ACP

American College of Physicians

internal medicine | *Doctors for Adults*

A Public Plan Option in a Health Insurance Connector

American College of Physicians

A Policy Monograph

2009

A Public Plan Option in a Health Insurance Connector

A Policy Monograph of the
American College of Physicians
July 11, 2009

This paper, written by Ryan Crowley, was developed for the Health and Public Policy Committee of the American College of Physicians: Richard Neubauer, MD, FACP, *Chair*; David Fleming, MD, FACP, *Vice-Chair*; David L. Bronson, MD, FACP; Robert M. Centor, MD, FACP; Robert A. Gluckman, MD, FACP; Richard P. Holm, MD, FACP; Mark Liebow, MD, FACP; Mark E. Mayer, MD, FACP; Robert McLean, MD, FACP; Kenneth Musana, MBchB, MSC, FACP; P. Preston Reynolds, MD, FACP; Matthew Rudy, *Student*; and Baligh Yehia, MD, *Associate*. It was approved by the Board of Regents on 11 July 2009.

How to cite this paper:

American College of Physicians. A Public Plan Option in a Health Insurance Connector. Philadelphia: American College of Physicians; 2009: Policy Monograph. (Available from American College of Physicians, 190 N. Independence Mall West, Philadelphia, PA 19106.)

For questions about the content of this Policy Monograph, please contact ACP, Division of Governmental Affairs and Public Policy, Suite 700, 25 Massachusetts Avenue NW, Washington, DC 20001-7401; telephone 202-261-4500. To order copies of this Policy Monograph, contact ACP Customer Service at 800-523-1546, extension 2600, or 215-351-2600.

Executive Summary

A number of health care reform proposals would establish a health insurance "connector" or "exchange," in which the uninsured would be able to shop for coverage from a number of participating insurers. In 2006, Massachusetts implemented a health care reform model built around the insurance connector. Essentially, private plans are required to offer a minimum level of benefits and abide by rules that require insurers to accept all applicants, limit cost-sharing, and charge the same premiums for all applicants (with some modifications). During his campaign, then-presidential candidate Barack Obama included the establishment of a national health insurance exchange (NHIE) that would allow individuals and small businesses to purchase coverage from participating private insurers as well as a newly established public plan option as part of his health reform proposal. The Obama plan would allow the insured to keep the insurance they have if they are satisfied with it. The "Call to Action" health care reform white paper, released by Senate Finance Committee Chairman Max Baucus (D-MT) in November 2008, would establish a health insurance connector that includes private insurance products and a public plan option; other proposals feature an insurance connector with a public option have been released by the Commonwealth Fund and University of California at Berkeley Professor Jacob S. Hacker (1, 2, 3).

The public plan option has generated significant controversy. Proponents of a public plan option argue that it is necessary to ensure that a fair and stable insurance option is available to all regardless of health status, to achieve administrative cost-savings, and to establish payment and delivery system reform based on prevention and care coordination. Some supporters also believe a public plan option would be able to use the negotiating power of the federal government to achieve cost savings from reduced provider payments. Opponents believe that introduction of a public option into a connector would lead to the destruction of the private insurance market, would create Medicare-style reimbursement rates that amount to price controls, and initiate government encroachment into individuals' health care decisions. Some also believe that eventually, erosion of the private insurance market would lead to a single-payer health care system. Organizations that have offered support for a public plan include the Service Employees International Union and Health Care for America Now!. Opponents include America's Health Insurance Plans and the Heritage Foundation.

It is difficult to determine what the effect of a public plan option would be since most proposals do not provide adequate detail regarding crucial elements like enrollment eligibility and provider reimbursement levels. Although this paper largely focuses on a public plan option that is similar to Medicare, the structure of a public program could change dramatically as legislators seek to reach consensus. During a Senate confirmation hearing, Secretary of Health and Human Services Gov. Kathleen Sebelius cited Kansas's state employee health insurance program and a public Medicaid plan available in California as examples of systems where public and private insurance options competed on a level playing field (4). Senator Chuck Schumer, a Finance Committee Democrat, also expressed that a government-backed self-insured plan like those that compete with private insurance products for state employees could be a compromise (5). Information from stakeholders can be telling, however. Senate Finance Committee Chairman Max Baucus has mentioned that the public plan option has been offered as a way to push insurers to support regulations like guaranteed issue and prohibitions on risk rating (6).

Some commentators have questioned the need for a public plan option, particularly if insurers operating in the health care connector would face aggressive regulation mandating they accept all applicants and prohibit medical underwriting. Public plan opponents like Stuart Butler of the Heritage Foundation have stated that a connector model similar to the Federal Employees Health Benefit program would maintain the free market aspect of the health care system (and would protect the employer-based insurance system) but could be regulated enough to protect consumers (7). Even some proponents of the public plan option have argued that if the public plan option were left out of a comprehensive reform package, a fair and equitable system based on a regulate private insurance market could still be created. Uwe Reinhardt opined that the German health care system could be used as a framework for a reformed American health care system since it offers choice of regulated insurance plans (or "sickness funds") to individuals purchasing coverage (8). Still, proponents of measured public plan participation, such as Len Nichols, believe that public distrust of private insurers justifies making public and private plans available to those who qualify (9).

In 2008, the American College of Physicians—the largest medical specialty society in the United States with over 129,000 physician and medical student members—published a paper titled *Achieving Affordable Health Insurance Coverage for All Within Seven Years*. The College recommended that Medicaid be expanded to cover all individuals with incomes at or below 100% of the federal poverty level, that tax-based subsidies be made available to the uninsured with incomes up to 200% who are not eligible for public coverage, and that new options be made available to small businesses to purchase coverage for their employees, among others (10). ACP also recommends that tax credit recipients be permitted to purchase coverage through state purchasing group arrangements modeled after the FEHBP. Additionally, in *Achieving A High Performance Health Care System With Universal Access*, the College recommended that federal and state governments consider adopting one or the other of two pathways to achieving universal coverage: either a single-payer system in which one governmental entity is the sole third-party payer of health care costs, or a pluralistic system with a legal guarantee that all individuals have access to coverage and sufficient government subsidies and funded coverage for those who cannot afford to purchase coverage through the private sector (11). In *Developing a Medicare Buy-in Program* ACP issued recommendations on establishing a Medicare Buy-in Program for people aged 55-64, including suggestions regarding financing structure, subsidies for low-income people, and a requirement that the program include those aged 55-64 regardless of their insurance status (12).

In this policy monograph, the College evaluates public plan options and will consider offering qualified and conditional support for such an option as part of comprehensive health care reform, providing that a number of stipulations are met.

Recommendation 1: ACP could provide conditional support to a public plan option, as part of comprehensive health care reform in the United States, based on the extent to which the plan is consistent with the following criteria:

- **A. The public plan should be required to meet the same rules and obligations as private plans within the insurance exchange.**
- **B. Insurance reforms, including guaranteed issue with prohibitions against risk selection based on preexisting conditions and modified community rating, should apply to all qualified plans offered through a health insurance exchange, public and private.**
- **C. Income-related premium subsidies are provided for those who cannot afford coverage.**
- **D. Both the public and private plans should adopt delivery system reforms that put primary care at the center of a patient's health care plan and establishes a reimbursement structure that incentivizes care coordination, rewards positive health outcomes, and promotes use of best practices and effective drugs and devices.**
- **E. Core benefits should include coverage of evidence-based preventive services.**
- **F. Safeguards are included to ensure that physician payments under a public plan are competitive with those of qualified private plans, to ensure adequate physician participation in all specialties and locations, and to ensure that flaws associated with existing Medicare payments to physicians are not carried over into a new public plan.**
- **G. The public plan should be managed in a way to reduce conflicts of interest.**
- **H. Participation by individual persons, physicians, and other providers in the public plan and private insurance options offered in a health insurance exchange should be voluntary. Physicians and other providers who participate in Medicare, Medicaid, or other currently operating public insurance programs should not be required to participate in any other public or private insurance plan offered in a health insurance exchange.**
- **I. The public plan should be required to maintain financial reserve funds similar to those required of private insurance plans.**

Recommendation 2: An expert advisory commission, including primary care physicians, should be created to recommend core benefits that would be required for all plans in a health insurance exchange. Plans could offer additional benefits to those covered.

Recommendation 3: Payment rates in a public plan should reflect efforts to improve quality, health outcomes, and cost-effectiveness using innovative models, such as the patient-centered medical home. Plan payments should be consistent with the following policies:

A. Payments have incentives for appropriate, high-quality, efficient, coordinated, and patient-centered care, informed by pilot tests of models that have shown to be effective in improving the quality and effectiveness of care provided. Specifically, such models should:

1. **Improve the accuracy, predictability, and appropriate valuation of primary care services and pay primary care physicians competitively with other specialties**
2. **Promote value and appropriate expenditures on physician services**
3. **Support patient-centered care and shared decision-making**
4. **Align incentives across the health care system**
5. **Encourage optimal number and distribution of physicians in practice and sufficient member access to physicians in all specialties and regions**
6. **Support use of health information technology**
7. **Recognize differences in physician practice characteristics**
8. **Reduce existing and avoid imposing new administrative burdens on physicians except as needed to ensure program integrity**
9. **Not carry over the flaws in existing Medicare payment methodologies, including the sustainable growth rate formula and undervaluation of primary care (13).**

B. Physician payment rates by private and public insurers operating in an insurance exchange should be regularly reviewed by an advisory group, including adequate representation of primary care physicians, to the organization operating the exchange.

1. **The group should issue an annual report with comparative data on how payment rates under the public plan compare with those from private insurers and with recommendations on updates in public plan payments to ensure that the payment rates to physicians are competitive and to ensure maximum physician participation in the public plan.**
2. **The group should report on physician participation in the public plan by specialty, geographic locale, and other criteria as needed to ensure that enrollees in the public plan will have sufficient access to primary and specialty care.**
3. **The group should also compare payment rates of primary care physicians with those of other specialists and recommend payment adjustments as needed to ensure that payments to primary care are competitive with other specialty choices.**
4. **The administrator of the public plan should have the authority to change payments as needed to increase physician participation based on the recommendations of the advisory group.**

Recommendation 4: To mitigate conflicts of interest, the health care connector and the public plan option should be managed by independent entities.

Background

Over the past decade, health care spending has become an increasing burden on individuals and families. Premium growth has exceeded growth in workers' earnings every year since the late 90s (14). The number of nonelderly people who pay at least 10% of their income on health expenditures has also increased, and low-income people are more likely to spend a greater amount of their income on health care (15). Although the United States leads other industrialized nations in the amount spent per capita on health care, performance measures suggest that the investment is not leading to improved health outcomes (16, 17). The United States ranks last among 19 industrialized nations in preventable mortality and scores poorly on avoidable hospitalizations rates (18). Further, over 46 million Americans have no health insurance and 25 million individuals under the age of 65 are underinsured (19). The number of uninsured is expected to grow to 54 million by 2019 (20). Policymakers and stakeholders have offered a number of proposals to increase access to health coverage, reduce inefficiencies in the health care delivery system, and control costs. ACP has also proposed a framework to expand health coverage access (21).

In 2006, Massachusetts enacted a comprehensive health care reform package that subsidizes coverage for the uninsured, requires employers to offer or fund insurance for their employees, mandates that individuals acquire coverage, and facilitates access to private insurance through a health insurance connector (22). So far, the number of uninsured in the state among adults aged 18-64 has dropped by almost half (23).

Similar to the Massachusetts model, a number of health care reform proposals, including those of President Barack Obama and Senate Finance Committee Chairman Max Baucus, support establishing a health insurance exchange or connector to assist the uninsured, small businesses and others in purchasing health insurance. Obama's and Baucus's plans would allow uninsured individuals and small businesses to choose from a variety of private plans as well as a new public plan option that has been described as being similar to Medicare. Proponents believe a public plan option can offer guaranteed benefits, lower administrative costs, and lower provider reimbursement rates that will translate to lower premiums for beneficiaries. To bolster this claim, supporters cite Medicare's relatively small administrative costs, ability to negotiate with providers to achieve lower prices, and efforts to mandate quality measures and value-based practices as evidence that a public plan would be a viable competitor with private health insurance products. Further, public plan supports feel that a stable government-backed insurance product is a critical tool to help hold private insurers accountable.

As noted above, a number of health reform proposals center around the idea that the uninsured should be able to acquire insurance through a health insurance exchange that will include private insurance products as well as a public insurance plan. Brief descriptions of notable proposals are below.

Prominent Health Care Reform Plans that Feature a Public Plan Option in a Health Insurance Exchange Model

President Obama's proposal

During the 2008 Presidential campaign, then-Senator Obama proposed a health care reform package with a health care insurance exchange as the centerpiece. Under Obama's plan, those without access to employer-sponsored or public insurance, small businesses, and the self-employed would be able to purchase coverage through the NHIE. In addition to a variety of private insurance options, the Obama proposal would also create a new public insurance option (called the National Health Plan or NHP) to compete with the private products. To make the plans affordable, income-based subsidies and small business tax credits would be made available to eligible purchasers. Obama has emphasized that persons who are satisfied with their existing insurance would be able to keep it.

Senator Baucus's Call to Action proposal

In November 2008, Senator Max Baucus, Chairman of the Senate Finance Committee, released "Call to Action," a white paper outlining his health care reform proposal. Like the Obama plan, the proposal would establish a nationwide health insurance pool to assist individuals and small businesses in purchasing coverage. The Baucus plan would also establish a public plan that would compete with private products in the Health Insurance Exchange. Plans within the Exchange would offer benefits at different level—high-, medium- and low-benefit options--and the public plan would be required to offer the same level of benefits and establish premiums in the same manner as the private plans. The Baucus plan would also allow people to keep their existing coverage. Provider rates would be determined by "balancing the goals of increased competition and ensuring access for patients to high-quality health care." (24)

Commonwealth Fund "Building Blocks" Proposal

The Commonwealth Fund, a private nonpartisan think tank, released their "Building Blocks" proposal in May 2008. The centerpiece of the proposal is a public plan and private health insurance exchange model (25). Businesses with fewer than 100 employees, the self-employed, and the uninsured would be eligible to purchase coverage through the exchange. The public option is called "Medicare Extra" and would feature enhanced benefits based on Medicare Part A and B. The Medicare Extra fee-for-service option would compete with Medicare Advantage HMOs and integrated health plans participating in the Federal Employee Health Benefit Program (FEHBP). Provider payment rates would be based on current Medicare reimbursement but may also include disease management and care coordination services if they prove to be successful in current Medicare demonstration projects. Additionally, Medicaid payment rates would be increased to equal Medicare payment levels; however, to help offset this increase, a 2% assessment on physicians would be implemented.

"Health Care for America" Proposal

Authored by Yale University professor Jacob Hacker, the Health Care for America (HCA) proposal permits the uninsured to enroll in a Medicare-like fee-for-service plan or a selection of private HMOs and other managed care coverage plans. All Americans are automatically enrolled in the public HCA plan unless they opt out for employer-sponsored insurance or a private HCA plan. The public plan would reimburse providers based on Medicare reimbursement rates (26). Public plan enrollees would be required to participate in a medical home program.

New America Foundation Proposal

In March 2009, Len Nichols and John Bertko of the New America Foundation released "A Modest Proposal for A Competing Public Health Plan." Expressing concern that the debate regarding the public plan option was become polarized, the authors laid out an alternative proposal that would require the public and private plans operating in a health care connector to compete with one another on a level playing field. Citing such examples as the CalPERS system, which offers California's state employees a choice between a government-backed self-insured preferred-provider option health plan or a number of private insurance alternatives, Nichols and Bertko state that a public plan option could compete on a level playing field with private insurers if it were required to abide by the same rules. Specifically, the public plan would be governed by an entity separate from the connector's governing body. Additionally, the public plan would be required to maintain reserves, could not be funded by the U.S. Treasury, and must adhere to the same rating and issuance rules required of private plans in the connector. Most important, the public plan would not use Medicare's negotiating power or payment rates; instead it would negotiate for rates with providers in a manner similar to private insurers. Savings would be garnered from innovations like health information technology, comparative effectiveness research, and new payment methods like bundling (27).

Analysis of the Public Insurance Plan Option

Level of coverage

According to a Commonwealth Fund's analysis of Senator Obama's health care proposal, the NHP would provide a level of coverage equal to the standard benefit provided in the FEHBP. The NHP would "cover essential medical services including preventive, maternity, and mental health care as well as disease management, care coordination, and self-management of care." (28) The plan would be modeled after Medicare (29). Private insurance plans in the NHIE would be required to offer coverage at the level of the NHP. Senator Baucus's public plan is also "similar to Medicare" with private plan benefits matching the public offering (30). The Medicare Extra public plan option of Commonwealth Fund's Building Blocks proposal would include Medicare Part A and B benefits and prescription drug coverage; however, cost-sharing levels would differ from Medicare fee-for-service (31). Benefit levels for the HCA plan would include Medicare benefits, as well as mental, prescription drug, and maternal and child health coverage. Additionally, preventive and well-child care would be covered at no out-of-pocket cost (32). Private plans would be required to offer benefits that are actuarially equivalent to the public plan.

Critics of the public plan option, particularly those focused on the Obama proposal, suggest that requiring all plans to offer a minimum benefit package would stifle innovation and probably increase costs for beneficiaries. Some argue that a minimum benefits package with significant cost-sharing would be more financially feasible (33). The Blue Cross Blue Shield Standard Family option, one of the more popular FEHBP plans, would cost $4279.08 for a year of coverage in 2009; the Mail Handlers Benefit Value option, a lower-priced plan with higher out-of-pocket costs, would cost a family $1334.64 in 2009 (34). Additionally, critics say that establishing a comprehensive plan as the minimum benefit level would push less-comprehensive plans (e.g., high deductible health plans) out of the market, reducing consumer choice. Other critics say the minimum benefits package will be subject to political interests, patient advocacy groups, and others who will add benefits that may be unnecessary and costly (35).

Enrollment Projections

A Lewin Group analysis of the Obama health care proposal predicts that 31.7 million people will enroll in the NHP, including 18.6 million that would be employed by firms that choose to purchase insurance through the NHP (36). A review of the Commonwealth Fund's Building Blocks reform plan, which includes a public-private health insurance exchange scheme similar to the Obama plan, predicted that two thirds of enrollees would choose a Medicare-style public plan over private insurance because the premiums would probably be lower (37). Similarly, the Lewin Group analysis of the Health Care for America proposal assumes that 70% of individuals would choose the public fee-for-service option and the rest would choose an HMO plan (38). Enrollment projections for the Baucus plan are not available.

As noted elsewhere in this paper, public plan enrollment depends on the level of premium (which is influenced by the provider reimbursement levels and administration costs of the public plan compared with those of private insurers) and the likelihood that employers will continue to offer health coverage to their employees if a public plan is available.

Provider Reimbursement Assumptions

The Obama plan offers little detail regarding reimbursement levels for physicians. Under this plan, "(p)roviders who see patients enrolled in the new public plan, the National Health Insurance Exchange, Medicare and FEHB will be rewarded for achieving performance thresholds on physician-validated outcome measures." (39) The plan does not specify what conditions would be measured or how physician input would occur. The Obama plan would also require certain patients to enroll in disease management programs and that medical home models be implemented; again, specifics on issues such as reimbursement are not presented. The Lewin Group analysis assumes that reimbursement levels under the NHP would be at the midpoint between Medicare and private insurer rates, and that only small employers and uninsured individuals (rather than all employers) would be included. Under this scenario, the Lewin Group estimates that physicians would see a –0.5% change as a percentage of total physician revenue (40). The Urban Institute analysis of the Obama health plan finds that a public plan would be able to aggressively negotiate with hospitals and physicians to reduce costs (41).

Further, the Commonwealth Fund analysis of the Building Blocks approach states, "With universal coverage, providers gain revenue on average, but some that now serve primarily private patients and few Medicaid or uninsured patients could see their revenues decline or become more restricted over time." (42) According to a Lewin Group analysis, national health spending would be reduced $20.8 billion due to a net reduction in provider payment rates (including the above-mentioned provider assessment).

Senator Baucus's "Call to Action" plan recommends similar pay-for-quality methods, but goes a step further in stating that the Sustainable Growth Rate payment formula needs to be replaced. Specifically, the plan says, "Rates paid to health care providers by this option would be determined by balancing the goals of increasing competition and ensuring access for patients to high-quality health care." (43)

The Health Care for America public plan would utilize the Medicare payment levels. Since Medicaid beneficiaries would be incorporated into the Health Care for America plan, it is assumed that reimbursement for their treatment will increase 14% for hospitals and 45% for physicians. Rates for individuals who transitioned from a private plan to the public HCA option would decrease by 26% for hospitals and 17% for physicians. Public plan beneficiaries would be required to select a medical home practitioner to coordinate their care. Reimbursement for primary care physicians providing medical home-related care would be reimbursed at a Medicare fee-for-service rate as well as a capitated per-person, per-month payment that Lewin assumes to be $4 per person per month. Overall, provider reimbursement would increase by $16.7 million due to payments for previously uncompensated care; however, total payment would decrease by $29 million due to the change in provider payment levels (44). The report does not state whether payments for medical home–related procedures were incorporated into the statistic.

The Lewin Group analysis of the Obama health proposal states that the level of provider reimbursement is the critical factor influencing enrollment in the NHP (45). Premium levels fluctuate based on the level of provider reimbursement. When payment levels are set between Medicare rates and private insurer rates, enrollment in the public plan is assumed to be 31.7 million. When public plan reimbursement is set at Medicare rates, enrollment increases to 42.9 million.

Both the Health Care for America and Building Blocks plans state that because the federal government can use its significant negotiating power to achieve lower reimbursement levels, premiums will be lower than in the private insurance market. Supporters of the public plan option contend that a public plan would encourage private insurers to use their bargaining power. They note that Medicare provider rates are significantly lower than private market rates and wider implementation of such reimbursement policy could lead to greater savings (46). Due to consolidation of the hospital industry and the need for insurers to establish extensive provider networks, hospitals are overpaid in the private market, especially in areas where hospital consolidation is more concentrated (47). Additionally, supporters argue, competition in the private market is limited because insurers "shadow price" one another, adopting their competitor's payment rates rather than negotiate with providers (48). Supporters also say the insurance industry is more focused on aggressively marketing to healthy people and not negotiating for better rates (49).

Opponents of the public plan option see the government as having an unfair advantage over the private market because of its significant negotiating power. The Heritage Foundation called the public plan payment level

"profoundly consequential" and expressed concern that even if a public option were to use new payment system rather than the current Medicare physician fee schedule, clinical innovation will be stifled and inefficiencies will be "institutionalized" if the government is able to fix prices (50). Heritage does state that reductions in provider payments would be "balanced somewhat" by reduced administrative costs, delivery reforms, and decreased uncompensated care costs. However, supporters counter that if the public plan sets rates too low, providers would refuse to participate, forcing the public plan to raise rates to remain competitive (51). Additionally, proponents argue that large insurers like Aetna and Wellpoint have a strong competitive advantage over small insurers in achieving lower prices for health services (52).

Both proponents and opponents of the public plan option cite Medicare's payment rates to bolster their case. According to the Medicare Payment Advisory Commission (MedPAC), Medicare pays physicians at a rate about 80% of private insurer rates (53). Despite this disparity, supporters maintain that Medicare participation among physicians is high (54). However, private plans may be more able to negotiate competitive contracts with providers, leading to more efficient price levels when compared with traditional Medicare (55). Additionally, Medicare Advantage private fee-for-service plans reimburse providers at traditional Medicare fee-for-service levels (56).

Opponents also believe that if a public plan option is implemented and is able to use the government's purchasing power to achieve lower reimbursement rates, providers will increase fees (or cost-shift) to private insurers (57). Some insurers and hospital advocates cite evidence that the margin on Medicare patients for hospitals is on average –9.4% compared with a 23.1% margin on patients with commercial health insurance plans (58). Based on these numbers, for a hospital to achieve constant margins it would have to increase costs to private insurers, amounting to $51 billion cost shift (59). The same researchers found that cost-shifting among physicians amounted to $37.8 billion (60). On the contrary, MedPAC argues that instead of shifting costs to private payers, hospitals aggressively control costs in times of financial stress (61). The CBO states that the impact of cost shifting on premium and payment rates on private insurance is likely to be relatively small (62).

Some provider groups have expressed concern regarding implementation of a public plan option, especially if the payment structure mimics that of Medicare. Mayo Clinic CEO Denis Cortese, MD, stated that Medicare has a history of underpaying for services and that providers may go out of business if public plan enrollment is high. Similarly, Nancy Nielsen, MD, president of the American Medical Association, reserved judgment until a concrete proposal is presented, but noted that public plans are often inadequately funded, leading to cuts to health care providers (63).

Proposals that seek to use the existing Medicare fee schedule as the public plan payment mechanism raise alarm largely because of the Sustainable Growth Rate, a built-in mechanism that acts as a spending target for certain goods and services provided under Medicare Part B. If overall spending is below the target, annual payment updates to Medicare providers are adjusted upward; if overall spending is above the target, payments are adjusted downward (64). Because of the SGR mechanism, physicians participating in Medicare have faced a cut in Medicare payments every year since 2002, forcing Congress to pass legislation to avert payment reductions. Medicare payment rates are scheduled to decrease by 21% on 1 January 2010 unless Congress takes action (65). Such a drastic cut in payments could lead to decreased access to care for patients. If a public plan were to adopt the Medicare fee schedule, it would inherit the same problems

of payment shortfalls, annual updates, and uncertainty. Policymakers have also expressed concern that low Medicare payment levels are to blame for the growing shortage of primary care physicians as well as the disparity between primary care practitioners and specialists (66).

Some opponents of a public plan option argue that a government-backed plan could resemble Medicaid, the federal-state health insurance program for the poor (67). Medicaid provider payments are determined by state governments and vary throughout the country. Medicaid payment rates are often well below the cost to provide care, and therefore, physician participations is low when compared with Medicare or private insurance (68). While there is evidence that average Medicaid fees have grown over the past 6 years, such increases have not kept up with inflation (69). The low provider rates paid by Medicaid programs have made it unaffordable for physicians to participate in the program and may contribute to access problems for enrollees. A public plan option that adopted a similar pricing structure would probably face the same issues (70).

Administrative and other cost-containment factors

Among the primary benefits of a public plan option, supporters argue, is its ability to efficiently administer benefits without the burden of marketing costs, broker fees, profit–taking, and responsibility to shareholders. Supporters say that a public plan option would have lower costs due to savings from administrative activities (71).

Evidence suggests that government-run health plans have lower administrative costs than those of the private insurance sector. Some studies show that Medicare administrative costs are about 5%, including costs associated with staff, office space, and premium and tax collection (72). When accounting for administrative cost relative to Medicare's high claims, the portion is about 6% to 8% (73). Other research by the CBO compared traditional Medicare fee-for-service administrative costs with Medicare Advantage. The analysis concluded that cost related to marketing, utilization management, network development and retention, and reinsurance for private plans was about 11%. The report stated that administrative costs for traditional Medicare were about 2%. The CBO does caution that utilization management practices of private insurers could lead to cost savings if the return of investment is greater than the cost of administration; however, results vary among geographic areas (74). Administrative costs and related overhead are particularly high in the individual and small group market, accounting for 40% of premiums in the individual market and 25% to 27% in the small group market. An analysis of administrative costs of Massachusetts health insurance plans found that from 2002-2007, Neighborhood Health Plan, a plan composed primarily of Medicaid beneficiaries, had the lowest administrative costs compared with other insurers in the commonwealth (75).

Obama has stated that introduction of a new public plan and creation of the NHIE would help rein in excessive administration costs that prevail in the private market. Further, given Medicare's relatively low administrative costs, a new public plan with a similar structure would keep administrative costs low. The Lewin Group analysis of the Obama health proposal estimates that administrative costs would decline by about $62.7 billion due to significant coverage expansions through government programs and the NHIE (76). The analysis also states that if the NHP paid providers at private insurance levels, premiums under the public plan would be 5% lower than private insurance premiums. This may be due to savings from administrative costs. National health spending under the Building Blocks proposal would be reduced by $15.4 billion (77).

According to the Lewin Group analysis of the Health Care for America plan, administrative simplification would reduce costs by $25.4 billion in 2007 (78). Senator Baucus's "Call to Action" plan would create an Independent Health Coverage Council to assist in determining who is eligible to participate in the public plan. The group would also help determine who will administer the plan, among other things. Such aggressive monitoring may limit administrative costs.

While administrative savings under the newly established public plan will probably occur, they may not be as significant as current government-run insurance plans like Medicare. For instance, if underwriting practices were eliminated in the NHIE, private insurers would not devote funds toward that activity. Further, the care coordination and disease management activities that would be utilized in a public plan option will probably increase administrative costs (79, 80).

Under all proposals, certain public plan participants would be required to enroll in programs to coordinate care and emphasize prevention. Obama's proposal would require all public plan participants to utilize disease management programs (81). Incentives to use generic prescription drugs would also be established in the public plan. The Lewin Group estimates that requiring the use of disease management in Medicare, the National Exchange and FEHBP would potentially save $43.6 billion over 10 years. However, according to the CBO, disease management efforts may not always yield cost reductions, particularly in the short-run (82).

Savings garnered through pay-for-performance programs (based on full application to all acute care hospitals of the CMS Premier Hospital Quality Initiative Demonstration) would be about $48.1 billion over 10 years (83). Overall, the Lewin Group analysis estimates that from 2010-2019, the Obama Plan would probably reduce national health spending by about $571 billion if the plan's proposed cost-containment strategies were implemented (this includes $321 billion in public program savings).

Opponents often cite Medicare as an example of how government-run health programs become bloated and inefficient and are too beholden to special interests to effectively control costs (84, 85). Supporters counter that Medicare has lower excess spending per beneficiaries than private insurers (86). Additionally, supporters cite evidence that private Medicare Advantage plans do not achieve savings when compared with traditional Medicare despite having an overall healthier population to cover (87).

Effect on Commercial Insurance Industry and Governance

The primary objection of opponents, particularly insurance companies and their political sympathizers, is that a government-run health plan will have significant advantages over private insurers and that fair competition will be impossible to achieve. Once insurers are forced out of business, establishment of a government-run single-payer health care system will be imminent (88). While opponents of the public plan option decry the potential erosion of private health insurance and the increasing influence of the federal government in health care, some proponents support the public plan option because it is the closest politically feasible alternative to a single-payer system. House Congressional Progressive Caucus leadership has stated that its members, many of whom support a single-payer health care system, will only support a comprehensive health care reform package if a public plan option operating in a health insurance connector is included (89).

Crowd-out estimates depend primarily on who is eligible to enroll in the public plan and the level of payment to providers. The Obama NHP proposal

would permit uninsured individuals and small businesses to join the public plan option. The Lewin Group estimates that 18.6 million people would be in firms that choose to drop private coverage in favor of the NHP coverage. However, this number would be somewhat offset by an increase of 8.6 million people newly enrolled in employer-provided private insurance (90). Opponents cite Lewin Group estimates that if all employers and individuals were made eligible for the public plan option, enrollment would be about $118 million (91). Under the Health Care for America proposal, enrollment in the newly created HCA pool would be about $128.6 million (including both public and private HMO membership). Employer-sponsored private insurance would be $122.2 million under the proposal, down from $157.0 under current law (92).

Proponents of the public plan believe such an option is needed to help keep private insurers in check. Citing evidence of adverse selection and denied enrollment (especially in the individual insurance market), public plan supporters say that a public plan paired with stronger regulation and competing on a level playing field with private insurers is the only way that risk segmentation and aggressive cherry-picking can be mitigated (93). Proponents also state that public and private insurers can play off their strengths—private plans offer more flexibility; public plans offer stability. For instance, Medicare has utilized care coordination methods developed by private insurance companies. Similarly, many private insurers emulated Medicare's hospital payment structure (94). Stability in the connector is at the core of reform proposals that include a public–private health insurance connector system. Guaranteed issue and community rating rules would be required of both public and private insurers participating in the connector. Because of this tighter regulation and requirement that all payers abide by the same rating rules and minimum benefits package, some opponents have questioned the need for a public plan (95).

Proponents predict that most if not all private plans will survive under a public–private connector scenario. For instance, private insurers who offer better networks and services than public plans will attract customers, as will private insurers who are able to translate better efficiency and care coordination savings into lower premiums (96).

Those who favor a public plan cite examples of existing models where private and public plans compete. For instance, private managed care organizations have served Medicaid beneficiaries since the 1970s (97). Many state employees are able to choose between a self-insured health plan run by the state or a private insurance product (98). Enrollment in the California state employee health insurance program is distributed fairly evenly between those participating in the state-run preferred provider organization plan and alternatives offered by private insurers like Kaiser Permanente and Blue Shield Access+. In January 2009, the Kaiser plan had the highest share of enrollment at 35% while 19% enrolled in PERS Choice, the largest state-run plan (99).

ACP has considered the pros and cons of a public plan and has concluded that it can support such an option, as part of a plan to comprehensively reform health care in the United States. Specifically, the College recommends:

Recommendation 1: ACP could provide conditional support to a public plan option, as part of comprehensive health care reform in the United States, based on the extent to which the plan is consistent with the following criteria:

- **A. The public plan should be required to meet the same rules and obligations as private plans within the insurance exchange.**
- **B. Insurance reforms, including guaranteed issue with prohibitions against risk selection based on pre-existing conditions and modified community rating, should apply to all qualified plans offered through a health insurance exchange, public and private.**
- **C. Income-related premium subsidies are provided for those who cannot afford coverage.**
- **D. Both the public and private plans should adopt delivery system reforms that put primary care at the center of a patient's health care plan and establishes a reimbursement structure that incentivizes care coordination, rewards positive health outcomes, and promotes use of best practices and effective drugs and devices.**
- **E. Core benefits should include coverage of evidence-based preventive services.**
- **F. Safeguards are included to ensure that physician payments under a public plan are competitive with those of qualified private plans, to ensure adequate physician participation in all specialties and locations, and to ensure that flaws associated with existing Medicare payments to physicians are not carried over into a new public plan.**
- **G. The public plan should be managed in a way to reduce conflicts of interest.**
- **H. Participation by individual persons, physicians, and other providers in the public plan and private insurance options offered in a health insurance exchange should be voluntary. Physicians and other providers who participate in Medicare, Medicaid or other currently operating public insurance programs should not be required to participate in any other public or private insurance plan offered in a health insurance exchange.**
- **I. The public plan should be required to maintain financial reserve funds similar to those required of private insurance plans.**

A public plan option competing on a level playing field with private insurers within a health care connector could reduce cost, foster innovative care models, and ensure market stability. The stable nature of a government-run health care plan could be an improvement over the existing individual and small group markets characterized by their volatility. It is difficult to assess the outcome of a public plan because few details on oversight, eligibility, provider reimbursement, and regulation are currently available. However, a public plan should be required to meet the same rules and obligations as private plans within the insurance exchange and governance of the public plan should be separated from the entity that has oversight of the connector. Most important, both the public and private plans should adopt delivery system reforms that put primary care at the center of a patient's health care plan and establishes a reimbursement structure that incentivizes care coordination, rewards positive health outcomes, and promotes use of best practices and effective drugs and devices.

The Medicare system includes both public fee-for-service option as well as a private insurance option. They do not operate on a level playing field related to provider access, reporting requirements, and payment policies (100). For instance, Medicare fee-for-service must be offered to all beneficiaries regardless of geographic location; private plans are not required to do so. Fee-for-service is also required to offer free choice of providers (as long as providers participate), whereas private Medicare plans are allowed to negotiate and establish limited provider networks. This has led to inefficiencies in the system. For instance, private Medicare plans are not required to operate in rural areas, so beneficiaries in those areas may have limited access to private Medicare. To remedy this situation, changes in payment policy facilitated private fee-for-service plans that were paid at levels well above fee-for-service Medicare, and as a result proved to be widely popular due to their reduced cost-sharing and/or enhanced benefits (that were a result of the subsidized payment) (101).

A public plan can act as an important check to the private market, ensuring that all patients, especially those with preexisting conditions, receive quality, affordable care (102). A number of analysts maintain that private plans would not be driven out of business should a public plan be introduced (103, 104, 105). Some private plans, especially those that are able to offer better access to providers, administer benefits efficiently, and adopt innovative cost-saving care models, will flourish. Similarly, private insurers can act as a check on the public plan; should the public insurance plan offer a limited provider network due in part to low reimbursement levels, a private plan with a more expansive provider network would be an attractive alternative to those who want a wider selection of providers. Additionally, as rates of employer-sponsored insurance coverage continue to decline, private insurers may be able to survive by serving individuals and businesses through public sector programs (106).

Public plans may have more of an incentive to establish long-term coordinated care and disease management strategies. Excessive churning in the private insurance market–where employees frequently switch health plans–acts as a disincentive for private insurers to invest in strategies that may improve outcomes over long periods (107). The stability and long job tenure of state government employees has led state governments to invest funds in long-term strategies to improve quality of care (108). The following recommendations offer suggestions on what an equitable public–private connector might look like.

The establishment of a private health insurance connector with a public plan option should include insurance reforms that will provide safeguards against adverse selection, guarantee access to all, and minimize premium fluctuations. Proponents of the public plan option argue that it is necessary to provide stable coverage to all because private insurers will aggressively pursue low-risk people who are cheaper to cover. Left unchecked, the public plan would become the insurer of last resort for sicker people with comprehensive health care needs (109). Such rules are important given the individual market's volatility and ability (in most states) to turn down applicants based on health status. Over 20% of people who attempt to acquire coverage in the individual market are turned down or charged more due to a preexisting condition, or had a health problem uncovered by their insurance plan (110). To ensure that insurance purchased through a public–private insurance exchange is accessible and affordable and that public and private insurers compete on a level playing field, a number of safeguards must be put in place. To mitigate the occurrence of adverse selection, consumer protections that guarantee enrollment (guarantee issue) and renewability (guaranteed renewability) and set the same premium for all beneficiaries (community rating) should be established, and all insurers

should be required to adhere to the same rules. Without these protections, the insurance connector would resemble the current individual or small group insurance markets and would therefore have little impact on reducing the level of uninsurance (111).

Evidence suggests that public plans, such as Medicare, attract less-healthy beneficiaries and that private Medicare plans are able to enroll healthier beneficiaries (112). In the nongroup market, 20% of applicants have health problems significant enough to substantially raise premiums (113). To fairly spread risk and ensure that the public plan does not fall victim to an adverse selection death spiral, a number of protections should be put in place. For instance, requiring all plans to accept applicants regardless of health status will prevent risk imbalance. Additionally, implementing community rating and prohibiting premium rating based on risk will make insurance more affordable. Community rating rules in a shared-risk pool could stabilize premiums for sicker people but could increase premiums for healthier applicants. Massachusetts established its health insurance connector and utilized existing guaranteed issue and modified community rating regulations for plans operating in the connector (114).

In addition, risk adjustment mechanisms should be utilized to further reduce adverse selection. Plans operating in the connector, whether public or private, would receive additional funds if their enrollees are disproportionately sicker than those in other plans operating in the pool. Proper risk adjustment will ensure premiums that better represent the cost of providing care rather than reflect the health status of the plan's enrollees (115). Private and public insurers should be permitted to collaborate on establishing the methods for risk adjustment. Medicare Advantage plans are paid a risk-adjusted payment based on patient data they submit to CMS. Payments are increased for sicker patients and adjusted downward for healthier patients (116). To minimize controversy, the coordinator of the insurance connector should collaborate with participating public and private payers on aspects of the risk-adjustment mechanism. In the 1990s, private Medicare insurers complained that risk adjustment based on utilization was punishing them for their efforts to coordinate care. To rectify the situation, CMS collaborated with health plans to design the risk-adjustment system (117).

Currently, health care providers are not required to participate in any public or private insurance system or program. The federal government, or its designee, should not require health care providers to participate in any new public or private insurance plan operating in a health insurance exchange. Practitioners currently participating in Medicare, Medicaid, Veterans Health Administration, or other public insurance program should be given the option to participate in any plan operating in a health insurance exchange.

To ensure that lower-income people are able to afford insurance, adequate subsidies should be provided. In the ACP paper *Achieving Affordable Health Insurance Coverage for All Within Seven Years*, the College recommends that public insurance programs be expanded to more people; that advance, refundable, and sliding-scale tax credits be provided to lower-income people who do not qualify for public programs; and an expert panel should be established to recommend initiatives to expand insurance coverage to higher income uninsured individuals (118).

To successfully compete on a level playing field, public and private insurance plans should be required to maintain financial reserve funds to cover costs. The public plan should operate under similar conditions. Accordingly, the public plan should be funded by sufficient premiums, with appropriate income-related subsidies to help those who cannot afford the premiums to be able to buy into

the plan, equivalent to the subsidies provided for other qualified plans offered through an exchange. Consideration could also be given to prohibiting public plans from accessing United States Treasury funds or other government appropriations to cover costs and shortfalls. The public plan should be required to establish a premium stabilization fund to ensure that savings are targeted toward lowering premiums (119).

Recommendation 2: An expert advisory commission, including primary care physicians, should be created to recommend core benefits that would be required for all plans in a health insurance exchange. Plans could offer additional benefits to those covered.

In the ACP position paper *Achieving Affordable Health Insurance Coverage for All Within Seven Years*, the College recommended that an expert advisory commission be created to, among other things, determine a core set of benefits that all payers would be encouraged to offer to beneficiaries (120). The Commission would be charged with issuing biennial reports with recommendations on benefit standards and cost-sharing limits.

Most proposals that include a public plan would permit variation in health plan benefits as long as they offer at least the minimum set of benefits. Examples of minimum benefits packages currently exist in public and private insurance programs. For instance, private Medicare plans that can provide core Medicare benefits below benchmark cost are required to transfer a part of the savings into benefits or premium cost reductions. Additionally, the Massachusetts health reform initiative requires that effective 2009, all health plans offer minimum creditable coverage that includes prescription drug and preventive care benefits provided by a physician (121).

Further, the federal government requires states (and private insurers who contract with the state to provide Medicaid coverage) to offer a minimum level of benefits to Medicaid enrollees providing they are medically necessary. These include inpatient and outpatient hospital care, nursing home care, and physician services. States also have the option to cover other benefits, such as prescription drugs (122). The expert commission authorized to determine core benefits should include practicing primary care physicians and should consider and incorporate clinical efficacy and comparative effectiveness data when available and applicable.

Recommendation 3: Payment rates in a public plan should reflect efforts to improve quality, health outcomes, and cost-effectiveness using innovative models, such as the patient-centered medical home. Plan payments should be consistent with the following policies:

A. Payments have incentives for appropriate, high-quality, efficient, coordinated, and patient-centered care, informed by pilot tests of models that have shown to be effective in improving the quality and effectiveness of care provided. Specifically, such models should:

1. **Improve the accuracy, predictability, and appropriate valuation of primary care services and pay primary care physicians competitively with other specialties**
2. **Promote value and appropriate expenditures on physician services**
3. **Support patient-centered care and shared decision-making**
4. **Align incentives across the health care system**
5. **Encourage optimal number and distribution of physicians in practice and sufficient member access to physicians in all specialties and regions**
6. **Support use of health information technology**
7. **Recognize differences in physician practice characteristics**
8. **Reduce existing and avoid imposing new administrative burdens on physicians except as needed to ensure program integrity**
9. **Not carry over the flaws in existing Medicare payment methodologies, including the sustainable growth rate formula and undervaluation of primary care (123).**

B. Physician payment rates by private and public insurers operating in an insurance exchange should be regularly reviewed by an advisory group, including adequate representation of primary care physicians, to the organization operating the exchange.

1. **The group should issue an annual report with comparative data on how payment rates under the public plan compare with those from private insurers and with recommendations on updates in public plan payments to ensure that the payment rates to physicians are competitive and to ensure maximum physician participation in the public plan.**
2. **The group should report on physician participation in the public plan by specialty, geographic locale, and other criteria as needed to ensure that enrollees in the public plan will have sufficient access to primary and specialty care.**
3. **The group should also compare payment rates of primary care physicians with those of other specialists and recommend payment adjustments as needed to ensure that payments to primary care are competitive with other specialty choices.**
4. **The administrator of the public plan should have the authority to change payments as needed to increase physician participation based on the recommendations of the advisory group.**

ACP supports major reform of our nation's health care delivery system to emphasize prevention, care coordination, quality, and use of health information technology through the Patient-Centered Medical Home (PCMH) model (124). The College has long advocated for payment reform; specifically, it has supported the elimination of the Sustainable Growth Rate, adoption of the PCMH model, and efforts to spur growth in primary care. In the paper *A System in Need of Change: Restructuring Payment Policies to Support Patient-Centered Care*, the College recommended that Medicare and other payers implement changes to support a new model of service delivery that uses systems that promote patient-centered, longitudinal, coordinated care. Additionally, ACP called for the elimination of the Sustainable Growth Rate formula for annual physician fee updates (125). ACP has also recommended initiatives to change the payment system to make primary care competitive with other specialties and has outlined a comprehensive framework toward achieving those goals in the paper titled, *Reforming Physician Payments to Achieve Greater Value in Health Care Spending*. Access to care and delivery system reform must happen concurrently if effective transformation is to be achieved. The existing health care system is fragmented and centered on providing reactive care rather than preventive care. This must change if quality care is to be standard and financial solvency is to be ensured. A public plan option established within a health care insurance exchange or connector as part of comprehensive health care reform must also utilize these crucial delivery system reforms. It is important that public and private insurers continue to design, test, and implement innovative health care delivery and payment models that promote patient-centered care, reward physicians for value-based practice, and facilitate effectiveness and efficiency across the health care sector. A public plan should be given the capability to adopt successful innovative payment models that achieve these goals while also strengthening the primary care workforce.

Proposals to use the current Medicare reimbursement structure as a basis for reimbursement under the public plan option raise significant concerns. In particular, payment levels for physicians participating in the public plan would amount to price controls that insufficiently compensate physicians for their work. It is widely believed that the current Medicare fee schedule is ineffective in promoting quality care and incentivizes volume-based rather than value-based health care. In its March 2009 report to Congress, MedPAC stated that it was dissatisfied with the current fee schedule updating mechanism for physician payments (126). Further, the Medicare fee schedule has resulted in improper utilization of services rather than cost containment (127). Proponents of the public plan option have cautioned that hospital closures, stifled innovation of new technology, and limited access to physician services could result if a government-run health plan strictly limits payments to providers under a public plan (128). The Lewin Group also states that under the Health Care for America Proposal, by 2017 public plan reimbursement rates will be substantially below private rates, potentially leading to limited access to providers and altered quality of care (129).

To be successful, a public health plan would not have to control prices to maintain access, promote quality care, and limit cost efficiencies. Len Nichols and John Bertko of the New America Foundation argue that a public health plan should not use the government's buying power to control rates, nor should providers be forced to participate. Instead, the government (or the plan's administrator) should negotiate with providers in a manner similar to the private market (130). Cost containment would be achieved through system-wide efficiencies rather than price controls. Noting the potential for compromise on

public plan option reimbursement, White House Office for Health Reform Director Nancy-Ann DeParle has stated that the public plan might pay doctors and hospitals at rates similar to those of private insurers (131). Nichols and Bertko suggest aggressive adoption of health information technologies, which are evidenced to reduce administrative inefficiencies and medical errors that lead to poor health outcomes and waste. Comparative effectiveness and best-practice research can also mitigate overuse of new technology and procedures of minimal benefit.

Jacob Hacker, author of the Health Care for America proposal, has offered solutions to improve the existing public reimbursement structure, including reforming the Medicare system to pay for greater efficiency, expanding the Payment Advisory Commission to acquire better information on the adequacy of provider payments, and giving doctors and hospitals a heightened advisory role when rates are determined (132). MedPAC or a similar entity should be required to review and issue annual reports on physician payments allocated by private and public plans operating in the health insurance connector. The entity should make recommendations on annual payment updates to ensure the continued participation of physicians and to strengthen payment parity between primary care physicians and specialists operating within the public plan. Should physician participation in the public plan drop, the entity reviewing payment levels for connector plans will recalibrate payment rates to increase physician participation to sufficient levels.

Additionally, the public plan should allow beneficiaries the option to enroll in a PCMH. The PCMH model promotes delivery of comprehensive, coordinated, patient-sensitive, preventive care. Under this model, practices are held accountable to health outcomes, health information technology is utilized to strengthen efficiencies, and care is made accessible to the patient. Implementation has been shown to yield significant cost savings. The Lewin Group's review of the Obama health care proposal determines that use of the medical home model to coordinate care for patients with multiple chronic conditions could lead to a savings of $132.9 billion from 2010 through 2019 (133).

The Health Care for America proposal requires public plan enrollees to establish a medical home "as an alternative to traditional fee-for-service," providing enhanced benefits at no additional cost to the beneficiary. The primary care physician would coordinate care and authorize referrals to specialists as well as oversee hospital and elective care. The Lewin Group acknowledges the benefits of an increased role for primary care providers, namely improved health outcomes and reduced costs. The analysis predicts that utilization of the medical home would reduce national health spending by $11.7 million in 2007, which includes payment adjustments for physicians (134).

Recommendation 4: To mitigate conflicts of interest, the health care connector and the public plan option should be managed by independent entities.

Some opponents of the public plan option argue that having the federal government offer a health care plan while regulating all health care plans in the insurance connector would be a conflict of interest. Citing issues related to the governance of Medicare, the Heritage Foundation raises concern that the exchange authority would be too receptive to outside interests and would negatively influence the use of new technology, adoption of infrastructure improvements, and patient choice (135). Further, opponents argue, objective governance is needed if private plans are to remain viable in the connector for those who

choose private coverage (136). ACP has recommended that an expert advisory commission be established to, among other things, recommend core benefits, assess coverage expansion effectiveness, recommend cost-sharing and benefit changes, and make recommendations on methods to maintain employer-sponsored insurance (137).

Among the options available to achieve objective governance of the insurance connector is to require that the public plan administrator report to the Secretary of Health and Human Services and that the exchange be governed by a nonprofit or public–private partnership that answers to an independent board (138). Construction of such an entity could be modeled after the Medicare Payment Advisory Commission. Senator Baucus's "Call to Action" plan would consider recommendations on governance made by the Independent Health Coverage Council, an entity composed of members from various parts of the health care sector established to ensure that adequate insurance options are available (139).

Governance depends on the level at which exchange exists. If exchanges are offered at the local or state level, regional or local managers could be appointed to oversee the program.

The Massachusetts health care exchange is governed by the Commonwealth Health Insurance Connector Authority. The Authority makes decisions on issues related to creditable coverage, program structure, and affordability. The authority meetings are open to the public and the board's membership is made up of state administrators, constituent representatives, and policy experts (14).

Conclusion

ACP has considered the pros and cons of the public plan option competing with private insurance products in a health insurance connector or exchange. ACP conditionally supports the establishment of a public plan option as part of a comprehensive health care reform proposal. A public plan option that competes on a level playing field with private insurers could help facilitate delivery system change, reduce costs, and ensure stability in the market. Establishing fair regulations that apply the same standards to both public and private insurance plans for minimum benefit packages, premium rating, and plan accessibility should help avoid unintended adverse consequences. However, separate, independent entities should be established for objective governance of the health care connector and the public plan option. For a public plan and the health insurance connector to operate effectively and fairly, the health care delivery system must be reformed to strengthen primary care and a new provider payment model should incentivize care coordination, reward positive health outcomes, and promote use of best practices and effective drugs and devices. Further, efforts to ensure affordability must also be established.

References

1. **Senate Finance Committee.** "Call to Action: Health Care Reform 2009." Washington., DC: Senate Finance Committee. November 12, 2008. Accessed at http://finance.senate.gov/healthreform2009/finalwhitepaper.pdf on July 13, 2009.
2. **Schoen C et al.** Building Blocks for Reform: Achieving Universal Coverage With Private and Public Group Health Insurance. Health Affairs May/June 2008; 27(3): 646-657.
3. **Hacker, JS.** Health Care for America: A proposal for guaranteed, affordable health care for all Americans building on Medicare and employment-based insurance." Economic Policy Institute. January 11, 2007. Accessed at http://www.sharedprosperity.org/bp180/bp180.pdf on July 13, 2009.
4. **Yoest P.** Sebelius Backs Public Health-Insurance Option. The Wall Street Journal. 2 April 2009. Accessed at http://online.wsj.com/article/SB123867881605182367.html on July 21, 2009.
5. **Volsky I.** Sebelius: Obama May Look To 'State Employee Health Plans' As Model For Competing Public Health Plan. Thinkprogress.org. 3 April 2009. Accessed at http://wonkroom.thinkprogress.org/2009/04/03/sebelius-public-compromise/ on July 21, 2009.
6. **Tumulty K.** Max Baucus and the "Public Plan." Time.com. Accessed at http://swampland.blogs.time.com/2009/03/26/max-baucus-and-the-public-plan/ on July 13, 2009.
7. **Butler S.** A Public Plan in Health Reform? Washington, DC: Heritage Foundation. Presented at the Alliance for Health Reform on April 27, 2009. Accessed at http://www.allhealth.org/briefingmaterials/StuartButlerPresentation-1446.ppt#9 on July 13, 2009.
8. **Reinhardt U.** "Health Reform Without the Public Plan: The German Model." New York Times, April 17, 2009.
9. **Nichols L.** "Public Plan: Time Bomb?" National Journal Online – The Health Care Experts. March 23, 2009. Accessed on May 6, 2009 at http://healthcare.nationaljournal.com/2009/03/the-public-plan-time-bomb.php
10. **American College of Physicians.** Achieving Affordable Health Insurance Coverage for all Within Seven Years: A Proposal from America's Internists, Updated 2008. Philadelphia: American College of Physicians; 2008: Position Paper.
11. **American College of Physicians.** Achieving A High Performance Health Care System With Universal Access: What The USA Can Learn From Other Countries, 2007. Philadelphia: American College of Physicians; October 2007. Position paper.
12. **American College of Physicians.** Developing a Medicare Buy-in Program. Philadelphia: American College of Physicians; 2006. Position paper.
13. **American College of Physicians.** Reforming Physician Payments to Achieve Greater Value in Health Care Spending. Philadelphia: American College of Physicians; 2009. Position Paper Accessed at http://www.acponline.org/advocacy/where_we_stand/policy/pay_reform.pdf on July 13, 2009.
14. **Kaiser Family Foundation.** Health Care Costs: A Primer. Washington, DC: Kaiser Family Foundation. March 2009. Accessed at http://www.kff.org/insurance/upload/7670_02.pdf on July 23, 2009.
15. **Kaiser Family Foundation.** Health Care Costs: A Primer. Washington, DC: Kaiser Family Foundation. March 2009. Accessed at http://www.kff.org/insurance/upload/7670_02.pdf on July 23, 2009.
16. **Kaiser Family Foundation.** Health Care Costs: A Primer. Washington, DC: Kaiser Family Foundation. March 2009. Accessed at http://www.kff.org/insurance/upload/7670_02.pdf on July 23, 2009.
17. **Commonwealth Fund, Why Not the Best? Results from the National Scorecard on U.S. Health System Performance, 2008.** New York: The Commonwealth Fund. July 2008. Accessed at http://www.commonwealthfund.org/usr_doc/Why_Not_the_Best_national_scorecard_2008.pdf on July 23, 2009.
18. **Commonwealth Fund, Why Not the Best? Results from the National Scorecard on U.S. Health System Performance, 2008.** New York: The Commonwealth Fund. July 2008. Accessed at http://www.commonwealthfund.org/usr_doc/Why_Not_the_Best_national_scorecard_2008.pdf on July 23, 2009.

19. **Attias M.** Senate HELP Committee Probes Problem of Underinsurance. The Commonwealth Fund. Washington Health Policy Week in Review. March 2, 2009. Accessed at http://www.commonwealthfund.org/Content/Newsletters/Washington-Health-Policy-in-Review/2009/Mar/Washington-Health-Policy-Week-in-Review-March-2-2009/Senate-HELP-Committee-Probes-Problem-of-Under-insurance.aspx on July 13, 2009.
20. **Congressional Budget Office.** Key Issues in Analyzing Major Health Insurance Proposals. December 2008. Accessed at http://cbo.gov/ftpdocs/99xx/doc9924/12-18-KeyIssues.pdf on July 13, 2009.
21. **American College of Physicians.** Achieving Affordable Health Insurance Coverage for all Within Seven Years: A Proposal from America's Internists, Updated 2008. Philadelphia: American College of Physicians; 2008: Position Paper.
22. **McDonough et al.** Massachusetts Health Reform Implementation: Major Progress And Future Challenges. Health Affairs [serial online]. 2008; 10.1377/hlthaff.27.4.w285. Accessed at http://content.healthaffairs.org/cgi/content/abstract/hlthaff.27.4.w285v1 on July 13, 2009.
23. **Long, SK.** On the Road to Universal Coverage: Impacts of Reform in Massachusetts at One Year. Health Affairs. 2008; 27(4): w270-w284. Accessed at http://content.healthaffairs.org/cgi/reprint/27/4/w270?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=&fulltext=On+the+Road+to+Universal+Coverage%3A+Impacts+of+Reform+in+Massachusetts+at+&andorexactfulltext=and&searchid=1&FIRSTINDEX=0&resourcetype=HWCIT on July 21, 2009.
24. **Senate Finance Committee.** "Call to Action: Health Care Reform 2009." Washington., DC: Senate Finance Committee. November 12, 2008. Accessed at http://finance.senate.gov/healthreform2009/finalwhitepaper.pdf on July 13, 2009.
25. **Schoen C et al.** Building Blocks for Reform: Achieving Universal Coverage With Private and Public Group Health Insurance. Health Affairs May/June 2008; 27(3): 646-657.
26. **The Lewin Group.** Cost Impact Analysis for the "Health Care for America" Proposal. February 15, 2008. Accessed at http://www.sharedprosperity.org/hcfa/lewin.pdf on July 13, 2008.
27. **Nichols L and Bertko J.** A Modest Proposal for a Competing Public Health Plan. Washington, DC: New America Foundation, March 2009.
28. **Collins S, Nicholson JL, Rustgi SD, Davis K, The 2008 Presidential Candidates' Health Reform Proposals: Choices for America.** New York: The Commonwealth Fund, October 2008.
29. **Pear, Robert.** "Insurers Seek Presence at Health Care Sessions." The New York Times 17 Dec. 2008: A24.
30. **Senate Finance Committee.** "Call to Action: Health Care Reform 2009." Washington., DC: Senate Finance Committee. November 12, 2008. Accessed at http://finance.senate.gov/healthreform2009/finalwhitepaper.pdf on July 13, 2009.
31. **Davis K et al.** Medicare Extra: A Comprehensive Benefit Option for Medicare Beneficiaries. Health Affairs [serial online]. 2005; 10.1377/hlthaff.w5.442. Accessed at http://content.healthaffairs.org/cgi/content/abstract/hlthaff.w5.442 on July 13, 2009.
32. **Hacker, JS.** Health Care for America: A proposal for guaranteed, affordable health care for all Americans building on Medicare and employment-based insurance." Economic Policy Institute. January 11, 2007. Accessed at http://www.sharedprosperity.org/bp180/bp180.pdf on July 13, 2009.
33. **Antos et al.** The Obama Plan: More Regulation, Unsustainable Spending. Health Affairs. November/December 2008; 27(6): w462-w471.
34. **Office of Personnel Management.** Non-Postal Premium Rates for the Federal Employees Health Benefits Plan. 2009. Accessed at http://www.opm.gov/insure/health/rates/nonpostalffs2009.pdf on July 13, 2009.
35. **Tanner M.** Questions and Answers About Obama's Health Care Plan. Washington, DC: Cato Institute. October 2008. Accessed at http://www.cato.org/pub_display.php?pub_id=9742 on July 13, 2009.
36. **The Lewin Group.** McCain and Obama Health Care Policies: Cost and Coverage Compared. Falls Church: The Lewin Group. 2008. Accessed at http://www.lewin.com/content/Files/The_Lewin_Group_McCain-Obama_Health_Reform_Analysis_Revised_10-15-08.pdf on July 13, 2009.

37. **Schoen C et al.** Building Blocks for Reform: Achieving Universal Coverage With Private and Public Group Health Insurance. Health Affairs. May/June 2008; 27(3): 646-657. Accessed at http://content.healthaffairs.org/cgi/content/full/27/3/646 on July 13, 2009.
38. **The Lewin Group.** Cost Impact Analysis for the "Health Care for America" Proposal. February 15, 2008. Accessed at http://www.sharedprosperity.org/hcfa/lewin.pdf on July 13, 2008.
39. **Obama for America.** Barack Obama and Joe Biden's Plan to Lower Health Care Costs and Ensure Affordable, Accessible Health Coverage for All. 2008. Accessed at http://www.barackobama.com/pdf/issues/HealthCareFullPlan.pdf on July 13, 2009.
40. **The Lewin Group.** Opening a Buy-In to a Public Plan: Implications for Premiums, Coverage and Provider Reimbursement. December 5, 2008. Accessed at http://www.lewin.com/content/publications/OpeningBuyInPublicPlan.pdf on July 13, 2009.
41. **J Holahan and L Blumberg, An Analysis of the Obama Health Care Proposal.** Washington: Urban Institute Health Policy Center, 2008. Accessed at http://www.urban.org/UploadedPDF/411754_obama_health_proposal.pdf
42. **Schoen C et al.** Building Blocks for Reform: Achieving Universal Coverage With Private and Public Group Health Insurance. Health Affairs May/June 2008; 27(3): 646-657. Accessed at http://content.healthaffairs.org/cgi/content/full/27/3/646 on July 13, 2009.
43. **Senate Finance Committee.** "Call to Action: Health Care Reform 2009." Washington., DC: Senate Finance Committee. November 12, 2008. Accessed at http://finance.senate.gov/healthreform2009/finalwhitepaper.pdf on July 13, 2009
44. **The Lewin Group.** Cost Impact Analysis for the "Health Care for America" Proposal. February 15, 2008. Accessed at http://www.sharedprosperity.org/hcfa/lewin.pdf on July 13, 2008.
45. **The Lewin Group.** McCain and Obama Health Care Policies: Cost and Coverage Compared. Falls Church: The Lewin Group. 2008. Accessed at http://www.lewin.com/content/Files/The_Lewin_Group_McCain-Obama_Health_Reform_Analysis_Revised_10-15-08.pdf on July 13, 2009.
46. **Clemente F.** A Public Health Insurance Plan: Reducing Costs and Improving Quality. Institute for America's Future. February 2008. Accessed at http://www.ourfuture.org/files/IAF_A_Public_Health_Insurance_Plan_FINAL.pdf on July 13, 2009.
47. **Holahan J and Blumberg L.** Can A Public Insurance Plan Increase Competition and Lower the Costs of Health Reform? The Urban Institute. October 3, 2008. Accessed at http://www.urban.org/publications/411762.html on July 21, 2009.
48. **Blumberg L.** Ask the Experts: A Public Plan Option Under Health Reform. Transcript. Kaiser Family Foundation. May 1, 2008. Accessed at http://www.kaisernetwork.org/health_cast/uploaded_files/050108_ask_publicprogram_transcript.pdf on July 13, 2009.
49. **Klein E.** Jacob Hacker Responds…To You! American Prospect (Online) March 3, 2009. Accessed at http://www.prospect.org/csnc/blogs/ezraklein_archive?month=03&year=2009&base_name=jacob_hacker_respondsto_you on July 13, 2009.
50. **Moffit R.** How a Public Health Plan Would Erode Private Care. Washington, DC: Heritage Foundation. December 22, 2008. Accessed at http://www.heritage.org/research/healthcare/bg2224.cfm on July 21, 2009.
51. **Blumberg L.** Ask the Experts: A Public Plan Option Under Health Reform. Transcript. Kaiser Family Foundation. May 1, 2008. Accessed at http://www.kaisernetwork.org/health_cast/uploaded_files/050108_ask_publicprogram_transcript.pdf on July 13, 2009.
52. **Uwe Reinhardt.** Health Care Experts: Assessing A New Public Insurance Program. National Journal Online. December 8, 2008. Accessed at http://healthcare.nationaljournal.com/2008/12/assessing-a-new-public-insurance-program.php on July 13, 2009.
53. **Medicare Payment Advisory Commission.** Report to Congress: Medicare Payment Policy. Washington, DC: MedPAC. March 17, 2009.

54. **Clemente F.** A Public Health Insurance Plan: Reducing Costs and Improving Quality. Institute for America's Future. February 2008. Accessed at http://www.ourfuture.org/files/IAF_A_Public_Health_Insurance_Plan_FINAL.pdf on July 13, 2009
55. **Dowd, BE.** Designing a Mixed Public and Private System for the Health Insurance Market. University of Minnesota working paper. Accessed at http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1340085 on March 24, 2009.
56. **Medicare Payment Advisory Commission.** Report to the Congress: Promoting Greater Efficiency in Medicare. Washington, DC: MedPAC. June 2007.
57. **Moffit R.** How a Public Health Plan Would Erode Private Care. Washington, DC: Heritage Foundation. December 22, 2008. Accessed at http://www.heritage.org/research/healthcare/bg2224.cfm on July 21, 2009.
58. **John Pickering.** Testimony before the Committee on Ways and Means Hearing on Health Reform in the 21st Century. March 11, 2009. Accessed at http://waysandmeans.house.gov/media/pdf/111/pick.pdf on March 24, 2009.
59. **John Pickering.** Testimony before the Committee on Ways and Means Hearing on Health Reform in the 21st Century. March 11, 2009. Accessed at http://waysandmeans.house.gov/media/pdf/111/pick.pdf on March 24, 2009.
60. **Fox W and Pickering J.** Hospital and Physician Cost Shift: Payment Level Comparison of Medicare, Medicaid, and Commercial Payers. Milliman, December 2008. Accessed at http://www.aha.org/aha/content/2008/pdf/081209costshift.pdf on July 21, 2009.
61. **MedPAC.** Report to Congress: Medicare Payment Policy, March 2009.
62. **Congressional Budget Office.** Key Issues in Analyzing Major Health Insurance Proposals. December 2008. Accessed at http://cbo.gov/ftpdocs/99xx/doc9924/12-18-KeyIssues.pdf on July 13, 2009.
63. **Abelson, R.** "A Health Plan for All and the Concern it Raises." New York Times, March 25, 2009; B4.
64. **Congressional Budget Office.** The Sustainable Growth Rate Formula for Setting Medicare's Physician Payment Rates. September 2, 2006. Accessed at http://www.cbo.gov/ftpdocs/75xx/doc7542/09-07-SGR-brief.pdf on July 13, 2009
65. **MedPAC.** Report to Congress: Medicare Payment Policy. March 2009.
66. **MedPAC.** Report to Congress: Medicare Payment Policy. March 2009
67. **U.S. Senate Republican Policy Committee.** A Government-Run "Public" Health Insurance Plan: Why Doctors, Hospitals, and Patients Will Lose. Washington, DC: Republican Policy Committee. March 24, 2009. Accessed at http://rpc.senate.gov/public/_files/032409GovernmentRunHealthInsurance.pdf on July 13, 2009.
68. **Milligan C.** Medicaid Reimbursement Policy. Baltimore: Center for Health Program Development and Management. September 6, 2006. Accessed at http://aspe.hhs.gov/medicaid/sept06/ChuckMilliganReimbursementPolicy.pdf on July 13, 2009.
69. **Zuckerman et. al.** Trends in Medicaid Physicain Fees. Health Affairs. 2009; 28, no. 3: w510–w519 Accessed at http://content.healthaffairs.org/cgi/reprint/hlthaff.28.3.w510v1?ijkey=FtFdm/8MJTtuk&keytype=ref&siteid=healthaff on July 13, 2009.
70. **U.S. Senate Republican Policy Committee.** A Government-Run "Public" Health Insurance Plan: Why Doctors, Hospitals, and Patients Will Lose.
71. **Holahan J and Blumberg L.** Can A Public Insurance Plan Increase Competition and Lower the Costs of Health Reform? The Urban Institute. October 3, 2008. Accessed at http://www.urban.org/publications/411762.html on July 21, 2009.
72. **Holahan J and Blumberg L.** Can A Public Insurance Plan Increase Competition and Lower the Costs of Health Reform? The Urban Institute. October 3, 2008. Accessed at http://www.urban.org/publications/411762.html on July 21, 2009.

73. **Matthews M.** Medicare's Hidden Administrative Costs: A Comparison of Medicare and the Private Sector. Council for Affordable Health Insurance, January 10, 2006.
74. **Congressional Budget Office.** Designing a Premium Support System for Medicare. Washington, DC: Congressional Budget Office. December 2006. Accessed at http://www.cbo.gov/ftpdocs/76xx/doc7697/12-08-Medicare.pdf on March 25, 2009.
75. **Analysis of Administrative Expenses for Health Insurance Companies in Massachusetts.** Massachusetts Division of Insurance. September 2008. Accessed on March 25, 2009 at http://www.mass.gov/Eoca/docs/doi/Consumer/MAAdminExpenseStudyReport.pdf
76. **The Lewin Group.** McCain and Obama Health Care Policies: Cost and Coverage Compared. Falls Church: The Lewin Group. 2008. Accessed at http://www.lewin.com/content/Files/The_Lewin_Group_McCain-Obama_Health_Reform_Analysis_Revised_10-15-08.pdf on July 13, 2009.
77. **Schoen C et al.** Building Blocks for Reform: Achieving Universal Coverage With Private and Public Group Health Insurance. Health Affairs May/June 2008; 27(3): 646-657.
78. **The Lewin Group.** Cost Impact Analysis for the "Health Care for America" Proposal. February 15, 2008. Accessed at http://www.sharedprosperity.org/hcfa/lewin.pdf on July 13, 2008.
79. **Holahan J and Blumberg L.** Can A Public Insurance Plan Increase Competition and Lower the Costs of Health Reform? The Urban Institute. October 3, 2008. Accessed at http://www.urban.org/publications/411762.html on July 21, 2009.
80. **David Kendell, Glenn Hackbarth.** Health Care Experts – Assessing a New Public Insurance Option. National Journal Online. December 12, 2008. Accessed at http://healthcare.nationaljournal.com/2008/12/assessing-a-new-public-insurance-program.php on July 13, 2009.
81. **Obama for America.** Barack Obama and Joe Biden's Plan to Lower Health Care Costs and Ensure Affordable, Accessible Health Coverage for All
82. **Congressional Budget Office.** Key Issues in Analyzing Major Health Insurance Proposals. December 2008. Accessed at http://cbo.gov/ftpdocs/99xx/doc9924/12-18-KeyIssues.pdf on July 13, 2009.
83. **The Lewin Group.** McCain and Obama Health Care Policies: Cost and Coverage Compared. Falls Church: The Lewin Group. 2008. Accessed at http://www.lewin.com/content/Files/The_Lewin_Group_McCain-Obama_Health_Reform_Analysis_Revised_10-15-08.pdf on July 13, 2009.
84. **Moffit R.** How a Public Health Plan Would Erode Private Care. Washington, DC: Heritage Foundation. December 22, 2008. Accessed at http://www.heritage.org/research/healthcare/bg2224.cfm on July 21, 2009.
85. **Antos et al.** The Obama Plan: More Regulation, Unsustainable Spending. Health Affairs. November/December 2008; 27(6): w462-w471.
86. **Clemente F.** A Public Health Insurance Plan: Reducing Costs and Improving Quality. Institute for America's Future. February 2008. Accessed at http://www.ourfuture.org/files/IAF_A_Public_Health_Insurance_Plan_FINAL.pdf on July 13, 2009
87. **Clemente F.** A Public Health Insurance Plan: Reducing Costs and Improving Quality. Institute for America's Future. February 2008. Accessed at http://www.ourfuture.org/files/IAF_A_Public_Health_Insurance_Plan_FINAL.pdf on July 13, 2009
88. **Grace-Marie Turner.** Health Care Experts – The Public Plan: Time Bomb? Accessed on March 25, 2009 at http://healthcare.nationaljournal.com/2009/03/the-public-plan-time-bomb.php
89. **Kaiser Family Foundation Capitol Hill Watch: Congressional Progressive Caucus Issues Letter Stating Majority of Members Will Only Support Health Reform That Includes Public Plan Option.** Kaiser Family Foundation. April 3, 2009. Accessed at http://www.kaisernetwork.org/daily_reports/rep_index.cfm?DR_ID=57857 on July 13, 2009.

90. **The Lewin Group.** McCain and Obama Health Care Policies: Cost and Coverage Compared. Falls Church: The Lewin Group. 2008. Accessed at http://www.lewin.com/content/Files/The_Lewin_Group_McCain-Obama_Health_Reform_Analysis_Revised_10-15-08.pdf on July 13, 2009.
91. **Volsky I.** What Kind of Public Option Compromise Would Grassley Support? Think Progress/The Wonk Room. March 20, 2009. Accessed at http://wonkroom.thinkprogress.org/2009/03/20/grassley-public/ on July 13, 2009
92. **The Lewin Group.** Cost Impact Analysis for the "Health Care for America" Proposal. February 15, 2008. Accessed at http://www.sharedprosperity.org/hcfa/lewin.pdf on July 13, 2008.
93. **Schoen C et al.** Building Blocks for Reform: Achieving Universal Coverage With Private and Public Group Health Insurance. Health Affairs May/June 2008; 27(3): 646-657.
94. **Hacker J.** The Case for Public Plan Choice in National Health Reform. Accessed at http://institute.ourfuture.org/files/Jacob_Hacker_Public_Plan_Choice.pdf on July 13, 2009.
95. **Stuart Butler and John C. Goodman.** Health Care Experts – The Public Plan: Time Bomb? Accessed on March 25, 2009 at http://healthcare.nationaljournal.com/2009/03/the-public-plan-time-bomb.php
96. **Holahan J and Blumberg L.** Can A Public Insurance Plan Increase Competition and Lower the Costs of Health Reform? The Urban Institute. October 3, 2008. Accessed at http://www.urban.org/publications/411762.html on July 21, 2009.
97. **Testimony of Janet Shikles, Director, Health Financing and Policy Issues of the General Accounting Office before the Senate Subcommittee on Health for Families and the Uninsured Committee on Finance.** Medicaid: Factors to Consider in Expanding Managed Care Programs. April 10, 1992. Accessed at http://archive.gao.gov/d38t12/146477.pdf on July 13, 2009.
98. **Nichols L and Bertko J.** A Modest Proposal for a Competing Public Health Plan. Washington, DC: New America Foundation, March 2009.
99. **CalPERS Office of Health Policy and Program Support.** 2008 Open Enrollment Statistics. February 18, 2009. Accessed at http://www.calpers.ca.gov/eip-docs/about/board-cal-agenda/agendas/hbc/200902/item-4b.pdf on July 13, 2009.
100. **Dowd, BE.** Designing a Mixed Public and Private System for the Health Insurance Market. University of Minnesota working paper. Accessed at http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1340085 on March 24, 2009.
101. **MedPAC.** Report to Congress: Medicare Payment Policy. March 2009.
102. **Hacker J.** Healthy Competition - The Why and How of "Public Plan Choice." N Engl J Med May 28, 2009. 360;22
103. **Holahan J and Blumberg L.** Can A Public Insurance Plan Increase Competition and Lower the Costs of Health Reform? The Urban Institute. October 3, 2008. Accessed at http://www.urban.org/publications/411762.html on July 21, 2009, Nichols and Bertko, Dowd
104. **Nichols L and Bertko J.** A Modest Proposal for a Competing Public Health Plan. Washington, DC: New America Foundation, March 2009.
105. **Dowd, BE.** Designing a Mixed Public and Private System for the Health Insurance Market. University of Minnesota working paper. Accessed at http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1340085 on March 24, 2009.
106. **Darling H.** Employment-Based Health Benefits and Public-Sector Coverage: Opportunity for Leadership. Health Affairs. 2006; 25, no. 6: 1487-1489.
107. **Clemente F.** A Public Health Insurance Plan: Reducing Costs and Improving Quality. Institute for America's Future. February 2008. Accessed at http://www.ourfuture.org/files/IAF_A_Public_Health_Insurance_Plan_FINAL.pdf on July 13, 2009

108. **McKethan et al.** What Public Employee Health Plans Can Do to Improve Health Care Quality: Examples from the States. Commonwealth Fund. January 2008. Accessed at http://www.commonwealthfund.org/usr_doc/McKethan_whatpublicemployeehltplanscando_1097.pdf?section=4039 on July
109. **Klein E.** Jacob Hacker Responds…To You! American Prospect (Online) March 3, 2009. Accessed at http://www.prospect.org/csnc/blogs/ezraklein_archive?month=03&year=2009&base_name=jacob_hacker_respondsto_you on July 13, 2009.
110. **Commonwealth Fund.** Nearly Nine of Ten Who Seek Individual Market Health Insurance Never Buy a Plan. The Commonwealth Fund. September 14, 2006. Accessed at http://www.commonwealthfund.org/Content/News/News-Releases/2006/Sep/Nearly-Nine-of-Ten-Who-Seek-Individual-Market-Health-Insurance-Never-Buy-a-Plan.aspx on July 13, 2009
111. **Congressional Budget Office.** Key Issues in Analyzing Major Health Insurance Proposals. December 2008. Accessed at http://cbo.gov/ftpdocs/99xx/doc9924/12-18-KeyIssues.pdf on July 13, 2009.
112. **Clemente F.** A Public Health Insurance Plan: Reducing Costs and Improving Quality. Institute for America's Future. February 2008. Accessed at http://www.ourfuture.org/files/IAF_A_Public_Health_Insurance_Plan_FINAL.pdf on July 13, 2009
113. **Congressional Budget Office.** Key Issues in Analyzing Major Health Insurance Proposals. December 2008. Accessed at http://cbo.gov/ftpdocs/99xx/doc9924/12-18-KeyIssues.pdf on July 13, 2009.
114. **McDonough et al.** Massachusetts Health Reform Implementation: Major Progress And Future Challenges. Health Affairs [serial online] 10.1377/hlthaff.27.4.w285 Accessed at http://content.healthaffairs.org/cgi/content/abstract/hlthaff.27.4.w285v1 on July 13, 2009.
115. **Dowd, BE.** Designing a Mixed Public and Private System for the Health Insurance Market. University of Minnesota working paper. Accessed at http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1340085 on March 24, 2009.
116. **Congressional Budget Office.** Medicare Advantage: Private Health Plans in Medicare. Washington DC: Congressional Budget Office. June 28, 2007. Accessed at http://www.cbo.gov/ftpdocs/82xx/doc8268/06-28-Medicare_Advantage.pdf on July 13, 2009.
117. **Dowd, BE.** Designing a Mixed Public and Private System for the Health Insurance Market. University of Minnesota working paper. Accessed at http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1340085 on March 24, 2009.
118. **American College of Physicians.** Achieving Affordable Health Insurance Coverage for all Within Seven Years: A Proposal from America's Internists, Updated 2008. Philadelphia: American College of Physicians; 2008: Position Paper.
119. **Nichols L and Bertko J.** A Modest Proposal for a Competing Public Health Plan. Washington, DC: New America Foundation, March 2009.
120. **American College of Physicians.** Achieving Affordable Health Insurance Coverage for all Within Seven Years: A Proposal from America's Internists, Updated 2008. Philadelphia: American College of Physicians; 2008: Position Paper.
121. **Long, SK.** On the Road to Universal Coverage: Impacts of Reform in Massachusetts at One Year. Health Affairs. 2008; 27(4): w270-w284. Accessed at http://content.healthaffairs.org/cgi/reprint/27/4/w270?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=&fulltext=On+the+Road+to+Universal+Coverage%3A+Impacts+of+Reform+in+Massachusetts+at+&andorexactfulltext=and&searchid=1&FIRSTINDEX=0&resourcetype=HWCIT on July 21, 2009.
122. **Shneider A and Garfield R.** Medicaid Benefits. Washington DC: Kaiser Commission on Medicaid and the Uninsured. Accessed at http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=14260 on July 13, 2009.
123. **American College of Physicians.** Reforming Physician Payments to Achieve Greater Value in Health Care Spending. Philadelphia: American College of Physicians; 2009. Position Paper Accessed at http://www.acponline.org/advocacy/where_we_stand/policy/pay_reform.pdf on July 13, 2009.

124. **American College of Physicians.** Achieving Affordable Health Insurance Coverage for all Within Seven Years: A Proposal from America's Internists, Updated 2008. Philadelphia: American College of Physicians; 2008: Position Paper.

125. **American College of Physicians.** A System in Need of Change: Restructuring Payment Policies to Support Patient-Centered Care. Philadelphia: American College of Physicians; 2006. Position Paper.

126. **MedPAC.** Report to Congress: Medicare Payment Policy. March 2009.

127. **Nichols L and Bertko J.** A Modest Proposal for a Competing Public Health Plan. Washington, DC: New America Foundation, March 2009.

128. **Holahan J and Blumberg L.** Can A Public Insurance Plan Increase Competition and Lower the Costs of Health Reform? The Urban Institute. October 3, 2008. Accessed at http://www.urban.org/publications/411762.html on July 21, 2009.

129. **The Lewin Group.** Cost Impact Analysis for the "Health Care for America" Proposal. February 15, 2008. Accessed at http://www.sharedprosperity.org/hcfa/lewin.pdf on July 13, 2008.

130. **Nichols L and Bertko J.** A Modest Proposal for a Competing Public Health Plan. Washington, DC: New America Foundation, March 2009.

131. **USA Today.** "White House Seeks Health Plan Compromise." USA Today: April 15, 2009. Accessed at http://www.usatoday.com/news/washington/2009-04-15-white-house-health-insurance_N.htm on July 13, 2009

132. **Klein E.** Jacob Hacker Responds…To You! American Prospect (Online) March 3, 2009. Accessed at http://www.prospect.org/csnc/blogs/ezraklein_archive?month=03&year=2009&base_name=jacob_hacker_respondsto_you on July 13, 2009.

133. **The Lewin Group.** McCain and Obama Health Care Policies: Cost and Coverage Compared. Falls Church: The Lewin Group. 2008. Accessed at http://www.lewin.com/content/Files/The_Lewin_Group_McCain-Obama_Health_Reform_Analysis_Revised_10-15-08.pdf on July 13, 2009.

134. **The Lewin Group.** Cost Impact Analysis for the "Health Care for America" Proposal. February 15, 2008. Accessed at http://www.sharedprosperity.org/hcfa/lewin.pdf on July 13, 2008.

135. **Moffit R.** How a Public Health Plan Would Erode Private Care. Washington, DC: Heritage Foundation. December 22, 2008. Accessed at http://www.heritage.org/research/healthcare/bg2224.cfm on July 21, 2009.

136. **Blumberg L.** Ask the Experts: A Public Plan Option Under Health Reform. Transcript. Kaiser Family Foundation. May 1, 2008. Accessed at http://www.kaisernetwork.org/health_cast/uploaded_files/050108_ask_publicprogram_transcript.pdf on July 13, 2009.

137. **American College of Physicians.** Achieving Affordable Health Insurance Coverage for all Within Seven Years: A Proposal from America's Internists, Updated 2008. Philadelphia:American College of Physicians; 2008: Position Paper.

138. **Nichols L and Bertko J.** A Modest Proposal for a Competing Public Health Plan. Washington, DC: New America Foundation, March 2009.

139. **Senate Finance Committee.** "Call to Action: Health Care Reform 2009." Washington., DC: Senate Finance Committee. November 12, 2008. Accessed at http://finance.senate.gov/healthreform2009/finalwhitepaper.pdf on July 13, 2009

140. **McDonough et al.** Massachusetts Health Reform Implementation: Major Progress And Future Challenges. Health Affairs [serial online] 10.1377/hlthaff.27.4.w285 Accessed at http://content.healthaffairs.org/cgi/content/abstract/hlthaff.27.4.w285v1 on July 13, 2009.

Product #501291060