Executive Summary
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How a Public Health Plan Will Erode Private Care

Robert E. Moffit, Ph.D.

When it comes to the deadly details, millions of Americans could be in for an unpleasant surprise. During the election campaign, President-elect Barack Obama promised—repeatedly—that Americans who already had health insurance would not face any changes in their coverage. He also promised that under his plan, the typical American family would save $2,500 annually in medical costs.

It turns out, however, that these promises cannot possibly be fulfilled. Under the health reform plan that the President-elect has outlined, including variations of his basic approach that have been refined by Senator Max Baucus (D–MT) and former Senator Tom Daschle (D–SD), President-elect Obama's pick for Secretary of Health and Human Services, millions of Americans will indeed lose their existing coverage, and the promised premium savings are unlikely to materialize.

The reason is that President-elect Obama has proposed (1) the creation of a new national health plan, run by the federal government and financed by the taxpayers; (2) an employer mandate enforced by a payroll tax; and (3) a congressionally created national health insurance exchange in which the government health plan, subsidized by taxpayers and having special advantages, would compete unfairly with private health insurance. The result would be a massive crowd-out of private health insurance coverage, especially employer-based coverage.

Ugly Scenarios. Senators Baucus and Daschle, unlike Obama, favor the imposition of an individual mandate on adult Americans to buy health insurance, but such a mandate is not nearly as consequential as a whole new government health plan. "The irony is that the public option—not the mandate—is far and away the most radical part of the plan," notes *The Wall Street Journal*. "Green eyeshade objections are obviously out of favor in modern Washington, but the reality is that the Baucus–Obama plan would be extraordinarily expensive as it slowly but relentlessly grew the government's share of health spending."

Most Americans under the age of 65 get private health insurance through employment, and the overwhelming majority are satisfied with it. The vast majority of American voters oppose any kind of government-controlled health plan if it means that they have to change their own health insurance coverage. In a recent survey, only 15 percent of Americans with private insurance would be willing to switch to a government health plan. But the combination of a government health plan and a new tax or mandated coverage by the employer would prove disastrous for millions of individuals and families enrolled in employer-based coverage. In an employer-based health insurance system, of course, employers, not employees, decide whether to continue or terminate coverage.

This paper, in its entirety, can be found at:
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Big Impact. The Lewin Group, a nationally prominent econometrics firm, estimates that the Obama plan would significantly reduce the number of uninsured, with 26.6 million additional Americans getting coverage by 2010. Lewin also estimates that the Obama plan would dramatically alter the way in which many Americans would be covered: 21.6 million would lose their private coverage, and an estimated 48.3 million would end up in public coverage through the new government health plan, as well as through the State Children's Health Insurance Program and Medicaid. Meanwhile, an estimated 18.6 million employees would find themselves in the new public plan as employers switched from private health insurance.

Since October 2008, when Lewin completed its initial analysis of the Obama proposal, even more detailed studies have brought to light other potential consequences of a public plan:

- **Greater cost-shifting.** American families already pay an estimated $1,788 annually in additional insurance costs because they routinely absorb the extra costs of government health programs, Medicare, and Medicaid. A new public plan, assuming it pays below-market rates to doctors and hospitals, would aggravate this cost-shifting.
- **Less private coverage.** The Lewin Group estimates that anywhere from 10.4 million to 118.5 million people would lose private coverage, depending on the new public plan's payment levels and the pool of eligible enrollees.
- **Lower hospital and physician revenues.** Under different payment and public-plan enrollment scenarios, Lewin estimates that hospitals could lose substantial revenues and that doctors would certainly lose from $2.8 billion to $36.4 billion annually.

Details Matter. President-elect Obama's rationale for a new public plan is that it would give Americans who are not enrolled in employment-based health insurance coverage, or those with insecure coverage, the opportunity to obtain stable, affordable health insurance with a guaranteed set of government-standardized benefits. But while it might look like a prescription for consumer choice and competition, the reality is very different.

Conclusion. A new public insurance plan to compete with private health plans through a "national health insurance exchange" is a Trojan horse for government control and the progressive destruction of Americans' private health insurance coverage.

The creation of a "Medicare-like" plan, in particular, would entail creation of a Medicare-like financing system—a shell game in which prices are held artificially below market rates while costs are shifted to private carriers and growing liabilities are shifted to the next generation of taxpayers. Congress would thus add to entitlement burdens that are already enormous. Meanwhile, it is hard to imagine how Congress and the Administration could be neutral in the national competition with private health plans: a competition in which they would staff, manage, and fund their own creation.

President-elect Obama claims that providing a public plan through a National Health Exchange would enhance personal choice and health plan competition. That is highly unlikely. Rather, such a system would erode private health insurance. While private health coverage would start to disappear more or less rapidly, hardly any aspect of remaining private health plans' business operations would be free from government control. That is not a prescription for the kind of choice or competition that would drive innovation, improve quality, or enhance the productivity of the health care sector. It would severely weaken private health insurance pools—and guarantee a severe loss of economic prosperity and personal liberty.

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> *So, if you have insurance you like, you keep that insurance. If you have a doctor you like, you keep that doctor. The only thing that changes for you is that your costs will go down.*
>
> —Senator Barack Obama,
> presidential campaign speech,
> Asheville, North Carolina,
> October 5, 2008

> *Details kill. If we get too far into the weeds, if we produce a 1,500- or 1,600- page bill, we're going to get hung up on all the details and we're never going to get to the principles.*
>
> —Senator Tom Daschle,
> Secretary of Health and
> Human Services Designate,
> Colorado Health Care Summit,
> Denver, December 5, 2008

When it comes to the deadly details, millions of Americans could be in for an unpleasant surprise. During the election campaign, President-elect Barack Obama promised—repeatedly—that Americans who already had health insurance would not face any changes in their coverage and that their costs would go down, saving the typical family $2,500 annually in premiums.[1]

It turns out, however, that these promises cannot be fulfilled. Under the health reform plan that the President-elect has outlined, including variations of his basic approach that have been refined by Senator

Talking Points

- A new public health insurance plan that competes unfairly with private plans in a national health insurance exchange would erode private coverage and radically expand government control of any surviving private plans.
- Under a new public plan, particularly one combined with incentives for employers to drop coverage, anywhere from 10 million to 118 million Americans would be pushed out of private coverage.
- Those Americans who remained in private coverage would see additional increases in their costs, assuming that the public plan shifts costs to the private sector as Medicare and Medicaid do today. Existing public health programs impose an annual insurance cost of $1,788 on a family of four.
- Doctors and hospitals would lose billions of dollars annually in revenues, especially if the new public health plan adopts Medicare payment rates.

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Max Baucus (D–MT) and former Senator Tom Daschle (D–SD), President-elect Obama's pick for Secretary of Health and Human Services, millions of Americans will indeed lose their existing coverage, and the promised premium savings are unlikely to materialize.

The reason is that Obama has proposed (1) the creation of a new national health plan, run by the federal government and financed by the taxpayers; (2) an employer mandate enforced by a payroll tax; and 3) a congressionally created national health insurance exchange in which the public health plan, subsidized by taxpayers and armed with special advantages, would compete unfairly with private health insurance.[2] The result would be a massive crowd-out of private health insurance coverage, especially employer-based coverage.

Ugly Scenarios. There are differences, of course, among the plans advanced by these three gentlemen. For example, Senators Baucus and Daschle, unlike Obama, favor the imposition of an individual mandate on adult Americans to buy health insurance. But such a mandate is not nearly as consequential as a whole new government health plan. As *The Wall Street Journal* has noted:

> The irony is that the public option—not the mandate—is far and away the most radical part of the plan. Green eyeshade objections are obviously out of favor in modern Washington, but the reality is that the Baucus–Obama plan would be extraordinarily expensive as it slowly but relentlessly grew the government's share of health spending.[3]

Most Americans under the age of 65 get private health insurance through employment, and the overwhelming majority of them are satisfied with it.[4] The vast majority of American voters oppose any kind of government-controlled health plan if it means that they have to change their own health insurance coverage.[5] Only a small minority of Americans with insurance—15 percent—would be willing to switch to some form of government health insurance.[6] But the combination of a public health plan and a new tax or mandated coverage by the employer would prove disastrous for millions of individuals and families enrolled in employer-based coverage. In an employer-based health insurance system, of course, employers, not employees, decide whether to continue or terminate coverage.

Big Impact. There are already tens of billions of dollars in cost-shifting from existing public health programs, Medicare, and Medicaid to individuals and families enrolled in private health insurance. The introduction of a new public plan, assuming payment levels below market rates, would aggra-

1. Obama News & Speeches, "Cutting Costs and Covering America: A 21st Century Health Care System," University of Iowa, May 29, 2007, at *http://www.barackobama.com/2007/05/29/cutting_costs_and_covering_ame.php* (December 15, 2008).
2. The prototype of the proposals that Obama, Baucus, and Daschle are promoting, especially a national health insurance exchange as an arena for a government plan to compete with private health plans, is the proposal developed by the Commonwealth Fund, a prominent liberal health policy group based in New York City. For a description of the Commonwealth Fund's proposal, see Cathy Schoen, Karen Davis, and Sara Collins, "Building Blocks for Reform: Achieving Universal Coverage with Private and Public Group Health Insurance," *Health Affairs*, Vol. 27. No. 1 (May/June 2008), pp. 646–657; see also Karen Davis, Cathy Schoen, and Sara Collins, "The Building Blocks of Health Reform: Achieving Universal Coverage and Health System Savings," Commonwealth Fund *Issue Brief*, May 2008.
3. "The Obama Health Plan Emerges," *The Wall Street Journal*, November 20, 2008.
4. Based on a December 2008 Gallup survey, 67 percent of Americans describe the coverage they have now as excellent or good. See Lydia Saad, "Americans Rate National and Personal Healthcare Differently," Gallup, December 4, 2008, at *http://www.gallup.com/poll/112813/Americans-Rate-National-Personal-Healthcare-Differently.aspx* (December 15, 2008).
5. Based on a December 2008 Rasmussen survey, 58 percent of Americans expressed opposition to the idea. See "Most Voters Say Leave My Health Insurance Alone," *Rasmussen Reports*, December 10, 2008, at *http://www.rasmussenreports.com/public_content/business/general_business/most_voters_say_leave_my_health_insurance_alone* (December 16, 2008).
6. "Americans Give Low Marks to U.S. Health Care, but 69% Rate Their Health Insurance Good or Excellent," *Rasmussen Reports*, July 7, 2008, at *http://www.rasmussenreports.com/public_content/politics/issues2/articles/americans_give_low_marks_to_u_s_health_care_but_69_rate_their-health_insurance_good_or_excellent*.(December 16, 2008).

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vate and increase these costs. Once again, details are crucial.

But beyond greater cost-shifting to private insurance is the very real loss of private health insurance coverage itself. In an October 2008 analysis, the Lewin Group, a nationally prominent econometrics firm based in Virginia, estimated that the Obama plan would indeed significantly reduce the number of the uninsured, with 26.6 million additional Americans getting coverage by 2010. Lewin also estimated that the Obama plan would dramatically alter the way in which many Americans would be covered: 21.6 million Americans would lose their private coverage, but an estimated 48.3 million would end up in public coverage through the new government health plan, as well as through the State Children's Health Insurance Program (SCHIP) and Medicaid, which is a welfare program.[7] In the course of this new configuration of American health insurance coverage, Lewin estimated, 18.6 million employees would find themselves in the new government plan as employers switched to it from private health insurance.[8]

More recently, the Lewin Group elaborated on the impact of a new government health plan offered in competition with private health plans and outlined the dramatic consequences, both for private coverage and for revenues earned by doctors and hospitals.[9] Under any scenario, Lewin estimated a crowd-out, or displacement of private health insurance, with the introduction of a new public plan. Key factors determining the impact would be the size of the eligible pool of employees and their dependents; the payment levels adopted by the new government plan; and whether those levels would be private payment levels, Medicare payment levels, or at midpoint between private payment and Medicare payment.

In calculating the alternative scenarios, the Lewin Group provided a range of potential impacts:

- **Lost Private Coverage.** With eligibility limited to employees in small firms and to individuals and the self-employed, at midpoint payment levels, an estimated 31.5 million persons would be enrolled in the government health plan, and an estimated 21.5 million would be switched out of private coverage. If the payment levels in the public plan were the same as Medicare, enrollment in the government plan would jump to 42.7 million, and a total of 31.8 million would be transitioned out of private coverage.

  If all employees were eligible for enrollment in the government plan, at Medicare payment levels, the shifts would be massive: 130.5 million Americans would be enrolled in the government plan, and 118.5 million would lose or be switched out of private health coverage. While some people might choose to join the public plan, many would have little or no choice in the matter, since their employers would drop their coverage.
- **Lost Hospital Revenues.** If eligibility for enrollment in a public plan was opened to all employees and payments were at a level midpoint between private and Medicare payment, hospitals would find themselves with a net reduction in payment of $7.3 billion in 2009. If all employees were eligible at Medicare payment levels, hospitals would see a net reduction in payment of $36.5 billion in 2009.
- **Lost Physician Revenues.** Doctors already struggle with Medicare and Medicaid payment levels, and medical practice would be further constrained by the introduction of a new government health plan. If all employees were eligible

7. See The Lewin Group, *McCain and Obama Health Care Policies: Costs and Coverage Compared*, October 8, 2008, at *http://www.lewin.com/content/Files/The_lewin_Group_McCain-Obama_Health_Reform_Report_and_Appendix.pdf* (December 16,2008); see also Greg D'Angelo and Paul L. Winfree, "The Obama Health Care Plan: A Closer Look at Cost and Coverage," Heritage Foundation *WebMemo* No. 2114, October 24, 2008, at *http://www.heritage.org/research/healthcare/wm2114.cfm* (December 16, 2008).
8. *Ibid.*
9. The Lewin Group, "Opening a Buy-In to a Public Plan: Implications for Premiums, Coverage and Provider Reimbursement," presentation to Republican staff of the Senate Finance Committee, December 5, 2008, at *http://www.lewin.com/content/publications/OpeningBuyInPublicPlan.pdf* (December 18, 2008).

for enrollment in such a plan, and if such a plan paid at Medicare payments levels, doctors would see a net reduction in their payment of $36.4 billion in 2009.

Details Matter. The President-elect's rationale for the provision of a new government plan is that it would give those Americans not enrolled in employment-based health insurance coverage, or those with insecure coverage, the opportunity to obtain stable, affordable health insurance with a guaranteed set of government-standardized benefits. But while it might look like a prescription for consumer choice and competition, the reality is very different.

Consider the components: a powerful regulatory body that runs a proposed National Health Exchange, enforcing a single set of rules; a rigged competition between private health plans and a government health plan that enjoys special advantages and potentially unlimited taxpayer subsidies; and another powerful federal agency—a board, council or institute—determining what medical services and benefits would be covered and reimbursed in Americans' health insurance. In the new public plan, as is the case for Medicare and Medicaid, costs would doubtless be controlled by cutting payments for medical goods and services, thus reducing their availability.

Given the structure, function, and dynamics of such a combination of proposals, the result would surely be a rapid evolution toward either a single-payer system of national health insurance or, at the very least, a highly regulated and painfully sluggish, centrally controlled system of health care in which private health plans and private medical practice are private in name only. Meanwhile, millions of Americans would lose their employer-based health insurance, and the artificially swollen and heavily subsidized government health plan would remain as the benchmark for "private" decisions concerning financing, benefits, and standards within the new National Health Exchange.

What a New Public Plan Would Look Like

There are two broad, yet very different, models for a government health plan among the leading health reform proposals: Medicare and the Federal Employees Health Benefits Program (FEHBP).

Under an earlier proposal advanced by the Commonwealth Fund, a prominent liberal think tank based in New York, the new government health plan would be "Medicare Extra," a plan based on Medicare for the under-65 population. Under Senator Baucus's proposal, the new public plan would also resemble Medicare. Under Senator Daschle's proposal, the new plan would be created by his proposed Federal Health Board, a powerful independent government agency, in consultation with Medicare officials.

Under President-elect Obama's proposal, the new public plan would be created by Congress with benefits similar to those found in the FEHBP and would compete with private plans in the National Health Exchange. While Obama has not been very specific about the functions of the Exchange, he has made it clear that it is to be a "watchdog," a powerful regulatory as well as administrative agency, and that it would enforce a common set of insurance and health policy rules, including guaranteed issue, rating limitations, and payment rules for health insurance, as well as rules governing benefits, quality, and efficiency standards.

In Obama's proposal, small businesses and individuals without access to group coverage through their workplace would be eligible for enrollment in the new public plan, as would those who are ineligible for existing public health programs such as Medicaid and SCHIP. Like Baucus and Daschle, Obama proposes combining a public health plan with an employer mandate, whereby employers who do not or cannot afford to offer private coverage are required to pay an as yet unspecified tax that would, in turn, help to finance coverage in the public program.[10]

10. In the Commonwealth Fund proposal, which is an earlier and more detailed version of the broad policy agenda promoted by Obama, as well as by Baucus, the payroll tax for business would be 7 percent, and it would impose an additional annual cost of an estimated $45 billion on employers who had not previously provided coverage for their employees. See Davis *et al.*, "The Building Blocks of Health Reform."

Under Obama's proposal, insurance rules would include guaranteed coverage, including the elimination of any restrictions on pre-existing medical conditions, as well as a requirement that the public plan and its competitors offer a fair set of premiums with minimal co-payments. Rules would apply to the new government plan and presumably any of the government plan's private competitors. For low-income people, special premium subsidies would allow them to enroll in the new public plan and the private health plans that would compete with it in the National Health Exchange.

A Medicare Model. Senator Baucus, as noted, has said that he favors a new public plan "similar to Medicare."[11] Likewise, Senator Daschle has called for a public plan to be developed by his proposed Federal Health Board in consultation with Medicare officials.

Details matter. In developing a public health plan, Congress would have to determine whether the plan should really be "like" Medicare or whether it should simply expand Medicare itself as proposed by a sizeable number of congressional champions of a single-payer system of national health insurance. As a practical matter, Medicare expansion would be the easiest and simplest option, but it would also mean expanding a financially troubled government program that is already facing disastrous liabilities.

Governance. If a simple expansion of Medicare is not on the table, the task becomes a bit more challenging. If Congress were to create a new public plan "like Medicare," then Congress would have to decide on its governance and presumably would recreate a system of central planning and administrative pricing that is at least broadly similar to the system that characterizes the existing Medicare program. This would include centralized benefit setting, financing, and regulation (a vast regime of rules, regulations, and guidelines, which consume tens of thousands of pages); Medicare-style decision-making with respect to medical necessity and appropriateness of medical services for reimbursement, claims processing and denial, or conditions that determine when and how patients could legally contract with private physicians outside the Medicare-like plan (if such private contracting were permitted at all); Medicare-style audits and investigations for fraud and abuse; and the often laborious grievance and appeals process for denial of patients' medical services or physicians' reimbursements.

Medicare's governance problems are legendary,[12] but it is unlikely that Congress could invent a Medicare-like program without reinventing the managerial and administrative paraphernalia and the inflammatory process of political decision-making that characterizes Medicare, including the ugly special-interest pleading, unless it were to abdicate its responsibilities for governing the new program and transfer them, as Senator Daschle has recommended, to a super agency, proudly unaccountable to doctors or patients and "insulated" from normal political influence in its disposition of benefits, drugs, or medical treatments.

This is, of course, the idea behind the parallel creation of a supremely powerful council, institute, or Federal Health Board.[13] The notion that a politically appointed body would also be "insulated" from politics is charmingly naïve.

Benefit Setting. Based on Medicare's historical record, health benefit setting, particularly the adoption of new therapies, devices, or medical

11. Senator Max Baucus (D–MT), "Call to Action: Health Reform 2009," November 12, 2008, p. 18, at *http://www.finance.senate.gov* (December 26, 2008).
12. See, for example, U.S. General Accounting Office, *Medicare Management: CMS Faces Challenges to Sustain Progress and Address Weaknesses*, GAO-01-817, July 2001; see also U.S. General Accounting Office, *Managing for Results: Federal Managers' Views on Key Management Issues Vary Widely Across Agencies*, GAO-01-592, May 2001.
13. See Tom Daschle, with Scott Greenberger and Jeanne M. Lambrew, *Critical: What We Can Do About the Health Care Crisis* (New York: Thomas Dunne Books, 2008); see also Baucus, "Call to Action," pp. 18–19. For a brief discussion of the proposal for a powerful board, see Robert E. Moffit, Ph.D., "How a Federal Health Board Will Cancel Private Coverage and Care," Heritage Foundation *WebMemo* No. 2155, December 4, 2008, at *http://www.heritage.org/research/healthcare/wm2155.cfm*. In a variation on this theme, Senator Baucus recommends that coverage decisions should be made by an Independent Health Coverage Council.

technologies, does not occur as rapidly in Medicare as it does in private health insurance. In fact, Medicare's benefit setting is often a slow and highly politicized process. The addition of a significant medical benefit in the Medicare program or a change in its payment rate often becomes a point of highly contentious congressional debate, as evidenced by the long and bitter multiyear battle over the addition of a Medicare drug benefit, which reached a fever pitch in the enactment and then the rapid repeal of the Medicare Catastrophic Coverage Act of 1988 and culminated in the enactment of the Medicare Modernization Act of 2003.

In creating a new public health plan, if Congress (as the board of directors of this new plan) does not transfer its responsibilities to a separate and powerful board or council as recommended by Daschle and Baucus, respectively, it must determine how precisely it would address breakthroughs in medical innovation and the fruits of that innovation in the form of medical benefits and treatments. If a new treatment becomes available and is priced according to market conditions in private plans, either Congress or a body authorized by Congress must first determine whether it will become available in the public plan (not a sure thing) and then decide how the treatment will be priced and under what conditions it will be reimbursed.

Once again, the idea behind the public health plan, at least as presented by its champions in the incoming Administration and Congress, is that it would compete directly with private health plans for the allegiance of employers—who will make the business decision to enroll their employees—or employees who do not have employer-based coverage or are self-employed. But any serious market competition would require a level playing field for the competitors. In order to create and maintain this level playing field, any benefit standard established in the public plan would also be applied to private health plans.

Congress, therefore, would have to mandate an equality of benefits at some level between the public plan and the private plans, and that would require either adding or subtracting benefits or fixing the prices for these benefits by legislative action to keep the contest at least superficially fair. As Michael Tanner, a senior fellow at the Cato Institute, has observed, "Private insurance companies would still exist, but they would operate much like public utilities with the government involved in deciding what benefits they offer, what they can charge, and how they operate."[14]

Tanner's observation, however, begs an obvious question: If the rules and standards, financing and benefits, reserve and solvency requirements, and consumer protections and guarantees are all the same for competing private plans and the public plan, then, logically, why should there be a public plan at all? A common set of market rules for insurers would be sufficient to achieve whatever public good is envisioned to ensure affordable coverage and fair competition. Otherwise, it would seem that the only reason to create a public plan would be simply to *have* a public plan—a meaningless exercise, unless the goal is public monopoly.

Payments. A second major issue for Congress to settle is the crucial one of how exactly it would set payments and prices of medical services in a new "Medicare-like" plan. In the Commonwealth Fund's version of the new government plan, "Medicare Extra," there would be no change: Payments to doctors and hospitals would be the same as they are in traditional Medicare.[15]

In traditional Medicare, medical services and procedures are priced according to the program's existing system of administrative pricing, a bewildering alphabet soup of fee schedules and payment formulas: the Diagnosis Related Groups (DRGs) for hospitals; the Resource Based Relative Value Scale (RBRVS) for physicians;[16] the Sustainable Growth Rate (SGR) for physician payment updates;[17] and the various administrative payment formulas for medical devices and Part B drugs. Most Members of Congress are firmly committed to Medicare's administrative payment systems, regardless of their

14. Michael D. Tanner, "Questions and Answers About Obama's Health Plan," McClatchy News Service, October 22, 2008, at *http://www.cato.org/pub_display.php?pub_id=9742* (December 16, 2008).

15. Schoen *et al.* "Building Blocks for Reform," p. 649.

manifest weaknesses, strongly opposing even modest reforms like competitive bidding for durable medical equipment.[18]

Senator Baucus says that he would not use the Medicare payment system for the new government health plan.[19] Assuming that anything even remotely resembling free-market pricing and payment for medical goods and services is simply out of the question—a fair assumption—it is hard to imagine how Congress would begin to field a Medicare-like plan in competition with private-sector health plans without Medicare-like payment rules. If Senator Baucus and his colleagues do not want to use those rules and are not going to embrace free-market pricing, they would have to develop a new system of administrative pricing and payment. The problem, of course, is that any new system of administrative pricing in which free-market forces are excluded and prices are fixed punishes clinical innovation or institutionalizes inefficiencies, and taxpayers who fund the government health plan routinely pay either too much to too little for medical goods and services.

When the Medicare physician fee schedule was authorized by the House Ways and Means Committee in 1986 in the face of determined opposition from the Reagan Administration, it took another three years for the proposal to be enacted and another five years for the payment reform to be fully implemented. For Congress, it would be a formidable task to re-invent an entirely new system of administrative payment for all medical professionals, as well as for drugs, devices, and technology, assuming that it would truly be different from Medicare or Medicaid.

Meanwhile, Congress has been either unwilling or unable to fix the obviously broken payment systems that now govern the financially troubled Medicare program. This is especially true of the physician-payment-update formula, automatically threatening massive Medicare payment cuts to doctors and setting off the ridiculous annual spectacle of Congressmen desperate to meet a yearly statutory deadline in time to undo their own handiwork.

Big Impact. Payment formulas for the new government plan, like the size of the eligible pool of enrollees, are crucial details. The degree to which Medicare payment is reproduced in the new government health plan is profoundly consequential in its

16. The theory underlying the Medicare physician fee schedule is in many respects an intellectual curiosity. It is based on the 19th-century notion that there is an "objective" economic value to commodities, including the labor required to produce goods and services. In the case of a doctor's provision of medical services, that objective value can be discovered, outside of the dynamics of a free market, through the methods of "social science." Social scientists would measure and weigh the time, energy, and effort necessary for a doctor to produce a medical service, along with other "inputs," and compare the relative values of these services on a statistical scale for purposes of reimbursement regardless of the value or benefit of the service to the patient. For a further discussion of this idea, see Robert E. Moffit Ph.D., "Back to the Future: Medicare's Resurrection of the Labor Theory of Value," *Regulation*, Vol. 15, No. 4 (Fall 1992), pp. 54–63, at *http://www.cato.org/pubs/regulation/regv15n4/reg15n4f.html* (December 16, 2008).
17. Under the SGR formula, updates in Medicare physician payment are tied directly to the growth of the national economy; increases in payment that exceed a target based on national economic growth are cut automatically the following year. On the SGR, see John S. O'Shea M.D., "The Urgent Need to Reform Medicare's Physician Payment System," Heritage Foundation *Backgrounder* No. 1986, December 5, 2006, at *http://www.heritage.org/research/healthcare/bg1986.cfm*; see also John S. O'Shea, M.D., "A Predictable Mess: Medicare's Physician Payment System Offers Lessons Against Drug Price Negotiation," Heritage Foundation *WebMemo* No. 1330, January 25, 2007, at *http://www.heritage.org/research/healthcare/upload/wm_1330.pdf*.
18. Dancing to the tune of special-interest lobbying, Congress aborted such a payment reform in summer 2008, even though it had previously authorized it in the Medicare Modernization Act of 2003. See Robert E. Moffit, "Medicare: Congress Is Poised to Block Competitive Bidding for Medical Supplies," Heritage Foundation *WebMemo* No 1959, June 18, 2008, at *http://www.heritage.org/research/healthcare/upload/wm_1959.pdf*.
19. But Baucus is very vague on what he would use: "Rates paid to health care providers by this option would be determined by balancing the goals of increasing competition and ensuring access for patients to high quality health care." Baucus, "Call to Action," p. 18.

impact on the doctors, hospitals, and private-sector health plans that are supposed to compete with it.

There is a big payment gap between public and private health care programs. Compared to payments in the private commercial markets, Medicare and Medicaid pay doctors and hospitals significantly less. According to the Lewin Group, the most recent data indicate that Medicare payments amount to 81 percent of private payments to doctors, while Medicaid payments to doctors amount to only 56 percent of private payments.[20] For hospitals, Medicare payment amounts to 71 percent of private payment, while Medicaid payment is 67 percent of private payment.[21]

Artificially low government payments by Medicare and Medicaid to doctors and hospitals guarantee that the true costs are shifted back to the private sector and generate even higher premiums for individuals and families in their private and employment-based health insurance. According to a recent report by Milliman Inc., a prominent actuarial consulting firm, this "hidden tax" amounts to $88.8 billion a year, or an additional annual cost of $1,788 in insurance for a family of four.[22]

For individuals and families that would remain in private health insurance, assuming that their coverage survived, similarly low payment schedules for a new government health plan would guarantee an even larger shift to them in higher health care costs. In other words, even if their coverage remained unchanged, it is highly unlikely that they would see a promised reduction in their health insurance premiums.

Champions of the government health plan often claim to be sincerely committed to "fair" competition between private health plans and their proposed public plan, but it is impossible to have a functioning national market in which pricing in one portion of the market (private plans) is driven by free-market conditions of supply and demand and pricing in the other (the public plan) is dictated by the government, either in the form of administrative pricing or through a system of price controls. To establish a level playing field, Congress would have to refrain from trying to set prices for thousands of medical treatments and procedures, as it does today for Medicare, and let the market determine those prices equally for the public plan and the private plans that are supposed to compete with it. The government plan and its managers would have to succeed, and therefore profit from their success in offering consumers what they want and need, or fail, lose market share, and absorb losses on their own—in which event, unlike other government-sponsored enterprises, the public plan should be permitted to go out of business without another taxpayer bailout: admittedly an unlikely scenario.

Alternatively, Congress would have to impose a universal system of administrative pricing on the public and private health plans alike, thus reintroducing the old Nixonian price controls for the health care sector of the economy. But importing Medicare- or Medicaid-style payment systems is also to import the annual congressional warfare over Medicare payment for doctors and other medical professionals into what is now left of the private sector. With government controlling the benefits as well as the price of the benefits, whether or not the payer is singular or plural, the result would be a government-run system.

Yet another option is for Congress simply to let the public health plan, with its administratively set, artificially low prices, undercut the private health plans and accelerate employer dumping of millions of employees into the "cheap" government health plan, thus rapidly driving private health plans out of business and rapidly eroding the provision of private health insurance altogether.

FEHBP Model. The second option for a government health plan actually does not exist, except in recent political rhetoric, and that is something called the "FEHBP Plan." President-elect Obama's proposed new public health insurance program would give "individuals the choice to buy affordable

20. The Lewin Group, "Opening a Buy-In to a Public Plan," p. 2.

21. *Ibid.*

22. Avram Goldstein, "Health Insurers Protect $88.8 Billion 'Hidden Tax'," Bloomberg.com, December 13, 2008.

health coverage that is similar to *the plan* available to federal employees."[23]

But Obama would also prescribe a comprehensive standardized benefits package not only for the public health plan, but also for any private health plans that would compete with the public plan in his proposed National Health Exchange. It would be "similar" to the benefit package available to Members of Congress.

Obama's presentation on this point is confusing, because in 2008 there were no fewer than 283 health plans, with different benefit packages, competing in the FEHBP. Under the FEHBP payment formula, the government, as an employer, makes an annual defined contribution that by law cannot exceed 75 percent of the premium costs of any given health plan in the program.

FEHBP plans differ greatly. For example, for 2009, the Blue Cross Blue Shield "standard option" plan, one of the most popular of the FEHBP's national plans, has an annual premium of $13,450, while the Mail Handlers–Value plan, a union plan offered on a national basis, has an annual premium of just $5,340. As American Enterprise Institute scholar Joseph Antos and his colleagues have noted, if the Blues' standard-option FEHBP plan were to be the fixed standard, the costs of coverage would be very high for many families:

> Families would not be able to purchase less expensive coverage, since all other insurance would be required to offer benefits at least as generous as those of the NHP (measured on an actuarial basis). This would create a large new entitlement, raising concerns about the fiscal sustainability of reform.[24]

In the Obama version, enrollees' payments would be standardized to make sure that premiums are "fair" and that co-payments are "minimal." Families that are ineligible for Medicaid or SCHIP would receive low-income subsidies to help them buy coverage either in the public plan or in the approved private plans that would compete with it in the National Health Exchange.

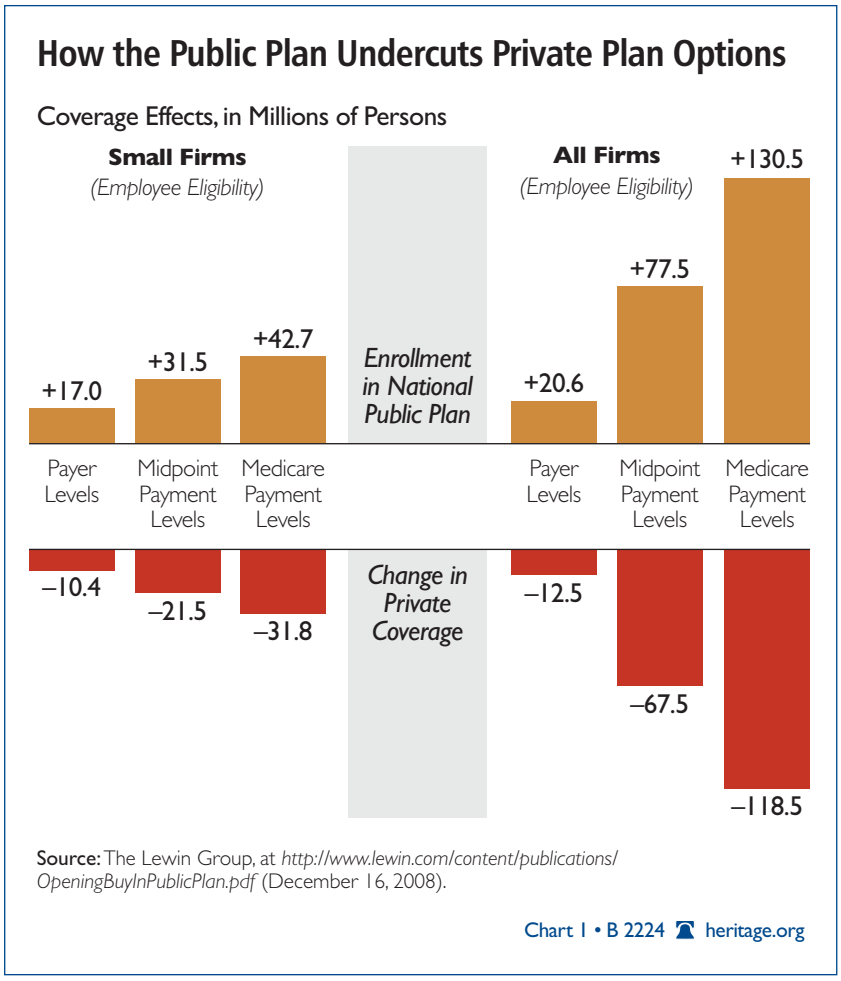
Deviation from FEHBP. Few topics in the American health care policy debate are more subject to misrepresentation—some of it deliberate, some of it rooted in ignorance—than the Federal Employees Health Benefits Program. Americans should not be under any illusions about how the FEHBP actually works, compared with the way it is often described. There are three significant differences between President-elect Obama's proposal and the reality of the FEHBP.

1. **The federal government does not enter a government-financed health plan into the competition with private insurers, either nationally or in any of the states where private health plans compete.** The national and state competition in the FEHBP—to the extent that one wants to liken it to competition in a health insurance exchange—is a competition among risk-bearing private health plans only.
2. **The FEHBP is a premium-support system.** There is no such thing as one "benefit package" or an "FEHBP Plan" that covers Members of Congress. There is a wide variety of packages that change annually and vary with plan type—ranging from high-deductible health savings account plans (HSAs) to managed care plans (HMOs and PPOs) and "fee for service" offerings—and that reflect yearly requests by the U.S. Office of Personnel Management (OPM), as an employer, in call letters (the federal government's annual communications to private health plans) before annual summer negotiations, as well as the different responses of health insurers in negotiations with the OPM staff and the ever-changing demand of consumers for health insurance products. The false impression often left with ordinary Americans is that there is a

23. "Barack Obama's Plan for a Healthy America: Lowering Health Care Costs and Ensuring Affordable, High Quality Health Care for All," undated, at *http://www.obama08-wa.com/files/Blog_Obama_Health_Plan.pdf* (December 16, 2008). Emphasis added.
24. Joseph Antos, Hans Kuttner, and Gail Wilensky, "The Obama Plan: More Regulation, Unsustainable Spending," American Enterprise Institute, September 16, 2008, at *http://aei.org/publications/pubID.28630,filter.all/pub_detail.asp* (December 16, 2008).

very special, single set of idealized health benefits uniquely and exclusively available to Members of Congress and federal workers and retirees.

3. **Under Obama's public plan, participants are to be charged "fair" premiums and "minimal co-payments."** In other words, the federal government would, out of necessity, fix premiums to make them "fair" and standardize other insurance payments. In the FEHBP, premiums and co-payments are determined by supply and demand. While the OPM negotiates rates and benefits with private carriers as an employer, its main regulatory job is consumer protection of its employees and retirees, which is understood as making sure that the premiums bear a reasonable relationship to the benefits offered and that plans are solvent and compatible with basic marketing rules. OPM does not in any way get into the business of imposing price controls on premiums or forcing health insurers to adopt a standard set of co-payments. In this key respect, the Obama proposal differs radically from the principles and practice of the FEHBP.



How Private Coverage Could Change

Based on independent assessments, there is no doubt that there would be a significant reduction in the number of uninsured Americans under Obama's proposal. There is also no doubt that private health insurance coverage would erode significantly—that it would be crowded out—with a government health plan operating within a national health insurance exchange.

Much would depend on the as yet unknown specifications that Congress would determine for eligibility for enrollment in the public plan, the size and scope of the proposed employer mandate and its tax, the exact functions of the proposed National Health Exchange, the payment and pricing of medical services in the new government health plan, and the private plans that are supposed to compete with it. Again, details matter.

The Lewin Group recently projected the impact of a new public plan based on the size of the eligible pool of enrollees and its payment rates. In terms of eligibility, if employees in small firms, the self-employed, and individuals were eligible for enrollment in the government health plan, there would be major increases in enrollment in the government plan and corresponding declines in private health insurance coverage. Assuming payment levels for doctors and hospitals at a midpoint between existing private payment and Medicare payment, Lewin estimates that enrollment in the national public plan would jump to 31.5 million Americans, while 21.5

million Americans would either lose their employer-based coverage or give up private health insurance coverage.[25] If the government health plan is offered with Medicare payment rates for doctors and hospitals, which are significantly lower than those found in the private sector, the impact would be greater: 42.7 million Americans would enroll in the government plan, and 31.8 million fewer Americans would have private health insurance.[26]

If employees in *all* firms, as well as self-employed persons and individuals, were eligible for enrollment in the government health plan, the impact would be enormous. In that case, at payment rates at a midpoint between the private sector and Medicare, Lewin estimates that 77.5 million Americans would be enrolled in the government plan, while 67.5 million Americans would be transitioned out of employer-based or private health insurance coverage. If Medicare payment rates were adopted in the government plan and the scope of eligibility was greatly expanded—encompassing *all* firms and all self-employed and other individuals—then the shifts in coverage would be titanic: 130.5 million people would be enrolled in the government health plan, and 118.5 million Americans would no longer have private health insurance.[27]

The Cost of a New Government Plan

With the creation of a new taxpayer-subsidized public health plan combined with an employer mandate, as recommended by President-elect Obama and Senator Baucus, Congress would be imposing new costs on businesses and almost certainly shifting more costs to private health plans. In the meantime, federal spending on health care would have to increase significantly, and their proposed health care delivery reforms would be unlikely to secure serious cost control.[28]

Fiscal discipline is unlikely. Senator Baucus has already indicated that the "pay as you go" rule—requiring spending cuts or tax increases—to finance health reform may not apply.[29] Taxpayers are also being promised that health care reform will somehow pay for itself, based on fanciful projections of future savings from various delivery initiatives. These savings will probably never materialize. Based on a rich history of failed government predictions with respect to health care costs, especially in Medicare, the projected costs of government health programs are almost always much greater than the government officials promise.

With regard to the specific impact of the new government plan itself, there is some early econometric analysis. The impact on different sectors of the health care industry, as well as the taxpayers, would vary by the payment levels and the pool of eligible enrollees in the new government plan—that is, whether the pool of eligible enrollees would be "broad," encompassing employees in *all* firms as well as individuals and the self-employed, or "narrow" and restricted to employees in *small* firms as well as individuals and the self-employed.

Another key factor is the details of the employer mandate: the size and scope of the mandate and the tax penalty imposed on firms for not offering health insurance to their employees as prescribed by Congress. Employer mandates, as economists have generally noted, would result in a reduction in wages and other compensation for employees and provide powerful incentives for firms to "dump" employees from private coverage into public coverage along with the payment of the as yet unknown tax.

For doctors and hospitals, the costs of the new government health plan in terms of lost revenues would be balanced somewhat by projected reductions in payments of administrative costs and uncompensated care costs as more and more patients were covered by the government's health insurance program.

25. The Lewin Group, "Opening a Buy-In to a Public Plan," p. 2.
26. *Ibid.*
27. *Ibid.*
28. For a discussion of this key point, see D'Angelo and Winfree, "The Obama Health Care Plan."
29. Alex Wayne, "Baucus's Proposed Health Care Overhaul May Disregard Pay-As-You-Go Rules," Alliance for Advancing Nonprofit Healthcare, November 18, 2008, at *http://www.nonprofithealthcare.org/documentView.asp?docID=1447*.

Hospitals. According to the Lewin Group, levels of payment at a midpoint between the private sector and Medicare would yield a net change for hospitals that would range from a positive increase of $14.9 billion (assuming a narrower pool of eligible enrollees) to a negative $7.3 billion. As Lewin estimates, however, if one assumes Medicare payment levels, the hospital payment reductions could be drastic: a loss of as much as $36.5 billion annually based on a broad eligibility of employees in all firms.[30]

Doctors. For doctors, whether the eligibility pool is broad or narrow, or whether the payment levels were at midpoint or at Medicare levels, there would be a net reduction in physician revenues. The most drastic reduction in physician revenue would come with the adoption of the government health plan that encompassed employees in all firms as eligible and paid physicians on the basis of Medicare rates: $36.4 billion in reduced physician revenue.[31]

Taxpayers. For taxpayers, there is as yet no clear answer to the specific question of how great the true costs of the new public health plan in particular, or whatever the incoming Obama Administration and the congressional leadership propose for health reform in general, will be.

The new public health plan, however, would be subsidized by the taxpayers, and the taxpayers would presumably assume all of its risks and liabilities, including inevitable unfunded liabilities of a health plan that promises artificially low premiums and co-payments. Unlike many state legislatures, Congress is unburdened by any legal requirement in the federal Constitution to balance the federal budget and can therefore simply make good any yearly losses or expansions by making a run on the Treasury or relying on deficit financing and the printing press.

The creation of a new government health plan beyond Medicare, Medicaid, and SCHIP would entail some hard thinking on the part of Congress as to how it would finance this new plan and what measures it would put in place to establish some modicum of fiscal discipline. It is understandable that some Members of Congress, as Senator Daschle has claimed, would be tempted to surrender some tough decisions affecting coverage and related costs to an enormously powerful Federal Health Board or some other unelected body insulated from the inflammatory process of democratic decision-making.

The Eternal Bailout. A new public plan would entail new public liabilities. In any case, Congress would have to decide whether or not to finance the new plan as Medicare is financed, put the bulk of spending on autopilot like spending on physician and drug benefits, and make up losses through increased taxation or debt. Or Congress would have to develop other alternatives. Once again, these details matter.

If Medicare itself or a newly created "part" of Medicare, as some suggest, is to serve as the new public plan in a national health insurance exchange, then Congress will have to determine whether its liabilities would be established separately and apart from the existing Medicare program or included within it.

From the taxpayers' standpoint, it would not make much difference: They would still be stuck with a much bigger bill either way. If liabilities were incurred as part of Medicare, for example, Congress would be adding to Medicare's long-term debt, which alone amounts to an enormous $36 trillion.[32] Yet no one in Congress and no one in either the outgoing Bush Administration or the incoming Obama Administration has yet indicated how Americans are going to absorb the hideously high entitlement costs that have already been incurred.

Conclusion

A new public insurance plan to compete with private health plans through a "national health insurance exchange" is a Trojan horse for govern-

30. The Lewin Group, "Opening a Buy-In to a Public Plan," p. 3.

31. *Ibid.*, p. 3.

32. For an updated discussion of the existing Medicare debt, see Greg D'Angelo and Robert E. Moffit, Ph.D., "Congress Must Not Ignore the Medicare Trustees' Warning," Heritage Foundation *WebMemo* No. 1869, March 26, 2008, at *http://www.heritage.org/research/healthcare/wm1869.cfm*.

ment control and the progressive destruction of Americans' private health insurance coverage.

The creation of a "Medicare-like" plan, in particular, would entail the creation of a Medicare-like financing system—a shell game in which prices are held artificially below market rates while costs are shifted to private carriers and growing liabilities are shifted to the next generation of taxpayers. Congress would thus add to entitlement burdens that are already enormous. Meanwhile, it is indeed hard to imagine how Congress or the Administration could remain neutral in the national competition with private health plans: a competition in which they would staff, manage, and fund their own creation.

President-elect Obama claims that providing a public plan through a National Health Exchange would enhance personal choice and health plan competition. That is highly unlikely. Rather, such a system would erode private health insurance. Short of a revolution in Washington's thinking, either Congress or a powerful Federal Health Board operating under its authorization would become increasingly prescriptive over health benefits, the adoption of medical technology and new medical treatments and procedures, and the pricing of these items, as well as the mechanisms that private health plans may or may not use to manage health care risks.

While private health coverage would start to disappear more or less rapidly, hardly any aspect of remaining private health plans' business operations would be free from government control. That is not a prescription for the kind of choice or competition that would drive innovation, improve quality, or enhance the productivity of the health care sector of the economy. It would severely weaken private health insurance pools and guarantee a severe loss of economic prosperity and—most important—personal liberty.

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