

fies our capacity to achieve it, or because the value of a competing public plan to the cause of health security has not been made clear. It will be because fear has won out over hope, blinding us to the sensible middle ground that lies before us.

Dr. Hacker reports receiving advisory-board fees from Pfizer and speaking fees from America's Health Insurance Plans, both of which he reports donating to charity. No other potential conflict of interest relevant to this article was reported.

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HEALTH CARE 2009

Public Health Care and Health Insurance Reform — Varied Preferences, Varied Options

Mark V. Pauly, Ph.D.

Health care and health insurance reform will surely require a mixture of public and private efforts for different population groups in different settings. One feature that might help with the choices Americans make as consumers, voters, and taxpayers is a menu of insurance plans managed by both public and private organizations for all population groups. People will end up with insurance they like better and that works better for them if they can select a plan from a large variety of options. Such an arrangement caters to the variability of consumers' preferences about insurance: how they want their insurer to limit or expand their choices of services, what level of financial protection they want, and how they want to interact with their insurance plan. Even now, some consumers select aggressive health maintenance organizations, others prefer mild preferred-provider organizations, while still others like high-deductible plans.

One aspect of health care that will have to be variable is the magnitude of public subsidies for insurance: families near the poverty line will be eligible for large subsidies, whereas the bulk of the population with moderate-to-high incomes will receive modest subsidies, primarily intended to help those who represent high risks. At present, these two groups face quite different insurance options: poor people may enroll in Medicaid or the State Children's Health Insurance Program, whereas most of the nonelderly population gets its insurance through employers, subsidized by the tax exclusion of compensation paid in the form of insurance premiums. The availability of options varies according to the employer's size: large firms usually offer the choice of a number of for-profit and nonprofit private plans, but no publicly administered plan; small firms almost always have only one private plan available. What reform should en-

vision is the expansion of offerings for all groups: many more private options for the heavily subsidized and moderately more private- and public-plan options for others. Such a framing of reform might also help in winning bipartisan approval for expanding insurance options for all.

What is the value of offering such choices? Why not have the government choose a single cost-containing plan that will ensure that all Americans can meet their health care needs affordably, and then declare victory against un-insurance and inflation of health care costs? One answer is that there is no plan that's been proven to achieve all these goals. Instead, there will need to be trade-offs among access, financial protection, and cost containment — and different Americans are willing to make different trade-offs. Particularly among the modestly subsidized, who pay mostly with their own money (even if it is disguised as their employers'

money, where employers that buy insurance must therefore pay lower wages), letting people have what they want is a good thing. Having insurance you prefer rather than what someone else selects for you will make you more likely to choose to be and remain insured — and makes it easier to enforce any mandate. Competition among plans provides incentives for each plan to be as efficient as possible. Of course, any opportunity to choose is also an opportunity to make a mistake, so furnishing good information to buyers will be crucial.

Above and beyond features of coverage and provider networks, some people prefer insurance plans with private-firm management that is selected by boards of directors and motivated to maximize profits or revenues, whereas others prefer plans run by government, with Congress serving (at some distance) as the board of directors. Some people trust the government to make choices they like and distrust private firms, whereas others distrust the government and prefer to take their chances with the market. As long as there are not enormous advantages to a large plan's dominating the market (and I do not think there are), allowing both such groups their preferred option is better than any single model of either sort.

Beyond market attractiveness, there is also a potentially important political gain. Strong and conflicting preferences for the market or government, even among people who agree on the need for health care reform and for reducing the number of the uninsured, have stymied the political process for years. Allow-

ing some Americans to make a choice they like even if others consider it a mistake will still be a hard concession for some, but a two-choice solution widely accepted as genuinely neutral may allow for progress that breaks the 40-year political logjam.

Both for proper market functioning and for honest political trade-offs, the setting in which plans compete must be neutral. Neutrality in economics requires that, at the outset, public and private plans have moderate market shares and have the same subsidies, rules, requirements, finances, and legal standing. Labeling as a "level playing field" a setting that begins with a dominant public plan, armed with federal purchasing and policing power and backed by political leverage, affronts the economic concept of a competitive market. There may be a case for a dominant plan like traditional Medicare in offerings for the poor or elderly or in local markets where providers have market power, but there is no evidence that Medicare has been successful at controlling spending growth.

If there is to be a neutral competitive market with public and private plans, advocates of both types of plans have to agree on fairness; you cannot have government defining the rules or, even more important, paying the umpires when it has teams on the field. Fairness means that plans need to start with small market shares — which implies that Medicare cannot be, or be linked to, the public plan.¹ Perhaps there should, at the start, be at least two competing public plans in every market. The financing of insurer revenues should

be uniform: the same subsidy, regardless of the plan a consumer chooses, and equal requirements that premiums cover costs. In addition, an action that is a simple contract dispute, such as alleged overbilling by a provider, cannot be a federal offense, with stricter penalties, if done within the government plan. The public plans should also be free to compete in a neutral setting, with no higher subsidies to private plans to get them into geographic markets where they otherwise could not survive, no rules about accepting all willing doctors or including weak providers in a network, and no limits on what or how plans can pay.

A public-plan option invites interested groups to lobby politicians to influence the plan's design and gives politicians power to advance their own views. But a framework in which this option is one among many reduces political risk. Given our limited knowledge about how to design insurance plans, there is little point to a political debate about the unknown and the unprovable. Instead, in this arrangement, the public plan's managers will be subject to the same market discipline as are managers of private plans; though they will have to satisfy their politician-directors, they will also have to offer plans that please consumers. The absence of incentives for caring about service to customers is the ritual complaint about public organizations; neutral competition creates such incentives. Currently debated design questions, such as whether existing state-run plans for state employees could be the public plans, which parts of plan operations might be contracted out and

which performed by civil servants, and which provider groups should be favored, would all be answered with a view toward drawing consumers to the plan. Arguments for or against a public plan will miss the point unless they focus on competition and choice.

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HEALTH CARE 2009

The Proposed Government Health Insurance Company — No Substitute for Real Reform

Victor R. Fuchs, Ph.D.

As pressure builds on the White House and Congress to deliver on their promise of health care reform, the idea of a government health insurance company to compete with for-profit and not-for-profit private companies is gaining political momentum. Advocates claim that this new company would be more efficient, honest, and successful in forcing lower reimbursement rates on physicians and hospitals.¹ However, a close look at how the present health care system functions, what its major problems are, and what reforms are needed to solve them suggests that this new idea is not the answer. The three major problems of the current U.S. system are that 45 million to 50 million people have no health insurance, the cost of care is high and rapidly increasing, and there are gross lapses in the quality of care. There is no reason to think that a government insurance company would make a significant dent in any one of these problems, let alone all three. To do that would require real reform

in the financing, organization, and delivery of care.

The United States currently has a complex combination of private and public health insurance coverage, including self-insurance and policies purchased from insurance companies (see graph). What role might a government insurance company play in this system? If it sold policies only in the individual market (which now covers 5.9% of the population, approximately 18 million people), its effect would probably be minimal: Medicare and Medicaid would not change, and employment-based insurance would continue to be the primary source of coverage. If the government company intended to compete in the employment-based insurance market, it would have to recognize that the largest source of coverage in the United States (accounting for 30% of the population) is employers that self-insure. The only thing these employers buy from so-called insurance companies is administrative services, which are in fact the main product that many in-

urance companies provide.² If the government company also sold administrative services, is there any reason to think that it would be more efficient than WellPoint, Aetna, Cigna, UnitedHealth Group, Blue Cross and Blue Shield Association, and other major companies that compete vigorously for that business? In the largest current government health care program, Medicare, administrative services have always been outsourced to private companies.

Approximately one fourth of the population obtains coverage through an employer that buys insurance from an insurance company. But in most cases, the premium that employer pays is “experience rated” — that is, adjusted every year on the basis of the previous year’s utilization. Would a new government company also experience rate premiums, or would it “community rate,” charging the same premium regardless of an employer’s utilization? If it used community rating, the government company would lose money rapidly because of adverse selection: firms with low utiliza-