



Rekindling Reform

Working to Achieve Quality Health Care for All

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Working Paper: A Public Plan Option on a Level Playing Field

INTRODUCTION: The Key Role of a Public Plan

Opinion polls in the United States show overwhelming support for access to health care as a matter of simple justice.

Government could guarantee this human right through social insurance. Medicare, a prime example of social insurance, has proven this in its coverage of elderly people and people with disabilities. A social insurance plan is a voluntary joint endeavor by members of the public, facilitated by government. But access to health care in the U.S. is dominated by private, investor-owned insurance companies, which treat health coverage as a market commodity. They continue to profit from skyrocketing costs and have shown no capacity or interest in containing them. As a result, at least one-third of the nation is either uninsured, under-insured, or insecurely insured. When people need health care, the prevailing system poses not only financial obstacles but bureaucratic, racial-ethnic, gender, and geographic barriers as well.

This failing system is causing widespread suffering in both economic and human terms. Runaway health care costs are a leading cause of bankruptcies for individuals and impose a severe economic burden on employers and on government. Lack of access to timely, adequate health care imposes human and societal burdens of serious illness, prolonged disability, and premature death.

The nation's leaders are under pressure to bring quality, affordable health care to all. As the nation considers new program choices, we urge at a minimum, that people be offered the choice of a social insurance option that can effectively use the tools and resources that uniquely enable government programs to serve the public interest. We suggest that this is the kind of choice that most voters were counting on in November when they opted for change. To offer less would deprive the nation of an alternative to the failed private insurance model.

Apart from its inherent administrative efficiency, a public plan can contribute uniquely to system-wide cost containment efforts. If the plan develops new operating efficiencies, these

Rekindling Reform is a project sponsored by some seventy academic institutions, professional organizations, civic associations, trade unions, local community groups and faith communities, aimed at achieving quality, affordable and accessible health care for all by stimulating informed public discussion and advocacy. Additional sponsors are welcome.

Rekindling Reform serves as a resource for strengthening the emerging health reform movement by creating a space for all organizations in the New York metropolitan region concerned about health care reform to share information, to dialogue and to collaborate on design and implementation of strategies for reforms on city, state and national levels.

would soon become public knowledge; it would have no reason to treat them as proprietary secrets in order to divert savings to corporate profit or executive salaries.

It has been suggested recently that the public and private plans should all be subject to a common regulatory regime and agency. That suggestion fails to recognize some fundamental differences in the nature of public plans (social insurance) and private plans (mainly commercial insurance), and the regulatory implications of that difference.

The primary accountability of commercial plans, by law, is to their investors. Much of the need for regulation of private insurance plans stems from the inherent conflict between their obligations to investors and those to beneficiaries. There, regulation aims at public accountability that would otherwise be absent. However, as already noted, a social insurance plan, is a voluntary joint endeavor by members of the public, facilitated by government. Accordingly, accountability and oversight functions here are largely different from those for commercial plans.

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

SPECIFIC PROPOSALS

A. The public plan

We propose the following provisions 1-9 as primary, defining features of the public plan. (One of them, point 2, will have important relevance for all plans.)

1. The public plan should be a **national** plan, administered by the government, like Medicare. It should be designed with the capacity to respond to regional differences in costs. To take advantage of existing infrastructure, it should be administered by a new subdivision of the Center for Medicare and Medicaid Services (CMS), parallel to and, when advantageous, coordinated with Medicare.
2. The public plan should be required to enroll anyone who applies to join it, at any time. (See also 11.)
3. The public plan should have **comprehensive benefits** – at least as broad as those of traditional Medicare. It should add preventive services, mental health and substance abuse, maternal and child health, and dental services, prescription drugs, eyeglasses, long term care including home and nursing home care, and rehabilitation services to improve as well as to maintain function. (See also 10.)

4. The public plan should be **affordable** and should impose no copayments, coinsurance or deductibles on its beneficiaries. The affordability criterion should vary by region, depending on regional costs. Beneficiaries whose incomes qualify them should get public subsidies. The subsidy would supplement an affordable sliding-scale income-based contribution from the beneficiary, a contribution of an amount based on realistic health care and living costs data (the self-sufficiency standard for the region). (See also 14.)
5. The public plan should enable its beneficiaries to choose their own doctors.
6. The public plan should have **authority to negotiate prices** for the goods and services it needs for its beneficiaries' care.
7. In the interest of both quality and cost containment, the public plan should provide incentives that **enhance the role and capacity for primary care** in the organization and delivery of services.
8. Beneficiaries of the public plan should have access to a simple, user friendly **appeals process** that renders timely decisions. The appeals process should incorporate all current appeals and due-process protections available to Medicare beneficiaries. (See also 20.)
9. The CMS entity administering the public plan should have an advisory arm to enable **guidance from beneficiaries, purchasers, and providers**. The entity should have an inspector general, who should report annually. Among the activities of the advisory arm should be one or more annual public hearings based on the inspector general's report.

B. Benefits in private plans

10. **Benefits in private plans** should be at least as comprehensive as in the public plan, in terms of both specific benefits and overall actuarial value.

C. Provisions pertinent to all plans

11. Each plan offered in a region should be required to accept anyone in that region who wants to be in the plan. It should charge the same rates to all of its subscribers and should have transparent terms and finances.
12. To facilitate people's informed choice and their enrollment in a plan, an agency is needed, to create and maintain a comprehensive, user friendly database as well as tools and staff sufficient to **enable people to compare plans** in detail and reliably. (This should not preclude marketing of/by individual plans.)
13. There should be significant, enforceable **penalties for deceptive or selective marketing**.

14. Many people, whether they choose a private plan or a public plan, will be able to afford coverage only with the help of public subsidies. Therefore, a **subsidy**, essentially a voucher, should be available to every income-qualified beneficiary. Irrespective of the plan chosen, the subsidy should be the same as if the beneficiary had enrolled in the public plan. (See also 4.)
15. Because, for many individuals and households, income expectation varies substantially during the course of a year, **adjustment of subsidies** to income changes could, for example, be combined with the personal income tax filing procedure. However, to minimize distress if the beneficiary's income falls significantly, premiums should be adjustable promptly in such cases.
16. There should be retrospective **risk adjusting payments among plans** so that no plan is at a competitive disadvantage if the people it enrolls are less healthy.
17. An eligible **person who fails to choose a plan** should be enrolled by default in the public plan.
18. In general, people should be able to **switch plans** within 60 days after first enrolling and during a 30 day period at the end of each year. They should also be able to switch plans quickly when they are faced with a change of employer health plans or when they experience a major change in family circumstances.
19. Clinicians and institutions should be **free to affiliate** with whichever health plans will welcome them. Insurers should be barred from imposing rules or offering incentives to prevent or dissuade providers from affiliating with the public plan.
20. There should be a **common final appeals agency** for beneficiaries of all plans. This would, in addition, be an important tool for monitoring enforcement of national standards for all plans, including ERISA plans.
21. In the first year, each plan should direct at least 85% of plan revenues to services delivered in patient care facilities or patients' homes. Higher standards should be met in subsequent years.
22. Functions that should be the responsibilities of an independent public agency are the plans information center (12), subsidy management (14, 15), risk adjustment (16), regulatory enforcement (11, 13, 19, 21), and final appeals (20).