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# Government as "Competitor": The Latest Prescription for Government Control of Health Care

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Certain recent proposals to ostensibly expand health care "choice" and "competition" would have exactly the opposite effect. One such recent proposal is to create a national health care "market" through a congressionally designed "national health insurance exchange" where a government health plan would compete directly with private health plans.[1]

The declared purpose of this arrangement is to give those Americans who were not enrolled in employment-based health insurance coverage, or those with insecure coverage, the opportunity to get stable, affordable health insurance that would have a guaranteed set of government standardized benefits (such as Medicare or a version of Medicare) calibrated for a younger population. Usually, this kind of proposal is accompanied by an employer mandate, whereby employers who do not offer private coverage are required to pay a tax that would, in turn, help to finance coverage in the competing public program.

**Government as Player *and* Umpire.** In the Federal Employees Health Benefits Program (FEHBP), the unique consumer-driven health program that covers federal workers and retirees—and which many cite as a functioning version of a "national health insurance exchange"—the United States Office of Personnel Management (OPM), the agency that administers the program, does not field an "OPM Health Plan" to compete with the hundreds of private health plans around the country. In the FEHB, competing health plans offer a variety of different benefit packages, from managed care offerings to health savings accounts plans. And in the FEHBP, the private health plans, not the taxpayers, assume the financial risks.

But the proposal for a national health insurance exchange with the government as a direct competitor is very different. The government would not only set the rules for the competition, but it would also enter into the competition as a player. The incentives governing the government plan and its powerful board of directors—presumably Congress—would not only be economic but also political. As a result, the role of consumers personally choosing value for their dollars would be dramatically diminished.

The likely incentives for government officials would be to set rules to advantage the government's own health plan and to disadvantage the private health plans, including setting the government's health plan premiums artificially low, reducing or eliminating cost-sharing requirements, or more heavily subsidizing certain benefits to make the government health plan more attractive than the private health plans. These plans would operate without incurring any of the normal financial risks that private health plans must bear.

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One could easily imagine a massive crowd out of private coverage, as employers dropped private coverage and paid the requisite tax. Likewise, lobbyists for businesses or private insurance industry executives may see the government health program as a convenient "dumping ground" for high-risk individuals or families, which would reduce business and insurance industry costs but would amount to massive adverse selection against the taxpayers.

America's entire health care economy would become an arena for special interest lobbying on a scale previously unimaginable. In such a political environment, the value of personal choice and anything at all resembling free market competition would mostly likely be rendered meaningless.

**Government Debt.** At the very outset, the prospects for such a "fair" competition seem remote. Private health plans would compete for consumers' dollars and would bear financial risks and absorb financial losses. The public plan, however, would be subsidized by the taxpayers, and the taxpayers would assume the risks and the liabilities. If the federal Medicare program itself served as the government competitor in the "national health insurance exchange," then whatever liabilities would be incurred by the new part of Medicare would be added to the current long-term debt of the Medicare program, which now amounts to an enormous $36 trillion.[2] In that case, the proposal would simply increase the already hideously high Medicare burden on current and future taxpayers that Congress thus far seems either unwilling or unable to address. If the program would be entirely separate from Medicare, and not "Medicare-like" in its financing, then Congress would have to discover some way to spare taxpayers yet another huge addition to their entitlement bills. It is fair to ask how Congress would handle the inevitable liabilities of the new public plan.

**Government Micro-Management.** Congress would determine the government health plan's benefit offerings with a high degree of specificity (if Medicare were the model for such a plan) and would also set the premiums, co-payments, and deductibles that enrollees would pay. In order to preserve some modicum of "fairness" for the competition to work, Congress would have to make sure that the health benefits and payment schedules for the private plans are comparable, thus standardizing the health benefit offerings of both the government and the private sector. This would make the offering to the public either identical or largely identical. The result: a centralized federal standardization of health benefit offerings on America's private health plans.

It is not enough to say that the public plan's benefits package would be just a "basic" package. In theory, that would be desirable; in practice, what is or is not "basic" invariably becomes a political decision regardless of personal wants, needs, or desires of enrollees. In state legislature after state legislature, lawmakers have altogether imposed more than 2,000 mandated health benefits on private health plans. "Basic" means many different things to many different people, including provider organizations that insist their medical practices must be legally required in health insurance offerings. This is yet another reason why health insurance rules, including rules governing health benefits, as well as risk-adjustment among radically diverse health insurance markets, should be left to the states.[3]

Medical science and technology constantly advance and generate new medical treatments and procedures that are incorporated into private health coverage. Assuming the proponents of "government competition" are sincere about maintaining fair competition between public and private insurance, they would have to either automatically add such new benefits to the government plan or somehow

1. This is very different from a state-based health insurance exchange, which is designed to promote personal ownership of portable health plans, purchased tax-free through an employer-based defined contribution arrangement. The proposal for a national health insurance exchange, with a government health plan to compete with private health plans, is embodied in Senator Barack Obama's (D–IL) health plan and is outlined in greater detail in the national health policy reform offered by the Commonwealth Fund. 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.
2. See Greg D'Angelo and Robert E. Moffit, Ph.D., "Congress Must Not Ignore the Medicare Trustees' Warning," Heritage Foundation *WebMemo* No. 1869, March 27, 2008, at *www.heritage.org/research/healthcare/wm1869.cfm*.


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limit their adoption in the private sector. There is a way to accomplish that, however, and it is thoroughly undesirable: Add the benefit and thus make it "formally" available, in black and white, as part of the government plan's offerings but then control the costs through caps on reimbursement or price controls. Medicaid is a prime example of how this process plays out, with doctors limiting or foregoing their Medicaid practice altogether.

It is easy to imagine, then, Congress imposing health care price controls on the private sector as well as the public sector. This would 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.

**Not the Right Prescription.** Proponents of government competition in a "national health insurance exchange" claim that it would enhance personal choice and health plan competition. That is highly unlikely. Rather, such a system would impose federal control over virtually every aspect of private health insurance, rendering it virtually indistinguishable from government insurance except for its direct financing. Congress would become increasingly prescriptive over benefits, the adoption of medical technology and new medical procedures, the pricing of these items, and the mechanism that plans may or may not use to manage health care risks. In other words, hardly any aspect of private health plans' business operations would be free from government regulation and control. That is not a prescription for health care choice or competition.

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3. It should be noted that in the FEHBP, for example, there is no federal risk adjustment mechanism at all. Risk-adjustment—carefully calibrating payments for different enrollees based on age, risk, or health status—is a formidable enterprise best left to the experimental capacities of innovative state legislators. For a discussion of this issue, see Edmund F. Haislmaier, "State Health Reform: A Brief Guide to Risk-Adjustment in Consumer-Driven Health Insurance Markets," Heritage Foundation *Backgrounder* No. 2166, August 1, 2008, at *www.heritage.org/research/healthcare/bg 2166.cfm*.