which performed by civil servants, and which provider groups should be favored, would all be answered with a view toward drawing consumers to the plan. Arguments for or against a public plan will miss the point unless they focus on competition and choice.

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HEALTH CARE 2009

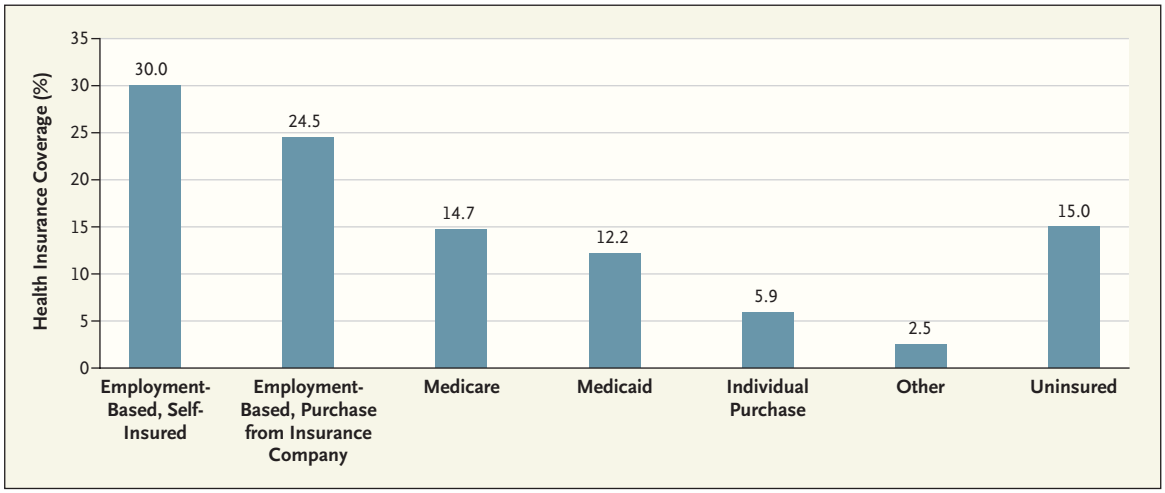
The Proposed Government Health Insurance Company — No Substitute for Real Reform

Victor R. Fuchs, Ph.D.

As pressure builds on the White House and Congress to deliver on their promise of health care reform, the idea of a government health insurance company to compete with for-profit and not-for-profit private companies is gaining political momentum. Advocates claim that this new company would be more efficient, honest, and successful in forcing lower reimbursement rates on physicians and hospitals.[1] However, a close look at how the present health care system functions, what its major problems are, and what reforms are needed to solve them suggests that this new idea is not the answer. The three major problems of the current U.S. system are that 45 million to 50 million people have no health insurance, the cost of care is high and rapidly increasing, and there are gross lapses in the quality of care. There is no reason to think that a government insurance company would make a significant dent in any one of these problems, let alone all three. To do that would require real reform in the financing, organization, and delivery of care.

The United States currently has a complex combination of private and public health insurance coverage, including self-insurance and policies purchased from insurance companies (see graph). What role might a government insurance company play in this system? If it sold policies only in the individual market (which now covers 5.9% of the population, approximately 18 million people), its effect would probably be minimal: Medicare and Medicaid would not change, and employment-based insurance would continue to be the primary source of coverage. If the government company intended to compete in the employment-based insurance market, it would have to recognize that the largest source of coverage in the United States (accounting for 30% of the population) is employers that self-insure. The only thing these employers buy from so-called insurance companies is administrative services, which are in fact the main product that many insurance companies provide.[2] If the government company also sold administrative services, is there any reason to think that it would be more efficient than WellPoint, Aetna, Cigna, UnitedHealth Group, Blue Cross and Blue Shield Association, and other major companies that compete vigorously for that business? In the largest current government health care program, Medicare, administrative services have always been outsourced to private companies.

Approximately one fourth of the population obtains coverage through an employer that buys insurance from an insurance company. But in most cases, the premium that employer pays is "experience rated" — that is, adjusted every year on the basis of the previous year's utilization. Would a new government company also experience rate premiums, or would it "community rate," charging the same premium regardless of an employer's utilization? If it used community rating, the government company would lose money rapidly because of adverse selection: firms with low utiliza-



Sources of Health Insurance Coverage for the U.S. Population, 2007.

The sum of the percentages exceeds 100% because some persons have insurance from more than one source. "Other" includes special programs for military retirees, military families, and disabled veterans. Data are from the Employee Benefit Research Institute (www.ebri.org/pdf/FFE114.11Feb09.Final.pdf) and the *Statistical Abstract of the United States, 2009* (www.census.gov/compendia/statab).

tion would opt for self-insurance or insurance companies that experience rate; those with high utilization would flock to the government company for the community rating.

As for the 15% of Americans who are currently uninsured, approximately three quarters of them are too poor or too sick to acquire insurance on their own; the other quarter are unwilling to buy insurance. The first group requires subsidization, which can be accomplished in a variety of ways, including income-tested programs such as Medicaid, single-payer plans such as Medicare, or a tax-financed universal-voucher approach. The government company could also be a vehicle for subsidies, but it would bring nothing special to the problem. Covering those who have been unwilling to buy insurance requires some form of compulsion — either an individual mandate or some form of taxation. A government insurance company is neither necessary nor sufficient for dealing with this segment of the population.

On the cost front, knowledgeable observers of Medicare from both inside and outside the program believe that it could obtain a substantial return on an increased investment in cracking down on fraud and reducing overuse of services. The failure to strictly monitor utilization is a result partly of regulatory and budgetary restrictions on Medicare and partly of political pressures. Surely a government insurance company would be handicapped by similar restrictions and pressures. The other part of the cost problem — rapid growth of expenditures over time — is attributable primarily to the adoption of new technology. Many policy experts believe that the solution is to create an independent institute for technology assessment.[3] A government insurance company would not help or hinder such an institute.

As for quality of care, improvement can occur in two ways. First, the level of "best practice" medicine can be raised by introducing new drugs, devices, and procedures and improving the understanding of diseases. Such advances are highly dependent on basic-science research and clinical research. The existence of a government insurance company would be largely irrelevant to the pace of medical progress. There is also great potential for improving the quality of care by bringing more of the country's actual practice closer to "best practice."[4] But neither public plans (Medicare and Medicaid) nor private insurance companies have been able to accomplish this.

Real reform begins by acknowledging that the three major problems — coverage, cost, and quality — must be attacked simultaneously. The United States has ample resources to provide the entire population with basic coverage for health care if we accept the necessity of subsidies for the poor and sick and compulsion for people who are otherwise unwilling to acquire insurance. Cost control requires fixed budgets for basic coverage so that expenditures and revenues are in balance,

as well as a payment system for providers that gives incentives for cost-effective care. It also requires an independent institute for technology assessment to provide physicians with needed information and to create a value-conscious environment for future biomedical innovations. Also, the average quality of care could be raised appreciably if every patient had access to an accountable care organization that used electronic health records effectively, provided coordinated care, and monitored processes and procedures.[5]

Supporters of a government health insurance company often point to Medicare as a model, noting its low overhead and high beneficiary satisfaction. But a new company would face a very different situation from that of Medicare, which has a captive audience and doesn't have to sell insurance and administrative services in competition with other companies. The new company would have to worry about adverse selection, and it presumably wouldn't have Medicare's access to the federal treasury to cover deficits. Moreover, Medicare, despite its assured market and huge buying power, is headed for insolvency; thus, it is a poor model for a new program that would be dependent on voluntary enrollment in a competitive marketplace.

Simply adding a government insurance company to the present mix would not result in universal coverage, bring costs under control, or materially improve the quality of care. Real reform requires replacing our inefficient, inequitable financing system with a simple, straightforward approach that subsidizes the poor and the sick and requires everyone to pay their fair share. It also requires changes in the organization and delivery of care that provide physicians with the information, infrastructure, and incentives they need to improve quality and control costs. A government insurance company is no substitute for real reform.

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