Backgrounder

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# A Federal Health Insurance Exchange Combined with a Public Plan: The House and Senate Bills

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Members of Congress, pursuing President Barack Obama's health policy agenda, want to create a national health insurance exchange as a platform for a public health care plan to compete against private health insurance.

Variants of the exchange proposal are embodied in the America's Affordable Health Choices Act of 2009 (H.R. 3200), promoted by the leadership of the U.S. House of Representatives,[1] and the Affordable Health Choices Act, sponsored by Senators Edward Kennedy (D–MA) and Chris Dodd (D–CT).[2] Both of these huge bills are backed by the President and the Democratic congressional leadership.

While a national health insurance exchange is sometimes described as a nationwide pool of health insurance providers that would facilitate access to coverage for individuals and employers, its major function would be to provide a platform for a government-run public health plan that, using Medicare-style administrative pricing, would "compete" against private health insurance. Congressional champions of the idea say that this would increase the range of choice and competition available to Americans. In fact, it would do exactly the opposite.

In reality, the result would be a massive erosion of private health insurance. According to a recent analysis by the Lewin Group, the nation's most prominent health policy econometrics firm, assuming full implementation of the House bill, 103.9 million Americans would be covered under the public plan, and 83.4 million people would no longer be covered

## Talking Points

- Federally designed health insurance exchanges would exercise regulatory, not merely administrative, functions and serve as the platform for a new public health care plan to compete against private health insurance.
- In the Senate bill, the exchange would be based in the states. In the House bill, there would be fewer private plan options and 48.4 percent fewer Americans with private coverage.
- The public plan's below-market, Medicare-based payment rates would give the government special advantages against private health plans, and persons who remained in private plans would pay an additional $460 annually.
- With decision-making power over health plan benefits, standards, and conditions of participation concentrated in a national health insurance exchange, Washington lobbyists and their multimillion-dollar campaigns would play an even greater role in health care.
- A federally designed health insurance exchange would consolidate federal control of the financing and delivery of medical services.

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by private health insurance.[3] Moreover, a federally designed health insurance exchange would consolidate federal control over the financing and delivery of Americans' medical services.

Initially, Americans may respond positively to the idea of a national health insurance exchange, but they are almost certainly unclear about its functions, how it would affect them, or which health policy problems it would solve. The maddeningly elastic language used in the health care debate can conceal as much as convey the true meaning of proposals embodied in the complex provisions of the mammoth House and Senate health care bills.

**A Better Alternative: A State Option.** A state-based health insurance exchange can indeed be a sound way to achieve a level playing field and a statewide market for a variety of different private health plans to compete directly for the business of employers and employees, individuals, and self-employed persons. That is why conservatives in Congress and elsewhere have promoted the exchange as a *voluntary* option for those states that could use such a mechanism as part of their reform of their often-dysfunctional health insurance markets.[4]

Though a health insurance exchange has been promoted as a policy initiative in many states, so far it has been translated into working models in two: Massachusetts and Utah.[5] Given the radical differences in these two states' insurance markets, regulatory climates, political cultures, and policy objectives, it is hardly surprising that the implementation and operation of a health insurance exchange is very different in these two states as well. It is further unsurprising that the concept has also been a source of seemingly limitless confusion as different proposals are advanced to achieve very different policy objectives.

The underlying policy objectives determine the functions of the health insurance exchange. In a truly competitive market based on real consumer choice and genuine competition, the suppliers of goods and services would operate on a level playing field and government would be confined to making and enforcing rules to protect consumers from fraud and misleading advertising, establishing minimum standards for health and safety, and enforcing contracts.

An exchange could facilitate that process. The government would not undermine competition by fielding its own enterprise with the special advantages of taxpayer subsidies, picking winners and losers, or imposing discriminatory tax or regulatory policies on different consumers or firms. The key to a level playing field is that the government would in no way favor one competitor over another or give any legal advantages to any player in the competition.

**Federal Control.** Based on the provisions of the House and Senate bills, as well as the proposals offered by President Obama, the structure and

1. For an overview of the House Bill, see Robert E. Moffit, "The House Health Care Bill: A Blueprint for Federal Control," Heritage Foundation *WebMemo* No. 2515, July 1, 2009, at *http://www.heritage.org/Research/HealthCare/wm2515.cfm*.
2. The act was reported out of the Senate Committee on Health, Education, Labor and Pensions on July 15, 2009. For a preliminary overview of the Senate bill, see Robert E. Moffit and Stuart M. Butler, "Why the Kennedy Health Bill Would Wreck Bipartisan Reform," Heritage Foundation *WebMemo* No. 2481, June 12, 2009, at *http://www.heritage.org/Research/HealthCare/wm2481.cfm*.
3. The Lewin Group, "Analysis of the July 15 draft of The American Affordable Health Choices Act of 2009," Memorandum from John Sheils and Randy Haught, The Lewin Group, to Stuart M. Butler, Vice President for Domestic and Economic Policy, The Heritage Foundation, revised July 23,2009, p. 5. Hereafter cited as Lewin Group House Draft Analysis.
4. For example, Senators Tom Coburn (R–OK) and Richard Burr (R–NC) and Representatives Paul Ryan (R–WI) and Devin Nunes (R–CA) are sponsoring the Patients' Choice Act of 2009 (S. 1099 and H.R. 2520). It creates an option for the states to pursue state-based health insurance exchanges, described by the sponsors as "a one-stop marketplace to compare different health insurance policies and select the one that meets their unique needs."
5. In Utah, the state health insurance exchange is an "Internet-based information portal" that connects individuals and families to comparative health plan information, enabling them to make the choice of a health plan and enroll electronically. It is designed to move the Utah market decisively in the direction of a consumer-driven system in which the financing would be based on an employer's voluntary defined contribution to the premium costs.


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dynamics of the national exchange would be very different from those proposed by reformers who design state health insurance exchanges as optional mechanisms for consumer choice and competition.

- Instead of a single market open to any willing private health plans, the leading House and Senate bills would allow participation only by plans that met highly prescriptive federal standards, foreclosing any other options for consumer choice and competition.
- Instead of establishing a level playing field among different insurers, the House and Senate proposals would foreclose the possibility of anything even barely resembling a genuinely level playing field for fair competition.
- Private health plans would assume all risks and remain subject to a variety of state and federal laws beyond the proposed House and Senate provisions for a level playing field.
- With the new public health plan, taxpayers would retain the risk, and the public plan would function apparently free of the legal requirements that burden private health plans.[6]

With Congress fielding its own plan in competition against private health plans, taxpayers would be forced in effect to underwrite the marketing costs of an entity designed to displace their own private coverage. Based on recent experiences with Fannie Mae and Freddie Mac, it is certain that Congress would force taxpayers to underwrite the cost overruns of such a health insurance enterprise no matter how unsuccessful its performance. Medicare alone, a prime example of congressional micromanagement, has an accumulated unfunded liability of $38 trillion.[7] In a national health insurance exchange, taxpayers could be certain that the deck would be stacked against private-sector players in a game that is rigged from the start.

## How Congress Would Create a Health Insurance Exchange

Among Administration and congressional champions of a national health insurance exchange, the structure or functions vary. Likewise, the intellectual rationale for the health insurance exchange is, based on the plain record, maddeningly elusive. If there is a specific health policy problem that a national health insurance exchange is designed to solve, it is not at all clear what exactly that problem is or why it simply cannot be solved by other, more direct and less intrusive means.

**The Obama Proposal.** President Obama proposed a national health insurance exchange as elemental to his health care reform agenda. There are precious few details in Obama's campaign documents on the national health insurance exchange itself or how it would function. He briefly described it as a "watchdog" agency.[8]

Thus, the national health insurance exchange would serve as a regulatory rather than purely administrative body. It would be a national rulemaker and enforce a common set of rating and insurance rules that would apply to private health plans within the national exchange, as well as to the public health plan itself. It would also serve as the

6. For example, a truly level playing field would not only subject the public plan to state health-benefit mandates, which the House bill does, but also apply to the public plan state and federal contract laws, state and federal taxes, tort laws that apply to insurance firms, state-level financial solvency requirements in states where the public plan would compete, accounting rules that measure current and future liabilities, state and federal taxes that are levied on private plans, antitrust laws, and state and federal privacy-protection laws. A level playing field would also require the public plan to abide by the laws and regulations that govern the marketing and sale of health insurance in the states where the public plan would compete.
7. On the gravity of Medicare's existing liabilities, see *2009 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, May 12, 2009, at *http://www.cms.hhs.gov/reports/trustfunds/downloads/tr2009.pdf* (July 24, 2009).
8. See "Barack Obama's Plan for a Healthy America: Lowering Costs and Ensuring Affordable, High Quality Coverage for All," at *http://www. barackobama.com/issues/healthcare*. See also Robert E. Moffit and Nina Owcharenko, "The Obama Health Plan: More Power to Washington," Heritage Foundation *Backgrounder* No. 2197, October 15, 2008, pp. 5–6, at *www.heritage.org/research/healthcare/bg2197.cfm*,

regulatory vehicle to enforce the decisions of his proposed "institute" to judge the comparative effectiveness of medical treatments and procedures.

A version of this idea of an "institute," the 15-member Federal Coordinating Council for Comparative Effectiveness Research, has already been enacted in the stimulus bill earlier this year. The new agency is charged with making determinations on the "comparative effectiveness" of different medical services, devices, drugs, and procedures. In short, in Obama's version, the national exchange would be not only an independent regulatory agency in itself, but also the central channel for the regulatory decisions of other federal agencies, governing both public and private insurance options.

Outside of this centralized system of muscular control, the rationale for the national exchange, at least as championed by independent health policy analysts, is somewhat elusive.

*First,* in sharp contrast to the champions of a statewide health insurance exchange—for whom the remedy of federal tax inequities is the primary rationale for its establishment—the President does not even *mention* the unfairness of existing federal tax policy, even though it undercuts millions of Americans' access to affordable health insurance.[9] If President Obama wanted to rectify this problem and advance progressive tax relief, as recommended by Jason Furman, one of his top economic advisers,[10] he could simply have proposed a consequential change in the federal treatment of health insurance and eliminated the unfairness and inefficiency of the current tax system. In other words, there would be no reason to create a national health insurance exchange to secure the objectives of a rational tax policy.

*Second,* the President is not pursuing a national exchange as a way to create a robust and competitive national market for health insurance. Health insurance is an odd exception to the general rule. There is a robust and competitive market for virtually every other set of goods and services in the economy, including complex items, and none of these requires the congressional creation of anything like a national exchange, administered by a commissioner, to facilitate their availability to consumers. If the President wanted to create a national market for health insurance, he could simply propose the repeal of outdated provisions of federal law that erect barriers to the purchase of health coverage across state lines. The President is obviously not interested in creating anything like a normal national, competitive market for health insurance.

*Third,* and most important, the national health insurance exchange would become the mechanism for the new government health plan to compete against private health insurance plans. This would seem to be its main function. The national health insurance exchange would be the "level playing field," or the arena for such a competition, and would thus serve as the key mechanism to secure the crowd-out of private health insurance coverage and pave the way for a single-payer system. As Martin Feldstein, professor of economics at Harvard University, has recently observed:

> The Obama plan to have a government insurance provider that can undercut the premiums charged by private insurers would undoubtedly speed the arrival of such a single payer plan. It is hard to think of any other reason for the administration to want a government insurer when there is already a very competitive private insurance market that could be made more so by removing government restrictions on interstate competition.[11]

9. Given the President's insistence on fairness and efficiency in the provision of health care, his omission of a serious reform of the federal tax policy that governs health insurance, the single most important ingredient in comprehensive health care reform, is conspicuous and inexplicable. Giving every taxpayer tax relief for the purchase of health insurance would spur real competition among private plans, different types of health care options, and greater personal ownership and portability of health insurance.
10. See, for example, Jason Furman, "Health Reform Through Tax Reform: A Primer," *Health Affairs*, Vol. 27, No 3 (May/June 2008), pp. 622–632.
11. Martin Feldstein, "Obama's Plan Isn't the Answer," *The Washington Post*, July 28, 2009, p. A17.

Again, based on the best independent evaluations of such an arrangement, millions of Americans throughout the United States would end up losing their private coverage, particularly if employers dumped workers and their families into the new public plan.

**The House Tri-Committee Bill.** Under Section 201 of Title II of the America's Affordable Health Choices Act of 2009, Congress would create a national health insurance exchange.[12] This exchange would be administered by a powerful Health Choices Commissioner who would head a new federal agency called the Health Choices Administration. The commissioner would be appointed by the President and confirmed by the Senate. Among the commissioner's chief duties would be to establish a process for the enrollment of eligible individuals and employers, to negotiate contracts with congressionally defined "qualified health plans," and to enforce statutory requirements relating to federally defined health benefits.

Under Section 208, the commissioner could approve health insurance exchanges created by a state or group of states that perform "all of the duties" of the national health insurance exchange and could terminate state exchanges that do not meet these federal standards.

Under Section 203, the commissioner would specify each year the health benefits and benefit levels (four levels are statutorily required based on cost-sharing) for health plans that participate in the national exchange,[13] consistent, of course, with congressionally determined benefit requirements. The commissioner would also establish a process for a phased-in enrollment of eligible individuals[14] and small businesses, and would have the authority to expand eligibility for enrollment in the exchange as the commissioner "deems appropriate." Assuming full implementation, the Lewin Group estimates that the number of Americans with private coverage would fall from 172.5 million to 83.4 million, a 48.4 percent reduction in private coverage.[15]

Under Section 204, the commissioner has contracting authority to solicit bids and enter into negotiation with federally "qualified" health plans on an annual basis, with an option for automatic renewal. Congress further specifies that these plans must be licensed in the states in which they operate and must comply with the commissioner's requirements to provide requested data or other information, as well as the commissioner's standards and procedures for "grievances and complaints" and "network adequacy." The commissioner would also see to it that approved health plans implement the subsidies and credits for persons needing assistance, participate in "risk pooling" arrangements, provide for "culturally and linguistically appropriate services and communications," and make contracts with "essential community providers."[16]

Under Section 205, the commissioner is to establish outreach and enrollment processes for

12. The congressional leadership has released two versions of the Tri-Committee bill. The version referred to here is the America's Affordable Health Choices Act of 2009 (H.R. 3200), as prepared by the Committees on Energy and Commerce, Ways and Means, and Education and Labor of the U.S. House of Representatives on July 14, 2009.
13. The four levels are basic, enhanced, premium, and premium plus. Under Section 203 of Title II, Congress prescribes the cost-sharing variations among these levels of coverage.
14. The House bill specifies the individuals who are not eligible for enrollment in the exchange: enrollees in Medicare, military health programs, the Veterans Administration, and, generally, Medicaid. Under Section 202, there is a major exception for certain Medicaid enrollees: childless adults with incomes under 133 percent of the Federal Poverty Level ($14,400) who had other coverage in the previous six months. These persons would be able to enroll in either the Medicaid program or the national health insurance exchange.
15. Lewin Group House Draft Analysis, p. 5.
16. This is a significant requirement because it relates directly to the mandatory provision of abortion. It is worth noting that during the Senate Health, Education, Labor and Pensions consideration of the Senate version of the health reform bill, Barbara Mikulski (D–MD) secured passage of an amendment requiring health plans to include "essential community providers" within their networks for women's' medical services. This would include clinics run by Planned Parenthood, a major abortion provider.

"exchange-eligible" individuals and for "vulnerable" populations, including adults and children with disabilities and cognitive impairments. Under Section 207, Congress would create a Health Insurance Exchange Trust Fund for the deposit of funds to finance the operations of the Health Choices Administration.

**The House Public Plan.** Under Section 221 of Title I, the Congress would require the Secretary of Health and Human Services to create a "public health insurance option" to be offered within the national exchange in 2013. The public plan would be required to offer the same benefits required by law for private health plans and obey the same insurance rules and other statutorily defined network and consumer protection requirements.

Under Section 222, the Secretary would set the premium to cover all benefit costs and projected administrative costs of the plan, as well as a "contingency margin." The bill would authorize an initial $2 billion for start-up costs and initial reserve requirements. Congressional sponsors insist that the public plan must be self-sustaining, based on its premium income.

Under Section 223 of Title I, the Secretary would set payment rates for doctors and hospitals and other medical professionals based on the Medicare payment rates, plus 5 percent for those health care professionals who also participate in the Medicare program. The bill would also abolish the Medicare update for physicians' services based on the Sustainable Growth Rate formula, a special formula for updating physicians' payment based on growth in the general economy.

By 2016, the Secretary would have greater flexibility in setting rates and would "modernize" payment for the public plan consistent with reforms in the delivery system to achieve higher quality care. For doctors and other medical professionals, Congress outlines the conditions for participation and would apply Medicare's existing anti-fraud and abuse rules to the public plan.

Because the payments in the House version of the public plan are based on Medicare payment rates, the Lewin Group estimates that the premiums for the public plan would be approximately 25 percent less than those obtainable in the private sector.[17] Payment below private market rates would ensure cost-shifting from the public plan to individuals enrolled in private health plans, which the Lewin Group estimates at $460 per person under the terms of the House bill.[18] Not surprisingly, moderate and conservative Democrats complain that the House bill tilts the playing field against private providers.[19]

Under Section 225, doctors who accept the payment in the public plan as payment in full would be "preferred physicians"; "non-preferred physicians" are those who agree to the balance-billing limitations that prevail in Medicare. For all physicians, the HHS Secretary would be authorized to make more detailed requirements, presumably through regulation, for "conditions of participation" in the public plan.

**The Kennedy–Dodd Bill.** Under Section 143 of Title I of the Senate bill, the Congress would create "affordable benefit gateways" that would function as a health insurance exchange for each state based on the proposed federal standards. The bill provides some flexibility for the states in setting up or administering these federally sponsored "gateways," and one gateway could operate in more than one state.

To assist the states in doing this, the HHS Secretary would provide grants and would have discretion over the amount of the grants given to the states. If a state was not making progress toward establishing a gateway in conformity with federal standards—for example, by including a public plan

17. Lewin Group House Draft Analysis, p. 14. Moreover, the public plan, as Lewin notes, would not provide either profit margins or broker commissions.
18. *Ibid.*, p. 18.
19. "Using Medicare's below-market rates would weaken the financial stability of our local doctors and hospitals and doctors." Letter to Hon. Nancy Pelosi, Speaker of the House of Representatives, and Hon. Steny Hoyer, Majority leader, from Representative Barron Hill (D–IN) *et al.*, July 9, 2009.

to compete against private health plans—the Secretary would have the power to intervene and establish such arrangements.

The gateway would fulfill the conventional administrative functions of a health insurance exchange, making health insurance available, providing information on the federally qualified health plans, and facilitating outreach to eligible individuals and their enrollment in plans provided through the gateway or other government programs such as Medicaid, SCHIP, or the new public plan. Gateways would also be able to contract with private entities, called "navigators," that would help to raise public awareness of the existence of the gateway and available health care plans. Health insurance plans that are not "qualified plans" could still operate outside of the gateway.

Under the Senate bill, the gateways would be required to establish a risk-adjustment system, thus providing an appropriate payment to health plans that have enrollees with health risks higher than the prevailing average in the state. Each year, the state-based gateways would also be required to report to the Secretary of Health and Human Services on their financial condition.

Under Title I of the Senate bill, the health benefits and medical procedures for health plans would be established by a new federal agency, a Medical Advisory Council. The council would be composed of medical experts who would make recommendations to the Secretary on what health benefits are "essential" and what would constitute "affordable coverage." The Senate bill would also provide a process for congressional review of the benefit decisions, and Congress could reject the Secretary's benefit decisions through a joint resolution of disapproval.

**The Senate Public Plan.** Under Title I of the Senate bill, Congress would create a new public plan, called the "community health insurance option," to compete against private health plans. This public plan would have to be offered in each state through the gateway and compete with private health plans in the gateway. Congress would establish a State Advisory Council to make recommendations to the Health and Human Services Secretary on the public plans' operations in each state.

The public plan would offer the "essential benefits" determined by the Medical Advisory Council, but the states could also require the public plan to offer additional benefits. The HHS Secretary would be authorized to set payment rates for doctors and hospitals, but they could not be higher than the "average rate" paid by health plans participating in the gateway. The HHS Secretary would also have the authority to contract with private entities to execute the duties associated with the public plan.

As with the House bill, the Senate bill would create a special trust fund for the financial operations of the public plan. The Senate sponsors intend that there would be no additional costs to the taxpayer beyond start-up costs and that premiums would cover the costs of the Senate version of the public plan.

**The Baucus Proposal.** Senator Max Baucus (D–MT), chairman of the Senate Finance Committee, is trying to produce *yet another* major Senate health care bill. Outside of a legislative product, however, Senator Baucus has also proposed a national health insurance exchange that would "organize affordable health insurance options, create understandable, comparable information about those options and develop a standard application for enrollment in a chosen plan."[20]

In the Baucus proposal, health plans participating in the national exchange would be able to compete on the national, regional, state, or local level, and benefit packages could differ "within reason," but they would have to meet federal actuarial standards.[21] Congress, however, would not actually do the work of fixing the actuarial standard or defining the meaning of coverage or affordability. Like former Senator Tom Daschle (D–SD),[22] Baucus would delegate such tasks to a special body of political appointees.

20. Senator Max Baucus (D-MT), "Call to Action: Health Reform 2009," p. 17, at *http://finance.senate.gov/healthreform2009/finalwhitepaper.pdf* (July 22, 2009).

21. *Ibid.*

This is also congruent with the Senate Health, Education, Labor and Pensions Committee bill, which would create a Medical Advisory Council, and the House Tri-Committee Bill, which, within statutory guidelines, would delegate authority to set health care benefits to the HHS Secretary with recommendations from an Advisory Benefit Committee whose members would be appointed by the Secretary.[23] In the Baucus proposal, a new agency, the Independent Health Coverage Council, would define the meaning of "affordability" and "coverage" for participating health plans, as well as standards for chronic care and quality reporting.[24] This would mean, of course, that Americans would be subjected to decisions over which they would practically have little or no control.

Under the Baucus proposal, health plan premiums would reflect differences in benefits, not risk, and premiums offered by plans in the national health insurance exchange would have to be the same as those offered outside of the exchange.[25]

In contrast to President Obama, Baucus appears to be more flexible: He would require a division of labor between federal and state authorities in the regulation of health insurance. While determinations of affordability, actuarial equivalence, and benefit standards would be federal responsibilities, all plans participating within the national health insurance exchange would be subject to state laws and regulations governing consumer protection, solvency, reserve requirements, and premium taxes.[26]

In short, the rules governing health plans in the national health insurance exchange would be both federal and state laws. The federal government would make rules governing the insurance coverage, and state governments would make and enforce rules governing consumer protection.

## The National Health Exchange and a New Public Plan

Irrespective of their differences, leading congressional health care proposals are strikingly clear in their main features: centralized decision-making in Washington and a dominant role for the federal government at the expense of the states in regulating health insurance.

Control by Washington means that special-interest politics concentrated in the nation's capital would dominate Americans' health care decisions even more than they do today. As with Medicare, it would be inevitable. According to *The Washington Post*, health care industry lobbyists have made $298.9 million in contributions to Members of Congress since 1989, and nearly 60 percent of that amount has gone to Members who sit on the five key congressional committees that handle health care legislation.[27]

Decisions would focus on a myriad of issues: what is or is not to be covered in the health benefits package; which and how many plans can participate in the national health insurance exchange;

22. In Senator Tom Daschle's version, the national health insurance exchange would be a national "pool" like the Federal Employees Health Benefits Program (FEHBP). The FEHBP has no public plan, and its regulatory regime is modest. Daschle's national exchange would be an administrative agency that would carry out the decisions of his proposed Federal Health Board. In Daschle's scheme, the board, modeled after the Federal Reserve Board, would serve as the ultimate arbiter of what is or is not to be offered to patients in public and eventually private health insurance plans, as well as what is or is not to be reimbursed. The board would work with Medicare officials to create a special government health plan that would also compete with private health plans in a national pool, Daschle's version of a national health insurance exchange. For further details, see Sen. Tom Daschle, with Scott S. Greenberger and Jeanne M. Lambrew, *Critical: What We Can Do About the Health Care Crisis* (New York: Thomas Dunne Books, 2008), especially pp.116–137.
23. Unlike the provisions of the Senate Health, Education, Labor and Pensions Committee bill, there are no provisions in the House bill for a congressional override of the Secretary's benefit decisions. Congress could, of course, intervene at any time and impose restrictions or guidance on the Secretary with respect to benefit matters.
24. Baucus, "Call to Action," p. 19.
25. *Ibid.*, p. 18.
26. *Ibid.*
27. Dan Eggen, "Industry Cash Flowed to Drafters of Reform," *The Washington Post*, July 21, 2009, p. 1.

which states—if any—will or will not be able to chart a more or less independent course. This would guarantee the frenzied lobbying of powerful special interests desperate to secure their competitive advantage.

It is fanciful to believe that government officials at HHS, a board, or a council would be able to devise a set of fair and equitable rules that would efficiently and effectively account for the very diverse and distinctive circumstances that prevail in different states across the country. Proposals to insulate such a process from special-interest politics by creating a body of politically appointed "experts," ensconced somewhere in the administrative offices of HHS, or a commissioner administering a National Health Exchange[28] reflect the triumph of fantasy over experience. No such body or official will be immune from either K Street lobbyists and their lucrative campaign coffers or powerful congressional committee chairmen.

**Politics of the Public Plan.** The introduction of a public, government-run health plan would further complicate the operation of a national health insurance exchange. If the exchange became a powerful regulatory agency—Obama's vision—Congress would have equally powerful incentives to set the rules to the advantage of its own health plan. This could be done in a variety of ways: by setting the government's health plan premiums artificially low (using Medicare rates as in the House bill); by reducing or eliminating cost-sharing requirements; or by manipulating benefits to make the government health plan more attractive than the private health plans. Congress would have every incentive to make sure that its own creation did not incur the legal or financial risks that private firms ordinarily bear.

Because the public plan is a political creation, political decisions would overrule all other considerations concerning key items: benefit levels, premium levels, co-payments, the kinds of medical treatments that could or could not be included. The annual lobbying circus that accompanies annual Medicare legislation is instructive as congressional leaders fight to preserve or maintain existing federal reimbursements for favored groups against competition, most recently for payment for durable medical equipment and supplies.[29]

A massive crowd-out of private coverage would be accelerated under the employer mandate, embodied in both the House and Senate bills, as employers dropped private coverage and paid the requisite tax. Likewise, lobbyists for businesses or private insurance industry executives might 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 also amount to significant adverse selection against the taxpayers. Faced with the rapidly rising costs of the public plan, let alone Medicare and Medicaid, taxpayers have demonstrably fewer lobbyists working on their behalf in Washington than those who are reimbursed with public or corporate money.

**Double-Edged Sword?** Lobbying for or against the policies and decisions of an administrator, council, or commissioner of a national health insurance exchange would be, of course, a two-way street. Once established, the legal and regulatory powers of such an agent or agency could turn out to be a double-edged sword, wielded by proponents of the public plan or advocates of private insurance. A public plan, after all, would be a wholly owned subsidiary of Congress.

Though admittedly far less likely, the political dynamics could run in a direction exactly the opposite of the "single-payer" conclusion for which the Left yearns so passionately. Congressional conservatives could decide—for budgetary or ideological reasons—to enact measures, amendments, and rid-

28. For Senator Daschle, the solution to the messy problem of special-interest lobbying would be simple: Remove the key decisions to a Federal Health Board that would function like the Federal Reserve Board and be insulated from the normal processes of democratic persuasion. Ideally, the more isolated the board (presumably) and the more authoritarian its decision-making, the better the policy outcomes would be. Even so, it is hard to imagine any such board affecting the health care of the entire nation and achieving any such political isolation from Washington politics.

29. See Christopher Lee, "Suppliers Fight Plan to Cut Medicare's Equipment Costs," *The Washington Post*, June 10, 2008, p. A8.

ers to expand private health plans and shrink the public option, create payment limitations or more restrictive reimbursement rules, and discourage public program enrollment. Currently, liberals in Congress, upset about existing levels of payments to private health plans in Medicare, which they deem excessive, are committed to rolling them back, hoping to halt the rapid growth of these increasingly popular Medicare Advantage health plan options.[30]

The more likely outcome of this political process is that the national health exchange would serve as an efficient mechanism to erode what is left of private health insurance. On the part of many in Congress, particularly those who favor a direct federal takeover of the entire system or the enactment of a single-payer health care system, the national health insurance exchange provides an arena for the destruction of the hated private health plans that, in their view, consume so many dollars in unwanted and unnecessary administrative costs and "immoral" profits.

There is good reason to believe that a public plan operating within a national health insurance exchange would accomplish the single-payer objective. In a December 2008 independent assessment of the likely impact of a public plan, the Lewin Group concluded that there would be major shifts from private to public coverage: Anywhere between 10.4 million and 118.5 million Americans, depending on how many are eligible for enrollment and the plan's payment rates, could be transitioned out of private health insurance.[31]

In its first analysis of the House Tri-Committee bill, Lewin estimated that, based on the statutory requirement for the use of Medicare rates as payment rates in the public plan, plus the progressive eligibility of all employees over time, the House bill would result in a dramatic expansion of government enrollment and that an estimated 113.5 million Americans would lose private coverage.[32] A recent Urban Institute study[33] and Lewin's most recent estimate of the latest version of the House bill show a smaller displacement of private coverage, but nonetheless a massive crowd-out.

During the markup of the Kennedy–Dodd bill, Douglas Elmendorf, director of the Congressional Budget Office (CBO), reported to the Committee on Health, Education, Labor and Pensions that, as a result of the provisions of the $1 trillion Senate bill, several million Americans would lose their employer-sponsored health insurance coverage.[34]

At the very least, the creation of a national health insurance exchange as a platform for a public plan to compete against private health insurance would cut short state innovation in health insurance market reform and accelerate the already rapidly growing federal domination of the financing and delivery of health care. Even more likely, it would ensure the eventual triumph of a single-payer system of national health insurance run by Washington. The national health insurance exchange combined with a public plan, falsely advertised as a mechanism to advance consumer choice and market competition, would be the institutional vehicle to guarantee the exact opposite.

30. On this aspect of the Medicare debate, see Kerry Weems, Acting Administrator, Centers for Medicare and Medicaid Services, "Medicare Advantage: Increased Spending Relative to Medicare Fee for Service," statement before the Subcommittee on Health, Committee on Ways and means, U.S. House of Representatives, February 27, 2008.
31. Cited in Robert E. Moffit, "How a Public Health Plan Will Erode Private Care," Heritage Foundation *Backgrounder* No. 2224, December 22, 2008, at *http://www.heritage.org/research/healthcare/bg2224.cfm*.
32. John Shiels, Vice President, The Lewin Group, "The Impact of the House Health Reform Legislation on Coverage and Provider Incomes," testimony before the Committee on Energy and Commerce, U.S. House of Representatives, June 25, 2009.
33. In the recent Urban Institute analysis, based on different assumptions, researchers project that roughly 47 million Americans would enroll in the new public plan. See John Holohan and Linda J. Blumberg, "Is the Public Plan Option a Necessary Part of Health Reform?" Urban Institute, Health Policy Center, June 2009, p. 8.
34. Senator Mike Enzi (R–WY), "Houston, We have a Problem! CBO Analysis of Kennedy Health Bill Highlights One Trillion Problems," press release, July 10, 2009; see also letter from Senator Mike Enzi to Douglas Elmendorf, Director, Congressional Budget Office, July 9, 2009.

## Conclusion

President Obama and the congressional leadership are intent on creating a national health insurance exchange. In its various legislative forms, their version of the health insurance exchange is a powerful regulatory agency; it is not merely an administrative agency to facilitate enrollment and to promote choice and anything remotely approaching free-market competition.

In many respects, the national health insurance exchange resembles a solution in search of a problem. If the President or Congress wanted to create a national health insurance market, they would not need to create a national health insurance exchange—they would merely have to repeal existing federal barriers to insurers competing across state lines. If the President and Congress wanted to fix the inequities of the federal tax law, a key rationale for creating a health insurance exchange at the state level, all they would have to do is to reform the federal tax laws governing health insurance and end the practice of discriminating against those who cannot or do not get health insurance through their place of work.

If the objective of the President and Congress is to expand the role of the federal government in providing health insurance and determining the kind of health insurance that Americans will get, the national health insurance exchange is a convenient tool for that federal expansion and control. It would be tantamount to a national arena for the public plan to undercut private health plans and erode existing private health coverage.

There is little doubt that a national health insurance exchange, combined with a public plan, can achieve that policy objective. But there is also little doubt that such an objective is not what most Americans had in mind when they embraced the cause of comprehensive health reform.

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