The Problem with a "Public Option"

David G. Anderson, PhD and Michael Blaszyk, MHA

March, 2020

Of the various health reform proposals espoused by the leading Democratic presidential candidates, the "public option" plans of Biden, Buttigieg, and Klobuchar sound considerably milder than the Warren / Sanders "Medicare for All" plan. But how mild are they really?

The intent of the "public option" plans is to extend government-paid, taxpayer-supported health insurance to more segments of the commercial population. (The ACA already extended it to the "working poor" who made too much money to qualify for Medicaid.) When Medicare was enacted in January, 1966, three quarters of seniors 65 or older were uninsured.[1] Medicare crowded out private insurance quickly: no private insurer could compete with a taxpayer-supported public program that covered 100% of the senior population. The situation in the commercial market today is very different. Most of this population is already covered by private health insurance, and the insurance market is crowded and competitive. How would a public option plan fare in this market?

Marketplace success for any health plan depends mainly on access to doctors, hospitals, and drugs, pricing, plan design (deductibles and co-pays), and member services. A plan's financial performance depends on the underlying risk (sickness) of its members and its ability to manage medical and administrative costs. If a public option plan were operated like a private health plan, it would be unlikely to run away with the market. After five years of experience, and despite unparalleled market awareness, the Obama health insurance exchanges, which utilize private companies, have attracted only 1.5 million unsubsidized members nationwide.[2]

But there is no reason to think a "public option" plan would be run like a private health plan. A "public option" plan administered and funded by the government would deviate from a private health plan in at least two ways:

1. A government plan would leverage other government programs, principally Medicare, to cut provider reimbursement; and
2. A government plan would not have to operate in an actuarily sound fashion because it would be backstopped by federal general funds, which would almost certainly be used within a few years to subsidize premiums.

David G. Anderson, PhD is a Senior Advisor at BDC Advisors, LLC and Executive Director of the Institute for Affordable Health Care (IAHC). He has been a strategy consultant to health systems, academic medical centers, health plans, and medical groups for over thirty years. Michael Blaszyk is Senior Executive Advisor for Beecken Petty O'Keefe & Company, a health care private equity firm. He was formerly Senior Executive Vice President and Chief Financial Officer of Dignity Health (now CommonSpirit Health).

Each of these points is discussed below.

1. Cutting Provider Reimbursement

As the world's largest payers, Medicare and Medicaid have already demonstrated their ability to control the prices they pay for services by forcing private plans to cross-subsidize their costs.

Figure 1. National Health Expenditures per Enrollee by Coverage Type (Indexed: 1987 = 100)

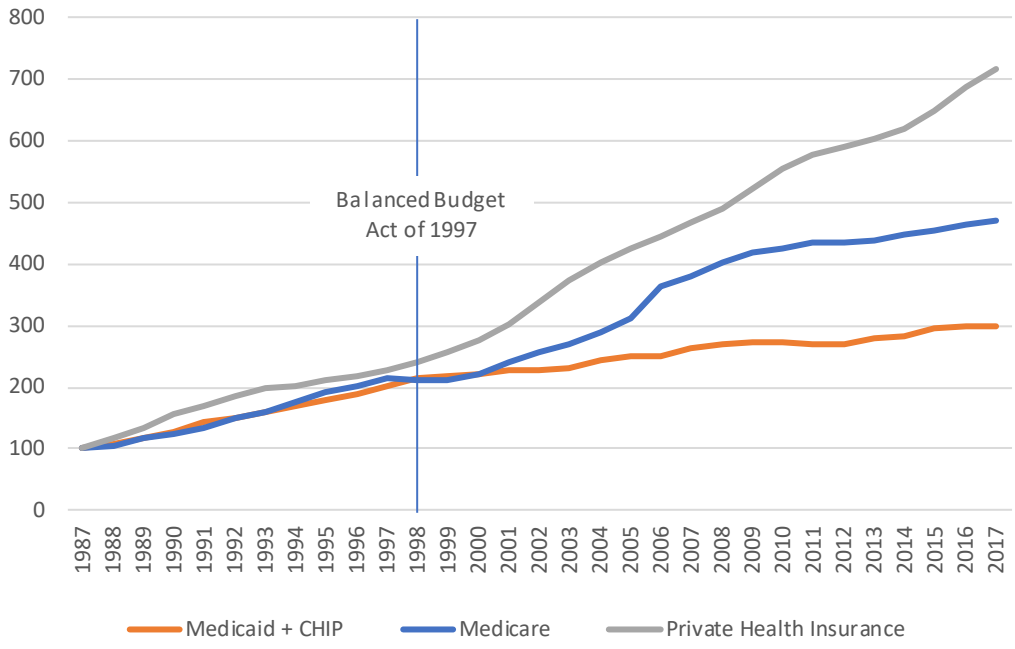


Figure 1 shows that since 1997, when the Balanced Budget Act was passed, the cost of health care for people with private insurance has grown 148% faster than inflation, while the cost of health care for Medicare and Medicaid enrollees has grown only 25% faster than inflation.[3] Why? Because government programs have underpaid providers, and providers have shifted their costs onto private payers. [See sidebar on why employers have been willing to pay inflated prices and why providers are still willing to treat government patients.] For over two decades, Medicare and Medicaid have been "free riding" on private commercial health care. If the cost of health care for public and private patients had grown at the same rate since 1998, private health insurance would cost 15% less, and Medicare and Medicaid would cost 45% more today than they do. Over 20 years, private payers have cross-subsidized government programs by almost $1½ trillion.

Provider rates paid by private insurers are now substantially higher than the rates Medicare pays. A 2016 study commissioned by Employers' Forum of Indiana and conducted by the Rand Corporation found that on average employers paid hospitals 2.7 times the amount Medicare would have paid for similar services. In our experience, this level of cross-subsidy is common, and the differential for Medicaid patients is even greater. (Differentials for organized physician practices are lower, but still significant.)

It would be politically difficult for a new "public option" to cut provider reimbursement immediately to Medicare levels. Initially, "public option" payments would probably recognize the difference between Medicare and private payment rates. Buttigieg, for one, has talked about paying providers 200% of Medicare. Over time, however, it is hard to believe that the administrator of the "public option" plan (likely CMS, the Medicare administrator) would keep paying providers twice as much as Medicare pays them. Budgetary pressures would force the administrator to cut provider reimbursement to reduce this differential, which would cause financial dislocations, short-run shortages of products and services, and long-run decapitalization of the industry.

2. Subsidizing Premiums

Faced with political pressure from members (beneficiaries) to keep their costs down, "public option" plan administrators would soon set premiums at levels that were politically acceptable and cover their costs through a combination of additional employer taxes and federal subsidies. As Lanhee Chen has pointed out, Medicare required unanticipated premium subsidies as early as 1968, two years after the program was enacted.[4] In 2018, Medicare cost $750 billion, of which only 56% was covered by receipts (payroll taxes, premiums, and payments from states). The $330 billion hole that remained was filled by drawdowns from the rapidly shrinking Medicare trust fund and contributions from the federal government's general fund.[5] In addition to requiring new taxes, subsidizing the "public option" plan would be another huge blow to the federal budget deficit, which is already facing runaway costs from Medicare, Medicaid, Social Security, and other entitlement programs.

A Super-Highway to Single Payer

A "public option" would create a super-highway to single-payer health care. Once the plan established itself as a new entitlement, gained significant enrollment, and opened government coffers, it would be relatively simple to replace private health insurance entirely, just as Medicare did in 1966. Plan administrators could simply set premiums at a level that underpriced private insurers and pass larger losses onto the federal government. Few employers enjoy administering health benefits, and they couldn't justify paying higher premiums to private health insurers when government was offering cheaper insurance with similar benefits.[6]

The Future of Private Health Care

From the end of World War II through most of the last century, private employer-funded health care, augmented with Medicare, has provided superior access, quality, and service for 80% of the U.S. population.[7] This "80/20" system gives 80% of the population better access to diagnostics, treatments, and new drugs and higher quality of care than other countries' government-funded health systems. This is presumably why 70-80% of Americans report being satisfied or very satisfied with their own health care on national surveys. In addition, the quality of care provided to the 80% has important spin-off benefits for the 20%, since the safety net system uses many doctors and hospitals funded by the private system (e.g., academic medical centers in urban centers).

Private employer-funded health care, however, does not guarantee health care as a "right" for all citizens. The 20% of the population who are unemployed and uninsured must rely their own resources and/or subsidized safety net institutions like public hospitals and federal, state, or community clinics. As a result, these patients may get less care than their peers in countries with single-payer systems,

especially if they live in rural areas without ready access to doctors or hospitals.[8] They may also have to pay more out-of-pocket for their health care than in other countries.

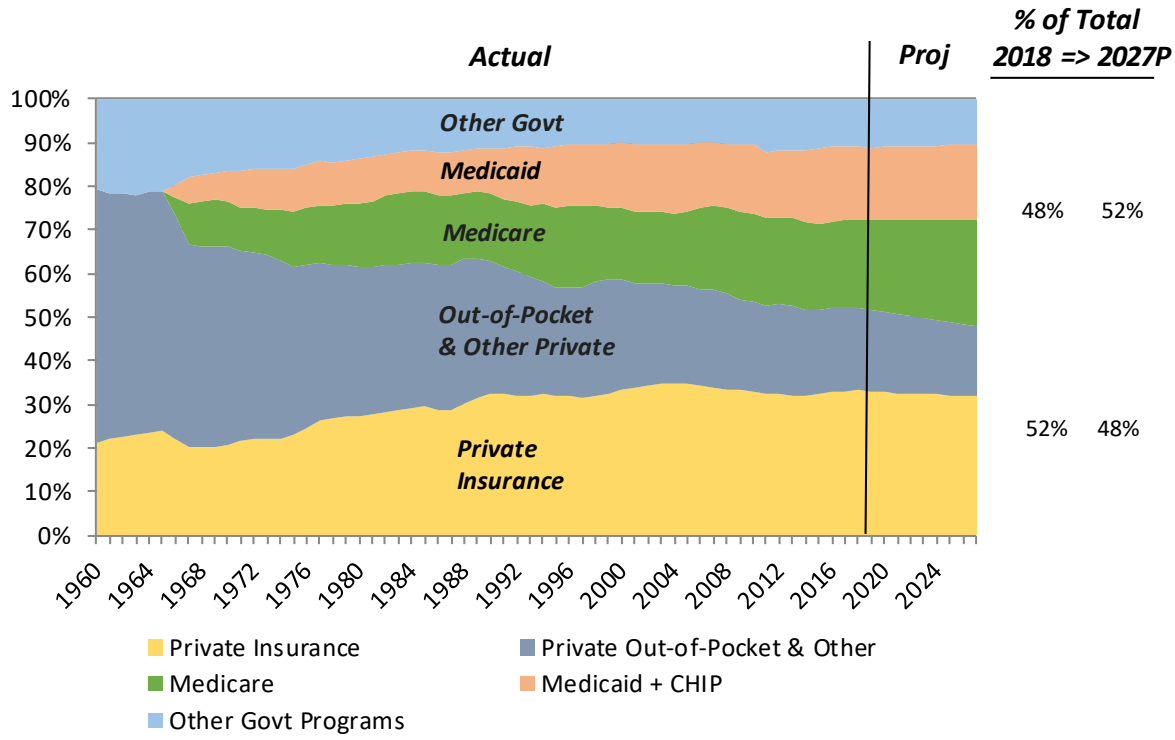
Perhaps more important politically, the employer-based system, as currently implemented, does not work well for people who transition between employers, a growing group in our mobile culture. People who spend time out of the workforce must purchase health insurance on the individual market, triggering repricing of their coverage, which can result in substantial increases in premiums where they have pre-existing conditions. As John Goodman and others have pointed out, there is nothing inherent in our employer-based system that precludes portability of insurance between employers except government laws and regulations.[9] In particular, if Congress offered the same tax deductibility of health insurance premiums to individuals that it offers to employers, portability and pre-existing condition issues would be quickly solved.

The alternative to private employer-funded health care, taxpayer-funded "single-payer" health care, has been the dream of progressives in the U.S. since the turn of the last century.[10] Wherever it is implemented, however, taxpayer-funded health care inevitably produces 20/80 health care. The bottom 80% of the population have to put up with longer wait times, less choice of providers, and less access to state-of-the-art diagnosis and treatment, and the 20% of the population who can afford it purchase private health insurance on top of their taxes to go around the public system and improve their access to care.

The reason for this is simple: No government can raise taxes enough to pay for all the health care that its entire population wants to consume. Taxpayer-funded single-payer systems, therefore, inevitably impose price controls on the health care their populations can access at government expense. These price controls can be implemented directly by government delivery systems, as in the UK's NHS, or indirectly by regulating insurance premiums, as in Germany and Switzerland. In either case, the results are similar: lower costs, yes, but also longer wait times, lower compensation for doctors, nurses, and other providers, less capital investment, and inevitably lower quality of care. National price controls also force global suppliers (e.g., pharmaceutical manufacturers and device manufacturers) to sell their products in these countries at a discount, shifting the burden for supporting R&D to private U.S. purchasers.[11]

Since enactment of the Great Society programs in the 1960s, we have been on a steady slope to more and more taxpayer-funded health care, as Figure 2 clearly shows.

Figure 2. Payer Mix of National Health Expenditures, 1960 – 2029(P)[12]



Going forward, as Figure 1 shows, CMS projects that taxpayers will fund more than half of total national health expenditures within a couple of years.[13] If this trend continues – or accelerates, as it would under all the Democratic candidates' proposals – our private employer-funded health care system will soon hit a tipping point, employers will decide to cut their labor costs and flip to supporting government health care, the system of cross-subsidization will collapse, and we will be left with one very expensive taxpayer-supported system.

We are approaching this tipping point.

Sidebar: Why Do Cross-Subsidies Work?

- *Why are employers willing to pay inflated prices for employee and dependent health care?* The answer is a complex combination of economic, cultural, and political factors. Providing health benefits is an efficient form of compensation. Himmelstein & Woolhandler estimated the value of tax savings to employers in 2015 was $326 billion, or about $2,700 per worker. Employers must also deal with the lack of an efficient market for individual health insurance. Given the tax deductibility of group health premiums and the dominance of group health plans, the individual health insurance market is thin and relatively expensive, which makes employer group health coverage even more valuable to employees and dependents. Beyond these economic factors, many employers finance employee health care because they truly care about protecting the health and welfare of employees and their families.

- *Why are providers willing to treat government patients whose reimbursement doesn't cover their fixed costs?* As with employers, both economic and cultural factors play a role. Medicare and Medicaid are large books of business for hospitals and they are loath to eliminate a major revenue source, even if they don't cover full costs. Beyond the economics, most hospitals are not-for-profit institutions that have legal and moral obligations to provide charity care that benefits their communities. Hospitals treat their losses on government-paid and uninsured patients as contributions to their communities, and they report them on community benefit surveys. Physicians have been less willing to subsidize government patients than hospitals: many doctors limit the number of government patients they treat, a growing number refuse to treat Medicaid patients, and some have dropped out of the Medicare program entirely. As a result, physician access for government-funded patients is shrinking.

Footnotes

[1] Finkelstein, A., "The aggregate effects of health insurance: Evidence from the introduction of Medicare," *Quarterly Journal of Economics, v. 122* (1), February, 2007.

[2] CMS, "Health insurance exchanges 2019 open enrollment report," March 25, 2019, https://www.cms.gov/newsroom/fact-sheets/health-insurance-exchanges-2019-open-enrollment-report .

[3] IAHC analysis based on CMS, National Health Expenditure Accounts, Table 17, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical. The Balanced Budget Act of 1997 (BBA), passed by a Republican congress, was intended to rein in government health care spending by cutting government payment rates to hospitals and medical groups. While private payers had subsidized public patients to some degree before the BBA, because the Act's cuts were so substantial, providers significantly increased their "asks" to private insurers and employers in order to maintain their historic service levels and incomes.

[4] Chen, L., "The myth of the 'moderate' public option," *Wall Street Journal*, January 23, 2020.

[5] Medicaid, which cost $597 billion in 2018 and is projected to grow 5-6% per year over the next decade, has minimal receipts and is almost completely dependent on state and federal general funds. CMS, National Health Expenditure Accounts, Table 05-5 Medicare Spending by Sponsor, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical .

[6] Health insurance is complex and expensive, requiring deep expertise in areas foreign to most employers' core businesses. Health benefits can generate dissatisfaction among employees and cause labor unrest and strikes in unionized companies. If employers believe a subsidized "public option" plan will provide adequate health care at lower cost, many will be tempted to sign on, even if they have to pay additional taxes to cover some of the costs.

[7] Atlas, SW, *In Excellent Health: Setting the Record Straight on America's Health Care.* Stanford, CA: Hoover Institution Press, 2011.

[8] Safety net care is very different than no care. The U.S. has had a robust network of safety net institutions since at least the mid-1800s, and the EMTALA law passed in 1986 requires all acute-care hospitals to provide emergency care to any patients who come to their emergency rooms, whether they have health insurance or not. Of course, this doesn't help in rural areas where there are no nearby hospitals. On the other hand, it is not clear that government-run health systems do any better. Studies of health care in Great Britain under the National Health Service have repeatedly shown substantial disparities between the care available to well-off people in desirable geographies and poor people who live in poorer areas. See, for example, Mitchell, R and Shaw, M, "Reducing Health Inequalities in Britain," Joseph Rowntree Foundation, September, 2000.

[9] Goodman, J., *Priceless: Curing the healthcare crisis*. Oakland, CA: The Independent Institute, 2012.

[10] Cogan J, *The High Cost of Good Intentions*, Stanford: Stanford University Press, 2017.

[11] Interestingly, the gap in national health expenditures between the U.S. and other advanced economies has grown as government funding has increased. In 1960, before Medicare and Medicaid were enacted, U.S. health care expenditures were 5.1% of GDP, while Canada's were 5.4%, Switzerland's 4.9%, and Austria's 4.3%. In 1970, U.S. drug costs per capita were comparable to drug costs in Belgium, France, Germany, and Greece. As late as 1975, when the U.S. spent 7.9% of GDP on health care, Germany and Denmark both outspent us at 8.4% and 8.7% of GDP, respectively (OECD Health Division's HealthData, 2013).

[12] Source: http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected.html

[13] This does not take into account the cross-subsidization discussed above. Taxpayer-funded health care already generates more than half the costs.