WebMemo
Published by The Heritage Foundation
No. 2482
June 12, 2009

A New Public Health Plan: How Congressional Details Will Impact Doctors and Patients

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President Obama and congressional leaders are proposing the creation of a new public health insurance plan to compete with private insurance plans. The President first proposed a public insurance option during the 2008 presidential campaign, but now the details and design of this new option—like most other aspects of the health reform legislation currently under development—have been left almost entirely to Congress.

Many in Congress are looking to Medicare as a model for a new public health plan, yet they fail to realize the consequences for patients and providers alike, as millions of Americans would lose the private coverage that they have today.

Crucial Details. According to the Lewin Group, a nationally prominent econometrics firm, the two most crucial design details of this new option are the size of employers eligible to buy into the new plan and the provider payment levels used for reimbursement under the plan.[1]

These key issues are bound to be contentious in the upcoming debate over health care reform.[2] The Obama campaign proposal would have made individuals without employer coverage, the self-employed, and small employers (defined as fewer than 25 employees) eligible for the public plan. But the President never specified provider payment levels or the method for determining reimbursement rates for doctors, hospitals, and other medical professionals for the thousands of medical services that would be delivered.[3]

Members of Congress and their staffs will thus have to hammer out these crucial details in legislation if a public plan is to be introduced.

Unlevel Playing Field. If Congress creates a public plan modeled on Medicare—as some have previously proposed—the result, of course, would be to undercut any pretense of a promised "level playing field" for competition with private health insurance.[4] Public plan premiums would be 25–40 percent lower than private insurance premiums as the public plan would reimburse providers less than private payers would—and often less than the cost of care delivered.

Payment rates for doctors and hospitals under public programs are set administratively, not by the market. They are, on average, lower than private payment rates for similar care.[5] Medicare provider payments for hospital care are only 71 percent of private rates, while Medicare provider payments for physician care are only 81 percent of private rates.[6] In other words, Medicare payment levels are roughly 19–29 percent lower than private levels.

Congress's ability to impose low provider payments and artificially reduce the cost of the public option compared to private insurance will increase

This paper, in its entirety, can be found at:
www.heritage.org/Research/HealthCare/wm2482.cfm
Produced by the Center for Health Policy Studies
Published by The Heritage Foundation
214 Massachusetts Avenue, NE
Washington, DC 20002–4999
(202) 546-4400 • heritage.org

enrollment in the public plan while crowding out, or displacing, existing private coverage.

Loss of Private Coverage. When considering a public plan modeled after Medicare, Lewin finds that the estimated reduction in the number of uninsured does not vary greatly (observing a change of only 800,000 individuals) as eligibility for the plan is extended beyond small employers to employers of all sizes.[7] Instead, there is a substantial increase in enrollment in the public plan and in the loss of private coverage.

If the public plan were opened to only small employers, enrollment in the public plan would reach 42.9 million, and 32 million Americans would lose their private coverage.[8] However, if the public plan is opened to all employers, enrollment in the public plan increases dramatically to 131.2 million, and 119.1 million Americans would lose their private coverage.[9] In this particular case, of the 171.6 million people who currently have private coverage, about 70 percent of them would lose the coverage that they have today.[10]

1. The Lewin Group, "Opening a Buy-In to a Public Plan: Implications for Premiums, Coverage and Provider Reimbursement," February 11, 2009, at *http://www.lewin.com/content/publications/OpeningBuyInPublicPlan.pdf* (June 11, 2009); see also the Lewin Group, "The Cost and Coverage Impacts of a Public Plan: Alternative Design Options," April 6, 2009, at *http://www.lewin.com/content/publications/LewinCostandCoverageImpactsofPublicPlan-Alternative%20DesignOptions.pdf* (June 11, 2009).
2. President Barack Obama, letter to Senators Edward M. Kennedy and Max Baucus, June 3, 2009, at *http://www.whitehouse.gov/the_press_office/Letter-from-President-Obama-to-Chairmen-Edward-M-Kennedy-and-Max-Baucus* (June 11, 2009). See also Robert Pear, "2 Democrats Spearheading Health Bill Are Split," *The New York Times*, May 30, 2009, at *http://www.nytimes.com/2009/05/30/health/policy/30health.html* (June 11, 2009); Robert Pear, "Kennedy and Baucus 'Seek Common Ground' on Health Care Legislation," The Caucus, May 30, 2009, at *http://thecaucus.blogs.nytimes.com/2009/05/30/kennedy-and-baucus-seek-common-ground-on-health-care-legislation/?hp* (June 11, 2009); "Text of a letter from Republicans on the Senate Finance Committee to the President," U.S. Senate, June 5, 2009, at *http://www.heritage.org/Research/HealthCare/upload/6509No_Public_Plan_SFCLetter.pdf* (June 11, 2009).
3. See Obama for America, "Barack Obama and Joe Biden's Plan to Lower Health Care Costs and Ensure Affordable, Accessible Health Coverage for All," at *http://www.barackobama.com/pdf/issues/Health careFullPlan.pdf* (June 11, 2009); The Lewin Group, "McCain and Obama Health Care Policies: Cost and Coverage Compared," October 15, 2008, pp. ES1–ES4, 5, 21, and Appendix B (B20–B27), at *http://www.lewin.com/content/publications/TheLewinGroupMcCain-ObamaHealthReformAnalysisRev10-15-08.pdf* (June 11, 2009).
4. Cathy Schoen, Karen Davis, and Sara R. Collins, "Building Blocks for Reform: Achieving Universal Coverage with Private and Public Group Health Insurance," *Health Affairs*, Vol. 27, No. 3 (May 2008), at *http://content.healthaffairs.org/cgi/content/abstract/27/3/646* (June 11, 2009); Cathy Schoen, Karen Davis, and Sara R. Collins, "The Building Blocks of Health Reform: Achieving Universal Coverage and Health System Savings," Commonwealth Fund, May 2008, at *http://www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2008/May/The%20Building%20Blocks%20of%20Health%20Reform%20%20Achieving%20Universal%20Coverage%20and%20Health%20System%20Savings/Davis_buildingblocks_1135_ib%20pdf.pdf* (June 11, 2009); Commonwealth Commission on a High Performance Health System, "The Path to a High Performance U.S. Health System: A 2020 Vision and the Policies to Pave the Way," February 2009, at *http://www.commonwealthfund.org/Content/Publications/Fund-Reports/2009/Feb/The-Path-to-a-High-Performance-US-Health-System.aspx* (June 11, 2009); "A Path to a High Performance U.S. Health System: Technical Documentation," prepared by The Lewin Group for the Commonwealth Fund, February 19, 2009, at *http://www.lewin.com/content/publications/LewinPATHTechnicalDocumentation.pdf* (June 11, 2009).
5. Congressional Budget Office, "Key Issues in Analyzing Major Health Insurance Proposals," December 2008, pp. XIX, 91–97, at *http://www.cbo.gov/ftpdocs/99xx/doc9924/12-18-KeyIssues.pdf* (June 11, 2009).
6. Ingenix Consulting in partnership with the Lewin Group, "The Obama Health Reform Proposal: Impact on Payers," December 8, 2008, p. 7. See also two other studies by the same authors: "The Obama Health Reform Proposal: Impact on Providers," December 9, 2008, p. 4;"The Obama Health Reform Proposal: Impact on Employers," December 16, 2008, p. 3, 5–6.
7. John Sheils, the Lewin Group, "The Cost and Coverage Impacts of a Public Plan," testimony before the Committee on Ways and Means, U.S. House of Representatives, April 29, 2009, at *http://www.lewin.com/content/publications/Testimony_April_29,_2009.pdf* (June 11, 2009).
8. *Ibid.*

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More specifically, of the estimated 157.4 million Americans who have private employer coverage, up to 107.6 million people could lose their private employer coverage, even if they like it and would prefer to keep it.[11]

Imposing Higher Costs on Individuals and Families. Increased enrollment in a new public plan would likely result in higher premiums for those with private insurance.

Historically, public programs—specifically Medicare and Medicaid—have reimbursed providers at levels below the costs of their services. For example, in 2003, on average, Medicare paid hospitals only 95 percent of the cost of providing services, while Medicaid paid hospitals only 89 percent of the cost of providing services.[12] These below-cost payments in public programs are at least in part offset by above-cost reimbursements to providers by private payers—as evidenced by hospital reimbursements to the tune of 122 percent of costs in 2003.[13] This cost-shift, in turn, inflates private health insurance premiums for individuals and families.[14]

The cost-shift dynamic plays a prominent role in the health care sector. A study by the actuarial firm Milliman calculated that public programs currently shift $88.8 billion in costs onto private payers per year, increasing the typical American family's annual private health insurance premium by $1,512, or 10.6 percent.[15] Moreover, Lewin speculates that a new public plan could increase the annual cost-shift per privately insured by as much as $526, which will only serve to further perpetuate the crowd-out of private insurance.[16]

Lower Incomes for Physician and Hospitals. A new public plan could also significantly reduce provider incomes. As more people gain insurance, physicians and hospitals would benefit from decreased levels of uncompensated care. However, the increase in public coverage along with new demands to provide services to the newly insured could outweigh any increased revenues from reductions in uncompensated care.

If all employers become eligible for the public plan, the annual net income of hospitals could fall by $36 billion while the annual net income of physicians could drop by $33.1 billion. Increasing demands on health care providers coupled with decreasing provider incomes could compromise patients' access to high-quality care. Faced with low reimbursement, doctors are already reportedly opting out of Medicare—a problem that is likely to be exacerbated with the creation of a new public plan.[17]

Consider the Consequences. Discussions surrounding the creation of a new public plan, based on Medicare and intended to compete with private

9. *Ibid.*
10. *Ibid.*
11. *Ibid.*
12. The Lewin Group, "Opening a Buy-In to a Public Plan"; see also Allen Dobson, Joan DaVanzo, and Namrata Sen, "The Foundation, History and Implications of the Cost-Shift Hydraulic," the Lewin Group, July 15, 2005, at *http://www.fah.org/fahCMS/Documents/Future%20of%20Hospital%20Care/Dobson%20slides%207.7.05%20History%20and%20Foundation%20of%20the%20Cost-Shift.pdf* (June 11, 2009); Allen Dobson, Joan DaVanzo, and Namrata Sen, "The Cost-Shift Payment 'Hydraulic': Foundation, History, and Implications," *Health Affairs*, Vol. 25, No. 1 (January 2006), at *http://content.healthaffairs.org/cgi/content/abstract/25/1/22* (June 11, 2009).
13. *Ibid.* Lewin suggests MedPAC data indicate that this cost-shifting hydraulic may have accelerated in recent years. As hospital payments declined to 91 percent of costs by 2007, over the same time private payer rates increased to 132 percent of costs.
14. The Lewin Group, based on its analysis of the available cost-shift literature, concludes that about 40 percent of the costs of low public payments and uncompensated care are passed on to the privately insured in the form of higher prices.
15. Will Fox and John Pickering, "Hospital and Physician Cost Shift: Payment Level Comparison of Medicare, Medicaid, and Commercial Payers," Milliman, December 2008, pp. 2–4, at *http://www.milliman.com/expertise/healthcare/publications/rr/pdfs/hospital-physician-cost-shift-RR12-01-08.pdf* (June 11, 2009).
16. Figure assumes Medicare payment rates and all employers eligible for the public plan. See Sheils, "The Cost and Coverage Impacts of a Public Plan."

health plans, have not adequately considered the potential consequences for patients and providers.

Creating a new public health plan option is likely in direct conflict with the many promises Congress and the Obama Administration have made regarding health reform.

While many claim that a public plan would merely represent an alternative choice to private health plans operating on "a level playing field," the reality is that Congress will use the government's power to artificially deflate the cost of the public plan by lowering provider reimbursement rates.

It has been suggested repeatedly that if Americans like their health plan they can keep it and that nothing would change except that they would pay less. But the creation of a new public plan modeled on Medicare could result in the loss of the private coverage that millions have today by undermining the current system of employer-sponsored insurance. Those who are actually able to keeping their private insurance will likely be forced to pay more—not less—to cross-subsidize the public plan.

While patients have been ensured their choice of doctor and care without government interference, great uncertainties remain regarding what the future holds for the doctor-patient relationship as millions of Americans are pushed into a new public plan.

The Devil Is in the Details. It is unlikely that Congress and the President will be able enact a major overhaul of the health care system that both includes a new public health insurance option and meets their many oft-stated promises.

When it comes to health care policy, what politicians promise is less important than the details of their policy prescriptions. Watch carefully.

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17. Julie Connelly, "Doctors Are Opting out of Medicare," *The New York Times*, April 1, 2009, at *http://www.nytimes.com/2009/04/02/business/retirementspecial/02health.html?_r=1* (June 11, 2009).