The Reincarnation of the Public Option

EYE ON WASHINGTON: GAIL R. WILENSKY, PHD

With the renewed interest and attention being given to the public insurance option lately, we once again are seeing the resurrection of an idea for consideration in the health policy arena that previously was defeated. Only time will tell if it will be adopted this time around.

Employer mandates were raised several times in the past and rejected before ultimately being incorporated into the Affordable Care Act (ACA), with the most recent of those previous instances being the 1993 Health Security Act. Even the idea of the coverage expansions enacted in the ACA had waxed and waned previously in the public policy debate.

Now, support for a public option by the Democratic presidential nominee, Hillary Clinton, as part of the Democratic platform and with President Barack Obama's endorsement, guarantees continuing interest in the idea irrespective of the outcome of the election.

2009-10 Experience

A public option was proposed in 2009 but was opposed not only by Republicans but also, more significantly, by moderate Democrats, led by Sen. Joe Lieberman (I-Conn.), who threatened to withhold their support if it was included. The co-ops (health plans established by the ACA under the Consumer Operated and Oriented Plan Program) were suggested as an alternative, guaranteeing a not-for-profit entity that would provide insurance and improve competition. But these plans have been notoriously unsuccessful, with only 11 of the original 23 co-ops that started remaining active, eight of which are considered endangered. Whether it is because they were new start-ups, had a risk-based capital ratio requirement higher than that for other insurers, or had lower-than-prudent pricing, or whether there is some other reason, the co-cops are not serving their intended function.[a]

Recent Exchange Experience

To date, most exchange enrollees have lived in areas with multiple plan issuers. According to the Obama Administration, 88 percent live in counties that had at least three issuers in 2016. The remaining 12 percent live in areas with one or two issuers.

However, as has become clear in recent months, many insurers have been reporting losses from their exchange business, and at least three—United Health Group, Humana, and Aetna—have announced they are reducing their exchange participation for 2017. (Cigna, however, announced its intent to expand its participation in a few markets for 2017.) The main challenges cited by insurers reporting losses are smaller and sicker populations than anticipated, unstable

participation (particularly among the special enrollees who have been granted permission to enroll outside the normal sign-up periods), and inappropriate pricing by insurers.

Not surprisingly, this situation prompted some industry observers to predict early on that insurers will propose significant premium price increases for 2017. As I noted in my July Eye on Washington column, nine states that are early submitters had requested average increased premiums of 12 percent for their silver plans, which cover about 70 percent of medical claims. Since then, the Covered California exchange, which has had a reputation for aggressive negotiations resulting in 4 percent average rate increases, has announced that its premiums will increase by 13.2 percent, on average, for 2017. As always, enrollees may be able to find cheaper plans by shopping around, but the move is a sign of the pricing challenges that insurers have been experiencing with their exchange enrollees.

Increasing interest in the public option idea is a direct outgrowth of the combined effect of some health plans announcing their intent to withdraw from the exchanges and of other plans requesting higher than previous rate increases (which will still need to be reviewed and approved by the state regulators). Obama's call for adding a public option was specifically addressed to counties "lacking competition." If the definition of "lacking competition" was similar to that set forth in the provision for a public plan included the Medicare Modernization Act of 2003, which established Medicare Part D, a public option would be made available in any county that lacked at least one HMO and one non-managed care plan. The public option has never been invoked for Part D for counties in which a plethora of plans have been available, although concerns have been raised about seniors possibly becoming overwhelmed by the sheer number of plans to choose from in some counties. Using the "less than two plan rule" from Part D would limit the availability of a public option, but it is unclear whether limited competition would be defined similarly.

The Political Challenges

The political challenges facing the adoption of a public option remain formidable despite the current flurry of advocates. Clearly, its future depends in part on the election outcome, but there is no likely scenario in which its adoption seems assured.

If Republican nominee Donald Trump is elected president, the public option presumably has no future. But even if Clinton is elected, the country is likely to continue with split government, with the Republicans at least controlling the House of Representatives, making adoption of the public option extremely unlikely. Even if Democrats were to gain control of both houses of Congress, they are unlikely to hold a supermajority in the Senate, which means the legislation could be subject to a filibuster by Republicans—not even taking into account any Democrats who also might oppose it. Several moderate Democrats who had opposed the public option in 2010 are no longer in the Senate—including Ben Nelson (D-Neb.) and Blanche Lincoln (D-Ark.) in addition to Lieberman. But other moderate Democrats, such as Sen. Claire McCaskill (D-Mo.), have voiced at least initial skepticism about the concept.

Some senators expressing interest in the idea of a public option, such as Sen. Chris Murphy (D-Conn), have envisioned it as a Medicare look-alike. They have talked about Medicare's low

overhead costs and support by seniors. The assumption has been the use of Medicare payment would allow for a plan similar to Medicare to be offered at a cheaper rate than has been available to enrollees in the exchanges.

The evidence to date, however, suggests that a public option would probably look more like Medicaid than like Medicare, because the only plans to date that have been able to achieve any positive margins in the exchanges are Centene and Molina, which are primarily Medicaid companies.[b] Their exchange offerings are based on their Medicaid provider networks. They also have focused on the lowest income portion of the exchange market—people who are accustomed to the tightest provider networks because they also are likely to have been past users of Medicaid.

Medicaid payments are typically significantly less than Medicare payments. People advocating for a public option should be clearer about what kind of public option is really possible—and there's not much chance it's Medicare.

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Footnotes

a. Wilensky, G.R., "Co-ops Discover the Challenges of Starting an Insurance Business," *The Milbank Quarterly*, Vol 93, Issue 2, 2015.

b. Bob Laszewski, B., "Why Are Centene and Molina Making Money on the Obamacare Exchanges?", *Forbes opinion*, May 6, 2016.

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