

Public Plan Option: Competitor or Predator?

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The Five (Not So) Easy Pieces of Health Reform
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Overview

- Public vs. private plans and the economic functions of insurance
- Impossibility of equal competition
- Some evidence from public provision of P/C insurance
- Conclusions

Economic function	Exchange w/o public plan	Public plan	Result
Risk-spreading & security	Private capital with guarantees	Off-balance sheet; tax favored	Unfair advantage for public plan
Risk-allocation	No risk rating; constraints on cost-sharing	Even more prescription	Increase costs vs. status quo
Non-claim operating expenses	Lower than status quo	Fees to private intermediaries	<u>Modest</u> reduction for public plan?
Claims settlement & monitoring	Private incentives	Public incentives & bureaucracy	Higher total costs for public plan
Provider payment	Private contracting	Medicare A&B model	<u>Modest</u> savings for public plan?
Innovation	Less than status quo	Medicare A&B model	Less with public plan

Unequal competition

- What's left on which to compete?

UW & pricing subject to TAC, CR

Benefit design & cost-sharing

Marketing

Risk-adjustment, surcharges on private sector

- Financial security

Private: Unpaid claim reserves; safety capital (including pandemic risk); capital regulation; tax and agency costs; state guarantees with ex post funding

Public: little or no capital, implicit or explicit too big to fail, taxpayers bear risk

- Private insurers' profit: how big are the rents?

The real action: bargaining and payment of providers

- Medicare plus 0-10% approach

Modest or minimal provider rents

Private payers already pay bulk of providers' fixed costs

Result: substantial crowd-out, reduced capacity, single payer

- Public plan pays private rates

What private rates?

What's the point of public plan?

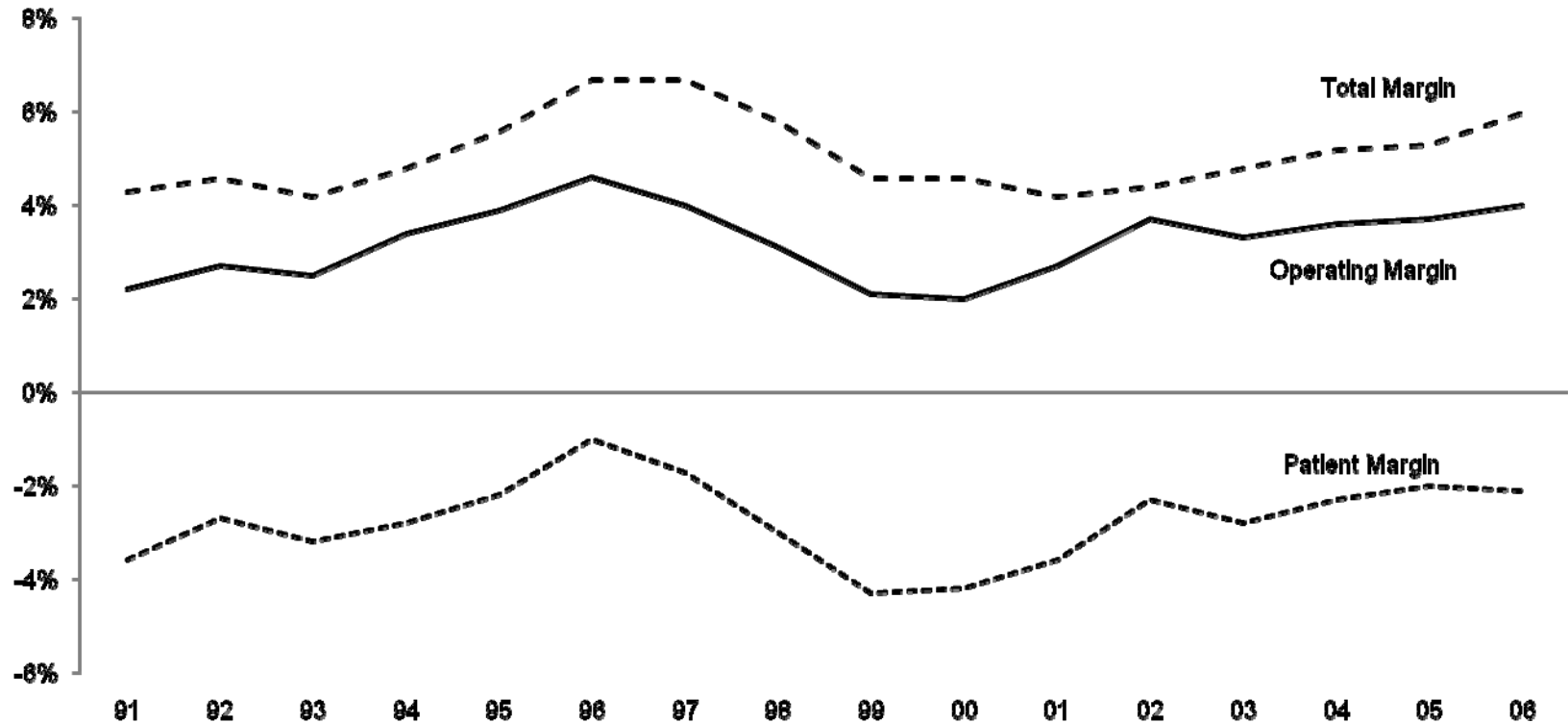
- Private plans pay public rates

Universal price controls (single payer "light")

Would require significantly higher payments than Medicare rates

What's the point of private plans?

Chart 4.2: Aggregate Total Hospital Margins, ⁽¹⁾ Operating Margins, ⁽²⁾ and Patient Margins,⁽³⁾ 1991 – 2006



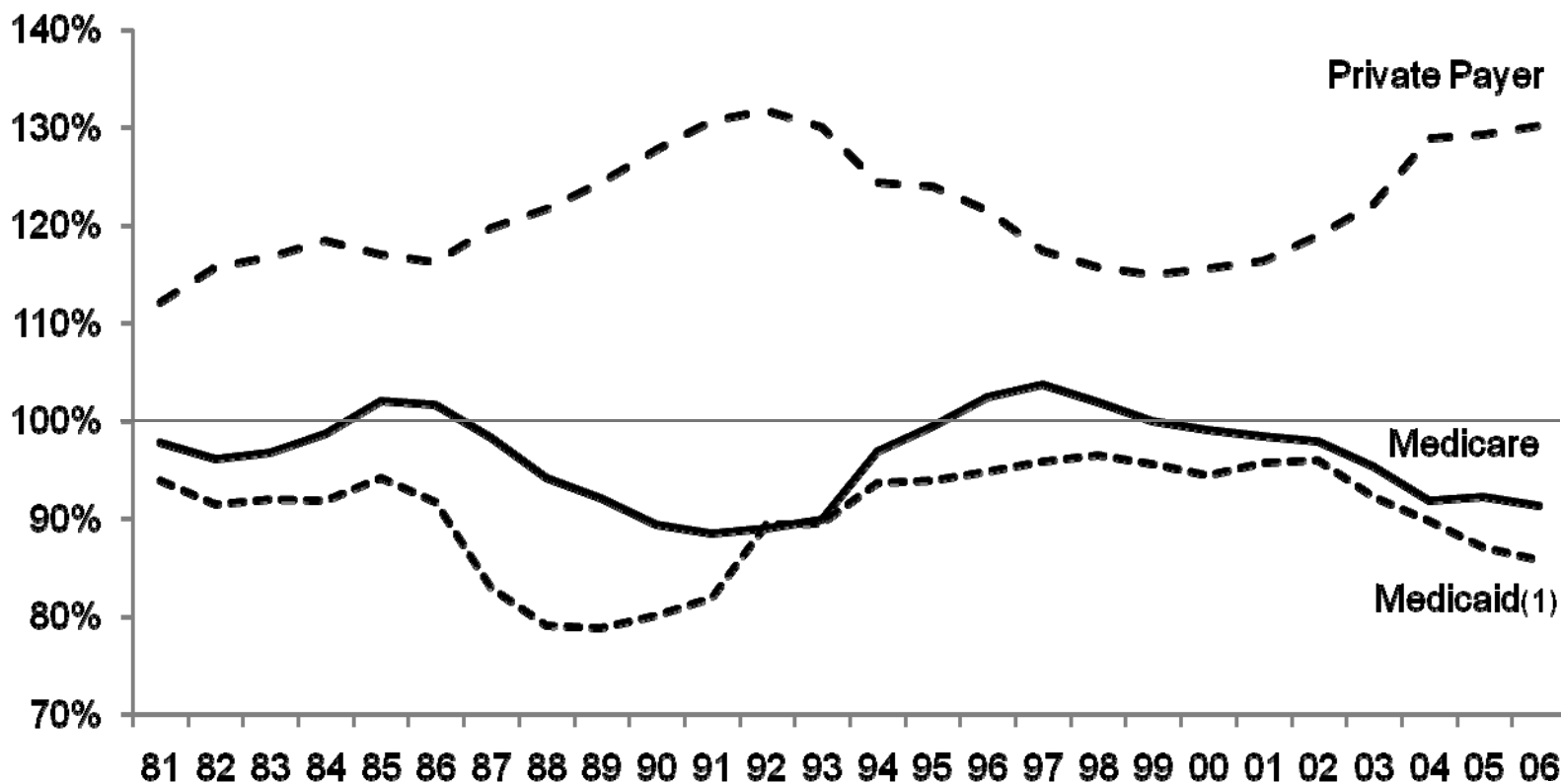
Source: Avalere Health analysis of American Hospital Association Annual Survey data, 2006, for community hospitals.

(1) Total Hospital Margin is calculated as the difference between total net revenue and total expenses divided by total net revenue.

(2) Operating Margin is calculated as the difference between operating revenue and total expenses divided by operating revenue.

(3) Patient Margin is calculated as the difference between net patient revenue and total expenses divided by net patient revenue.

Chart 4.6: Aggregate hospital payment-to-cost ratios for private payers, Medicare, and Medicaid, 1981–2006



Source: Avalere Health analysis of American Hospital Association Annual Survey data, 2006, for community hospitals.

(1) Includes Medicaid Disproportionate Share payments.

Evidence from public provision of P/C insurance

- Federal crop and flood insurance: Large taxpayer subsidies; complete crowd-out

Private administration with substantial fees

Weak enforcement of mandatory purchase requirements

Reduced incentives for risk mgmt (adverse selection, moral hazard)

- State cat funds (natural cats, med mal): Large subsidies, crowd-out

Reduced incentives for risk management (location, protection)

Undercapitalized, policyholders / taxpayers bear substantial risk

- Competing workers' compensation state funds

Markets of last resort; some established after state price controls caused extensive crowd-out and collapse of "residual markets" in early 1990s

Exempt from FIT; assessments of private insurers / employers

Undercapitalized vs. private insurers, implicit or explicit put options

No detailed study of effects on costs, but evidence that price controls increase costs, and no evidence of real efficiencies

Conclusion

- The potential efficiencies from an ostensibly competing public plan are modest; the potential inefficiencies are significant
- Equal competition between a public plan and private plans is infeasible
- A public plan would be the precursor to a single payer system
- It would be better to have that debate on the merits rather than about the illusory benefits of public-private competition

Health insurance and healthy behavior

- Unhealthy behavior is a major cost driver
- Reform proposals talk about education, disease management
- Allow some degree of cost-sharing, but otherwise completely ignore the potential of insurance to provide efficient incentives for healthy behavior
- Rather than considering existing impediments to using insurance to encourage healthy behavior, reform proposals would essentially forbid risk rating and constrain cost sharing
- The view: individuals are not accountable for their health

Poor health is totally beyond individual control

Failure to buy insurance before illness is beyond individual control or the fault of private insurers

Incentives don't matter when it comes to health