

HEALTH CARE FOR AMERICA NOW!

Response to Proposal to Make Establishment of a Public Health Insurance Plan Option Contingent on a 'Trigger'

A proposal has been floated to delay establishment of a new public health insurance plan option under health care reform until private insurance market concentration reaches even greater levels. This 'trigger' proposal is an attempt to deny people the choice of health plans. It would delay needed federal action, impede efforts to bring competition and choice to the health insurance market, and result in higher health care costs being loaded on to families and businesses across America.

The Private Insurance Track Record

- Insurers have increased premiums 87% over the past 6 years. Premiums have doubled in the last 9 years, increasing 4 times faster than wages.
- Profits at 10 of the country's largest publicly-traded health insurance companies in 2007 rose 428 percent from 2000 to 2007, from \$2.4 billion to \$12.9 billion, according to U.S. Securities and Exchange Commission filings.
- States have tried to control insurance company behavior and rates, unsuccessfully, for decades. Federal reforms might have success at the margins, but insurers will always be one step ahead of the sheriff.
- The result? 400 corporate mergers in 13 years, leading to anti-competitive markets in 94% of markets in the U.S., according to data compiled by the AMA.
- Under any real trigger – one based on standards broadly recognized by antitrust experts – 94% of the country would qualify today. The insurance market is broken, nationwide.

A 'Trigger' Proposal Misses the Point

- Now is the time for action. Consumers shouldn't have to wait any longer for the federal government to intervene to fix a broken system. This should be reform for all, not reform for select states.

- People want a choice of a public or private health insurance plan. Given the choice between a public-only system, a private-only system, or a mix of the two, 73% of Americans want a choice of a public or private plan.
- Americans' frustrations aren't just because of the number of choices they have, but the kind of choices available. Many Americans want an alternative to private insurers that are charging them more for less care. In a 2006 Harris Interactive survey, only 7% of Americans said they found insurance companies "generally honest and trustworthy."
- A public health insurance plan 'trigger' based on market concentration in the entire state only sees part of the picture. Health care markets are local. For example:
 - In Oregon, the top insurer statewide (Providence Health & Services) controls only 25% of the market, but in Medford, OR, the top insurer (Regence Blue Cross Blue Shield) has 67% of the market. So the people of Medford would be denied choices just because there's a more competitive market in some other parts of the state.
 - In Delaware, the top two insurers control 65% of the market, but they control 80% of the market in Dover. Will people in Dover be denied more insurance choices because of variations in the numbers statewide?
 - New York's statewide market is more competitive than in most states. Statewide, the top insurer (GHI) controls 26% of the market, but in Ithaca, the top insurer has 76% of the market and the top two insurers control 91% of the market. Shouldn't people in Ithaca have another choice?

Death by Paperwork for the Public Option

- A 'trigger' would require the creation of a new public plan, from scratch, when certain market conditions are reached. From the time the trigger is reached, it would take an extended period to create a public option, leaving the private plans free to profit off markets the government can certify today as anti-competitive and unfair to consumers.
- Creating 50 state-based public plans wastes money on administration that would be better spent paying for health care. To achieve the greatest efficiencies and compete with mega-insurers, a public health insurance plan should be national, not state-based.

A Public Health Insurance Plan is a Necessary Competitor

- Properly designed, a public health insurance plan will:

- **Provide Stability** by being in every market. Private insurers move in and out of markets, change benefits, contract with different providers and alter cost-sharing at will.
- **Promote Efficiency.** A public health insurance option can achieve lower growth and, through fair competition, can force private insurers in the marketplace to find efficiencies as well. Between 1997 and 2006, per enrollee spending in private insurance grew 59% faster than spending in Medicare. If private insurance controlled growth as well as Medicare over the past decade, employers and families would see much lower premiums than they do today.
- **Advance Innovation.** Our current health care system does not deliver value. In the private market, innovations in care management are trade secrets. A national public health insurance plan can be an implementer of delivery system reforms across the country, in every market.
- **Foster Transparency.** Public health insurance plans operate with a heightened level of transparency in governance, coverage decisions, payment rates, provider payment arrangements, utilization data, and payment reforms. In contrast, private plans have proven to do the opposite, for instance not disclosing basic utilization data and withholding information on provider payment incentives.

The Medicare Part D Program Demonstrates that the Threat of a Trigger Doesn't Work to Lower Costs and Protect Consumers

- The Medicare Part D prescription drug program included a trigger for a public Medicare drug plan when there are not sufficient choices among private Part D plans. The trigger has never been pulled, forcing consumers to deal with higher prices and lower quality plans.
- Despite the threat of a trigger, private insurance Medicare Part D plans pay more for drugs than government plans:
 - A report by Families USA on the top 20 drugs used by older adults found the VA had lower prices than those charged by the most popular Part D plans. For half of the drugs studied, the lowest price available under a Part D plan was at least 58 percent higher than the price charged by the VA.
 - The Congressional Budget Office in December projected that if drug manufacturers were required to give Medicare Part D plans the same rebates they give the Medicaid program, the federal government would save \$110 billion between 2010 and 2019

- Despite the threat of a trigger, private insurance Part D plans provide fewer medication choices and harm access:
 - The VA has 4,778 separate drugs on its formulary, approximately 478 more than the 4,300 drugs covered by the average Medicare Part D plans. In 2006, the VA dispensed prescriptions for 1,416 drugs not on the VA formulary.
 - The HIV Medicine Association and the American Academy of HIV Medicine surveyed their members and found 83 percent said their patients had trouble getting medicine from Medicare private drug plans.
 - A survey of U.S. psychiatrists by the American Psychiatric Institute for Research and Education found 53 percent of respondents said their patients with Medicare and Medicaid had problems getting drugs from their Part D plans
- Despite these deficiencies, including lower access and higher costs, the ‘trigger’ under Medicare has not been pulled – and appears to have been designed not to be pulled.