The ‘Public Option’ on Health Care Is a Poison Pill

Some Democratic candidates are pushing it as a free-choice version of Medicare for All. That’s good rhetoric but bad policy.

By David U. Himmelstein and Steffie Woolhandler Yesterday 8:00 am

Illustration by Tim Robinson.

Health care reform has been the most hotly contested issue in the Democratic presidential debates. Bernie Sanders and Elizabeth Warren have been pushing a single-payer Medicare for All plan, under which a public insurer would cover

everyone. They would ban private insurance, except for items not covered by the public plan, such as cosmetic surgery or private rooms in hospitals. The other Democratic contenders favor a "public option" reform that would introduce a Medicare-like public insurer but would allow private insurers to operate as well. They tout this approach as a less traumatic route to universal coverage that would preserve a free choice of insurers for people happy with their plans. And some public option backers go further, claiming that the system would painlessly transition to single payer as the public plan outperforms the private insurers.

That's comforting rhetoric. But the case for a public option rests on faulty economic logic and naive assumptions about how private insurance actually works. Private insurers have proved endlessly creative at gaming the system to avoid fair competition, and they have used their immense lobbying clout to undermine regulators' efforts to rein in their abuses. That's enabled them to siphon hundreds of billions of dollars out of the health care system each year for their own profits and overhead costs while forcing doctors and hospitals to waste billions more on billing-related paperwork.

Those dollars have to come from somewhere. If private insurers required their customers to pay the full costs of private plans, they wouldn't be able to compete with a public plan like the traditional Medicare program, whose overhead costs are far lower. But this is not the case: In fact, taxpayers—including those *not* enrolled in a private plan—pick up the tab for much of private insurers' profligacy. And the high cost of keeping private insurance alive would make it prohibitively expensive to cover the 30 million uninsured in the United States and to upgrade coverage for the tens of millions with inadequate plans.

Public option proposals come in three main varieties:

Medicare for All!

§ *A simple buy-in.* Some proposals, including those by Joe Biden and Pete Buttigieg, would offer a Medicare-like public plan for sale alongside private plans on the insurance exchanges now available under the Affordable Care Act. These buy-in reforms would minimize the need for new taxes, since most enrollees would be charged premiums. But tens of millions would remain uninsured or with coverage so skimpy, they still couldn't afford care.

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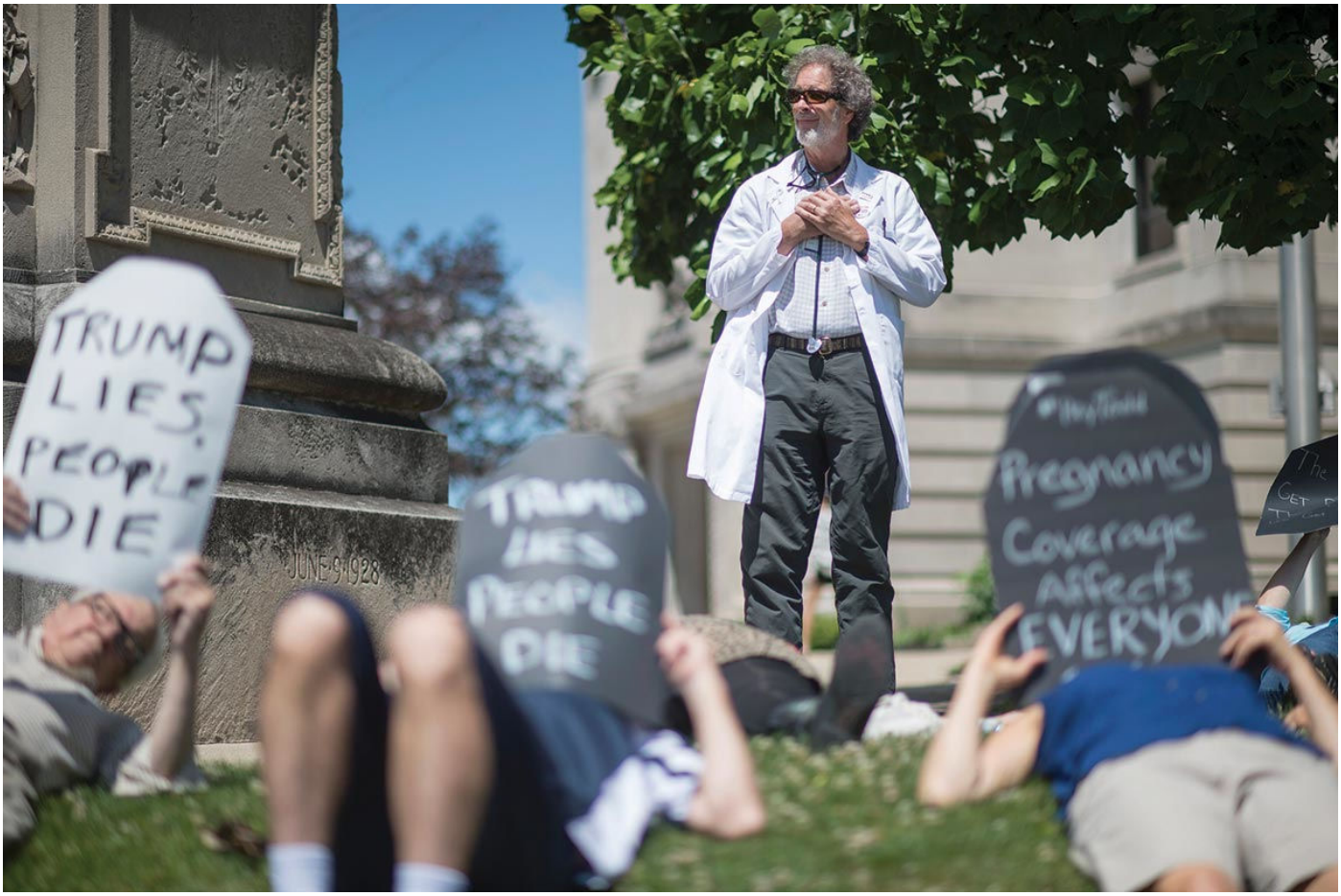
§ *Pay or play.* This variant (similar to the plan advanced by the Center for American Progress and endorsed by Beto O'Rourke) would offer employers a choice between purchasing private insurance or paying a steep payroll tax (about 8 percent). Anyone lacking employer-paid private coverage would be automatically enrolled in the public plan. The public option would be a good deal for employers who would otherwise have to pay more than 8 percent of their payroll for private coverage—for example, employers with older or mostly female workers (who tend to use more care and incur high premiums) or with lots of low-wage workers (for whom 8 percent of payroll is a relatively small sum). But many firms employing mostly young, male, or highly paid workers (e.g., finance and tech) would likely stay with a private insurer.

§ *Medicare Advantage for All.* The public option approach favored by Kamala Harris would mimic the current Medicare Advantage program. Medicare Advantage plans are commercial managed care products currently offered by private insurers to seniors. The Centers for Medicare and Medicaid Services (CMS), the federal agency that administers Medicare, collects the taxes that

pay for the program and passes the funds ($233 billion in 2018) along to the insurance companies. Under this approach, the public option would operate alongside the private Medicare Advantage plans and compete with them, as the traditional fully public Medicare program currently does.

No working models of the buy-in or pay-or-play public option variants currently exist in the United States or elsewhere. But decades of experience with Medicare Advantage offer lessons about that program and how private insurers capture profits for themselves and push losses onto their public rival—strategies that allow them to win the competition while driving up everyone’s costs.



Single payer now! Robert Stone of Physicians for a National Health Program at a demonstration against a GOP Senate bill in Bloomington, Indiana, June 2017. *(The Herald-Times via AP / Chris Howell)*

In US Health Insurance, Good Guys Finish Last

A public option plan that facilitates enrollees' genuine access to health care can't compete with private insurers that avoid the expensively ill and obstruct access to care. Despite having overhead costs almost seven times that of traditional Medicare (13.7 versus 2 percent), Medicare Advantage plans have grown rapidly. They now cover more than one-third of Medicare beneficiaries, up from 13 percent in 2005. Greed has trumped efficiency, and the efforts of regulators to level the playing field have been overwhelmed by insurers' profit-driven schemes to tilt it.

Private insurers employ a dizzying array of profit-enhancing schemes that would be out of bounds for a public plan. These schemes, which continually evolve in response to regulators' efforts to counter them, boil down to four strategies that are legal, in addition to occasional outright fraud.

§ *Obstructing expensive care*. Plans try to attract profitable, low-needs enrollees by assuring convenient and affordable access to routine care for minor problems. Simultaneously, they erect barriers to expensive services that threaten profits—for example, prior authorization requirements, high co-payments, narrow networks, and drug formulary restrictions that penalize the unprofitably ill. While the fully public Medicare program contracts with any willing provider, many private insurers exclude (for example) cystic fibrosis specialists, and few Medicare Advantage plans cover care at cancer centers like Memorial Sloan Kettering. Moreover, private insurers' drug formularies often put all of the drugs—even cheap generics—needed by those with diabetes, schizophrenia, or HIV in a high co-payment tier.

Insurers whose first reaction to a big bill is "claim denied" discourage many patients from pursuing their claims. And as discussed below, if hassling over claims drives some enrollees away, even better: The sickest will be the most

hassled and therefore the most likely to switch to a competitor.

§ *Cherry-picking and lemon-dropping,* or selectively enrolling people who need little care and disenrolling the unprofitably ill. A relatively small number of very sick patients account for the vast majority of medical costs each year. A plan that dodges even a few of these high-needs patients wins, while a competing plan that welcomes all comers loses.

In the employer market, cherry-picking is easy: Private insurers offer attractive premiums to businesses with young, healthy workers and exorbitant rates to those with older, sicker employees. As a letter this summer to *The New York Times* put it, like casinos, health insurers are profitable because they know the odds of every bet they place—and the house always wins.

The CMS, in theory, requires Medicare Advantage plans to take all comers and prohibits them from forcing people out when they get sick. But regulators' efforts to enforce these requirements have been overwhelmed by insurers' chicanery. To avoid the sick, private insurers manipulate provider networks and drug formulary designs. Despite the ban on forcing enrollees out, patients needing high-cost services like dialysis or nursing home care have switched in droves from private plans to traditional, fully public Medicare. And as a last resort, Medicare Advantage plans will stop offering coverage in a county where they've accumulated too many unprofitable enrollees, akin to a casino ejecting players who are beating the house.

Finally, Medicare Advantage plans cherry-pick through targeted marketing schemes. In the past, this has meant sign-up dinners in restaurants difficult to access for people who use wheelchairs or offering free fitness center memberships, a perk that appeals mainly to the healthiest seniors. But higher-tech approaches are just around the corner. Will Oscar, the health insurer founded by Jared Kushner's brother—with Google's parent company as a

significant investor—resist the temptation to use Google's trove of personal data to target enrollment ads toward profitable enrollees like tennis enthusiasts and avoid purchasers of plus-size clothing or people who have searched online for fertility treatments?

§ *Upcoding,* or making enrollees look sicker on paper than they really are to inflate risk-adjusted premiums. To counter cherry-picking, the CMS pays Medicare Advantage plans higher premiums for enrollees with more (and more serious) diagnoses. For instance, a Medicare Advantage plan can collect hundreds of dollars more each month from the government by labeling an enrollee's temporary sadness as "major depression" or calling trivial knee pain "degenerative arthritis." By applying serious-sounding diagnoses to minor illnesses, Medicare Advantage plans artificially inflate the premiums they collect from taxpayers by billions of dollars while adding little or nothing to their expenditures for care.

Though most upcoding stays within the letter of the law and merely stretches medical terminology, the CMS's (rare) audits of enrollees' charts indicate that Medicare Advantage plans are collecting $10 billion annually from taxpayers for entirely fabricated diagnoses. And that's only a small fraction of their overall take from upcoding. Private insurers keep most of this pilfered money for their profits and overhead, but they use a portion to fund added benefits (for example, eyeglasses or slightly lower co-payments for routine care) that attract new enrollees and help private plans to seemingly outcompete traditional Medicare.

§ *Lobbying to get excessive payments and thwart regulators.* Congress has mandated that the CMS overpay Medicare Advantage plans by 2 percent (and even more where medical costs are lower than average). On top of that, Seema Verma, Trump's CMS administrator, has taken steps that will increase premiums significantly and award unjustified "quality bonuses," ignoring

advice from the Medicare Payment Advisory Commission that payments be trimmed because the government is already overpaying the private plans. And she has ordered changes to the CMS’s Medicare website to trumpet the benefits of Medicare Advantage enrollment.

In sum, a public option insurer that, like traditional Medicare, doesn’t try to dodge unprofitable enrollees would be saddled with more than its share of sick, expensive patients and would become a de facto high-cost, high-risk pool. The CMS’s decades-long efforts to level the playing field have been thwarted by insurers’ upcoding, belying their promises of fair competition. And insurance companies have used their political muscle to sustain and increase their competitive advantage over traditional Medicare. The result: The public plan (and the taxpayers) absorbs the losses while private insurers skim off profits, an imbalance so big that private plans can outcompete a public plan despite squandering vast sums on overhead costs, CEO salaries, and shareholder profits.

Fighting Big Pharma: Bernie Sanders on a trip with diabetes patients to purchase lower-cost insulin at a pharmacy in Windsor, Canada, July 2019. *(Reuters / Rebecca Cook)*

Single Payer Would Save, Public Option Won’t

This year alone, private insurers will take in $252 billion more than they pay out, equivalent to 12 percent of their premiums. A single-payer system with overhead costs comparable to Medicare’s (2 percent) could save about $220 billion of that money. A public option would save far less—possibly zero, if much of the new public coverage is channeled through Medicare Advantage plans, whose overhead, at 13.7 percent, is even higher than the average commercial insurer.

Moreover, a public option would save little or nothing on hospitals’ and doctors’ sky-high billing and administrative costs. In a single-payer system, hospitals and other health facilities could be funded via global, lump-sum

budgets—similar to the way cities pay fire departments—eliminating the need to attribute costs to individual patients and collect payments from them and their insurers. That global budget payment strategy has cut administrative costs at hospitals in Canada and Scotland to half the US level. The persistence of multiple payers would preclude such administrative streamlining, even if all of the payers are charged the same rates. (Under Maryland's mislabeled global budget system, the state's hospitals charge uniform rates but continue to bill per patient; our research indicates that their administrative costs haven't fallen at all, according to their official cost reports.)

Similarly, for physicians and other practitioners, the complexity involved in billing multiple payers, dealing with multiple drug formularies and referral networks, collecting co-payments and deductibles, and obtaining referrals and prior authorizations drives up office overhead costs and documentation burdens.

The excess overhead inherent to multipayer systems imposes a hidden surcharge on the fees that doctors and hospitals must charge all patients—not just those covered by private insurance. All told, a public option reform would sacrifice about $350 billion annually of single payer's potential savings on providers' overhead costs, over and above the $220 billion in savings it could sacrifice annually on insurers' overhead.

Finally, a public option would undermine the rational health planning that is key to the long-term savings under single payer. Each dollar that a hospital invests in new buildings or equipment increases its operating costs by 20 to 25 cents in every subsequent year. At present, hospitals that garner profits (or "surpluses" for nonprofits) have the capital to expand money-making services and buy high-tech gadgets, whether they're needed or not, while neglecting vital but unprofitable services. For instance, hospitals around the country have invested in proton-beam-radiation therapy centers that cost hundreds of

millions of dollars apiece. (Oklahoma City alone now has two.) Yet there's little evidence that those machines are any better for most uses than their far cheaper alternatives. Similarly, hospitals have rushed to open invasive cardiology and orthopedic surgery programs, often close to existing ones. These duplicative investments raise costs and probably compromise quality.

Meanwhile, primary care and mental health services have languished, and rural hospitals and other cash-strapped facilities that provide much-needed care spiral toward closure. As in Canada and several European nations, a single-payer system could fund new hospital investments through government grants based on an explicit assessment of needs, instead of counting on private hospitals to use their profits wisely. That strategy has helped other nations direct investments to areas and services with the greatest need and to avoid funding wasteful or redundant facilities. Public option proposals would perpetuate current payment strategies that distort investment and raise long-term costs.

Because a public option would leave the current dysfunctional payment approach in place, it would sacrifice most of the savings available via single-payer reform. The bottom line is that a public option would either cost much more or deliver much less than single payer.

Why Not Import German, Swiss, or Dutch Health Care?

Public option proponents often cite Germany, Switzerland, and the Netherlands as exemplars of how private insurers can coexist with thriving public health care systems. But they ignore the vast differences between those nations' private insurers and ours.

The nonprofit German "sickness funds," which cover 89 percent of the population (only wealthy Germans are allowed to purchase coverage from for-profit insurers), are jointly managed by employers and unions—a far cry from

our employer-based coverage. The government mandates identical premium rates for all the sickness funds, takes money from those with low-risk enrollees and subsidizes others with older and sicker ones, and directly pays for most hospital construction. All sickness funds offer identical benefit packages, pay the same fees, and cover care from any doctor or hospital.

Although the details differ, a similarly stringent regulatory regime applies in Switzerland, whose system descended from Otto von Bismarck's original German model, and as in Germany, the government funds most hospital construction. While for-profit insurers can sell supplemental coverage, only nonprofits are allowed to offer the mandated benefit package.

Since 2006, the Netherlands has been transitioning from the German-style universal coverage system to a more market-oriented approach championed by corporate leaders. However, the government pays directly for all long-term care, and a strong ethos of justice and equality has pressured both public and private actors to avoid any erosion of social solidarity. The Netherlands has long enjoyed ready access to care, and its system hasn't descended (yet) into an American-style abyss. But under the new regime, hospital administrative costs have risen nearly to US levels, overall health costs have increased rapidly, doctors complain of unsustainable administrative burdens, and even in such a small nation, tens of thousands of people are uninsured. Insurers spend massively on marketing and advertising, and private insurers' overhead costs average 13 percent of their premiums. Moreover, the United States and the Netherlands aren't the only places where for-profit insurers' overhead costs are high: They average 12.4 percent in Switzerland, 20.9 percent in Germany, and 26.2 percent in the United Kingdom.

Transforming the immensely powerful, profit-driven insurance companies of the United States into benign nonprofit insurers in the Swiss or German mold would be as heavy a lift as adopting Medicare for All. Nor can we count on the

cultural restraints that have thus far softened the Dutch insurers’ rapacious tendencies and prevented a reversal of that country’s long-standing health care successes.

A final point: While allowing private insurers to compete with a public plan amounts to a poison pill, the same isn’t true for supplemental private plans that are allowed to cover only those items excluded from the public benefit package. While Canada bans the sale of private coverage that duplicates the public plan’s benefits, it has always allowed supplemental coverage, and that hasn’t sabotaged its system.

The efficiencies of a single-payer system would make universal coverage affordable and give everyone in the United States their free choice of doctors and hospitals. But that goal will remain out of reach if private insurers are allowed to continue gaming the system. Preserving the choice of insurer for some would perpetuate the affordability crisis that has bedeviled the US health care system for generations. Proponents of the public option portray it as a nondisruptive, free-choice version of single payer. That may be good campaign rhetoric, but it’s terrible policy.