CDA October 24, 2009
AITE and Pomperaug High School
Resolved: The US should implement a "public option" as part of comprehensive health care reform.

Health Care Reform Glossary

From WebMD©

Co-ops: Private, nonprofit health organizations, run in states or regionally, to compete with private insurance companies.

Individual mandate: Requiring people to purchase health insurance or pay a penalty.

Medicare: Federal insurance program for people 65 and older and the disabled. It covers about 45 million Americans.

Medicaid: Government insurance plan for the poor and disabled covering roughly 60 million people.

Public plan or option: A government-run health plan, similar to Medicare, that would compete with private insurance plans in a marketplace or exchange.

Rationing: Government or another entity would allocate scarce medical services to patients.

Single payer: A financing system in which doctors and hospitals would bill a single entity, such as the federal government, for services.

Socialized medicine: European-style health system where the government employs health care providers and owns and operates health care facilities.

Public health insurance option

From Wikipedia, the free encyclopedia

A **public health insurance option** (**public insurance option** or **public option** for short) is a proposed health insurance plan that would be offered by the U.S. federal government. It is present in America's Affordable Health Choices Act of 2009 (H.R. 3200) as a **Qualified Health Benefit Plan**.

President Barack Obama promoted the idea while running for election.[1] Since becoming President, Obama has downplayed the need for a public health insurance option including calling it a "sliver" of health care reform,[2] but has still not given up pursuing one.[3] Congressional Democrats have tended to support this idea, stating that it would drive down premiums and provide choice where few options exist. Congressional Republicans have tended to oppose the idea, stating that it would cause the private health insurance industry to collapse.[1] Since the Qualified Health Benefit Plan would initially keep rates for services between Medicare and most private insurers, private insurers have complained that this will result in cost-shifting to them.[1]

Rationale

Supporters of a public plan, such as *Washington Post* columnist E.J. Dionne, argue that many places in the United States have monopolies in which one company, or a small set of companies, control the local market for health insurance. A government run plan would thus create new competition. Dionne has labeled a public option a "monopoly-buster."[4] Economist and *New York Times* columnist Paul Krugman has stated that traditional ideas of beneficial market competition do not apply to the insurance industry given that insurers must engage in risk pooling. Krugman has written, "the most successful companies are those that do the best job of denying coverage to those who need it most."[5]

In a public rally at Cincinnati in September 7, 2009, President Barack Obama said, "I continue to believe that a public option within the basket of insurance choices would help improve quality and bring down

costs."[6]

Alternative plans

An alternative that has been proposed is to pump federal money into various private non-profit health insurance cooperatives (co-ops) to get them to become large and established enough to provide cost savings[7] and into setting up transparent health insurance exchanges that would host them among health insurers.[8] These co-ops would likely be statewide.[8] Howard Dean and other Democrats have been critical of abandoning a public option in favor of co-ops, questioning whether the co-ops would have enough negotiating power to compete with private health insurers.[2] Prominent economists such as 2008 Nobel Economics Laureate, Paul Krugman, and Robert Reich have also questioned co-ops ability to become large enough to reduce health care costs significantly and thus support the public option instead.[9][10]

Those desiring reform beyond the public health insurance option have argued for a single-payer system,[11] which is planned to be brought for a vote[12]. A single-payer system has been claimed by some as politically difficult,[11] and Barack Obama has come out against it, stating in a joint session of Congress, "...it makes more sense to build on what works and fix what doesn't, rather than try to build an entirely new system from scratch."[13] Obama had expressed that he is a proponent of a single payer universal health care program during an AFL-CIO conference in 2003.[14]

Criticism

Michael F. Cannon, a senior fellow of the CATO Institute, has argued that the federal government can hide inefficiencies in its administration and draw away consumers from private insurance even if the government offers an inferior product. Cannon referred to a study by the Congressional Budget Office that found that profits account for less than 3% of private health insurance premiums, and he commented that the lack of a profit motive reduces incentives to eliminate wasteful administrative costs.[15] The chief executive of Aetna, Ron Williams, has stated on the *News Hour with Jim Lehrer* that a public option creates a situation where "you have in essence a player in the industry who is a participant in the market, but also is a regulator and a referee in the game". He said, "we think that those two roles really don't work well."[16] Republican Senator Charles Grassley has remarked, “The government is not a fair competitor... It's a predator.”[4]

Why the Public Option Isn't Dispensable

Health reform may not work without it.

By Timothy Noah, Slate: prescriptions. Posted Monday, Aug. 17, 2009, at 7:07 PM ET

Speculation is rife that the White House will cut loose the "public option"—i.e., the creation of a government health-insurance program to compete against private insurers. The signals aren't new; I began worrying about this nearly six months ago. (See "Is Obama Soft on Health Insurance?") The political mainstream seems to be greeting the latest hints from Health and Human Services Secretary Kathleen Sebelius and others with its usual shrug that politics is the art of the possible; to make a deal, all sides may have to give something up. The trouble in this instance is that *political* pragmatism conflicts with *programmatic* pragmatism. Without a public option, there's a very real danger that health reform simply won't work. It might even make things worse.

…

At the broadest possible level, the public option is necessary simply because it's impossible to identify a successful health system *anywhere in the world* based on a for-profit insurance model. If profit-driven health insurance could be made to work, then surely somebody would have figured it out by now. Paul Krugman, in an Aug. 17 *New York Times* column, likens health reform to the reforms Switzerland instituted in 1994: "[E]veryone is required to buy insurance, insurers can't discriminate based on medical history or pre-existing conditions, and lower-income citizens get government help in paying for their policies." But there's a significant difference. In Switzerland, private insurers are required to provide basic

health coverage *on a nonprofit basis*. Under Obamacare, private insurers will continue to seek profits, and it's quite possible that the new regulatory restraints imposed on them (take all comers, don't punish the sick with higher premiums, don't seek out fine-print reasons to cancel policies after policyholders get sick, etc.) will inspire them to find ever-more-ingenious ways to avoid payouts. President Obama often says that a public option will help keep the private insurers honest. What he doesn't say, but surely knows, is that private insurers' duties to their shareholders may be irreconcilable with their duties to their customers. Should that prove true, a public option would provide a necessary refuge.

The president has been demonizing private health insurers lately, but the insurance industry has thus far done little publicly to oppose health reform, for two reasons. The first is that the public option, which insurers fear (perhaps with some justice) would drastically reduce their market shares, may never make it out of the Senate. The second is that the *rest* of health care reform will probably prove even more profitable to health insurers than the creation of Medicare was to physicians. Under health care reform's "individual mandate," every American will have to purchase health insurance or pay a substantial tax penalty (under the House bill, a 2.5 percent tax on modified adjusted gross income). Under its "employer mandate," all but the smallest businesses will have to offer employees health insurance or pay a substantial tax penalty (under the House bill, 8 percent of payroll). Pause for a moment to consider what these two requirements will mean for the health-insurance industry's bottom line. "The Health Insurers Have Already Won," *Business Week* proclaimed in an Aug. 6 cover story. Granted, the insurers will have to operate under some new restrictions, but these will probably be far less severe than advertised. According to *Business Week*, the health insurer United Health has already talked the Senate finance committee down from a 75 percent required average reimbursement level for medical bills to 65 percent.

If, as *Business Week* predicts, health reform will be a fantastic boon to private health insurers, then those increased profits will make health insurers *even more powerful* politically than they are today. That, in turn, will make it even harder to create a public option in the future.

How might health reform *without* a public option make things worse?

To answer this question, it's necessary to explain what health reformers mean when they recite that dreadful Beltway jargon "bending the cost curve." Sometimes they mean that health costs need to stop devouring an ever-expanding share of tax dollars and the economy. That's a very real but somewhat abstract and long-term concern. Sometimes, though, when health reformers discuss the need to check medical inflation, they refer to the more immediate reality that health insurance is rapidly becoming unaffordable to ordinary people. That problem will become significantly more urgent if health reform enacts, as it almost certainly will, an individual mandate. The government risks putting itself in the position of forcing people to buy something they can't afford.

To avert this possibility, health reformers would expand eligibility for Medicaid up to somewhere between 130 percent and 150 percent of the poverty line (currently about $22,000 for a family of four). They would also subsidize health-insurance premiums on a sliding scale for people with incomes up to 400 percent of the poverty line. No family receiving a subsidy would be required to pay more than 12.5 percent of its income on health insurance. (Click here for additional details.) Needless to say, this part of health reform will require exquisite fine-tuning to prevent the legislation from becoming more burden than benefit for the uninsured people it seeks to help. It is also the part least likely to attract significant attention from the press and the public at large, which means it's the part that congressional cost-cutters will be most tempted to chip away at as the bill moves toward final passage.

A public option wouldn't solve this dilemma immediately, especially in the drastically diminished form it has assumed in the bills thus far passed by four congressional committees. (According to one Congressional Budget Office estimate, only 2 million people would participate in the new government health-insurance program.) But at least it would establish a beachhead, making it possible for political pressure to prompt the government to expand eligibility and loosen up restrictions on negotiating price reductions with doctors, hospitals, and drug companies. You can also think of the public option as a pressure valve. Without it, the government's attempt to remake the health sector risks blowing itself to

smithereens.

*Timothy Noah is a senior writer at **Slate**.*

Article URL: http://www.slate.com/id/2225506/

The Dangers of Fannie Mae Health Care

A public plan would *have certain advantages. That's precisely the problem.*

The Wall Street Journal, JUNE 26, 2009, By JOHN E. CALFEE

President Obama and most congressional Democrats say they want to preserve private health insurance. They also want to add a "public plan" to compete with private insurance plans. Their basic argument is that a public plan would offer needed competition, save money through low administrative costs and zero profits, realize greater economies of scale, and be a superior negotiator of the prices of medical services and technology.

The first three arguments are bogus. The fourth argument is only half-bogus -- but the half that isn't reveals a great danger: If a public plan is inserted into private insurance markets, the American health-care system could rapidly evolve into a single-payer system, which would have devastating effects on R&D for new medical technology.

The first argument, that we need a public plan to spur competition, just isn't plausible. Hundreds of health insurance plans already exist, and employer benefit managers can choose among numerous alternatives. There is no lack of firms willing to compete to provide health insurance.

As to the second argument, what is to be saved by avoiding profits? Nonprofit health insurance firms are common, including many of the Blue Cross-Blue Shield plans. Nonprofit status has not proved to be a reliable source of efficiency and cost-saving. The addition of new nonprofit cooperatives and the like -- as a bipartisan group of senators has proposed -- would make little difference, unless the new plans are given the power to set prices and take on extra risk supported by government subsidies.

Would a public plan have lower administrative costs? Well, how often are public enterprises run more efficiently than private ones? Why did practically all economically advanced nations dismantle their public airlines, phone companies, and so on, invariably obtaining lower administrative costs and consumer prices?

As Stanford University health economist Victor Fuchs has pointed out, what "insurance" firms actually sell to large employers -- which account for the single largest segment of the entire health-care market -- is usually administrative services, not actual insurance. (Large companies are not insured; they pay benefits directly.) There is no reason to expect a Medicare-like public plan to match the administrative efficiency of Aetna, Blue Cross-Blue Shield, Cigna, UnitedHealth Group, and WellPoint. Medicare doesn't even try. It outsources most administrative services to the private sector.

Turning to public plans like Medicare and Medicaid for more efficient administration is a fool's errand.

What about economies of scale? Aetna currently serves about 18 million subscribers, UnitedHealth Care serves between 25 million and 30 million, and WellPoint more than 35 million. That is more than is served by the health-care monopoly of Canada (population 33.6 million), and more than the entire health-care systems of most European nations. Once a plan reaches a few million subscribers, there may not be a lot of economies of scale left that can enable public plans to provide lower prices.

Finally, there is the crucial task of negotiating prices for doctors, hospitals, clinics, drugs, devices and thousands of other items essential to modern health care. Here, there are really two arguments for a public plan. The first is about bargaining skill and the firm size, basic ingredients in any negotiating environment.

There is no reason to think the administrators of a public plan will possess skills superior to those honed by private plan personnel during years of negotiations under the pressure of competition. Nor is there any reason to think that mere size would help.

True enough, relatively small European nations routinely obtain better drug prices than are achieved by mammoth American pharmacy benefit managers such as Express Scripts (50 million patients) and Medco (60 million patients), each of whose numbers exceed the entire citizenry of all but the largest European nations. Even sparsely populated New Zealand (population four million) gets better prices than the giant drug-price negotiators in the American private market.

Their success is due to what economists call "monopsony power." Monopsony occurs when a single buyer negotiates prices with several competing sellers (as opposed to monopoly, where there are many buyers but one seller).

Thus, if you want to sell your branded drug in New Zealand, your prices are negotiated with PharMac, a branch of the government. Much the same is true when selling to Canada, Germany, the Netherlands, and essentially the entire developed world save the United States. The negotiating power of these government entities results from monopsony, not superior skill.

For example, the various sellers of cholesterol drugs (Lipitor, Crestor, and so on) have to compete with one another while they all face a single government negotiator. If one seller balks at government prices, it leaves competitors to pick up more sales. The same is true for most other drug classes and most medical devices. This uneven battle ensures that negotiated prices will be well below those in a competitive market.

But here is where the huge risks of creating a "public plan" to compete with private insurance firms come into focus. Foremost among these risks are the effects of monopsony power in the purchase of medical technology.

The U.S. is unique because it alone is the source of half of world-wide profits that provide the payoff for the complex, lengthy, and expensive process of developing new treatments. When other nations construct their health-care systems, they ignore the impact of their pricing policies on R&D incentives. As the dominant R&D funding wellhead, we do not have that option.

Competitive markets have generated the prices and the profits necessary to induce a steady flow of medical innovation in this country. A public plan option would tend to dismantle that system. The people in charge will not know how to set reimbursement levels to motivate reasonable R&D efforts, and there is no reason to expect them to try. In public plans, the tried-and-true method is to push the prices of suppliers down until something gives -- too few doctors willing to take on Medicare patients, for example -- and then to ease up. That is a destructive approach to medical technology R&D.

Who knows what drugs will not be developed if reimbursement levels for a new multiple-sclerosis treatment are too measly? In virtually every advanced economy but our own, pricing authorities simply make sure prices are high enough so that existing drugs continue to be made available. We can expect a public plan here to do the same. The inevitable result is to drastically under-incentivize R&D.

This problem would not matter if a public plan remained small -- but it would likely grow into a monster. Monopsony negotiating power will generate lower prices, so many consumers will switch to a public plan. Employers eager to offload health-care costs will also dump unwilling employees into the public plan. That is the basis for the Lewin Group's much-cited prediction that a public plan would come to dominate any market in which it is allowed to compete.

Bargaining power, however, is far from the only potential source of below-market prices for public plans. In the home mortgage market, the public plans -- known as Fannie Mae and Freddie Mac -- were for years viewed by investors as less risky because they would be bailed out by the federal government if they took on too much risk. That translated into lower prices (the interest rates paid by borrowers), which eventually translated into extraordinary and unseemly growth, culminating in bankruptcy and a federal bailout.

The lesson for health insurance is clear. All insurance plans -- especially in health-care markets -- have to take on risk. Prudent planning, including the maintenance of reasonable financial reserves, is necessary. That increases costs. It would be all too easy for a public plan to gain a competitive advantage by taking on extra risk while keeping prices low because everyone would expect the federal government to take

care of financial surprises down the road.

In sum, a public plan would possess formidable and perhaps overwhelming competitive advantages -- generated not by efficiency but by the artificial advantages of "public" status. This would have two disastrous consequences. The first will be to cause most Americans now covered by private insurance to move to public insurance -- one step away from single-payer health care. The second will be to undermine incentives to develop more of the immensely valuable medical technology that is central to all of health care.

Mr. Calfee is a resident scholar at the American Enterprise Institute.

Why We Need a Public Health-Care Plan

Without the government as competition, the private sector has little incentive to improve.

The Wall Street Journal, JUNE 24, 2009. By ROBERT B. REICH

Why has health-care reform stalled in Congress? Democrats, after all, control both Houses, and President Obama, whose popularity remains high, has made universal health care his No. 1 priority. What's more, an overwhelming majority of the public wants it. In the most recent Wall Street Journal/NBC News poll, 76% of respondents said it was important that Americans have a choice between a public and private health-insurance plan. In last week's New York Times/CBSNews poll, 85% said they wanted major health-care reforms.

So why the stall? Mainly because Congress can't decide how to pay for it. The hardest blow came last week when the Congressional Budget Office (CBO) estimated that the trial-balloon bill emerging from the Senate Health Committee would cost a whopping $1 trillion over 10 years and would cover only a fraction of Americans currently without health care. According to the CBO, another tentative bill, this one coming out of the Senate Finance Committee, would cost even more -- $1.6 trillion.

That spells political trouble. Republicans who never batted an eye over George W. Bush's wild spending habits have become born-again fiscal hawks. Blue Dog Democrats are nervous about mounting deficits. Even the president admits that the flow of red ink in future budgets keeps him up at night.

No one wants to raise taxes or even be accused of thinking about the subject. But honest politicians have to admit that universal health care will require additional revenues. The likeliest sources are limits on certain tax deductions and a cap on tax-free employer-provided health care. Would the public go along? The most intriguing finding in last week's New York Times/CBS poll was that most respondents said they would be willing to pay higher taxes to ensure everyone had health insurance.

But before we even get to this point, it's important to recognize that those terrifying CBO cost projections significantly overstate the costs. They did not include potential cost savings from the lynchpin of health-care cost containment: a so-called public option that would give people who don't get health care from their employer the choice of a public insurance plan. Why? For the simple reason that the Senate committees hadn't yet agreed on a public option. Yet without a public option, the other parties that comprise America's non-system of health care -- private insurers, doctors, hospitals, drug companies, and medical suppliers -- have little or no incentive to supply high-quality care at a lower cost than they do now.

Which is precisely why the public option has become such a lightening rod. The American Medical Association is dead-set against it, Big Pharma rejects it out of hand, and the biggest insurance companies won't consider it. No other issue in the current health-care debate is as fiercely opposed by the medical establishment and their lobbies now swarming over Capitol Hill. Of course, they don't want it. A public option would squeeze their profits and force them to undertake major reforms. That's the whole point.

Critics say the public option is really a Trojan horse for a government takeover of all of health insurance. But nothing could be further from the truth. It's an option. No one has to choose it. Individuals and

families will merely be invited to compare costs and outcomes. Presumably they will choose the public plan only if it offers them and their families the best deal -- more and better health care for less.

Private insurers say a public option would have an unfair advantage in achieving this goal. Being the one public plan, it will have large economies of scale that will enable it to negotiate more favorable terms with pharmaceutical companies and other providers. But why, exactly, is this unfair? Isn't the whole point of cost containment to provide the public with health care on more favorable terms? If the public plan negotiates better terms -- thereby demonstrating that drug companies and other providers can meet them -- private plans could seek similar deals.

But, say the critics, the public plan starts off with an unfair advantage because it's likely to have lower administrative costs. That may be true -- Medicare's administrative costs per enrollee are a small fraction of typical private insurance costs -- but here again, why exactly is this unfair? Isn't one of the goals of health-care cost containment to lower administrative costs? If the public option pushes private plans to trim their bureaucracies and become more efficient, that's fine.

Critics complain that a public plan has an inherent advantage over private plans because the public won't have to show profits. But plenty of private plans are already not-for-profit. And if nonprofit plans can offer high-quality health care more cheaply than for-profit plans, why should for-profit plans be coddled? The public plan would merely force profit-making private plans to take whatever steps were necessary to become more competitive. Once again, that's a plus.

Critics charge that the public plan will be subsidized by the government. Here they have their facts wrong. Under every plan that's being discussed on Capitol Hill, subsidies go to individuals and families who need them in order to afford health care, not to a public plan. Individuals and families use the subsidies to shop for the best care they can find. They're free to choose the public plan, but that's only one option. They could take their subsidy and buy a private plan just as easily. Legislation should also make crystal clear that the public plan, for its part, may not dip into general revenues to cover its costs. It must pay for itself. And any government entity that oversees the health-insurance pool or acts as referee in setting ground rules for all plans must not favor the public plan.

Finally, critics say that because of its breadth and national reach, the public plan will be able to collect and analyze patient information on a large scale to discover the best ways to improve care. The public plan might even allow clinicians who form accountable-care organizations to keep a portion of the savings they generate. Those opposed to a public option ask how private plans can ever compete with all this. The answer is they can and should. It's the only way we have a prayer of taming health-care costs. But here's some good news for the private plans. The information gleaned by the public plan about best practices will be made available to the private plans as they try to achieve the same or better outputs.

As a practical matter, the choice people make between private plans and a public one is likely to function as a check on both. Such competition will encourage private plans to do better -- offering more value at less cost. At the same time, it will encourage the public plan to be as flexible as possible. In this way, private and public plans will offer one another benchmarks of what's possible and desirable.

Mr. Obama says he wants a public plan. But the strength of the opposition to it, along with his own commitment to making the emerging bill "bipartisan," is leading toward some oddball compromises. One would substitute nonprofit health insurance cooperatives for a public plan. But such cooperatives would lack the scale and authority to negotiate lower rates with drug companies and other providers, collect wide data on outcomes, or effect major change in the system.

Another emerging compromise is to hold off on a public option altogether unless or until private insurers fail to meet some targets for expanding coverage and lowering health-care costs years from now. But without a public option from the start, private insurers won't have the incentives or system-wide model they need to reach these targets. And in politics, years from now usually means never.

To get health care moving again in Congress, the president will have to be clear about how to deal with its costs and whether and how a public plan is to be included as an option. The two are intimately related. Enough talk. He should come out swinging for the public option.

Mr. Reich, professor of public policy at the University of California at Berkeley and former Secretary of Labor under President Clinton.

The 'Public Plan' Would Be the Only Plan

It's impossible for private insurers to 'compete' with government.

The Wall Street Journal, JUNE 15, 2009, By SCOTT E. HARRINGTON

The Obama administration and the Democratic congressional leadership appear poised to create a "competing" government health insurer as part of its health-care reform. President Obama believes this would provide "a better range of choices, make the health care market more competitive, and keep the insurance companies honest," as he wrote to Sens. Edward Kennedy and Max Baucus on June 2.

In reality, equal competition between a public plan and private plans would be impossible. The public plan would inexorably crowd out private plans, leading to a single-payer system.

Advocates claim that a public plan would achieve significant savings in administrative costs. Among other omissions, they ignore that a significant proportion of private insurers' expenses are incurred for creating and maintaining provider networks, and for monitoring payments to reduce waste and fraud. Private health plans have a strong incentive to spend a dollar as long as the expected savings in payments is at least a dollar. The resulting expenditures increase reported administrative costs, but they save money overall. A public plan will not have comparable incentives.

The argument that a public plan would not need profits and would prevent excessive private-plan profits is populist rhetoric. Profits are needed to earn normal returns on the capital that private insurers invest to back the sale of coverage and to make promises to pay claims secure. They have not been excessive compared with other industries. A public insurer wouldn't have to hold amounts of capital comparable to private plans. It would be backed by taxpayers. Nor would it likely be subject to the same taxes that private insurers pay, including those on investment returns from holding capital. "Competition" on this level just isn't possible.

Equal public-private competition in reimbursing hospitals and physicians is likewise a nonstarter. One proposal is for a public plan to pay Medicare rates, perhaps with a small markup. Because Medicare reimbursements already entail substantial cost-shifting to private payers, any expansion of Medicare payment rates, with or without a modest markup, would further shift costs to private payers and accelerate the crowd-out of private plans.

The alternative of having private plans reimburse providers at public-plan rates would require significantly higher reimbursements than under Medicare to avoid bankrupting many hospitals and physicians. This "single-payer light" approach would produce universal price controls on medical services and raise the obvious question: Why bother with private plans?

Having the public plan instead pay private-plan rates would violate a major objective of many advocates: cutting costs by reducing reimbursements. Even if politically feasible, this approach would need to address complex design and administrative challenges to benchmark rates negotiated between thousands of providers and numerous private health plans.

With or without a public-plan option, reform legislation is almost certain to substantially narrow the dimensions on which health plans compete. Given the fixation of many reform proponents' on attempting to ensure that no person's premiums or coverage terms will be related to health status, private plans will be required to accept all applicants, probably at rates that vary only with age and geographic region. There will be heavy constraints on benefit design and marketing, perhaps with ex post transfers of funds among insurers to even out profitability. Under the guise of preventing "cherry picking" health customers, a government-run plan could easily be accompanied by additional constraints or surcharges on private plans to deter them from offering attractive options.

The simple truth is that equal competition between a government health-insurance plan and private plans

would be impossible. An ostensibly competing public plan would make a single-payer system inevitable. Health-care providers and other Americans should recognize this reality and be prepared for the consequences.

Mr. Harrington is professor of health-care management and insurance and risk management at the Wharton School of the University of Pennsylvania.

The Private Option

Employment-based health insurance is in big trouble, but don't blame Obama.

Slate: moneybox. Posted Thursday, Sept. 10, 2009, at 4:34 PM ET, by Daniel Gross

Americans who have health insurance, we are told, are largely satisfied with it and terrified of losing it. Many of them assume that employment-based insurance—for all its flaws—is preferable to any other system. And last night President Obama went out of his way to tell people who get their insurance from employers that they had nothing to fear:

"[I]f you are among the hundreds of millions of Americans who already have health insurance through your job, Medicare, Medicaid, or the VA, nothing in this plan will require you or your employer to change the coverage or the doctor you have. Let me repeat this: Nothing in our plan requires you to change what you have."

That's true. But powerful trends in the broader economy will. Even without reform, lots of people with employer-provided insurance are losing it. And those who still have it may find they'll be less satisfied with it in the future.

The latest report from the Census Bureau on income, poverty, and health insurance is full of interesting data. (For example, median household family income in 2008, at $50,303, was below where it was in 1998. Heckuva job, Bushie, Greenie, and the whole economic team!) Perhaps the most surprising census data are the significant evidence that, even absent a reform bill, the United States is slowly nationalizing health care. In 2008, enrollment in Medicare and Medicaid rose from a combined 81 million to a combined 85.6 million. Add in military health care, and some 87.4 million Americans in 2008 got health insurance directly from a government source—about 29 percent of the total. Meanwhile, health insurance became less tethered to work. The percentage of people covered by employment-based health insurance fell from 59.3 percent in 2007 to 58.5 percent 2008, and the percentage of those working full-time and part-time who lacked health insurance rose in 2008. The ranks of those getting insurance from employers include a substantial number of public employees—teachers, state workers, etc. (In August, government accounted for about 17 percent of payroll jobs.) Add those folks to the people receiving coverage from Medicare, Medicaid, and the military, and, as Jon Bon Jovi once put it, "we're half way there." *Most* of the Americans who have insurance may already be getting it through the government, one way or another.

Scroll down to Table C-1 on Page 59 and check out the long-term trends. Since 2000, a period of generally low unemployment, the portion of the population getting insurance directly from the government rose from 24.7 percent to 29 percent, while the portion receiving employment-based coverage fell from 64.2 percent to 58.5 percent.

These data don't tell the whole story about the decline of employment-based insurance. Not all insurance is created equal. If you're a top dog at Goldman Sachs, your employer will provide a gold-plated plan and pick up the tab, which can run up to $40,000. If you're a clerk at Whole Foods, your employer will offer a low-premium high-deductible policy—which is great for people who have extra cash and don't have much occasion to use health care services. For most workers, the experience is somewhere in between Whole Foods and Goldman Sachs: Employers and workers share the costs of a plan that provides decent coverage.

Economists have correctly noted that wages haven't risen more in this decade in part because companies are paying more for benefits like health insurance. True. But employers have also been passing on rising

costs to employees. And according to a new report by Mercer Consulting, companies are planning on doing a lot of that in 2010. If employers simply reupped existing plans, Mercer's survey finds, costs would rise by 9 percent. But according to preliminary findings, "respondents plan to shave three percentage points off their annual renewal rates through a variety of cost-saving actions, holding overall cost growth to 5.9 percent next year." How? The "first line of defense" is "shifting costs to employees." Mercer notes that between 2004 and 2008, the median family deductible for in-network services in the type of plan offered by the largest number of employers soared from $1,000 to $1,850. Translation: Employees who used their insurance plans with any frequency saw their wages reduced by $850 in that period. And it looks like there are more such "cuts" coming. Next year, Mercer reports, "nearly two-thirds of all respondents (63 percent) will again ask employees to pay a greater share of health plan costs." Forty percent say they'll ask employees to pay a bigger chunk of the monthly premium, and 39 percent will boost deductibles or increase co-payments. Oh, and 18 percent say they plan to get rid of "more generous health plan options" as a way to move into cheaper ones like consumer-directed health plans. The upshot: Most people who receive employer-based health insurance will either be paying more for the same plan or be offered a plan that shifts more costs on to them.

It's understandable that those who have insurance from their employers are concerned about reform and what they might lose. But those who expect to hold on to the same employer-provided health benefits at the same cost are living on a prayer.

*Daniel Gross is the Moneybox columnist for **Slate** and the business columnist for* Newsweek.

Article URL: http://www.slate.com/id/2227984/

Health Care Systems

From Wikipedia, the free encyclopedia, OECD Statistics

Country	Life expectancy	Infant mortality rate	Physicians per 1000 people	Nurses per 1000 people	Per capita expenditure on health (USD)	Healthcare costs as a percent of GDP	% of government revenue spent on health	% of health costs paid by government
Australia	81.4	4.2	2.8	9.7	3,137	8.7	17.7	67.7
Canada	80.7	5.0	2.2	9.0	3,895	10.1	16.7	69.8
France	81.0	4.0	3.4	7.7	3,601	11.0	14.2	79.0
Germany	79.8	3.8	3.5	9.9	3,588	10.4	17.6	76.9
Japan	82.6	2.6	2.1	9.4	2,581	8.1	16.8	81.3
Norway	80.0	3.0	3.8	16.2	5,910	9.0	17.9	83.6
Sweden	81.0	2.5	3.6	10.8	3,323	9.1	13.6	81.7
UK	79.1	4.8	2.5	10.0	2,992	8.4	15.8	81.7
US	78.1	6.7	2.4	10.6	7,290	16.0	18.5	45.4

The United States is alone among developed nations with the absence of a universal health care system.[50][51] Healthcare in the U.S. does, however, have significant publicly funded components. Medicare covers the elderly and disabled with a historical work record, Medicaid is available for some, but not all of the poor,[52] and the State Children's Health Insurance Program covers children of low-income families. The Veterans Health Administration directly provides health care to U.S. military veterans through a nationwide network of government hospitals; while active duty service members, retired service members and their dependents are eligible for benefits through TRICARE. Together, these tax-financed programs cover 27.8% of the population[53] and make the government the largest health insurer in the nation.