



THE AMERICAN SOCIETY OF MEDICAL DOCTORS

— PROTECTING THE BOND BETWEEN DOCTORS AND PATIENTS —

Public Plan in Health Reform: Pied Piper of Care?

Abstract: *Creation of a public plan is highly likely in any health reform proposal to emerge from Congress this year. Such a plan will likely result in coverage for the uninsured and under-insured and reduce the costs of uncompensated care provided by physicians. However, a public plan based on Medicare will inadequately compensate physicians for the cost of care and more than balance-out any gains from increased coverage. New federal agencies conducting comparative effectiveness research may result in rationing of care on the European model and interfere in sanctity of the doctor-patient relationship.*

Executive Summary

The creation of a public plan to “compete” with private plans in providing health care coverage to Americans under age 65 lacking insurance has emerged as one of the most controversial proposals in the debate over health care reform. It is a central plank in most Democratic plans.¹ Supporters stress its ability to provide stability, wide pooling of risks, transparency, affordable premiums, broad provider access and the capacity to collect and use patient information on a large scale to improve care.²

Opponents, on the other hand, see the public plan as little more than a stalking-horse for a single-payer, government run health care system similar to Canada and Europe. They view a public plan as an effort to undermine the traditional insurance model by creating a government agency with the power to extort price concessions from provider groups that private insurance could not match. The new public plan will use its powers to set artificially low payment rates. The result will be public plan rates far lower than that of private insurers. The public plan’s lower rates would be an incentive for businesses to eliminate their existing coverage and shift their employees into the public plan. Once participation in the public plan reaches a certain critical mass, private insurance options would disappear and the government would be left as the sole provider of health care in the United States.³

¹ Rep. Pete Stark, Extension of Remarks, *Congressional Record*, January 6, 2009, p. E23.

² Jacob S. Hacker, Ph.D., “Health Competition – The Why and How of ‘Public Plan Choice’”, *New England Journal of Medicine*, Vol. 360, No. 22, May 28, 2009, pp. 2269.

³ The Heritage Foundation, *The Public Health Plan: What Seems to be the Problem?*, <http://blog.heritage.org/2009/05/21/the-public-health-plan-what-seems-to-be-the-problem>



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Physicians should be wary of any proposal designed to create a new Medicare system. Medicare administratively sets payment rates for physicians. The payment rates set by Medicare fail to compensate physicians fully for the treatments they provide patients.⁴ Physicians should also be concerned about how the government will implement and use comparative effectiveness review. A public plan administration working in conjunction with an agency determining which benefits are most cost-effective could lead to rationing of care in the name of savings and interfering in the doctor patient relationship.

Public Plan

President Obama endorsed the concept of a public plan early on in his campaign. The public plan proposal is based on 2001 paper by University of California-Berkley political science professor Dr. Jacob Hacker, Ph.D. According to Dr. Hacker, a public plan must be properly structured, compete on a truly “level playing field” with private plans, and have the authority to use its bargaining power to encourage greater value in health care delivery.

A level playing field means requiring that public and private plans operate under the same rules. It also includes establishing mechanisms to ensure that risk adjustment protects plans from being competitively disadvantaged if they enroll a less healthy group of people. Finally, it requires regional pricing that allows private and public plans to compete within regions on the same terms without having the public plan compete on a national basis with regionally based private plans.⁵

The most critical element of the public plan approach is creation of a public body with the authority to bargain for reasonable rates from a range of cost control options. The savings achieved would have to be “scorable” by the Congressional Budget Office (CBO) in order to produce budget savings for the national budget.⁶ Supporters walk a fine line in trying to structure a body that would have the ability to control costs in a meaningful way without creating a structure with overt price controlling features.

According to Dr. Hacker, the most effective and easily implemented model for the new public plan is a “Medicare-like” plan that builds upon Medicare’s administrative infrastructure and basic framework of coverage. He proposes that the new public plan be separate from the existing Medicare program’s risk pool. He also recommends the new public plan be different from the existing Medicare program regarding payment and benefits by structuring a national,

⁴ Congressional Budget Office, “Key Issues in Analyzing Major Health Insurance Proposals,” December 2008, pp. XIX, 91-97, at <http://www.cbo.gov/ftpdocs/99xx/doc9924/12-18-KeyIssues.pdf>

⁵ Jacob S. Hacker, Ph.D. “Health Competition: How to Structure Public Health Insurance Plan Choice to Ensure Risk-Sharing, Cost Control, and Quality Improvement,” Institute for America’s Future, April 2009.

⁶ Ibid.



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comprehensive approach rather than fragmented coverage under the existing Medicare program.⁷ Indeed, Dr. Hacker sees the creation of a comprehensive national and regional plan for Americans under-65 as a format that could be used to reform the existing Medicare system into something similar.

Critics of the public plan are quick to point out that it is highly unlikely private plans will ever be able to compete with a government plan, especially one with the power to set payment rates through regulation or statute. Physicians already face arbitrary cost reductions imposed by the Medicare Sustainable Growth Rate (SGR). Although Congress generally repeals the rate changes, the potential \$1 to \$1.6 trillion dollar cost of the proposals currently under consideration leave very little room in the budget. There is also some doubt as to whether Dr. Hacker really believes in competition, since he is on record stating that there is too much competition in the private insurance market and that “competition does not require an endless array of choices but rather a reasonable number of meaningfully different choices.”⁸

The United States has a complex combination of public and private insurance coverage, including self-insurance and policies purchased from insurance companies. Nearly 170 million Americans get their insurance through their employers. Within this system, large employers self-insure and hire insurance companies to manage their programs while smaller employers buy their coverage directly. A hodge-podge of state insurance mandates as well as small risk pools makes this approach expensive. Indeed, for individuals, the costs can almost be prohibitive or lead to inadequate choice.

Although Medicare is held up as an example of how a public plan would operate to reduce costs in the overall system, the existing payment rates for Medicare, as well as Medicaid, are driving higher costs in the commercial market because of cost-shifting. This is caused by inadequate payments to hospitals and physicians. A 2008 study conducted by Milliman found that in 2007, Medicare and Medicaid under-compensated physicians and hospitals by approximately \$88.8 billion.⁹ The physician portion of that underpayment totaled \$37.8 billion.¹⁰

The creation of a public plan would exacerbate this problem. A 2009 study by the Lewin Group found that a public program would have a significant impact on provider payments. On the one hand, expanding coverage would reduce uncompensated care for uninsured people and

⁷ Ibid.

⁸ Jacob S. Hacker, Ph.D., “Health Competition – The Why and How of ‘Public Plan Choice’”, *New England Journal of Medicine*, Vol. 360, No. 22, May 28, 2009, pp. 2269

⁹ Milliman, “Hospital & Physician Cost Shift: Payment Level Comparison of Medicare, Medicaid, and Commercial Payers,” December 2008, pp 7.

¹⁰ Ibid, pp. 7.



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would result in increased health services utilization for the newly insured, all of which would represent new revenues to providers. However, these increases in revenues would be largely offset by reductions in payment levels for people who shift from private insurance to the public plan and the provider's cost of providing additional care to the newly insured.¹¹

Assuming the public plan is open to all individuals and all employees, physician net income would fall by about \$33.1 billion in 2010, or about 6.8-percent of physician incomes. The effect on physicians would be smaller under a scenario where large firms are prohibited from participating in the public plan. In that case, physician income net of practice expenses would fall by \$3.0 billion.¹² The figure below presents estimates of the impact of the public plan program on provider incomes under the alternative payment level assumptions for the public plan.

Figure 8
Impact on Hospital and Physician Net Income in 2010 (billions)

	Hospital Income		Physician Income	
	Small Firms Only	All Firms Eligible	Small Firms Only	All Firms Eligible
Assuming Medicare Payment Levels				
Payment Level Reduction	-\$10.7	-\$58.0	-\$6.0	-\$36.1
Payments for Previously Uncompensated Care	\$22.0	\$22.0	\$3.0	\$3.0
Net Change	\$11.3	-\$36.0	-\$3.0	-\$33.1
Change as a Percent of Total Revenue	1.0%	-4.6%	-1.6%	-6.8%
Assuming Midpoint Payment Levels (i.e., between Medicare and Private Payer Rates)				
Payment Level Reduction	-\$6.1	-\$29.3	-\$4.8	-\$19.8
Payments for Previously Uncompensated Care	\$22.0	\$22.0	\$3.0	\$3.0
Net Change	\$15.9	-\$7.3	-\$1.8	-\$16.8
Change as a Percent of Total Revenue	2.0%	0.9%	-0.5%	-3.1%

Source: The Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

Physicians should also be aware of proposals to raise income eligibility standards for Medicaid as part of the public plan. Many of the newly Medicaid-eligible beneficiaries already are covered by employer-provided or individually purchased insurance. Many of these individuals will shift from the private to the public system. A 2004 Robert Wood Johnson Foundation survey of 22 studies of the relationship between government insurance programs and

¹¹ The Lewin Group, "The Cost and Coverage Impacts of a Public Plan: Alternative Design Options," Staff Working Paper #4, April 6, 2009, pp. 6 at http://www.lewin.com/content/publications/Testimony_April_29_2009.pdf

¹² Ibid. pp. 6



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private coverage concluded that substitution of government for private coverage “seems inevitable.”¹³ While Medicare only reimburses physicians at 81-percent of cost, Medicaid is far worse in reimbursing at 56-percent.¹⁴

Government enthusiasm for comparative effectiveness in conjunction with a public plan also raises potential red flags for physicians and other providers. The 2009 Stimulus Package included a provision authorizing \$1.3 billion for the federal Agency for Healthcare Research and Quality to conduct a “comparative effectiveness research program.”¹⁵ The bill also created a Federal Coordinating Council for Comparative Effectiveness, to coordinate comparative effectiveness research throughout various federal government departments and agencies.¹⁶

The drive for comparative effectiveness in Congress comes from studies that have found that nearly 30-percent of all U.S. health spending produces no discernable value.¹⁷ Medicare spending varies widely from region to region without any evidence that the variation is reflected in the health of patients or procedural outcomes.¹⁸ CBO suggests that the United States could save as much as \$700 billion annually if we could avoid treatments that do not result in the best outcomes.¹⁹

While it may make sense to fund studies that test and develop information on the effectiveness of various treatments and technology, there is a real danger in having the government fund such efforts. The question that would need to be answered is, would comparative effectiveness research simply be used to provide information or would it be used to impose a government-dictated way of practicing medicine. Does the government intend to use comparative effectiveness to ration care? Do they intend to set strict coverage policies that interfere with decisions of physicians on how want to treat their patients? There is no doubt that health care systems in other countries use comparative effectiveness research as the basis of rationing. For example, in Great Britain, the National Institute on Clinical Effectiveness makes such decisions, including a controversial determination that certain cancer drugs are “too

¹³ Getsur Davidson et al., “Public Program Crowd-Out of Private Coverage: What are the Issues?” Robert Wood Johnson Foundation Research Synthesis Report no. 5, June 2004.

¹⁴ Igenix Consulting in partnership with the Lewin Group, “The Obama Health Reform Proposal: Impact on Payers,” December 8, 2008, p.7.

¹⁵ American Recovery and Reinvestment Act of 2009, HR 1, 111th Congress, 1st Session, *Congressional Record*, 155 (February 12, 2009), H 1423

¹⁶ *Ibid*, p. H 1326

¹⁷ Gerard Anderson and Kalipso Chalkidou, “Spending on Medicare Care: More is Better?” *Journal of the American Medical Association*, 299, no. 20, May 28, 2008, pp. 2444-45.

¹⁸ Elliot Fisher, Julie Bynum and Jonathan Skinner, “Slowing the Growth of Health Care Costs – Lessons from Regional Variation,” *New England Journal of Medicine*, 360, no. 9 (2009): 849-52

¹⁹ Peter Orszag, “Opportunities to Increase Efficiency in Health Care,” (statement of the Congressional Budget Office at the Health Reform Summit of the Committee on Finance, United States Senate, June 16, 2008).



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expensive.”²⁰ The German health care system uses an elaborate system of independent boards to limit care options and access to new therapies and treatments.

Support for a single-payer, national health care system is strong within the Democratic caucuses in Congress. Unable to push aggressively for a single-payer system, a public plan has become a line in the sand for liberal and progressive Democrats. A majority of Democrats in both the House and Senate favors creation of a public plan as a means to rationalize costs, ensure commonality of benefit design and guarantee full coverage for all Americans.²¹

However, Democrats in Congress have found this approach to be a hard sell with the public and with the more conservative and moderate members of their own party. While Democrats in the House may be able to use their majority power to ram through an expansive health reform bill with a public plan, their chances in the Senate are far from certain. Neither of the plans currently emerging from the Senate Finance or Health Committee have provided any meaningful details on how a public plan would be structured and Republicans in the chamber appear to be united in opposing a public plan unless it were a fall-back option. Senate rules pose the challenge of gathering 60 votes to bring a bill to a vote. With Republicans likely to be united in opposing a bill with an expansive public plan, Democrats cannot afford to lose any of their own members.

As details emerge on the true structure of the public plan, physicians should be careful to examine how closely to Medicare the new administrative function is structured. Other issues to monitor include:

- How will the public plan set payment rates?
- Will the public plan underpay physicians like the Medicare program?
- Will large employers be eligible to participate in the public plan and will this result in the end of the employer-provided health care system in the United States?
- Will the private insurance system survive or will we end up with a single government plan over the next few years?
- Will the public plan utilize comparative effectiveness data emerging from the federal government as a means to ration care and interfere in the doctor-patient relationship?

²⁰ Jacob Goldstein, “U.K. Says Glaxo’s Breast Cancer Drug Isn’t Worth the Money,” *Wall Street Journal*, July 7, 2008.

²¹ Stark, pp. E22