

National Coalition on **BENEFITS**

Discussion of a “Public Plan” Raises Serious Concerns

For many years, the American people have sent two clear messages about America’s healthcare system. First, Americans want to see change and improvements in the cost and quality of—as well as the access to—health care coverage. And, second, Americans highly value the health benefits they receive through their employer.

The National Coalition on Benefits (NCB) believes the American people are right about both points. We do need change and improvements in our health care system. But we also believe that such change must not erode those parts of the health care system that are working.

The members of the National Coalition on Benefits have a direct and real stake in the outcome of health reform efforts. The employer-provided health care coverage market provides benefits to 170 million members of American working families. Several surveys and studies have consistently shown that employees value and want to keep these benefits.

For decades, employers have provided health benefits for solid business reasons. However, our health care system is on a financially unsustainable path with costs rising at rates that far exceed economic growth. In particular, according to government estimates, over the period 2008-2018, average annual health spending growth (6.2%) is anticipated to outpace average annual growth in the overall economy (4.1%). By 2018, national health spending is expected to reach \$4.4 trillion and comprise over one-fifth (20.3%) of GDP. The increase in overall health spending has a direct impact on health insurance premiums because premiums generally track the underlying growth of health services. Consequently, if we fail to address these underlying costs and improve our health care system, rising health care costs will threaten the viability of U.S. businesses of all sizes and put job security, pay increases and other vital employee benefits at risk for millions of American workers.

A strategy to control costs, therefore, must be at the foundation of any effort to improve the health care system. Controlling spiraling health care costs will benefit every American seeking access to quality, affordable care and makes it possible for employers to continue their role as voluntary sponsors of health plans for their employees. Faced with a severe and continuing economic crisis, employers simply cannot absorb new burdens, including increased cost shifting from government programs to private plans.

While a concrete proposal for a public plan has yet to be drafted, we have serious and specific concerns about the concept.

The Public Plan Option Could Skew the Medical Marketplace Against and Overwhelm Private Voluntary Employer Coverage

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The difficulty millions of Americans experience in trying to secure individual health insurance, and the challenges faced by many small and medium sized employers, has led to the conceptual development of a proposed “public health plan option”. This concept, which could be implemented under a wide range of possible structures, is troubling for many employers who already voluntarily provide sound, effective and efficient health care coverage. It also overlooks the ability of systematic insurance market reforms to address those concerns which have led to the development of the government-run health plan concept and the importance of private sector solutions to bringing health care costs under control and improving overall quality.

We know there has not been a concrete proposal for a “public plan” introduced to date. Even still, we are concerned that such an arrangement could not overcome what have historically been insurmountable objections to the impact on the private sector of plans that are publicly managed. Medicare and Medicaid are prime examples of the challenges that a public plan could present, including the need for constant attention to fraudulent transactions, misaligned provider incentives, and inflationary pressures.

The purchasing power of a public plan defines the medical marketplace and shifts costs. Under a public plan arrangement, the government is likely to become the biggest payer for health services, as is the case with Medicare. We are concerned that the government’s rate-setting policies would essentially shift costs that providers cannot charge to the public plan onto private payers. Medicare and Medicaid already set many provider rates below the prevailing market price point, resulting in private payers — particularly group health insurance — already paying more to make up for the shortfall.

According to a 2008 Milliman actuarial study,¹ Medicare reimburses hospitals at an average of 70% of private plan reimbursements and pays physicians 78% of what they receive from private plans. Medicaid reimburses hospitals at an average of 67% of private plan rates and pays physicians at an average of 53% of private plan rates.

Whether, as experts debate, Medicare pays too little or private insurance pays too much, the incontrovertible fact is that the private insurance market power cannot compete with an array of public plans that set prices based on statutory fiat. We are concerned that the new public plan could decide by authority of law what it would pay, and providers, in reaction, would seek more from private participants to cover costs and earn profits.

Determination of the range of benefits and coverage available: We are also concerned that a public plan might allow special interest groups an opportunity to apply undo pressure on the reimbursement process. This would overwhelm any

¹ Milliman, *Hospital and Physician Cost Shift: Payment Level Comparison of Medicare, Medicaid & Commercial Payers* study, December 2008.

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viable attempt to use evidence based guidelines to achieve quality and cost-effectiveness. As we see in the example of current Medicare and State mandates, provider constituencies, in tandem with beneficiaries, have been successful in protecting or “fencing in” the coverage of care for which there is insufficient evidence to conclude that measurably positive health outcomes are achieved as a result. Whatever reform is passed must include protection against pressures to fence in coverage that is not evidence based as effective, efficient, and safe.

Adverse risk selection. A public plan's inherent ability to withstand infinite administrative costs, and set provider reimbursement rates, could prevent voluntary employer-sponsored group health plans from being able to compete and continue offering benefits. We are concerned that the public plan would not have access to the same range of quality providers as higher paying private options. Eventually care in such plans would have to be rationed to accommodate provider shortages, with beneficiaries experiencing long wait times to receive treatment. Young, healthy group health plan beneficiaries—those who might imagine they do not need to utilize very much care—are likely to opt for the cheaper public plan coverage. Meanwhile, those heaviest utilizers of care would remain with the employer and other private plans that afford them immediate access to quality providers. Before long this adverse selection would be unsustainable, and the employer's risk pool would essentially be dismantled. Alternatively, employers faced with increasing health care costs in the private marketplace would be forced to increase cost sharing by employees or reducing payroll costs by shifting jobs elsewhere.

We have serious reservations about any arrangement in which employer plans are forced to compete with a public plan option. We fear the public plan could significantly disrupt the medical coverage marketplace by taking virtually complete control of reimbursement— even dwarfing the current influence of Medicare and Medicaid. In fact a recent study by The Lewin Group for The Commonwealth Fund estimates that by 2014 up to 105 million Americans could be enrolled in a “public plan.” This could lead to all of the negative consequences inherent in the out-of-favor single-payer models: fewer quality practitioners, long wait times for treatment, rationing of care, a chilling effect on research and development of new treatments and therapies, and worse public health.

As a result, the introduction of a public plan could also undermine the pledge many lawmakers have made to their constituents: “If you are satisfied with your current employer-based coverage, you may keep it.”

We believe that a sensible, consensus approach to health reform should build on our voluntary employer-based health care system and not undermine the essential role of employers in our health care system. We believe insurance market reforms that present every American with affordable access to quality care will forestall the perceived need for a public plan, and is a more effective path to universal coverage.