

Can a Public Insurance Plan Increase Competition and Lower the Costs of Health Reform?

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Senator Barack Obama has proposed having a public plan available to those seeking coverage in a purchasing arrangement, such as the Federal Employees Health Benefits Plan. Senators Hillary Clinton and John Edwards had similar proposals. In the academic world, Jacob Hacker of Yale University has articulated the same proposal in his Health Care for Americans plan.² Likewise, the reform approach we (with Len Nichols of the New America Foundation) outlined in 2001, under the auspices of the Robert Wood Johnson Foundation's Covering America project, would have required each participating state's purchasing pool to include its own managed fee for service plan.³

The basic idea behind this approach is to develop a government-funded plan that would follow the traditional Medicare program in many respects and would compete with private insurers for covered lives. It could be modeled after the traditional Medicare program, but that is not a necessity; other government self-funded plan models are possible. Using the Medicare example, the plan could use Medicare's evolving systems of payment for hospitals, physicians, and other providers. The levels or rates of payment could be the same or perhaps somewhat higher than Medicare but lower than typical private payments today. The public plan could also use Medicare policies to determine what types of services, including new procedures and technologies, would be covered, and it could take advantage of Medicare research on medical homes, chronic care coordination programs, and health information technology and adopt them when cost-effective. Benefits would differ from Medicare in that they would be structured more like typical employer-based insurance, including pharmaceuticals, out-of-pocket maximums, and common levels of cost sharing. The expectation is that the administrative costs of the public plan would be below those of the private competitors.

The intent of the competing public plan is to use the administrative efficiencies of government-run health insurance plans, as

well as the purchasing power of government to control costs. The underlying argument is that individual insurers do not have (or are unwilling to use) the market power to counter the pricing power of many hospital systems or physician specialties. This seems likely to remain true even if reforms lead to more aggressive competition in insurance/managed care markets. Thus, the power of a larger purchaser motivated to contain costs is needed to control rising health care expenditures.

The concerns over the use of a public plan are that its purchasing power will be overused⁴ and will lead to the elimination of the private market and to a government-run health care system. The overuse of monopsony power, seen by some as inevitable because of budgeting constraints, could then lead to reduced access, lower quality, and the explicit rationing of health care due to constraints on supply and financing. There is also concern that government plans have unfair advantages over private plans: they don't need to maintain reserves, earn profits to attract capital, or pay premium taxes.

In this brief, we argue that using a public plan is a good idea and will likely contribute to cost containment but is probably not a panacea. It's likely to have lower administrative costs and to exert more control over provider payment rates. But there are clear limits on the use of government power as a payer. As a

result, concerns that it will drive out strong private competitors are misplaced.

Administrative Cost Savings

According to the evidence on administrative costs, government-run plans have lower administrative expenses than private plans, particularly those in the individual and small group market. Woolhandler, Campbell, and Himmelstein find that private insurance overhead amounted to 11.7 percent of premiums, compared with 3.6 percent overhead for Medicare and 6.8 percent for Medicaid.⁵ Estimates of Medicare administrative costs are often understated because they often exclude the costs of CMS administrative staff, office space, and collecting Medicare premiums and payroll taxes.⁶

After accounting for these, Matthews finds administrative costs of government programs to be in the neighborhood of 5 percent.⁷ Private administrative costs, including profit, commissions, and taxes, are as high as 30 percent in the individual market, 23 percent in the small group market, and 12.5 percent in the large group market. In part, Medicare administrative costs are low because of the higher average claim costs. High fixed costs of insurance administration mean that lower levels of claims, due to a healthier group or a lower actuarial value of the plan, will have higher administrative costs relative to claims. When Matthews adjusts for the larger claim levels in Medicare, he finds that the program's administrative costs, if a more representative segment of the population were being covered, would be 6–8 percent, still lower than in private plans.

The Congressional Budget Office (CBO) has conducted a comparison that gets around both the claim size and the understatement of government administrative costs problem. CBO compared the administrative costs and private health plans participating in Medicare with those of the traditional Medicare program. Both estimates would underestimate Medicare administrative costs for the reasons given above, but the key point is the differential.⁸ CBO concludes that administrative costs and profits account for 11 percent of private plans, while the administrative costs of the Medicare

fee-for-service program are less than 2 percent of expenditures. Thus, several studies have concluded that there is a significant difference between public and private plan administrative burdens; consequently, a public plan with the same benefits as a private plan should be lower cost simply from administrative efficiencies.

The savings thought inherent in a competing public plan can be overstated, however. The administrative costs of health insurance plans lie in claims processing, utilization review and provider profiling activities, disease and chronic care management, marketing, underwriting, collecting premiums and profits.⁹ Several of these functions—for example, claim processing, claims and utilization review, and care management and premium collection—would all be part of any public plan. In a system that includes competing plans within an exchange, marketing costs may be reduced but do not disappear. Underwriting costs would presumably be eliminated, but commissions and profits for private plans would not. Thus, while administrative costs would likely be lower in a new public plan, they are not likely to be as low as in current public plans. Further, administrative costs of private plans within a purchasing exchange would not be as high as we now see in the individual and small group market. Thus, while differences will remain, they are not as great as some expect.

Provider Payment Rates

The second reason for having the government play a role as a competing plan is because insurer and hospital markets are increasingly dominated by large insurers and provider systems. The increased concentration has made it difficult for the nation to reap the benefits usually associated with competitive markets.¹⁰ The consolidation in the insurance market has not led to strong insurers who are willing or able to negotiate effectively with dominant hospital systems. As a result, countervailing power on the demand side may be needed to control costs.

Insurance markets have become dominated by a small number of large insurers. For example, Robinson found that in all but 14 states, three or fewer insurers accounted for 65 percent of the commercial market in 2003.¹¹

The Herfindahl-Hirschman Index (HHI) is a measure of market concentration used by the Department of Justice and the Federal Trade Commission to analyze markets and evaluate whether mergers and acquisitions should be blocked.¹² Thirty-four states had HHIs of greater than 1800, the level at which the federal guidelines deem markets highly concentrated and therefore of anti-trust concern. Robinson also found, when examining data from 2000 to 2003, that while medical care costs grew considerably faster than inflation during these years, private insurer revenue increased even faster. Thus, the market power of insurers meant that they were not only able to pass on health care costs to purchasers but to increase profitability at the same time.

Dominant insurers do not seem to use their market power to drive hard bargains with providers, for at least four reasons. First, insurers believe, probably correctly, that they cannot attract enrollees without including flagship hospitals. As a consequence, large and expensive teaching hospitals, have little incentive to negotiate with insurers and lower prices. Second, small insurers do not aggressively compete over price. Rather, rising premiums and increased profitability of nondominant firms¹³ provide indirect evidence of shadow pricing by smaller insurers; that is, smaller insurers do not seem to compete on premiums to gain market share but rather seem to follow the pricing of the dominant insurer. Competition in insurance markets is often about getting the lowest risk enrollees as opposed to competing on price and the efficient delivery of care.¹⁴ Third, the market is affected by the lack of clear information necessary to allow individuals to effectively shop for plans based on benefits, price, and quality. Without active competition, the dominant insurers have no need to bargain aggressively with providers. Finally, the consolidation of hospital systems that has occurred in recent years has also severely limited insurers' ability to negotiate with hospitals for lower rates.

Hospital consolidation has expanded rapidly since about 1990, in part as a response to the growing market power of insurers and managed care plans.¹⁵ Often hospitals have allied with physician group practices to further

strengthen their bargaining power. Estimates from Vogt and Town suggest a one-third reduction in the number of local hospital systems over this period in metropolitan areas.¹⁶ Further, 88 percent of large metropolitan areas are in highly concentrated markets (HHIs greater than 1800) as defined by the Federal Trade Commission and the Department of Justice.¹⁷

Results from several studies on the impact of consolidation are mixed, but they generally suggest that hospital prices are, at a minimum, 5 percent higher than in less concentrated markets. Several studies show larger increases.¹⁸ When consolidation occurs among hospitals geographically close to one another, price increases have been substantially larger, as much as 40 percent or more.¹⁹ Further, there is evidence of shadow pricing; rival hospitals also have increased prices in response to market consolidation.²⁰ Other evidence suggests that hospital consolidation has produced cost savings for the consolidated hospitals; together with evidence of increased prices, this suggests that increased market power has led to increases in hospital profitability.²¹ Finally, while the evidence is somewhat mixed, it suggests that hospital consolidation does not improve the quality of care.²²

One response to insurer and hospital consolidation is that there should be more aggressive antitrust enforcement.²³ The recent history of The Federal Trade Commission and Department of Justice efforts in this area has not been encouraging. Indeed, since 1994, the agencies have suffered an unprecedented seven consecutive defeats in litigated cases.²⁴ The agencies remain committed to antitrust enforcement,²⁵ and antitrust review still discourages some planned mergers.²⁶ However, to us, this path does not now seem a promising way to address the consolidation issues on a broad scale,²⁷ particularly given that in so many markets the key mergers have already occurred.²⁸

Another response to consolidation in the insurer and hospital markets is to use a public plan with a substantial number of covered lives as an engineer of cost containment. Medicare has clearly had some success in restraining

hospital and physician payments. For example, in 2005, the private payment-to-cost ratio for hospitals exceeded 1.20, while Medicare payments were about 4 percent below hospital costs.²⁹ Medicare physician payments are also 20 percent less than rates paid by commercial insurers in 2006.³⁰ Moreover, Boccuti and Moon have shown that the Medicare program had slightly lower average rates of growth in spending for comparable services between 1970 and 2000 than private insurers.³¹ Finally, White has shown that Medicare payment policies have reduced Medicare cost growth over time, particularly for hospital and post-acute care services; spending growth for the nonelderly did not show similar reductions.³²

There are, however, limits to the savings that can be achieved with the government as a strong competing payer. While the government will likely have considerable power to set provider payment rates, it is not likely to use all the market power it has available. The problem is that the government, as a strong buyer, becomes responsible for the health and stability of the system. If it limits hospital and physician payments too strictly, it faces the risk of perhaps causing hospital closures, slowing down the introduction of new technologies by more than is socially desirable, limiting access to physician services, and affecting the quality of individuals seeking medical education.

Politics (pressure from provider organizations, and public concern) also tends to weaken the will of policymakers to aggressively contain costs. The fact that the government will not use all the power available is evident from Medicare payment and coverage decisions. An example is the sustainable growth rate (SGR) policy introduced in 1998.³³ The intent was to not allow real spending per Medicare beneficiary to grow faster than the national economy as measured by per capita growth in gross domestic product (GDP). If Medicare spending for physician services grew faster than GDP, then the annual increase in physician fees would be less than the increase in physician input prices, and fees could even be reduced.

The intent of the policy was to give physicians a strong incentive to control

utilization. The problem is that the measure of compliance applies to physicians in the aggregate, not at the individual level. But individual physicians are unlikely to believe that their own behavior materially affects the outcome being measured. As a consequence, expenditure growth has typically exceeded the increase in GDP. But rather than see physician fees decline, Congress has consistently (with the exception of 2002) provided for continued fee increases. Most recently, Congress agreed to small increases in Medicare fees for 2008 and 2009, rather than see the scheduled 10.5 percent reduction in fees be implemented. Regardless of whether Congress made the correct decision in this case, it is an example of how difficult it is for the government to use its power to reduce provider payments.

Another example of the limits to government power is Congress's unwillingness to let Medicare negotiate with drug companies over prescription drug prices. Another is the approval of computed tomography angiography by Medicare carriers in response to intense lobbying from physician specialists who employ the procedure despite limited research evidence and skepticism by the Medicare Coverage Advisory Committee.³⁴

The Likely Scenario

We think that a public plan would not drive out private competitors and result in a government takeover of the system, nor would it be fully successful in controlling cost growth. Rather, there is a more realistic scenario for how public plans would operate as competitors with private plans in a purchasing pool or exchange arrangement. The public plan would lead to control of cost growth, but the extent of control would be limited for the reasons noted above. Private plans would not disappear. Private plans that offer better services and greater access to providers, even at a somewhat higher cost than the public plans, would survive the competition in this environment. It is also conceivable that private plans offering a lower-cost option—for example, lower premiums than the public plan, say by exploiting care management innovations, and network and payment rate limitations—could stake out a separate competitive niche in some markets. This depends in part on how payment rates are

set by the public plan. If we are right that there is a real constraint on the use of government power, then it is entirely feasible that lower-cost private plans could survive.

The presence of private plan competition will place a constraint on how penurious a public plan can be. Public plans would have to keep physicians and hospitals reasonably happy, otherwise enrollees would exit to private plans. The presence of a well-run public plan would constrain private spending, as the plans would have to compete on price, which does not frequently occur today. Private insurers who are not adding much value and lack clout are likely to disappear in the face of public competition. But at the same time, those that are able to offer a superior product through high levels of efficiency, satisfaction in consumer preferences and ease of access to quality medical services will survive in a reformed market. Incentives for them to innovate in the areas of cost containment and service delivery will be enhanced by the presence of a well-run and effective public plan. Integrated health systems, for example, would likely do well because of their inherent efficiencies.

Another issue with a competing public plan is that it could be attractive to individuals in poor health or with disabilities. This is particularly true if the public plan develops state-of-the-art care management programs. The market can provide a disincentive for private insurance plans to develop model programs for treatment of, say, diabetes, asthma, or HIV/AIDS because this increases the likelihood that the plans will attract patients with these conditions. The public sector does not have the same motivation; in fact, the public sector should be able to contract for the best care management systems available. But to the extent better care management attracts poorer risks to the public sector, it will be important that this not be reflected in the pricing of the public program option. To the extent that patients with these

kinds of health conditions enter public plans, there are savings to the remaining private plans. Some higher costs could compensate for certain government advantages (no need for reserves, profits, taxes), but there will still be a need for risk adjustment. Most of the excess cost of these higher-risk patients that are borne by the public sector should be paid for either through an assessment on the competing private plans or through taxes.

Conclusion

Having a competing public plan will neither destroy the private insurance market nor lead to a government takeover. Private plans are attractive because of their ability to be responsive to consumer demands for choice and their innovations resulting from both the profit motive and desire to attract a larger enrollment base. Public plans are attractive because they can offer better access to necessary care for diverse populations, they have lower administrative costs, and they can be large-scale purchasers with a strong negotiating position with providers. The presence of both types of plans should allow the advantages of each to enhance a reformed insurance marketplace while protecting the markets from the potential negative consequences of each type acting alone.

The competing public plan is likely to be useful as part of a cost-containment strategy, but it is not all that is needed. Using electronic medical records; evaluating the cost effectiveness of new technologies; developing ways to manage the care of high-cost chronically ill individuals; designing cost-sharing structures that encourage the use of high-value services; developing payment reforms that better price services to align with costs; and implementing public health measures to reduce obesity, smoking, diabetes, and other chronic conditions all need to be part of the system as well.

NOTES

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- ²⁴ Unprecedented is the word used by scholars Peter J. Hammer and William M. Sage in “Critical Issues in Hospital Antitrust Law,” *Health Affairs* 22, no. 6 (2003): 88–100, at 90, note 5. A very recent account noted, “Two of the FTC’s latest efforts to thwart mergers fizzled” (Lauren Pollock, “Inova Drops Merger Proposal after Delays by FTC Are Seen,” *Wall Street Journal*, June 9, 2008, Page B4).
- ²⁵ See FTC and DOJ, *A Dose of Competition*, note 16 above.
- ²⁶ Pollock, “Inova Drops Merger Proposal,” note 23 above.
- ²⁷ The bedrock of antitrust analysis is the geographic area within which hospital concentration affects prices, yet “the law concerning hospital market definition is in shambles,” conclude Hammer and Sage, “Critical Issues,” note 23 above, at 90.
- ²⁸ A very recent FTC enforcement action may indicate a shift toward more assertive antitrust policy, or it may constitute an exception that proves the rule. In 2005, a federal Administrative Law Judge ruled that Evanston Northwestern Healthcare violated the Clayton Act by previously acquiring nearby Highland Park Hospital and called for divestiture. The hospital appealed the ALJ’s decision to the full FTC, which ruled in August 2007 that the merger had been anticompetitive but that, given the passage of time and Northwestern investment in its acquisition, the appropriate remedy was not divestiture but fully separate negotiation of health plan rates by the two parts of the merged system. *In the Matter of Evanston Northwestern Healthcare Corporation and ENH Medical Group, Inc.*, Docket No. 9315 <http://www.ftc.gov/os/adjpro/d9315/index.shtm> (last accessed 25 July 2008). The final decision on the remedy was issued only on April 28, 2008, and a hospital decision on appeal is evidently still pending.
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