate existing private-market coverage, hinder access to care, exacerbate the worst elements of existing public health programs (including inefficiencies, high costs and bureaucracy) and would be financially infeasible in the long run.

BACKGROUND

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

Leading proposals for a public option or a buy-in to a public program would make these programs available to consumers purchasing coverage through the state or federal marketplace. Many proposals would allow public plans to pay providers using Medicare rates, something private plans are unable to do. Whether using Medicare rates or not, as public plans, these plans would have the power to dictate prices, provider networks and provider reimbursements. Additionally, a public plan could potentially indemnify itself for unexpected costs, allowing it to offer coverage at below-market costs. It would also have an unfair advantage calculating its medical loss ratio (MLR), as administrative costs could be assumed by other sections of the government where private insurers would have no similar offset. In any event, this is not true competition where all players in a market play by the same rules. In any market, if one participant has an unfair advantage, others are quickly pushed out of the

[1] Lanhee J. Chen, Ph.D., Tom Church, and Daniel L. Heil. The Budget and Tax Effects of a Federal Public Option after COVID-19. October 20, 2020.
[2] Ibid.

market. In this case, the end result might be that the public option or buy-in would ultimately be the only option for consumers.

NAHU strongly opposes the creation of government-run plans to compete with the private insurance market. A public plan would create an unleveled playing field with devastating results on private-market coverage. According to a study, the government would set public-option premiums approximately 25% below the market value of comparable private insurance plans.[3] Since a public plan could set provider reimbursement rates similar to existing public programs, it would significantly undercut the rates paid to providers by private insurers. More individuals with public coverage characterized by low reimbursement rates will result in devastating financial losses for hospitals, especially in rural areas. Ultimately, provider participation could diminish and we risk losing our top physician specialists, sole practitioners and smaller private practices, which would be of further detriment to access of care.

Additionally, one of our most serious concerns about the public option and buy-in proposals is their potential to further exacerbate the cost-shift that already drives up healthcare spending. Cost-shifting is a hidden tax on private payers that occurs when government payment rates are too low and providers shift costs to the privately insured to make up the difference. The public-plan reimbursement rates result in these costs being shifted onto private insurers and plan enrollees. The Congressional Budget Office (CBO) found that the introduction of a public option would create pressure for cost-shifting onto employer-sponsored coverage and private plans on the ACA exchanges in 2013.[4]

We are also concerned about the effect of public plans and buy-in programs on the employer-sponsored health coverage system. Most proposals allow people with employer coverage to opt out and instead buy into the public program. A 2021 study conducted by FTI Consulting found that over 1.5 million currently insured individuals will likely forgo private insurance under the proposal.[5] We are concerned about the effect pulling people out of employer-sponsored plans would have on those who remain in employer plans, and whether the remaining employer plan pool would be damaged as a result of lower participation. Moreover, we are concerned about the coverage adequacy a public plan would be able to offer to Americans. Existing public plans often provide less coverage and restrict provider access more than the average employer-sponsored plan, with the CBO estimating that the benefit package for Medicare is 15% below the average employer-sponsored plan. Under Medicaid, specialists are often inaccessible without long waits. Under a public option, Americans could find it increasingly difficult to make appointments with physicians and other healthcare providers. This is

[3] FTI Consulting. Assessing the Impact of a Public Option on Market Stability and Consumer Choice. November 19, 2019.
[4] Ibid.
[5] FTI Consulting. Ripple Effects: Potential Impacts of a National Public Option on Provider Viability and Disparities in Access to Care. July 14, 2021.

because lower payments would make it increasingly unaffordable for providers to see patients – particularly with additional patients becoming covered under the public option.

HISTORY OF PUBLIC-OPTION PROPOSALS

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

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

PUBLIC-OPTION ALTERNATIVES IN THE FINAL ACA PACKAGE

Two public-option alternatives ultimately were implemented from the final ACA package that was signed into law: Consumer Operated and Oriented Plans (CO-OPs) and a Basic Health Program (BHP). The CO-OPs were proposed by Senator Kent Conrad (D-ND), then chairman of the Senate Budget Committee, to create publicly funded state and regionally based non-profit health plans to compete alongside private insurers by negotiating directly with healthcare providers for low-cost rates. At its start, 23 CO-OPs were established with federal funding before Congress ultimately eliminated any further funding for new entrants in early 2013. The BHP

was proposed by Senator Maria Cantwell (D-WA) to create a public-sponsored option for non-Medicaid-eligible people with family incomes between 133% and 200% of the federal poverty level. The BHP is funded by the federal government, which pays 95% of what BHP enrollees would have received in marketplace subsidies. Minnesota and New York are the only states to implement a BHP to date.

The CO-OP program has largely failed its objectives, with just three of the 23 original CO-OPs remaining as of September 2020, and serves as a poor indication for the viability of federally funded plans. Designed to generate market-based competition within the newly created marketplaces, many CO-OPs were encouraged to compete largely on price, thus attracting a higher share of sicker consumers. They were hit especially hard by lower-than-anticipated risk-corridor payments made available to insurers and CO-OPs that were designed to provide plans protection from unexpectedly large claims due to sicker enrollees. CO-OPs with the lowest pricing strategy to attract higher volume were hit hardest by the low risk-corridor payments, given their comparably higher share of risk to other marketplace carriers. While the risk-corridor payments were favorable to the CO-OPs in their first year, providing $2.9 billion in payments, in 2015 all insurers combined received only $362 million, or 12.6% of expected payments, largely due to funding cuts made by Congress.

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

NAHU POSITION

With the latest calls for a public option, NAHU strongly opposes all legislative proposals that would create a public option or a buy-in to an existing public plan to compete with private insurers. NAHU strongly believes that the ACA does need to be modified in a number of ways, but that a public option or an option to buy in to an existing public program would not enhance consumer choice, but would instead reduce the viability of private coverage. Instead, we support solutions that build on the strength and stability of the employer-provided and ACA health coverage that millions of Americans rely on today.