

That was an immensely powerful speech by the President this week. Equally important was the release of the “Framework” by Senator Baucus, which details a potential bi-partisan compromise to cover the nation’s 46 million uninsured and rein in costs and premiums ever-rising at more than twice the rate of worker’s wages and the growth in all other good and services.

While there are many questions that need to be better answered as the House and Senate move towards merging and passing bills that could be resolved in a Conference Committee this fall, two salient ones are 1) public plan vs. cooperatives and 2) bending the cost curve. As the perceived value of the public plan or the cooperative is to slow rising costs and improve quality, in some senses, the two issues are really the same question, but with very different answers.

The cost of American health care is twice as high as the average for other developed nations, and for all that spending, it produces poor health outcomes for US citizens as compared to citizens of many other countries. The high price of American medicine is a function of high priced doctors, hospitals, nurses, prescription drugs, high administrative costs, an imbalance of specialty and primary care and high priced, high frequency testing. It is not a function of too many doctor visits or too many hospital days; at least as compared to the rest of the developed nations, Americans do not stand out as “frequent users”. Our nation’s poor outcomes are partly due to a poorly organized delivery system, with too little prevention and primary care and poor connections among providers and between payors, providers and patients. Our poor quality outcomes are not due to poorly trained doctors or weak performing hospitals (in fact we range from average to truly excellent), it is due to a poor performing system of care. Furthermore although we Americans have low to moderate use of health services, about 30% of what we do use has little or no medical value; it is “useless use”.

For the purposes of this discussion, let’s first assume that the public plan is a lot like Medicare. In other words, it has low administrative costs, broad choice of providers, fee for service reimbursement and reimbursement levels significantly above Medi-Cal which pays well under cost, but below private insurance, which pays well over cost. It works well enough that most seniors like it quite a lot. From the perspective of doctors and hospitals that provide care to many of the uninsured, this would be a vast improvement on the little or nothing they are often able to collect from an uninsured patient. This model does little to provide a coherent delivery system, reduce the 30% of care that is medically unnecessary, place an emphasis on primary care and prevention or “bend the cost curve”; it does provide a usual source of care, and it does put a small brake on the high prices of American health care. If large numbers of the insured could buy that public plan option, the brake on price

escalation could be somewhat stronger, but the bills being considered in Congress allow only the uninsured, individuals and some small employers to have access to the Exchange and thus to the opportunity to choose a public plan; larger businesses and their employees have no access to the public plan. Do private hospitals, commercial health plans and private doctors have much to fear from such a Medicare-like public competitor? I would argue, they have little to fear, and as a corollary, reformers have little to gain because there is no real reform in the delivery system.

Now let's assume, the cooperatives are a lot like Group Health Plan in Washington, Geisinger in Western Pennsylvania, Health Partners in Minnesota or Inter-Mountain in Utah. In other words, it is a non-profit Integrated Delivery Network (like Kaiser Permanente in California) with a connected network of doctors and hospitals, but probably smaller, nimbler and with less market power. This model puts an emphasis on prevention and primary care and reduces the 30% of care that is medically unnecessary and the excessive use of high cost testing, but unfortunately it does little to change high provider prices. If you have one or more cooperatives in every state and if they can achieve breakthroughs in the local markets, coops may improve quality and increase competition; these are very big though achievable "ifs". The problem for cooperatives is that in communities with no competition now, it will be difficult for cooperatives to gain a foothold, and in markets with lots of vigorous competition, it will be difficult for cooperatives to develop their niche in the market. Neither health plans nor local providers want to cannibalize their existing markets to make way for a new competitor. On the other hand, the Local Initiatives and County Organized Health Systems (COHS) have thrived in California, and a number are successful competitors in the Healthy Families market, which is somewhat like an Exchange. If we can solve the entry challenges for cooperatives with some form of safe harbor for them to grow and develop, I would argue that reformers have more to gain by fostering locally run cooperatives than by perseverating on a Medicare style public plan because the cooperatives have the ability to transform the local delivery system in ways that a Medicare style public plan cannot.

To put it differently, how do you want to bend the curve by controlling high prices or reforming the delivery system? The convenient label of public plan or cooperative is misleading; these are in fact very different concepts and approaches being put forward. The universe of options to bend the cost curve does not begin and end with public plans or coops, there are other alternatives.

What do you think and have you expressed your First Amendment rights lately to tell your Congressperson?