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THE CASE FOR PUBLIC PLAN CHOICE IN NATIONAL HEALTH REFORM

KEY TO COST CONTROL AND QUALITY COVERAGE

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EXECUTIVE SUMMARY

Leading political figures, including President-Elect Barack Obama,[1] Senate Finance Committee Chair Max Baucus,[2] and Secretary-Designate of the Department of Health and Human Services Tom Daschle[3] are proposing to offer a new public insurance option to Americans who lack employment-based coverage. The public plan would be similar to conventional Medicare (the "public Medicare plan," as distinguished from private plans that contract with Medicare) in that it would be managed by the federal government and pay private providers to deliver care. The public plan would be offered through a new national insurance "exchange," where it would compete with private insurance plans.

This policy brief sets out the argument for public plan choice. The core argument is that public insurance has distinct strengths and thus, offered as a choice on a level playing field with private plans, can serve as an important benchmark for private insurance within a reformed health care framework. This is not an argument for a universal Medicare program, but instead for a "hybrid" approach that builds on the best elements of the present system—large group plans in the public and private sectors—while putting in place a new means by which those without access to secure workplace insurance can choose among health plans that provide strong guarantees of quality, affordable coverage. The case made in this brief is that this menu of health plans *must* include a good public plan modeled after Medicare if the broad goals of reform—universal insurance and improved value—are to be achieved.

First, public insurance has a better track record than private insurance when it comes to reining in costs while preserving access. By way of illustration, *between 1997 and 2006, health spending per enrollee (for comparable benefits) grew at 4.6 percent a year under Medicare, compared with 7.3 percent a year under private health insurance.* At the same time, Medicare has maintained high levels of provider participation and patient access to care.

Medicare has proven superior at cost control not just to health plans in the private sector, but also to private plans that contract with the federal government, such as those offered through the Federal Employees Health Benefits Program (FEHBP)—suggesting that public insurance can outperform private plans even in the context of insurance reforms.

Second, over the last generation, public insurance has pioneered new payment and quality-improvement methods that have frequently set the standard for private plans. More important, it has the potential to carry out these vital tasks much more effectively in the future, using information technology, large databases of practices and outcomes, and new payment approaches and care-coordination strategies. Indeed, a new public plan could spearhead improvement of existing public programs as well as private plans.

Third, public plan choice is essential to set a standard against which private plans must compete. Without a public plan competing with private plans, we will continue to lack strong mechanisms to rein in costs and drive value down the road. As a benchmark, a new public plan alongside private plans will help unite the public around the principle of broadly shared risk while building greater confidence in government over the long term.

Public plan choice will allow Americans to realize the benefits of both public and private plans: flexibility and security, innovation and stability, and market and democratic accountability. And, according to opinion polling, this is what most Americans want: public and private insurance competing side by side so that they can choose the best option for themselves and their families.

ACKNOWLEDGEMENTS

This brief was prepared with the joint support of the Center for Health, Economic & Family Security, U.C. Berkeley School of Law, and the Institute for America's Future in Washington, D.C. At the Center, Ann O'Leary, Melissa Rodgers, and Rachel Pepper provided invaluable assistance at every stage of the process. At the Institute, Roger Hickey and Diane Archer also offered extensive encouragement and help from beginning to end. Special thanks go to Frank Clemente for his rich forays into the evidence concerning the comparative performance of Medicare and private health insurance as well as his helpful guidance on matters big and small. Alex Lawson provided ample research assistance, Monica Sanchez enlivened the brief with valuable out-of-the-blue findings, and Ami Parekh did some of the original research on public and private plans. The media teams at both Berkeley and the Institute for America's Future, including Toby Chaudhuri, Janet Gilmore, and Susan Gluss, provided impressive support for the release of this brief. In addition, extremely helpful comments on a previous draft were provided by Gary Claxton, Debbie Curtis, David Cutler, Judy Feder, Leif Wellington Haase, John Holahan, Richard Kirsch, Deborah LeVeen, John Rother, Ellen Shaffer, Kenneth Thorpe, and Micah Weinberg. Marilyn Moon offered her deep insight on how best to analyze Medicare and private health spending—assistance supplemented by the able advice of Elise Gould. All of these experts' assistance greatly improved the brief, but in no way makes them responsible for its content or claims.

In recent years, the need for comprehensive health reform has become glaringly apparent. Health insurance premiums have skyrocketed, more than doubling from 1999 to 2008,[4] while the scope and generosity of private coverage have plummeted. Not only have the ranks of the uninsured continued to expand, but, in addition, the number of Americans who have insurance yet lack adequate protection against medical costs has increased dramatically.[5] Roughly half of bankruptcy filings are related to medical care, with the vast majority of medical bankruptcies involving households that *have* insurance coverage.[6] Employers, workers, states and localities, and the federal government—all have seen their budgets under siege because of runaway health care costs and all require immediate relief.

Amid the crisis has emerged a growing recognition not just of the need for action but also of the virtues of a public-private "hybrid" approach to health reform. Hybrids are "organizational arrangements that use resources and/or governance structures from more than one existing organization."[7] In health insurance, a public-private hybrid would build on the best elements of the present system: large group plans in the public and private sectors. At the same time, it would involve putting in place a new means of allowing Americans without access to secure workplace coverage to choose among insurance plans that provide strong guarantees of quality affordable coverage, with these guarantees including a guarantee of effective cost control—the central prerequisite of health security over the long run.

An essential feature of the hybrid approach is what this brief calls "public plan choice"—the creation of a new public plan modeled after Medicare that would be available to Americans younger than 65 who lack employment-based coverage. Leading political figures, including President-Elect Obama and Senate Finance Committee Chair Max Baucus, have advocated public plan choice. The Obama proposal, for example, would "make available a new national health plan . . . open to individuals without access to group coverage through their workplace or current public programs."[8] Similarly, Senator Baucus' proposal envisions a national insurance pool offering private plans alongside "a new public plan option, similar to Medicare."[9] These reform blueprints do not propose "Medicare for all." Rather, they build on group health plans in the public and private sectors to ensure that all Americans without good coverage are able to choose between public insurance with broad choice of providers and regulated private plans.

This policy brief lays out the case for public plan choice. It shows, first, that public insurance has a better track record than private insurance when it comes to reining in costs while providing inclusive, stable coverage with broad choice of providers. Our nation's largest public insurance plan, Medicare, has greatly improved its cost-control record over the last generation, and like other programs of public insurance, it has done so with low administrative costs while offering wide choice of medical providers.

The second key argument for public plan choice is that it is a prerequisite for substantially improving the quality and effectiveness of American medical care. Medicare has devoted increasing resources to improving the value of the care that it finances, but far more investment is needed. A new public insurance plan for those younger than 65 would enable the testing and evaluation of potential delivery system and payment reforms; the collection, reporting, and use of ongoing performance data; and the streamlining of paperwork and administration in ways that would not be possible without a broad public plan. If we simply try to regulate our private insurance system into shape, we will continue to lack strong institutional mechanisms to rein in costs and drive value down the road.

Third, and finally, the choice of a public plan alongside private plans will create an important benchmark for inclusive quality coverage that private plans will need to compete to match. As this brief shows, public and private insurance each have distinct strengths. Private insurance has been quicker to provide new benefit options and offers greater flexibility in benefit design and payment strategies, while public insurance has proved more stable and better capable of controlling costs while ensuring access, especially for the most vulnerable. Acting alongside each other, with enrollees able to choose between them on a level playing field, public and private insurance can serve simultaneously as a safety valve and a spur for improvement for each other.

Even within a reformed system, private plans will continue to have incentives to engage in activities that undermine health security, such as tailoring their benefits or provider networks to discourage less healthy people from enrolling. Moreover, acting alone, private plans have historically paid insufficient attention to obtaining greater value. This is in part because of their limited reach, inherent instability, and the frequent movement of patients in and out of their subscriber base, and in part because of their generally weak incentives to invest in broadly distributed information on quality or to share their performance data with other interested parties. Public plan choice creates an institutional "check and balance," encouraging private plans to uphold high standards of quality, affordability, and access.

In sum, public plan choice is essential if the broad goals of reform—universal insurance, greater value, and improved quality—are to be achieved. At the same time, it has the value of uniting Americans around the principle of broadly shared risk, while promising to build greater confidence in government over the long term.

The brief is not meant to be an exhaustive analysis of the relative strengths and weaknesses of public and private insurance.[10] (A companion report to be issued by the Institute for America's Future provides additional comparative data.) Rather, it is an attempt to make the case that public insurance has unique virtues that require its availability as a vital choice for all nonelderly Americans without secure workplace coverage. Despite the important place of public plan choice in the reform proposals of all the leading Democratic candidates for president during the 2008 election—including, of course, President-Elect Obama—the rationale for this crucial design feature of their plans has been insufficiently explored. Moreover, critics of public plan choice have made grossly exaggerated charges against Medicare that require an even-handed rebuttal.[11] Against the backdrop of these charges and the perennial handwringing about the risks to the federal budget posed by health spending, the real strengths of public health insurance are often insufficiently appreciated.

We might say, with Winston Churchill, that public health insurance is the worst alternative except for all the others. But we do not need to say that. What we can say instead is that public plan choice gives Americans the opportunity to choose for themselves how *they* value the strengths and weaknesses of a public, Medicare-like plan and competing private health plans. As health policy expert Jeanne Lambrew puts the point, the question is not why nonelderly Americans without secure workplace coverage should have the same choice that seniors do: enrolling in a public or private plan. The question is: "Why should policymakers give private insurers the exclusive right to cover Americans? If private insurers can better meet our goals for the health system, why object to a level competition with public plans?"[12]

WHAT IS PUBLIC PLAN CHOICE?

In essence, public plan choice is simple. Many reform plans envision the creation of new national or regional purchasing pools. Such pools, often called "exchanges," allow those without good employment-based insurance to choose among large private health plans, providing a basis for group pooling of medical risks similar to that provided by large employers. The public insurance option simply makes a public plan available alongside the private plans that can be enrolled in through the exchange. This plan will compete with private plans, ensuring an insurance product with broad choice of providers and encouraging private plans to match the administrative efficiencies, cost-control abilities, and quality-improvement capacities of public insurance.

Although simple in broad conception, public plan choice raises a number of questions about how the public plan should be structured (whether, for example, it would piggyback on Medicare or be separate), how it should compete with private plans (how, for example, the private plans would be paid to ensure that they did not cherry pick healthy patients, leaving less healthy enrollees in the public plan), and who should be able to enroll in the plan (whether, for example, it would replace Medicaid for working poor Americans or only be available to workers without other sources of coverage). The last section of this brief takes up the most important of these issues, namely, how to create a level playing field for public-private competition. The main purpose of the brief, however, is to discuss the rationale for public plan choice, not the exact form it should assume.

By the same token, the brief does not take up another attractive idea that is compatible with public plan choice: opening up Medicare to 55 to 64-year olds without workplace coverage. The rationale for such a Medicare buy-in is similar to that for public plan choice, but a buy-in raises separate issues that are beyond the scope of this brief.

Nor, finally, does this brief discuss proposals for simply expanding Medicare coverage, such as Representative Pete Stark's Americare Act[13] or the Medicare for All Act of 2006[14] introduced by Senator Edward Kennedy and Representative John Dingell—although the logic behind these proposals obviously relates to some of the advantages of public insurance discussed in this brief. Instead, the analysis focuses on proposals with two overarching features: (1) they include some sort of "pay or play" requirement permitting employers to choose between contributing to the cost of covering their workers through a new insurance exchange or providing coverage directly, and (2) they allow those enrolled in the exchange to choose between public and private insurance—that is, public plan choice.

The best way to illustrate the broad mechanics of public plan choice is to look at several proposals that include it: President-Elect Obama's campaign blueprint, Senator Baucus' recent proposal, the Commonwealth Fund's "Building Blocks" plan, and, finally, a proposal I prepared for the Economic Policy Institute in 2007: "Health Care for America."

The Obama Proposal

Under the Obama proposal, the new national public plan would be offered alongside a range of regulated private insurance options. These private options would be provided through a new "National Insurance Exchange." At the same time, larger employers that did not provide good coverage would be required to contribute to the cost of their workers' coverage through the national framework.

The public insurance option in the Obama proposal would be an attractive alternative to private insurance. To quote the Obama campaign release on the proposal, "The plan will have the following features:

- **Guaranteed eligibility.** No American will be turned away FROM ANY INSURANCE PLAN because of illness or pre-existing conditions.
- **Comprehensive benefits**. . . . The new public plan will include coverage of all essential medical services, including preventive, maternity and mental health care. Coverage will include disease management programs, self management training and care coordination for appropriate individuals.
- **Affordable premiums, co-pays and deductibles.** Participants will be charged fair premiums and minimal co-pays and deductibles for preventive services.
- **Subsidies.** Individuals and families who do not qualify for Medicaid or SCHIP but still need assistance will receive income-related federal subsidies to keep health insurance premiums affordable."

The Baucus Proposal

The Baucus proposal is similar to the Obama plan. A "Health Insurance Exchange" would be created to allow individuals without workplace coverage and small businesses to obtain affordable insurance. The exchange would offer highly regulated private plans, but also "a new public plan option, similar to Medicare." This option, according to the proposal, would offer the same level of benefits as private plans. The proposal also specifies that "rates paid to health care providers by this option would be determined by balancing the goals of increasing competition and ensuring access for patients to high-quality health care." The guiding consideration in creating the public plan option is "to ensure that the public-private insurance competition lowers costs and improves quality."

The Commonwealth Fund Plan

The Commonwealth Fund's 2008 "Building Blocks" proposal envisions offering a Medicare-like public plan to people under 65, along with a choice of private plans offered through an insurance "connector." These new plan options would be open to businesses with fewer than 100 employees, the self-employed and everyone without Medicare or large-employer insurance. Analyses by the Lewin Group, an independent health consulting firm, found that nearly everyone would be covered under the proposal, with about 40 million in the new public plan.

"Health Care for America"

The Obama, Baucus, and Commonwealth proposals overlap with a plan I first presented in 2001 and refined for the Economic Policy Institute in 2007: "Health Care for America." The core of this plan is a requirement that employers either cover their workers or contribute to the cost of coverage through a new national pool, "Health Care for America," through which Americans may choose between either public insurance or regulated private plans. Under this proposal, according to the Lewin Group, virtually all the U.S. population would be insured. A large majority of those younger than 65 would be covered by private insurance, either through their employers (roughly half of the nonelderly) or through private plans offered within the new pool (roughly 12 percent). But in addition to these private

options, a new public plan that builds on the strengths of Medicare while fixing its most serious shortcomings would also be available to those buying coverage through the new insurance pool. The Lewin Group projected that roughly 28 percent of nonelderly Americans would be covered under the new public plan envisioned in Health Care for America.

The public plan in Health Care for America would offer all services provided by Medicare as well as comprehensive mental health, maternal and child health services, and comprehensive prescription drug coverage. Monthly premiums for those enrolled through the workplace, including the self-employed, would be scaled to income, and cost sharing would be limited based on income: People in poverty would pay virtually nothing for their care. As a share of income, the maximum amount of allowable cost-sharing would be 2.5 percent for those between 100 and 150 percent of the federal poverty level, 5 percent for those between 150 and 300 percent of the poverty level, and 7.5 percent for those over 300 percent of the poverty level. Finally, the public plan would offer a "medical home" that would give enrollees enhanced benefits at no additional premium if a primary care physician coordinated all care and authorized specialty referrals, hospital admissions, and elective inpatient and outpatient procedures.

In short, the public insurance option in leading proposals is a core source of stable, quality benefits with relatively limited cost-sharing requirements. The main reason that the public plan in these proposals can promise such benefits, as the next section makes clear, is that public insurance has the proven capacity to provide the same level of benefits for less than private insurance, as well as to better restrain the increase in spending over time.

COST-CONTROL ADVANTAGES OF PUBLIC INSURANCE

It is often assumed that private health plans are much more efficient than public health insurance. Yet a range of studies demonstrate that public insurance is able to provide a given level of benefits for less than they would cost through private insurance. Lower administrative costs and the ability to bargain for lower service and drug prices chiefly explain this advantage, as does the obvious lack of a profit margin in public programs. These features of public insurance not only allow it to offer the same coverage for less than private plans. They also, the evidence suggests, allow it to better restrain the increase in costs over time while preserving inclusive coverage.

The remainder of this section focuses on the relative performance of Medicare and private health insurance in controlling costs. The Medicare program is under financial strain and has evident flaws that require correction, but it has performed far better relative to private health insurance than conventional wisdom suggests. And, as the next section of this brief discusses, a new public plan modeled on Medicare could do even better.

Administrative Efficiencies

Perhaps the most obvious advantage of public insurance is that it is inexpensive to administer. The public Medicare plan's administrative overhead costs (in the range of 3 percent) are well below the overhead costs of large companies that are self-insured (5 to 10 percent of premiums), companies in the small group market (25 to 27 percent of premiums), and individual insurance (40 percent of premiums).[15]

These administrative spending numbers have been challenged on the grounds that they exclude some aspects of Medicare's administrative costs, such as the expenses of collecting Medicare premiums and payroll taxes, and because Medicare's larger average claims because of its older enrollees make its administrative costs look smaller relative to private plan costs than they really are. However, the Congressional Budget Office (CBO) has found that administrative costs under the public Medicare plan are less than 2 percent of expenditures, compared with approximately 11 percent of spending by private plans under Medicare Advantage.[16] This is a near perfect "apples to apples" comparison of administrative costs, because the public Medicare plan and Medicare Advantage plans are operating under similar rules and treating the same population.

(And even these numbers may unduly favor private plans: A recent General Accounting Office report found that in 2006 Medicare Advantage plans spent 83.3 percent of their revenue on medical expenses, with 10.1 percent going to non-medical expenses and 6.6 percent to profits—a 16.7 percent administrative share.)[17]

The CBO study suggests that even in the context of basic insurance reforms, such as guaranteed issue and renewability, private plans' administrative costs are higher than the administrative costs of public insurance. The experience of private plans within FEHBP carries the same conclusion. Under FEHBP, the administrative costs of Preferred Provider Organizations (PPOs) average 7 percent, not counting the costs of federal agencies to administer enrollment of employees. Health Maintenance Organizations (HMOs) participating in FEHBP have administrative costs of 10 to 12 percent.[18]

In international perspective, the United States spends nearly six times as much per capita on health care administration as the average for Organization for Economic Cooperation and Development (OECD) nations. Nearly all of this discrepancy is due to the sales, marketing, and underwriting activities of our highly fragmented framework of private insurance, with its diverse billing and review practices.[19] Indeed, according to research by the Commonwealth Fund, the United States could save up to $46 billion a year if it spent what other countries with mixed public-private insurance systems, such as Germany, spend on insurers' administrative costs.[20]

Bargaining Leverage

The government has another advantage when it comes to holding down costs: It is capable of using its concentrated purchasing power to pioneer new payment methods that bring down costs. Medicare's improving cost-control performance over the last quarter century tracks closely the introduction of innovative changes in hospital payment using a prospective payment system in 1983 (a system by which hospitals are paid a pre-determined rate for each Medicare admission based on the patient's diagnosis at the time of admission) and the creation of a resource-based physician fee schedule (a scale of national uniform relative values for all physicians' services) and volume controls on overall Medicare physician spending in the 1990s.[21] While Medicare's methods of paying providers clearly require improvement, especially with regard to physician payment, the program's record is still notably superior to that of private insurance.

Perhaps the simplest way to look at Medicare's bargaining power is to compare Medicare rates with those paid by private insurance. According to the Medicare Payment Advisory Commission (MedPAC), Medicare's rates for physicians are 81 percent of private rates—a clear sign of superior negotiating leverage. For hospitals, MedPAC estimates that

Medicare pays around three-quarters of what private payers do.[22] These differentials have been relatively stable, and as noted below, they have not had the negative effect on provider participation or revenues that critics often suggest. Indeed, for-profit hospitals made record profits in 2007,[23] and the number of physicians billing Medicare is actually increasing faster than enrollment in Part B medical insurance.[24]

Another source of comparative insight is the relative costs of the public Medicare plan and private plans that contract with the program through Medicare Advantage. The gap between the administrative costs of the public Medicare plan (2 percent) and those of private plans (11 percent) has been mentioned. But the experience of private plans within Medicare offers a more general portrait of the (limited) ability of private plans to restrain costs.

As is well known, Medicare Advantage plans are substantially overpaid relative to what it would have cost to provide coverage to the same enrollee in the public Medicare plan—13 percent more on average per person, as calculated by MedPAC and confirmed by the CBO.[25] This overpayment reflects two main problems: a method for paying plans that subsidizes their participation in Medicare Advantage and the ability of the plans to attract healthier (and hence less costly) people with Medicare. Both of these problems can and should be addressed—in Medicare and in any new framework for public-private competition.

Yet the larger lesson of Medicare Advantage is that private plans do not appear to have strong tools for controlling costs relative to the public Medicare plan. The most tightly regulated HMOs have been shown to perform roughly as efficiently as the public Medicare plan does, but according to MedPAC, most private plans are not as efficient as the public Medicare plan. *All but HMOs bid to provide Medicare Part A and Part B benefits for more than the public Medicare plan spends on the same benefits—often much more.* Indeed, the fastest-growing category of Medicare Advantage plan, private fee-for-service plans are the least efficient and most costly for Medicare, with their bids for Part A and B benefits fully 108 percent of the public Medicare plan's costs.[26]

Were Medicare permitted to bargain directly for drug prices, moreover, there is no question it would receive better deals than currently offered to private payers. The CBO has found that drug prices under four federal programs—including the Veterans Health Administration (VHA) and Medicaid—are on average 49 percent below the average wholesale price of the drugs.[27] Another recent study found that the lowest price available for the top 20 drugs prescribed to seniors were 58 percent cheaper under the VHA plan than under Medicare Part D.[28] Medicare's private plans negotiated drug manufacturer rebates of only 8.1 percent in 2007.[29]

The failure of private insurers to obtain affordable prices is borne out by international comparisons as well. A recent McKinsey study finds that branded drugs in the United States are 60 percent more expensive than in Canada, with its "single payer" provincial insurers, and that the top-selling drugs of leading drug companies are 2.3 times more expensive here than in other rich nations, where public-sector bargaining is prevalent.[30]

Is Bargaining Unfair?

Government's use of its countervailing power to hold down prices is often criticized. A recent study released by the American Hospital Association, the Blue Cross Blue Shield

Association, and America's Health Insurance Plans claims, for instance, that Medicare and Medicaid grossly "underpay" providers, leaving private insurers to pick up the difference.[31] The study simply assumes, however, that all payers should pay the same rates and that the total level of payments to providers is appropriate. (As the press release touting the study says, "The study does not assess appropriate levels of payment, but rather the disparities among current payment rates.")[32] The whole point of bargaining, however, is to gain volume discounts and restrain total spending—insofar as doing so is consistent with ensuring good access to providers and high-quality care. So far, there is little evidence that Medicare bargaining has undermined access or quality.

It is worth remembering, after all, that price bargaining is exactly what HMOs and other big health plans were supposed to do—only Medicare appears to do it better. The consolidation of the private insurance market over the last two decades was widely expected to bring down costs. (In 16 states, the dominant carrier accounts for at least 50 percent of private enrollment; in 36 states, the top three carriers account for at least 65 percent of the market.[33]) Yet it obviously has not. Instead, private plans are passing on rising costs to individuals while increasing their profitability. The reasons for this are multiple, and they go to the heart of the argument for a public plan alongside private plans.

First, the hospital market has grown increasingly concentrated, giving providers considerable market power of their own in negotiations with insurers. In areas where hospital concentration has proceeded farthest, the evidence suggests, hospital prices and profitability are higher without commensurate increases in service quality.[34] Second, private insurers appear to have largely acquiesced to these price increases. As John Holahan and Linda Blumberg explain, "Dominant insurers do not seem to use their market power to drive hard bargains with providers . . . . Competition in insurance markets is often about getting the lowest risk enrollees as opposed to competing on price and the efficient delivery of care."[35] Both of these trends provide strong reason for doubting that private insurance payments are the appropriate standard for public payments.

In reviewing the evidence on hospital pricing, the March 2008 MedPAC report concludes that the public Medicare plan should *not* emulate the private sector in pricing. It notes that "hospital costs and Medicare profitability vary widely. Some hospitals are efficient enough to have low costs, positive Medicare margins, and high quality scores. Other hospitals have higher costs and lower Medicare margins. The Commission finds that, because of high private-payer payment rates, those hospitals often face little financial pressure to control their costs. Medicare should encourage hospitals to be efficient and control their costs, rather than accommodate high cost-growth resulting from lack of financial pressure."[36]

Nonetheless, the effects of concentrated purchasing power on the revenues of providers is understandably of central concern. Studies of cost shifting by the public Medicare plan onto private payers have produced mixed results:[37] The general conclusion is that there is some, albeit a much smaller amount than suggested by critics of Medicare pricing. A careful 2006 study of hospital cost-shifting in Medicare concludes that "a 1 percent relative decrease in the average Medicare price is associated with a 0.17 percent increase in the corresponding price paid by privately insured patients"—meaning that around 17 cents of every dollar in relative reductions in public Medicare plan payments to private hospitals are shifted onto private patients. [38] If this estimate is correct, then cost

shifting from the public Medicare plan amounted to less than 10 percent of the overall increase in hospital prices to private payers between 1997 and 2001—the period under study.

MedPAC is required to review carefully the adequacy of the public Medicare plan's payments. Its most recent report concludes that "Most of our indicators of payment adequacy for hospital services are positive. More Medicare-participating hospitals have opened than closed each year from 2003 on, and the number of facilities closing in 2006 was less than one-sixth the peak in 1999. Further, the proportion of hospitals offering specialty services such as cardiac catheterization and MRI rose more in 2005 than in any of the previous seven years. These data suggest continued access to care for Medicare beneficiaries."[39]

A similar story can be told with regard to the public Medicare plan's physician payments. Medicare's fee schedule clearly requires reform for a variety of reasons. But it has not resulted in a physician exodus from the program, as critics suggest. In its most recent databook, MedPAC reports that 97 percent of physicians were accepting some new public Medicare plan patients—virtually the same rate as are accepting private PPO patients—with 80 percent reporting they accepted all or most patients.[40] And despite the aging of the population, the number of physicians participating in the public Medicare plan has more than kept pace with the growth of enrollees.[41]

According to surveys, people with Medicare are more likely to say they never have to wait for doctors' appointments than those aged 50 to 64 with private insurance, and 9 out of 10 said they had "no problem" finding a doctor or a specialist to treat them.[42] The survey evidence shows generally stable access to primary care physicians and specialists over the last few years, although there has been an increase in the share of the elderly who report having a "big problem" finding a new primary care physician.[43] And Medicare's negotiated rates do not appear to have dented patient satisfaction with the program. AARP has found that 80 percent of people with Medicare are either "extremely" or "very satisfied" with their health care and access to physicians, a higher rate than for 50 to 64 year olds with private insurance.[44]

Finally, it is worth emphasizing that any national reform proposal that included public plan choice would involve a major expansion of insurance coverage. (Many reform proposals would also upgrade Medicaid payment rates to bring them closer to Medicare and private payments.) This expanded coverage would mean that providers would be paid for a much higher share of the services they delivered. These new revenues could well exceed any negative income effects that occurred due to a public plan bargaining for lower prices.

Long-Term Cost Control

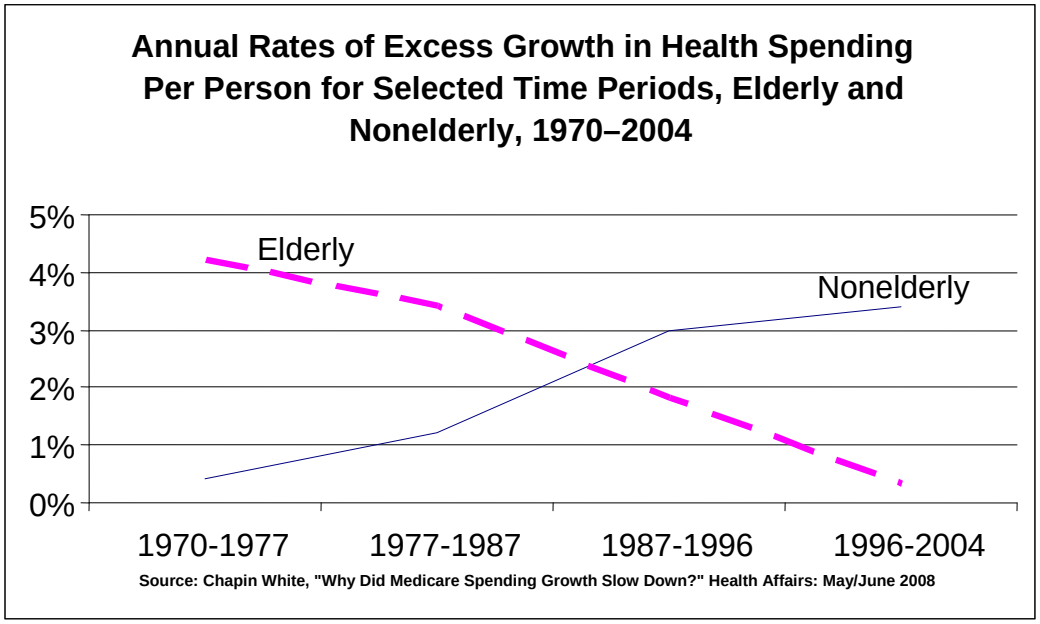
The evidence strongly indicates that a public plan can provide coverage less expensively than private insurance without impairing access or quality. Yet the greatest potential cost-control advantage of a public plan is its ability to restrain the *rate of increase of costs over time*—the key to maintaining good coverage without excessively burdening public and private budgets.

Although you would not know it from the debate over Medicare's finances, Medicare has become increasingly effective at restraining the "excess growth" of spending—that is, per capita cost growth in excess of overall economic growth (accounting for population aging).[45] Excess cost growth is a critical measure of the sustainability of any health plan,

because it shows how quickly spending will rise as a share of personal and business budgets over time. A recent study that examined excess growth in spending on Medicare services between 1975 and 2005 found that the annual rate of excess growth fell from 5.6 percent during 1975-1983, to 2.1 percent during 1983-1997, to 0.5 percent during 1997-2005.[46] Put another way, since Medicare payment controls were put in place in the early 1980s, Medicare spending has grown much more slowly than in the past—and in the most recent period (1997 to 2005), it grew only slightly faster than the economy overall, adjusting for population aging.

It is not possible using these data to compare Medicare excess growth directly with private insurance excess growth. However, a rough comparison is provided by contrasting excess spending growth among the nonelderly, most of whom are covered by private insurance, with excess cost growth among the elderly, 97 percent of whom are covered by Medicare. As Figure 1 shows, excess cost growth for the nonelderly was 3.4 percent between 1996 and 2004. That is, spending grew 3.4 percentage points faster than the economy. The comparable figure for the elderly—again, virtually all of whom are covered by Medicare—was *0.3* percent.[47]

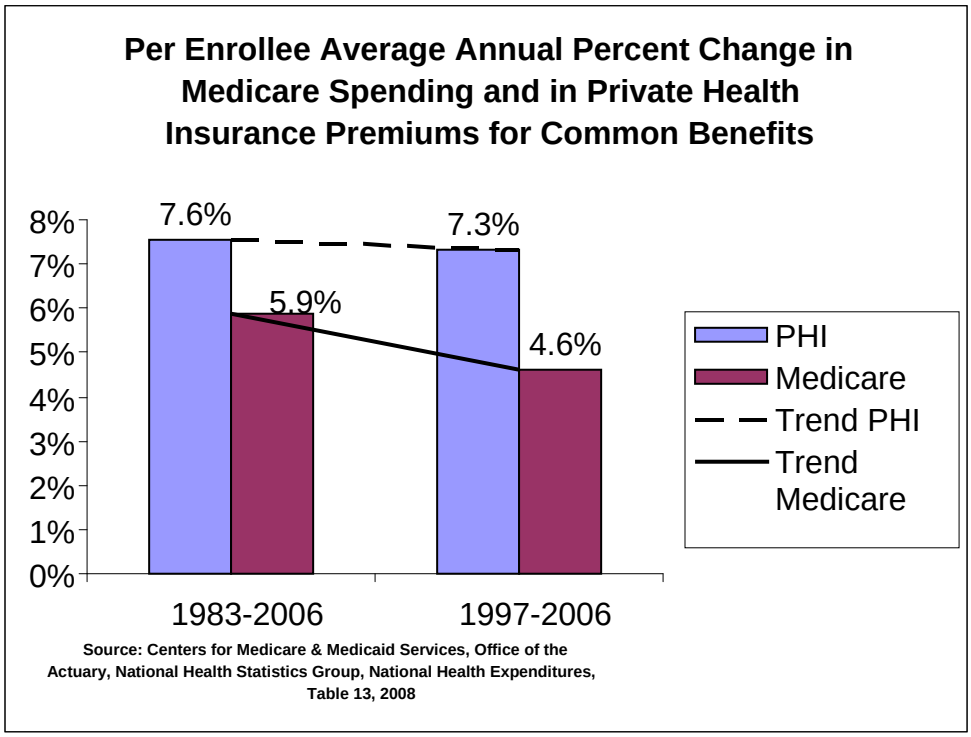
Figure 1



A more direct comparison is provided by examining Medicare and private insurance spending for comparable benefits in recent decades.[48] As Figure 2 shows, private plans' spending per enrollee has grown substantially faster than Medicare spending per enrollee, especially in the last decade or so. Private insurance outlays per enrollee grew an average of 7.6 percent a year between 1983 and 2006, compared with 5.9 percent growth in per enrollee spending under Medicare—a 22 percent difference. (1983 was the year in which Medicare's prospective payment system for hospitals was implemented; 2006 is the last currently

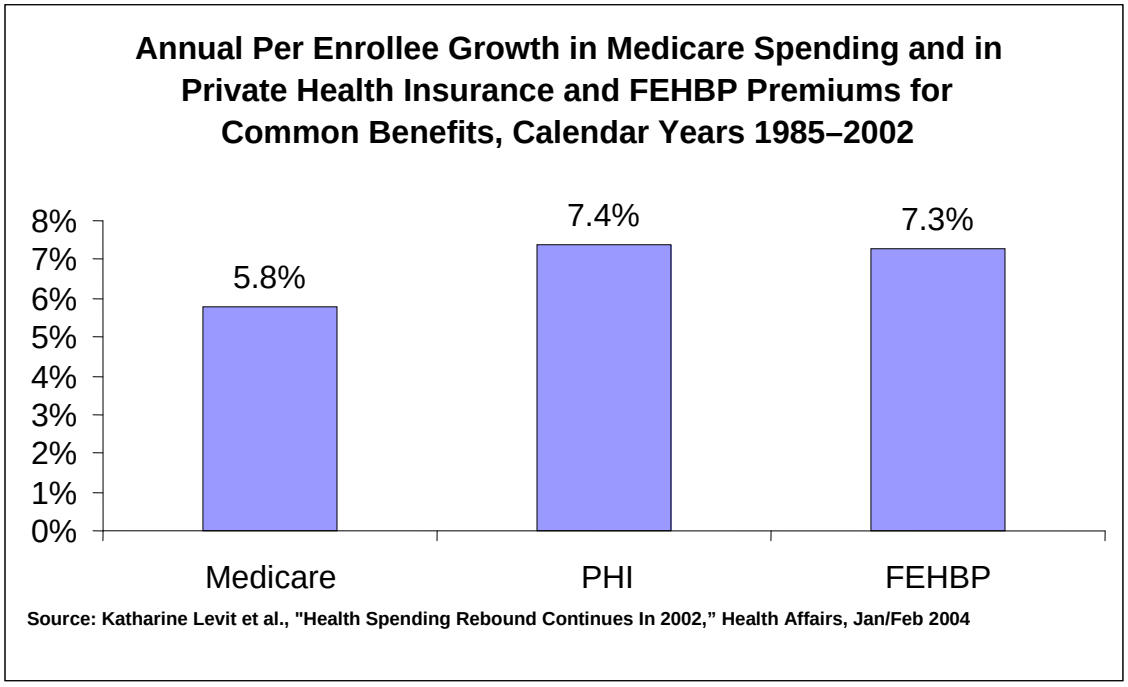
available data year.) The gap is even bigger in recent years. Between 1997 (when the Balanced Budget Act of 1997 further constrained Medicare spending) and 2006, private health insurance spending per enrollee grew at an annual rate of 7.3 percent, compared with an annual growth rate of 4.6 percent under Medicare—a full 37 percent difference. As these comparisons indicate, not only has Medicare more successfully restrained the rate of increase of per enrollee spending, the rate of growth is also on a steeper downward trajectory under Medicare than under private insurance.

Figure 2



The Federal Employees Health Benefits Program has frequently been invoked as a model for national reform, and indeed it provides one template for a national insurance exchange offering competing private plans. It is not, however, a model of cost restraint when compared with Medicare. As Figure 3 shows, FEHBP's annual growth rate of per enrollee spending averaged 7.3 percent from 1985 to 2002 (the most recent currently available data year) compared with 5.8 percent for Medicare.[49] Indeed, the growth rate for FEHBP is virtually identical to that for private health insurance over this period (private health insurance grew 0.1 percent faster on an annual basis between 1985 and 2002.) This suggests that simply replicating FEHBP on a broader scale—without public plan choice—would be unlikely to provide the long-term cost restraint essential for successful reform.

Figure 3



A similar story is told by foreign experience. Other rich nations all rely on public or quasi-public insurance more than the United States does. (They do not, however, all rely on a single public insurer, and many have public and private insurance operating side by side.) And taken as a whole these nations not only spend much less on health care as a share of their economy than we do; they have seen their health costs slow dramatically in recent decades, while U.S. costs have continued to grow much faster than the economy.

Looking at the longstanding members of the Organization for Economic Cooperation and Development, the average excess rate of per capita spending growth between 1985 and 2002 was around one half of 1 percent for nations other than the United States—more or less the recent Medicare experience. Over the same period, per capita medical spending in the United States grew more than 2 percentage points faster than the economy.[50] If U.S. spending had grown at the rate of spending growth in the rest of the OECD, health care would have consumed 11 percent of our economy in 2002, as opposed to 14.6 percent—a dollar difference of $436 billion greater than what the federal government spent on Medicare *and* Medicaid that year.[51]

An Illustrative Example: Health Care for America

The effect of the administrative and payment savings of public insurance can be seen in the Lewin Group estimates of my "Health Care for America" plan. The Lewin Group estimated that, thanks to public plan choice, the proposal would achieve sufficient one-time savings to cover the expense of the increased utilization caused by broadening coverage for the uninsured and those without adequate coverage. Even more striking, the proposal would result in $1 trillion in national savings over ten years.

The clearest evidence of the savings produced by the public plan is its premiums, which are estimated to be about 23 percent lower than comparable private insurance for the same set of benefits for the same population.[52] These savings are principally due to the two unique features of a public plan already highlighted: its simplified administrative structure, and its ability to bargain for better rates. The Lewin Group estimates that the savings would amount to nearly $1,000 per year, with average enrollee costs in the public plan totaling "$3,250 compared to $4,230 under a private insurance product in 2007."[53]

Similar results are reported by the Lewin Group in its analysis of the Commonwealth Fund's "Building Blocks" proposal for reform, which also includes a public plan option. Premiums for the public plan in the Commonwealth proposal "represent significant savings—more than 30 percent below average employer premiums."[54]

Again, a new public plan could do much more than Medicare currently does to ensure that bargaining for better prices did not negatively affect access to providers or impair the quality of care. But the need to improve Medicare should not blind us to the progress that the program has made in restraining costs while maintaining provider participation and patient satisfaction. Nor should the necessity of reforms in Medicare be seen as an argument against public plan choice. In fact, a new national public plan available to the nonelderly could spearhead quality-improvement initiatives in both Medicare and the new plan. Such quality enhancements—and the unique role that a new public plan could play in advancing them—is the subject of the next section of this brief.

A PUBLIC PLAN CAN SPEARHEAD QUALITY IMPROVEMENTS

It is widely recognized that major efforts are needed to improve the quality and cost-effectiveness of medical care. No sector of American health care is immune from responsibility for these problems, or exempt from the challenge of fixing them. Yet Medicare has been a leader in trying to reform the system, and in partnership with a new public plan for nonelderly Americans, it could lead the way in spearheading quality improvements in both the public and private sectors.

The Surprising Success Story of the VHA

Perhaps the most powerful example of how investments in quality improvement by a public plan can pay off is provided by the Veterans Health Administration. The VHA has used its integrated framework to create a model evidence-based quality-improvement program that delivers the highest quality care in the nation, as measured by adherence to established treatment protocols. In the rest of American health care, only around half of adults and children receive the care they should. The share in the VHA is over two thirds.

How does the VHA do it? Beginning in the early 1990s, VHA leadership instituted both a sophisticated electronic medical record system and a quality measurement approach that holds regional managers accountable for several processes in preventive care and in the management of common chronic conditions. Other changes include a system-wide commitment to quality improvement principles and a partnership between researchers and managers for quality improvement.[55]

The VHA's promulgation of specific performance measures and emphasis on accountability—possible only because of the broad reach of its coverage—appear to be at

the heart of its success. The use of computerized reminders and electronic records; the emphasis on standing orders, improved inter-provider communication, facility performance profiling, leveraging of academic affiliations, and accountability of regional managers for performance; and the creation of a more coordinated delivery system—in tandem, these reforms have allowed the VHA to create and uphold high standards of quality.[56]

Medicare's Improving Quality Record

The Medicare program is not, of course, the VHA, and some of the lessons provided by the VHA integrated system are not applicable to an insurance program like Medicare. Yet key elements of the VHA strategy—notably, greater emphasis on research-based coverage decisions, improved use of information technology, and increased stress on performance measures and accountability—could be effectively used in Medicare and a new public plan for the nonelderly, and indeed it is unclear how they could be developed *without* such a coordinated public-sector effort.

Medicare already shows unique quality advantages over private insurance when it comes to reliable patient access to affordable care—advantages that would carry over to a new public plan for the nonelderly. Elderly Americans with Medicare report that they have greater access to physicians for routine care and in cases of injury or illness than do the privately insured.[57] They are also half as likely as nonelderly Americans with employment-based insurance to report common access problems, such as skipping a medical test, treatment, or follow up, and failing to see a doctor when sick.[58]

Over the last two decades, moreover, Medicare has increasingly emphasized improved payment methods and rigorous reviews of technology and treatment, and it has made increasing investments in quality monitoring and improvement. Revealingly, private plans generally use the public Medicare plan's criteria for covering treatments as their standard of medical necessity, and they have adopted many of Medicare's innovations in payment methods. As Robert Berenson and Bryan Dowd note in a recent *Health Affairs* article, "Traditional Medicare has been the source of important payment innovations, moving many payment systems away from fee-for-service to prospective payment, such as the diagnosis-related group (DRG) prospective payment system (PPS) for inpatient services. The resource-based relative value scale (RBRVS) for physician fees, despite its flaws, has been adopted widely by private plans . . . . Commercial insurers also look to Medicare to make initial technology approval decisions and to initiate more-aggressive payment denials—for example, for 'never' events and medically ineffective treatments."[59]

Still, much more needs to be done. MedPAC, Senate Finance Committee Chair Max Baucus, and others have made a host of recommendations for how to reform the Medicare system, many of which are underway or under development and could be quickly adopted by a new public plan operating in tandem with Medicare.[60] These innovations could be made available to private payers, and, as they do today, many would likely follow the lead of Medicare. The innovations include:

- Developing practice guidelines and quality measurements that will allow for value-based purchasing (a policy mechanism that links payment to performance).
- Requiring public reporting by providers of quality indicators to help purchasers and payers get maximum value.

- Testing the effectiveness of new technology.
- Developing a pay-for-performance system based on quality outcomes.
- Finding alternatives to the fee-for-service-based system for physician payment.
- Shifting payment methods and rates to better reward primary care providers and increase their supply and to decrease the oversupply of specialty physicians, who are escalating costs without necessarily improving quality.
- Building a system based on coordinated care for those with chronic diseases, rather than maintaining our current fragmented care.
- Removing wide geographic variations in care from one region of the country to another, which are largely driven by a community's supply of specialists and technology rather than the services patients actually need.

Public Insurance Has the Potential To Lead the Quality Revolution

Medicare and a public plan for those under 65 would be well positioned to lead these efforts—*if* they were given the tools to collect and maintain extensive outcomes data, test new methods of providing and paying for care, and use their market power to promote quality and cost effectiveness in both the public and private sectors.

The simple truth is that private insurance has few incentives to conduct comparative-effectiveness research, and limited scope to influence the practices of providers and other insurers even when they do. Comparing the clinical effectiveness of tests, procedures, and drugs with their alternatives is critical to increasing effectiveness and reducing costs. But for insurance companies, it is expensive and the benefits, if made public, are not theirs alone. As MedPAC has noted, "Because the [public dissemination of] information can benefit all users and is a public good, it is underproduced by the private sector."[61]

Moreover, insurance companies are generally reluctant to share private information that will allow others to learn lessons about how best to contain costs and improve quality. For instance, *U.S. News and World Report* recently noted that 126 health care plans refused to provide data to a national accrediting agency that was needed for the magazine to rank plan performance.[62] Transparency in Medicare has helped identify huge variations in spending per capita across the country and to determine that areas with higher per capita spending score no better on quality measures, and often score worse.[63] Private insurers have far fewer incentives to make such information public.

In addition, private insurers have limited incentive to attract or treat those with chronic and costly disease or behavioral health problems such as obesity—the patients who are least likely to sign up for private plans in Medicare Advantage. This is the population that private insurers have the greatest incentive to avoid through targeted advertising and risk selection (which, existing research suggests, can only be partially addressed through better risk adjustment).[64] Plans that adopt innovative strategies for disease management may find themselves attracting less healthy patients, discouraging them from engaging in such innovations. On the other side of the equation, patients with greater health needs may desire the greater stability or choice of providers that a public plan can provide. Studies have consistently shown that the public Medicare plan attracts people with poorer health status than do Medicare private plans.[65] Yet these are precisely the patients most in need of

innovations in treatment and care coordination. A public plan, which by nature will take all comers and will be attractive to those in poorer health status, is best poised to improve the treatment of these patients and disseminate the lessons learned to the private sector.[66]

Finally, participation in public plans is much more stable. Insurers move in and out of markets, change their benefits frequently, shift the providers with which they contract, and so on. In the private employment sector, a change in jobs or employment status can of course result in a loss of coverage. But even within the comparatively stable contexts of Medicare Advantage and FEHBP, plan turnover is high, and provider participation also fluctuates substantially.[67] All of this churning is costly, undermines continuity of care, and is difficult for enrollees, particularly those who require coordinated care.

The effects of plan turnover on the quality of care remain poorly understood, but important clues are provided by 2001 and 2002 surveys of people in Medicare whose private Medicare plans terminated or reduced service areas.[68] The surveys found that health plan withdrawal not only harmed the finances of those affected, but also had negative effects on mental and physical health, with the consequences most pronounced for the most vulnerable patients. In the 2001 survey, for example, 22 percent of those seeing a specialist reported they had to stop seeing their specialist, and "fifteen percent said they did not get some prescribed medication since leaving their former plan. Disabled individuals, those in fair or poor health, and people of color reported the most trouble with access to care."[69]

No less important, the greater stability of enrollment and provider participation gives public insurance a greater potential to reap the rewards of investments in prevention and general health improvement that may have up-front costs. One of the costs of the fragmentation of health insurance is that health plans may not benefit from measures that improve the health or long-term health expenditures of enrollees. It is important to recognize that the potential benefits to health plans go beyond monetary savings to include the value of better health and well-being that such measures may produce, insofar as enrollees recognize these broader benefits and reward health plans for them. As Randall Cebul and his colleagues explain, "In principle, insurers could capture some of this value in the form of higher premiums, if they could count on long-term relationships with employer groups or individual policy holders . . . . But insurance companies cannot count on such long-term relationships with many or most insured individuals."[70] Cebul and his colleagues cite a recent study of diabetes management at a private HMO: The study showed a positive social return for diabetes management, but the private return for the plan was negative in the first years and zero over the course of a decade—in part because the turnover of enrollees meant that the plan did not reap the potential benefits of long-term health improvements.[71]

A public plan with a relatively stable enrollment base would be best poised to make long-term investments in patients' health that deliver financial and social benefits down the road. This is yet another respect in which a new public plan, working with Medicare and private plans, could spearhead the testing and evaluation of potential delivery-system and payment reform; the collection, reporting, and use of ongoing performance data; and the streamlining of paperwork and administration in ways that would not be possible without a core role for public insurance for nonelderly Americans.

PUBLIC PLAN CHOICE AS A BENCHMARK

Public and private insurance have distinct strengths and distinct weaknesses. Private insurance is generally more dynamic and flexible than public insurance, but at the same time less stable and more administratively complex and costly. Public insurance is better at spreading risks broadly—given the extreme concentration of medical costs, private plans inevitably have incentives to "cherry-pick" healthier patients—but this advantage carries with it the potential cost of a lesser capacity to adapt rapidly to changing technology or the distinctive personal circumstances of individuals. Thus, a public-private hybrid can provide an important check on both the public and private sectors, ensuring flexibility *and* stability, market accountability *and* democratic accountability, inclusive social protection *and* private innovation—in short, a broadened range of *good, meaningful* choices.

Moreover, public and private plans can learn from each other as they exploit their strengths and remedy their weaknesses. Expanded coverage of prescription drugs by Medicare HMOs, for example, demonstrated the feasibility of drug coverage for the elderly and helped to increase political pressure for drug coverage for all people with Medicare. The development of performance measures for Medicare private plans provided a template for projects testing comparable measures under the public Medicare plan. Similarly, innovations in coordinating care for elders with chronic illness in private plans have provided a useful foundation for care-coordination demonstrations in the public Medicare plan.[72]

Meanwhile, private insurers have emulated Medicare's prospective payment system for hospitals, physicians and nursing homes, and many of the early techniques of utilization review were first developed by Medicare and later diffused to private insurers. Recently, Aetna, WellPoint, and other larger insurers have moved to ban payments for care that results in serious errors—following the lead of Medicare's effort to stop paying the cost of treating bed sores, falls, and other preventable injuries and infections. And no one doubts that Medicare has provided an important fallback for elderly and disabled Americans who have substantial health needs or whose private plans exit the market or switch benefits or providers.

The Need for a Level Playing Field

For the competitive and learning advantages of public-private competition to be realized, public and private plans must compete side by side on a level playing field. The purpose of this paper is not to outline the proper relationship between public and private insurance within a national insurance pool—that is the topic of a separate forthcoming policy brief. But, at a minimum, a level playing field requires that (1) both the public and private plans offer a good, comparable basic package of benefits; (2) private plans are regulated to ensure that they accept all comers, guarantee renewability of coverage, offer similar rates to all enrollees, and do not limit coverage for preexisting conditions; (3) adequate monitoring be in place to ensure that selective marketing or disenrollment does not occur; and (4) payments to the plans are risk adjusted so that plans that enroll a large number of the highest-cost patients that account for most national health spending are not disadvantaged.

Additional steps that may be needed to ensure fair competition—some potentially controversial—include (1) paying private plans a mix of prospective and retrospective payments to simultaneously encourage them to provide care efficiently and indemnify them against high-cost enrollees (this could include "clawing back" some amount from private

plans that end with a highly favorable mix of enrollees as well); (2) a "hold harmless" principle that enrollees in the public plan would not have to pay higher premiums than enrollees in private plans if the higher costs of the public plan were due to the disproportionate enrollment of higher-cost patients; and (3) automatically enrolling those in the pool who do not choose a plan into the public plan as the default source of coverage. (Automatic enrollment in the public plan for those not choosing a plan would help the public plan to obtain a broad mix of risk, which may be difficult otherwise, because of the tendency for less healthy enrollees to enroll in the public plan. In addition, it would give those who did not choose a plan the broadest potential selection of providers.)

On the other hand, private plans will need assurances that the public plan will not trim provider rates so much that the plans are subject to cost shifting that drives up their premiums (although, as noted, the extent of cost shifting is often exaggerated) and both the public and private plans will have to be governed by an administrative structure that ensures fair representation of the interests of contracting private plans as well as patients, providers, employers, and the public at large. In particular, competition between the public and private plans probably should not be governed by the agency running the public plan itself, but instead by some higher-level body, such as the new national health board envisioned in a number of leading proposals for reform.

Why Regulation of Private Insurance is Not Enough

As this discussion suggests, some of the shortcomings of private plans, such as their strong incentive to select healthier enrollees, can be partially addressed through regulations and new payment policies, including the twin requirements of open enrollment and community rating and measures to risk-adjust payments to plans so their incentive to attract less costly patients is reduced. Nonetheless, even with such regulations and payment reforms, a public plan competing with private plans is essential.

First, as already discussed, the Medicare program outperforms private insurance on costs and access even when compared with private plans that are regulated to ensure broad coverage, such as plans in FEHBP and Medicare Advantage. Medicare Advantage not only exercises substantial regulatory authority over private plans, but also has invested increasing resources in risk adjustment.[73] Yet while Medicare Advantage plans have delivered broader services and diversity of plan offerings, they have certainly not delivered lower costs. Instead, they have resulted in the federal government spending *more* on Medicare than it would have otherwise—excess costs are projected to total nearly $150 billion between 2009 and 2017.[74] Although these costs are principally the fault of a flawed method for paying private plans (one that should not be emulated in a new national pool), they suggest that simply regulating or adjusting payments to private plans to reduce risk selection will not guarantee that private plans focus on value.

Second, as emphasized throughout this brief, a competing public plan is needed to set a benchmark for private plans even in the context of private insurance regulations and risk adjustment—neither of which can be expected to fully change the incentives of private plans.[75] Just as our nation's Founders wanted ambition to check ambition to ensure that the "parchment barriers" of the Constitution were adhered to, public plan choice is a source of "checks and balances" designed to ensure that private plans have to uphold high standards of performance.

CONCLUSION

This brief has made three main points. First, public health insurance outperforms private insurance in controlling costs while maintaining access and benefits—even when compared with private plans that are regulated to ensure broad coverage. Second, public insurance has also made major strides in quality improvement, and a new public plan working with Medicare alongside private plans would be able to make much greater strides in the future. Third, a competing public plan is essential to set a benchmark for private plans, providing a "check and balance" that ensures private plans, as well as the public plan, uphold high standards.

Without public plan choice, on the other hand, we will continue to lack strong institutional mechanisms to rein in costs and drive value down the road, putting the broader goals of reform and our nation's public and private budgets at risk. Although expanding insurance and upgrading inadequate coverage will require substantial up-front investments, any viable proposal for affordable quality health care for all must be able to contain long-run health costs. Ensuring that mechanisms for effective cost restraint are embodied in national health reform is essential—and a key argument for public-private competition.

A preview of the potential challenges that face efforts to control costs without public plan choice is provided by the difficulties that Massachusetts has faced in restraining costs within its groundbreaking health reforms. One element of Massachusetts reforms involves the creation of a new "Connector" (that is, exchange) that allows private insurers to sell group-style policies to lower-income Massachusetts residents who lack insurance. The Connector—which, crucially, does not include a public plan alongside private options—has been the major means by which uninsured Massachusetts residents have gained coverage.

Unfortunately, however, premiums and co-payments within the Connector are rising rapidly. As five strong advocates of the law report, "An essential challenge is confronting rising premium inflation. Average increases of 8–12 percent have been implemented by major Massachusetts insurers for 2008. Continuing increases undermine affordability…and undermine the law's intent."[76] A critic of the law makes the point more sharply, "[P]remiums have continued to rise faster than the background inflation rate . . . The only way to hold them in check is to cut benefits or increase deductibles and co-payments . . . . Insurance will quickly become too expensive, as well as increasingly inadequate."[77]

Private insurance and public insurance have distinct strengths and weaknesses, and thus should be encouraged to compete side by side to attract enrollees on a level playing field that rewards plans that deliver better value and health to their enrollees. Public insurance can be a benchmark for private plans and a source of stability for enrollees, especially those with substantial health needs. Private plans can provide an alternative for those who feel that public insurance does not serve their needs and a source of continuing pressure for innovation in benefit design and care management strategies. And both should have a chance to prove their strengths and improve their weaknesses in a competitive partnership. If, as many critics of public plan choice contend, the private sector can provide greater value than the public sector, then private plans should have nothing to fear from competing on a level playing field with a new public plan. The alarm bells ringing among private insurers suggest that they recognize some of the key advantages of public insurance, too.

This brief has emphasized the strengths of public insurance not to belittle the virtues of private plans, but because too often the strengths of public insurance are missed—especially with regard to structural reforms that can drive long-term cost control and quality improvement. The evident need for the improvement of Medicare and other public programs should not be taken as an argument against allowing nonelderly Americans without secure workplace coverage to have the same choice that America's seniors and people with disabilities do: enrolling in a public or private plan. Public plan choice is an essential means of guaranteeing quality, affordable care, setting a high standard that private plans must compete to meet. At the same time, it has the value of uniting the public around the principles of broadly shared risk while building greater confidence in government over the long term.

Perhaps that is why Americans have long been strongly supportive of public-private hybrids in health care, believing that neither the government nor private insurance should be the sole source of coverage in a reformed system. In polls, a Medicare-like program covering all Americans beats the current system hands down. Yet Americans are even more receptive toward a mandate on employers to provide coverage.[78] Historically, Americans have been deeply divided about their preferred approach to expanding health insurance. Although repeated surveys find a majority endorsing "national health insurance" for most of the second half of the twentieth century, when asked explicitly, Americans split evenly between those who favor administration of insurance benefits by government and those who prefer subsidies for private insurers.[79] Thus, Americans seem to desire a combination of both private employment-based coverage and expanded public programs.

As in many areas, moreover, Americans value choice in health care—most important, choice of physicians, but also choice of health plans. During the debate over reform in the early 1990s, for example, 81 percent of the public reported that it was important or essential for a proposal to give "people a choice of different types of health insurance plans." Americans embrace choice of insurance not because they ideologically favor markets in health care, but because they have limited trust in either government or private insurers and want protection against the potential shortcomings of each.[80]

A recent poll commissioned by the Health Care for America Now! coalition shows that public plan choice is highly popular. The poll tested the relative support for a proposal similar to President-Elect Obama's for public-private choice against a market-driven plan based on tax credits for individuals, similar to Senator John McCain's. The public preferred—by a two-to-one margin—the first proposal to guarantee Americans "a choice of health plans they can afford, either from a private insurer, or from a public plan" in which "[e]mployers and individuals could choose to keep their current health plans." Nearly two-thirds of respondents gave the public plan choice proposal a rating of six or higher on a ten-point scale ranging from zero (strongly negative) through five (neutral) to ten (strongly positive), with a near majority (47 percent) giving it an 8, 9, or 10. By contrast, the tax-credit plan was rated a five or below by more than half of respondents.[81]

Allowing public insurance and private plans to compete on a level playing field is the key to cost control and quality coverage. Most Americans strongly favor public plan choice, and they should be given that choice.

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