

# THE CASE FOR PUBLIC PLAN CHOICE IN NATIONAL HEALTH REFORM

## KEY TO COST CONTROL AND QUALITY COVERAGE

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### KEY FINDINGS

A health care system that contains costs and drives value **must** include a good public plan if the broad goals of reform—universal insurance and improved value—are to be achieved. Private insurance and public insurance have distinct strengths and weaknesses, and thus should be encouraged to compete side by side to attract enrollees on a level playing field that rewards plans that deliver better value and health to their enrollees. Public insurance has a better track record at reining in costs, while preserving access; it has pioneered key quality and payment innovations that have often set the standard for private plans; it is essential to set a standard against which private plans must compete to drive value and can be a source of stability for people. Private plans are a source of new benefit options, and continuing pressure for innovation in benefit design and care management strategies.

According to opinion polling, most Americans want public and private insurance competing side by side so that they can choose the best option for themselves and their families.<sup>1</sup> Both should have a chance to prove their strengths and improve their weaknesses in a competitive partnership.

The **public plan is essential** if we are to accomplish the following three vital improvements to our health care system:

1. **Contain Costs.** Public insurance has a better track record than private insurance when it comes to reining in costs while preserving access.
  - a. Between 1997 and 2006, health spending per enrollee for comparable benefits grew at 7.3 percent a year under private health insurance, compared with 4.6 percent under Medicare.<sup>2</sup>
  - b. Private plans have been unable to bargain for lower prices, despite increasing concentration of health plans. Instead, private insurers have passed on costs while increasing profitability.<sup>3</sup>
  - c. The public Medicare plan's administrative overhead costs (in the range of 3 percent) are well below the overhead costs of large companies that are self-insured (5 to 10 percent of premiums), companies in the small group market (25 to 27 percent of premiums), and individual insurance (40 percent of premiums).<sup>4</sup>
  - d. The U.S. could save up to \$46 billion a year if it spent what other countries with mixed public-private insurance systems, such as Germany, spend on insurers' administrative costs.<sup>5</sup>
  - e. A public plan is capable of using its concentrated purchasing power to reduce costs.<sup>6</sup> In 2006, for example, Medicare physician payments were significantly lower than rates paid by private insurers, according to Medicare Payment Advisory Commission (MedPAC), yet 97 percent of physicians are accepting some new public Medicare patients.<sup>7</sup>
2. **Improve Quality.** Public insurance has pioneered new payment and quality-improvement methods that have frequently set the standard for private plans.
  - a. The Veterans Health Administration (VHA) has used its integrated framework to create a **model evidence-based quality-improvement program**. In the rest of the American health system, only around half of adults and children receive the care that they should. The number in the VHA is just over two-thirds.<sup>8</sup>
  - b. Medicare already shows unique quality advantages over private insurance when it comes to **reliable patient access to affordable care**. Elderly Americans with public Medicare report that they have greater access to physicians for routine care and in cases of injury or illness than do the privately

insured.<sup>9</sup> They are also half as likely as nonelderly Americans with employment-based insurance to report common access problems, such as skipping a medical test, treatment, or follow up, and failing to see a doctor when sick.<sup>10</sup>

- c. Medicare has increasingly emphasized **improved payment methods** and rigorous reviews of technology and treatment, and it has made increasing investments in quality monitoring and improvement. It has moved many payment systems to prospective payment, such as the diagnosis-related group prospective payment system for inpatient services. Private plans generally use the public Medicare plan's criteria for covering treatments as their standard of medical necessity, and they have adopted many of public Medicare's payment innovations. Private plans have also adopted the resource-based relative value scale for physician fees. Medicare often also leads the way on technology approval decisions and determinations about treatments that are medically ineffective.<sup>11</sup>
3. **Drive value.** Public plan choice is essential to set a standard against which private plans must compete.
- a. **Transparency in public Medicare plan** has helped identify huge variations in spending per capita across the country and to determine that areas with higher per capita spending score no better on quality measures, and often score worse.<sup>12</sup> Insurance companies, on the other hand, are generally reluctant to share information. For instance, *U.S. News and World Report* recently noted that 126 health care plans refused to provide data to a national accrediting agency that was needed for the magazine to rank plan performance.<sup>13</sup>
  - b. A new **public plan** partnering with Medicare would have **substantial incentives to invest in quality improvement as compared with private insurance.** For one, private insurance will always have limited incentive to treat those with chronic and costly disease, yet they are the ones most in need of innovations in treatment and care coordination. A public plan, which by nature will take all comers, is best able to treat them and disseminate the lessons learned to the private sector.<sup>14</sup>
  - c. **Participation in public plans is much more stable.** Insurers move in and out of markets, change their benefits frequently, shift the providers with which they contract, and so on. All of this churning is costly, undermines continuity of care, and is difficult for enrollees, particularly those who require coordinated care, as well as for providers. And, the greater stability of enrollment and provider participation gives public insurance a greater potential to reap the rewards of investments in prevention and general health improvement that may have up-front costs but reduce long-range costs.

<sup>1</sup> Celinda Lake, "Findings from a Nationwide Survey of 800 likely voters and six focus groups in Richmond, Philadelphia, and Denver," prepared by Lake Research Partners for USAction, January-February 2008.

<sup>2</sup> Cristina Boccuti and Marilyn Moon, "Comparing Medicare And Private Insurers: Growth Rates In Spending Over Three Decades," *Health Affairs*, March/April 2003; 22(2): 230-237.

<sup>3</sup> MedPAC, *Report to the Congress: Medicare Payment Policy*, March 2008, 59-63, 80.

<sup>4</sup> Cathy Schoen, et al., "Building Blocks for Reform: Achieving Universal Coverage With Private And Public Group Health Insurance," *Health Affairs*, Volume 27, No. 3, May/June 2008, 647.

<sup>5</sup> The Commonwealth Fund Commission on a High Performance Health System, *Slowing the Growth of U.S. Health Care Expenditures: What Are the Options?* January 2007, 4.

<sup>6</sup> Chapin White, "Why Did Medicare Spending Growth Slow Down?," *Health Affairs*, Volume 27, No. 3, May/June 2008.

<sup>7</sup> MedPAC, "A Data Book: Healthcare Spending and the Medicare Program; Section 5: Access to Care in the Medicare Program," June 2008, Chart 5-3, p. 55.

<sup>8</sup> Congressional Budget Office, "The Health Care System for Veterans: An Interim Report," December 2007, 14.

<sup>9</sup> Medicare Payment Advisory Commission, "Report to the Congress: Medicare Payment Policy," March 2008, 84.

<sup>10</sup> Karen Davis and Sarah R. Collins, "Medicare at Forty," *Health Care Financing Review*, Winter 2005-2006, 27(2): 53-62.

<sup>11</sup> Robert A. Berenson and Bryan E. Dowd, "Medicare Advantage Plans At A Crossroads--Yet Again," *Health Affairs* Web Exclusive, November 24, 2008, 35.

<sup>12</sup> Congressional Budget Office, *Geographic Variation in Health Care Spending*, Feb. 2008.

<sup>13</sup> USNews.com, *Health Insurance Plans That Hide Their Data*, Nov. 7, 2008.

<sup>14</sup> Marilyn Moon, Urban Institute, "Solvency and Affordability in Medicare," Testimony before the Health Subcommittee, Committee on Energy and Commerce, April 9, 2003, 8.