Why Government-Run Public Plan is Misguided

- Reforms to the private insurance markets are widely recognized as necessary. But the creation of a government-run public plan is a bad idea and a waste of resources that would likely displace tens of millions of happily insured Americans and exacerbate the worst elements of our current system: gross inefficiency, high costs, and bureaucracy. Creating a mammoth, complex, hugely expensive, ill-designed reform that is not likely to be popular when understood.
- As a prominent Lewin study concluded, a government-run public plan would likely attract consumers not by virtue of superior performance on cost control and quality, but by its ability to exploit unfair advantages that would tend to shift and hide its costs away from enrollees and enrollee premiums.[1] Nearly 6 out of every 10 Americans (118 million) with private coverage could lose their current health care coverage, and 130 million Americans could end up on a government-run health care plan if the government sets payment rates at Medicare rates.
- Expansion of government-run programs could also exacerbate the cost-shift that already drives up average health care spending by $1,788 (or 10.7 percent) annually per family.[2] A government-run plan would exacerbate the cost shift because when government payment rates are too low, providers shift costs to private payers to make up the difference.
- Existing public plans provide less coverage and restrict provider access more than the average employer-sponsored plan. The Congressional Budget Office (CBO) estimated that the benefit package for Medicare is 15 percent below the average employer-sponsored plan. Under Medicaid, specialists are often inaccessible without long waits. Under a new government-run plan, Americans will find it more and more difficult to make appointments with physicians and other health care providers. This is because lower payments will make it increasingly unaffordable for providers to see patients—particularly the increasing number of patients with public coverage.
    - MedPAC: 30% of Medicare enrollees seeking a new primary-care physician have difficulty finding one
    - MedPAC: 30% of physicians taking no new Medicaid patients
- Public programs like Medicare moreover lag behind the private insurance industry in terms of containing cost and improving quality. Medicare ***just recently*** started refusing to pay medical care providers for 'never events' where a patient suffers a knowable and catastrophic mistake such as having the wrong limb removed. The private insurance market has been doing this for years.
- A government-run plan like Medicare does not have to comply with varying state insurance regulations nor does it have to underwrite applications because

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[1] The Lewin Group, "The Cost and Coverage Impacts of a Public Plan: Alternative Design Options," Staff Working Paper #4, April 6, 2008.

[2] Millman, "Hospital and Physician Cost Shift Payment Level Comparison of Medicare, Medicaid, and Commercial Payers," December, 2008.

Medicare is open to all seniors at the same cost. Reforming the insurance market could significantly reduce administrative costs for private plans.

- Private insurers must build provider networks. These networks can include high-value providers and exclude low-quality providers. Except for certain circumstances, including criminal acts, Medicare is forbidden from excluding poor quality providers. It lets in everyone who signs up. So one question to ask is, will a public plan have Medicare's indifference to quality -- or invest in the cost of a network?
- Private insurers must negotiate rates. Medicare just fixes prices using a statutory and regulatory scheme. And anyone who imagines a public plan would be less costly than private plans must keep the following issue front and center: In the many procedure categories where Medicare's statutory price does not cover full provider costs, shortfalls are shifted to private payers who end up subsidizing the public program. So, will a public plan negotiate rates or simply use fiat as a means of gaining subsidies from private insurance?
- Private insurers must combat fraud -- or go out of business. Indeed, these payers have every incentive to invest in antifraud personnel and strategies down to the point where return and investment are equal. But anyone who thinks that a public plan could serve as a "yardstick" for the private sector needs to consider Medicare's dismal record with regard to fraud, waste and other abuse.
- In fact, the total amount of Medicare fraud is unknown. The government does not measure or estimate fraud in its programs; instead, it measures payments made "in error." According to Medicare's own most recent data, payments made in error amount to over $10 billion annually. (Medicaid's payment errors in 2007 equaled a whopping $32.7 billion, according to a report by the Department of Health and Human Services.) Others have claimed Medicare's payments made in error are much higher. Even with the inclusion of the budget of the inspector general for the Department of Health and Human Services, Medicare spends less than one-fifth of 1% on antifraud measures -- a small fraction of what private plans invest in their efforts to build a network of honest providers.
- And because of the vagaries of politics, in four of the past five years Congress has turned back Medicare's pleas for $579 million of additional antifraud funding, on the grounds that these dollars subtract from the budget funds for curing cancer and anti-obesity campaigns. Based on experience, Congress will always underinvest in fraud. Yet according to a House of Representatives Budget Committee hearing in July 2007, return on investment for certain Medicare antifraud measures were estimated to be in excess of 13-1. Will a public plan also hemorrhage from fraud because of chronic Congressional underinvestment?
    - "The significant size of Medicare's erroneous payments suggests that the program's low administrative costs may come at a price." MedPAC, March 2009
    - "The traditional fee-for-service Medicare program does relatively little to manage benefits, which tends to reduce its administrative costs but may raise its overall spending relative to a more tightly managed approach." CBO, December 2008

Private administrative costs cover important services like disease management programs and research to determine which interventions actually work. It is ironic that the same

advocates who frequently cite the need for the government to spend billions in taxpayer dollars to improve health outcomes are the same who decry the high administrative costs in health care plans. As Ezekiel Emanuel, an adviser to President Obama on health care (and brother of White House Chief of Staff Rahm Emanuel), wrote, "The idea that we could wring billions of dollars in savings [from cutting administrative costs] is seductive, but it wouldn't really accomplish that much. For one thing, some administrative costs are not only necessary but beneficial. Following heart-attack or cancer patients to see which interventions work best is an administrative cost, but it's also invaluable if you want to improve care."[3] Additionally, Medicare loses up to $60 billion to Medicare fraud each year due to inadequate scrutiny of claims. While private health providers pay (out of administrative costs) for programs to keep fraud to a minimum, the federal government invests little, and as a result taxpayers pay more.

- None of these considerations should be interpreted as a defense of the status quo, or a denial of the fact that major health reform is needed.
- The creation of a government-run public insurance plan would make the government the gatekeeper – the controller of prices and the provider of coverage. Health care decisions would increasingly be made in Washington and subject to political pressures that take into account neither patient needs nor economic realities. The cost of the program would be such that the effort to pay for it would become the central concern of American politics – crowding out other government priorities. As is seen around the world, health care is a central part in ballooning welfare states.
- There are really only two ways to keep costs under control: by building a real marketplace in which cost-conscious consumers make choices in a more efficient delivery system or by imposing arbitrary limits, determined by the government, on care.

[3] Ezekial Emanual and Shannon Brownlee, *Washington Post* Op-Ed, "5 Myths on Our Sick Health Care System," November 23, 2008.