

Report on the 2009 Health Care Reform Debate and the Necessity of a Public Option

Jeff Snyder
Rachel Cruz
Grace Boyd-Pollack
Brittani Mack
Drew Petrilli

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Abstract

This paper explores why a congressional decision on healthcare should include a government sponsored public option. It begins by exploring the differences in our healthcare system before and after the formation of Health Maintenance Organizations under the Nixon Administration. It leads to the conclusion that a public option is a crucial piece of the upcoming reform through a comparison with other countries and a discussion of the benefits and possible pitfalls of public health care.

Introduction

A congressional decision on healthcare must include a government sponsored public option in order to decrease our nation's dependency on an industrialized healthcare system. A public system provides many benefits to our society and can integrate well with the private insurance system we have now. We will demonstrate how a public option can work through an exploration of the crucial differences in our healthcare system before and after the formation of Health Maintenance Organizations under the Nixon administration, by discussing the benefits and potential detriments of implementing such a system, and by comparing and contrasting other global healthcare systems similar to the public options proposed in Congress.

Review of the Literature

In order to present this report, our group drew on a wide array of information sources. Scholarly opinions from the medical community were drawn from peer-reviewed medical journals as well as the American Association of Physicians. Many of the facts and statistics were also drawn from several university studies.

For broader perspectives on these issues, information from organizations such as the World Health Organization and the Central Intelligence Agency databases was consulted. To help synthesize much of this information, as well as translate difficult political language, we made use of newspapers such as the Washington Post and the New York Times. Sources from these publications included both objective journalism as well as editorials from leading experts on health care and the economy.

Healthcare in the United States: the Historical View

Human health is one of the most important dimensions to maintain. The U.S. spends 14% of its Gross Domestic Product (GDP) on health care (Markovich, 2003). One of the most common forms of health care in the U.S. are Health Maintenance Organization (HMOs).

HMOs were set in place as a means of providing quality care and to help with the high costs of health care services. Prior to the HMO Act of 1973, "cooperative health plans" could be found in states such as California, Washington, Oregon, Oklahoma and Washington DC. One of the reasons HMOs did not emerge then was because of the resistance from organized medicine.

Leaders in the American Medical Association (AMA) believed these would violate the integrity of medical decision making and provide inferior care. Doctors in the AMA also believed it would lead to “socialized medicine”. In the 1960’s the growth of health care costs accelerated leading to the foundation of several small HMOs. By the early 1970’s political conservatives embraced the idea of HMOs as an alternative to “socialized medicine”. With President Nixon’s passing of the HMO Act, individual HMOs would receive endorsement from the federal government with the requirement that employers must offer coverage from at least one qualified HMO to its employees (Markovich, 2003). Public health is also available to those who may be unemployed. Programs like Medicare and Medicaid covers the elderly and unemployed. As of 2007 around 21.9% of all the federal government expenditures were spent on these programs (Rachlis, 2009).

Our current HMO plans operate by charging a fixed fee that each member pays in advance. In return, the HMO will provide the needed medical services with a minimum out-of-pocket cost to the patient. HMO plans have the benefit of lower out-of-pocket costs for consumers over fee-for-service plans. In addition to this there are also comprehensive “first dollar benefits”, in which the plan pays benefits before the insured pays out-of-pocket expenses, allowing the employer to control cash flow. There are also fewer claims forms with less paper work (Gold, 1991). The individual also has the ability to receive treatment if they have the money to pay for it, lowering the wait time for individuals to get treated.

Despite the advantages of HMOs, employers reported higher overall satisfaction with conventional plans (Gold, 1991). Shortcomings exist such as limitations on covered services and reduced accessibility. An HMO is not a public service organization. HMOs are in business to make money, and the more people they can enroll, the greater the profit. Since the HMO is the provider and paying the medical bill, it is responsible for making a determination as to medical necessity, not the patient or his physician. This is called “utilization review”, where the HMO determines whether or not a requested treatment is covered (Berlin, 2009). Therefore, if a doctor recommends a necessary treatment for a patient, an HMO with potentially no medical background can deny it. People are receiving less needed health care to try and defray costs.

Without reform, the quantity and quality of health care will decrease due to the low affordability of inclusive coverage. The addition of a strong public option would lead to a less costly, more manageable, and higher quality system for everyone.

Health Care Reform, the Stupak Amendment, and the Public Option

The inner-workings and details of the current health care reform bills and their amendments have been an issue that has been clouded by constant argument in the both chambers of Congress. It would appear that every time a citizen goes to pick up a newspaper, Congress is in upheaval over how to reform health care in the most effective and affordable way.

The reform bill passed in the House of Representatives had major concessions on the side of what some media outlets refer to as the more “liberal” democrats. A provision in the bill, previous to being passed in the House, was to include what politicians and the media are referring to as a “robust public option” in which the fixed rates for the Medicare system would be roughly applied to all people under the government plan (Lochhead, 2009).

This provision failed to pass the House, and if a public option should pass as a provision in the Senate, it may mandate that rates will have to be negotiated between the federal government and the medical community if the Senate does not revive the provision of a more or less fixed rate public option. Another major concession on behalf of the House was the passing of H.R. 3962 with Rep. Stupak’s (MI) amendment to the bill. This was the amendment that stated very clearly that the Federal government will not provide funding or subsidization of abortion procedures. This means that the vast amount of subsidization for both public and private plans will exclude these types of procedures. The bill’s only clause is that funding may be applied in cases of rape, incest, or if the life of the mother is in jeopardy due to the pregnancy: all clauses that are, in effect, up for debate in any given medical setting, with the exception of incest (Legislative Digest, 2009). This amendment essentially concludes that the issue of abortion is a non-issue as far as healthcare for women goes. Senator Harry Reid gave his opinion that the senate may pass a similar amendment to their version of the bill. A Pro-life online periodical has recently published Senator Harry Reid’s stance on government funding for abortion procedures; “I expect that the bill that will be brought to the floor will ensure that no federal funds are used for abortion and that the rights of providers, health care facilities, like Catholic hospitals, will be protected, so I believe we can work that out, and we will” (Ertelt, 2009).

The fact that a government run insurance plan tied to fixed rates was conceded plays a very large role in health care costs for our nation in the future. According to a report by the Urban Institute, a fixed rate public option plays a major role in keeping prices for services down among insurers as well as health providers. To paraphrase a part of the report, in 2006, a study of several major metropolitan areas found that 88% of those areas were said to have very little competition between health care providers, in turn giving providers a large amount of market leverage and a lot of room to dictate their prices to insurance companies which base their prices to consumers upon what these providers charge (Berenson et al., 2009).

The public option debated in Congress is one based on negotiable rates with these hospitals that have already proven to have a lot of power in the market. What evidence is there that a government plan would have more leverage in the market to keep costs down for their service if it still had to negotiate prices with providers like traditional insurance plans? For that matter, what’s to say a government plan with negotiable rates will be any kind of decent competition for other insurance markets? A study in 2008 found that of 314 metropolitan areas in the U.S., 89% of those were found to have one sole insurer in the area controlling a giant part of the market (approximately 30%) (Berenson et al., 2009). Similar to providers, or any other market in our economy, this kind of disproportionate market power increases costs for consumers. If a government-run, not for profit insurance plan with negotiable rates with providers were to be passed into legislation, it too would be much more expensive due to a weak hand in the existing market.

The crux of the health reform legislation appears, from educated studies, to be the empowerment of individual citizens in the market. Concentrated market power in both the insurance market as well as the healthcare provider market means that these two service providers in conjunction squelch any hope that consumers have of keeping costs down for themselves. According to Ezra Klein of the Washington Post, Legislation enacting an insurance exchange market could be a powerful tool in placing more power in the hands of the consumer, and increasing competition among private insurers. Currently, the exchange market legislation's language includes provisions such as restricting insurers from barring coverage of pre-existing conditions. Also, with "innovative legislation" such as standardizing billing and payment methods, millions if not billions of dollars could be saved in administrative costs (Klein, 2009).

People covered under their employer's health insurance do not have many options in choosing health care coverage. Individuals seeking insurance on an unregulated market have no power in negotiating prices (Klein, 2009). This insurance exchange legislation would provide a market where many insurance providers would be lined up and placed directly in competition with each other. This alone forces the insurers to compete by presumably offering better service for less money, if the common economic sense of all other markets in the country applies. Government regulations such as restricting non-coverage of pre-existing conditions and dictating a minimum level of comprehensive care would arm consumers further with the power it would take to give them and their families affordable insurance coverage, especially considering government subsidies for lower-income people that would not restrict specific plans to specific income brackets. It would also vastly decrease insurance monopolization in certain areas of the country, giving some of the market leverage the insurers have to the consumers.

Both urban.org report, and economics expert Ezra Klein (2009) agree that it is not only the health insurers that drive up the cost of healthcare for the consumer, but also the concentrated market of health providers. It would be impractical to suggest perhaps government incentives to increase competition among providers, as that would not be the most effective way to drive down hospital costs. According to the Urban Institute study, it appears that the major cost to consumers in both insurance and provider markets come with cost negotiations between providers and insurers. This is why it is imperative to have the government run plan with a fixed rate. A fixed rate insurance policy that is not-for-profit and placed on the insurance exchange market would ensure lower costs from providers (Klein 2009a).

First of all, if consumers knew that the public option would definitely be a lower-cost option, it would provide the large customer base the plan needs to stay in business (Klein, 2009b). Also, a fixed rate public option would decrease market leverage for providers in this specific government plan. This would provide an acceptable norm for the price of services, therefore setting an example for other insurers to follow and remain competitive with this attractive insurance option. This will, in effect, tell hospitals that they may no longer charge exorbitant amounts of money for services which are equally as effective, yet less expensive in other countries. Most importantly, a strong public option will decrease the high concentration in market power for both insurers and providers, and place some of that power to the hands of the consumers.

Much controversy appears to remain in Congress over how to pay for this bill, should an equally expansive bill be ultimately agreed upon by both congressional entities. According to the New York Times, recent cost estimates are around one trillion dollars (Hulse and Pear, 2009) This money will be spent on such things as expanding Medicaid to more people and offering government subsidies in order to aid lower-income citizens in their purchasing of insurance plans (Congressional Budget Office, 2009), as well as the planning, organization, and execution of a public option. The CBO states that several measures are being undertaken to assure that our nation can balance the budget on the bill. Measures such as amending income tax on high-income individuals and families have been considered by many people in Congress. In addition to these tax amendments, the CBO has included fines (as penalty for not abiding by a mandated purchase of insurance) to be paid by businesses and individuals alike in the balancing of this bill's cost (CBO, 2009).

Considerations when Designing a Public Option

The primary goal of a healthcare system is to insure the health of the people who rely on it. There are forty-three million Americans with no health insurance (The American College of Physicians, 2004). A public plan that covers lower middle-class Americans who cannot afford private insurance, as well as those people who fall through the cracks in the current healthcare system are necessary to ensure that more people become insured. A public plan is an efficient way to decrease the number of uninsured. During economic lulls, employers reduce benefits forcing employees to bear the brunt of their medical costs and “as unemployment rises, states cut back on the number of people eligible for public insurance programs” (The American College of Physicians, 2004). If a public insurance program were implemented, a majority of people would be less affected by unemployment rates.

One of the major points of reform is to lower the cost of healthcare. The uninsured make a large contribution to its outstanding cost, as the uninsured go to the hospital with serious conditions, conditions that could have been prevented or treated with little cost. Treating the illnesses in the advanced cases is much more expensive (University, 2001). As proposed, a strong public plan would decrease the number of uninsured, thereby decreasing the cost of healthcare. The decreased cost would be attributed to the newly insured people who would be more likely to get treated for a minor ailment when it is still minor and less expensive to treat. Uninsured people who would not go to the doctor for a seemingly minor ailment, could then develop something potentially life threatening, requiring more expensive and extensive care.

Another group of people who should be included in the development of a strong public option are those with a preexisting condition. Most insurance companies do not cover pre-existing conditions: heart disease, cancer, acne and pregnancy. This leaves people who have chronic, potentially serious diseases or disorders without insurance. The problem with the current system is that health insurance providers cannot supply preexisting condition insurance and still compete with the other companies because they would have to raise rates. Those companies would get the sick people and the company with lower rates would get the healthy people (Vitez, 2009). Regulation of the current insurance market as well as a public option that covers these people would be ideal, especially to cover the sickest people, those who are denied coverage everywhere

else. This could be accomplished by an option that is available and affordable for people who have a preexisting condition.

Another benefit to a public option would be its low overhead cost. There is no need for a public insurer to spend large sums of money on advertising. A public insurer has no motive for profit, which would insure that the sickest people are taken care of. A public option would be a major move toward affordable healthcare for all Americans.

Some people fear that a public option would provide unfair competition to private insurers. While this may seem the case on the surface, a public option could be a way to provide adequate competition to private insurers. “The entire health care system would benefit from additional competition. The American Medical Association reported recently that insurance markets lack robust competition in more than 90 percent of metropolitan areas; in 16 states one insurer writes at least half the policies” (Brownstein, 2009). A strong public option can force these companies with broad consumer bases to innovate and provide comparable or even better care options.

Wait times are another potential shortcoming to a public option; if more people have access to healthcare, then people will have to wait longer to receive certain health services. The longer people wait for certain treatments, the more their health is negatively affected (Prentice, 2007). The one great benefit to the United States healthcare system is that people who can pay for healthcare can get it expediently, but this type of healthcare favors the few who can afford it. A better healthcare system extends its healthcare to most or all of its citizens rather than the precious few who can afford it.

Politics is one of the main obstacles to a public option. Many people fear the idea of socialized medicine; this fear is ungrounded. The United States already has “socialized medicine” in public programs such as Medicare and Medicaid. The illegitimacy of this fear can also be seen when the U.S is compared to countries with “socialized” medicine. In terms of health care system performance, as of 1999 the U.S. was rated number 37. United States citizens spend almost twice the amount of money per capita (ranked number one) as other countries. To rank 37th in overall healthcare despite this expenditure is absurd (WHO, 2000). Other countries which provide more public healthcare options at lower cost can provide a useful model; a model that indicates that whichever choice the U.S. makes it should include a public one.

A Cross Cultural Perspective

As each country is composed of various political and economic systems, the United Kingdom and Japan are two capitalist democracies that have similar health care plans. In examining how these plans work within both countries, it is evident that there are many factors to consider. It is critical to take a look at each country’s infant mortality rate as well as average life span. This can provide us with insight as to how their health care reflects upon its population. This section focuses on how each of these countries' plans work, what they entail, and how much it costs both the governments and the average family.

The health care system in the United Kingdom is a single-payer plan. This is a system which is paid for mostly by taxation and distributed to health care providers through the National Health

Service (NHS). About 8.3% of Gross Domestic Product is spent on this system. The NHS is run by the government, and ensures that hospital doctors are paid on a salary, whereas general practitioners who have private practices are paid depending on the number of patients they are treating. Other specialized practitioners work outside of the NHS, but only attend to patients who pay privately as well. In regards to co-payments, average families pay nothing for most, but not all, of the services provided. Services that may require some co-payments are dental care, eyeglasses and 5% of prescriptions. The elderly as well as the younger segment of the population do not have to pay drug co-payments (Frontline, 2008).

Despite criticisms that patients wait a long time before seen by a clinician, or that there is a lack of variety in choice of practitioners, the United Kingdom has addressed this issue. The country has attempted to encourage competition between hospitals. Hospitals now contend against one another for NHS funds. Patients can also choose where they would like to be treated. Although this system is not perfect, it yields positive results. The United Kingdom ranks number thirty-six out of two-hundred and twenty-four countries in regards to life expectancy. The United States is ranked at number fifty at 78.11 years of age. The average citizen of the UK has a life expectancy of 79.01 years. The estimated infant mortality rate for the year 2009 is 4.85 out of 1,000 live births where as the infant mortality rate for the year 2009 in the United States is at 6.26% (CIA, 2009a). US

While the United Kingdom health care system is referred to as “socialized medicine,” Japan uses a “social insurance” system. Each and every citizen of Japan must have health insurance. If it is not provided by the employer, it can be attained through a non-profit organization. If the citizen cannot afford either, they are further subsidized by public assistance. Unlike the United Kingdom, a majority of hospitals and doctors are private. Its citizens are able to go to whichever specialist or practitioner at any time they choose. This is unlike the United Kingdom system in a sense that they do not have to see a general practitioner before being referred to a specialist. In order to maintain low prices, the Ministry of Health and physicians both agree on procedure costs. The GDP spent on health care is even lower than the United Kingdom at 8% (Frontline, 2008). The average family spends around \$280 a month in addition to employers paying over half of the cost. For co-payments, a citizen must pay 30% of the procedure cost, but the entire amount paid in a month is adjusted according to income (Frontline, 2008).

Japan has one of the longest life expectancies. Out of two-hundred and twenty-four countries, it is ranked at number three. The average life expectancy of a Japanese citizen is 82.12 years old (CIA, 2009b). The infant mortality rate is also much lower than the United States at 2.79 deaths out of 1,000 live births in 2009 (ranked fourth lowest out of two-hundred and twenty-four other countries) (CIA, 2009a).

Our Recommendations

- Including a strong, fixed rate public option in United States healthcare reform is ideal. It provides many benefits to our society, including increased coverage for a large majority of citizens as well as needed competition to private insurance companies. We can also see that systems like this have worked across the globe. Both Japan and the United Kingdom have a version of a public health care system that functions as well, if not better

than, the system we have in place in the U.S. Our history and our present demonstrate the need for change; a public health care option is a necessary step toward the future.

- Anti-abortion legislation is an unnecessary addition to the Healthcare reform bill. There is already legislation in place to cover this issue and according to a study by the Guttmacher Institute, only 13% of abortions nationwide are billed to private insurance (Kaiser, 2009). This is a very small percentage and few of those are affected by the amendment at all. The addition of legislation on abortion is ineffective in discouraging abortion from happening, and only serves to lengthen the debate surrounding the reform bill. Abortion truly is a non-issue here and continuing to discuss it is unnecessary.
- The formation of more accessible means to gain accurate, up-to-date information on congressional activity. Many Americans are unaware of exactly what is happening in Congress. They are confronted by media frenzy and can have difficulty deciphering the fact from the fiction or gaining any objective information. Including the populous in government is a key element in a Democracy, but the means of communication in our country has become difficult to find. Better publicity regarding means of accessing accurate information and updates on Congressional activity would be a great benefit to the public. It would allow them to participate in government with a full understanding of present issues and political positions. Over time, better communication between the populous and government would lead to a society that is more balanced in its positions of power and a more active and satisfied populous.

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