



## Private Health Plans: Where Is the Value? What Is the Point?

By Clark C. Havighurst

*Are private health plans being touted for a central role in a reformed health care system for the right reasons? Health care providers and suppliers naturally prefer private plans to a government monopsony. Moreover, like health insurers themselves, providers and suppliers have no objection to old and new regulation that, in the name of protecting patients and creating a generous entitlement, limits what health plans can do in tailoring insurance products to consumers' differing circumstances and preferences. Yet health reform could have catastrophic cost consequences if consumers are given little opportunity or reason to economize.*

Liberals and conservatives have been wrangling over whether health reform should include a public health plan to compete with private ones. With or without a public option in the picture, however, regulatory and other constraints affecting American health plans and health services could easily defeat the main purpose of maintaining a competitive market for health coverage. That purpose should be to give the participating firms unique incentives to satisfy consumers' diverse needs and to do so as efficiently as possible. In most fields of human endeavor, competition yields immense benefits, easily justifying the extra costs that competitive markets entail (for product innovation and marketing, for example). But offering consumers multiple private health plans rather than a single public one is a clearly superior policy only if the private plans—which are regularly accused of having excessive, unspecified “administrative costs”—actively engage in tailoring options to suit people's differing circumstances and preferences. Unfortunately, in the collectivist, one-size-fits-all health system currently being

crafted by Congress, it is not obvious that private health plans will serve consumers well enough to justify their preservation.<sup>1</sup>

At least since the experiment with managed health care ended in the late 1990s,<sup>2</sup> regulation and other barriers to innovation have made private health plans distinguishable from one another only in relatively insignificant ways. Indeed, most observers now view private health plans only as financing mechanisms, the sole purpose of which is

### Key points in this Outlook:

- More attention needs to be paid to creating conditions under which competition can actually bring overall costs down.
- The health care bills being considered by Congress do not do this.
- The legislation should focus on getting incentives right and on clearing away barriers to innovation by private health plans.
- Otherwise, what is the point of having private health plans?

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to make costly health services easily affordable by ordinary persons. On the other hand, few commentators acknowledge even the possibility that private plans could be valuable agents for their members in making health *coverage*, as well as the specific services they finance, affordable.<sup>3</sup> Yet, given the apparent alternatives—either further wasteful spending of whole percentage points of GDP or a politically driven, government-run system—more attention needs to be paid to creating conditions under which competition among private health plans could bring the overall cost of health care under appropriate control.

National health reform should therefore ensure that, beyond spending whatever public subsidies government can responsibly provide, consumers can also benefit by limiting their spending on health coverage to whatever they feel they can afford. The value of private health plans to the economy does not lie merely in making health care cheap for patients. Instead, their principal *raison d'être* should be their creativity in designing and administering coverage appropriate for people with different preferences and resources. For example, lower-income people might want lower cost sharing (to make it easier to afford essential services) but be willing, in order to compensate for the higher premiums thus necessitated, to accept limited coverage in extreme circumstances in which the benefits of care seem unlikely to equal the costs incurred. In general, health reform should encourage private health plans to offer different levels of coverage, each with a price tag accurately reflecting the value of the coverage provided. The current reform movement seems pointed in just the opposite direction, toward mandating high-cost coverage for all and hiding or deferring the potentially staggering cost to the nation of paying for it.

## Set Our Health Plans Free

Private health plans are not accustomed to performing the tasks they could most usefully perform for consumers. The obstacles that have prevented them from keeping health coverage affordable and health care efficient are not so much inherent in the nature of health care or health insurance as they are regulatory, legal, and political. State insurance mandates, for example, already raise costs significantly, and occupational licensing imposes often arbitrary limits on what competent lower-priced professionals may do for patients. More fundamentally, legal and political risks effectively preclude a health plan from offering coverage that obligates it to pay for anything

less than whatever some medical expert may deem “medically necessary.”<sup>4</sup> And state tort law requires, under threat of costly malpractice suits, that all services meet a “professional” standard of care. Like medical necessity, this vague regulatory standard is set with only possible benefits, not costs, in mind.<sup>5</sup>

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A crucial reason existing health-sector regulation and public policy in general neglect the cost dimension in health care choices is the longstanding tax subsidy for employer-financed health coverage. Because employees' taxable wages have not included the value of such coverage, workers have generally believed (contrary to what economists have shown) that employers, not they themselves, bear most of their coverage's cost. This misperception has caused them, as voters, generally to approve any legislation that seems to promise them more or better health care. Politicians are thus enabled, and happy, to oblige provider or patient groups seeking special, cost-increasing protections.<sup>6</sup> Employers and labor unions have also been pleased to use generous health benefits, paid for unknowingly by the workers themselves, to demonstrate their concern for worker welfare. Indeed, ever since World War II, union leaders have found it so advantageous to claim credit for the generous health benefits they negotiated for their members that they never put their unions' full political weight behind a national health program.

The ironies here are huge: whereas in other Western nations trade unions led successful fights for state-dominated health systems, organized labor in the United States has had special reasons to give only lip service to the socialist cause. Although the tax subsidy thus left the lucrative field open for private health plans, it also undermined the cost-consciousness of consumer-voters and thus greatly distorted the market and political choices people made. With incentives pushing in precisely the wrong direction, health-plan competition never delivered on competition's usual promise of low prices and efficiency. Thus did American health policy

and one-sixth of the nation's economy become a disaster area. For big-government advocates, of course, the obvious crisis is an opportunity: they are happily promising to rescue the nation from an intolerable situation largely of government's own making. To be sure, it would not be easy to meld a competitive market for health insurance with a supplementary public program aimed at making coverage universal. Nevertheless, important efficiencies and large welfare gains could be expected if cost-aware consumers were given opportunities to make well-informed, meaningful choices in the market for health coverage.

As long as health insurers' only significant function is the simple one of financing health care, government itself is probably capable of performing that role nearly as well as they do, without incurring competition's added costs. Moreover, a government-run plan would be, like Medicare, in a strong position to give consumers and taxpayers relief from very high prices by exercising its monopoly power vis-à-vis providers and suppliers. Indeed, it is this threat to health industry incomes that has naturally given rise to a strong coalition of special interests dedicated to the proposition that any reforms should create an even larger province for private insurers. Significantly, no one in this coalition is arguing with much conviction that private plans should be preserved because of their potential ability to control overall costs and to offer valuable economizing opportunities to differently situated consumers.<sup>7</sup> It seems to be mostly special-interest politics keeping private health plans in the game.

The question then arises why so many consumer-voters themselves seem to be wedded to a private system when a public one resembling the politically popular Medicare could yield significant price reductions (which might, of course, be offset by providers' shading of quality or boosting of output, things Medicare has never been able to control). Some, to be sure, have purely ideological objections. Others may simply and reasonably fear that, in the long run, government would not meet their needs as well as the private plans to which they are accustomed. Still others may accept conservatives' arguments that government-dictated low prices would have destructive long-term effects on the supply of health services and on the flow of therapeutic innovations. As noted above, however, circumstances (and some special interests) have long conspired to keep consumer-voters mostly ignorant about just how much they are actually paying for their current coverage with all its wasteful features. Naturally, few legislators and no special interests see any advantage in having ordinary consumers

enlightened about how much skin they already have in the health care game. We have no way of knowing, therefore, how consumers, appreciating the magnitude and nature of the cost-benefit tradeoffs involved, would divide in making a political choice between a single-payer plan and a market offering a meaningful variety of private options. This *Outlook* suggests the conditions— theoretically, even if not politically, achievable—under which consumers could reasonably expect to have their true interests served by private plans of their own (or a trusted agent's) choosing.

### **Reform: More or Less Freedom for Private Plans?**

The health insurance industry, while vigorously opposing a public option, has lately signified its willingness to accept extensive new federal regulation in a reform bill.

Insurers have declared themselves comfortable, for example, with the idea of a government-mandated minimum benefit package. And they should be. After all, they can count on entitlement-minded policymakers, heavily lobbied by industry groups, to mandate, at least at the outset, coverage that is substantially more generous (and revenue producing) than basic health security requires. The "essential benefits package" envisioned in the current House bill, for example, would be based on recommendations of an advisory committee including major stakeholders but no one representing the individuals who pay insurance premiums and taxes.<sup>8</sup> (Neither employers nor unions nor self-appointed consumer representatives have nearly the same interest in controlling costs as those who ultimately pay them.) Priorities set by such a body would reflect cost-increasing logrolling of the sort commonly found in legislatures: "I'll support your project if you'll support mine." The cost-increasing generosity on which the reformers insist is also reflected in proposed prohibitions of any annual or lifetime limit on an individual's claims.

The insurance industry has also indicated that it would accept requirements that health plans eschew all medical underwriting and charge only community rates—that is, the same price to healthy and less healthy individuals and groups. Such requirements appeal to liberal lawmakers because they effectively convert true private insurance (which seeks to pool only risks that are similar *ex ante*) into social insurance, which forces the healthy to subsidize those with predictable needs. They also neatly avoid the tax-and-spend label by having consumers pay only

“premiums” and by never having their money pass through government’s hands. Not only are voters thus deceived into blaming insurers and the system, not legislators, for their cost burdens, but the Congressional Budget Office, in “scoring” legislative proposals, need not count costs thus shifted to healthier premium payers except to the extent larger public subsidies are required.

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The Obama administration has yet to present a credible scenario to justify its claim that reforms creating new, regulation-backed entitlements will control costs, let alone control them sufficiently. Indeed, not only is cost control being largely finessed for now, but the regulatory regime Congress is likely to create will also put a new floor under costs, giving consumers even fewer opportunities to reduce their spending on marginally valuable health care and coverage. Yet now more than ever, the economy needs consumers to spend on things besides nonessential health care, and consumers themselves have other pressing needs, such as making mortgage payments, educating their children, buying new cars, and rebuilding their retirement accounts. What the nation and consumers need most is reasonable economizing options in the huge gap between today’s costly conventional coverage and no coverage at all. So far, it does not appear that private health plans will be allowed, let alone encouraged, to offer such options.

### **Private Plans: Tweedledum versus Tweedledee?**

What need is there, then, for private health plans if all they do is administer coverage prescribed by Congress, a public bureaucracy, state law, and the medical profession? Possibly their main saving grace will be their ability to offer additional layers of generous coverage, lower cost sharing, or access to better providers than conventional alternatives. Although the House bill provides for “premium”

plans, it seems to contemplate only variations in levels of cost sharing—seemingly failing to perceive that, as observed above, lower cost sharing is more appropriate for insured people with lower rather than higher incomes. (Only the tax subsidy explains why high earners would want minimal cost sharing.) In any event, the viability of more generous plans would depend on whether they are allowed to deny coverage for preexisting conditions whenever a patient needing care seeks to upgrade his coverage. Current bills seem not to recognize that a rule against medical underwriting—which might make sense in getting everyone covered initially—ought not to prevent richer plans from protecting themselves (and longer-term premium payers) against opportunistic plan switching.

**Private versus Public Rationing.** Letting people have high-end coverage if they want it is probably reasonable enough to maintain competing private health plans in a system of near-universal coverage. But consumers, taxpayers, small employers, and the overall economy would benefit much more if reforms also left room for relatively unspecified lower-cost options (including high-deductible coverage closely integrated with health savings accounts).<sup>9</sup> Certainly there should be some screening of options on the menu of choices, and public subsidies should be both adequate to ensure that no option is a bad one and distributed in such a way as to discourage plans from avoiding, say, enrollees with chronic conditions. Beyond these protections, however, there should be few regulatory constraints on health-plan competition to give good value for whatever consumers are able and choose to spend. Consumers need to understand, of course, that, while economizing choices may make sense for them, some risk is involved and negative consequences are possible. Upgrading coverage only after disaster strikes should not be an option.

Truly low-cost options would necessitate some contractual limits on individuals’ and providers’ freedom to draw on the plan’s premium pool.<sup>10</sup> Designing and administering such contracts are tasks requiring expertise and sensitivity to consumers’ and patients’ differing needs and preferences, skills that are more likely to be found and fostered in the private sector. Many observers are troubled, of course, by the prospect that coverage might be thus rationed, preventing some patients from receiving desired services. But stricter waste prevention, including limits on financial access to marginally beneficial care, would be reasonable for many consumers today and is inevitable in any event (most likely under government

compulsion) at some point not far down the road. How many thinking persons would object, for example, if a private health plan, to keep its premiums affordable, included in its contract (with appropriate disclosure) a limit on financing treatment for such conditions as glioblastoma, the incurable brain tumor that recently killed Senator Edward Kennedy? Although some such *ex ante* choices will inevitably be regretted *ex post*, such hardships are not different in kind from those resulting from other safety-related choices people rationally make in their daily lives.

Anecdotes manifesting explicit economic tradeoffs in the face of imminent tragedy, real or imagined, naturally make good stories for the media and tug at the public's heartstrings. But they would be far easier to tolerate if they were a logical consequence not of government intervention or breaches of private contracts but of economizing choices made *ex ante* by consumers with good information in a relatively free market. Consumers uncomfortable with letting conventional insurers conceive and administer contractual limits on their coverage could take their business to nonprofit entities, including mutual insurers or private cooperatives. Appeals and remedies for breach of contract should be available but only through processes respectful of freedom of contract and the parties' contractual intent. Charity would presumably be available in especially appealing cases.

**Integrating Financing and Delivery.** A no less essential but far more attractive justification for maintaining multiple private health plans is the possibility that they would facilitate the integration of providers into efficient, cost-conscious delivery systems resembling, say, the Kaiser Permanente health plans or the Cleveland Clinic. It is not implausible to think that competing plans could do a better job than government in creating or fostering environments in which physicians cooperate and coordinate their efforts to give consumers and patients the right mix and quality of services for whatever they have to spend. Under the right circumstances, health plans would develop different arrangements with providers to facilitate the implementation of plan policies on how the limited resources in the premium pool could be most advantageously deployed.

Unfortunately, the chances that private health plans will efficiently restructure the financing and delivery of health care are not good. Neither the managed-care strategy of the 1990s nor the Medicare Advantage program designed to encourage the development of integrated

systems for caring for the elderly had appreciable success in getting health plans to organize physicians or to alter their incentives and opportunities to overtreat patients. The main barriers in each case were physicians' insistence on professional autonomy (including limited accountability for costs) and the relatively lucrative inducements of fee-for-service medicine. This inertia will persist unless Congress emphatically nudges the system away from fee-for-service. For example, subsidies might be greater for consumers enrolling in plans that compensate their providers mostly in other ways. In any event, redesigning the tax subsidy is necessary to get consumers to value fully the efficiencies integration can bring.

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Although the Obama administration has promised to change the way providers are paid, its proposal simply to reduce payments to health plans under the Medicare Advantage program would sacrifice an opportunity to modify that program to eliminate or minimize the conflicts of interests inherent in much fee-for-service medicine. Thus, reforms could restructure Medicare Advantage with new features discouraging fee-for-service payment and otherwise encouraging the creation of integrated delivery systems. Removing the current requirement that a Medicare Advantage plan's coverage at least duplicate Medicare's own would invite sensible contractual departures from Medicare's unduly open-ended entitlements.

### **Outlook: Gloomy**

There is very little chance that Congress, despite the Hippocratic principle of "First, do no harm" and the challenging questions its members encountered during their recent summer recess, will now focus carefully on getting incentives right and on clearing away the many regulatory and other barriers to economizing innovation by private health plans. To be sure, many legislators now

appear tempted to omit the public option from the reform bill for ideological or political reasons. If the final bill retains the regulatory features common to the leading proposals seen thus far in the House and the Senate, however, “reform” will play directly into insurers’ and providers’ hands. Like other industries, insurers and health care providers are happiest when the government, through regulation and otherwise, minimizes the economic competition in which they must engage. Indeed, observers of all stripes should be suspicious of the support the Democrats’ reform movement has received most of this year from insurers, provider groups, and pharmaceutical manufacturers.<sup>11</sup> How can reforms yield net benefits to ordinary Americans if industry interests feel well served?

The Obama-sponsored reforms are virtually certain to leave private health plans largely immune to what Harvard Business School’s Clay Christensen has termed “disruptive innovation.” Christensen has observed how in other industries innovative firms have sometimes departed radically from deep-seated industry paradigms in order to give consumers new, low-cost options. Such options have typically involved some sacrifice of supposed quality—but not, as it turned out, quality that all consumers valued highly.<sup>12</sup> Although such outside-the-box innovations have occasionally occurred in health care delivery, they have appeared almost exclusively in integrated health plans or where patients were paying their own bills because they were uninsured or had high-deductible coverage. Unfortunately, the impending reforms are likely to preclude disruptive challenges to the tenet—originating in the professional paradigm of medical care and embodied in all insurance coverage in the United States—that cost is an illegitimate criterion in coverage and treatment decisions whenever a patient might benefit.

What about taxing employees’ health benefits? This idea has resurfaced in the frantic search for new revenue to finance the Obama agenda. A far better reason for taxing workers on the actuarial value of employer-financed coverage, however, would be to make them more aware of how much their current coverage actually costs them. Increased cost consciousness should translate directly into greater demand for, and appreciation of, health plans’ economizing efforts. Although such a new tax burden on individuals would naturally meet political resistance, its effect could be offset by an actuarially determined, refundable tax credit for anyone spending at least that amount on basic coverage. The availability of the tax credit would also induce most uninsured persons to get at least basic

insurance, obviating the punitive sanctions that government is currently threatening to impose. One wonders, of course, whether Obama’s professed willingness to listen to new ideas extends to ideas supported by Republicans, like refundable tax credits, that he rejected too quickly in the election campaign.

Although today’s politicians would never be caught acknowledging that cost considerations might sometimes justify denying a patient a desirable product or service, they are on the brink of creating a system in which government (not individuals looking out for their own welfare) will soon have to preside over the rationing of valuable health services. In the meantime, a new government-imposed entitlement will have put the entire U.S. economy, already on the shakiest ground in memory, at seriously increased risk. It can only be hoped that the nation will not come to rue an Obama-era decision—as well as similar decisions by earlier administrations, both Republican and Democrat—not to reform the health care system along lines suggested by market principles. At least it is still not too late to redesign and significantly increase public subsidies for lower-income insurance purchasers while nudging relatively unfettered health plans into creatively helping cost-conscious consumers decide for themselves how, and how much of, the resources they have available should be spent on health care.

## Notes

1. For early observations that private plans justify their existence only if they are able to, and do in fact, offer consumers a range of meaningful choices, see Clark C. Havighurst, “Why Preserve Private Health Care Financing?” in *American Health Policy: Critical Issues for Reform*, ed. Robert B. Helms (Washington, DC: AEI Press, 1993), 87–115, available at [www.aei.org/book/10](http://www.aei.org/book/10); and Clark C. Havighurst, “Decentralizing Decision Making: Private Contract versus Professional Norms,” in *Market Reforms in Health Care: Current Issues, New Directions, Strategic Decisions*, ed. Jack Meyer (Washington, DC: AEI Press, 1983), 22–45. The latter chapter warned market-oriented reformers that they “could go wrong . . . by assuming too readily that interacting private parties and institutions would be free and uninhibited in their competitive efforts to translate consumer cost concerns into economizing behavior by providers.”

2. Clark C. Havighurst, “How the Health Care Revolution Fell Short,” *Law and Contemporary Problems* 65, no. 4 (2002): 55–101.

3. But see Mark V. Pauly, "Competition and New Technology," *Health Affairs* 24, no. 6 (2005): 1523–35, which recognizes health plans' lack of contractual freedom as a reason costs of new technology are uncontrolled; and Clark C. Havighurst, "How the Health Care Revolution Fell Short."

4. Clark C. Havighurst, *Health Care Choices: Private Contracts as Instruments of Health Reform* (Washington, DC: AEI Press, 1994), available at [www.aei.org/book/111](http://www.aei.org/book/111).

5. Clark C. Havighurst, "Private Reform of Tort-Law Dogma: Market Opportunities and Legal Obstacles," *Law and Contemporary Problems* 49, no. 2 (1986): 143–72. For a critique of proposals for altering malpractice rules by contract, see Jennifer Arlen, "Contracting Out of Liability: Medical Malpractice and the Cost of Choice" (Public Law Research Paper no. 09-41, New York University School of Law, August 2009). It is not clear why Arlen has any confidence that "effective reforms to malpractice liability" by state legislatures will find a good balance between quality improvement and the numerous transaction and other costs attributable to the tort system. See Patrick Atiyah, "Medical Malpractice and the Contract/Tort Boundary," *Law and Contemporary Problems* 49, no. 2 (1986): 287, 300, a concession, by a distinguished British scholar normally preferring parliamentary solutions to policy problems, that "at the end of the day," because of the difficulty of achieving sound reforms in American legislatures, contractual modifications of patient rights may be better than no reform at all.

6. See Clark C. Havighurst, "How the Health Care Revolution Fell Short," 77–94, which explains "the legal and political consensus that strongly supports prescriptive regulation of health care and the systematic hiding of health care costs from those who pay them." The cited discussion concludes: "[T]he model of health care decision-making that is increasingly taking hold in the public mind and in regulatory policy is one that marginalizes the health plan as a responsible player. This model serves physicians and the provider community well, while also protecting those consumers/voters who especially want health care to be available to them without constraints. The political process has proved a powerful tool enabling special interests to shape the system to their liking. The costs of the system, borne in large measure by the mass of Americans who cannot easily afford such luxury, remain—by apparent design—hidden well enough that the day of reckoning is at least delayed." *Ibid.*, 94.

7. *Ibid.*, 77–94. The political economy of health care has long been driven in large measure by the preferences of upper-middle-class voters, who have been content to see the increased costs of regulation—costs that they themselves would willingly pay—also loaded onto lower-income people with insurance. This influential class is now, however, in a political battle that threatens to expose them to higher taxes to finance conventionally

generous coverage for the entire population. It would seem wise for the upper-middle-class voters, at some point, to break ranks with the insurer-provider coalition and endorse a system in which public and private costs would be significantly lower because regulation would no longer preclude lower-income persons from making economizing choices.

8. *America's Affordable Health Choices Act of 2009*, HR 3200, 111th Cong., 1st sess., Open Congress (July 14, 2009), § 123 (a) (5), available at [ww.opencongress.org/bill/111-hr3200/text](http://www.opencongress.org/bill/111-hr3200/text) (accessed October 13, 2009). This section of the Act requires the committee to include "providers, consumer representatives, employers, labor, health insurance issuers, . . . representatives of relevant governmental agencies, and at least one practicing physician or other health professional," as well as "experts in . . . health care financing and delivery, . . . racial and ethnic disparities, . . . care for those with disabilities, [and] . . . children's health."

9. Mark A. Hall and Clark C. Havighurst, "Reviving Managed Care with Health Savings Accounts," *Health Affairs* 24, no. 6 (2005): 1490–1500.

10. Clark C. Havighurst, *Health Care Choices: Private Contracts as Instruments of Health Reform*, 157–330.

11. Insurers recently broke from these ranks to question the Senate Finance Committee's bill on the grounds that its provisions no longer would ensure that a high percentage of healthy persons would obtain coverage. Several private health insurance trade associations (America's Health Insurance Plans and the BlueCross BlueShield Association) expressed concern that, without a strong individual mandate to purchase insurance in the final bill, premiums for those with private insurance would have to rise to unacceptable levels. The viciousness of the resulting counterattack on the insurance groups by the White House and its allies was proportionate to both the validity of the insurers' objection and the Obama administration's hope that voters will not learn how much the cost of their coverage is likely to increase under ObamaCare. See, for example, Paul Krugman, "A Hatchet Job So Bad It's Good," *New York Times*, October 16, 2009. Krugman, after grudgingly conceding in less than a column inch the validity of the insurers' point (and proposing even bigger public subsidies as if that were a simple solution), roundly attacked the insurers on other, mostly insubstantial grounds.

12. See Clayton M. Christensen, Jerome H. Grossman, and Jason Hwang, *The Innovator's Prescription: A Disruptive Solution for Health Care* (New York: McGraw Hill, 2009); and Jason Hwang and Clayton M. Christensen, "Disruptive Innovation in Health Care Delivery, a Framework for Business-Model Innovation," *Health Affairs* 27, no. 5 (2008): 1329–35, which states that "a disruptive product is actually not as good as what existing customers are already using [but is] usually simpler, convenient, and more affordable."