ABSTRACT The “public option” for health insurance, as defined by the 111th Congress, grew from roots planted in California in 2001. Progressives supported it as a voluntary transition toward single-payer insurance, while conservatives opposed it as a government “takeover” of health care. Although present in several interim bills and in legislation passed in November 2009 by the House of Representatives, the public option was omitted from the legislation passed by the Senate in December 2009 and from the final package adopted by both houses in March 2010. Lack of support among moderate Democrats, opposition from Republicans, and ambiguous messages from the White House are among the explanations for the public option’s defeat. However, there is nothing in the recently enacted legislation that would prohibit states from creating a public option in their exchanges.

As the 111th Congress drafted legislation for comprehensive health care reform, the proposal to offer Americans the choice of a so-called public option became one of the most hotly contested issues. From the beginning there was confusion, not only over what constituted a public option, but also what it would mean to the U.S. health care system and the American people. The public option raised the long-standing question: What is the appropriate role of government in achieving health insurance coverage for all Americans?

We trace the rise and fall of the public option, as it came to be defined in the recent health care reform debate, and as experienced by two proponents intimately involved in the process. We recount the public option’s emergence in California in 2001 and 2002 and chronicle its demise in Congress in 2009–10. Progressives supported a public option as an alternative to the for-profit health insurance industry, with expectations that it would control costs, promote competition, and prompt delivery reforms and lower provider charges through the bargaining power of a large government payer.

The proposal to increase the role of government in achieving these aims fueled the concerns and opposition of conservatives—as well as those of private insurers, providers, and other interest groups representing the supply side of the health economy. Ultimately, the public option failed as a result of many factors, including lack of support from moderate and conservative Democrats, opposition from Republicans and health care interest groups, and ultimately an absence of strong support from the White House.

Chronology Of The Public Option
Public health insurance, in the form of Medicare, Medicaid, and the Children’s Health Insurance Program (CHIP), has existed in the United States for decades, as have proposals to expand those programs. However, the public option, which first surfaced in 2001–02, represented an entirely new idea. The concept was to offer a pub-
licly insured plan in direct competition with other options for private health insurance coverage, in the hope of driving down both premiums and underlying health care costs.

**BIRTH IN CALIFORNIA** The idea of a public option within a state-based health insurance exchange was initially set forth in a proposal known as CHOICE. This was part of California’s Health Care Options Project (HCOP), an initiative to update and develop ideas and options on how to expand coverage in California, and was funded by a federal planning grant to the state Health and Human Services Agency. The CHOICE proposal built on the model of managed competition, with its array of competing private managed care plans. However, it added a new option, the public option, to the exchange, to broaden the array of choices available to individuals and families. The public option was also designed to compete with private plans in the exchange and to serve as a policy compromise between a single-payer system and managed competition among private plans.

The CHOICE proposal was developed by a group of health care leaders who convened at the University of California, Berkeley, during 2001–02, under the direction of one of the authors, Helen Halpin (Schauffler). Under the CHOICE proposal, nonelderly Californians could enroll in the private managed care plans or the new public option offered through the exchange. CHOICE would allow any willing licensed health care provider to participate in the public plan, and would pay providers Medicare rates. It was designed to grow the pool of people purchasing in the exchange as quickly as possible.

The Lewin Group assessed the impact of CHOICE on coverage and costs. Its analysts predicted that within one year of its enactment, 64 percent of Californians would elect to get coverage through the exchange, with approximately 32 percent of them (more than eleven million) enrolling in the public option.

In 2003, CHOICE in California served as the basis for a national reform proposal published in the Robert Wood Johnson Foundation’s Covering America Series, “Getting to a Single Payer System Using Market Forces: The CHOICE Program.” The national CHOICE proposal gave each state responsibility for administering a new insurance exchange, contracting with managed care plans, and creating and administering a new public plan. However, the CHOICE proposal was not immediately embraced at the state or federal level, and it would not reemerge until the 2008 presidential campaign.

**THE PRESIDENTIAL PRIMARIES** John Edwards was the first Democratic presidential candidate in the 2008 election to release a health reform proposal; he did so in February 2007. His proposal encompassed the principles of CHOICE, with each state creating a health insurance exchange offering competing private plans as well as a new public plan option. Individuals and employers could elect to purchase insurance through the exchange.

Edwards saw the public option as a potential transition to single-payer insurance. In discussing the public option, he stated: “American consumers will decide what works best. [A marketplace where private insurance competes with government plans] could continue to be divided. But it could go in one direction or the other, and one of the directions is obviously government or single payer. And I’m not opposed to that.”

At least three factors were behind the Edwards proposal. First, the candidate said that he believed there was “a legitimate and strong argument” for a single-payer plan, but he also understood that many Americans “like the health care they have and are nervous about entirely government-controlled health care.” Second, Peter Harbage, a longtime health care adviser to Edwards and the other author of this paper, had served as assistant secretary for health in Gov. Gray Davis’s administration in California between 2001 and 2003. It was the Health and Human Services Agency under the Davis administration that oversaw the grant under which the CHOICE proposal was developed. Third, Harbage went on to serve as the senior health policy adviser to the Edwards presidential campaign from 2003 to 2008, and he continued to voice support for the basic principles and framework of CHOICE.

The Edwards campaign released its plan two weeks after another public plan proposal was put forward by Jacob Hacker of Yale University. Hacker’s proposal, built on his 2003 plan for expanding Medicare, would have created a federal Medicare-like public plan through which individuals or employers could purchase coverage.

The public plan Hacker envisioned was structured differently from CHOICE and did not embrace the state-based managed competition model that was the foundation for the public option in the CHOICE and Edwards proposals. Hacker went on to become one of the strongest proponents of the public option, contributing to the policy discussion through writing and advocacy as a professor at the University of California, Berkeley, and in partnership with the Campaign for America’s Future. His advocacy proved important in advancing the idea of the public option among key Democratic constituencies.

The health care reform proposals developed by...
the campaigns of Barack Obama12 in May 2007 and Hillary Clinton13 in September 2007 also included health insurance exchanges with a public option. The Obama team became aware of the CHOICE model in April 2007.14 Shortly thereafter, Halpin joined the Obama campaign’s health policy committee.

The three leading Democratic candidates’ versions of the public option were quite similar. They varied primarily with respect to who was eligible to purchase through the exchange, and whether the exchange was administered at the federal or state level.

**The Path Through Congress** Following President Obama’s inauguration in January 2009, the U.S. Congress began its work on comprehensive health care reform. House Speaker Nancy Pelosi (D-CA) pledged at the time that the House bill would include a public option.15 Indeed, a public option offered through a private insurance exchange was included in all three versions of the bill passed by House committees in the summer of 2009 (House Ways and Means and House Education and Labor on 17 July 2009; House Energy and Commerce on 31 July 2009), as well as in the bill passed by the full House of Representatives on 7 November 2009 (the Affordable Health Care for America Act, HR 3962). A public option was also included in the bill passed by the Senate, Education, Labor, and Pensions Committee on 15 July 2009 (the Affordable Health Choices Act, S 1679).

Senate Democrats were engaged in a highly contentious debate throughout the fall of 2009, and the political life of the public option changed almost daily. The debate reached a critical impasse in November 2009, when Sen. Joseph Lieberman (I-CT), who usually caucuses with the Democrats, threatened to filibuster the Senate bill if it included a public option.

During this period, several alternatives were considered. One compromise proposal included a Medicare buy-in for people age fifty-five and older. However, both Senator Lieberman and Sen. Olympia Snowe (R-ME) opposed the Medicare buy-in, which evoked concerns similar to those raised about the public option. Sen. Kent Conrad (D-ND) proposed using nonprofit health care cooperatives to compete with for-profit plans, but this concept also sparked little enthusiasm.

Debate over the public option continued as additional proposals were made to narrow eligibility for the public option and to raise the rates paid to providers above Medicare levels. When those, too, failed to garner enough support, the public option was eliminated from the Senate bill.

Sen. Charles Schumer (D-NY) and Sen. Jay Rockefeller (D-WV) made last-minute attempts to introduce amendments to include a public option as the bill was about to be voted on by the Senate Finance Committee. Those failed, and there was no public option in either the bill that emerged from that committee or the bill that passed the full Senate on 24 December 2009 (the Patient Protection and Affordable Care Act, HR 3590). The option was also omitted from the president’s proposal, Principles for Health Reform, released 22 February 2010 prior to a bipartisan health care summit. Likewise, it was not present in the budget reconciliation bill passed by the House and Senate and signed into law by President Obama in March 2010.

**Public Option: Benefits And Risks**

The broken U.S. health care system, and the practices of the for-profit health insurance industry, provided the rationale for many Democrats to support a public option in 2009. Many believed that regulation alone would not be effective in reining in the anticonsumer practices of private insurance companies. Public-option proponents argued that the market needed to be reformed from the inside out, by creating a new choice for consumers—many of whom did not want to be mandated to purchase health insurance in a for-profit marketplace.

**Impact On Health Care Markets**

Proponents argued that a public option would have a major impact on the structure of the U.S. health care market.16 They believed that it would create a more competitive marketplace, particularly in states with few insurance options.17 It was also hoped that the public option would help keep private insurers honest.18 If consumers felt mistreated by private insurance, they could vote with their feet and choose the public option. Economic theory suggests that fear of market loss would motivate private insurers to change their behavior. Opponents of the public option, however, feared that private plans could not compete against it and that, over time, it would erode both the individual and group health insurance markets.

**Impact On Accountability**

The public option was also designed to increase accountability in health insurance.19 By definition, it would be accountable to elected officials. This represents a fundamental difference from for-profit health insurance, with its fiduciary responsibility torn between policyholders who need medical care and stockholders who expect a return on equity.

**Impact On Costs**

There was broad agreement among supporters that the public option could contain costs.20,21 By creating a large, new health
care purchaser, proponents believed the public option could be effective in negotiating reduced unit costs. They also argued that the lower administrative costs of a public plan would mean a greater proportion of health care dollars would go toward paying for medical care.21

There was strong disagreement, however, over the degree to which a public option would affect costs. Estimates varied considerably according to the plan design evaluated and the estimator’s vantage point. For example, the Congressional Budget Office (CBO) studied both the original House bill, which offered a public plan that would pay Medicare rates plus 5 percent, and the House Energy and Commerce Committee bill, which featured negotiated rates. The CBO analysis found that the Medicare rate-based plan would save $110 billion over ten years, versus $25 billion under negotiated rates.22 Conservatives, on the other hand, argued that the public option would end up costing more than it collected from policy holders and thus would eventually balloon the deficit.23

ROLE OF GOVERNMENT What progressives saw as the benefits of a public option, conservatives saw as its flaws. Expanding government’s role as a payer through a public option was framed by conservatives as a move toward socialism.24 In addition, medical care providers feared that a larger government role would lead to low payment rates, expanded rate setting, and government control over health care, regardless of the structure of the public option.

The opposing views held by supporters and opponents contributed to the outsize debate around the public option, which often eclipsed other important issues in health reform. After all, the pros and cons of the public option could be condensed into sound bites about “taking on big insurance companies” or “a government takeover of health care” in a way that the complex issues of health care financing could not. And at a time when other major efforts—such as the bailout of Wall Street and the federal stimulus bill—were perceived as having expanded the role of government, the press and public were open to a narrative about the dangers of big government in health care. In retrospect, the nature of the debate over the public option was somewhat predictable, given the circumstances.

Issues In Policy Design

For the most part, the basic characteristics of the CHOICE model for the public option5 remained in place as the idea was discussed and developed throughout 2009. However, disagreements among its supporters came to define the substantive policy debate. There were three central questions: how much to pay physicians and hospitals; whether there should be a single, federal purchaser or a number of smaller state or regional purchasers; and how to determine eligibility for purchasing in the exchange. Both sides of the debate suffered from a lack of data to make their points, with ideology often trumping analysis and opinion offered in lieu of evidence.

USE OF MEDICARE RATES The Medicare-like approach would have tied payments to Medicare reimbursement, with proposals for using 100 percent or more of Medicare rates.5,8,25 Those who supported using Medicare rates focused on the potential to lower costs. Opponents, on the other hand, were concerned about unintended consequences. Some economists feared that Medicare rates would lead to cost shifting and reduced access to care, with few providers willing to accept low Medicare payments.20,26 With Medicare rates already leaving tight margins for providers, many of them feared for their future financial viability.

FEDERALISM There was also disagreement over whether the public option should be one national plan or a number of state or regional plans. Many resisted the idea of a national insurance pool, which struck them as “big government,” while supporters said that a national approach would reduce administrative costs and was necessary to create a strong price negotiator.6,11 Those seeking a state or regional approach viewed the potential market strength of a national plan as something to be feared, primarily because it might lead to national rate setting.24 They were also concerned that states would have no control over how the insurance exchange and public option were designed, and they argued that each state or region was best positioned to meet the needs of its constituents and design the options to fit its market.5

ELIGIBILITY Another design issue concerned eligibility for the exchange. The more people who were eligible to purchase in the exchange, the larger the risk pool would be, and the greater
the potential savings. However, there was never a shared understanding of how big might be “too big.”

In most of the bills, individuals who were not eligible for either existing public or employer insurance would have been eligible to purchase through the exchange and to have the choice of the public option. The differences across bills related to how much access to give employers. Most bills included provisions for small employers to move their workers into the exchanges, with some proposals phasing in eligibility over time based on firm size. Other proposals would have enabled any employer, regardless of size, to move workers into the exchange or simply let each worker decide. The issue boiled down to how important it was to preserve the employer insurance market. Clearly, the small-group market was not serving small firms well, and new options for them were a priority. But for those who wanted to see the public option succeed and attract a large, stable risk pool, it was important to open the exchange to anyone with employer coverage. This side feared that limiting eligibility could lead to adverse selection into the public plan, threatening its long-term viability. In contrast, others were worried that opening the exchange to large employers would cause many of them to stop providing coverage, thereby breaking the pledge that people who were happy with their current coverage could keep it.

The CBO estimated that only eleven to twelve million Americans—less than 5 percent of the population—would enroll in the public option under the House bill, which restricted employers’ eligibility for exchange participation. In contrast, the Lewin Group estimated that the number of enrollees in the public option could be as high as 100 million—approximately 32 percent of the population—if workers for all firms were allowed to purchase insurance through the exchange.

**The Politics Of The Public Option**

The public option was the darling of the progressive wing of the Democratic Party. It also proved to be surprisingly resilient and popular among the public, as measured in opinion polls. The strongest supporters included progressive interest groups led by labor unions—most notably the AFL-CIO and SEIU—consumer groups, and civil rights organizations. The strongest opponents were the health care and health insurance industries, conservative interest groups, and small businesses represented by the Chamber of Commerce and the National Federation of Independent Businesses.

Unlike the Republicans, who remained unified in their opposition, the Democrats split. Ideological divisions between progressive and more moderate Democrats made progress in Congress difficult, despite majority-party status. Speaker Pelosi was able to pass legislation with a public option in November 2009, notwithstanding concerns from conservative “Blue Dog” Democrats. However, Senate Majority Leader Harry Reid (D-NV) was never able to find the support of sixty senators required to prevent a threatened Republican filibuster. The Democratic senators who expressed the greatest concern were from more conservative states, such as Arkansas and Louisiana.

**The Public Debate** As conservatives framed the public option as “socialism,” claims of a “government takeover” of health care captured the attention of the mainstream media, nearly excluding coverage of the policy debate taking place. Republican opposition grew directly out of a stated desire to limit the role of government in health care and a fear that even a weak public option would provide a foundation for further expansion of the government’s role in health care.

Support for the public option was equally fervent. The former Vermont governor Howard Dean, through MoveOn.org, Democracy for America, and Health Care for America NOW!, along with Richard Trumka, president of the AFL-CIO, orchestrated a national campaign for the inclusion of the public option in health reform. In March 2009, Dean, Trumka, and the organizations they worked with drew “a line in the sand,” indicating that any bill that did not include a public option was not real reform. The political action thus mobilized was successful in persuading more than 400,000 group members across the country to sign a petition and to contact their members of Congress in an appeal to preserve the public option.53

**Within The White House** Opinion regarding how best to approach health care reform, including the public option, appeared to be split inside the White House. As a result, many supporters of the public option faulted President Obama for not pushing the concept more forcefully. One of the earliest signs that the public option was a negotiable item for the administration came in July 2009, from Rahm Emanuel, the White House chief of staff. Emanuel floated the idea of a “trigger” that would enable the public option only if the desired competition and cost control failed to materialize.

During the congressional recess in August 2009, at the height of the town hall pushback against health reform, other administration voices began to downplay the importance...
of the public option.\textsuperscript{35} The secretary of health and human services, Kathleen Sebelius, said that the public option was “not the essential element for reform.”\textsuperscript{35} President Obama stated at a town hall meeting: “The public option, whether we have it or we don’t have it, is not the entirety of health reform. This is just one sliver of it, one aspect of it.”\textsuperscript{35}

Ambiguity inside the White House sprang from several sources. Foremost was the White House’s desire to try to forge a bipartisan bill. By the fall of 2009, some of the Senate’s moderate Democrats had moved to support a drastically curtailed public option without ties to Medicare and only as a trigger, while Republicans remained uniformly opposed to the idea. Sen. Max Baucus (D-MT), chair of the Senate Finance Committee, spent months trying to forge a bipartisan bill with a subgroup of his committee, but he ultimately could not secure a single Republican vote.

It has been suggested that the White House was employing a negotiating tactic in being intentionally vague about its support for the public option.\textsuperscript{36} By remaining vague, the president was able to perform a necessary balancing act, satisfying his progressive base without threatening more-moderate Democrats. Indeed, when presented with critical opportunities to draw a line in the sand in support of the public option, or to even offer policy details, the president did not take them.\textsuperscript{37} Knowing that Senate support for the public option was weak, President Obama did not put himself out in front on this issue, lest he threaten his ability to enact any reform in the process.\textsuperscript{38}

**THE END GAME: RECONCILIATION** In February 2010, when the House and Senate were negotiating a budget reconciliation bill to amend the Senate health care reform bill and pave the way for final passage, yet another political scramble over the public option ensued. A letter authored by Sen. Michael Bennett (D-CO) called for a vote on the public option through budget reconciliation.\textsuperscript{39} The letter was eventually signed by forty Senators, just ten shy of the needed fifty. But after all was said and done, the leadership in both the House and the Senate were more committed to passing a bill than to keeping the public option alive.

On 12 March 2010, as she prepared for her final push to pass reform legislation, House Speaker Pelosi shut the door on using reconciliation to preserve the public option. While citing the lack of support in the Senate, Pelosi was also aware of the deep concerns that moderates in her caucus had regarding the public option. The narrow vote (219–212) in the House on 21 March 2010 suggests that every possible vote was needed. The House passed the Senate bill (HR 3590) and the reconciliation bill without a public option.

**Conclusion**

It is difficult to recall a federal health policy proposal that has seen such dramatic ups and downs as the public option endured. There were clearly wild swings in both the hopes and fears attached to it, and its death and rebirth were proclaimed repeatedly over the course of a long process of debate.

Even though comprehensive health care reform has been enacted without a public option, the proposal could reemerge if the public becomes dissatisfied with the progress of health reform. A more likely venue for rebirth, however, is adoption at the state level. States could choose to create a public option today, and there is nothing to stop a state from offering one in its new insurance exchange. If and where any of these possibilities play out will depend on the political climate in individual states, with heavily Democratic states the most likely places for a renewed debate. □
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Helen A. Halpin is a professor at the University of California, Berkeley, where she also serves as director of the Center for Health and Public Policy Studies and chair of the policy and politics track for the Ph.D. program in health services and policy analysis. She received her doctoral degree in social welfare policy from the Heller School at Brandeis University and her master’s degree in health policy and management from the Harvard School of Public Health, where she also was on the faculty from 1978 to 1982.

Halpin was a health policy adviser to the presidential campaign of Barack Obama. She took a sabbatical from Berkeley in 2008 to serve as a campaign surrogate, speaking throughout northern California on the campaign’s health reform proposals. “It was the most important work that I could possibly do at the time,” she says.

She was a key intellectual force behind the development of the public-option proposal that became a centerpiece of early Democratic plans for health care reform—but that was omitted from the final package that Obama signed into law in March 2010. Perhaps not surprisingly, she says that she was troubled over the past year as the public-option proposal was “slowly dismantled with every incremental decision” made in the health reform debate.

Halpin has written more than 100 policy reports and briefs; published hundreds of papers; crafted several book chapters; and testified frequently before the U.S. Senate and the California legislature. She is currently vice chair of public health impact analysis for the California Health Benefits Review Program, created by the state legislature to review proposals to mandate insurance benefits and assess their likely impact.

Halpin lives part time in France, where she serves as a deputy editor of the journal Public Health Reviews, published by the l’École des Hautes Études en Santé Public (School of Public Health) in Rennes. She says that this binational perspective has reinforced her belief that the United States “is, in many ways, ahead in research and public health policy.” But then again, “Europe is years ahead in its social contract with its people.”

Peter Harbage is president of his own consulting firm, Peter Harbage Consulting, which undertakes reports and analyses for clients including the Robert Wood Johnson Foundation and the Commonwealth Fund. Harbage’s work focuses largely on health reform in California, where he previously served as assistant secretary for programs and fiscal affairs with the California Health and Human Services Agency. He is also a lecturer at the University of Southern California’s School of Policy, Planning, and Development, as well as a frequent opinion writer for such publications as the Los Angeles Times and the San Francisco Chronicle. Harbage holds a master’s degree in public policy from the University of Michigan.

Harbage’s first experience in active health policy making came in 1993, when he served as an intern on the White House Health Care Task Force under President Bill Clinton. He went on to serve as a senior health policy adviser to the presidential campaigns of former North Carolina Democratic Senator John Edwards in 2004 and 2008. He credits Edwards as being the candidate who did the most to popularize the public option during the 2008 campaign.