Public Plan Option

June 2009 American Academy of Actuaries

Policymakers are debating whether health reform proposals should include a public plan option that will compete with private plans. If such a public plan option is included, creating a fair and competitive marketplace requires a level playing field between the public and private plans.

Whether to include a public plan option that will compete with private plans is a key part of the current health reform debate. The American Academy of Actuaries' Health Practice Council neither advocates for nor opposes the concept of a public plan. Nevertheless, if a public plan is included, certain actuarial issues must be considered. In particular, creating a fair and competitive marketplace requires a level playing field between the public and private plans. Otherwise, the viability of a particular plan or sets of plans could be threatened.

From an actuarial perspective, a level playing field requires the following:

Issue and rating rules must be the same for the private and public plan options.

Creating a level playing field for issue and rating rules will help mitigate concerns regarding adverse selection between plans. Such adverse selection occurs when individuals with high health spending migrate to plans that offer benefits and cost-sharing that best align with their health care needs. Certain issue and rating rules can exacerbate adverse selection. Guaranteed issue provisions and prohibiting premium variations by health status can be more advantageous to individuals with high health spending, whereas permitting underwriting and premium variations by health status can be more advantageous to individuals with low health spending. Therefore, if for example, underwriting and premium variations by health status were permitted in private plans, but not the public plan, individuals with high health costs would migrate to the public plan, thus raising the average costs of the public plan relative to the private plan. The opposite would occur if underwriting and premium variations were permitted for the public plan, but not the private plan. Holding public and private plans to the same issue and rating rules would help ensure competition is based on efficiencies and quality of care rather than on differences in enrollee risk characteristics.

Premium rates must be actuarially sound.

Premium rates must be adequate to cover claims and operating expenses, for both public and private plans. Any introduction of a public plan should be subject to full cost accounting in the identical manner as required of private insurers today. Also, to ensure plan solvency in the event that plan expenditures exceed premiums, private plans are required to carry surplus to cover the difference; premiums include a risk charge to fund this surplus. Public plans are not at risk of insolvency, per se. Unless the government itself becomes insolvent, it has other revenue resources that can be used to meet its health plan obligations. To ensure that the public plan premiums are self-supporting, and therefore on a comparable basis with private plans, the public plan should include a premium rate stabilization fund. Under this approach, public plan premiums would include a mechanism to fund the stabilization fund, which would in turn be used to cover any unexpected differences between plan ex-

Other Statements on CRITICAL ISSUES IN HEALTH REFORM

Actuarial Equivalence
http://www.actuary.org/pdf/health/equivalence_may09.pdf

Individual Mandate
http://www.actuary.org/pdf/health/individual_mandate_may09.pdf

Market Reform Principles
http://www.actuary.org/pdf/health/market_reform_may09.pdf

Gender Considerations in a Voluntary Individual Health Insurance Market
http://www.actuary.org/pdf/health/gender_may09.pdf

American Academy of Actuaries
1850 M Street NW • Suite 300 • Washington, DC 20036 • 202.223.8196 • www.actuary.org

penditures and premiums, rather than relying on general federal funds. Such a premium rate stabilization fund is included as part of the Federal Employees Health Benefit Program.

Benefit package requirements must be the same for private and public plan options.

Adverse selection can also occur when there are different benefit options available; individuals who expect to have greater medical needs will tend to opt for more generous coverage. And those who expect to need a particular type of service will opt for plans that include that service in the benefit package. To prevent adverse selection between the private and public plans based on benefit design, any benefit package requirements need to be comparable between the private and public plan options.

Any premium subsidies must be available for both private and public plan options.

If individuals are eligible for premium subsidies, they should be allowed to use those subsidies toward either a public plan or a private plan. This is necessary not only for fair competition, but also to help avoid adverse selection between the private and public plans.

In addition, if a default enrollment mechanism is included, eligible participants should be spread between all participating plans, and not limited to the public plan option.

Provider payments must be comparable for all plans.

Setting the public plan's provider payment rates at Medicare rate levels could help control plan costs, but could also result in cost shifting to private plans and reduced access to providers. This could, in turn, cause a significant crowd out of private insurance coverage. The public plan payments should be set to balance the tradeoffs between ensuring adequate access to care and controlling plan costs.

Other state requirements must also apply to public plan option.

States place a variety of other requirements on private health plans that also would need to be considered. For example, many states assess health plans to fund high-risk mechanisms, regulatory activities, and guarantee funds. States also require a variety of other non-benefit requirements on health plans, ranging from consumer protections to market conduct examinations and audit and actuarial certification requirements. The public plan must also be subject to such laws and regulatory requirements, as appropriate.

Members of the Health Practice Council and Federal Health Committee include: Alfred A. Bingham Jr., MAAA, FSA, FCA, vice president of the Health Practice Council; Patrick L. Collins, MAAA, FSA, vice-chairperson of the Health Practice Council; David A. Shea Jr., MAAA, FSA, chairperson of the Federal Health Committee; David V. Axene, MAAA, FSA, FCA; Rowen B. Bell, MAAA, FSA; Karen Bender, MAAA, ASA, FCA; Ian G. Duncan, MAAA, FSA, FIA, FCIA; Paul Fleischacker, MAAA, FSA; Donato Gasparro, MAAA, FSA, FCA; Warren R. Jones, MAAA, ASA; Darrell D. Knapp, MAAA, FSA; Laura Beth Lieberman, MAAA, FSA; Timothy J. Luedtke, MAAA, FSA, FCA; Karl Madrecki, MAAA, ASA; Mark E. McGuire, MAAA, FSA; Catherine M. Murphy-Barron, MAAA, FSA; Geoffrey C. Sandler, MAAA, FSA; John J. Schubert, MAAA, ASA, FCA; Sudha Shenoy, MAAA, FSA, CERA; P.J. Eric Stallard, MAAA, ASA, FCA; Sara C. Teppema, MAAA, FSA, FCA; Michael J. Thompson, MAAA, FSA; Thomas S. Tomczyk, MAAA, ASA, FCA; Rod Turner, MAAA, FSA; Cori E. Uccello, MAAA, FSA, FCA; Shari A. Westerfield, MAAA, FSA; Thomas F. Wildsmith, MAAA, FSA; and Dale H. Yamamoto, MAAA, FSA, FCA, EA.