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The “Public Plan Option”: Myths and facts

Myth: A public option will increase choice for patients. Fact: A public plan option will not increase choice of what matters for our health: choice of caregivers and choice in location of care. Patients will still have a limited choice of provider restricted by networks and will pay more to see providers outside of their network. Patients will still have to seek authorization for treatment. The public option will add one more plan to the hundreds of plans that already exist.

Myth: A public option will enable patients to keep their own doctor, regardless of changes in employment or health. Fact: A public plan option does not guarantee patients can keep their doctor regardless of employment or health because it leaves the employer based system of health care provision intact. If an employer chooses to change to a new plan, patients may have to change their doctor or pay higher fees to stay with their doctor. Insurers have strong financial incentives to enroll the healthy while avoiding the sick patients; thus if a patient becomes ill, they still risk losing their employer based insurance.

Myth: A public option will force private health insurers to compete on a level-playing field, especially in limited markets. Fact: The Medicare HMO experience shows private plans undermine fair competition despite regulations. They avoid the expensively ill (called “cherry-picking”) and use their marketing power to attract the healthiest patients. Private HMO Medicare also costs 12 to 19% more than traditional Medicare despite having a healthier population. The current Medicare experience combined with experience in many different states that have tried this type of reform shows that public plans are left with the sickest patients and fail due to rising costs while the private insurers continue to collect premiums from the healthiest patients and maintain their high profits.

Myth: A public option will provide everyone with the security that quality, affordable coverage will always be there. Fact: Our health care system is unsustainable. Health care reform that includes a public plan option will add hundreds of billions of additional dollars annually on top of 2.5 trillion dollars, (twice what any nation spends per person). We have vast domestic and international experience with public option schemes, and in no case have they resulted in universal coverage. This is because private insurance companies seek to enhance their profits by screening out sick and unprofitable patients, ultimately relegating most of the sick and costly to the public system, which quickly comes unraveled due to rising costs. Absent effective cost control, any increase in coverage or benefits will quickly be erased by rising costs. In conclusion, a public plan option does not lead toward single payer, but toward the segregation of patients, with profitable ones in private plans and unprofitable ones in the public plan.

Myth: A public option will provide better care to patients by driving innovation in the quality of care physicians provide. Fact: A public plan option would not improve overall quality: (1) it would leave in place the deficiencies that have resulted in very high costs with the poorest health care value of all nations, (2) it would keep intact for-profit, investor-owned hospitals, HMOs and nursing homes that have higher costs and score lower on most measures of quality than their non-profit counterparts, (3) it would add yet another payer to our fragmented system perpetuating challenges to coordinated care, for example, there will still be a need to collect premiums, track enrollment, disenrollment, etc, and hospital/NH payment will still require the an enormous billing apparatus.

Myth: A public option will reduce health care costs. Fact: The public option will not reduce health care costs for several reasons: there are no savings on physician office bureaucracy (\$85 billion annually would be saved annually with single payer), no savings on hospitals' billing or internal cost tracking (\$90 billion annually would be saved with single payer, hospitals already use computerized uniform bill UB-82), no savings on NH/home care bureaucracy (\$24 billion annually would be saved with single payer), inadequate insurance overhead reduction (\$93 billion annually would be saved with single payer). In summary, studies show that even if more than 50% of patients switch to a public plan, this will only result in 1/7 of the savings that could be achieved under a national health care system (\$47 billion v \$363 billion annually savings). Adding a public option to the array of private insurance companies in existence will only exacerbate the waste and inefficiency inherent in a patchwork system of health care finance. In their drive to fight claims, issue denials and screen out the sick, insurance companies generate more than \$350 billion in administrative paperwork waste. The proposed insurance industry regulator entity will only add another layer of needless bureaucracy to this already bloat-heavy system. Maintaining this system means that no effective cost control is possible and the system will rapidly deteriorate as costs increase. Only single payer can expand and improve coverage to everyone without spending more than we are now.