Why a Public Plan is Unnecessary

Christopher J. Conover, PhD, Research Scholar, Center for Health Policy,
Sanford School of Public Policy, Duke University
September 1, 2009

Proponents of a public health insurance plan, including President Obama, claim it is needed to stimulate competition.[1] There are five good reasons to question this claim. First, the evidence shows that at the national level, the health insurance market generally is highly competitive for a large fraction of privately insured individuals. Second, both at the state and local level, markets that appear to lack competition are dominated by non-profit firms whose economic incentives are no different than a public plan. Moreover, insurance plan concentration to some extent appears to have been a helpful counterweight to the growing market power of providers in recent years. Third, in areas where lack of competition is an issue, there are tools to restore competition that would be vastly superior to reliance on a public plan. Finally, real world experience demonstrates that head-to-head competition among private insurers can produce sizable premium savings even without a public plan.

The sheer number of plans (nearly 1300) and modest profitability levels among private insurers demonstrate that at the *national* level, the health insurance market generally is highly competitive for the 61% of privately insured Americans who now purchase their coverage through large groups. Thus, it makes little sense, as the current House bill does, to allow for the possibility of a public plan being offered to such groups.

At the *state* level, concentration in health insurance markets appears less disturbing than it appears for two reasons. First, most concentrated markets tend to be dominated by nonprofit plans (mostly Blue Cross/Blue Shield plans). Second, market concentration is not necessarily associated with adverse outcomes. For nonprofit Blue Cross/Blue Shield plans, increased market share historically has been shown to be associated with lower payments to providers, lower administrative costs and lower premiums. While things possibly may have changed since then, even today market concentration among health insurers has a relatively small effect on current levels or recent growth in health spending. Specifically, the most recent available data shows there is only a small relationship between the share of the market controlled by the two largest firms and state-level private per capita health spending. As well, health insurance market concentration explains only a small part in the rates of increase in private per capita health spending between1999-2004. This is inconsistent with the view that concentration is allowing health insurers to exploit their members. Instead, it is consistent with a more plausible view that concentration in the health insurance industry has provided a useful corrective to the equally disturbing growth in concentration of hospital and physician markets over the past decade.

Moreover, even at the *local* level, roughly three quarters of local markets that appear to have weak competition are dominated by nonprofit plans: such plans are no different than a public plan in terms of profit motive. However, if the problem of sluggish private sector competition is limited in geographic scope, then creating a national public plan to address that problem is overkill. It would be preferable and far less risky to find more targeted solutions. In areas where lack of competition adversely affects those seeking to purchase health insurance, policymakers have ample tools to restore competition that would be superior to reliance on a public plan. These include more vigilant state regulation of the individual and small group markets, more aggressive antitrust enforcement and allowing interstate sales of health insurance.

Finally, real world experience with the Medicare drug benefit (where fierce competition among private health plans has contributed to cost savings of nearly 40%), the federal employee health benefits program (which for decades generally has experienced lower premium growth than private health insurance and Medicare) and the State of California (whose market-oriented approach to health care has reduced its level of spending relative to the U.S. by nearly one third in just 25 years) have demonstrated convincingly that competition among private insurers can work very effectively even without a public plan.

Here's the evidence to support those conclusions.

National Market is Highly Competitive

At the national level, the private insurance market already is highly competitive, particularly for large groups. Nationwide, there are nearly 1,300 companies that provide health insurance coverage.[2] But apart from the sheer number of plans available, there is strong evidence of robust competition for the employers who rely on this market.

Robust Competition in the Large Group Market

Competition is very robust in the market serving 129.1 million Americans who obtain their health benefits through large groups. These individuals represent 58% of those with private health insurance in the U.S.:[3]

- **Self-Funded ERISA Plans**. For 80 million plan members in large, multistate private employers with self-insured benefits, "the number and relative size of local health plans may be largely irrelevant."4 The federal ERISA law preempts states from regulating such plans offered by private employers (federal, state and local health benefits are not covered by ERISA), thereby allowing such firms to offer standardized benefits across state lines.5 There is robust head-to-head competition among national insurers for this business: the largest plan serving this multistate market in 2003 had only a 15% market share; together, the 7 largest plans in this market had a market share of only 75%.[6]

- **FEHBP**. This includes 7.8 million federal employees, retirees and their dependents.[7]
- **Military Health**. This includes nearly 11 million individuals covered through TRICARE (for military retirees as well as families of active duty, retired, and deceased service members), CHAMPVA (for dependents and certain survivors of veterans) and VA Health (for veterans).[8]
- **State Employees and Dependents**. This includes 8.0 million workers, retirees and their dependents; 58% of such workers are in self-insured plans,[9] so there should be no perverse incentives of private insurers to deny coverage or discriminate against high-risk plan members. But even in states with insured benefits, state employees tend to be the largest single insured group in the state, giving the state a high degree of leverage to protect the plan's members from any market abuses.
- **Local Employees/Schoolteachers**. This includes 22.3 million local employees, retirees and their dependents.[10] In some states, local employees and/or schoolteachers are part of the state employee group, thereby conferring on them the same sort of purchasing clout.

MODEST PROFITABILITY LEVELS

Further evidence of the industry's competitiveness is seen in its relatively modest profitability levels:

- **For-Profit Health Insurers**. Despite recent industry consolidation,[11] the largest companies (i.e., members of the Fortune 1000) within the health care insurance/managed care industry earned a profit of only 6.2% in 2007 (ranging from a low of 1.4% for Healthnet to a high of 6.6% for Aetna), ranking the industry's profitability #28 among 75 industries compiled by *Fortune* magazine.[12]
- **Nonprofit Health Insurers**. The foregoing figures do not include nonprofit health insurers such as Blue Cross and Blue Shield plans–which covered 31% of those with private insurance in 2003[13]–or large nonprofit HMOs such as Kaiser. From 1997-2001, profitability levels for nonprofit Blue plans were 1-2 percentage points lower than in for-profit Blue plans,[14] although in 2002-2003 they "enjoyed financial results equal to or better than those of their for-profit counterparts."[15]
- **Industry-wide Profits**. Across the entire insurance industry (i.e., inclusive of all for-profit companies large and small, as well as nonprofit insurers), profits amount to 4 percent of premiums, or 2.8% after taxes.[16]

Were health insurers truly able to exercise considerable market power, we would expect far fewer competitors and much higher levels of profitability. In light of this, and assuming a level playing field, adding one more public plan to this mix cannot credibly add to the fierce competitive pressures already felt in this market. It would be hard to justify giving these large employer groups access to a public plan, especially since they have demonstrated by their own behavior that private coverage is perfectly acceptable. Yet the House Tri-Committee health reform plan unaccountably allows (in Year 3 of the plan) employers of ***any*** size to purchase coverage through the national health insurance exchange in which the public plan will be offered.[17] Admittedly, it establishes a "Health Choices Commissioner" to make this decision, but if it's a bad idea, does it make sense to leave that choice to a federal bureaucrat?

State-Level Concentration in Health Insurance Markets is Relatively Benign

Leaving aside the 83 million Americans covered by public plans such as Medicare and Medicaid, there are 124 million Americans (including 46 million uninsured) who purchase their coverage in local markets that theoretically might be too concentrated for competition to work well to enforce market discipline. These include:

- **Individual Health Insurance Market**. 17.1 million non-elderly had coverage through the non-group market in March 2008, but there also were 37.9 million uninsured without current access to employer group coverage who also are potential buyers in this market.[18] Some federal regulations apply to the entire market,[19] but state regulations vary widely.[20]
- **Small Group Market**. All states except Washington DC regulate the small group market. While this market therefore receives greater regulatory scrutiny in terms of market conduct, small firms are at a disadvantage relative to large firms: due to economies of scale, they must pay higher premiums than large firms to obtain identical levels, they have less bargaining power in negotiating prices and they are more vulnerable to practices such as re-underwriting of coverage (raising premiums in response to higher claims) or facing spiraling premium costs in a line of business that is expiring. In 2008, 30.7 million Americans obtained their health coverage from employers with fewer than 50 workers.[21]
- **Insured ERISA Plans**. There are 39 million Americans who obtain private coverage through employer plans that are not self-funded. Such plans do not enjoy the protection from costly state regulations and premium taxes accorded to their self-funded counterparts, so they too face higher costs and fewer choices than large companies in the multistate market.[22]

Most Low Competition States Dominated by Nonprofit Plans

Three recent studies show the extent of concentration in health insurance markets at the state level. Each illustrates that nonprofit health plans tend to dominate in most areas where concentration appears problematic.

STATE-LEVEL COMMERCIAL INSURANCE MARKETS

One study examined the overall market for commercial health insurance in 2002-03, inclusive of all types of plans offered. All states were included except AK, HI and ND. Based on 1997 federal antitrust guidelines:

- **Market Concentration**. 34 states had "highly concentrated" markets; another 12 states had "concentrated" markets and only 3 were below the threshold for a low level of antitrust concern.[23]
- **Nonprofit Plan Dominance in Concentrated Markets**. However, in 26 of the 34 "highly concentrated" states, the dominant insurer is a nonprofit Blue Cross plan (the 8 exceptions are CO, CT, GA, IN, KY, ME, MO and NH).[24]
- **Dominant Insurer Market Share**. The same study showed that in 43 states, the largest firm controlled 30% or more of the market; in 16 states, this market share exceeded 50%.[25]
- **Nonprofit Firm Dominance of Dominant Insurer Markets**. But again, nonprofit plans account for 79% of the first group (the 9 exceptions being the 8 states listed earlier plus OH) and 75% of the second (the exceptions being CT, ME, NH and VA).[26]

STATE-LEVEL HMO/PPO MARKETS

The second study examined the market in 2005 for HMO/PPO products only [HMO=health maintenance organization; PPO=preferred provider organization]. This information is reported for 44 states (excluding DC, KS, MS, ND, PA, SD and WV). This study has been updated using 2006 data,[27] but because the findings are nearly identical and the report using 2005 data is readily available on-line, the analysis that follows is based on the 2005 figures. Using the same 1997 antitrust guidelines cited earlier:

- **Market Concentration**. In 2005, 42 states had "highly concentrated" markets and 2 (NY, OR) were "concentrated."[28]
- **Nonprofit Plan Dominance in Concentrated Markets.** However, in 72% of the highly concentrated states and both concentrated states, the largest insurer is a nonprofit plan.[29]
- **Dominant Insurer Market Share**. In 2005, the largest firm controlled 30% or more of the market in 36 states; in 25 of the 44 states examined, this market share exceeded 50% .[30] However, by 2006, the number of states having a dominant insurer holding half or more of the market had declined to 15 of 42 states analyzed.[31]
- **Nonprofit Firm Dominance of Dominant Insurer Markets**. Of the 25 states with a single dominant insurer controlling at least half the market, all but 9 are nonprofit plans (exceptions being CT, GA, IN, KY, ME, MO, NH, VA and WI); of the 36 states with a dominant insurer controlling 30% of the market, nonprofit plans account for 72% (i.e., excluding 9 plans just referenced plus OH).[32]

STATE-LEVEL SMALL GROUP MARKETS

The GAO surveyed the small group market in December 2007; of 47 states that reported (excluding AK, MI, NM, PA), GAO found:

- **Number of Health Plans**. The median state had 27 different health plans providing coverage to small groups,[33] ranging from a low of 4 carriers in RI to 328 in IN.[34]
- **Dominant Insurer Market Share**. Excluding 8 states without small group market share data (DC, GA, HI, IN, KS, NE, NV, VA), the dominant insurer had 30% or more of the market in 34 states and 50% or more in 17 states.[35]
- **Nonprofit Plan Dominance of Dominant Insurer Markets**. Of the 17 states where a single plan had 50% or more of the market, all but two of these plans are nonprofit (ME and NH being the exceptions). Thus, in one of the major markets for which a new public plan is targeted, nonprofit insurers constitute 88% of the dominant insurers. If the definition of dominant insurers is extended to include all plans with a market share of 30% or more, nonprofit insurers still constitute 76% of the total (CT, KY, MO, OH, VT, WI being the additional exceptions).[36]

Taking the 2003 and 2005 studies together, it is worth noting that in ***all*** states but CA, NV, NY, and OR, the largest insurer is a Blue Cross or Blue Shield plan (and in CA, NY and OR, the largest plan is nonprofit). Likewise, in the small group market, "thirty-six of the 44 states supplying information on the top carrier identified a Blue Cross and Blue Shield (BCBS) carrier as the largest carrier, and in all but 1 of the remaining 8 states, a BCBS carrier was among the five largest carriers."[37] GAO also found that BCBS market dominance had grown since 2002: "the median market share of all the BCBS carriers in 38 states reporting this information in 2008 was about 51 percent, compared to the 44 percent reported in 2005 and the 34 percent reported in 2002 for the 34 states supplying information in each of these years."[38]

Admittedly, in 11 of the 47 BCBS-dominated states, the Blue plan is now for-profit (CO, CT, GA, IN, KY, ME, MO, NH, OH, VA, WI), but these figures highlight the extent to which the problem of market concentration originated in state policies (e.g., tax exemption) that favored certain types of plans rather than through natural market forces. If having a nonprofit Blue plan dominate a market is problematic, the most straight-forward solution to this problem may be to revisit whether tax exemption or similar privileges are warranted.

The standard explanation by health economists for why highly concentrated health insurance markets do not necessarily give plans market power to obtain supra-normal profits is that such markets are contestable.[39] That is, even in concentrated markets, the credible threat of entry can produce "competitive" market conditions, including lower prices, increased quantity and more efficient administrative cost structures.

THE IMPACT OF MARKET CONCENTRATION ON HEALTH SPENDING

Although it may seem counterintuitive, market concentration in health insurance markets is not always associated with adverse outcomes. A study of nonprofit Blue Cross/Blue Shield plans, using data from 1986-1988 found that higher market share was associated with:

- **Lower Provider Payments**. A 10% increase in market share was associated with an 11.6 percent reduction in payments to providers. In addition, a 10% increase in plan size (number of members) was correlated with a 5% reduction in provider payments.[40] This suggested plans had and were exercising monopsony power to hold down health care costs in the form of payments to providers.
- **Lower Administrative Costs**. Similarly, a 10% increase in market share produced a 6.9% reduction in administrative costs. A 10% increase in plan size was associated with a 1.66% reduction in such costs.[41]
- **Lower Premiums**. A 10% increase in market share resulted in a 6.2% premium reduction.[42]

Thus, for nonprofit plans, market concentration appears to have the beneficial effect of allowing them to reduce provider payments and lower administrative costs, resulting in savings that evidently are passed along to plan members in the form of lower premiums. This is hardly a "problem" in need of a solution. Admittedly, these results say nothing about what happens in markets where a for-profit plan is the dominant insurer; moreover, even for nonprofit plans, things may be different two decades later. Yet the simple correlation between the state-level market share held by the two largest health plans and per capita private medical spending in 2004 (the latest year available) is only 0.33.[43] This is statistically significant, but it also implies that market share explains only about 10% of the differences in private health spending across states. Thus, market concentration among insurers is far from the most important factor in explaining high health care costs. The correlation between this same market share figure and the annualized increase in private health spending over the past 5 years is only 0.17, which is not statistically significant.

WHY LOCAL MARKET CONCENTRATION DOES NOT REQUIRE A PUBLIC PLAN SOLUTION

But the foregoing state-level look at competition does not tell the whole story. As suggested in the AMA study: "The realities of the delivery of health care, as well as the marketing and other business practices of health insurers, lead to a conclusion that health insurance markets are local. From the standpoint of the market for health insurance, most sellers (insurers) market locally, for the obvious reason that purchasers (employers) are interested in purchasing health insurance products that will service their employees in proximity to where they work and live."[44] There is concentration in many local markets, but nonprofits plans dominate most of these. To the degree concentration in local markets is thought to be a problem, there are far better more targeted solutions that do not pose the drawbacks of a public plan.

Most Low Competition Local Markets Dominated by Nonprofits

Even when we examine competition from a city-level perspective, nonprofit firms again dominate the lion's share of areas in which lack of competition appears to be a problem. The 2005 study cited earlier also examined market concentration in the nation's 313 Metropolitan Statistical Areas (MSAs):

- **Market Concentration**. Based on 1997 federal antitrust guidelines:
    - In 2005, 96% of 313 MSAs were classified as *highly concentrated*;[45] in the update using 2006 data, 94% of 314 MSAs were so designated.[46]
    - Likewise, in 96% of MSAs, one health plan accounted for at least 30% of the combined market in 2005; [47] this figure had declined to 89% of 314 MSAs in 2006. [48]
- **Nonprofit Plan Dominance.** But again, in 61.3% of these MSAs, a nonprofit Blue plan is dominant and in another 10.9%, the nonprofit Blue plan is the second largest competitor.[49] Thus, for-profit plans represent the dominant 2 plans in only 27.8% of markets.

Since a "distrust of private insurers is a central motivation for the public plan option"[50] and a public plan purportedly would "be reassured by…an entity that was designed to break even, to not earn a profit,"[51] one might expect the public to have the same level of trust in a nonprofit plan as a public plan, since neither would be expected to make a profit. This should be especially true in light of the evidence that high market share for nonprofit Blue plans appears to result in lower premiums. If so, then concerns about market concentration would be limited to only about one quarter of the country.

But even one quarter of local markets may substantially overstate the extent to which insurer concentration is really a problem. After all, rising concentration in health insurance markets cannot be completely understood without the realization that "provider markets, particularly hospital markets, have also become increasingly concentrated in recent years." Specifically, the fraction of large metropolitan area residents living in highly concentrated hospital markets rose from 71% in 1990 to 88% by 2003.[52] There is substantial evidence that hospital rates are much higher in concentrated markets,[53] suggesting that absent countervailing power from insurers, patients might be just as vulnerable to exploitation by providers as they purportedly are to profit-motivated insurers. Increasing insurer competition while leaving in place concentrated markets for hospitals or doctors may well make patients ***worse*** off rather than better. Conversely, only in markets lacking provider concentration will enhancing competition among insurers likely improve matters.

However, if the problem of sluggish private sector competition is limited in geographic scope, then creating a national public plan to address that problem is overkill. It would be preferable and far less risky to find more targeted solutions.

Superior Alternatives to Addressing Lack of Competition

Admittedly, there are some public plan proponents who argue that public distrust of private insurers extends to nonprofit plans as well,[54] in which case the foregoing analysis may not be persuasive. However, whether it is one-quarter of the country or nearly the entire country where weak competition is a concern, there are far more direct and less risky approaches to addressing this problem than establishing a public plan.

More Vigilant Insurance Regulation

First, to the extent that lack of competition is a problem, it is most keenly felt in the markets for non-group and small group coverage. But these are the very markets where state regulatory oversight of market conduct already is (or could be) most intense. If, as public plan proponents claim, "key data about administrative costs and factors driving premiums are not publicly available,"[55] there's no reason in principle state regulators could not require this of health plans serving the two markets already under regulatory scrutiny.

More Aggressive Antitrust Enforcement

But if public plan proponents truly are correct that "the insurance industry is hard to regulate,"[56] then aggressive antitrust enforcement offers far greater promise for restoring competition than would a public plan. In a recent merger challenge, "the DOJ [Department of Justice] recognized that where a health plan accounts for more than 30 percent of a physician's practice revenue, the health insurer can have monopsony power to the detriment of patients."[57] But of course, this concern would apply with equal force to a public plan that commanded a sizable market share. Thus, using the tools and criteria already developed by federal antitrust regulators to limit the size of health plans would be superior to simply replacing a private monopsony with a public one. Antitrust regulators also have the advantage of being able to use these same tools to focus on the problem of provider concentration; this would avoid the risk of unilaterally disarming a beneficial countervailing force in the insurance market that has been able to constrain the ability of providers to exercise their own market power.

An important reason this has not happened to date is that currently, "as interpreted by the courts, the law exempts the business of insurance from [federal] government and private antitrust liability, unless the conduct is unregulated by a state or goes beyond otherwise actionable restraints of trade to constitute boycotts, coercion or intimidation."[58] Thus, this approach may require repeal of this antitrust exemption, an idea that already has been proposed in Congress.[59]

INTERSTATE SALE OF HEALTH INSURANCE

Realistically, more rigorous antitrust enforcement could take a long time, especially if the problem of concentrated insurance markets is pervasive. For at least two decades, "the most important source of competitive pressure in health insurance has been the availability of new entrants, including start-up HMOs and carriers from adjacent geographic regions."[60] But because states were given the authority to regulate insurance more than 6 decades ago, insurance companies wanting to sell products across state lines must comply with a myriad of different state regulations, including mandated benefits, premium taxes, solvency requirements, and similar rules. Collectively, such state regulations are estimated to increase premiums by 10 to 96%.[61] As well, there are widespread geographic variations in health spending that are related to differences in practice patterns. Consequently, average premiums vary nearly five-fold across states.[62] Removing regulatory barriers to cross-border sales thus offers the prospect of greatly increasing competition and reducing costs very quickly. This is not an unprecedented idea: for example, Medicare law already generally preempts state regulation of Medicare Advantage (private) plans but allows the states to regulate plan solvency and licensure.[63] There are several alternative approaches to reducing barriers to cross-border sales:

- **Interstate Sales of Insurance Plans**. One option–as illustrated by a proposal of Representative John Shadegg's (R-AZ) and Senator Jim DeMint's (R-SC) ***Health Care Choice Act*** (H.R. 2355 and S.1015)–would allow interstate sales of private insurance plans while preserving states' primary responsibility for the regulation of health insurance.[64] A recent analysis found that in some cases, NJ residents could achieve a premium savings of more than 50% simply by crossing the border to purchase the identical coverage in Pennsylvania, where regulation and health costs are far lower.[65] Nationally, this approach would reduce costs sufficiently that this policy change alone could reduce the number of uninsured by about 12 million.[66]
- **Federal Certification of Health Plans**. This would allow health insurance plans that meet federal regulations governing large self-insured plans be permitted to offer plans on a nationwide basis free of state regulations (except perhaps day-to-day market conduct). This approach would reduce health costs nationally by about 7 percent.[67]
- **Harness Competitive Federalism**. There are a variety of approaches to allowing cross-border sales while retaining regulatory authority at the state level along with suitable safeguards to ensure states handle such regulation even-handedly and responsibly.[68]

The approaches just described are much more sensibly limited options that would address lack of competition where it exists without creating a public plan that simply duplicates the pressure of market forces for health insurers to provide good value for the money.

And even if we believe lack of competition among health insurers is a national phenomenon, these approaches offer excellent prospects for reducing costs without the corresponding risks posed by a public plan.

Competition Can Work Without a Public Plan

But how do we know that competition can be relied upon to produce the desired results? Because we have real-world experience with competition in health care:

Medicare Part D Experience

Over strong objections from those who now argue most fervently for a public plan, the Medicare drug benefit was provided exclusively through private plans rather than through a Medicare-like public plan structure. What happened?

- **Widespread Choice of Drug Plans**. Since not a single private stand-alone drug plan existed when the drug benefit was enacted, "a major source of uncertainty was whether private insurers would be willing to sponsor stand-alone prescription-drug plans. Ultimately, *concern about the viability of the private-drug-plan market was unwarranted*… In 2006 and each year thereafter, beneficiaries across the country have had access to *dozens of stand-alone plans* and, in many counties, at least as many Medicare Advantage drug plans."[69] There now are nearly 1,700 stand-alone drug plans and more than 2,000 Medicare Advantage plans from which to choose.[70]
- **36% Increase in Drug Coverage**. Similarly, despite deep misgivings about whether a voluntary benefit actually would significantly expand coverage, the number enrolled in drug plans surged: 66% of Medicare enrollees had drug coverage in 2004, compared to 90% in 2009.
- **Massive Cost Savings**. There also was deep skepticism about whether private plans could possibly drive costs lower than if the government directly negotiated "take-it-or-leave-it" prices with drug manufacturers. Yet compared to original budget estimates for Medicare Part D, ten-year costs now are projected to be 38.5% lower than originally planned;[71] 85% of this cost reduction has been attributed to "a direct result of competition and significantly lower Part D plan bids."[72]

Yet *no public plan* was needed to stimulate the fierce private sector competition that produced these results. If pure private sector competition works this well for the elderly, it is incumbent on public plan proponents to explain why it would not work for the rest of the country.

FEHBP EXPERIENCE

For nearly six decades, the Federal Employees Health Benefits Program has provided health coverage to the president, all members of Congress, federal employees and dependents (7.8 million people were covered in 2008[73]). Key features include:

- **No Standard Benefit**. Quite unlike Medicare, FEHBP offers no standardized health plan, but instead trusts its plan members to choose from a wide selection of plan choices ranging from high-deductible consumer-directed health plans with companion health savings accounts to managed care plans (HMOs and PPOs) to very comprehensive fee-for-service plans.
- **Numerous Plan Choices**. There are almost 300 health insurance plans available to members,[74] including a dozen national plans, over 250 health maintenance organization (HMO) options, and dozens of High Deductible plan options. Thus, workers have an ample selection of plan choices regardless of where they live.
- **Incentive to Shop Wisely**. Unlike many employers who may contribute 80, 90 or 100% of a plan's premium regardless of cost, the federal government pays either 72 percent of the average premium or 75% of the premium of the specific plan selected, whichever is less. This provides strong incentives to avoid expensive plans that are above average in cost, but diminishes the incentive to select a plan whose costs are far below average.

By empowering nearly 8 million plan members to vote with their feet every year, FEHBP has stimulated a fierce competition among private health plans to provide good value for the money to its members (and the taxpayers who finance these public employee benefits). As a consequence:

- **Performance Superior to Private Insurance.** Annual growth in FEHBP spending per enrollee typically has been lower than in private health insurance plans with the exception of a few isolated time periods.[75] This should not be surprising given that 85% of employers do not give their employees any choice among health plans.[76] Even of those given a choice of plan, less than one in five receive a fixed dollar contribution towards their health coverage and only a fraction of these are permitted to reap the full economic benefit of making cost-conscious choices.[77] But large employers such as Stanford that have adopted models similar to FEHBP have reported premium savings of 43% relative to the cost of offering a single fee-for-service health plan.[78]
- **Performance Superior to Medicare.** Its overall performance is best summed up by Harry Cain–a former vice president of the Blue Cross/Blue Shield Association with decades of experience with both the FEHBP and Medicare–who stated in 1999 that 'the FEHBP has outperformed Medicare every which way–in containment of costs both to consumers and the government, in benefit and product innovation and modernization, and in consumer satisfaction."[79] Indeed, an exhaustive comparison with Medicare has shown that FEHBP is superior on a variety of dimensions, including control of costs per enrollee, quality, stability and rate of improvement in benefits, and innovativeness.[80]

Moreover, because of extensive choice of plans, FEHBP has easily been able to accommodate occasional instances in which a participating health plan failed, with minimal disruption for the beneficiaries.[81] FEHBP has achieved all these benefits without ever including a public plan option. If members of Congress see no need for a public plan for themselves, why should it be necessary for any other Americans?

COMPETITION IN CALIFORNIA

California is widely viewed as having one of the most competitive health insurance markets in the country, with fierce head-to-head competition between nonprofit Kaiser, for-profit Wellpoint, and nonprofit Blue Shield, among others. In the mid-1980's, the state greatly deregulated its health system, discarding Certificate of Need and strongly encouraging a movement towards selective contracting with health providers that fundamentally altered business as usual by stimulating fierce head-to-head competition. What happened?

- **Performance Superior to Nation**. California's per capita health spending had been 18-20% above the national average from 1966-1980. By 2004, it had plummeted to 12% ***belo***w the national average.[82]
- **Shrinking Burden of Health Spending**. Similarly whereas health spending as a percent of GDP was 4% higher than in the U.S. in 1980, by 2004 it was 17% lower. While this burden rose nationally by 11% between 1993 and 2004, California was a rare state in which this measure actually *declined* slightly during the same period.[83]

Competition among private health plans is not just a theoretical ideal: it works on the ground, and the experiences we've had with Medicare Part D, FEHBP and in the state of California should leave little doubt that it is a strategy that can reap great rewards for the nation if it is given a chance.

CONCLUSIONS

Proponents of a public health insurance plan, including President Obama, claim it is needed to stimulate competition. Yet the evidence shows at the *national* level, the health insurance market generally is highly competitive for the 61% of privately insured Americans who now purchase their coverage through large groups.

At the *state* level, concentration in health insurance markets appears less disturbing than it appears for two reasons. First, most concentrated markets tend to be dominated by nonprofit plans (mostly Blue Cross/Blue Shield plans). Second, market concentration is not necessarily associated with adverse outcomes. For nonprofit Blue Cross/Blue Shield plans, increased market share historically has been shown to be associated with lower payments to providers, lower administrative costs and lower premiums. While things possibly may have changed since then, even today market concentration among health insurers has a relatively small effect on current levels or recent growth in health spending. Specifically, there is only a small relationship between the share of the market controlled by the two largest firms and state-level private per capita health spending. As well, health insurance market concentration explains only a small part in the rates of increase in private per capita health spending between1999-2004. This is inconsistent with the view that concentration is allowing health insurers to exploit their members. Instead, it is consistent with a more plausible view that concentration in the health insurance industry has provided a useful corrective to the equally disturbing growth in concentration of hospital and physician markets over the past decade.

Moreover, at the *local* level, roughly three quarters of local markets that appear to have weak competition are dominated by nonprofit plans: such plans are no different than a public plan in terms of profit motive. In areas where lack of competition adversely affects those seeking to purchase health insurance, policymakers have ample tools to restore competition that would be superior to reliance on a public plan. These include more vigilant state regulation of the individual and small group markets, more aggressive antitrust enforcement and allowing interstate sales of health insurance.

Finally, real world experience with the Medicare drug benefit (where fierce competition among private health plans has contributed to cost savings of nearly 40%), the federal employee health benefits program (which for decades generally has experienced lower premium growth than private health insurance and Medicare) and the State of California (whose market-oriented approach to health care has reduced its level of spending relative to the U.S. by nearly one third in just 25 years) have demonstrated convincingly that competition among private insurers can work very effectively even without a public plan.

Next Installment: 9. Why a Public Plan Will Encourage Unfair Cost-Shifting

NOTES

[1] J.S. Hacker, The Case for Public Plan Choice in National Health Reform, (Berkeley, CA: Center for Health, Economic & Family Security, U.C. Berkeley School of Law; and Institute for America's Future, December 17 2008), L.M. Nichols and J.M. Bertko, A Modest Proposal for a Competing Public Health Plan, New America Foundation, March 11 2009).

[2] About AHIP http://www.ahip.org/content/default.aspx?bc=31.(accessed July 15 2009).

[3] Author calculations from March 2008 health insurance coverage figures reported in DeNavas-Walt: C. DeNavas-Walt, B.D. Proctor, and J.C. Smith, *Income, Poverty, and Health Insurance Coverage in the United States: 2007*, Pub. no. P60-235 (Washington, DC: U.S. Census Bureau, 2008), Table C-3.

[4] J.C. Robinson, "Consolidation and the Transformation of Competition in Health Insurance," *Health Affairs* 23, no. 6 (2004): 17.

[5] W. Pierron and P. Fronstin, *ERISA Pre-Emption: Implications for Health Reform and Coverage*, Employee Benefit Research Institute, February 2008), 3.

[6] Robinson, "Consolidation and the Transformation of Competition in Health Insurance," 17.

[7] General Accountability Office, *FEHBP Coverage of Specialty Prescription Drugs*, (Washington, DC: U.S. General Accountability Office, April 30 2009), 2.

[8] DeNavas-Walt, Proctor, and Smith, *Income, Poverty, and Health Insurance Coverage in the United States: 2007*, Table C-1.

[9] Pierron and Fronstin, *ERISA Pre-Emption: Implications for Health Reform and Coverage*, 11.

[10] State/Local Employees http://ushealthpolicygateway.wordpress.com/payer-trade-groups/health-insurance-coverage/public-health-insurance/government-employee-health-benefits/statelocal-employee-plans/.(accessed August 1, 2009).

[11] Robinson, "Consolidation and the Transformation of Competition in Health Insurance."

[12] Fortune 500: Our Annual Ranking of America's Largest Corporations http://money.cnn.com/magazines/fortune/fortune500/2008/industries/223/index.html.(accessed July 20 2009).

[13] Robinson, "Consolidation and the Transformation of Competition in Health Insurance," 17.

[14] C.J. Conover and M.A. Hall, "Section VI: Potential Impact of Conversion on Profitability," in *Assessment of Potential Impact on Accessibility and Affordability of Health Care. Report for North Carolina Department of Insurance*, (2003).

[15] Robinson, "Consolidation and the Transformation of Competition in Health Insurance," 19.

[16] Calculated by author from Congressional Budget Office, *Key Issues in Analyzing Major Health Insurance Proposals*, (Washington, D.C.: The Congress of the United States, Congressional Budget Office December 2009), 69-70.

[17] J. Sheils and R. Haught, *Analysis of the July 15 Draft of the American Affordable Health Choices Act of 2009. Memorandum to Stuart Butler (Heritage Foundation: Vice President, Domestic and Economic Policy Studies)*, (Falls Church, VA: The Lewin Group, July 17 2009), 2.

[18] Individual Health Coverage http://ushealthpolicygateway.wordpress.com/payer-trade-groups/health-insurance-coverage/private-health-insurance/non-group-coverage/.(accessed August 1, 2009).

[19] For example, "HIPAA Eligible" individuals are guaranteed the right to purchase individual coverage with no pre-existing condition exclusion periods when they leave group coverage. To be HIPAA Eligible, a person must have had at least eighteen months of prior coverage, not interrupted by a gap of more than sixty-three days in a row, and the last day of prior coverage must have been in a group health plan. In addition, upon leaving group coverage one must elect and exhaust any available COBRA continuation coverage or similar state continuation coverage. A HIPAA eligible individual cannot be eligible for any other group coverage or Medicare, and must apply within sixty-three days for HIPAA coverage. The Kaiser Family Foundation, "Non-Group Coverage Rules for HIPAA Eligible Individuals, 2008," in *statehealthfacts.org* (Data Source: Data as of December 2008. Data compiled through review of state laws and regulations and interviews with state health insurance regulatory staff. Data collection and analysis at the Health Policy Institute, Georgetown University. Special Data Request, February 2009. , accessed August 25, 2009).

[20] The Kaiser Family Foundation, "Individual Market Guaranteed Issue (Not Applicable to HIPAA Eligible Individuals), 2008," in *statehealthfacts.org* (Data Source: Data as of December 2008. Data compiled through review of state laws and regulations and interviews with state health insurance regulatory staff. Data collection and analysis at the Health Policy Institute, Georgetown University. Special Data Request, February 2009. , accessed August 25, 2009). This site also lists rate restrictions, portability rules, and standardized plan requirements applicable to the individual market.

[21] Group Health Coverage http://ushealthpolicygateway.wordpress.com/payer-trade-groups/health-insurance-coverage/private-health-insurance/group-coverage/.(accessed August 1, 2009).

[22] Ibid.(accessed.

[23] Robinson, "Consolidation and the Transformation of Competition in Health Insurance," 15.

[24] Author calculations from Ibid.: Exihibit 2.

[25] Ibid.: 13.

[26] Author calculations from Ibid.: Exihibit 2.

[27] American Medical Association, *Competition in Health Insurance: A Comprehensive Study of U.S. Markets: 2008 Update,* (Chicago, IL: American Medical Association, 2008).

[28] American Medical Association, *Competition in Health Insurance: A Comprehensive Study of U.S. Markets: 2007 Update*, (Chicago, IL: American Medical Association, 2007), Table 1.

[29] Author calculations from Ibid.

[30] Ibid.

[31] J. Holahan and L.J. Blumberg, *Is the Public Plan Option a Necessary Part of Health Reform?* , (Washington, DC: Urban Institute, Health Policy Center, June 26, 2009), 2.

[32] Author calculations from American Medical Association, *Competition in Health Insurance: A Comprehensive Study of U.S. Markets: 2007 Update*, Table 1.

[33] General Accountability Office, *Private Health Insurance: 2008 Survey Results on Number and Market Share of Carriers in the Small Group Health Insurance Market*, (Washington, DC: U.S. General Accountability Office, February 29, 2009), 2.

[34] Ibid., Table 1.

[35] Ibid.

[36] Author calculations from Ibid.

[37] Ibid., 2.

[38] Ibid., 3.

[39] S.E. Foreman, J.A. Wilson, and R.M. Scheffler, "Monopoly, Monopsony and Contestability in Health Insurance: A Study of Blue Cross Plans," *Economic Inquiry* 34, no. 4 (1996): 962.

[40] Ibid.: Table IV.

[41] Ibid.: Table V.

[42] Ibid.: Table VI.

[43] Calculations by author using market share data for Jan. 1 2005 reported in American Medical Association, *Competition in Health Insurance: A Comprehensive Study of U.S. Markets: 2007 Update*, Table 1. and state health expenditure data from Centers for Medicare and Medicaid Services, "Health Expenditures by State of Residence, 1991-2004 (September 2007) (Zip, 315 Kb)." (U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, 2007). Private spending per capita by state of residence was approximated as follows: (Total personal health spending minus Medicare spending minus Medicaid spending)/(Total population minus Medicare beneficiaries minus Medicaid enrollees).

[44] American Medical Association, *Competition in Health Insurance: A Comprehensive Study of U.S. Markets: 2007 Update*, 2.

[45] Ibid., Table 1.

[46] Holahan and Blumberg, *Is the Public Plan Option a Necessary Part of Health Reform?* , 2.

[47] American Medical Association, *Competition in Health Insurance: A Comprehensive Study of U.S. Markets: 2007 Update*, 2.

[48] Holahan and Blumberg, *Is the Public Plan Option a Necessary Part of Health Reform?* , 2.

[49] Calculations by authors using American Medical Association, *Competition in Health Insurance: A Comprehensive Study of U.S. Markets: 2007 Update*, Table 1.

[50] Nichols and Bertko, *A Modest Proposal for a Competing Public Health Plan*, 5.

[51] Len Nichols comment in S. Butler, J. Hacker, and L. Nichols, "The Public-Plan Option: A Roundtable with Stuart Butler, Jacob Hacker, and Len Nichols," *Health Affairs Blog* (2009): 2.

[52] W. Vogt and R. Town, *How Has Hospital Consolidation Affected the Price and Quality of Hospital Care?*, Robert Wood Johnson Foundation, 2006), 1.

[53] Ibid., 4.

[54] Nichols and Bertko, *A Modest Proposal for a Competing Public Health Plan*, 5.

[55] Ibid.

[56] Ibid.

[57] American Medical Association, *Competition in Health Insurance: A Comprehensive Study of U.S. Markets: 2007 Update*, 2.

[58] Bill to Repeal Mccarran-Ferguson Act Antitrust Exemption for Insurance Business Introduced. http://www.crowell.com/NewsEvents/Newsletter.aspx?id=306.(accessed August 15 2009).

[59] Ibid.(accessed.

[60] Robinson, "Consolidation and the Transformation of Competition in Health Insurance," 20.

[61] S.T. Parente et al., *Consumer Response to a National Marketplace for Individual Insurance*, (Minneapolis, MN: Carlson School of Management, University of Minnesota, June 28 2008), Appendix 4.

[62] Ibid., Appendix 3.

[63] T.S. Jost, "Health Care Reform Requires Law Reform," *Health Affairs Web Exclusive* (2009): w764.

[64] Parente et al., *Consumer Response to a National Marketplace for Individual Insurance*, 1.

[65] S.T. Parente, "Consumer Response to a National Marketplace for Individual Insurance" (Paper presented at An Interstate Commerce Route to a National Market for Health Insurance, Washington, DC, July 31 2008).at 24:40

[66] Parente et al., *Consumer Response to a National Marketplace for Individual Insurance*, 1.

[67] J.F. Cogan, R.G. Hubbard, and D.P. Kessler, *Healthy, Wealthy, and Wise: Five Steps to a Better Health Care System* (AEI Press/Hoover Institution, 2005), 72.

[68] T. Miller, "Geographic Monopolies Vs. Choice & Competition in Health Insurance Regulation: Starting a Market-Driven Race to the Top" (Paper presented at An Interstate Commerce Route to a National Market for Health Insurance, Washington, DC, July 31 2008). 4-7.

[69] P. Neuman and J. Cubanski, "Medicare Part D Update — Lessons Learned and Unfinished Business," *New England Journal of Medicine* 361 (2009): 407 (emphasis added).

[70] Ibid.: Table 1.

[71] Centers for Medicare and Medicaid Services, *Medicare Prescription Drug Benefit's Projected Costs Continue to Drop*, (Baltimore, MD, January 31, 2008).

[72] Centers for Medicare and Medicaid Services, *Medicare Drug Plans Strong and Growing*, (Baltimore, MD, January 30, 2008).

[73] General Accountability Office, *FEHBP Coverage of Specialty Prescription Drugs*, 2.

[74] Guide to Health Plans http://www.checkbook.org/newhig2/AboutGuide.cfm.(accessed July 15, 2009).

[75] K. Levit et al., "Health Spending Rebound Continues in 2002," *Health Affairs* 23, no. 1 (2004): Exhibit 5.

[76] Kaiser Family Foundation and Health Research & Educational Trust, *Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2008*, September 24 2008), Exhibit 4.1. Such firms account for 49% of workers covered through employer-based health plans (Exhibit 4.2).

[77] A.C. Enthoven, "Employment-Based Health Insurance Is Failing: Now What?," *Health Affairs* (2003): w3-242.

[78] "Positive News from Stanford's Managed Competition Health Plan," *Stanford GSB News*, February 2005.

[79] H.P. Cain, II, "Moving Medicare to the FEHBP Model, or How to Make an Elephant Fly," *Health Affairs* 18, no. 4 (1999): 30.

[80] W. Francis, *The FEHBP as a Model for Medicare Reform: Separating Fact from Fiction*, (Washington, DC: Heritage Foundation, August 7 2003).

[81] Cain, "Moving Medicare to the FEHBP Model, or How to Make an Elephant Fly," 36-37.

[82] Author's calculations from data reported in K. Levit, "Personal Health Care Expenditures, by State: 1966-82," *Health Care Financing Review* 6, no. 4 (1985): Table 5. Centers for Medicare and Medicaid Services, *Health Expenditures by State of Provider: State-Specific Tables, 1980-2004*, (Baltimore, MD, February 2007).

[83] Author's calculations from data reported in Centers for Medicare and Medicaid Services, *Health Expenditures by State of Provider: State-Specific Tables, 1980-2004*.