Understanding the Competitive Effects of a Public Option

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Brendan S. Maher, *The Private Option*, 2020 **Mich. St. L. Rev.** 1043 (2021).

Proposals to allow individuals to buy into a public health insurance program such as Medicare have been circulating for over a decade and have been the subject of much academic work. In *The Private Option*, Professor Brendan Maher offers an important addition to that literature by exploring how the competition between public and private payors that is inherent in public option proposals is likely to play out with respect to three key functions of health insurance: risk bearing, cost control, and ensuring quality care. It is a careful, highly readable, and non-ideological piece of scholarship that should be helpful to a range of stakeholders – from students trying to understand how health insurance markets function to policymakers trying to weigh the benefits of current health reform proposals. While not Pollyanna-ish, the article is ultimately hopeful, making an underappreciated case for the public option by explaining how competitive pressure from a public payor might result in better private health insurance options.

The article begins by explaining the various roles that health insurers play in the United States, focusing on three primary functions: risk-bearing, cost control, and encouraging quality care. The remainder of the article is devoted to evaluating how private payors might behave in a world in which they must compete against a public option. This evaluation is accomplished by assessing the comparative advantages of public and private payors with respect to the three primary functions of insurers previously identified. With respect to risk-bearing, the article unsurprisingly concludes that public payors have an enormous advantage over private payors. Indeed, Maher admits, if insurers were solely serving a risk-bearing function, no private payor could effectively compete with the government. As a result, it is unlikely that a public option would create genuine competition with respect to the risk-bearing function of insurance.

The next two functions, controlling cost and ensuring quality, are more likely to respond to competitive pressures in the face of a public option. The article explores a wide variety of tools that can be used to control cost and improve quality, and concludes that some of these tools favor public payors, while others favor private payors. For example, the government has a distinct advantage in the ability to control cost through rate setting. However, that advantage is somewhat bounded, in that providers will exit the system if reimbursement rates are set too low.

When it comes to ensuring quality care, however, Maher does not believe public payors hold an advantage. Indeed, he thinks it more likely that competitive pressures will result in private payors innovating in this space, and will perhaps result in private payors offering higher-quality products for higher prices when faced with a public option competitor. For example, if provider reimbursement rates in the public option are low, superior providers might elect not to participate in the public option. If so, private insurers might be able to capture such providers and sell a higher priced product tied to superior provider quality. An added benefit of this type of competition is that having multiple payors using different incentive and payment structures should continue to encourage a wide variety of providers to enter and remain in the market.

The article also explores the critical intersection of cost and quality – what is commonly referred to as high-value health insurance. As Maher explains, most health insurance policies, whether public or private, generally cover medical treatments that are clinically beneficial, but avoid differentiating between treatments based on their relative effectiveness or cost-effectiveness. As the article acknowledges, this has been a long-standing and difficult issue to solve, despite the repeated urging of health policy scholars. Americans are unenthusiastic about payors overruling the judgment of treating physicians, and have rejected rationing efforts along these lines. In my view, one of the most important arguments this article makes is that public/private competition in health insurance markets may create the

dynamic that finally results in acceptance of health insurance coverage terms that are premised on cost-effectiveness of treatments and services. Maher's argument is multi-faceted, but is based in part on the likelihood of private insurers being nimble enough and having enough relevant data to offer a product distinct from what a public payor is likely to offer. For example, although the public option is likely to enjoy lower reimbursement rates than private payors, private payors may be able to offer a competitive product by offering some combination of evidence-based coverage terms (or perhaps even coverage terms that embrace personalized medicine), coverage terms based on minimum levels of cost-effectiveness, and high-quality providers. Maher is careful not to suggest that a public payor couldn't accomplish the same result, but realistically explains that it may be politically more difficult to enact such distinctions in a public program.

In the end, *The Private Option* argues that government has an overwhelming advantage on risk bearing, a meaningful advantage on cost, no advantage on quality, and a seeming disadvantage on cost-effectiveness – a dynamic that is likely to lead to real competition among insurers. Private payors, Maher argues, may take bold steps in response to a competitive public option. The resulting experimentation could be immensely valuable, and would be lost if health reform eliminates private payors. While I might be more skeptical of the likely behavior of private insurers when faced with competitive pressure, Maher makes a compelling case that a competitive health insurance market with both public and private payors is well worth pursuing.

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