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**Public Plan Choice and Play-or-Pay:  
Critical Elements to Ensure Accountability and Affordability  
and to Control Costs**

I thank the committee for the honor of speaking today about the pressing need for national health reform based on the principles of shared risk, shared responsibility, and personal responsibility. For national reform to succeed, it must create accountability in American health insurance, expand coverage while making it more affordable for workers and their families, and adequately fund our health care priorities while putting in place the preconditions for long-term savings to the federal budget. The draft legislation prepared by the special tri-committee promises enormous progress in meeting all three of these goals.



My remarks are divided into two parts. In the first, I explain why the “public-private hybrid” approach embodied in the tri-committee draft legislation is vital to ensuring accountability in American health insurance. I focus in particular on the need for a public health insurance plan that Americans without secure workplace coverage can choose as a coverage option that will compete with private plans. In the second part, I emphasize the need for shared responsibility to expand affordable coverage. Here I focus on the constructive role that employers can play in providing or helping to finance coverage so that affordable insurance is available to all Americans through the workplace connection. Both accountability within the insurance market and shared responsibility are necessary to slow the growth in health care costs not just for workers and their families but also for employers, states, and the federal government.

## **I. THE NEED FOR ACCOUNTABILITY IN AMERICAN HEALTH INSURANCE<sup>1</sup>**

In recent years, the need for comprehensive health reform has become glaringly apparent. Health insurance premiums have skyrocketed, more than doubling from 1999 to 2008,<sup>2</sup> while the scope and generosity of private coverage have plummeted. Not only have the ranks of the uninsured continued to expand, but, in addition, the number of Americans who have insurance yet lack adequate protection against medical costs has

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<sup>1</sup> This section is based on Jacob S. Hacker, “The Case for Public Plan Choice in National Health Reform: Key to Cost Control and Quality Coverage” (Berkeley: Center on Health, Economic & Family Security and Washington: Institute for America’s Future, 2008) and “Healthy Competition: How to Structure Public Health Insurance Plan Choice to Ensure Risk-Sharing, Cost Control, and Quality Improvement” (Berkeley: Center on Health, Economic & Family Security and Washington: Institute for America’s Future, 2009) available at <http://www.law.berkeley.edu/chefs.htm> (last accessed June 2009). Additional citations are available in these briefs.

<sup>2</sup> Kaiser Family Foundation and Health Research & Educational Trust, “Survey of Employer Health Benefits” (2008) available at <http://ehbs.kff.org/images/abstract/7814.pdf> (last accessed June 2009).

increased dramatically.<sup>3</sup> More than half of bankruptcy filings are related to medical care, with the vast majority of medical bankruptcies involving households that *have* insurance coverage.<sup>4</sup> Employers, workers, states and localities, and the federal government—all have seen their budgets under siege because of runaway health care costs and all require long-term relief.

Amid the crisis, there has emerged a growing recognition not just of the need for action but also of the virtues of a “public-private hybrid” approach to health reform. The approach to reform embodied in the tri-committee draft legislation is such a model—a model that builds on the best elements of the present system: large group plans in the public and private sectors. By lowering the cost of care and requiring that all firms eventually contribute to the cost of coverage, the legislation would encourage employers to continue to provide health insurance. At the same time, it would put in place a new means—the so-called health insurance exchange—of allowing Americans without access to secure workplace coverage to choose among group insurance plans that provide strong guarantees of quality affordable coverage over time.

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<sup>3</sup> Cathy Schoen and others, “How Many Are Underinsured? Trends Among U.S. Adults, 2003 and 2007,” *Health Affairs* 27 (4) (2008): w298–w309 available at [http://www.commonwealthfund.org/publications/publications\\_show.htm?doc\\_id=688615](http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=688615) (last accessed June 2009).

<sup>4</sup> David U. Himmelstein and others, “Medical Bankruptcy in the United States, 2007: Results of a National Study,” *The American Journal of Medicine*, June 5, 2009, available at <http://download.journals.elsevierhealth.com/pdfs/journals/0002-9343/PIIS0002934309004045.pdf> (last accessed June 2009); David Himmelstein and others, “Illness and Injury As Contributors To Bankruptcy,” *Health Affairs* February 2, 2005, available at <http://content.healthaffairs.org/cgi/reprint/hlthaff.w5.63v1> (last accessed June 2009).

### *The Case for Public Plan Choice*

An essential feature of this new framework for obtaining group coverage is “public plan choice,” the creation of a new public plan modeled after Medicare that would be available to Americans younger than 65 who lack good employment-based coverage. Public plan choice is not by any stretch of the imagination “Medicare for all.” Rather, it simply creates a public health insurance plan with incentives to focus on value and innovation that competes on a level playing field with private insurers within the new insurance exchange. Private employment-based coverage would continue, and workers without such coverage would be able to choose from a menu of options that includes a range of private group plans as well as the new public health insurance plan.

Moreover, this new public health insurance plan should be—and is, in the draft legislation—self-supporting (that is, it should be financed by the same sources as any other plan within the exchange, notably, individual premiums, employer contributions, and income-related subsidies). It should also be—and is—subject to the same rules as the private plans and be separate from the national exchange, so the referee (the exchange) does not have a player (the plan) in the game.

This idea is overwhelmingly popular. In a June 12-16 poll conducted by the *New York Times* and CBS News, 72 percent of those questioned supported a government-administered insurance plan that would compete with private insurance. The support for a public plan came from Republicans and Democrats alike. Half of those who identified as Republicans said they supported a public plan (versus 39 percent of Republicans who were opposed), along with three-quarters of independents and nine out of ten Democrats.

*Choice, Accountability, and “Healthy Competition”*

The aim of public plan choice is healthy competition—that is, competition to make Americans better cared for and more secure. Such competition requires not an endless array of choices, but rather a reasonable number of *meaningfully different choices*. In much of the country today, health insurance competition is remarkably limited. Most metropolitan areas have no more than a few dominant insurers in control of the market. And these companies are often unable or unwilling to rein in health care costs. At times it may even be in their interest to pay higher rates to key doctors and hospitals, passing on these higher costs to individuals and employers, so as to make it difficult for weaker insurers to build competitive provider networks and bring costs down. Even the largest insurers are hard-pressed to enter established markets.

Because the hospital market has grown increasingly concentrated, moreover, providers wield considerable power of their own to drive up the rates they receive from insurers and restrict competition. In areas where hospital market concentration has grown the most, hospital prices and profitability are very high, yet service and quality of care is no better than in other areas, the evidence suggests.<sup>5</sup> As John Holahan and Linda Blumberg of the Urban Institute explain, “Dominant insurers do not seem to use their market power to drive hard bargains with providers . . . . Competition in insurance markets is often about

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<sup>5</sup> John Holahan and Linda Blumberg, “Can a Public Insurance Plan Increase Competition and Lower the Costs of Health Reform?” (Washington: Urban Institute Health Policy Center, 2008) available at [http://www.urban.org/UploadedPDF/411762\\_public\\_insurance.pdf](http://www.urban.org/UploadedPDF/411762_public_insurance.pdf) (last accessed June 2009).

getting the lowest risk enrollees as opposed to competing on price and the efficient delivery of care.”<sup>6</sup>

A public health insurance plan would create greater competition for insurers and providers and greater choice for Americans. Indeed, a key reason for public plan choice is that public health insurance offers a set of valued features that private plans are generally unable or unwilling to provide. Stability, wide pooling of risks, transparency, affordability of premiums, broad provider access, the capacity to collect and use patient information on a large scale to improve care—these are all hallmarks of public health insurance that private plans have inherent difficulties providing. On the other hand, private plans are generally more flexible and more capable of building integrated provider networks, and they have at times moved into new areas of care management in advance of the public sector.

In short, public and private plans have unique strengths, and both should have an important role in a reformed system. Public plan choice simply means that all Americans without good workplace coverage, not just the elderly or the poor, should have access to the distinctive strengths of a public health insurance plan, as well as the strengths of private plans. Such healthy competition has long been the stated rationale for encouraging Medicare to include *private* plans alongside the public program. The argument for a competitive partnership between public insurance and private plans applies at least as strongly to nonelderly Americans as it does to those in Medicare.

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<sup>6</sup> Holahan and Blumberg, “Can a Public Insurance Plan Increase Competition and Lower the Costs of Health Reform?”

Healthy competition is about accountability. If public and private plans are competing on fair and equal terms, the choice of enrollees between the two will place a crucial check on each. If the public plan becomes too rigid, more Americans will opt for private plans. If private plans engage in practices that obstruct access to needed care and undermine health security, then the public plan will offer a release valve. New rules for private insurance could go some way toward encouraging private plans to focus on providing value. But without a public plan as a benchmark, backup, and check on private plans, key problems in the insurance market will remain.

*Public Plan Choice is Essential to Cost Control*

Perhaps the most pressing of these problems is skyrocketing costs. Public health insurance has much lower administrative expenses than private plans, it obtains larger volume discounts because of its broad reach, and it does not have to earn profits as many private plans do. Furthermore, experience suggests that these lower costs are accompanied by a superior ability to control spending over time. Medicare has a better track record than private health plans in controlling costs while maintaining broad access to care, especially over the last fifteen years. By way of illustration, *between 1997 and 2006, health spending per enrollee (for comparable benefits) grew at 4.6 percent a year under Medicare, compared with 7.3 percent a year under private health insurance.*<sup>7</sup>

Over the last generation, public insurance has pioneered new payment and quality-improvement methods that have frequently set the standard for private plans.

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<sup>7</sup> Hacker, "The Case for Public Plan Choice."

More important, it has the potential to carry out these vital tasks much more effectively in the future, using information technology, large databases of practices and outcomes, and new payment approaches and care-coordination strategies. Indeed, a new public plan could spearhead improvement of existing public programs as well as private plans.

To be sure, there are reasonable concerns about how a new public plan will use its bargaining power—concerns reflected in current proposals for state-based public plans, consumer cooperatives established by the states, or even private insurers under public contract. Yet a watered-down public plan or a private alternative to a public plan would not serve the three vital functions of a competing public health insurance plan—to be a “benchmark” for private plans, a “backup” to allow consumers access to a good plan with broad access to providers in all parts of the country, and to serve as a cost-control “backstop.” Consumer cooperatives, for example, will be extremely difficult to create and are unlikely to serve as a backup in most of the nation. They will also lack the ability to be a cost-control backstop, much less a benchmark for private plans, because they will not have the reach or authority to implement innovative delivery and payment reforms.

In sum, public plan choice is essential to set a standard against which private plans must compete. Without a public plan competing with private plans, we will continue to lack strong mechanisms to rein in costs and drive value down the road.

## II. THE NEED FOR SHARED RESPONSIBILITY<sup>8</sup>

The other crucial aspect of the draft legislation is the requirement that employers either provide health insurance to their workers or help fund coverage for those workers through the new national insurance exchange—often known as “play-or-pay.” A play-or-pay requirement is a cornerstone of the hybrid reform approach of building on the current system of job-based coverage while providing new options to broaden coverage to the uninsured. Financing any health coverage expansion will be challenging. An employer requirement makes it easier by providing an important source of funding and reducing the direct cost to the federal government. At the same time, such a requirement is essential if reform is to avoid greatly reducing the provision of employment-based insurance.

Play-or-pay is distinct from what might be called “play-or-penalty,” in which firms that do not directly provide health benefits are fined for their noncompliance but those fines do not directly fund their workers’ coverage. In play-or-pay proposals, employer contributions are not penalties, but payments for the coverage of their workers, whose enrollment in the exchange flows from the employers’ decision to contribute. This is crucial to ensuring that workers do not fall through the cracks and to creating broad public support for the exchange, which might otherwise be seen as only for the less advantaged. The exchange should be open to all employees of firms that choose to pay, regardless of worker income or firm size, with reasonable premiums for higher-income workers.

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<sup>8</sup> This section is based on Ken Jacobs and Jacob S. Hacker, “How to Structure a ‘Play-or-Pay’ Requirement on Employers: Lessons from California for National Health Reform” (Berkeley: Labor Center and Center on Health, Economic & Family Security, 2009) available at <http://www.law.berkeley.edu/chefs.htm> (last accessed June 2009). Additional citations are available in the brief.

### *Why Have a Play-or-Pay Requirement?*

Job-based coverage is still the major means by which nonelderly Americans receive health benefits, about 62 percent of whom get their health coverage through their employer or the employer of a family member. Replacing employer financing would require substituting highly visible taxes or mandates on individuals for the relatively hidden contributions now made (nominally at least) by employers.

In the absence of a binding employer requirement, moreover, the direct costs to the federal government would substantially increase. Firms with large numbers of low-wage workers who would qualify for new subsidies for insurance would have less incentive to cover their workers directly. How extensive such crowd-out would be is a matter of debate. Employee benefits tend to be “sticky,” at least in the short run. Benefits are highly valued by employees, and risk-averse employers may be reluctant to take advantage of the option of dropping coverage. But over time employers should be expected to move toward benefit strategies that minimize their costs, including allowing their workers to be covered by public programs or subsidized individual insurance.

Finally, employer responsibility requirements serve to level the playing field between firms that do and do not provide coverage. The vast majority of medium and large firms offer health care on the job, at least to their full-time workers. Many small firms, particularly higher-wage firms, also provide coverage. Yet a substantial share of firms do not, with rates of non-provision highest among small employers. In firms that do offer coverage, eligibility and benefits vary substantially. Nationally, 77 percent of the

uninsured work or have a family member who works, and are not self-employed. A quarter of the working uninsured are in firms with fewer than ten workers; another third are in firms with 10 to 99 employees. The final 41 percent work for employers with more than 100 workers. Nearly one-third of those who are covered through a job are covered by a business with fewer than 100 workers.

When firms do not provide coverage, or only provide coverage to a limited fraction of their workforce, it raises the costs of employment-based coverage and puts pressure on firms that do offer benefits to cut back their offerings. One path by which this occurs is the shifting of the costs of caring for the uninsured: As uninsured workers and their dependents are forced to rely on emergency rooms for care, costs are shifted not only onto the public but also into the health premiums of firms that do offer coverage. It is estimated that the cost of uncompensated care raises health premiums by between 5 and 10 percent. Another path is spousal and dependent coverage: A firm offering family benefits picks up the cost of spouses working in firms without health care and the costs of dependents that might have been insured by another firm.

#### *How the Play-or-Pay Requirement Should be Structured*

Play-or-pay should apply to as broad a range of firms as possible. While there are valid concerns about the effect of such a requirement on small employers, it is important to keep in mind that small employers would benefit from a health-care expansion that provided coverage to their employees. A survey by Small Business Majority found support from more than half of small business owners in California for a reform proposal

along these lines. They were willing to accept the requirement that they contribute to health care in return for the ability to access an affordable plan for their workers. Concerns about impacts on small businesses would be best addressed through a sliding scale requirement on firms, rather than by excluding small firms from the requirement altogether.

Moreover, the play-or-pay requirement should apply to all of a firm's employees as well as their employees' spouses and non-working children. While 97 percent of large firms offer health coverage, they only cover an average of 70 percent of their employees. In fact, three out of four workers who do not have coverage through their employer work at firms where fellow workers have coverage. The plurality of these uncovered workers are not eligible for coverage (45 percent); the next largest share have not taken-up coverage (30 percent), often because the costs are viewed as prohibitive. If part-time workers are excluded from a play-or-pay requirement, it creates a strong incentive for employers to offer part-time employment as a way of reducing costs. There is evidence of significant labor market sorting along these lines in Hawaii as a result of its health-care mandate. A requirement on part-time workers can be structured so that it is not economically burdensome on employers.

### *The Economic Benefits of Shared Responsibility*

The main argument against employer requirements is that they place a tax on employment, leading to fewer jobs. Recent economics research as well as the experience of California strongly suggests, however, that these concerns are overstated when it

comes to the play-or-pay proposals currently under consideration, with their relatively modest employer requirements.

Firms may absorb the costs of an employer requirement in a variety of ways. Over time, we would expect a large share of the cost to be passed on to workers through forgone wage increases. Pass-throughs to consumers are also well documented. After the passage of the health-care ordinance in San Francisco, many restaurants added small health-care surcharges to their checks to cover the costs of the program.

The main concern is for workers at or near the minimum wage. As long as all employers face the same rules, however, firms with workers at or near the minimum wage may pass on part of the cost to consumers without impacting their ability to compete. The vast majority of firms that currently do not offer health benefits are in markets where their competitors also do not provide benefits, and thus would see increases similar to those of their competitors. Moreover, the incremental costs even for these firms would be small.

It is also important to keep in mind that health reforms with employer requirements promise new benefits for firms and workers as well as new costs. Many firms that provide coverage for working dependents of their employees would no longer have to. Some firms that provide coverage would also benefit from the option of enrolling their workers in the new exchange. All firms would benefit from the reduction in unpaid medical bills incurred by the uninsured. Firms would further benefit from any savings due to a reduced rate of health-care cost growth.

Expanded access to health care can also be expected to raise productivity through improved worker health and labor force participation, and better matches of jobs to workers skills. Workers without insurance are more likely to miss necessary care, less likely to receive treatment for chronic conditions, and more likely to suffer from debilitating conditions that keep them out of the workforce. Broader coverage is likely to result in decreased absenteeism and exits from the labor force due to disability. Health insurance also plays an important role in worker mobility decisions. Universal coverage would decrease “job-lock” and improve matches between workers skills and positions.

In sum, the net impact of a broad health-care reform that included shared responsibility for employers would be positive for business and the economy as a whole.

## CONCLUSION

Health reform is essential for improving the economic security of American workers and their families. Broadening and upgrading coverage and lowering and subsidizing premiums will immediately help struggling Americans as they cope with the worst economic downturn in at least a generation. These vital reforms will also represent a rescue package for state and local governments facing rising Medicaid and CHIP costs, for doctors and hospitals that treat the uninsured and inadequately insured, for community institutions that help people in distress—in short, for all the rapidly fraying threads of our health care safety net. No less important, creating a public plan to compete with private plans while bringing as many Americans as possible into a reformed insurance framework is essential for bringing down the rate of increase of costs over time and to reducing the long-term financial threat of health care to American workers and their families, employers, states, and the federal government.