Understanding Insurance: Will a Public Option or Co-op Get Us Where We Want?

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A “public option” (ie, allowing individuals to purchase government-run health insurance) has been proposed as a solution for achieving universal health coverage in the United States. Politicians have told us not to fear a public option because government-run programs such as Medicare work well—without any of the dreaded rationing of care that critics claim would occur. Recent town hall meetings have demonstrated that many elderly Americans are satisfied with their Medicare coverage and will fight fiercely to protect it.

Medicare does provide good benefits—with the working population paying for current retirees. Today, however, Americans are living an average of 4.3 years longer than they were in 1965, when the program started. In addition, the percentage of the US population receiving benefits has jumped from 9.5% at the program’s inception to 13% today—a 37% increase.

As more and more “baby boomers” retire, the Medicare-eligible population is projected to expand to 16% by 2020 and to 19.3% by 2030. According to a May 2008 speech by Richard W. Fisher, president and chief executive officer of the Federal Reserve Bank of Dallas, the present value of unfunded liabilities for Medicare Part A (hospitalizations) is $34.4 trillion; for Medicare Part B (physicians), $34 trillion; and for Medicare Part D (drug benefits), $17.2 trillion. These numbers represent a grand total of $86 trillion of unfunded entitlements that our children and grandchildren will be paying for us.

Increased longevity and demographic shifts account for part of the funding dilemma. The continued expansion of benefits and increased demand for costly new medical technology account for the rest of the problem. Given the extent of our current obligations, is the proposal of another publicly funded healthcare program responsible? There are three things that people want in any health plan. First, the plan should be responsibly administered and financially solvent. Second, it should provide good coverage at an affordable price. Third, the plan should not bankrupt the country, the insurance companies, or the individuals paying for it. A key issue to keep in mind is that a public program must be underwritten correctly or it will lose money. Nationwide, health insurers have been operating with only about a 2% profit margin in recent years. Although we want everyone covered, do we really believe that government is more efficient than the private sector?

Nonprofit and For-Profit Private Options

Where is the money in private health insurance going? About 85% of each premium dollar goes to pay claims (ie, the medical-loss ratio), and roughly 10% goes to administrative costs. Highmark Blue Cross Blue Shield, a nonprofit insurer based in Pittsburgh, Pennsylvania, has an explicit policy to keep its medical-loss ratio near 90%. Nonprofit insurers are granted this special tax status because they provide a needed public service. Nonprofits are good for the insurance industry because they help keep the for-profit insurers honest in premium pricing. Conversely, the for-profit insurers have incentive to reduce administrative costs to remain competitive in the marketplace and eke out a profit. The for-profit competitors force the nonprofits to keep their administrative costs from ballooning.

Politicians claim that public health programs have cheaper administrative costs than programs in the private sector. An examination of the evidence, however, casts doubt on that assertion.

How Medicare Works

The Centers for Medicare & Medicaid Services (CMS) pays third-party administrators and private insurers to pay the claims of patients. There is no one in the federal government who directly pays claims.

According to an April 2009 testimony before the US Senate by the director of Financial Management and Assurance of the US Government Accountability Office, Congress refused the CMS’s annual requests for about $580 million to combat fraud in 4 of the last 5 years—only to allow the CMS to waste at least $36 billion annually in “improper payments.” The chief counsel for the Department of Health and Human Services’ Office of Inspector General recently told Congress, “Although we cannot measure the full extent of healthcare fraud in Medicare and Medicaid, everywhere we look we continue to find fraud in these programs.”

Thus, it would appear that both nonprofit and for-profit private insurance carriers have an advantage over the government because they can use common sense, rather than relying on an act of Congress, to administer a plan.
Important Points to Consider

In order to better understand the current healthcare debate, it is important to keep the following ideas in mind when listening to the political pundits:

1. If Medicare was correctly underwritten, the program would not have the estimated $86 trillion deficit. Certainly, the terms of the policy and the premiums would be different in a responsibly administered program.

2. If a public plan is poorly underwritten, plan premiums will be below cost. Because the private sector—unlike the government—cannot subsidize losses by printing more money, the below-cost public plan will wipe out the private sector in time. In fact, the government will have an incentive to price its product below cost, as this will allow bureaucrats and politicians to claim they are providing a needed “service” to the American public.

3. Even if underwritten correctly and administered responsibly, a public plan provides no advantage over a private group plan with risk pooling. Furthermore, more attention will be paid to disease management, utilization review, and combating fraud under private sector coverage.

4. Eliminating the insurers’ requirement that applicants disclose preexisting illnesses or conditions when applying for a plan will not solve the problem of lack of universal coverage. Instead, it will force insurers to adjust premiums upward somewhat to account for the added risk of not being able to medically underwrite customers. Very large premium increases will result from the fact that individuals are not obligated to maintain continuous coverage—either individually or through their employers—for the privilege of being exempt from medical underwriting and waiting periods. According to the Patient Protection and Affordable Care Act (HR 3590)10,11 under consideration by Congress, the penalties for failing to maintain coverage would be $95 in 2014, $350 in 2015, $750 in 2016, and indexed thereafter. Common sense dictates that healthy people will elect to pay the proposed fine, and then they will join a health plan only after they become sick. This means that both public and private risk pools will be skewed to the sick, which—in turn—means that health insurance will become less affordable for everyone else.

5. State laws prevent competition from entering the marketplace in certain regions of the country. Health insurance should be allowed to be sold across state lines.

6. There is no need to create insurance cooperatives (ie, co-ops) or to operate exchanges to make privately run, but government-defined group benefit plans available. Medicare Supplemental Insurance (ie, MedSup, Medigap) is such a product, with about a dozen standardized options from which to choose. Anyone older than age 65 can buy MedSup coverage from any carrier licensed to sell it in their state. Slightly better pricing might be available with a group, such as the American Association of Retired Persons, but other, nongroup plans remain competitive. An individual does not have to join a group to be exempt from underwriting for preexisting conditions. Co-ops take considerable time and money to build and are advantageous only for future political organization.

7. Section 1322 of the Patient Protection and Affordable Care Act12 mandates the creation of co-ops. Under this legislation, private insurers or related entities in existence before July 16, 2009, cannot qualify as health insurance issuers in co-ops. Whatever one may think about current insurers, they have the people who know how to do the job. Private insurers have the systems and processes already in place to service the needs of their customers, to issue insurance cards, to offer a network of providers, and to pay claims. The co-op provision in HR 359012 necessitates that a number of new nonprofit companies will pop up and apply for startup loans and grants from the federal government. Who exactly will these new nonprofits be? After paying their premium dollars, will customers get the services they expect? Will claims be paid in a timely manner? Considering that the new nonprofits will have no track records, what assurance does the public have that any of these companies will be there tomorrow to pay claims? Does this situation open the public up to a substantial amount of potential fraud? Are state regulators prepared to handle the task of monitoring these companies, given the large number of new entities that will undoubtedly arise due to the amount of money at stake?

Of course, we can always rely on the government to protect us from the hucksters ... can’t we?

8. It’s important to remember that the private sector is administering current government health plans. Administrative costs may appear to be lower under public programs because the government will not pay for services to fight fraud, waste, and abuse. However, the belief that total coverage costs will decrease as part of a public program is ludicrous, as current government claims data demonstrate.9 In reality, with a public option, there will be less competition—and eventually no competition. At that point, to cut costs, physicians and hospitals will be forced to take whatever payments the government decides or they will go out of business. That is not a good plan for sustainability.

Hospitals may close. Doctors may emigrate. Where would that leave the American people?

If you are an advocate for a public option, please ask yourself a couple questions. Does Congress have the capacity to respond promptly to the
changing needs and demands of consumer citizens and to make sound business decisions? Good healthcare policy would have dictated that, several years ago, the age of Medicare eligibility be increased to 69 years. Yet, because of political reasons, there is probably not a single politician who would dare make such a suggestion, given that senior citizens are among the most active voting blocks. Isn’t such past political history an indicator of future performance?

Conclusion
It seems a violation of the current Medicare contract with Americans to take on additional public health plans when we do not have foreseeable means of paying for obligations already promised to the insured. A private-sector insurance carrier attempting to lure new customers with such a scheme would be prohibited from doing business by state regulators. Why should the federal government be held to a lesser standard when it is proposing to offer similar services?

References


10. The Patient Protection and Affordable Care Act, HR 3590, 1501 (2009).

11. The Patient Protection and Affordable Care Act, HR 3590, 5000A (2009).

12. The Patient Protection and Affordable Care Act, HR 3590, 1322 (2009).

Editor’s Note: Dr Smith submitted this editorial in December 2009. Although the “Patient Protection and Affordable Care Act” (H.R. 3590) was signed into law in March 2010, Dr Smith’s comments remain relevant to the future of healthcare in the United States.

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