A Market-Oriented Perspective on a Proposed Public Plan

Scott E. Harrington*

December 18, 2009

Introduction

On November 7, 2009, the U.S. House of Representatives narrowly approved legislation to mandate that all individuals be covered by health insurance coupled with Medicaid expansion, premium subsidies for low income persons, creation of a health insurance exchange (or exchanges) with strong restrictions on health insurance underwriting and pricing, and creation of a government-run health insurer – the public option – to compete with private health plans. On November 21 the U.S. Senate voted 60-39 along straight party lines to approve for floor debate a bill with the same broad outlines. The proposed creation of a public plan has played a major role throughout the reform debate, and continued sharp disagreement over the creation of a public plan has contributed to subsequent stalemate in the Senate.

This policy brief provides a market-oriented overview of key issues associated with the creation of a public plan.[1] The main points are:

- Although individual and small group health insurance markets are highly concentrated in many states, buyers have a choice among numerous insurers and plans in most states, including one or more non-profit insurers. There is no evidence that the antitrust exemption for the "business of insurance" has contributed to higher health insurance costs, premiums, or profits. Experience under the Federal Employees Health Benefits Program and Medicare prescription drug coverage indicates that effective competition among health insurers is possible without a public option.
- The potential savings from lower administrative costs and profits under a public plan are modest. Health insurers' profit margins typically average about three percent (less for non-profit insurers); and administrative expense ratios average about 11-12 percent. Medicare's much lower administrative expense ratio largely reflects higher average medical claim costs; the exclusion of general overhead, enrollment, and billing costs; and that Medicare does not negotiate with providers, engage in medical management, spend much to reduce fraud, or incur state premium taxes or regulatory compliance costs that affect private insurers.
- If a public plan were to base reimbursement on Medicare rates, with or without a modest markup, the plan would shift some costs to and increase potential crowd-out of private health plans, and it would threaten the financial stability of some hospitals and physicians. Having the public plan negotiate rates with voluntary provider participation would reduce those risks, but pressure for cost control could cause reimbursement and participation rules to tighten over time.
- Even with negotiated rates and other safeguards that have been proposed, equal competition between private insurers and a public plan is infeasible. A public plan would hold less capital than private insurers and ultimately be backed by taxpayers, and it would not pay the taxes that private insurers pay.

*Alan B. Miller Professor of Health Care Management and Insurance and Risk Management, Wharton School, University of Pennsylvania and adjunct scholar at AEI (http://scottharringtonphd.com).

Health Insurance Competition

President Obama and Speaker of the House Nancy Pelosi strongly support a public plan option as a means to promote competition, choice, and to "keep insurance companies honest." Some analysts argue that a public plan could improve competition and help lower costs by reducing profits, administrative expenses, and lowering reimbursement to providers (Hacker, 2008, 2009; Holahan and Blumberg, 2008; also see Nichols and Bertko, 2009). Pauly (2009) explains how a public option could provide choice to people who prefer dealing with government. Other observers stress that the case for a public plan is weak, that level competition would not be feasible, and that a public plan would inexorably crowd out private health insurance (e.g., Cannon, 2009; Francis, 2009b).

Private health insurance markets are characterized by high market concentration at the state level (Robinson, 2004; American Medical Association, 2007; GAO, 2009; also see Dafny, in press). Concentration is much lower when measured at the national level. The extent and scope of economies of scale or other entry barriers at the state level other than some states' restrictive underwriting, rating, and coverage regulations is not clear. Effective entry and competition often depend on the ability to utilize relatively large provider networks and achieve sufficient scale to contract effectively with hospitals and physicians. In most states, insurers are able to contract with and utilize the services of large medical service organizations as an alternative or supplement to direct contracting. Consolidation in many private health insurance markets has coincided with increased consolidation of hospitals and hospital-provider networks, increasing insurers' ability to negotiate favorable rate with providers (and vice versa).

Over half of the employer-sponsored health insurance market is self-funded. Employers generally choose among insurers and numerous third-party administrators for accessing provider networks and claims administration. Reported insurance market concentration figures generally do not reflect the self-funded market served by non-insurance third-party administrators. Those intermediaries and self-funding in general represent a significant source of competition for insurance companies in the employer-sponsored market except for small group coverage. Although often highly concentrated, buyers in the individual and small group markets have a choice among numerous insurers and plans in most states (except, for example, in New York, with pure community rating), including one or more non-profit insurers.[2]

During October 2009 hearings by the Senate Judiciary Committee on possible repeal of the limited antitrust exemption for health and medical liability insurance, Senate Majority leader Harry Reid testified that (Reid, 2009) "exempting health insurance companies has had a negative effect on the American people" and that "there is no reason why insurance companies should be allowed to form monopolies and dictate health choices." Despite these and other allegations of large health insurers engaging in abusive monopolistic practices while enjoying protection from antitrust laws, there is no evidence that the limited antitrust exemption for the "business of

insurance" has contributed to higher health insurance costs, premiums, or profits, or, as implied by Senator Reid, of "health insurance monopolies . . . making health care decisions for patients."

In contrast to many property/casualty insurers, health insurers do not cooperate in estimation of medical claim loss development or projection of future claim costs. There is no evidence that the exemption has contributed to higher market concentration. It does not prevent review and challenge of mergers of health insurers by the Department of Justice. Mergers and acquisitions of health insurers are also subject to approval by state regulators.[3] Repealing the antitrust exemption would not significantly increase competition, and it would not make health insurance coverage less expensive or more available. Repealing the exemption for medical liability insurance would not lower its cost or prevent future malpractice insurance crises, such as those that occurred in the mid 1970s, mid 1980s, and earlier this decade. The unintended consequences could include increased costs, reduced rate accuracy, less competition in already fragile malpractice insurance markets, and attended adverse effects on providers.

Experience under the Federal Employees Health Benefits Program (FEHBP) and Medicare Part D (prescription drugs) indicates that effective competition among health insurers is possible without a public option. For decades Federal employees and members of Congress have purchased their health insurance through this program, under which numerous private insurers compete for employees' business subject to oversight by the federal Office of Personnel Management. The FEHBP is generally acknowledged to work reasonably well, with high levels of employee satisfaction (Francis, 2009a). The provision of Medicare Part D coverage by private plans has likewise been successful, with most seniors able to choose among numerous competing plans.

Profits and Administrative Expenses

Public plan supporters argue that health insurers' profits and administrative expenses are excessive or even unnecessary, driving up the cost of coverage, and that a public plan would achieve substantial savings on these dimensions.[4] Administrative expenses are viewed as especially high for individual and small group coverage. Table 1 summarizes data on health insurers' profits, medical loss ratios, and administrative expense ratios from a variety of sources and time periods. Health insurers' profit margins (net income to revenues) typically average about 3 percent (less for non-profits), medical loss ratios average roughly 85 percent (higher for non-profits than for-profits), and administrative expense ratios average about 11-12 percent.[5] The aggregate margin for administrative expenses and profits in private plan premiums, including premium equivalents for self-funded plans, has averaged about 12 percent since the mid 1960s (with little or no trend). Sherlock (2009) reports an administrative expense ratio of 11 percent and 16 percent in 2007 for the individual and small group markets, respectively, using data primarily from Blue Cross Blue Shield plans covering 36 million lives.[6]

Insurers' administrative expenses include marketing, provider and medical management, account and member administration, general overhead, and state premium taxes (which average about two percent of premiums) (Sherlock, 2009; American Academy of Actuaries, 2009). Administrative expense ratios and medical

loss ratios can vary widely across insurers in relation to (1) their mix of individual, small group, administrative services only (ASO), and Medicare/Medicaid related contracts; (2) how they account for ASO contract fees and expenses (including whether they are based on premium equivalents for those contracts); and (3) insurers' relative emphases on different types of managed care (Robinson, 1997).

Private insurers' administrative expense ratios are commonly compared with those of Medicare, which are about 1.5 percent of costs in the fee-for-service program (CBO, 2008). The low expense ratios for Medicare reflect a number of differences from private plans (Sherlock, 2009; American Academy of Actuaries, 2009), including:

1. Per capita claim costs are much higher for Medicare, reducing administrative expenses as a proportion of total costs.
2. Reported Medicare administrative costs usually exclude general overhead for the Center for Medicare and Medicaid Services.
3. Enrollment and billing costs are reflected in Social Security Administration accounts and not attributed to Medicare.
4. Medicare does not negotiate with providers, engage in medical management, or spend much to reduce fraud and abuse.
5. Medicare does not incur state premium taxes or incur regulatory compliance costs that affect insurance companies.

Importantly, private health plans have strong incentives to spend money to detect and prevent fraud and abuse if the expected savings exceeds the expenditure. The resulting expenditures increase reported administrative costs. A public plan might not have comparable incentives. It commonly is argued that too little money is spent to combat Medicare fraud and abuse, with tens of billions of dollars lost annually.

Provider Reimbursement

A critical issue in the creation of a public plan is how reimbursement rates for health care providers would be determined. Private payers on average reimburse hospitals and physicians at much higher rates than Medicare (e.g., American Hospital Association, 2009, charts 4.6 and 4.7). Many public plan supporters' advocate cutting costs by using Medicare reimbursement rates or Medicare rates plus a nominal percentage (Hacker, 2008). However, to the extent that Medicare reimbursements already require higher payments from private payers, an expansion of Medicare payment rates, with or without a modest markup, would require even higher private payer rates and increase potential crowd-out of private plans, assuming that providers would accept or be required to accept such reimbursement rates.[7] A strategy of linking public plan reimbursement to Medicare rates would also threaten the financial stability of hospitals and physician practices that currently operate at low margins.[8]

Requiring a public plan to negotiate rates with voluntary participation from providers, as proposed in the House and (previous) Senate bills, represents an uneasy and potentially unstable compromise. It is inconsistent with a major objective of public plan supporters. While it apparently reduces the risk of substantial cost shifting,

private insurance crowd out, and adverse financial effects on providers, the risk remains that pressure for cost control would cause a public plan's reimbursement and participation rules to tighten over time.[9]

Is a Level Playing Field Feasible?

The market penetration of any public plan would depend on numerous factors concerning eligibility, pricing, and provider participation rules. A Lewin Group study prepared by Shiels and Haught (2009) estimated that an aggressive public plan reimbursing at Medicare rates would capture a large share of the overall market if open to employer plans. The CBO projects that the public plans proposed by the House and Senate would attract fewer than 5 billion people by 2019. The CBO also projects that a public plan would have higher average premium rates than private plans because it would attract a less healthy population. If a public plan were to attract less healthy people, the strong possibility exists that regulations would be modified to shift more costs to private plans than contemplated under current "risk adjustment" proposals.

Nichols and Bertko (2009) set forth criteria, shown in Table 2, for a public plan to compete equally with private plans. If legislation creating a proposed public plan reflected those criteria, it would still be difficult to ensure their implementation. For example, legislative language that public plan premiums include a contingency margin might not ensure self-sustaining premium rates in an environment of substantial pressure to make coverage affordable. Table 2 also shows two additional criteria, related to health insurers' capital and taxation that would be necessary for truly level competition.

Profits are needed to earn the normal returns on capital that private insurers invest to back the sale of coverage and make promises to pay claims secure. The three largest publicly-traded health insurers, UnitedHealth, Wellpoint, and Aetna reported premium-to-capital ratios of 3.5, 2.9, and 3.3, respectively, at year-end 2008 (based on generally accepted accounting principles, "GAAP"). The aggregate premium-to-capital ratio for the 13 largest publicly-traded health insurers combined was 3.7 (A.M. Best, 2009b). The aggregate premium-to-capital ("surplus") ratio for non-profit Blue Cross Blue Shield plans was 3.1 (A.M. Best, 2009a, based on statutory (regulatory) accounting principles, "SAP"). This means that health insurers typically hold 27-35 cents of capital for each dollar of premiums they receive in a given year.

These ratios and underlying amounts of capital are associated with an "A" financial strength rating for the typical health insurer. Holding such capital may require a pre-tax margin in premiums of 2-3 percentage points (American Academy of Actuaries, 2009). If a public plan were required to hold a capital cushion and/or to maintain some form of "premium stabilization" reserve, it would not hold the amount of capital that a private insurer would need to achieve an A rating. It would hold less capital and ultimately be backed by taxpayers.[10]

A public insurer also would not face the same premium and income taxes that private insurers face (including taxes on investment returns from holding capital, which increase the cost of holding that capital). Given that state premium taxes average about two percent of premiums, the total premium and income tax differential

between a public and private plans could approximate 3-4 percent of premiums. As a result, a public plan could have an artificial cost advantage related to capital and taxation of 5 percent or more of premiums.

References

Alabama Department of Insurance (2007), Examination report, Blue Cross Blue Shield of Alabama, December 31.

American Academy of Actuaries (2009), Critical issues in health reform: Administrative expenses, American Academy of Actuaries, Washington, D.C., September.

American Medical Association (2007), Competition in health insurance – A comprehensive study of U.S. markets, 2007 update, The American Medical Association.

A.M. Best Co. (2009a), Blue Cross Blue Shield results indicate a negative impact in 2008, *Best's Special Report, 2008 Market Review*, August 10.

A.M. Best Co. (2009b), Multiple issues adversely impact health care results for 2008, *Best's Special Report, 2008 GAAP Financial Review*, May 4.

American Hospital Association (2009), *Trendwatch Chartbook 2009 – Trends in Hospital Financing*, The American Hospital Association and Avalere.

Cannon, M. (2009), Fannie Med: Why a 'Public Option" is hazardous to your health, *Cato Policy Analysis,* No. 642, August 6.

Casalino, L., S. Nicholson, D. Gans, T. Hammons, D. Morra, T. Karrison, and W. Levinson (2009), What does it cost physician practices to interact with health insurance plans? *Health Affairs Web Exclusives* 28: w533-w543.n

Congressional Budget Office (2008), *Key issues in analyzing major health insurance proposals*, Pub. No. 102.

Congressional Research Service (1988), *Costs and effects of extending health insurance coverage*, October.

Dafny, L., Are health insurance markets competitive? *American Economic Review*, in press.

Francis, W. (2009a), *Putting Medicare consumers in charge: Lessons from the FEHBP* (Washington, D.C.: AEI Press).

Francis, W. (2009b), Why a new public plan will not improve American health care, *Heritage Foundation Backgrounder*, No. 2267, May 5.

Government Accountability Office (2009), *Private health insurance: 2008 survey results on number and market share of carriers in the small group health insurance market*, GAO-09-363R, February 27.

Gray, J. (2009), Blue Cross and Blue Shield of Alabama disputes Obama remarks, *The Birmingham News*, September 9.

Hacker, J. (2008), The case for public plan choice in national health reform, Berkeley Law and Institute for America's Future, December 17.

Hacker, J. (2009), Healthy competition: How to structure public health insurance plan choice to ensure risk-sharing, cost control, and quality improvement, Berkeley Law and Institute for America's Future Policy Brief, Advancing National Health Reform, April.

Haislmaier, E. (2009), Health insurance co-ops: How Congress could adopt the right design, *Heritage Foundation Backgrounder,* No. 2290, June 25, 2009.

Holahan, J. and L. Blumberg (2008), Can a public insurance plan increase competition and lower costs of health reform? The Urban Institute Health Policy Center.

Miller, T. (2009), Health insurance co-operatives: Too weak, too strong, or still too undefined? American Enterprise Institute.

Nichols, L. and J. Bertko (2009), A modest proposal for a competing public health plan, New American Foundation, Health Policy Program.

Pauly, M. (2009), Public health care and health insurance reform – varied preferences, varied options, *New England Journal of Medicine* 360: 2271-2273.

Reid, H. (2009), Statement of Senator Harry Reid, Senate Judiciary Committee Hearing on "Prohibiting Price Fixing and Other Anticompetitive Conduct in the Health Insurance Industry," October 14, 2009.

Robinson, J. (1997), Use and abuse of the medical loss ratio to track health plan performance, *Health Affairs* 16: 176-187.

Robinson, J. (2004), Consolidation and the transformation of competition in health ins., *Health Affairs* 23: 11-24.

Sherlock, D. (2009), Administrative expenses of health plans, Sherlock Company, Prepared for Blue Cross and Blue Shield Association.

Shiels, J. and R. Haught (2009), The cost and coverage impacts of a public plan: Alternative design options, The Lewin Group, Staff Working Paper No. 4, April 6.

Steinbrook, R. (2009), The end of fee-for-service medicine? Proposals for payment reform in Massachusetts, *New England Journal of Medicine.*

Swartz, K. (2003), Reinsuring risk to increase access to health insurance, *American Economic Review* 93: 283-287.

Table 1

Private Health Insurers' Medical Loss Ratios, Administrative Expense Ratios, and Net Income Margins

Sample	Profit or expense measure	Value	Source
All private health insurance, 1965-2008[a]	Average premium margin for profit and admin. expenses	12.2%	National Health Expenditure Data
All private health plans, 2006	Admin. expense ratio	12%	CBO (2008)
All risk-based (non self-funded) private health insurance (SAP), 2006-2008	Average medical loss ratio Average admin. expense ratio Average net income margin	87% 11% 2%	Donahue (2009)
Publicly-traded health insurers (GAAP)	Average net income, percent of revenues, 1990-2008	3.3%	Compustat[b]
	Industry net income margin, 2007 Industry rank, 2007 Industry net income margin, 2008 Industry rank, 2008	6.2% 28 2.2% 35	*Fortune* industry rankings (annual)
	Net income / revenues, 2007 Medical loss ratio, 2007 Admin. expense ratio, 2007 Net income / revenues, 2008 Medical loss ratio, 2008 Admin. expense ratio, 2008	5.3% 81.6% 16.8% 3.1% 82.9% 18.0%	A.M. Best (2009a)
Non-profit Blues (SAP)	Net income / revenues, 2007 Medical loss ratio, 2007 Admin. expense ratio, 2007 Net income / revenues, 2008 Medical loss ratio, 2008 Admin. expense ratio, 2008	1.0% 87.3% 12.2% 1.4% 86.5% 11.9%	A.M. Best (2009b)
Blue Cross Blue Shield and other plans, 26 million lives, 2007	Commercial insured admin. expense ratio Commercial ASO admin. expense ratio[a] Small group admin. expense ratio Individual market admin. expense ratio	11% 7% 11.1% 16.4%	Sherlock (2009)
Private health insurers, 2002-2007	Admin. expense ratio, Mass. insurers Admin. expense ratio, other Northeast insurers Admin. expense ratio, nationwide	10.9% 11.1% 11.6%	Oliver Wyman (2009)

[a]Includes estimated premium equivalents for self-funded plans [b]Author's calculations.

Table 2

Criteria for Level Competition between a Public Plan and Private Insurers

Nichols and Bertko (2009)	• Public plan administrators must be accountable to an entity other than the one regulating the marketplace. • Rules and regulations must be the same as for private plans. • The public plan cannot be Medicare. • Provider participation must be optional. The public plan must not be able to leverage Medicare or other public program to force providers to participate. • The public plan should not use Medicare rates. It should allow providers the freedom to negotiate as with private insurers. • Premium subsidies should not be dependent on choice of the public plan. • The public plan must be actuarially sound. • Public and private insurers should adhere to the same rules regarding reserves. • Because a government plan cannot be insolvent, it should be required to establish a premium stabilization fund. • Public plans should be treated the same as private plans in terms of special assessments or levies.
Other	• The public plans should be taxed the same way as private insurers, including payment of state premium taxes. Alternatively, private insurers should be exempt from taxes. • The public plan should be required to hold enough capital, eventually maintained by premiums, that would allow it to receive an A or better financial rating if it were not backed by the government.

Notes

[1] This paper draws from portions of my AEI working paper, The Health Insurance Reform Debate, available at http://www.aei.org/paper/100065. An edited version of that paper is forthcoming in *The Journal of Risk and Insurance.*

[2] A non-profit insurer has the largest market share in some states. In his health care speech before a joint session of Congress on September 9, 2009, the President pointed to Alabama as an example of high market concentration. The state's largest health insurer, the nonprofit Blue Cross and Blue Shield of Alabama, has about a 75% market share (Gray, 2009). A representative of the company indicated that its "profit" averaged only 0.6% of premiums the past decade, and that its administrative expense ratio is 7% of premiums, the fourth lowest among 39 Blue Cross and Blue Shield plans nationwide. A December 31, 2007 report by the Alabama Department of Insurance indicates that the insurer's ratio of medical-claim costs to premiums for the year was 92%, with an administrative expense ratio (including claims settlement expenses) of 7.5%. Its net income, including investment income, was equivalent to 2 percent of premiums in that year. A *Consumer Reports* survey reported that Blue Cross and Blue Shield of Alabama ranked second nationally in customer satisfaction among 41 preferred provider organization health plans. These data suggest that efficiency could help explain the company's large market share, as opposed to a lack of competition—especially since there are no obvious barriers to entry or expansion in Alabama faced by large national health insurers.

[3] The Department of Justice challenged the 2005 merger of UnitedHealth Group and PacifiCare, and obtained a consent decree requiring the divestiture of certain portions of the latter organization's commercial health business for the merger to close. Earlier in 2009, the Pennsylvania Insurance Commissioner Joel Ario entered a ruling that derailed a proposed merger between the state's two largest health insurers, Highmark and Independence Blue Cross. The antitrust exemption did not prevent lawsuits by the American Medical Association (AMA) and New York Attorney General Andrew Cuomo over allegedly flawed databases operated by Ingenix, a UnitedHealth subsidiary, and used by several major health insurers. The suits alleged that use of the databases led to underpayments to physicians for out-of-network care. UnitedHealth settled the cases and agreed to fund an independent database. The AMA subsequently sued Aetna and Cigna for reimbursement of alleged underpayments.

[4] Another issue has been the costs to providers of interacting with private insurers (see, e.g., Casalino, et al., 2009, providing survey evidence of physician time spent interacting with private insurance plans).

[5] The higher administrative expense ratios shown for publicly-traded insurers based on generally accepted accounting principles (GAAP) in part reflect that the ratios include expenses for administrative expenses for self-funded ASP arrangements in the numerator and ASO fees in the denominator, whereas statutory accounting principles (SAP) offsets ASO fees against expenses.

[6] Sherlock notes that assertions that administrative expenses in the individual and small group markets are often 30 percent are higher are based on estimates by Hay Huggins for the Congressional Research Service (1988), which in significant part were based on underwriters' projections, and that such assertions often are based on ratios of expenses to medical claim costs rather than premiums.

[7] CBO (2008) provides background on theory and evidence concerning cost shifting.

[8] The American Hospital Association, for example, reported an aggregate operating margin for U.S. community hospitals of approximately four percent in 2007, and about one-fourth of hospitals had negative operating margins (American Hospital Association, 2009, charts 4.1 and 4.2).

[9] The creation of government-authorized co-ops, proposed in both bills, would likewise create some risk of on-going subsidies by taxpayers (if not by private health insurance buyers), of crowd-out of other plans, and of eventual conversion to a government-run plan if created as an alternative to a public plan. (Haislmaier, 2009, elaborates the basic features of co-ops and how they might be designed; also see Miller, 2009.) The CBO projects that government authorized, non-profit co-ops would have little market penetration. The need for or role for co-ops is not transparent, given that non-profit insurance companies already offer health insurance in many states and are dominant players in some states. Non-profit insurers would be expected to expand and enter additional states if many new buyers who seek health insurance as a result of premium subsidies and/or the legal mandate to buy coverage prefer dealing with non-profit insurers. Co-ops would not have any inherent advantage over private health insurers in establishing provider networks, negotiating with providers, and monitoring healthcare utilization and fraud. Like a proposed public plan, government-authorized co-ops would likely be backed implicitly if not explicitly by taxpayers. They would probably not have to hold the amounts of capital that private health insurers hold, and they would not have to pay income or premium taxes that private for-profit and non-profit insurers must pay. There could be pressure for government-authorized co-ops to offer artificially low premium rates, with an attendant risk that they would experience persistent operating losses and require additional subsidies. Although co-ops would initially be required to negotiate their own reimbursement rates with providers, substantial pressure could arise over time for centralized negotiations. As would be true for a public plan, any ability of co-ops to undercut reimbursement would shift more costs to other payers, increasing crowd out of other health plans.

[10] In principle, an iron-clad premium stabilization fund might fully substitute for capital. That result seems unlikely in practice, especially in view of the history of other federal insurance programs.