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OP-ED CONTRIBUTORS

## The Only Public Health Plan We Need

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CONGRESS will soon decide whether to create a public health plan to compete with private insurance companies and thus lower the cost and raise the quality of care.

Everyone assumes that a public plan means a government-sponsored insurer that makes payments to doctors and hospitals, whether in the form of Medicare or — the latest idea — state-sponsored cooperatives. But Medicare has a dismal record of controlling costs and improving quality, and we lack evidence that co-ops could do any better.

A better public plan would not be a new government-run insurer at all, but rather a government-chartered mechanism that would let employers and individuals buy health coverage from private insurers in a manner that uses the three most essential market forces — choice, competition and incentives — to reduce the price and improve care.

Congress is already looking to create federal or state “exchanges” through which individuals could comparison shop for health insurance. Exchanges pool large numbers of people and give them access to various health care plans — so that individuals can enroll in the plan of their choice, and so that risks and administrative costs can be spread widely.

An exchange is a key feature of the public plan we'd like to see, but it's only one element. Two other features are needed to give an exchange the power to pressure insurers — whether health maintenance organizations, preferred provider organizations, or fee-for-service plans — to hold down prices and improve care.

First, the exchange would need to act on behalf of a critical mass of people — at least 20 percent of the insured population that does not already receive Medicaid or Medicare. Only a pool of this size could attract serious bids from insurers. To amass such a large purchasing pool, Congress might need to require that all government employees, or all employers with fewer than 100 employees, join the pool.

Second, the exchange would need to ensure that no subsidies for health insurance, whether provided by employers or the government (through the tax system), exceed the price submitted by the lowest-bidding qualified insurer and benefit package. All individuals in the pool would be free to join any insurer that submits a bid. But enrollees would have to pay out of pocket — and preferably with after-tax dollars — any amount above the price of the lowest-bidding plan.

This second feature would ensure that all parties would have a strong incentive to enroll in the lowest-cost plans.

If insurance buyers had this incentive, insurance sellers would finally face what's been entirely missing in America's health insurance market: a powerful reason to put together good, economical plans.

How would insurers lower prices and raise quality? By passing their incentive along to doctors and hospitals. To maximize their revenue from insurance companies, doctors and hospitals would need to provide better care at a lower price — something they can accomplish only by squeezing out error, waste and inefficiency.

This type of public plan has already been proven to work. In Dane County, Wis., the state employee health plan operates a purchasing pool on behalf of nearly 24 percent of the roughly 350,000 insured residents of the county who don't get coverage from Medicaid, Medicare or other federally subsidized programs. These state employees (and their spouses and children) choose from among four well-regarded H.M.O.'s as well as a fee-for-service alternative. The state limits its contribution to a dollar amount just below the prices bid by the comparably low-priced H.M.O.'s, and requires enrollees to pay much of the cost of the high-priced, inefficient fee-for-service alternative.

Even though the Wisconsin plan doesn't follow all the rules for the ideal public plan exchange, the state spends far less per employee in Dane County than it does in other parts of the state, where a key feature — a big enough pool — is missing. According to a December 2007 study, individual coverage in Dane County cost the state \$360 to \$1,500 a year less than in the rest of Wisconsin, and family coverage was \$950 to \$3,840 less — even though all state employees have similar incentives to choose economically.

Yes, the United States needs a public plan to discipline the private insurance market. But simply adding another insurer, whether it's Medicare or a cooperative, won't do the job. At worst, it would simply add a high-cost, mediocre-quality insurer to a market already crowded with them. At best, it would misuse the government's power to set prices without getting at the underlying errors, waste and inefficiency in America's overpriced health care system.

What we need instead is a public plan that will impose a stern and lasting discipline on our insurance market — and at the same time insure everyone, provide excellent benefits and offer abundant choices.

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