

A Public Health Insurance Plan: Reducing Costs and Improving Quality

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Executive Summary

President Barack Obama, Senate Finance Committee Chairman Max Baucus and others have proposed frameworks for reforming the health care system that would allow Americans to keep their employer-provided coverage or, if they do not have such coverage obtain it through a public or private insurance plan that is available through a “national health insurance exchange,” where plans would compete with each other for members.¹ Like the public fee-for-service Medicare plan, the new public health insurance plan in this exchange would be managed by the federal government but would pay private health care providers to deliver care.

This report explains why a public health insurance plan that competes on a level playing field with private insurance plans in an exchange offers the best promise for reining in health care costs, encouraging greater efficiency and quality, and providing people with financial security. Moreover, authoritative studies show that the savings that can be achieved by insuring millions of people in a public health insurance plan may be enough to pay for covering the 46 million Americans currently without insurance.

The findings in this report are based on comparing information that is available about Medicare’s public health insurance plan (the traditional fee-for-service program); Medicare Advantage plans, which are run by private insurers; and the Federal Employees Health Benefits Program, which offers private insurance through an exchange only available to federal employees.

This report highlights the proven track record of significant cost savings that have been achieved under Medicare’s public health insurance plan relative to private insurance and ways to improve upon Medicare in constructing a new public health insurance plan for people under age 65.

This report contains the following findings:

Medicare has controlled health care costs much better than have private health insurers over the last 25 years

- Private health insurance spending per enrollee grew 29 percent faster than Medicare spending between 1983 and 2006, and it grew 59 percent faster than Medicare spending between 1997 and 2006, according to Centers for Medicare and Medicaid Services (CMS) data. The spending was for comparable benefits. The beginning of these two time periods – 1983 and 1997 – correspond to major reforms to Medicare’s provider payment policies designed to deliver greater value for our health care dollar.
- The annual rate of “excess growth” in health spending for elderly people, nearly all of whom are covered by Medicare, has plummeted since the 1970s whereas “excess growth” in health spending for the non-elderly, most of whom have private insurance, has risen sharply, according to a study published in *Health Affairs*. Excess spending growth is the amount spent per person above the amount the economy grows (GDP and accounting for population aging). It is best for health care spending not to exceed the rate of growth of the economy otherwise it can become unaffordable. For the elderly, excess spending growth was just 0.3 percent from 1996-2004, whereas excess spending growth among the non-elderly was 3.4 percent.

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- The Federal Employees Health Benefits Program (FEHBP), which is a health insurance exchange for private plans only, is often touted as a model for how to structure a health insurance exchange under a reformed system. Yet, the annual growth per enrollee in private plan premiums under FEHBP was 26 percent higher between 1985 and 2002 (the latest years available) than the growth in premiums under Medicare for a common set of benefits, according to a study published in *Health Affairs*. FEHBP plan premiums rose at the same pace as private insurance premiums, suggesting that it is the type of insurance plan (public or private), rather than the functioning of the exchange, that curbs spending.
 - Despite Medicare's relative success in slowing the growth of its spending compared with private insurance, people with Medicare report better access to routine care than people that are privately insured. A Medicare Payment Advisory Commission (MedPAC) study found that 75 percent of people with Medicare reported "never" having a delay in access to routine care in 2007 compared with 67 percent of people in private health plans.

The private insurance market is highly consolidated and needs competition from a public health insurance plan to lower skyrocketing premiums

- In 16 states the dominant carrier accounts for at least 50 percent of private insurance enrollment, and in 40 states the top three carriers account for between 60 and 100 percent of the market, according to a study published in *Health Affairs*. The membership of UnitedHealth and WellPoint grew from 32 million in 2000 to 67 million in 2007, or 36 percent of the national market for commercial health insurance, according to the American Medical Association. In this increasingly consolidated insurance market, employer-paid premiums have increased an average of 9 percent a year since 1999.
- Dominant insurers are not driving hard bargains for reduced prices from hospitals because insurers want to offer their customers access to flagship hospitals, which are not reducing their rates to private carriers. Hospital system consolidation has made it difficult for insurers to negotiate the best prices the way Medicare's public health insurance plan does. But large insurer profits show that companies can make money regardless of whether they can reduce health care costs so they have limited incentive to do so.
- Increased concentration of private insurance is resulting in record profits and CEO pay. The combined profits of 14 of the country's largest private health insurance companies rose from \$3.5 billion in 2000 to \$15 billion in 2007 – an increase of 330 percent, according to company Securities and Exchange Commission filings. At the same time, the CEOs at the health insurance companies were compensated a combined \$147.6 million in 2007 – an average of \$10.5 million each. This is 259 times more than the \$40,690 an average worker made that year.
- A public health insurance plan that competes with private plans on a level playing field will inject competition into what has become a consolidated and uncompetitive insurance market, thereby reining in costs.

Administrative costs are dramatically lower under public health insurance plans, resulting in enormous savings to the system

- The administrative costs and profits of Medicare Advantage plans, which are run by private insurance companies, accounted for 11 percent of spending in 2005, according to the Congressional Budget Office (CBO). By comparison, Medicare's public health insurance plan, which insures a similar population to Medicare Advantage, had administrative costs of less than 2 percent. A recent GAO study found an even bigger gap

in 2006 – private Medicare Advantage plans spent 16.7 percent of their revenue on administrative costs (10.1 percent) and profits (6.6 percent).

- The administrative costs of private insurance plans under FEHBP are much higher than Medicare's, averaging between 7 percent and 15 percent, depending on the type of private plan, according to a Henry J. Kaiser Family Foundation study.
- Private health insurance industry spending for administration and profits jumped 12 percent *a year* from 2000 to 2005, according to CMS data analyzed by the Commonwealth Fund. This was 40 percent faster than overall health expenditure growth of 8.6 percent and 50 percent faster than hospitals' and physicians' spending growth.
- Private health insurance industry employment grew 52 percent from 1997 to 2007, according to Bureau of Labor Statistics data. During the same time, enrollment in private health insurance plans (including both employer-sponsored and individually purchased insurance for those under 65) grew by just 3.4 percent. Moreover, employment of physicians, nurses and other health care providers grew by 26 percent, and employment in the overall economy grew by just 12 percent.

Bargaining power of public health insurance plans significantly reduces provider costs

- The public Medicare plan pays hospitals about 25 percent less than private insurers pay for comparable benefits, according to MedPAC. Yet, virtually all hospitals participate with Medicare. Despite complaints about Medicare payment rates, U.S. for-profit hospitals reported \$43 billion in profits in 2007, their best single-year jump in profits in at least 15 years, according to the American Hospital Association.
- Analysts believe that dominant insurers are not driving a hard bargain for reduced prices from hospitals. This is because hospital system consolidation has made it difficult for insurers to negotiate the best prices the way Medicare does with its larger market share. Experts have found that nearly 9 out of 10 metropolitan areas are considered highly concentrated hospital markets, which can push up inpatient hospital costs by as much as 40 percent in some markets.
- Hospitals and insurance companies claim that Medicare's much lower prices result in a shifting of costs to the private sector. MedPAC has concluded that Medicare prices are appropriate to force hospitals to be more efficient and better control their costs. CBO has found that, in all probability, hospitals shift substantially less than half of the costs of reductions in public payment rates to private insurers. An authoritative study estimated that at most 17 percent of the Medicare public health insurance plan's lower hospital costs were shifted onto private payers.
- Medicare pays physicians 19 percent less than private insurers for comparable services, according to MedPAC. Yet, 97 percent of all doctors are taking new Medicare public health insurance plan patients, virtually the same rate as are accepting private PPO patients, which have a much more limited network of doctors. Moreover, the number of physicians billing Medicare is growing substantially faster than enrollment growth in Medicare Part B, which pays for physician services.
- MedPAC has found that patient access to physicians is about the same under the public Medicare plan as it is for those with private insurance who are 50 to 64. Moreover, lower payment rates to physicians have not affected patient satisfaction. AARP found that 80 percent of people with Medicare are either "extremely" or "very satisfied" with their

health care and access to physicians, a higher rate than for 50 to 64 year olds with private insurance.

- Drug prices are much lower under public health insurance plans. CBO has found that drug prices under four federal programs – including Medicaid – receive price discounts averaging 49 percent. There is no comparable data for drugs under Medicare Part D, a program under which only private insurers provide prescription drug coverage. However, Medicare’s Part D plans negotiated drug manufacturer rebates of only 8.1 percent in 2007, much less than Medicaid’s 26 percent rebates, according to a congressional study.

In a head-to-head competition, the public Medicare plan is much better at containing costs than private Medicare Advantage plans

- Private Medicare Advantage plans are being paid 14 percent more than Medicare’s public health insurance plan for providing comparable coverage in 2009, according to MedPAC. This costs nearly \$1,250 more per Medicare beneficiary per year.
- CBO has found that private Medicare Advantage plans are no more cost-effective than the public Medicare plan, but that those enrolled in Medicare’s public health insurance plan are at greater risk of health problems and therefore *more costly* to cover.
- The private Medicare Advantage FFS plans, which are allowed to pay physicians at the public Medicare FFS rates, are being paid 18 percent more in 2009 than it would cost to cover the same people under Medicare’s public health insurance plan. This is costing taxpayers an extra \$1,368 a year for each of the 2 million people in these private plans.
- The private Medicare Part D prescription drug program has administrative expenses that are almost six times higher – 9.8 percent vs. 1.7 percent – than the public Medicare plan, according to a congressional study.

Independent analyses show substantial savings can be achieved from a public health insurance plan that competes with private insurance plans

The Lewin Group, a premier national health care consulting firm, has estimated the effects of two proposed reform plans that would let employers continue to provide coverage through private insurance plans and would create a health insurance exchange where individuals and small businesses could get coverage either through a private or a new public health insurance plan for people under 65. Lewin estimates that covering 97 percent of the 46 million who are uninsured would cost about \$50 billion a year, but the additional costs would be largely offset through lower administrative costs and lower provider reimbursements under the public health insurance plan. Enrollment in the new public plan would be about 40 million, but employers would still provide most of the coverage through private plans.

Quality and effectiveness innovations occurring under the public Medicare plan show that public health insurance plans have greater potential to drive the quality revolution than do private plans

The quality and effectiveness innovations occurring in the public Medicare plan combined with its power in the marketplace shows why public health insurance plans overall have greater potential to drive the quality revolution than do private plans, although the best outcomes will be achieved if public and private plans work together as partners. MedPAC, Senate Finance Committee Chairman Max Baucus and others have made a host of recommendations about how to reform the Medicare system, many of which are underway or under development and could be quickly adopted by a new public health insurance plan for those under 65. They include:

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- Developing practice guidelines and quality measurements for value-based purchasing.
 - Requiring public reporting by providers of quality indicators to help purchasers and payers get maximum value.
 - Testing the effectiveness of new technology.
 - Developing a pay-for-performance system based on quality outcomes.
 - Finding alternatives to the fee-for-service based system – shifting from a system that rewards providers for volume of services to one that rewards for better outcomes.
 - Shifting payment methods and rates to better reward primary care providers and to increase their supply while decreasing the oversupply of specialty physicians, who are escalating costs without necessarily improving quality.
 - Building a system based on coordinated care for those with chronic diseases, rather than maintaining our current fragmented care.
 - Removing wide geographic variations in care from one region of the country to another, which are largely driven by a community’s supply of specialists and technology rather than the services patients actually need.

If Congress wants to drive value in the health care system, it can design a new public health insurance plan offered in an exchange that will be best positioned to lead these efforts because:

- The large market share of a new public health insurance plan for people under 65 will have the resources and power to reshape market practices to promote quality and cost effectiveness.
- Public health insurance plans have more incentive than private plans to improve quality in order to curb costs because they operate under tight fiscal constraints and cannot pass their costs along to private payers, such as employers, as insurance companies can do.
- Public health insurance plans operate in the open and are widely scrutinized by the government, providers and the media. Private insurers operate mostly in secret, which limits accountability and the ability of others to learn lessons about containing costs and improving quality.
- Participation in public health insurance plans is much more stable for enrollees as well as for providers. As a result, a new public health insurance plan for those under 65 has much greater potential to reap the rewards of investments in prevention and general health improvement that require up-front spending but reduce long-range costs, particularly since most people will eventually be covered by Medicare.
- Private insurers try to avoid covering people with chronic and costly health problems. A public health insurance plan has no incentive to avoid higher-risk individuals, and is therefore better positioned to test and implement best treatment methods and widely disseminate them.
- Private insurers have limited incentive to conduct comparative effectiveness research and disseminate their findings; it is very expensive and the benefits of finding cost-saving protocols if made public are not theirs alone.

Public health insurance plans increase choice, competition and accountability

- A public health insurance plan offers people more choice: an alternative to private insurance as well as broader access to health care providers.
- A public health insurance plan will promote competition, which will place an important check on both public and private plans.

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- A public health insurance plan will promote accountability and transparency because it must meet the test of democratic support, whereas the billing, payment, claims and outcomes data and care management practices of private plans are largely proprietary.

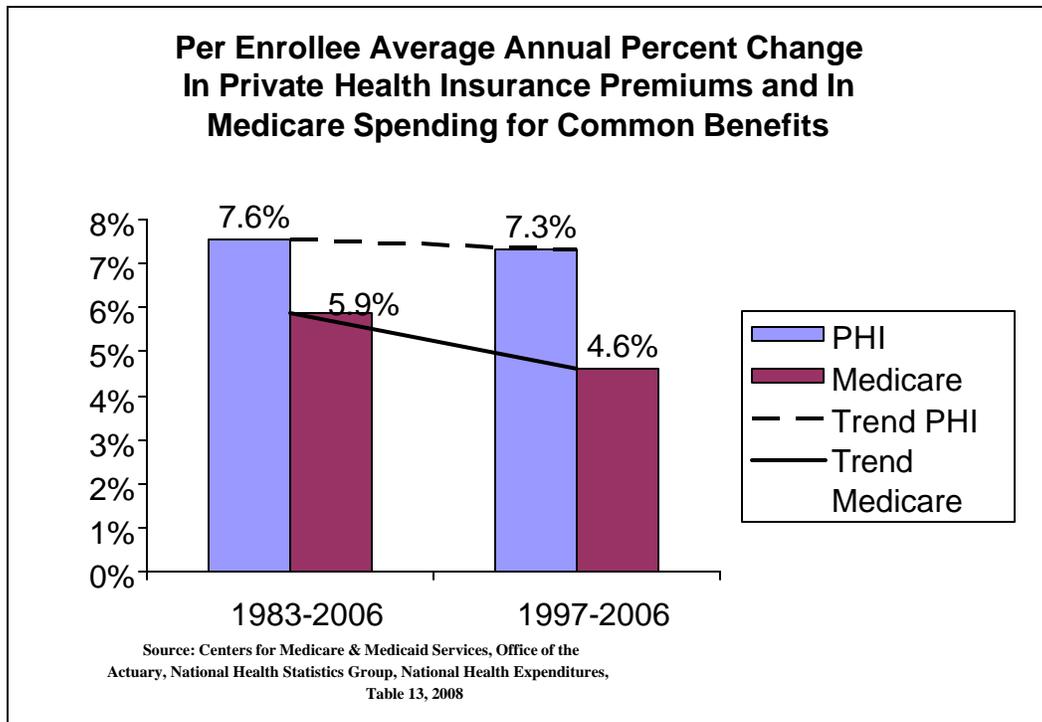
A New Public Health Insurance Plan is Essential to Contain Costs

Medicare has controlled health care costs much better than have private health insurers over the last 25 years

The most obvious advantage of a new public health insurance plan is that it would save large sums of money because it is relatively inexpensive to administer and it has the market leverage to secure better rates with providers. The track record of the public Medicare plan compared with private health insurance bears this out.

- **Private health insurers' average annual spending *per enrollee* grew 29 percent faster than Medicare spending between 1983 and 2006, and it grew 59 percent faster than Medicare between 1997 and 2006.** Centers for Medicare and Medicaid Services data shows that private health insurance spending per enrollee for comparable benefits grew an average of 7.6 percent a year between 1983 and 2006 compared with Medicare's growth of 5.9 percent, or 29 percent more. Between 1997 and 2006 private health insurance spending per enrollee grew an average of 7.3 percent compared with Medicare's growth of 4.6 percent, or 59 percent more.² [See Figure 1]

Figure 1



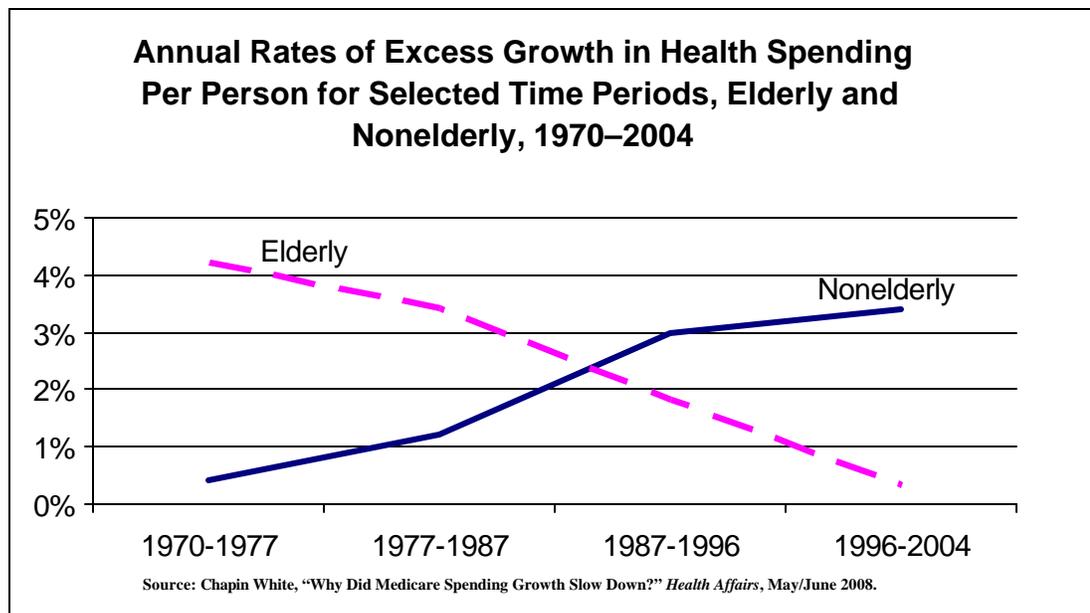
Medicare’s substantial cost savings over the last quarter century compared with private insurance track the introduction of changes in hospital payment policies using a prospective payment system in 1983 and the introduction in the mid-1990s of controls on overall Medicare physician spending.³

Figure 1 also shows that the rate of change per enrollee is on a much steeper downward trajectory under Medicare than under private insurance. Medicare spending per enrollee declined 22 percent between 1983-2006 and 1997-2006. Spending for private insurance declined 4 percent between the comparable periods.

- **The annual rate of “excess growth” in health spending for elderly people, nearly all of whom are covered by Medicare, has plummeted compared with that for the non-elderly, most of whom have private insurance.** Excess spending growth is the per capita cost growth in excess of overall economic growth (GDP and accounting for population aging). It is best for health care spending not to exceed the rate of growth of the economy otherwise it can become unaffordable.

For the elderly, excess spending growth plummeted from 4.2 percent during the 1970s to 0.3 percent during 1996-2004, according to a *Health Affairs* article. By comparison, excess spending among the non-elderly rose from 0.4 percent in the 1970s to 3.4 percent during 1996-2004. The dramatic slowdown in the elderly’s excess growth is attributed to Medicare’s strong bargaining with providers, especially with hospitals. The increase in Medicare managed care enrollment, changes in Medicare cost-sharing and system-wide spending trends played little role.⁴ [See Figure 2]

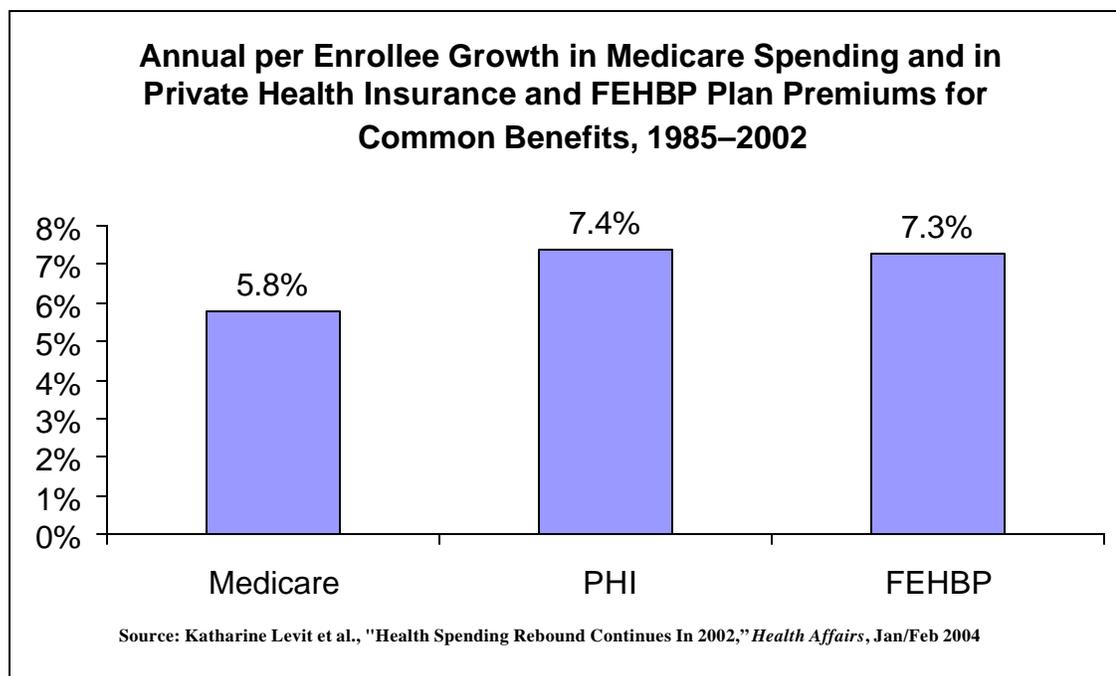
Figure 2



- Annual growth in private plan premiums per enrollee under the Federal Employees Health Benefits Program has been 26 percent faster than the growth in premiums under Medicare for a common set of benefits.** Some proponents of health care reform suggest a national health insurance exchange should be created that offers a choice of private plans only similar to FEHBP, which excludes competition with a public health insurance plan. This would be a mistake for numerous reasons, among them the much higher growth in the cost of getting coverage for each enrollee under FEHBP compared with Medicare. FEHBP private plans' annual premium growth rate per enrollee was 7.3 percent from 1985 to 2002 (the most recent year for which comparable data was available), whereas Medicare spending per enrollee climbed 5.8 percent a year during the same period.⁵ [See Figure 3]

What is also significant about these findings is that FEHBP plans' premiums rose at virtually the same pace as other private insurance premiums, suggesting that it is the type of plan (private vs. public), rather than how the exchange functions, that curbs spending.

Figure 3



- Despite Medicare's relative success in slowing the growth of its health care spending, people with Medicare have not gone without needed care compared with those younger than 65 in private insurance plans.** A MedPAC study found that 75 percent of people with Medicare reported "never" having a delay in access to routine care in 2007 compared to 67 percent of people in private health plans. Conversely, only 3 percent of people in both Medicare and in private plans said they "always" had a delay in access to routine care. And only 10 percent of people with Medicare said they should have seen a doctor for a medical problem but did not, compared to 12 percent of people in private health plans.⁶

The private health insurance market is highly consolidated and needs competition from a public health insurance plan to lower skyrocketing premiums

- **The private insurance market is highly concentrated.** In 16 states the dominant carrier accounts for at least 50 percent of private insurance enrollment, according to a study in *Health Affairs*. In 40 states the top three carriers account for between 60 and 100 percent of the market.⁷ The American Medical Association has found that the membership of the top two insurers, UnitedHealth and WellPoint, grew from 32 million in 2000 to 67 million in 2007 – 36 percent of the national market for commercial health insurance.⁸
- **Private health insurance companies have a poor track record controlling premiums.** From 1999 to 2008, employer-provided health insurance premiums for families increased 119 percent – an average of 9 percent a year.⁹
- **Dominant insurers are not driving a hard bargain for reduced prices from providers.** Urban Institute researchers point to four reasons why insurers are not driving a hard bargain with providers: Insurers need to offer their customers access to flagship hospitals, which are not reducing their rates to private carriers; small insurers follow the premium pricing structure of large insurers, rather than compete on price, and the industry as a whole competes based on limiting risk by marketing to the healthiest people; there is little information to help consumers choose among insurers based on benefits, price and quality; and hospital system consolidation, which limits competition, has made it difficult for insurers to negotiate the best prices the way the public Medicare plan does.¹⁰
- **Increased concentration of private insurance is resulting in record profits and CEO pay.** Profits at 14 of the country's largest private health insurance companies rose from \$3.5 billion in 2000 to \$15 billion in 2007 – an increase of 330 percent, according to company Securities and Exchange Commission filings. [See Figures 4 and 5] At the same time, the CEOs at these health insurance companies were compensated a combined \$147.6 million in 2007 – an average of \$10.5 million each. [See Figure 5] This is 259 times more than the \$40,690 an average worker made that year.¹¹
- **Private plans need competition from a public health insurance plan to lower rates.** The huge run-up in insurance company premiums and profits in recent years shows that the industry can make money regardless of whether it succeeds at reducing health care costs, so companies have limited incentive to do so. A public health insurance plan that competes with private plans on a level playing field will help to drive competition and rein in premiums in an increasingly consolidated insurance market.

Figure 4

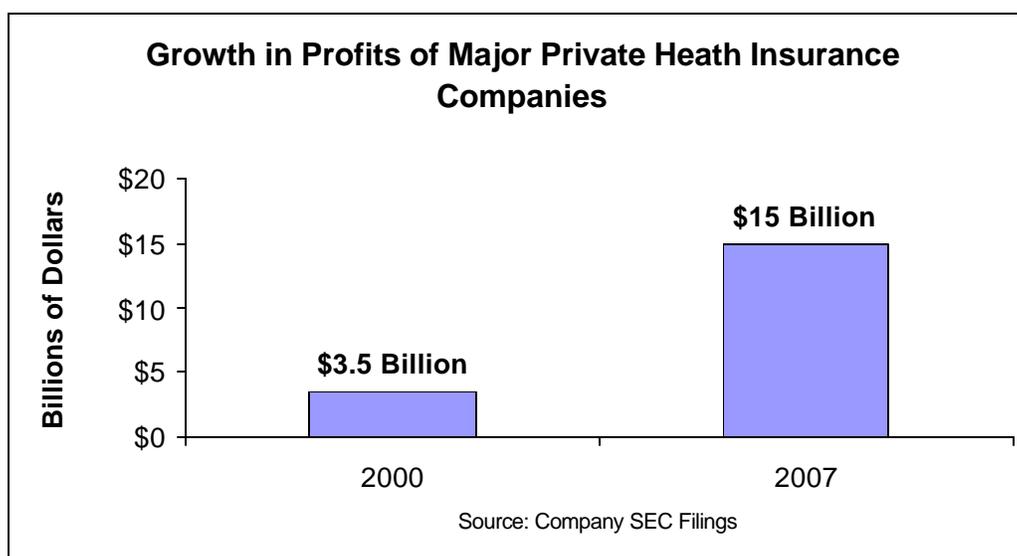


Figure 5

Profits and CEO Compensation for Major Private Health Insurance Companies

Company	2000 Net Income \$ Millions	2007 Net Income \$ Millions	% Change 2007 vs. 2000	CEO	Value of Total Compensation \$ Millions
Aetna	\$127.1	\$1,831.0	1,340.6%	Ronald A. Williams	\$23.0
Amerigroup Corporation	\$18.8	\$116.5	519.2%	Jeffrey L. McWaters	\$8.2
Centene Corporation	\$7.2	\$73.4	914.4%	Michael F. Neidorff	\$8.8
CIGNA Corporation	\$987.0	\$1,115.0	13.0%	H. Edward Hanway	\$25.8
Coventry Health Care	\$61.3	\$626.1	920.7%	Dale B. Wolf	\$14.9
Health Net	\$163.6	\$193.7	18.4%	Jay M. Gellert	\$3.7
Humana	\$90.1	\$833.7	825.8%	Michael McCallister	\$10.3
Principal Financial Group	\$358.8	\$860.3	139.8%	J. Barry Griswell	\$11.8
Sierra Health Services*	-\$199.9	\$94.1	147.0%	*	*
Torchmark Corporation	\$362.1	\$527.5	45.7%	Mark S. McAndrew	\$4.7
UnitedHealth Group	\$736.0	\$4,654.0	532.3%	Stephen J. Hemsley	\$13.2
Universal American	\$22.9	\$84.1	267.4%	Richard A. Barasch	\$1.6
Unum Group	\$538.9	\$679.3	26.1%	Thomas R. Watjen	\$7.3
WellPoint	\$226.0	\$3,345.4	1,380.3%	Angela F. Braly	\$9.1
WellCare Health Plans**	**	**	**	Todd S. Farha	\$5.3
Total	\$3,499.9	\$15,033.9	329.6%		\$147.6

Source: Company SEC filings. The companies are listed in the Corporate Library's "Insurance Health and Disability" category.

All of these companies, with the exception of Torchmark, are members of America's Health Insurance Plans.

*Sierra Health Services has been acquired by UnitedHealth Group.

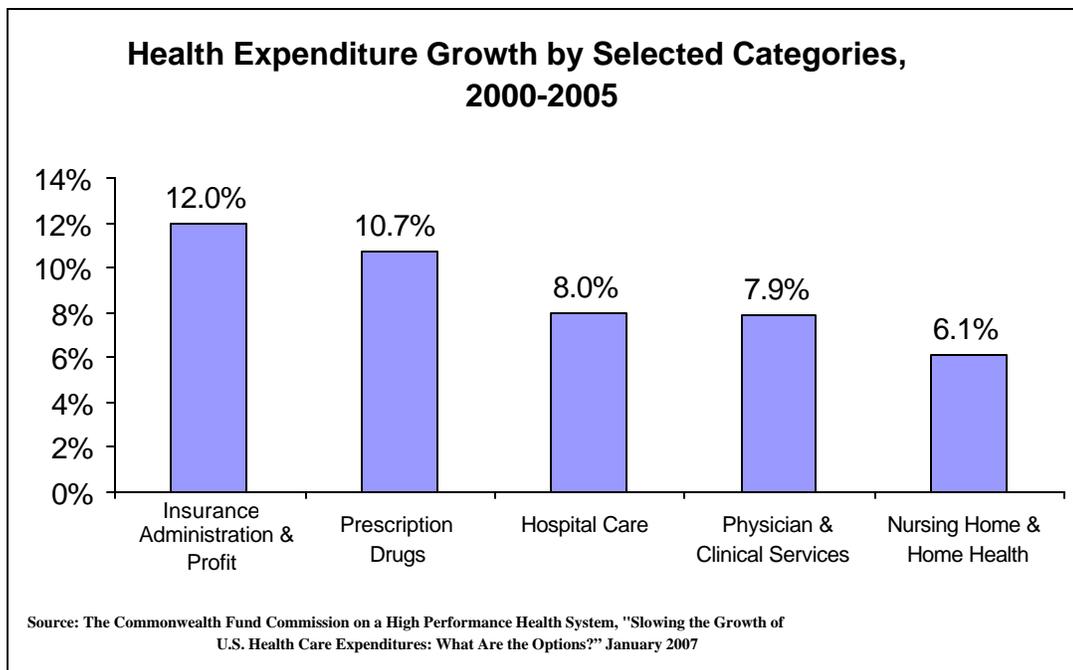
**WellCare Health Plans did not exist in 2000 and it has not filed quarterly or annual reports since 2007 when its offices were raided by the FBI. Its CEO compensation figure is from 2006.

Administrative costs are much lower under public health insurance plans

Public insurance plans are much less expensive to administer compared with private insurance plans.

- **Medicare’s administrative costs are about one-fifth those of private insurance.** The Congressional Budget Office has found that administrative costs, including profits, of all private insurance plans average about 12 percent – with small group plans and individual plans eating up 26 percent and 30 percent of each premium dollar, respectively.¹² CBO has also found that the administrative costs and profits of private Medicare Advantage plans accounted for 11 percent of spending in 2005. By comparison, Medicare’s public health insurance plan, which insures a similar population to Medicare Advantage, has administrative costs of less than 2 percent.¹³ A recent GAO study found an even bigger gap in 2006 – private Medicare Advantage plans spent 16.7 percent of their revenue on administrative costs (10.1 percent) and profits (6.6 percent).¹⁴
- **FEHBP private plans’ administrative costs are much higher than Medicare’s costs.** The administrative costs of PPOs participating in FEHBP, which is just private plans, averages 7 percent, not counting the costs of federal agencies to administer enrollment of employees, according to a Henry J. Kaiser Family Foundation study. HMOs participating in FEHBP have administrative costs of 10 to 15 percent.¹⁵
- **The fastest rising component of health care spending is private insurance administrative overhead and profits.** CMS data analyzed by the Commonwealth Fund found that private health insurance (PHI) industry spending for administration and profits jumped 12 percent a year from 2000 to 2005. This was 40 percent faster than overall health expenditure growth of 8.6 percent, and it was 50 percent faster than growth in spending for hospitals and physicians.¹⁶ [See Figure 6]

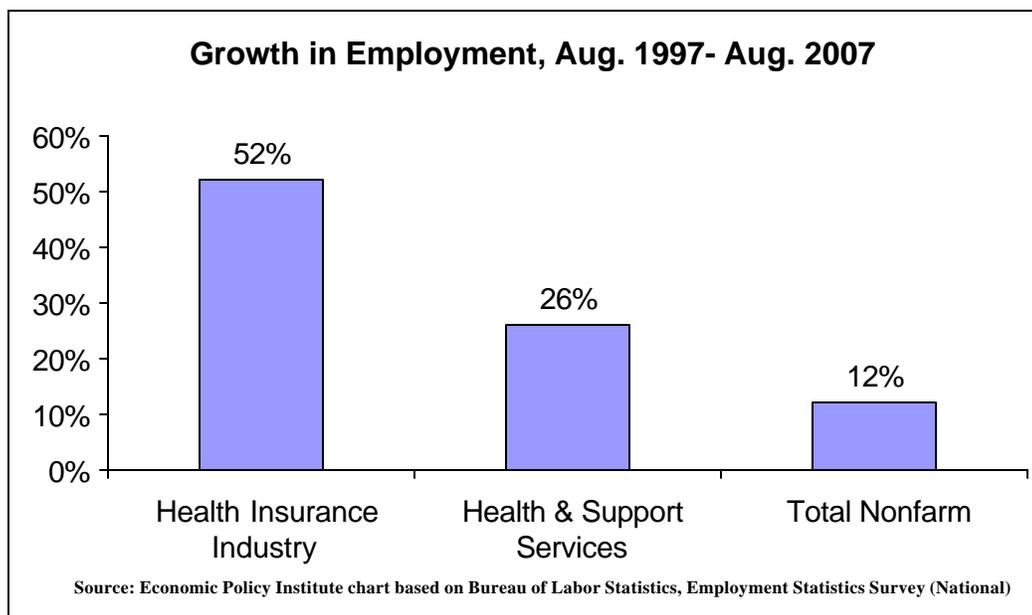
Figure 6



- Private health insurance industry employment grew 52 percent in the last 10 years.** The private health insurance industry needs employees to market its products, determine who to cover and carefully review claims. Remarkably, employment in the private health insurance industry grew 52 percent between 1997 and 2007, from 293,000 to 444,000. During the same time, employment of physicians, nurses and other health providers grew by 26 percent, and employment in the overall economy grew by just 12 percent.¹⁷ [See Figure 7]

This surge in insurer employees was not matched by a surge in enrollment. Between 1997 and 2007, enrollment in private health plans (including both employer-sponsored and individually purchased insurance for people under 65) rose by just 3.4 percent, from 174 million to 180.4 million, according to the Employee Benefit Research Institute.¹⁸

Figure 7



Bargaining power of public health insurance plans significantly reduces provider costs

The dramatically lower annual growth in spending per Medicare enrollee compared with that of private health insurance over the last quarter century is a testament to the strong bargaining power of a public health insurance plan and the program’s ability to reform payment systems. Medicare has led the effort to make payment system innovations, including moving payment for hospital inpatient services away from fee-for-service to prospective payment. Medicare’s physician payment system, which has flaws that Congress is preparing to fix, also has been widely adopted by private plans.¹⁹ But private insurers clearly lack Medicare’s market share to negotiate comparable price reductions or system reforms.

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- **Medicare secures much better hospital rates than private insurers and the hospitals participate.** Medicare saves about 25 percent on its hospital payments for comparable services relative to private insurers, according to MedPAC,²⁰ yet virtually all hospitals participate with Medicare. Despite complaints about Medicare payment rates, U.S. for-profit hospitals reported \$43 billion in profits in 2007, their best single-year jump in profits in at least 15 years, and an overall profit margin of 6.9 percent.²¹
 - MedPAC has found that the much higher costs of private insurers were because “hospitals had regained the upper hand in price negotiations due to hospital consolidations and consumer backlash against managed care.”²²
 - Experts have found that nearly 9 out of 10 metropolitan areas are considered highly concentrated hospital markets, as defined by government measures. The merger of hospitals has raised inpatient hospital costs by at least 5 percent in less concentrated markets but by as much as 40 percent in markets where merging hospitals are located nearby. This concentration has limited insurer ability to secure price breaks similar to those that public health insurance plans have been able to secure.²³
 - Hospitals and insurance companies claim that Medicare’s much lower prices result in a shifting of costs to the private sector. But, in reviewing the evidence on hospital pricing, MedPAC has concluded that the public Medicare plan should not emulate the private sector in pricing. It notes that “hospital costs and Medicare profitability vary widely. Some hospitals are efficient enough to have low costs, positive Medicare margins, and high quality scores. Other hospitals have higher costs and lower Medicare margins. The Commission finds that, because of high private-payer payment rates, those hospitals often face little financial pressure to control their costs. Medicare should encourage hospitals to be efficient and control their costs, rather than accommodate high cost-growth resulting from lack of financial pressure.”²⁴
 - Studies of cost shifting by the public Medicare plan onto private payers have shown mixed results.²⁵ The general conclusion is that there is some price shifting, though a much smaller amount than suggested by critics of Medicare pricing. CBO has found that “[t]he available evidence indicates that hospitals shift less than half of the costs of reductions in public payment rates to insurers – and in all probability, substantially less.”²⁶ That finding is consistent with a 2006 study of hospital cost-shifting in Medicare, which concluded that “a 1 percent relative decrease in the average Medicare price is associated with a 0.17 percent increase in the corresponding price paid by privately insured patients.”²⁷ In other words, around 17 cents of every dollar in relative reductions in public Medicare plan payments to private hospitals are shifted onto private payers.
 - **Medicare secures much better physician payment rates than private insurers and physicians participate.**
 - **Medicare physician payments were 19 percent less than rates paid by private insurers in 2006 for comparable services yet doctor participation is growing, according to MedPAC.**²⁸ MedPAC found that 97 percent of physicians are accepting
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- some new public Medicare patients – virtually the same rate as are accepting private PPO patients,²⁹ even though PPO plans have a much more limited network of participating providers. Moreover, the number of physicians billing Medicare is actually increasing faster than enrollment in Part B, which pays for physician services. From 2001 to 2006, Part B enrollment rose by 6.9 percent but the number of physicians with 15 or more Medicare patients grew by 8.7 percent, and physicians with 200 or more Medicare patients grew by 12.9 percent.³⁰
- **Patient access to physicians is about the same under Medicare as for those with private insurance who are 50 to 64.** A 2007 MedPAC survey found that people with Medicare found it easier to get routine care than did those with private insurance (75 percent vs. 67 percent). Medicare patients also found it easier to see a specialist (85 percent vs. 79 percent). However, those with private insurance found it easier to see a primary care physician (82 percent vs. 76 percent).³¹
 - **Lower payment rates to physicians have not affected patient satisfaction.** AARP found that 80 percent of people with Medicare are either “extremely” or “very satisfied” with their health care and access to physicians, a higher rate than for 50- to 64-year olds with private health insurance. People with Medicare were more likely to say they never had to wait for doctors’ appointments. Nine out of 10 people with Medicare said they had “no problem” finding a doctor or a specialist to treat them.³²
 - **Medicare’s physician payment system still needs significant reform.** The physician participation rates and patient satisfaction rates are very strong. But, it is generally acknowledged that the Medicare Sustainable Growth Rate payment system is not working for doctors and for the program as a whole and needs to be reformed.
 - **Drug prices are much lower under public health insurance plans.** CBO has found that drug prices under four federal programs – including the Veterans Administration (VA) and Medicaid – receive price discounts averaging 49 percent.³³ There is no comparable data for Medicare Part D, a program under which only private insurers provide prescription drug coverage. However, Medicare’s private plans negotiated drug manufacturer rebates of only 8.1 percent in 2007, much less than Medicaid’s 26 percent rebates, according to a congressional study.³⁴ Moreover, the lowest prices available for the top 20 drugs prescribed to seniors were 58 percent cheaper under the VA plan than under Medicare Part D.³⁵

Medicare’s public health insurance plan costs much less than Medicare’s private plans

Medicare is essentially running a head-to-head competition between its public health insurance plan and private plans under Medicare Advantage – and the public health insurance plan is winning. This despite a CBO finding that people in Medicare’s private plans had a 6 percent to 12 percent less risky health status than those in the public health insurance plan – meaning they were less costly to care for.³⁶

Private plans were added to the Medicare program with the promise that they would make health care delivery more efficient and less costly. The expectation was that those more efficient plans would be able to offer people better benefits and thereby attract more patients. But the program has actually encouraged inefficiency, according to MedPAC, by providing excessive payments that allow the private plans to provide extra benefits to attract new patients, rather than have the private plans pay for those extra benefits through greater efficiency.³⁷

- MedPAC has found that Medicare Advantage's private managed care plans, which compete with the public Medicare plan, are being paid an average of 14 percent more per person for comparable coverage in 2009,³⁸ or nearly \$1,250 more each.³⁹
- CBO reports that the private plans are no more cost-effective than the public Medicare plan.⁴⁰ The extra payments are used to reduce individual cost-sharing and premiums and to increase benefits. Without such inducements, enrollment in Medicare Advantage plans would plummet.⁴¹ Even with those inducements, the vast majority of people with Medicare (more than 75 percent) continue to choose the public plan over the private Medicare Advantage plans. Moreover, it is estimated that the overpayments to private plans have significant implications for Medicare's fiscal sustainability. For example, CMS estimates that Medicare's hospital trust fund will be exhausted 18 months sooner because of the overpayments,⁴² and it will accelerate if private plan enrollment grows.
- A recent GAO study found that private Medicare Advantage plans reaped \$1.3 billion more in profits than they originally claimed they would in 2006 – a jump of 61 percent over what they had projected. As discussed earlier, the GAO also found that the companies spent 16.7 percent of their revenue on administrative costs (10.1 percent) and profits (6.6 percent) in 2006.⁴³
- Private Medicare Advantage fee-for-service (PFFS) plans account for about 60 percent of Medicare Advantage's total enrollment growth.⁴⁴ They are allowed to pay physicians at the public Medicare plan's FFS rates, but they are being paid 18 percent more than it would cost to cover the same people under the public health insurance plan in 2009, according to MedPAC.⁴⁵ This is costing Medicare an extra \$1,368 each a year for two million enrollees.⁴⁶ According to MedPAC, "PFFS plans are nearly identical to Medicare FFS but with an added layer of marketing, operating and administrative costs, and profits."⁴⁷ Even with these much higher rates private plans are lagging well behind Medicare Advantage PPO and HMO plans in quality measures, MedPAC has found.⁴⁸
- The Medicare Part D prescription drug program, which is only available through private insurers, has administrative expenses, sales costs and profits that were almost six times higher than Medicare's public health insurance plan – 9.8 percent vs. 1.7 percent – according to a congressional study.⁴⁹
- Medicare Part D is not holding down drug prices. According to AARP, the average annual increases for brand name drugs most commonly used by people with Medicare were 7.3 percent in 2006 and in 2007, after the Part D program kicked in. The average price between 2003 and 2005 was less – about 6.4 percent.⁵⁰

Huge Savings Can Be Achieved Through a Public Health Insurance Plan Competing With Private Plans

In 2007 and 2008, three significant health care reform plans were proposed that are similar in approach and included public health insurance plans – from President Obama, Jacob Hacker’s Health Care for America Plan published by the Economic Policy Institute, and The Commonwealth Fund. All three proposals would maintain a strong private insurance market for employers to continue providing private coverage and for individuals to enroll in private coverage under a national exchange while creating a public insurance plan with broad risk pooling primarily to serve individuals and small businesses. The plans offer a generous benefits package, require most employers to provide coverage for their employees or pay into a public fund, and offer subsidies to small businesses and individuals to help provide coverage.

The Lewin Group, a premier national health care consulting firm, has estimated the effects of the three plans.

President Obama’s Plan

The Obama plan, which he proposed during the Democratic primary campaign, assumes that most people who currently get coverage through their employer will continue to do so. Those individuals without insurance or who are self-employed or employed by a small business will be able to buy coverage through a national health insurance exchange, which offers a selection of private plans and a new publicly-operated insurance program. Obama’s plan would reduce the number of uninsured by about 26.6 million people. Lewin estimates the number of people getting coverage under the public health insurance plan would be about 32 million and most Americans under 65 would still get their coverage through employer-sponsored plans.⁵¹

Jacob Hacker/Economic Policy Institute Plan

The Hacker/EPI plan requires employers to provide coverage to their workers through private insurance or self insurance, or to pay for their employees health through a national insurance pool that would offer a public Medicare-like fee-for-service option (with a requirement that enrollee care be coordinated through a medical home) and private HMO and other managed care options. Lewin’s analysis of the Hacker/EPI plan found that premiums would be 23 percent lower than comparable private insurance for the same set of benefits for the same population. It estimated that nearly everyone would be covered, with about 40 million moving from private insurance into the new public health insurance plan (not including those with Medicaid) and about 150 million with employer-sponsored coverage and other forms of private insurance. Lewin estimated increased spending of \$53 billion to cover the uninsured and underinsured. This would be

paid for with \$25 billion in administrative savings, \$21 billion in savings from requiring patient use of a medical home and from drug discounts, and \$29 billion in lower payments to providers, much of which they would recover through payments for previously uncompensated care. While overall national health spending would remain the same, federal spending would increase by about \$50 billion a year as the burden is reduced on households and state and local governments.⁵²

The Commonwealth Fund Plan

The Commonwealth Fund proposed establishment of a Medicare-like public health insurance plan for people under 65, along with a choice of private plans offered through an insurance “connector” open to businesses with fewer than 100 employees, the self-employed and everyone without Medicare or large-employer insurance. Lewin’s analysis of the public health insurance plan found that premiums would be 30 percent lower than in employer-sponsored plans because of Medicare’s lower administrative costs and lower payment rates to providers. It estimated that nearly everyone would be covered with about 40 million in the new public health insurance plan; most of those with employer-sponsored insurance would keep it. Covering everyone would add about \$52 billion in spending, but that cost would be offset significantly through lower administrative costs (\$15 billion) and cuts to provider reimbursements (\$21 billion).⁵³

Public Health Insurance Plans Are Leading the Quality Revolution

Health policy experts, providers and politicians all recognize that a revolution is needed in our health care delivery and financing system to reduce fragmentation, improve quality and effectiveness and contain costs. Both public and private insurance plans must derive far more value and efficiency from the system.

The quality and effectiveness innovations occurring in the public Medicare plan, and also at the Veterans Health Administration (VHA), combined with their power in the marketplace show why public health insurance plans overall have greater potential to drive the quality revolution than do private plans, although the best outcomes will be achieved if the public and private plans work together as partners sharing their successes and failures.

A bipartisan group of distinguished experts organized by The Commonwealth Fund, which includes Glen Hackbarth, the chairman of MedPAC, policy experts and insurance industry leaders recently stated that it will not be possible to reorganize our health care delivery systems and reform our provider payment systems unless government is the leader. It noted that “National leadership can encourage the collaboration and coordination among private-sector leaders and government officials that are necessary to set and achieve national goals for a high performance health system. It can also develop national aims for health system performance, set priorities and targets for improvement, create a system for monitoring and reporting on performance, and issue recommendations concerning the practices and policies required to achieve those targets.”⁵⁴

Medicare’s central role also has been recognized and endorsed by a distinguished and bipartisan group of former government officials, academics and private health care plan executives, including former CMS administrators Nancy-Ann DeParle (President Clinton) and Gail Wilensky (President George H.W. Bush) and insurance company executives George C. Halvorson (Kaiser Permanente, CEO), John W. Rowe (Aetna, CEO), and Leonard D. Schaeffer (WellPoint, board chairman). Recognizing the leading role that CMS has played in developing a “quality strategy based on quality measurements and incentives,” the group has urged, among other things, that payment for performance become a top national priority with Medicare leading the effort.⁵⁵

Notwithstanding its leading role in reforming the system, Medicare has some built-in limitations when it comes to improving quality that can be better overcome with a new public health insurance plan for people under 65. First, let us look at the many good things Medicare has accomplished.

Medicare's strong track record

MedPAC, Senate Finance Committee Chairman Max Baucus and others have made a host of recommendations about how to reform the Medicare system, many of which are underway or under development and could be quickly adopted by a new public health insurance plan for those under 65.⁵⁶ These innovations then could be made available to private payers, and, as they do today, many would likely follow the lead of Medicare and a new public health insurance plan in their coverage and payment decisions. The innovations include:

- Developing practice guidelines and quality measurements that will allow for value-based purchasing.
- Requiring public reporting by providers of quality indicators to help purchasers and payers get maximum value.
- Testing the effectiveness of new technology.
- Developing a pay-for-performance system based on quality outcomes.
- Finding alternatives to the fee-for-service based system – shifting from a system that rewards providers for volume of services to one that rewards for better outcomes.
- Shifting payment methods and rates to better reward primary care providers and to increase their supply while decreasing the oversupply of specialty physicians, who are escalating costs without necessarily improving quality.
- Building a system based on coordinated care for those with chronic diseases, rather than maintaining our current fragmented care.
- Removing wide geographic variations in care from one region of the country to another, which are largely driven by a community's supply of specialists and technology rather than the services patients actually need.

If Congress wants to drive value in the health care system it can design a new public health insurance plan offered through an exchange that will be best positioned to lead these efforts. Here's why:

- **Payment system reform is central to improving quality and outcomes and controlling costs; public health insurance plans with large market share are needed to drive such reform.** Reshaping market practices to promote quality and cost effectiveness, testing new methods of providing and paying for care, and collecting and maintaining extensive data on providers and their patient outcomes requires plans with a very large market share and an incentive to focus reform on the 26 percent of the population with multiple chronic conditions.⁵⁷ Medicare has played the leading role in this area in the past and it will do so in the future. So can a new public health insurance plan with a younger population group.

As Robert Berenson and Bryan Dowd noted in a recent *Health Affairs* article, “Traditional Medicare has been the source of important payment innovations, moving many payment systems away from FFS to prospective payment, such as the diagnosis-related group (DRG) prospective payment system (PPS) for inpatient services. The resource-based relative value scale (RBRVS) for physician fees, despite its flaws, has

been adopted widely by private plans....Commercial insurers also look to Medicare to make initial technology approval decisions and to initiate more-aggressive payment denials—for example, for ‘never’ events and medically ineffective treatments.’⁵⁸

- **Public health insurance plans have more incentive to improve quality in order to curb costs.** Private insurers are under much less pressure to curb costs because they can increase premiums without public debate, reduce risks by avoiding certain population groups, shift costs to people with complex conditions, or deny claims payments based on contract fine print in order to increase profits. Moreover, they have much less incentive to invest up-front in curbing long-term costs because of frequent member turnover. On the other hand, a public health insurance plan cannot avoid covering those who are eligible, and it cannot increase its budget or premiums or negotiate lower provider payments without a major public debate in Congress, from which they are increasingly under pressure to reduce spending because of long-term fiscal challenges.
- **Public health insurance plans operate in the open; private insurance plans operate in secret.** Insurance companies operate with little transparency, which greatly limits accountability and the ability of others to learn lessons about how best to contain costs and improve quality. 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.⁵⁹ On the other hand there is great transparency in the public Medicare plan, which has voluminous public reporting, is overseen by Congress, extensively analyzed by numerous federal agencies and scores of academic researchers, scrutinized by providers and closely watched by the media. One example of the benefits of this transparency: Medicare data has helped identify huge variations in spending per capita across the country and that areas with higher spending per beneficiary score no better on quality measures, and often score worse.⁶⁰ Private insurers have few incentives to make such information public because they can pass rising costs along to payers, and they want to keep such information secret to get a leg up on the competition.
- **Participation in public health insurance plans is much more stable, improving quality and cost savings.** Public plans are an important source of stability – for enrollees as well as for providers. Insurance companies move in and out of markets, change their benefits frequently, shift the providers with which they contract, and so on. A change in an individual’s job or employment status can result in a loss of coverage, which is much less likely to occur with a public health insurance plan. All of this churning is costly, undermines continuity of care, and is difficult for providers and enrollees, particularly those who require coordinated care. Because of the greater stability of enrollment and provider participation, a public health insurance plan also has much greater potential to reap the rewards of investments in prevention and general health improvement that require up-front spending but reduce long-range costs, particularly since most people will eventually be covered by Medicare’s public plan when they turn 65.

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- **Private health insurers have strong incentives to avoid treating those with substantial health problems.** In 2004, 5 percent of the U.S. population accounted for 49 percent of overall U.S. health care spending, and 20 percent of the population was responsible for 80 percent of health care costs.⁶¹ Those are the people with chronic and costly diseases whom private insurers most avoid through targeted advertising and risk selection. Yet, they are the most in need of innovations in treatment and care coordination. A public health insurance plan, which is required to cover anyone who is eligible and has no profit incentive to avoid higher-risk individuals, is most willing to treat them and disseminate the lessons learned to the private sector.⁶²
 - **Private health insurers have limited incentive to conduct comparative effectiveness research.** Comparing the clinical effectiveness of medical tests, procedures and drugs with their alternatives are critical to increasing treatment effectiveness and reducing costs. But for insurance companies it is very expensive and the benefits of their investment, if made public, are not theirs alone. As MedPAC has noted, “Because the [public dissemination of] information can benefit all users and is a public good, it is under produced by the private sector.”⁶³

Improvements needed to Medicare and a new public health insurance plan

Creation of a new public health insurance plan for those under 65 provides an opportunity to take the best of Medicare and innovate in new ways that Medicare has begun to do but, much like private plans, has had trouble doing because of tradition, institutional inertia and structural impediments.

- Medicare’s physician payment system needs significant reform. In recent years that system has used the Sustainable Growth Rate expenditure target that MedPAC acknowledges is “widely considered to be flawed; it neither rewards physicians who restrain volume growth nor punishes those who prescribe unnecessary services.” Rather than reimburse in ways that create incentives for unnecessary and expensive care, public health insurance plans (and private plans too) need to bundle payments to reduce overutilization, develop payment incentives to coordinate care, pay for performance rather than for any services regardless of quality, and use comparative-effectiveness information when developing treatment protocols.⁶⁴
- MedPAC notes that historically, Medicare’s payment system has not valued primary care services enough in comparison to specialty services – a situation that needs to be reversed in order to improve the system’s efficiency while not compromising quality.⁶⁵
- The public Medicare plan’s tri-partite structure has contributed to its difficulties in developing payment systems that reward physicians for coordinating patients’ care across health care settings and providers. Medicare is divided into Part A for hospital care, Part B for physician care and Part D for prescription drug coverage, which is offered by private insurers only.⁶⁶ Moreover, because the public health insurance plan allows people to see any provider they like – and often that involves multiple providers – it can be

difficult to identify the practitioner most responsible for the patient's care to serve as coordinator.⁶⁷

- Medicare's public health insurance plan underfunds administrative investments that are needed to improve quality and detect waste, fraud and abuse. That's because such expenses come from an annual appropriation, which has not kept pace with the program's growth and increased complexity, rather than from the part of Medicare's budget that automatically increases with beneficiary growth.⁶⁸

Many of these problems could be avoided with a new public health insurance plan.

Lessons from the Veterans Health Administration

The VHA is a good example of the power of a public health insurance plan to improve quality. VHA has used its integrated network to create a model evidence-based quality-improvement program that delivers the highest-quality care in the nation, as measured by adherence to established treatment protocols. More than two-thirds of patients in the VHA receive the care that they should; in the rest of America only around half of adults and children receive the care that they should. The VHA does it through a system-wide commitment to quality improvement principles, accountability to specific performance measures, a sophisticated electronic medical record system and a quality measurement approach for preventive care and the management of common chronic conditions. This is all possible because of the integrated, broad reach of its coverage, which is possible through a large public health insurance plan.⁶⁹

Public Health Insurance Plans Increase Choice, Competition and Accountability

About 60 percent of people under 65, or 157 million, receive health care coverage through employer-sponsored health plans, many run or administered by private insurers. Many employers and individuals highly rate their coverage. At the same time there is strong public support for giving people more choices in health care – both the plans available to them and the providers caring for them. For example, a recent survey conducted by Lake Research Partners found that 73 percent of voters want everyone to have a choice of private health insurance or a public health insurance program. This preference cut across all demographic and partisan groups, including Democrats (77 percent), Independents (79 percent) and Republicans (63 percent).⁷⁰

- **A public health insurance plan offers more choice – an alternative to private insurance.** A public-plan option provides an easy-to-understand plan with clearly specified benefits that offers an alternative to private health insurance products. Many people will not take advantage of this option, but some individuals likely will. Moreover, the competition that will develop between the public health insurance plan and private plans will benefit everyone as they compete based on quality and cost.
- **A public health insurance plan offers a wide choice of providers.** As with Medicare, because of its large size and bargaining power a public health insurance plan could provide at least as much provider choice as can most private insurers, if not more. For instance, 97 percent of physicians accept new patients under the public Medicare plan, about the same percent as accept private PPO patients,⁷¹ even though PPO networks have fewer participating physicians than Medicare. And virtually all hospitals accept Medicare and private insurance.
- **A public health insurance plan promotes competition with private insurers.** Having public and private plans compete on a level playing field provides an important check on each. Private plans will be required to act very differently within a national health insurance exchange and in competition with a public health insurance plan than they do now in the private market. Unlike public insurance, private insurers have strong incentives to reduce their exposure to the risk of medical costs by weeding out or charging higher rates to less healthy patients, marketing their plans selectively to healthy populations, and hiding limits on their coverage in the fine print of policies. Such practices can be regulated by the government, but the incentives will always be strong to find loopholes. Fostering competition with a public health insurance plan on a level playing field provides an additional layer of protection against insurers engaging in practices that are at odds with American values.

As the authors of the Commonwealth Fund’s “building blocks” proposal argue, competition between a public insurance plan and private plans “could lead to a transformation of the private insurance market, as private insurers endeavor to ‘meet the competition’ by lowering overhead, adopting a tougher stance in provider payment negotiations, and adopting innovative practices in pursuit of higher value or lower premiums.”⁷²

- **A public health insurance plan promotes accountability and transparency.**

Accountability and transparency are much stronger under public health insurance plans because they must meet the test of democratic support. Benefits are specified in law and updated through a public legislative process, as occurs with Medicare now. Public plans are the subject of voluminous reports examining their practices and effectiveness. By contrast, the billing, payment, care management practices and claims and outcomes data of private plans are for the most part proprietary information, opaque to most plan participants and largely off limits to government oversight. Experts are concerned that the 23 percent of people in private Medicare Advantage plans is undercutting the program's ability to track overall performance because those plans do not provide the claims data used for national studies. They are not required to provide claims data based on the argument that private plans are prepaid for services, rather than paid for each service performed.⁷³

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