The Public Option

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Well, I'm peeved today. Yesterday, I made the supreme effort to get into the current issue of Health Affairs (Vol. 29, No 6), which has the title "Moving Forward on Health Reform." At least it was nice of them not to change it to "health insurance" reform, as the President did later in his campaign to get legislation passed. I hoped for an in-depth analysis of the law and the pathways for implementation, with some consideration of advantages and disadvantages of different approaches.

What I got instead was mostly pablum – rehash of old news and very superficial (and sometimes inane) discussions of some of the provisions of the law. There were, admittedly, a couple of good articles, but the issue was generally disappointing. I think it might be a good education support for people who know little or nothing about healthcare reform, but is some areas it even does a disservice to the goal of education.

For instance, there is an article on the "public option" proposal by Helen Halpin and Peter Harbage (who are, respectively, a Professor of Public Health at UC Berkeley and a consultant) which barely touches on the issue of provider contracting as an issue in the "public option." The discussion focuses on the use of Medicare rates and the effect that a public option using Medicare rates would have on provider financial viability and on willingness of providers to accept patients covered by the public option (barely touched upon) resulting in the possibility of a provider shortage for enrollees in the public option. What is missing is a discussion of a new entrant into the commercial insurance arena with legally mandated provider payment rates that are substantially below market.

For those of you to whom the consequences of this scenario are not obvious, let me detail them briefly. First, understand that about 85% of the health care premium dollar is spent on provider services. Second, understand that, in most communities, not only is Medicare the second-lowest payer to providers (only Medicaid is ever lower), but physician providers are currently facing a statutory 21% reduction in fees that will probably never take place, but which has been accumulating over many years because of an interesting formula for calculating changes in the physician fee schedule (which is a completely different discussion). Private insurers must generally negotiate fee schedules with providers, and providers are generally not willing to accept Medicare fee rates from private insurers – Medicare PLUS 20% to 40% is more frequent (I will discuss why this is so in a subsequent paragraph). The most cost-saving proposals for a "public option" program IMPOSE the Medicare fee schedule on providers (well, it makes sense, doesn't it? If you pay less to providers for the same service, you will save money!). So, what happens? The medical cost basis for the "public option" program is about 20% lower than for private insurers. Since medical cost is 85% of total expenditures, that would

reduce total cost by 17% (20% of 85%). If I am the person running the "public option" program and my costs are 17% lower, I am going to reduce my premium charges – after all, I AM running a not-for-profit government-supported company after all, am I not? If my premium charges are lower, I will attract a clientele who are interested in lower premium payments. If my access to physicians is worse and my customer service is worse, then I will attract people for whom premium is more important than access to providers or customer service. Who are these people? They are the well people who might today not be buying insurance at all! As these people crowd into the "public option" program, they remove premium from the private insurance companies they might otherwise have purchased insurance from, but they remove very little healthcare cost. In the face of a decrease in revenue without a corresponding decrease in costs, private insurers will have to raise premiums to break even, resulting in an even larger differential between the private programs and the "public option." This is known in the business as the "death spiral" and will result in private companies leaving the marketplace because they cannot compete with the "public option."

Clearly, if you favor a government-run single payer system, this is a way of getting there without having to come out into the open to tell the story. The insurance industry opposed this option in just the way that General Motors and Ford would oppose an initiative that would drive them out of business.

One possible adjustment proposed by the insurance industry was that the "public option" programs should have to negotiate a fee schedule with physicians rather than impose one (whether based on Medicare or not). This imposes two costs on the "public option" programs – their medical care costs will be higher (presumably comparable to those of the private payers) and they will also have to bear the cost of creating, negotiating and maintaining provider contracts, which is a significant cost borne by the private payers (as part of the 15% of revenue not spent on health care). The insurance industry felt that the imposition of these costs and duties would effectively "level the playing field," but that option was clearly not acceptable to those who viewed the "public option" as a way of saving money, for obvious reasons.

So, back to the issue of why physicians and hospitals want higher fees from private payers than from Medicare. Physicians and hospitals indicate that Medicare fees either just barely do or just barely do not cover their cost of doing business. To the extent that physicians and hospitals need to have operating margins (or profits) to remain functional, they need to be paid more than an amount that covers operating costs. Since they cannot negotiate with Medicare for higher fees, they must negotiate with private payers to develop a high enough payment schedule so that they can achieve their desired operating margin for their whole businesses in the payments from private insurers. In addition, there are currently uninsured patients in the system who do not pay anything for the care they receive – the cost of that care must also be recouped from somewhere. It does not come from Medicare and Medicaid, so it must come from payments made by private insurers. This is known as "cost shifting."

The issue, from the insurance company point of view, is that there is a cost associated with the care of the uninsured in this country, and that cost is borne entirely by the insurance companies in their contracts with providers. No, they aren't going bankrupt, because they pass

those costs on to those who pay premiums. It has been estimated that something more than $1000 per year of the insurance premium for a family plan is entirely related to the care of the uninsured population. It is a strange public policy that puts a private industry in charge of paying for the costs associated with a social problem, but that is how the current program works – Medicare and Medicaid pay low enough fees that the providers overcharge private payers to make up for the losses they incur by treating the uninsured population.

Can one wonder why the insurance companies should advocate for the government picking up its portion of this cost?

