Cato supports public option?

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A white paper from Cannon and Pohida (2021) calls for applying "public option principles" to Medicare. Who would have thought that the Cato Institute would call for a public option?

Well in fact, the do not really call for a public option. The proposal should be called introducing a voucher system into Medicare. Under the proposals, Medicare beneficiaries would receive a fixed voucher–adjusted for income and health status–that individuals could used to pay for premiums for whatever insurance they choose, public (Medicare Fee-for-service) or private (Medicare Advantage). The approach is not too dissimilar from one previously proposed by the American Enterprise Institute (AEI) titled "The Best of Both Worlds." The authors authors explain why they believe this would be a useful system, writing:

Economists have proposed eliminating these perverse incentives by having Medicare directly pay each enrollee a fixed subsidy the enrollee can apply to either traditional Medicare or private insurance. Program administrators would take the money Medicare otherwise would pay to providers and insurers and give those funds directly to enrollees as a monthly payment, just as Social Security does. In 2022, they would divide $783 billion among the program's 66 million enrollees, such that enrollees would receive an average subsidy of $11,900. Medicare would then adjust individual allotments according to each enrollee's health status and income (see below), such that all enrollees could afford a standard health insurance plan comparable to traditional Medicare. The net effect is that enrollees would receive approximately the same subsidy they would under current law.

A key issue is how well can people shop across plans. Are quality measures clear? Are the meaningful? Are they free from provider gaming?

The authors cite a paper where Don Berwick–a former CMS administrator–notes that the current provider payment schemes may not incentivize quality.

Even if payment schemes were sensitive to quality, and even if consumers could see the difference between better and worse care, [incentives for quality] improvement would be weakened by the distance between the patients and the payment rules. People and payers who

might be quite willing to pay a premium for more fully integrated chronic disease care, for the option of a group visit, or for detailed management of their lipid medications do not have the option to do so because of fixed fee schedules and complex payment rules. This is particularly true under Medicare. In effect, people do not have the option to pay for what they want, even if what they want is better than what they have.

As I posted recently, Medicare now has a large number of value-based programs, but not many of these alternative payment models have had a large impact on quality.

The authors claim that the voucher-based system will lead to more creative ways to pay providers.

…public-option principles require eliminating favoritism toward fee-for-service payment, or whatever payment rules the government plan happens to employ. Applying that principle to Medicare would increase demand for prepaid group plans and other non-fee-for-service arrangements, promoting dimensions of quality Medicare currently discourages

Also, more standardization of health plans makes it easier to shop across plans; standardizing, however, leads to less innovation as well. The major underlying assumption is that by allowing more competition, cost should fall and outcomes should rise. Skeptics would point out that administrative costs will likely rise as health plans compete and there could be more cost savings with a single payer option. While the later point is valid in a static setting; over the long-run competition tends to be the most effective way to bring down cost.

Another key issue is, how does one adjust for health status and income? While in principle this is easy to do (Medicare Advantage already has their subsidies from CMS risk-adjusted for health status), in practice health systems and insurers may have more information than does the government when making this adjustment. Further, transitory employment shocks–while less of an issue for the Medicare population–can make estimating individual income a challenge.

Despite these numerous challenges, the idea is interesting and the white paper is worth read.