Why a public/private universal health insurance system is still the right approach

Stuart H. Altman

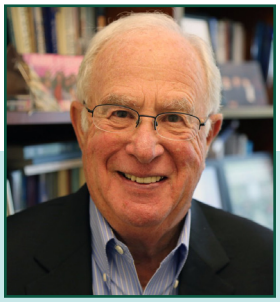
With millions of Americans losing their jobs *and* their employment-based health insurance during the pandemic, it is easy to argue that the entire employer-subsidized health insurance system should be abolished and replaced by a government-financed single-payer approach. I disagree.

Yes, we need to have a much stronger safety net supported by an expanded social insurance system. But where possible we should continue to rely on private funds generated by employers and employees. Without these private funds I fear we will have a chronically underfunded public health care delivery system for most Americans and a separate system for individuals who have the means to pay for superior care.

On a personal note, I have just gone through a major illness which cost several hundred thousand dollars. Nowhere in that ordeal did my family have to worry about paying the bill. I was well covered by Medicare and supplemental private insurance. As we recover from the terrible ordeal of COVID-19 and the realization that countless Americans will face staggering healthcare expenses, I can only hope that they will be as fortunate in their health insurance coverage. Alas, I know this is not the case. Millions of Americans are denied even the legislatively mandated social insurance coverage afforded by the original Affordable Care Act (ACA) law — and I recognize that full ACA coverage still leaves gaps that I didn't face. Yes, these gaps need to be filled, but I reject the idea that the best way to plug them is to destroy the ACA and put in its place a government-financed health insurance system.

Universal coverage does not necessarily mean an all-government-financed system. Several of the best European systems, such as in Germany, Switzerland, and the Netherlands, rely on private coverage paid for by employers and workers. In Germany, the split in premium payments between the two is 50/50, with the premium amount set by the federal government. Overall health spending is controlled by government through the level of premium income. These systems appear to have functioned better during the COVID-19 crisis than those supported primarily by government. This is no accident. Systems financed by government often face budget limits which have limited the availability of hospital ICU beds and expensive equipment. (The COVID-19 problems in the U.S., although extensive, are not directly related to what we spend on our healthcare system.)

The inevitably limited budgets of government-financed systems are my main concern about moving to a health system too reliant on government payments. Yes, I believe strongly in a social insurance system, and in safety-net programs for those who need them. And yes, as the coronavirus crisis abates we will need



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a transition approach that includes greater public funding. But as our economy improves and Americans get back to work, we should expand the public/private coverage of the ACA.

To understand why, look at what is happening in our current financing system. Since the mid 1970s, states have put tight limits on Medicaid provider payments. Today, Medicaid pays 80 percent or less of what hospitals believe are their costs of providing care. Since 2010, Medicare has fallen into the same pattern. (While I do believe that we can provide good health care for less, there are limits to how much less.) In 2018, Medicare payments averaged less than 90 percent of hospital costs. So how do hospitals survive if not prosper? They charge privately insured patients up to 300 percent above Medicare rates. A recent RAND study of private insurance payments to hospitals in 25 states found that they averaged 240 percent above Medicare rates.[1] If these hospitals had been paid only Medicare rates, their revenues would have fallen by 50 percent. There is little question that government-supported patients are subsidized by private payments. What would happen if the higher private payments disappeared?

Some have suggested creating public-option plans that compete with private insurance and pay providers close to Medicare rates. Washington State enacted such a plan. But it was forced to set hospital payments at 160 percent of the Medicare rates, and to generate sufficient acceptance by providers it may need to pay closer to 180 percent. That raises concerns that the premium for the public plan will not be much lower than private premiums, with the result that few will join.

Let me be clear: I do not believe we should continue to accept the high prices charged by most hospitals. Prior to COVID-19, many states passed legislation setting growth benchmark limits on total medical spending, particularly private insurance premiums. Value-based private insurance had also gained more acceptance. These options were designed to bring down medical spending in an orderly way without negatively affecting access or quality of care. These constraints should continue in the future.

So, as we think about a post COVID-19 world we should build upon the original ACA structure; we should expand and solidify the social insurance segment by lowering the age of Medicare eligibility to 60 for those not working, and assure that all Americans have access to the Medicaid provisions of the original ACA; we should expand subsidized private insurance to limit the cost-sharing provisions for low-income individuals and end part-year or minimal- coverage plans. Most importantly, we should restore the mandate that every American must have adequate coverage. A comprehensive but balanced public/private system offers the best safeguard that a high-quality delivery system will be maintained and available to all.

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ENDNOTES

1. C. White and C. Whaley, "Prices Paid to Hospitals by Private Health Plans are High Relative to Medicare and Vary Widely," RAND Report, May 2019.