Health Care Reform Series: The Public Option

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In the previous article of this series, I explored proposals in the Affordable Health Choices Act (AHCA) as introduced by congressional democrats. This article will explore the public option, which has not yet been defined by the AHCA, though Senate Majority Leader, Harry Reid, last week encouraged members to move ahead on drafting the language.

Acting Senate Health, Education, Labor and pensions Committee Chairman Sen. Christopher Dodd, D-Conn., right, talks with the committee's ranking Republican Sen. Mike Enzi, R-Wyo., center, and Sen. Judd Gregg, R-N.H. on Capitol Hill in Washington, Tuesday, June 23, 2009, during the committee's markup on health care legislation. (AP Photo/Harry Hamburg)

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There is little chance that anything crafted by democrats is going to meet the requirements of the Republican Party—save the possibility of Maine's two senators, Susan Collins and Olympia Snowe, neither of which appears to be on board just yet.

In addition, the conservative Blue Dog Democrats have made public a list of demands that for all intents and purposes, oppose a public option that would be operated by the public sector:

> We are concerned, however, about a "Medicare-like" public option and its ability to achieve all of the benefits put forth by its proponents. How a public option is constructed and allowed to compete are critically important to ensuring families have the ability to keep their current health coverage and continue to see the doctor of their choice.

Another proposal by the Blue Dogs, which seems to be gaining traction with Obama officials, is that the public option would only become effective or "triggered," if the private market failed to bring about the desired changes of reform. This would include some $80 billion in cuts that the pharmaceutical industry has committed to making over the next decade, in addition to $155 billion in cuts committed to by hospitals over the same period. Needless to say, I have very little confidence that these for-profit entities are not themselves gaining more from these proposals than the general public - if only for the purposes of killing a public option for the next decade.

One must assume it would take at least a decade to study any substantial outcomes for reform legislation passed today, essentially placing a public option on the back-burner for an indeterminate amount of time. Not surprisingly, the more money any particular public official has received from the health care industry; the more likely it is that they do not support a public option.

The larger, Congressional Progressive Caucus has also expressed demands, which are in direct opposition to those of the Blue Dog's. They will not support any plan that does not include a Medicare-like, public option. A public option is expected by supporters to introduce greater competition to the market in an industry that has largely consolidated in recent decades; reducing real competition - and choice - as a result.

As mentioned in the article on The Patients' Choice Act, private industry fears that a public option would put them out of business, and for good reason. As one source noted, "Multiple studies conclude that administrative costs in public plans are lower than those in private plans." As discussed in previous articles in this series, publicly-funded plans currently have a standard of care that applies to everyone enrolled and removes the fragmentation endemic with private insurers.

One of the biggest problems with Medicare is that the reimbursement rates have not kept pace with rising costs, which means it actually costs physician's money to see these patients. As a result, doctors have begun capping the number of individuals on these public plans that they are able to serve.

The public option would pay 10 percent above Medicare reimbursement rates, but if quality control is largely missing from the reform package, the public option plan will likely face the same inflationary problems experienced with Medicare. For the same reasons, the private sector may be expected to fail at reigning in health care costs as well. The AHCA has not yet designed a vision for the public health option, preferring to deal with the less- contentious provisions of the bill first, but as mentioned above, are expected to begin crafting the language for one very soon.

I have much more optimism in the ability of the private sector to adapt to current reforms in the AHCA than their fears would imply. Even if the AHCA requires all insurers to offer a standard plan to anyone who requests it, there will still be an incentive for private insurers to require prohibitive premiums from "high-risk" patients, or less comprehensive coverage that meets the minimum requirements, but is not as inclusive as say, the public option—theoretically to discourage them from obtaining coverage through the private sector and funneling them into public plans—much like they do now.

Private insurers will still have the same incentive to attract healthier individuals to their plans, resulting in an unsustainable public system that is mired in debt because it is footing the bills for those with the highest health care expenses, while the healthier individuals who would normally subsidize these costs all cluster into the private sector where lower premiums will ensure undercutting the public option.

As mentioned in the first part of the analysis of the AHCA, state health insurance exchanges if designed properly, and with the appropriate authority to enroll consumers without the input of private insurers could avoid this, but it will likely be a tough sell to opponent's already emboldened by current proposals for increased government involvement.

The plan would expand Medicaid to those earning 150 percent above the poverty line, and include single, childless adults. SCHIP would cover individuals up to 26 years old. Individuals earning between 150-500 percent above the poverty line would qualify for subsidies on a sliding scale to contribute toward insurance costs. Also, individuals making 500 percent or below the poverty level would not pay more than 10 percent of their income toward healthcare.

Massive new federal subsidies will undoubtedly accompany any legislation enacted by Congress. If the government does not provide health care directly through a single-payer tax structure, there will have to be subsidies to make it profitable to the private sector, and to ensure the coverage mandate is feasible for lower and middle-income individuals.

Administering all of the various subsidies will continue to be a drain on costs if the exchanges are less standardized and offer a multitude of choices. The more standardized the plans, and the fewer vendors there are providing services through the exchanges; the more efficient they will be—and the less choice there will be. It is worth noting that the Congressional Budget Office has found that states have less incentive to control for costs when administrating federal subsidies.

Advocating for the continued existence of a multitude of government plans, including Medicare, Medicaid, SCHIP, the Veteran's Administration, in addition to hundreds of plans offered through the private sector, only adds to the further fragmentation of a system, which seems counterintuitive if your goal is to standardize the system, but fitting if your goal is to provide the bureaucratic morass of choice.

The Cato Institute purports that "Kennedy does not include any estimate of how much his plan would cost, nor any proposal for how to pay for it. More details will undoubtedly emerge, but it is very clear that the Kennedy plan would put one-sixth of the US economy and some of our most important, personal, and private decisions firmly under the thumb of the federal government."

Indeed, there has been little insight provided into how Congress plans to raise revenues to transform the health care system, which will require an influx of cash to meet the immediate goals of providing subsidies, expanding Medicaid and SCHIP, and reimbursing providers for switching to electronic medical records (EMR). EMR's will cut-down on costs by rooting out duplication and providing a history that follows the patient through their entire health care related life.

Figures between $1-2 trillion have been floated as the expected cost of reforms over the next decade, and democrats in the House have expressed the possibility of taxing the wealthy. This will likely garner strong opposition by conservative democrats and republicans in coming weeks.

In the long-term, there is more than enough money to sustain the health care system. We spend far more than every other industrialized nation in the world, which provide affordable coverage to all of their citizens. It is a matter of figuring out how we can ensure that most of the health care dollar is being spent toward patient care; not profits, not research and development, not advertising, and not in a bureaucracy created to deny care.

Other criticisms of the plan come from those who support a Medicare-like, single-payer system for everyone, but their cause seems to be gaining little traction in Congress, as the political feasibility for such an endeavor seems highly improbable. Some critics support a national health insurance exchange that would be operated at the federal level, above the state exchanges proposed by the AHCA; thereby creating a greater level of standardization.

One crucial piece of the puzzle that is conspicuously absent in the debate on health care reform, and missing from proposals on both sides is better containing costs on pharmaceuticals. The rest of the industrialized world places caps on what companies can charge, which leaves the U.S.—the biggest innovators in the industry—primarily subsidizing the research and development costs of the world. We are also shouldering their exorbitant profits, which well exceed costs associated with R&D. It also seems highly wasteful that health care dollars are being spent to advertise pharmaceuticals to consumers who have no expertise to determine

which best suit their needs. In addition to the obvious waste, physicians are spending precious time explaining a variety of prescription drugs to questioning patients, rather than tending to their needs.

Another point left absent in the current debate—but mentioned in the PCA—is so-called tort reform. As a professional in the industry pointed out to me, a better way of looking at this issue is through quality control. A physician who faces risks of medical liability lawsuits is going to go beyond their best medical judgment and order what he/she may think are unnecessary procedures, just to ensure all bases have been covered and that they are insulated from a lawsuit. Capping payouts is not going to address the central issue of quality control, or the fact that juries are making decisions without the medical expertise necessary to guide them. Nonetheless, our current efforts at quality control in this area are greatly flawed and waste billions of dollars a year.

The CBO estimates the AHCA will only net coverage for about 16 million of the nearly 50 million uninsured - after accounting for the individuals who will lose their employer-sponsored coverage. The problem with the debate between private and public control of the health care system is that it focuses on political feasibility, as opposed to the fundamental problems that actually plague it. This should not be an ideological debate, but a practical one that focuses on the real problems in our health care system. The public/private debate is built of straw and used to manipulate the public while the real questions go unanswered. Politicians must be cognizant of the law of unintended consequences in their efforts to effectively reform health care.

America need not reinvent the wheel with respect to health care reform. There are universal systems all around the world that are providing coverage to all or most of their citizens and we would be doing ourselves a favor by observing what has worked, what has not, and by acting accordingly.

The following video presents Rick Scott, mentioned in a previous article as the national spokesperson against health care reform:

This video provides insight into the “false claims” Scott insists are being made against him. The reader can decide whether pointing out that Scott was the CEO of a company, which was found guilty on 14 felony counts of defrauding the government, constitutes a “personal attack,” as Scott suggests.

Scott has claimed his experience—including that with Columbia/HCA—as a basis for his authority on the health care system. Yet, when asked to respond to the fact that he was forced to resign in disgrace after making a $1.7 billion settlement with the government, Scott insists he was not personally charged with anything. But, the company that he was charged with overseeing was. Apparently, he is an authority on the industry—even though he had no clue what was going on right under his nose.

As one congressman noted, Rick Scott as the face against health care reform, is like Bernie Madoff serving as the face against financial regulations.

In the upcoming section I will explore some of the other health care systems of the world and their relative success in providing quality care and containing costs. Any reforms must have an eye to these two critical goals and in shifting the emphasis from an industry that favors profit, to an industry that favors the patient/provider relationship, and affordable, quality care. Determining the proper incentives to derive the desired results will be critical to any solution.

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