

A Publicly Owned Health Insurance Plan for Oregon
Background, Initial Findings and Preliminary Business Plan
August 13, 2010

In 2009, the Oregon Legislature passed a law (HB 2009) to establish the Oregon Health Authority and begin planning for comprehensive health reform. The bill included the following as one of the Oregon Health Authority's duties:

Develop and submit a plan to the Legislative Assembly by December 31, 2010, with recommendations for the development of a publicly owned health benefit plan that operates in the exchange under the same rules and regulations as all health insurance plans offered through the exchange, including fully allocated fixed and variable operating and capital costs.ⁱ

The following is a report on the history and legislative background of publicly owned health insurance plans, a summary of the arguments for and against publicly owned plans, and a preliminary list of strategic issues, organization and governance options, cost considerations and the elements of a business plan. A draft report with more details on the rationale for a publicly owned plan will be published in September, and the business plan will be finalized in October. This report will be used to prepare a formal plan to be submitted to the Legislative Assembly prior to the December 31 deadline.

History and Legislative Background

The "publicly owned health benefit plan" described in HB 2009 was not created in a vacuum.ⁱⁱ The concept of a publicly owned health insurance plan (POHIP) had been developed during the previous decade. One of the earliest detailed plans was the CHOICE proposal, developed by a group of California health care leaders as part of the Health Care Options Project (HCOP) in 2002.ⁱⁱⁱ During the next several years, the concept became part of a much larger discussion of potential health reform approaches at the state and federal level.

The POHIP concept gained additional exposure when it was included in the primary campaign proposals of the major Democratic candidates in 2007-08. John Edwards, Hilary Clinton, and Barack Obama all included a POHIP in their health reform proposals.^{iv} After the Presidential election, a series of papers by Jacob Hacker elaborated the case for a POHIP in national health reform^{vvi}, and many other experts contributed their ideas to the proposal. During this time, advocates in

Oregon were successful in adding language to the state's health reform bills regarding a publicly owned health plan.

In the development of a national reform plan, a POHIP was included in the House and Senate HELP Committee bills in the summer of 2008. A POHIP was not included, however, in the Senate Finance Committee bill, and a revised House bill in October 2009 weakened several elements of the original proposal. Ultimately, a POHIP was not included in the Patient Protection and Affordable Care Act that passed Congress in March 2010. Recently, a bill has been introduced in Congress to add a POHIP to the PPACA^{vii}, although it not expected that this bill will pass in the current session.

Publicly Owned Health Insurance Plan: Definition and Assumptions

Publicly owned health insurance plans exist in the current health system. The most obvious examples are Medicare and Medicaid, which are government-owned health insurance plans for the elderly and poor, respectively. (These are insurance plans, which are different from government-owned health care delivery systems such as the Veterans Health Administration. Medicare and Medicaid contract with private hospitals, physicians and other suppliers to provide services to beneficiaries.) In the current context, however, a POHIP can be defined as a health insurance plan that is:

- Created by legislative action and owned by a public authority
- Accountable to the general public through a legislatively defined governance structure
- Self-insured, i.e., insurance risk is held by a public authority and not transferred to a private entity.
- Managed by a public organization, although some administrative functions may be outsourced to private service contractors

It is also understood that a POHIP is not the sole source of health insurance for a specific segment of the population. It is offered as a choice along with private health insurers, thus the common label of "public option".

For the purposes of this report, there are other assumptions about the design of a POHIP. Specifically:

- The POHIP would be offered only within a health insurance exchange, which will be created under the framework defined in the PPACA. It will not be offered outside the exchange to individuals, small employers or large employer groups.

- The POHIP will operate “under the same rules and regulations as all health insurance plans offered through the exchange”, per the language of HB 2009.^{viii}
- The POHIP will be expected to be financially self-sustaining. Operating expenses and ongoing capital requirements will be covered by premiums charged to enrollees. Start-up costs will be repaid over a reasonable period.

The Rationale for a Publicly Owned Health Insurance Plan

Advocates have advanced a series of arguments in favor of a POHIP. They believe a POHIP would:

- **Increase choice.** Many rural and small town markets are dominated by one or two health insurers. A POHIP would offer a new choice to people in those areas.
- **Promote competition.** A POHIP could create stronger incentives for private health insurers to improve the value they offer to enrollees, e.g., lower costs, improved quality and service.
- **Set a standard for best practices.** A POHIP could become a model for the improved delivery of care, good customer service, improved health outcomes, reductions in health disparities, value-based benefit designs, etc.
- **Counter the adverse effects of market concentration.** As described in a 2009 Urban Institute report, “. . . health insurance markets today, by and large, are simply not competitive. And as such, these markets are not providing the benefits one would expect from competition, including efficient operations and consequent control over health care costs. . . . The role of the government plan is to counter the adverse impacts of market concentration and, in doing so, slow the growth in health care costs.”^{ix}
- **Lower costs, leading to lower premiums^x.** A POHIP might be able to achieve lower costs due to several factors:
 - Lower administrative expenses than private health insurers, due to less marketing and advertising and lower executive compensation
 - Lower provider payment rates
 - Innovative provider payment mechanisms, leading to a reduction in the unnecessary use of health services, as well as an improvement in health outcomes
 - No need to generate returns for shareholders

- **Offer the option of a publicly owned plan.** In the context of an individual requirement to have health insurance, many believe that people should have a choice of publicly owned plan as well as private health plans.
- **Establish accountability to the general public.** Many people believe that private health plans do not operate in the public interest, since they are accountable to shareholders. A POHIP would be accountable to the general public.
- **Offer a trusted choice.** A POHIP could be more responsive to its enrollees, improve transparency, and build public confidence.

Arguments Against a Publicly Owned Health Insurance Plan

Opponents have articulated a series of concerns about a POHIP. They believe a POHIP would:

- **Create unfair competition.** Despite POHIP advocates' claims that it would operate on a "level playing field" with private plans, opponents are skeptical that this would be the case. They believe that any government-owned plan would receive certain benefits or exemptions from laws and regulations that apply to private plans.
- **Eventually eliminate the private insurance market.** As a result of competitive disadvantages, private insurers would withdraw or be forced out of the market. Ultimately, the market would devolve to a single payer system, with everyone enrolled in a government insurance plan. (Some opponents believe that this is the POHIP advocates' hidden agenda.)
- **Be a misuse of government power.** Opponents fear that a POHIP would use the government's authority to set the rates paid to hospitals and providers at levels below those paid by private insurers. This in fact was an element of the original House and Senate HELP Committee bills in 2009, and it is part of the new bill recently introduced in Congress.
- **Create a cost shift.** If the POHIP were to pay hospitals and providers below the rates paid by private insurers, many fear that the hospitals and providers would simply increase the rates charged to private insurers. As a result, private health insurance premiums would go up faster than underlying medical cost trends. The savings from a POHIP would be illusory, since the lower costs would be offset by shifting the costs to private plans.
- **Not be allowed to fail.** Opponents are skeptical of the assurances that a POHIP would be required to be financially self-sustaining. If

the POHIP runs into financial difficulties in future years, opponents expect the government to step in to “bail it out”.

Key Strategic Issues

In the development of a business plan for the POHIP, a number of key strategic issues will need to be addressed. The following is a preliminary list of issues:

- *Core Business Strategy.* What would be the POHIP’s strategy for achieving superior value vs. private health plans? For example, will it offer lower cost with the same quality and service, or higher quality and service at the same cost? It is difficult for any product or service to offer superior customer value on all dimensions; choices will need to be made.
- *Administrative Costs.* How would the POHIP actually achieve lower administrative costs? Most of the administrative functions of a private insurance plan -- e.g., claims processing, customer service, provider contracting, accounting and financial management, etc. -- will also be incurred by a POHIP. Are there some functions that a POHIP will not need or could accomplish at lower cost? How much lower could the POHIP’s administrative costs be?
- *Medical Management.* How strong would the POHIP’s medical management function be? There is a trade-off: a strong utilization management function will incur higher administrative costs but lower medical costs, while a weaker UM function will have lower administrative costs but incur higher medical costs.^{xi}
- *Provider Network Strategy.* How much would the POHIP pay hospitals and providers? This was a key issue in the different versions of the House bills in 2009. In early versions, the publicly owned plan would have paid providers at rates pegged to Medicare. In later versions, the publicly owned plan would have negotiated rates with providers, leading to payment rates that would likely be similar to those paid by private plans. This decision could have a dramatic effect on provider participation, access to care, quality of care, and hospitals’ access to capital markets. There is a related question regarding whether providers would be required or incented to participate in the POHIP, even if payment rates are below those of private plans. Some experts feel that this would be necessary due to the strong bargaining position of large provider systems.^{xii}
- *Size.* Many feel that the size (i.e., number of enrollees) of the POHIP is important. Increased size can help the POHIP to use economies of scale to keep administrative costs low. In addition,

size can help to attract providers and provide some degree of negotiating leverage with providers. How big should the POHIP be to achieve these goals?

- *Adverse Selection.* Many experts feel that a POHIP would be subject to adverse selection, i.e., sicker people would be more likely to join a POHIP than a private plan, thereby driving up the medical costs and premiums for the POHIP.^{xiii} Although risk adjustment mechanisms may offset this, the CBO believes that they will be insufficient to fully compensate the POHIP for adverse selection.^{xiv} What can be done to avoid or mitigate the danger of adverse selection?
- *Financing of Start-up Costs.* The POHIP will incur expenses prior to its opening to enrollees. These start-up costs will include planning, infrastructure development, and marketing. In addition, the POHIP will need to create initial financial reserves as well as a contingency fund for excess medical costs. How will these costs be financed? What will be the expectations to pay back the initial financing?

Organization and Governance Options

It will be important to establish an organization and governance structure consistent with the POHIP's mission. It appears that there are two basic options, each with two sub-options.

- **Standalone plan.** In this option, the POHIP would have its own management, governing board, and administrative processes. It would look like a private health insurance plan, with the potential distinguishing features listed above. In this arrangement, there are two possible sub-options:
 - State agency within the Oregon Health Authority. This would be consistent with goal of bringing state health-related functions under the OHA. Its effectiveness and ability to respond quickly to changing needs might be limited, however, by state procurement and personnel policies.
 - Public corporation. This would allow greater flexibility in procurement and personnel policies, but it might be limited in its ability to coordinate its activities with other state agencies, e.g., the Oregon Health Plan. Oversight and public accountability would need to be achieved by a strong and representative governing board.
- **Buy-in to existing plan.** One way to offer a publicly owned plan is to allow people to buy in to existing public plans. For example,

people could be allowed to join the Oregon Health Plan. Those who are above the maximum incomes for Medicaid eligibility would pay their own “premiums” to the OHP, but they would have access to Medicaid providers and benefits. OHP would administer their benefits in the same way it does currently for OHP enrollees.

A second option would allow people to join the Public Employees Benefit Plan (PEBB). People would pay their own premiums, but they would have access to PEBB’s self-insured plan (and perhaps other private plan options) and its providers and benefits. In this scenario, it would probably be advisable to maintain separate risk pools for state employees and new “buy-in” enrollees.

Costs of a POHIP – Preliminary Summary

There are three basic categories of costs:

- **Start-up.** As described above, these include planning, infrastructure development, and marketing. In addition, the POHIP will need to create initial financial reserves as well as a contingency fund for excess medical costs. Estimates of these costs will be developed for future reports.
- **Medical.** These are the costs of the insured medical benefits paid to providers on behalf of enrollees. The key drivers of these costs are underlying medical cost trends in the community, characteristics of the enrollees (including the potential impact of adverse selection), and provider payment rates. It is expected that these costs (as well as administrative expenses – see below) will be covered by premiums.
- **Administrative.** As noted above, these include claims processing, customer service, provider contracting, accounting and financial management, and related functions. The variables that will determine the level of these expenses are the number of enrollees, the provider network strategy, utilization management and marketing tactics.

In general, most experts believe that the administrative costs for a POHIP will be somewhere in a range between 2% and 12% of premiums.^{xv} The low end of the range is the traditional Medicare program, which has administrative costs of 2%. (This excludes the Medicare Advantage program, for which administrative costs are 11%). For comparison, the average administrative costs in Medicaid are 7.7%. In private health insurance generally, they are 12% (Blue Cross Blue Shield national average). In large, self-

insured employer groups, the costs are estimated to be 8-9%, and in small groups the administrative costs are estimated to be 20-30%.^{xvi}

Development of a Business Plan

The business plan for a POHIP will include the following elements:

- Core Business Strategy. This will identify and assess customers' needs, competitors' strengths and weaknesses, and the POHIP's potential competitive advantages and basic value proposition.
- Start-up Costs and Financing. This will consist of estimates of start-up costs, including planning, infrastructure development, and marketing. It will also include an assessment of potential financing options.
- Operating Expenses. This will provide estimates of medical costs as well as administrative expenses. The analysis will also show estimated expenses at different levels of membership. The assumptions regarding the POHIP's operational plan will also be described.
- Revenues. This will provide estimates of premium revenues, based on the expense forecasts, margin requirements, and repayment of start-up costs.

According to the Work Plan, a more detailed description of the rationale for a POHIP will be done in September. The final analysis of arguments for and against the POHIP, the recommendations regarding organization and governance, and the business plan will be completed in October.

ⁱ House Bill 2009, Sec. 9 (1)(L), 75th Oregon Legislative Assembly--2009 Regular Session

ⁱⁱ Much of this section is based on an excellent summary of the policy and political debates about the public option. Halpin HA and Harbage P. The origins and demise of the public option. Health Affairs 29, No. 6 (2010): 1117-1124.

ⁱⁱⁱ Schaffler HH. CHOICE. California Health Care Options Project. Sacramento (CA): Health and Human Services Agency; 2002.

^{iv} Edwards '08: Universal health care through shared responsibility. Feb. 5, 2007; Clinton '08: American health choices plan: quality, affordable health care for every American. Sep 17, 2007; Obama '08: Barack Obama's plan for a healthy America. May 7, 2007.

^v Hacker JS. The case for public plan choice in national health reform. Berkeley

-
- (CA): Campaign for America's Future and UC Berkeley Center for Health, Economic, and Family Security; 2008.
- ^{vi} Hacker JS. Healthy competition: how to structure public health insurance plan choice to ensure risksharing, cost control, and quality improvement. Berkeley (CA): Campaign for America's Future and UC Berkeley Center on Health, Economic, and Family Security; 2009.
- ^{vii} Kaiser Health News, It's back: House Democrats Argue Anew for Public Option. July 23, 2010. Available from: <http://www.kaiserhealthnews.org/Daily-Reports/2010/July/23/More-On-Public-Option.aspx>
- ^{viii} House Bill 2009, Sec. 9 (1)(L), 75th Oregon Legislative Assembly--2009 Regular Session
- ^{ix} Holahan J and Blumberg LJ. Is the public plan option a necessary part of health reform? Washington (DC): Urban Institute Health Policy Center; 2009. Available from: <http://www.urban.org/publications/411915.html>
- ^x There are many analyses of the potentially lower costs and premiums of a POHIP. The most recent is the CBO analysis of H.R. 5808, the new public plan bill in Congress. CBO concluded that the public plan's premiums would be 5-7% lower, on average, than private plans in the exchanges. The key factors were rates paid to providers, administrative costs, the effects of utilization management, and the impact of adverse selection. (Elmendorf DW. Analysis of a proposal to offer a public plan through the new health insurance exchanges. Letter to the Honorable Fortney Pete Stark, July 22, 2010. Available from: <http://www.cbo.gov/doc.cfm?index=11689>
- ^{xi} Halpin HA and Harbage P. *op cit*
- ^{xii} Holahan J and Blumberg LJ, *op cit*.
- ^{xiii} Holahan J and Blumberg LJ, *op cit*.
- ^{xiv} Elmendorf DW, *op cit*.
- ^{xv} Merlis M. Simplifying administration of health insurance. Washington (DC): National Academy of Social Insurance, 2009. Available from: <http://www.nasi.org/research/2009/simplifying-administration-health-insurance>.
- ^{xvi} Kingsdale J and Bertko J. Insurance exchanges under health reform: six design issues for the states. *Health Affairs* 29, No. 6 (2010): 1158-1163.