

A Publicly-Owned Health Insurance Plan

Initial Presentation to the
Oregon Health Policy Board

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History and Legislative Background

2002: CHOICE proposal – California

2007-08: Presidential primary campaigns

2009: Oregon legislation (HB2009): specific language re
“publicly-owned health benefit plan” within the
exchange

2009-10: National health reform

- Included in initial House bills and Senate HELP bill

- Excluded from Senate Finance bill and final ACA

July 2010: Reintroduced in Congress

What Makes a Health Plan a “Public Plan”?

- Owned by a public authority
- Accountable to the general public
- Insurance risk held by a public authority
- Managed by a public organization, although some functions may be outsourced
- Not necessarily a “government-run” delivery system
- Examples: Medicare, Medicaid

Some Assumptions about a Publicly-Owned Health Insurance Plan

- Offered only within the Exchange.
- Operating “under the same rules and regulations as all health insurance plans offered through the exchange” [HB 2009]
- Expected to be self-sustaining
 - Operating expenses and ongoing capital covered by premiums
 - Start-up costs repaid over a reasonable period

Advocates' Rationale for a Publicly-Owned Health Insurance Plan

- ✓ Increases choice
- ✓ Promotes competition – incentive for private health insurers to improve value
- ✓ Sets a standard for best practices: model for improved delivery of care, customer service, reduction in disparities, value-based benefit design, etc.
- ✓ Counters the adverse effects of market concentration

(cont.)

Advocates' Rationale for a Publicly-Owned Health Insurance Plan (cont.)

- ✓ Lower costs → lower premiums
 - Lower administrative expenses
 - Less marketing and advertising
 - Lower executive compensation
 - Lower payment rates set or negotiated with providers
 - Innovative provider payment mechanisms
 - No need to generate returns for shareholders

Advocates' Rationale for a Publicly-Owned Health Insurance Plan (cont.)

- ✓ Since there is an individual mandate, people should have a choice of public as well as private health plans
- ✓ Accountability to the general public, not just to shareholders
- ✓ Offers a trusted choice, improves transparency, builds public confidence

Opponents' Arguments against a Publicly-Owned Health Insurance Plan

- ✗ Unfair competition to private health insurers
- ✗ Would eventually eliminate the private insurance market
- ✗ Simply a path to a “single payer” system

(cont.)

Opponents' Arguments against a Publicly-Owned Health Insurance Plan (cont.)

- ✗ Misuse of government power to underpay providers
- ✗ Danger of cost shift to privately insured patients, if POHIP pays providers & hospitals less
- ✗ Even if POHIP is set up to be self-sustaining, the government wouldn't let it fail – would step in to bail it out

Key Strategic Issues

- What would be the POHIP's strategy for achieving superior value vs. private health plans? For example:
 - Lower cost (with same quality and service)?
 - Higher quality and service (with same cost)?
- How would the POHIP achieve lower administrative costs? How much lower?
- How strong would the medical management function be?
 - Trade-off between strong UM (high admin costs/lower med costs) and weak UM (low admin costs/higher med costs)

(cont.)

Key Strategic Issues (cont.)

- What would its provider network strategy be?
 - How much would it pay providers?
 - If rates are negotiated, how much leverage would a POHIP have?
 - Would providers be required to participate in POHIP in order to participate in OHP? or other incentives?
 - What would the impact of payment rates be on access to care, quality of care, hospitals' access to capital markets?

(cont.)

Key Strategic Issues (cont.)

- Why is size important? How big does it need to be?
 - Economies of scale
 - Attract providers
 - Negotiating leverage with providers
- How can the POHIP minimize the danger of adverse selection?
- How would start-up costs be financed?

Organization and Governance Options

- Standalone plan
 - State agency
 - Public corporation
- Buy-in to existing plan
 - PEBB
 - OHP

Each has pros and cons – further analysis needed.

How Much will this Cost?

- Start-up costs (planning, infrastructure development, marketing, initial reserves): *TBD*
- Ongoing administrative expenses
 - Range: 2% (Medicare FFS) – 12% (BCBS average)
 - Variables: size, network strategy, utilization management, marketing
 - *Estimates need refinement – more analysis needed.*

Elements of the Business Plan

- Strategic and operational plans
- Start-up costs and financing
- Expense estimates: medical costs and administration
- Revenue estimates

Work Plan for Development of Business Plan

	September	October
Rationale, pros and cons	Final rationale	Final analysis of pros and cons
Organization and governance models		Final recommendations
Business Plan		Final analysis

Decisions for the Board – Preliminary List

- Issue 1: Organization and governance
 - Standalone plan (state agency or public corporation) or Buy-in to existing plan (OHP or PEBB)?
- Issue 2: Provider network strategy
 - Broad or select network? Provider payments negotiated or set by POHIP? Payments at market or below?
- Issue 3: Administrative functions and expenses
 - How much for medical management? marketing & sales?
- Issue 4: Financing of start-up costs
 - How much? How long for payback?