Executive Summary
Backgrounder
Published by The Heritage Foundation
No. 2267
May 5, 2009

Why a New Public Plan Will Not Improve American Health Care

Walton J. Francis

A sticking point in crafting major national health care reform legislation, according to media accounts, is whether or not Congress should create a new "public plan" as an alternative in competition with private insurance plans. The role of a public plan has become something of a litmus test in the debate over reform. *The Washington Post* correctly says the "fixation on a public plan is bizarre and counterproductive."

Key Questions. Little noticed in the debate by the media are the fundamental questions about the "public plan" option: Specifically what kind of public plan is proposed? What purposes is a public plan expected to serve? Would a public plan that competes with private plans achieve those purposes more effectively than competition among private plans alone, or would it subvert those purposes? Is there any reason to think that a public plan modeled on Medicare, and directed by the same congressional micro-management, can better deliver lower cost and higher quality care than private plans? Why should Medicare have to be doubled or tripled in size in order to lead health care innovation? Why should Americans believe that after 40 lethargic years the Medicare program, as run by Congress, will be transformed into an innovative, nimble program that can reform health care and reduce waste and overuse of health care services?

Four recent proposals for a public health plan—by Professor Jacob Hacker of the University of California at Berkeley; the Commonwealth Fund, a prominent liberal think tank in New York; John Holahan and Linda Blumberg of the Urban Institute; and an innovative public plan option by Len Nichols and John Bertko of the New America Foundation—address these questions. These proposals vary, from a rigid Medicare model displacing most private insurance (Hacker) to a sincere attempt at a level playing field (New America Foundation). Unfortunately, they all fail to prescribe a feasible solution for the role of a public plan in health care reform.

Four Proposals for Public Plans

1) The "Healthy Competition" Plan. Professor Jacob Hacker, a political science professor at the University of California at Berkeley, has become virtually a one-man industry in favor of expanding a benefit-enriched variant of Original Medicare to Americans of all ages.

Under the conditions that Professor Hacker insists are essential—government price controls and virtually mandatory provider participation—"Original Medicare" would be modestly enriched as "Medicare Plus" and become the overwhelmingly

This paper, in its entirety, can be found at:
www.heritage.org/Research/HealthCare/bg2267.cfm
Produced by the Center for Health Policy Studies
Published by The Heritage Foundation
214 Massachusetts Avenue, NE
Washington, DC 20002–4999
(202) 546-4400 • heritage.org

dominant plan, with private plans tolerated as second-class alternatives to government-run health care.

2) The Commonwealth Fund Proposal. Under the Commonwealth proposal, developed by Dr. Karen Davis and her colleagues, Original Medicare benefits would also be enriched into "Medicare Extra," a program with a $5,000 ceiling on out-of-pocket expenses in which coinsurance would be reduced and preventive care would be free, prescription drugs would be covered, and hospital and physician deductibles would be unified and set at a combined level of $250 a year (compared to the current combined level of over $1,100 a year). However, like Professor's Hacker's plan, the basic structure of Original Medicare would stay in place and Medicare is intended to become the overwhelmingly dominant plan for Americans of all ages.

3) The Holahan–Blumberg Proposal. John Holahan and Linda Blumberg of the Urban Institute have written the provocative "Can a Public Insurance Plan Increase Competition and Lower the Costs of Health Reform?" in which they suggest that many variations of a public plan could be used, not only Medicare or a program expanding and changing Medicare.

4) The Nichols–Bertko Proposal. Len Nichols and John Bertko have achieved a *tour de force* with their "Modest Proposal for a Competing Public Health Plan." They demonstrate that it would be theoretically possible to create a competing public plan that would not crowd out private insurance or compete unfairly through mandatory provider participation and payment rules not available to private plans.

Nichols and Bertko argue that head-to-head competition is important to keep pressure on the public plan from "having financial incentives to stint on the quantity and quality of care." However, the model they propose has no proponents, would be unlikely to work, and would not meet advocates' underlying purpose of public domination of health insurance.

Conclusion

Members of Congress and other advocates of a coercive public plan should explain why they favor compulsory participation by health care providers accompanied by stringent wage and price controls. They should also explain why free-market language like "competition," "bargaining," and "level playing field" is used to—falsely—describe such a system.

Advocates of a public plan usually argue that Original Medicare's administrative costs are lower than those of private plans, and a major source of savings that could finance health reform. But this argument ignores the problem that one of the main reasons Medicare's administrative costs are low as a percentage of its overall spending is that it fails to control both wasteful spending—as much as one-third of all Medicare spending—and fraud. The worse Medicare performs, the better its ratio of administrative costs appears; and the less it spends on administration, the worse it performs. Some of Medicare's inability to control waste is inherent in its structure, and some is due to congressional decisions to reduce administrative spending below the prudent levels recommended by each Administration. Why is this failure labeled a success, and why is this a management and oversight model to expand?

The real reason why a number of health policy analysts and politicians favor a public plan is because they see it as a way to crowd out private health care options, paving the way to a single-payer system. Members of Congress who support this agenda should be asked directly why they favor a "single-payer" system, and why some proponents of such a system cover it with a smoke screen of misleading rhetoric. Karen Ignagni, president and CEO of the America's Health Insurance Plans, the trade association for private plans, argues that if the goal of the public plan is to crowd out private insurers, "let's have a debate on a government-run system."

It is about time.

—Walton J. Francis is a self-employed economist and policy analyst, expert in analysis and evaluation of public programs. He pioneered the systematic comparison of health insurance plans from a consumer perspective as primary author of CHECKBOOK's Guide to Health Plans for Federal Employees. *This annual online publication rates plans in the Federal Employees Health Benefits Program, which is often cited as a model for health reform. He has testified before Congress on Medicare reform and FEHBP reform, and has worked as a consultant to the Centers for Medicare and Medicaid Services. The views expressed in this article are his own.*

Backgrounder

Published by The Heritage Foundation

No. 2267
May 5, 2009

Why a New Public Plan Will Not Improve American Health Care

Walton J. Francis

A sticking point in crafting major national health care reform legislation, according to media accounts, is whether or not Congress should create a new "public" plan as an alternative to private insurance plans. The role of a public plan has become something of a litmus test in the debate over reform. *The Washington Post* correctly says the "fixation on a public plan is bizarre and counterproductive."[1]

During the presidential campaign, candidate Barack Obama prominently championed competition among private health plans as well as a new public plan to compete against them. Senate Finance Committee Chairman Max Baucus (D–MT) has also endorsed the idea. Ranking Republican committee member Senator Chuck Grassley (R–IA) strongly opposes it. Senator Edward Kennedy (D–MA) and newly installed House Energy and Commerce Committee Chairman Henry Waxman (D–CA) are long-time advocates of installing a government-run plan as the primary, perhaps only, national health insurance system.

Health policy is one of the few areas of public policy in which advocates of government-run programs (as opposed to market-based or government-regulated private programs) have a strong and credible presence. Various schemes have been proposed, including true single-payer systems modeled along the lines of the Canadian or British systems of government health insurance. Others argue for a less radical departure from current insurance. Karen Davis, for instance, president of the Commonwealth Fund, argued forcefully in testimony before Congress last

Talking Points

- A sticking point in crafting major national health-care-reform legislation is whether Congress should create a new "public plan" as an alternative to private insurance.
- During the presidential campaign, Candidate Obama championed competition among private health plans as well as a new public plan to compete against them.
- The real reason why a number of policy analysts and politicians favor a public plan is because they see it as a way to crowd out private health care options, paving the way to a single-payer system.
- Four recent proposals for a public health plan all fail to prescribe a workable solution for health care reform.
- Members of Congress who support a public plan should be asked why they favor a "single-payer" system and why they are unwilling to say so.
- It is time that these questions are answered in order that the real debate over health reform can begin.

This paper, in its entirety, can be found at:
www.heritage.org/Research/HealthCare/bg2267.cfm

Produced by the Center for Health Policy Studies

Published by The Heritage Foundation
214 Massachusetts Avenue, NE
Washington, DC 20002–4999
(202) 546-4400 • heritage.org

year for using Medicare as a key component in "achieving universal coverage through a seamless system of private and public health insurance."

Key Questions. Little noticed in the debate by the media are the more fundamental questions about the "public plan" option: Specifically what kind of public plan is proposed? What purposes is a public plan expected to serve? Would a public plan that competes with private plans achieve those purposes more effectively and efficiently than competition among private plans alone, or would it subvert those purposes? Is there any reason to think that a public plan modeled on Medicare, and directed by the same congressional micro-management, can better deliver lower cost and higher quality care than private plans? Why should Medicare have to be doubled or tripled in size in order to lead health care innovation?

Four recent proposals for a public health plan—by Professor Jacob Hacker of the University of California at Berkeley; the Commonwealth Fund, a prominent liberal think tank in New York; John Holahan and Linda Blumberg of the Urban Institute; and an innovative public plan option by Len Nichols and John Bertko of the New America Foundation—address these questions. These proposals vary, from a rigid Medicare model displacing or "crowding out" most private insurance (Hacker) to a sincere attempt at a level playing field (New America Foundation). Unfortunately, they all fail to prescribe a reasonable or workable solution for the role of a public health plan, or demonstrate its value for health care reform, though for very different reasons.

Proposals Based on Medicare

The "Healthy Competition" Plan.[2] Professor Jacob Hacker, a political science professor at the University of California at Berkeley, has become virtually a one-man industry in favor of expanding a benefit-enriched variant of the original Medicare program to Americans of all ages.

Under the conditions that Professor Hacker insists are essential—government price controls and virtually mandatory provider participation—"Original Medicare" (in contrast to "Competitive Medicare"—Medicare Advantage and Medicare Prescription Drug Plans) would be the overwhelmingly dominant plan operating under a single-payer system with private plans tolerated as second-rate alternatives. Professor Hacker denies that he recommends expanding Original Medicare by carefully arguing that because the benefits of his plan would be richer and costlier—with alleged overall savings from price controls (his "Medicare Plus" is similar to "Medicare Extra," as outlined in the Commonwealth Fund proposal)—and the risk pool different, it would not be the same plan.

However, it would be administered by the same Centers for Medicare and Medicaid Services (CMS), using the same payment rules, and using the same private contractors to pay claims, as in Original Medicare. The reality is that he proposes to enrich the Original Medicare benefit package, and intends his public plan to displace most private-sector health plan enrollment.

The titles of Professor Hacker's more recent writings are euphemistic: "The Case for Public Plan Choice in National Health Reform," or "How to Structure Public Health Insurance Plan Choice to Ensure Risk-Sharing, Cost Control, and Quality Improvement." In its essentials, Hacker's proposal seems to be virtually identical to the Medicare Extra proposal outlined by the Commonwealth Fund. The Lewin Group, a nationally prominent

1. "Reforming Health Care: How a Government-run Plan Could Fit—or Not," *The Washington Post*, April 27, 2009, at *http://www.washingtonpost.com/wp-dyn/content/article/2009/04/26/AR2009042602072.html* (May 4, 2009).
2. Jacob S. Hacker, "Healthy Competition: How to Structure Public Health Insurance Plan Choice to Ensure Risk-Sharing, Cost Control, and Quality Improvement," Institute for America's Future and The Center on Health, Economic and Family Security, University of California, Berkeley, April 8, 2009, at *http://www.ourfuture.org/healthcare/hacker* (May 4, 2009); Hacker, "The Case for Public Plan Choice in National Health Reform: Key to Cost Control and Quality Coverage," Center on Health, Economic and Family Security, University of California, Berkeley, December 16, 2008, at *http://institute.ourfuture.org/report/2008125116/case-public-plan-choice-national-health-reform* (May 4, 2009); and Hacker, "Medicare Plus: Increasing Health Coverage by Expanding Medicare," Robert Wood Johnson Foundation, October 31, 2003, at *http://www.rwjf.org/pr/product.jsp?id=39853* (May 4, 2009).

econometrics firm based in Virginia, evaluated the Commonwealth Fund proposal as saving almost enough to finance its expansions and evaluated the latest version of the Hacker plan as similarly cost-effective.[3]

In all cases, the Lewin conclusions about the savings from a public plan are simply mechanical arithmetic: Lewin estimates cost savings calculated directly from Medicare price controls (without any allowance for increases in wasteful overutilization and fraud, but assuming cost shifting to private plans), assumes that these relative cost savings will make the plan's premium lower than the alternatives by this amount, and assumes that the vast majority of Americans will enroll in this lower premium public plan.[4]

Professor Hacker says that the same rules should apply to public and private plans, and repeatedly claims to want a "level playing field" for competition among them. In fact, Professor Hacker is opposed to real competition.[5] He recommends, for instance, that the default enrollment option for all Americans who do not take positive steps to select another plan should be the public plan, arguing that the public interest would be best served by maximizing enrollment in the public plan, with private plans implicitly relegated to the role of safety valves. In other words, there would only be a veneer of private plan participation.

Most important, Professor Hacker proposes requiring private health care providers to participate in the public plan at rates set by the government. Such a requirement is not competition, nor is it a level playing field as any economist understands those terms.

The Commonwealth Fund Proposal.[6] Under the Commonwealth proposal, developed by Dr. Karen Davis and her colleagues, Original Medicare benefits would also be considerably enriched as "Medicare Extra," a program with a $5,000 ceiling on out-of-pocket expenses in which coinsurance would be reduced and preventive care would be free, to which prescription drug coverage would be added,[7] and in which the hospital and physician deductibles would be unified and set at a combined level of $250 a year (compared to the current combined level of over $1,100 a year). However, like Professor's Hacker's plan, the basic structure of Original Medicare would stay in place.

This new public plan, "Medicare Extra," would be available to both the elderly and the working age population, along with competing private plans, such as Medicare Advantage and Federal Employees Health Benefits Plans. The Original Medicare infrastructure, including government-dictated payment rates, would remain essentially unchanged with some tweaking to reward innovations, such as evidence-based medicine and use of health informa-

3. The Lewin Group, "Cost Impact Analysis for the 'Health Care for America' Proposal," February 15, 2008, at *http://www.sharedprosperity.org/hcfa/lewin.pdf* (April 21, 2009). For an analysis of the 2003 Hacker proposal, see John Sheils and Randall Haught, the Lewin Group, "Cost and Coverage Analysis of Ten Proposals to Expand Health Insurance Coverage," Appendix E, October 2003, at *http://www.esresearch.org/publications/SheilsLewinall/E-Hacker.pdf* (May 4, 2009). The Lewin Group evaluated the 2003 version of the Hacker proposal as expanding Medicare to cover an additional 113 million people.
4. The experiences of both Competitive Medicare and the FEHBP demonstrate that assumptions such as these are patently erroneous; but there can be little doubt that a government-favored and government-advantaged public plan can receive sufficient financial or other advantages to crowd out most private-plan enrollment.
5. Hacker, "Healthy Competition," uses the phrase "level playing field" 22 times.
6. Karen Davis, "Public Programs: Critical Building Blocks in Health Reform," testimony before the Finance Committee, U.S. Senate, June 16, 2008, at *http://finance.senate.gov/healthsummit2008/Statements/Karen%20Davis%20Testimony.pdf* (May 4, 2009). See also Cathy Schoen, Karen Davis, and Sara R. Collins, "Building Block for Reform: Achieving Universal Coverage with Private and Public Group Health Insurance," *Health Affairs* (May/June 2008), at *http://content.healthaffairs.org/cgi/reprint/27/3/646?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=&author1=schoen&fulltext=universal+coverage&andorexactfulltext=and&searchid=1&FIRSTINDEX=0&resourcetype=HWCIT* (May 4, 2009).
7. The fate of the free-standing Part D Medicare Prescription Drug Program is not mentioned; but it can be deduced that it would be abolished in favor of a single government-established formulary and government control of drug prices. As Dr. Davis delicately puts it, her Medicare reforms would "allow prescription drug prices to be negotiated" by the government.

tion technology. Savings would be financed by a doubling of Medicare enrollment with providers paid at rates potentially even lower than present Medicare rates and reductions in administrative costs for newly covered persons.

Based on such assumptions, the Lewin Group claims that this program would achieve universal coverage at a minimal net cost increase. Davis does not focus on administrative arrangements or competitive arrangements in an otherwise extensive list of system characteristics (for example, premium assistance, mandatory participation, employer "play or pay"). Tellingly, however, she says that the default enrollment option would be Medicare Extra, and that no private fee-for-service plans would be allowed to compete with Medicare Extra.

The Public Plan as a Cost-Control Mechanism

The Holahan–Blumberg Proposal.[8] John Holahan and Linda Blumberg of the Urban Institute have written the provocative "Can a Public Insurance Plan Increase Competition and Lower the Costs of Health Reform?" in which they suggest that many variations of a public plan could be used, not only Medicare or a program expanding and changing Medicare.

They argue that a public plan would have the market power to offset the recent national trend toward increased hospital concentration, and would be needed to control private-sector costs. They admit, however, that "politics (pressure from provider organizations) also tends to weaken the will of policymakers to aggressively contain costs." They use the repeated annual failure of the Congress to adhere to its own statutorily established sustainable growth rate formula to control physician payments as evidence. Therefore, they correctly argue, the public plan would be unlikely to reduce prices as much as might otherwise be theoretically possible.

Interestingly enough, Holahan and Blumberg also argue that private health plans would be more likely than a public plan to offer better services and greater access to providers, even if their costs were higher, and thereby attract significant numbers of enrollees. The major benefit they see from an expanded public plan is that it would be better able than private plans to overcome the market power of monopsonistic local hospital markets. Unlike Dr. Davis and Professor Hacker, however, they make no claims that a public plan would be more likely than private plans to be able to foster innovations that would improve quality and reduce costs for health care.

Holahan and Blumberg cite the savings in administrative costs (a questionable proposition, as described below) as a second argument for the creation of a new public plan. They claim to favor a market in which public and private plans compete for customers, but they nowhere evidence any concern over the structural conditions and rules of the game that would be necessary for a genuine competition to take place.

They are vague on whether or not they favor compulsory participation and price controls. However, in the Holahan-Blumberg proposal, the proverbial cat leaps out of the bag when they say, "it is entirely feasible that lower-cost private plans could survive."[9] With this statement, they are admitting that they have *no intention* of creating what economists would normally consider a level playing field. Presumably, they also know that if a new public plan were to operate under anything like the strict rules for neutrality applied to both the public plan and the private options proposed by Len Nichols, director of the New America Foundation's Health Policy Program, and John Bertko, an actuarial consultant to that program, it would have little market power. They describe a public plan that would set Medicare-like rates and compel participation to the verge of bankruptcy: "The problem is that…if it limits its hospital and physician payments too strictly, it faces the risk of perhaps causing hospital closures."[10] Thus, implicit in their proposal is that the

8. John Holahan and Linda J. Blumberg, "Can a Public Insurance Plan Increase Competition and Lower the Costs of Health Reform?" Urban Institute Health Policy Center, 2008, at *http://www.urban.org/health_policy/url.cfm?ID=411762* (May 4, 2009).
9. *Ibid.*, p. 5.

core requirements for a public plan are the ability of the government to compel provider participation and to dictate the prices of the medical goods and services provided.

There are at least two problems with this rationale. First, it assumes both that local monopolies are a problem so serious that health care costs cannot be controlled without breaking the power of local hospitals to set prices that force up private insurance costs. Second, it assumes that no less-drastic solutions are possible.

Quite apart from improving antitrust enforcement, there is a relatively simple solution already used in Medicare Advantage: requiring providers to accept Medicare prices in geographic areas where there are few competitors, participation is necessary to meet government network adequacy requirements, and private health plans and providers cannot reach a negotiated agreement. This is not an ideal solution, but it is certainly far less radical than a system that requires most Americans to join Medicare in order to obtain reasonable prices from monopsonists.

An Idealistic Prescription for Health Plan Competition

The Nichols–Bertko Proposal.[11] Len Nichols and John Bertko have achieved a *tour de force* with their "Modest Proposal for a Competing Public Health Plan." They demonstrate that it would be theoretically possible to create a competing public plan that would not crowd out private insurance or compete unfairly through mandatory participation and payment rates set by law and not available to private plans.

Nichols and Bertko argue that head-to-head competition is important to keep pressure on the public plan from "having financial incentives to stint on the quantity and quality of care." To achieve workable competition, they create a list of nine "Conditions for Fair Competition" that would level the playing field while using a public plan to achieve some of the key objectives favored by Davis, Holahan, Blumberg, and Hacker: cost containment and innovation.

Crucial Conditions. Nichols and Bertko insist on a truly level playing field for any such competition. Key among these conditions: The public plan cannot be administered by the same agency that governs the marketplace for insurance; the public plan cannot be Medicare; and the public plan cannot use Medicare or any other public program to force providers to participate. Most fundamentally, they argue that the same rules should govern all plans, public or private. Unlike Professor Hacker, Nichols and Bertko actually define a "level playing field," and set conditions to assure rather than prevent that result.

From the perspective of a free-market economist, the Nichols and Bertko proposal has a great deal of merit. In fact, they are not the only or the first analysts to argue for the merits of a genuinely level playing field for public versus private competition. Professor Mark Pauly, a prominent health care economist at the Wharton School at the University of Pennsylvania, also makes a forceful case for the idea. In his book, *Markets Without Magic: How Competition Might Save Medicare*, Pauly attempts to show that private health plans can compete with Original Medicare, and, in the process, provide the elderly with health care and insurance that are arguably the best hope to save the Medicare program from fiscal insolvency and runaway spending levels over the long run.[12] Pauly's argument, however, is not that the public plan has unique advantages in controlling costs, or is even a necessary competitor, but that innovative private health plans are the best hope to restrain costs and spending over the long run, regardless of whether Original Medicare is a competitor.

Practical Problems. The Nichols–Bertko proposal, however, has serious flaws in its own terms

10. *Ibid.*, p. 4.
11. Len M. Nichols and John M. Bertko, "A Modest Proposal for a Competing Public Health Plan," Health Policy Program, New America Foundation, March 2009, at *http://www.newamerica.net/publications/policy/modest_proposal_competing_public_health_plan* (May 4, 2009).
12. Mark V. Pauly, *Markets Without Magic: How Competition Might Save Medicare* (Washington, D.C.: AEI Press, 2008).

and may provide a cover for pernicious proposals that may find Congress and the taxpayers in the worst of all worlds: compulsory participation and administered price controls whose terms are set by the "rent seeking" endemic to the political system. Such a process would achieve little in cost containment (compared to what is needed) for the very reasons articulated clearly by Holahan and Blumberg:

Reason 1. The kind of public plan that Nichols and Bertko propose is not advocated by any of the political parties participating in the current national debate. They describe a public plan that is, by law, exactly the same as a private insurance firm, except that it is administered by government bureaucrats. It would be similar to a government-run airline competing with United Airlines, a government-run university competing with Harvard, or a government-run restaurant chain competing with McDonald's. [13]

It is hard to imagine why anyone on Capitol Hill should support such a plan, since it is not likely to achieve any of the objectives desired by the leading advocates of this option. Nor could any sensible person believe that the government enterprise, with no special taxpayer subsidies, would be capable of competing on even terms in any such markets and provide a service that is preferred on grounds of either cost or performance.

Consider the experience of the Veterans Administration (VA) health care system. It offers prescription drug coverage. But one-third of the Veterans who previously obtained "free" medicines through the VA system signed up for Medicare Part D, where drug coverage is provided through competing private health plans, paying about $300 a year for better access and a much broader choice of drugs. As recently stated by former CMS Administrator Mark McClellan, M.D.: "At this point, I don't know many Republicans who are confident a public option could work without making it look like another private sector choice. And then what would be the point?"[14]

Reason 2. Nichols and Bertko's "Conditions for Fair Competition" are necessary, but not sufficient. Nichols and Bertko say that the public plan should not be able to "leverage Medicare" and "force providers to participate." Medicare is sometimes characterized as a monopsonist, meaning it is the sole purchaser of medical services. That is not quite right. Hospitals, in particular, participate in Medicare because it would be impossible to stay in business if they did not. Their business model, which depends on attracting large volumes of sick patients and large numbers of skilled physicians to serve them in the facility, would fail if senior citizens could not be served in their facility for a broad range of conditions.

But the situation is even more dramatic than that. Could a hospital even survive if it were seen turning its back on serving the needy elderly? As Pauly puts it, Medicare's muscle is "much more consistent with political power than with economic monopsony power." A more specific condition would be needed, which might run along the following lines: No public plan should be allowed to enroll more than two-thirds of providers of each type (physicians, pharmacies, etc.) within its service area. Hence, no opprobrium would attend a provider who declined to participate.

Nichols and Bertko's conditions are also not sufficient because Congress could, and likely would, still impose onerous conditions on all public and private plans—conditions that only the public plan would be able to meet at reasonable cost.[15] Also, while the condition that the public plan and the

13. There are many areas of the economy in which "public" institutions compete with private institutions of the same type. But virtually without exception, the public institution is given major financial advantages. For example, parents who wish to use private rather than public schools are not allowed to use the government subsidy to defray the private tuition cost (with some exceptions for parents of children with disabilities). Public universities charge lower tuition than private universities because of the substantial direct government subsidies they receive from state governments. Public utilities often receive local monopoly powers as well as exemptions from paying property or corporate taxes. However, public and private hospitals usually compete on fairly level playing fields since most hospital payments are now uniform or close to uniform across institutions. In some respects, most private hospitals have advantages (for example, fewer indigent patients).

14. Ricardo Alonso-Zalvidar, "Democrats Seek Compromise on Health Care Plan," Associated Press, April 2, 2009, at *http://www.newsvine.com/_news/2009/04/02/2632867-democrats-seek-compromise-on-health-care-plan* (May 4, 2009).

market operator not be the same agency is vital, it may not be sufficiently specified. The Department of Health and Human Services (HHS) could probably not operate it, since CMS influence would likely lead to violations of those conditions. HHS uses an internal "clearance" system whereby a regulation cannot be issued by HHS agency A without rewriting it to obtain the concurrence of HHS agency B, or facing protracted delay and the prospect of sending a messy dispute to the Secretary—who may well side with agency B. So a new agency would be needed because no HHS agency could avoid strong pressures to accommodate Medicare policies.

Reason 3. Practically speaking, the Nichols–Bertko model cannot work. No government entity has ever run a real full-featured health insurance plan directly. The federal government has few employees with the skills needed to handle all the dimensions of such an endeavor.

A reminder: Original Medicare is not a true insurance plan.[16] It makes no guarantees as to maximum out-of-pocket expense. It manages no care. It does not identify and select providers for a network. It does not negotiate with providers. It collects premiums almost exclusively by deductions from Social Security payments—not from tens of millions of individuals or millions of employers. It simply sets national provider prices and pays 99.9 percent of all claims rapidly and without serious scrutiny to almost any licensed provider in America. Nor is the Federal Employees Health Benefits Plan (FEHBP) an insurance plan—it is an employee compensation program that contracts with private health plans to compete for enrollees through a voucher-like premium subsidy.[17]

The proposed government-run plan would likely fail rapidly as it attempted to be as nimble as private plans in providing the kinds of coverage and services desired by potential enrollees in a dynamic competitive market.

Nichols and Bertko strongly insist that there is substantial real-world experience in both state and federal government in running public health plans.[18] But all such experience is similarly limited. Those states that offer health plans for their employees, nonetheless, still operate the plan through a private insurance firm such as Blue Cross, similar to many Fortune 500 companies' arrangements under the Employee Retirement Income Security Act (ERISA). Few would call this a "public" plan. Self-insuring for the potential cost of covering expensive claims and establishing benefit parameters such as deductible and coinsurance is not the same as operating a full-service insurance plan and performing all the functions of such a plan—directly negotiating with providers, establishing operating medical review systems,[19] collecting premiums, and so on.

More fundamentally, states sponsoring such plans typically offer only one PPO plan and a handful of health maintenance organization (HMO) options. This is hardly robust market competition, and the state-sponsored plans would be unlikely to survive in a truly competitive market. For example, most states that operate a public plan that competes with private plans for employee enrollment have premium-sharing arrangements that benefit the

15. For example, the government now requires that private fee-for-service plans in the Medicare Advantage program monitor provider quality when, by definition, these plans have little or no ability to do so given the inherent characteristics of their model.
16. True insurance indemnifies against the cost of rare events, such as death, an automobile accident, a flood, or a fire, and does not pay routine bills.
17. Walton Francis and the editors of Washington Consumers' CHECKBOOK magazine, *CHECKBOOK's 2009 Guide to Health Plans for Federal Employees* (Washington, D.C.: Center for the Study of Services, 2008), at *http://www.guidetohealthplans.org* (May 4, 2009).
18. Len M. Nichols, testimony before the Committee on Health, Education, Labor, and Pensions, U.S. Senate, March 24, 2009, at *http://help.senate.gov/Hearings/2009_03_24/Nichols.pdf* (May 4, 2009).
19. Private insurance plans typically have hundreds of physician and nurse employees whose jobs include arranging or providing case management and monitoring provider quality. These expert staff resources are one of the larger categories of so-called administrative costs. Neither Medicare nor any state "human resources" program hires consequential numbers of such professionals to perform these and related functions for state employees enrolled in the self-insured plan.

high-cost PPO plan, to the disadvantage of HMOs. Any arrangement that pays, say, 90 percent of the costs of every plan creates an immense competitive disadvantage to frugal and efficient health plans. (So, the Nichols–Bertko list of key conditions might also have to include an FEHBP-like or Medicare Prescription Drug Plan-like premium support design, where enrollees get much or most of the savings from frugal plan choice).[20]

Finally, there is yet another problem. Medicare is not the only major health insurance program facing draconian cost increases. States that sponsor health plans for their employees and retirees have experienced and will experience similar cost pressures. Until recently, states could fund their health insurance costs on a pay-as-you-go basis. However, new rules by the Government Accounting Standards Board require accrual accounting.[21] Estimates of unfunded liabilities of both state and local governments for health care and other non-pension benefits of their retirees exceed one trillion dollars. While "self-funding" is not directly either a cause or a result of these liabilities, this massive fiscal time bomb suggests that state stewardship of their health plans has not been fiscally or budgetarily prudent.[22]

Reason 4. A full public plan would not be able to compete effectively with private health plans unless the public plan included additional authorities. It would have to allow salaries and bonuses to be paid without reference to government pay scales. It would have to allow firing of employees at will, and otherwise be exempt from government personnel policies. It would have to be exempt from crippling government procurement statutes (as are Medicare Advantage plans). It would have to be able to bypass the cumbersome Administrative Procedure Act process for issuing regulations. These conditions would be needed in order for the plan to even begin operation. There is a model, the government-sponsored enterprise (GSE), which comes close to meeting these conditions. But the GSE's former shining examples, Freddie Mac and Fannie Mae, suggest its many weaknesses.

Reason 5. The Nichols–Bertko model still will not work because Congress will not let the public plan fail. In real market competition, unsuccessful firms fail and go out of business. Based on a rich history of experience with government-sponsored enterprises and programs, Congress can be depended upon to break Nichols and Bertko's conditions for a level playing field expediently and as often as needed to preserve the public plan. For example, if the original premium-sharing formula did not position the government health plan at an advantage, it would be easy for Congress to tinker with premium-sharing in ways that achieved that result. It is difficult to imagine creating a public enterprise like this and allowing it to fail. Taxpayers will be summoned for bail-out duty.

The Major Problems of a Public Plan

Price Controls. Many of the advocates of a public health plan want a true single-payer system. Their tolerance of some features of a competitive system is largely a symbolic gesture. Other public-plan supporters want government compulsion and price controls with an end result that is essentially the end of private insurance.[23] The Lewin Group forthrightly predicts that using Medicare's price controls and mandatory provider participation (what Lewin more delicately calls "exceptional leverage"), would enroll 119 million people, most of

20. Many states also operate "high risk pools" for persons who are uninsurable due to previously existing and expensive conditions. All states operate Medicaid programs. High-risk pools are small programs that provide heavy subsidies to enrollees who have no other option, and total national enrollment is only about 200,000 people. Medicaid is discussed later in this analysis.
21. Greg D'Angelo, "State and Local Governments Must Address Unfunded Health Care Liabilities," Heritage Foundation *WebMemo* No. 1808, February 11, 2008, at *http://www.heritage.org/Research/HealthCare/wm1808.cfm*.
22. Not one of the advocates of a public plan discusses the need—and the putative requirement under GASB standards—for the public plan to establish reserves on an accrual basis if it is to compete evenly with private plans. Medicare has trust funds, but does not use accrual accounting for future obligations, and has an actuarial deficit in the tens of trillions of dollars. Presumably, the advocates would exempt the public plan from GASB standards.
23. See "The End of Private Health Insurance," *The Wall Street Journal*, April 13, 2009.

who were previously enrolled in private plans.[24] In reality, Lewin says, the so-called public-plan option is not about competition among plans, but about imposing Medicare as a *de facto* "single-payer" plan with the centralization of health care decisions in the hands of the Congress that is a feature of any single-payer scheme.[25]

Professor Hacker is proposing something that will achieve the same objective. His proposal refers throughout to "bargaining" over rates between Medicare and providers such as doctors, hospitals, and pharmacies. This is simply an erroneous description of reality. There is no bargaining in Medicare. Two parties do not sit across the table from each other and reach an agreement on mutually advantageous terms. In fact, the government sets Medicare payment rates by statute. There is some tinkering around the margin by the bureaucrats, but their freedom to maneuver is tightly circumscribed. The providers have no freedom at all. The rates provided are "take it or leave it" rates. Few providers can refuse to participate because they would be forced out of their profession and into bankruptcy.

While Professor Hacker uses sugar-coated language to describe his proposal, he makes it perfectly clear in a rebuttal to Nichols and Bertko that he is indeed proposing a system of compulsory provider participation with price controls.[26]

Most puzzling about this debate are two key problems with the model advocated by Hacker, Davis, Holahan, and Blumberg, and modeled by Lewin. First, there is ample evidence from the annual ritual whereby Congress suspends the imposition of sustainable growth rates (SGR) on physicians that the American political system is unlikely to impose draconian or even tight wage and price controls on health care providers through a public health care plan. If Lewin is correct that hospitals can today recover from low Medicare rates by charging prices above costs to private payers, this source of revenue will largely disappear under its modeled outcome with predictable political results as the community hospitals in each congressional district intensify political pressures on Members of Congress. Hence, the Lewin model must be wrong in its predicted savings, which depend on the assumption that Medicare payment rates will remain at current levels or go even lower as other health plans willing to pay higher provider prices are driven out of business.

Second, as documented extensively in studies by the Dartmouth Institute for Health Policy and Clinical Practice, the basic problem of cost control is one of controlling overuse.[27] Price controls create large incentives to increase rather than decrease use of unnecessary health care. In fact, the SGR formula, which supposedly reduces prices if use increases, directly creates a large incentive for individual physicians to make up in volume what they cannot achieve in price increases. Why, then, the insistence on expanding Medicare wage and price controls to even more medical procedures when the problem lies elsewhere and may even be aggravated?

Outdated Provider Participation Scheme. There is another problem implicit in both the Davis and Hacker models. Both emphasize their desire to have Medicare operate as a fee-for-service program that, unlike private plans, does not limit participation to preferred providers who meet plan standards for cost control or quality of care. This is to deny the public plan the most potent tool for potential utilization and cost control of the arsenal available to insurance plans today.

24. John Sheils and Randy Haught, "The Cost and Coverage Impacts of a Public Plan: Alternative Design Options," The Lewin Group *Staff Working Paper* No. 4, April 6, 2009, at *http://www.lewin.com/content/publications/LewinCostandCoverageImpactsofPublicPlan-Alternative%20DesignOptions.pdf* (May 4, 2009).
25. For an analysis of likely consequences, see Robert A. Book, "Single Payer: Why Government-Run Health Care Will Harm Both Patients and Doctors," Heritage Foundation *WebMemo* No. 2381, April 3, 2009, at *http://www.heritage.org/Research/HealthCare/wm2381.cfm*.
26. Hacker, "Healthy Competition," pp. 20–21.
27. Elliott S. Fisher, Julie P. Bynum, and Jonathan S. Skinner, "Slowing the Growth of Health Care Costs—Lessons from Regional Variation," *New England Journal of Medicine*, Vol. 360, No. 9 (February 26, 2009), pp. 849–852, at *http://content.nejm.org/cgi/content/full/360/9/849* (May 4, 2009).

The problem facing Original Medicare, which will only be compounded under any version of "Medicare Extra," whether as proposed directly by the Commonwealth Fund or implicitly by others, is that to deny a physician (or other provider) participation in the dominant public plan is to destroy his livelihood. This requires, in turn, due-process standards to protect providers from potentially arbitrary as well as catastrophic government decisions.

Private plans do not face this problem to anywhere near the same degree because there are so many plans. A physician who loses his preferred participation status under Blue Cross can still be preferred with Aetna, or vice versa, and as well serve patients who are willing to pay more out of network. [28] Hence, the kind of new public plan advocated under these proposals would virtually be forced to allow any provider who has not committed some egregious fault to participate.

Administrative Cost and Fraud. An exceptionally good analysis by Kerry Weems and Benjamin Sasse, former officials at the Department of Health and Human Services, highlights the essential flaws in one of the main arguments used by proponents of a public plan: "As the case of Medicare's anemic anti-fraud efforts painfully illustrates, less management and lower administrative costs do not necessarily mean the program is really less costly."[29]

Davis, Hacker, and Holahan and Blumberg all argue that a public plan would cost less than private plans because its administrative costs are lower. This is a terribly misleading assertion and entirely an artifact of false comparisons that do not include all public and private costs. For example, assuming that fraud levels in Original Medicare are 10 percent of payments after spending 5 percent on administration, and in private plans fraud levels are reduced to 5 percent of payments after spending an extra 1 percent on administrative costs for effective fraud prevention (some think the differential is far greater), Original Medicare's failure to have effective fraud controls raises the denominator while lowering the numerator. On these numbers, for $100 of delivered care, Medicare seemingly spends $5 but actually spends $15 ($5 in administrative costs and $10 in fraud), while the private plan spends $11 ($5 plus $1 plus $5 lost to fraud) for the same $100 of delivered care. What is worse, the higher the actual fraud level, the "better" the Medicare administrative cost appears as a percentage of total spending. So the purported administrative savings are entirely illusory when both numerator and denominator are appropriately adjusted.

There are many other missing or misrepresented costs in direct Medicare–private plan comparisons. For example, average enrollee medical costs in Medicare are roughly double those in the private sector simply because of enrollee age, so Medicare achieves per-enrollee economies of scale unavailable to any plan (including Medicare Extra) covering a less elderly population. Unlike private plans, Original Medicare does not cover most prescription drugs, small claims where administrative costs are much higher as a fraction of benefits. Government accounting does not assign the costs of capital to federal programs, or even estimate the economic welfare burden costs of using taxes to finance public programs.[30] Most important, the administrative costs that Medicare imposes on providers are not accounted for in government budgets. If a Medicare claim costs the government $2 to process, and the provider $3 to prepare, the administrative cost of a $100 claim is counted as $2, not $5, in the federal

28. Original Medicare does not allow an out-of-network option as is common in private plans whereby the plan pays a lower share of charges from non-network providers. Physicians must agree to participate in the program fully (with a minor variation depending on whether they process the paperwork for the patient, and the flexibility to accept some, but not all, Medicare-covered seekers of services), or not at all. If a patient uses a physician who has completely severed relationships with Medicare, Medicare pays none of the cost.
29. Kerry N. Weems and Benjamin E. Sasse, "Is Government Health Insurance Cheap?" *The Wall Street Journal*, April 14, 2009, at *http://online.wsj.com/article/SB123966918025015509.html* (May 4, 2009).
30. Merrill Matthews, "Medicare's Hidden Administrative Costs: A Comparison of Medicare and the Private Sector," The Council for Affordable Health Insurance, January 10, 2006, at *http://www.cahi.org/cahi_contents/resources/pdf/CAHI_Medicare_Admin_Final_Publication.pdf* (May 4, 2009).

budget. Again, the purported lower cost of Medicare administration is overstated.

Some of these factors have been adjusted in comparative studies. But no existing study accounts for all these differences, or for some of the largest ones, such as fraud control.

Excess Use. Then there is the matter of managing patient care to improve outcomes and reduce costs. Medicare spends zero on this function.[31] Private plans spend around 5 percent in administrative costs to manage care (second surgical opinions, precertification for hospital stays, and the review of preferred provider outcomes, etc.) and often save around 10 percent in reduced use of health care services. Medicare's administrative costs look better arithmetically because the denominator is higher and the numerator is lower, but the advantage is again entirely illusory—$100 in frugal care costs the private plan $16 (the previous $11 plus $5), while Medicare is spending $120 and wasting $20—$10 on fraud and $10 on overuse in addition to the $5 it spends on bill paying. Again, the worse the actual performance, the better Medicare's administrative costs appear as a percentage of total spending.

The real-world numbers are likely even better than these illustrative calculations—researchers at Dartmouth estimate that waste (including fraud, even though they do not use that term) consumes about one-third of Original Medicare's costs. That is, to deliver $100 of frugal care, Medicare spends $150, $50 of which is for unnecessary use. As to fraud, Original Medicare will never be able to match the performance of private plans. Those plans use provider networks and drop providers who bill too much. They do not know, and do not need to know, whether a given provider is fraudulent or merely wasteful (they do, of course, also use far more sophisticated techniques that are included in their administrative cost figures). Medicare, however, cannot drop a provider without costing that person or organization its livelihood, and Medicare is encumbered by government due-process requirements as well. In one recent case, HHS administrative law judges reinstated hundreds of fraud artists from Southern Florida who had appealed the cancellation of their Medicare billing privileges.[32]

Champions of the public plan often overlook these facts about Medicare. Those proponents also overlook the crucial point that no governmental entity in the United States actually administers a true health insurance plan, meaning a plan that employs the arsenal of tools routinely available to private health plans. If such a plan did exist, there is no reason to believe, based on experience, that it would be able to exceed the performance of private plans in either fraud control or case management.

Not one success story exists for direct government-run health plans operating in an environment where they are required to attract enrollees who have other choices. (The "free" care provided by the military to uniformed personnel and by the VA to veterans is essentially "take it or leave it" care with no realistic alternative at the same level of cost). This is not to say that private plans have a strong success record in controlling costs—but they do have the potential tools and nimbleness to achieve reforms that are simply beyond the powers of a bill-paying machine like Medicare.

Government as Umpire. Of course, there are success stories among competitive systems in which government does not operate a plan, but operates a system in which private plans compete. The FEHBP has long outperformed Medicare in every way—control of costs, improving benefits, and enrollee satisfaction.[33] It is not uncommon for advocates of a new public plan to cite data for some time period purporting to show that Medicare controls costs better than the FEHBP.[34] But these comparisons are flawed unless they control for benefit *improvements* over time. Adjusting for benefit improvement for

31. Medicare does have a quality feature termed "Pay for Performance." Under this approach, hospitals and doctors are paid a few percent more or less depending on how they score on important quality-of-care indicators. But the differential payments are based strictly on formulas, and modify only the statutorily set payment rates. There is no real "management" of care at all by Original Medicare.
32. Department of Health and Human Services, Office of the Inspector General, "South Florida Medical Equipment Suppliers: Results of Appeals," October 2008, OEI-03-07-00540, at *http://oig.hhs.gov/oei/reports/oei-03-07-00540.pdf* (May 4, 2009).

the one-third of a century from 1975 through 2008, the average annual adjusted increase in Medicare costs per enrollee was 7.9 percent, compared to 7.0 percent for the FEHBP.[35]

Both Medicare Advantage and Medicare prescription drug plans have proven successful in the last several years on a variety of metrics. Although Medicare Advantage plans have had unnecessarily high premium support levels (most recently estimated by MedPAC at about 14 percent higher than Original Medicare, but about to be reduced substantially by HHS or Congress or both), they have succeeded amazingly well at reducing costs to enrollees and improving benefits. Their average benefit design is as good, or better, than that proposed by Dr. Davis of the Commonwealth Fund for "Medicare Extra." In particular, the vast majority of PPO and fee-for-service plans have an explicit limit on out-of-pocket costs that is less than $5,000 (HMOs, of course, usually have a *de facto* limit). On average, Medicare Advantage plans save most enrollees about $2,000 a year that those enrollees would otherwise have spent on Medigap premiums to fill the wide-open holes in Original Medicare's benefits. And because those enrollees do not have zero percent coinsurance by virtue of Medigap wraparound, Original Medicare saves substantially in reduced overuse, probably about as much as, and perhaps more than, the 14 percent premium subsidy differential.[36]

These programs achieve their impressive success without the bother and encumbrance of having an "800-pound gorilla" public plan among the competitive offerings. In fact, were it not for the incredible "stickiness" of health plan enrollment choices, particularly among the elderly, it is likely that Original Medicare would not have retained anywhere near its current 78 percent market share.

The Medicaid Comparison. There are government-run health plans that lack Medicare's overwhelming political and market power. They do not perform all the functions of private plans, but perform more of them than does Medicare and more of them than do most states' employee benefit plans. Medicaid plans pay allegedly competitive rates to providers, many of whom can and do elect not to accept those rates and do not participate in the program (only about one-half of physicians participate).[37]

Medicaid administrative costs run on the order of 10 percent or more of total costs (there is vast state-to-state variation). Fraud is rampant. Overall costs grow at even faster rates than that of Medicare. Rent-seeking is endemic. Many, if not most, providers whom the states manage to entice into participating are bimodal: dedicated and able ones performing a public service at considerable financial sacrifice on the one hand, and the least competent bottom of the barrel on the other hand. Medicaid is so unattractive to potential enrollees that some estimates place the number of uninsured who are Medicaid eligible but decline to enroll at as high as 10 million.[38]

33. Harry P. Cain, II, "Moving Medicare to the FEHBP Model, or How to Make an Elephant Fly," *Health Affairs*, Vol. 18, No. 4 (July/August 1999), pp. 25–39, at *http://content.healthaffairs.org/cgi/reprint/18/4/25?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=&author1=cain&fulltext=fehbp&andorexactfulltext=and&searchid=1&FIRSTINDEX=0&resourcetype=HWCIT* (May 4, 2009). Some recent studies suggest that Medicare enrollees are more satisfied with their plans than private enrollees, but these studies do not control for differential benefits (Medicare plus Medigap is far richer) or for the well-known propensity of older enrollees to score plans far higher than younger enrollees in the same plan.
34. One often-cited study addressed all private plans, not the FEHBP, and controlled only for drugs, not other benefit differences. Cristina Boccuti and Marilyn Moon, "Comparing Medicare and Private Insurers: Growth Rates in Spending over Three Decades," *Health Affairs*, Vol. 22, No. 2 (March/April 2003), pp. 230–237, at *http://content.healthaffairs.org/cgi/reprint/22/2/230?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=&author1=boccuti&fulltext=medicare&andorexactfulltext=and&searchid=1&FIRSTINDEX=0&resourcetype=HWCIT* (May 4, 2009).
35. Walton Francis, *Putting Medicare Consumers in Charge: Lessons from the FEHBP*, forthcoming from AEI Press.
36. Andrew J. Rettenmaier and Thomas R. Saving, *The Diagnosis and Treatment of Medicare* (Washington, D.C.: AEI Press, 2007).
37. However, pharmacies find it almost impossible to decline to participate in Medicaid, no matter how low its payment rates or how cumbersome its bureaucratic procedures. The community pressures and potential adverse publicity they face are simply too strong.

To be sure, Medicaid serves many of the poorest and least healthy Americans (not to mention elderly residents of nursing homes). No other program comes close to this focus. But most other public programs and private insurers also serve many poor and ill persons, if not as high a proportion. And the uninsured, on average, are far less disadvantaged than Medicaid enrollees.

Any Member of Congress or other advocate who argues for a public plan should be asked to provide a detailed comparison to the closest non-compulsory model we have in America today, government-run Medicaid, with respect to quality and costs. Based on that comparison, they should then be politely asked why any sensible person should even consider inflicting such an option on the uninsured when private plans are already proven to be ready and able to expand coverage by millions of people virtually overnight, as evidenced by successful launches of the Medicare Advantage and prescription drug plans in Medicare Part D.

The Stealth Reversal of the Medicare Modernization Act (MMA). In 2003, Congress enacted far-reaching reforms in Medicare. Two were of great importance: the creation of a new Medicare Prescription Drug Program, and the reform and expansion of what is now called Medicare Advantage. Both these reforms overcame decades of inertia, and both are arguably wildly successful. The Part D program, for instance, has achieved something almost unheard of in government—it was created on schedule and below estimated cost. Indeed, Part D has kept its costs almost one-third below the original careful and prudent cost estimates of the CMS actuaries and the skilled staff at the Congressional Budget Office through private-plan innovations, such as encouraging a massive shift to lower-cost generic medicines.

Why, then, should these MMA programs be obliterated in the name of health care reform in a 180-degree reversal of the policy decisions made a half-dozen years ago? If Medicare Extra and Medicare Plus are to be provided to seniors at a taxpayer cost certain to measure in the tens of billions of dollars annually, who will pay and who will benefit? Will Medigap policies be banned, or will they continue to provide wrap-around coverage at vast expense through inducing wasteful overuse of health care? If Medigap policies continue to cover more than 90 percent of enrollees in Original Medicare, will the principal effect of Medicare Extra or Medicare Plus simply be to reduce seniors' Medigap premium costs without consequentially affecting their actual coverage? Why is this new spending on Medicare beneficiaries a top priority when tens of millions of Americans have no health insurance at all?

Conclusion

Members of Congress and other advocates who argue for a coercive public plan along the lines proposed by Hacker, Davis, Holahan, and Blumberg should be asked to explain why they favor compulsory participation by health care providers, accompanied by stringent wage and price controls. They should also be asked to explain why they use free-market language like "competition," "bargaining," and "level playing field" to—falsely—describe such a system. They should be asked why they favor government coercion for most Americans' health insurance.

They should also be asked why Original Medicare should to be expanded to cover most of the American population in order for it to improve quality or better control costs through improved methods of payment and administration. Is Medicare, the largest health plan in America, and the plan that covers over three-fourths of all seniors, not large enough as is to achieve all those desirable reforms and innovations mentioned by Hacker and Davis? What potential reforms could be so difficult to achieve in a $400 billion program as to require doubling, tripling, or quadrupling the number of people it covers?

Relatedly, they should be asked what reason exists to believe that Medicare can be expected to achieve innovations and reform that have somehow eluded it for the first forty years of its existence?

38. See, for example, an estimate of about 11 million eligible for Medicaid and SCHIP, but not participating, in Lisa Dubay, John Holahan, and Allison Cook, "The Uninsured and the Affordability of Health Insurance Coverage," *Health Affairs* Web Exclusive, November 30, 2006, at *http://content.healthaffairs.org/cgi/content/abstract/hlthaff.26.1.w22* (May 4, 2009).

What has changed that will ensure that Medicare will achieve brand new innovations in bundled payments, in case management, in disease management, in coverage decisions made on cost-effectiveness grounds, and in other areas of reform in vogue today? Considering that "Medicare" is not an independent entity, but one micro-managed by the Congress, what reason exists to believe that the Congress can newly empower itself to ignore constituent pressures, lobbying, lowest-common-denominator decisions, and above all the cardinal principal of politics in America: inflict no pain on the *status quo*? Put most succinctly, why would not the most likely outcome be that "the real price of a public health plan [is] less innovation and lower quality" than we can expect from private plans?[39]

Advocates of a public plan usually argue that Original Medicare's administrative costs are lower than those of private plans, and a major source of savings that could finance health reform. But this argument ignores the problem that one of the main reasons Medicare's administrative costs are low as a percentage of its overall spending is that it fails to control both wasteful spending—as much as one-third of all Medicare spending—and fraud. The worse Medicare performs, the better its ratio of administrative costs appears; and the less it spends on administration, the worse it performs. Some of Medicare's inability to control waste is inherent in its structure, and some is due to congressional decisions to reduce administrative spending below the prudent levels recommended by each Administration. Why is this failure labeled a success, and why is this a management and oversight model to expand?

The real reason why a number of health policy analysts and politicians favor a public plan is because they see it as a way to crowd out private health care options, paving the way to a single-payer system. Members of Congress who support this agenda should be asked directly why they favor a "single-payer" system and why they are unwilling to say so forthrightly. Karen Ignagni, president and CEO of the America's Health Insurance Plans, the trade association for private plans, argues that if the public plan will crowd out private insurers, "let's have a debate on a government-run system."[40]

It is about time that these questions be asked—and answered—so that the real debate over health reform can begin.

—Walton J. Francis is a self-employed economist and policy analyst, expert in analysis and evaluation of public programs. He pioneered the systematic comparison of health insurance plans from a consumer perspective as primary author of CHECKBOOK's Guide to Health Plans for Federal Employees. *This annual online publication rates plans in the Federal Employees Health Benefits Program, which is often cited as a model for health reform. He has testified before Congress on Medicare reform and FEHBP reform, and has worked as a consultant to the Centers for Medicare and Medicaid Services. The views expressed in this article are his own.*

39. See Dennis G. Smith, "The Real Price of a Public Health Plan: Less Innovation and Lower Quality," Heritage Foundation *Backgrounder* No. 2263, April 24, 2009, at *http://www.heritage.org/Research/HealthCare/bg2263.cfm*.

40. Quoted in Reed Abelson, "A Health Plan for All and the Concerns It Raises," *The New York Times*, March 25, 2009.