

Top 7 Myths About The Public Health Insurance Plan

Karl Rove has [penned an editorial](#) in the Wall Street Journal attacking the [public health care option](#). Rove's 'myths' echo the poll-tested talking points of [Frank Luntz](#) and other conservatives determined to protect the private insurer's monopoly over coverage and deny Americans choice. Below is a fact-check of Rove's assertions. [Download a [PDF version](#).]

Myth 1: [A public option is unnecessary.](#)

Myth 2: [Private competition in Medicare Part D has reduced costs.](#)

Myth 3: [A public plan would shift costs to Americans with private insurance.](#)

Myth 4: [A public plan will lead to a welfare state.](#)

Myth 5: [The public option is too expensive.](#)

Myth 6: [Americans will be forced into a public option.](#)

Myth 7: [The public option would put a bureaucrat between you and your doctor.](#)

MYTH 1: A public option is unnecessary: "It's unnecessary. Advocates say a government-run insurance program is needed to provide competition for private health insurance. But 1,300 companies sell health insurance plans. That's competition enough." [WSJ, [6/11/2009](#)]

TRUTH: *Insurer and hospital markets are dominated by large insurers and provider systems.* Private insurers rarely negotiate with dominant hospital systems and typically pass on the higher costs to beneficiaries in the form of higher premiums. Already, "1 in 6 metropolitan areas in a 2008 study of more than 300 U.S. markets is dominated by a single health insurer that controls at least 70% of consumers enrolled in health maintenance organizations or preferred provider organizations." Such consolidation negates any real competition. Without it, insurers don't negotiate prices and boost their profits. In fact, "there have been over 400 health care mergers in the last 10 years," and premiums have risen "nearly eight times faster than average U.S. incomes." A public plan could, in an environment of head-to-head competition, push private insurance companies to negotiate more aggressively with providers and dramatically lower health care spending." [Urban Institute, [10/03/2008](#); LA Times, [4/09/2009](#)]

MYTH 2: Private competition in Medicare Part D has reduced costs: "The results of robust private competition to provide the Medicare drug benefit underscore [the ability of private competition to lower prices]. When it was approved, the Congressional Budget Office estimated it would cost \$74 billion a year by 2008. Nearly 100 providers deliver the drug benefit, competing on better benefits, more choices, and lower prices. So the actual cost was \$44 billion in 2008 — nearly 41% less than predicted. No government plan was needed to guarantee competition's benefits." [WSJ, [6/11/2009](#)]

TRUTH: Medicare Part D beneficiaries have experienced significant cost increases.

According to a recent analysis by the Kaiser Family Foundation shows “significant increases in premiums, costsharing amounts, use of specialty tiers, and utilization management restrictions since 2008 that could have important implications for beneficiaries’ access to needed medications and out-of-pocket expenses.” [KFF, [6/2009](#)]

MYTH 3: A public plan would shift costs to Americans with private insurance:

“Second, a public option will undercut private insurers and pass the tab to taxpayers and health providers just as it does in existing government-run programs. For example, Medicare pays hospitals 71% and doctors 81% of what private insurers pay.” [WSJ, [6/11/2009](#)]

TRUTH: Private insurer payments promote medical inefficiency. A new public option will change the way the health care reimbursement system so that we pay for value, not volume and reward efficient providers. According to MedPAC, Medicare rates are adequate and consistent with the efficient delivery of services. In fact, over-payments by private insurers to health-care providers drives up overall costs. “Hospitals which didn’t rely on high payment rates from private insurers ‘are able, in fact, to control their costs and reduce their costs when they need to’ and ‘combine low costs with quality.’” [WSJ, [3/17/2009](#)]

MYTH 4: A public plan will lead to a welfare state: “If Democrats enact a public-option health-insurance program, America is on the way to becoming a European-style welfare state.” [WSJ, [6/11/2009](#)]

TRUTH: Americans will choose a public health insurance plan from a menu of different options. The private insurance market isn’t going anywhere. Private insurers will play an important role in providing more integrated coverage options than the public plan and would retain a “brand advantage” (in the same way that a lot of people rather have the branded drug than the generic) for consumers. Private insurers who “offer a superior product through high levels of efficiency, satisfaction in consumer preferences and ease of access to quality medical services” will thrive in a reformed market. [Urban Institute, [10/03/2008](#)]

MYTH 5: The public option is too expensive: “Fourth, the public option is far too expensive. The cost of Medicare — the purest form of a government-run “public choice” for seniors — will start exceeding its payroll-tax “trust fund” in 2017. The Obama administration estimates its health reforms will cost as much as \$1.5 trillion over the next 10 years. It is no coincidence the Obama budget nearly triples the national debt over that same period.” [WSJ, [6/11/2009](#)]

TRUTH: A public option will lower family premiums. If a public plan is “far too expensive” and has higher premiums, then Americans will not enroll. But if a public plan offers lower premiums, it will motivate private insurers to lower their costs. As a result, health care costs would decrease across the board.

MYTH 6: Americans will be forced into a public option: “Government-run health insurance would crater the private insurance market, forcing most Americans onto the government plan.” [WSJ, [6/11/2009](#)]

TRUTH: The government would not force Americans to purchase coverage from the public plan, but Rove would force everyone under 65 to enroll with a private insurer. Rove is essentially arguing that the public plan would work too well. It would use its inherent efficiencies to lower family premiums and force private insurers to aggressively negotiate on behalf of their beneficiaries.

MYTH 7: The public option would put a bureaucrat between you and your doctor: “The public option puts government firmly in the middle of the relationship between patients and their doctors.” [WSJ, [6/11/2009](#)]

TRUTH: A public option improves the doctor-patient relationship. Existing reform legislation explicitly preserves the doctor-patient relationship. As a draft of the HELP bill notes, “a strong doctor-patient relationship is essential to the practice of medicine, and patients have a right to an effective doctor patient relationships...Doctors, nurses, and other health professional have the right to judge what is best for their patients.” Moreover, the public plan’s payment innovations would reward doctors for providing quality care and spending more time listening to their patients. [HELP Legislation, [6/09/2009](#)]