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To be successful, health care reform must build on three strong pillars of America's national character: personal responsibility, shared responsibility, and shared risk. Thankfully, these are the three pillars of America's Affordable Health Choices Act.

Shared and personal responsibility means that employers and individuals should be expected to contribute to the cost of their coverage. Yet this responsibility creates a countervailing *obligation* on the part of the government—to ensure that workers and the most vulnerable firms have a choice of affordable options that are secure and stable.

Which brings me to the third vital pillar of reform: shared risk. Shared risk means we need a new national insurance exchange that allows workers without secure workplace coverage to access good group health plans, with premium assistance to ensure affordability for middle-class Americans as well as lower-income Americans. And, crucially, it means that this exchange must include, as a choice, a public health insurance plan competing on a level playing field with private insurers.

The public health insurance plan is a linchpin of this distinctively American strategy. It will provide a stable *backup* for those without workplace insurance, a high

benchmark for private plans, and a cost-control *backstop* for enrollees and the nation as a whole. In most of the country, a small number of large (often for-profit) health plans are the only real choice available to consumers and employers. Lacking effective competition and facing highly consolidated provider groups, private plans are passing on costs to enrollees and employers, rather than improving their own efficiency.

New rules for private insurance—including strict limits on out-of-pocket maximums, a ban on the use of health characteristics to vary premiums, and a minimum 85 percent standard for "medical loss ratios" (how much plans actually spend on care, rather than administration and profits)—could go some way toward encouraging plans to focus on value, rather than screening out those most likely to need care or shifting costs onto consumers. But without a public plan as a backup and benchmark, key problems in the insurance market will remain.

The most pressing of these problems is lack of affordability, which is why the most important motive for a competing public plan is to provide a cost-control backstop. Public insurance has much lower administrative expenses than private plans, it obtains larger volume discounts, it does not have to earn profits as many plans do, and the experience of Medicare suggests that it has a superior ability to control spending while maintaining broad access over time.

For the public plan to work, it must have the ability to set up an extensive network of hospitals and physicians immediately. Providers should be asked to "opt out" of providing coverage under the new plan if they accept Medicare patients, rather than required to "opt in." The plan should also be able to use modified Medicare rates. Allowing the secretary to "negotiate" rates—that is, to figure out service prices in

consultation with providers starting from scratch—is a recipe for paying more, raising the cost of the public plan. The Congressional Budget has made clear it will not credit negotiated rates with producing savings.

Some have said that we should wait to see if private health insurance turns itself around *before* we create a public plan. This would be a grave mistake. Any reasonable “trigger” based on the failure of private insurance to provide affordable comprehensive coverage should have been pulled a long time ago. Triggers have not worked in the past, and a trigger has no chance of working unless it is based on a single national standard and prompts the immediate creation of a national public plan, rather than the introduction of a public plan on a decentralized market-by-market basis. But supporters of the trigger have not seriously entertained ideas like these because they do not seriously entertain a competing public plan.

A public plan is needed on the first day a new insurance exchange is up and running. And this plan should be a *national*, *public* plan, not the regional health care cooperatives that some have called for. Cooperatives are not a serious means of reliably achieving any of the public plan’s critical goals of serving as a backup, benchmark, and backstop. They would not be available on the same terms nationwide. They would not have the reach or authority to drive broadly implemented delivery and payment reforms or to act as strong public-spirited competitors to private insurers. Indeed, they would face the same problems in breaking into markets that smaller private competitors face today. Investment analysts Carl McDonald and James Naklicki recently concluded that coops “would be destined to fail from the moment of creation.”

Make no mistake: Americans want to have the choice of enrolling in a public health insurance plan. Even after weeks of lies and misleading attacks, strong majorities continue to want a choice between private insurance plans and a public plan. Unlike the naysayers, *they* appear to recognize that such competition is the key to creating greater choice and accountability in increasingly consolidated insurance markets.

Personal responsibilty, shared responsibility, and shared risk—these are the three pillars of an American solution. Together they will 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.