Backgrounder

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The Public Health Insurance Option: Unfair Competition on a Tilting Field

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President Barack Obama is insisting that health care "reform" include an insurance plan operated by the federal government, claiming that this "public option" is necessary to provide competition against the private insurers. Senate Majority Leader Harry Reid (D–NV) has said that the government plan would play a role like that of the U.S. Post Office, which he apparently believes is keeping Federal Express and UPS honest and efficient.[1]

This upside-down rhetoric reflects a mindset stuck in the 1930s, deriving its guiding political philosophy from the joy and relief felt by John Steinbeck's Joads when they found shelter in a government-run camp on their migration from Oklahoma to California. It does not fit modern America.

Advocates of the government insurance plan assure us that it would compete with private insurers on a level playing field. In reality, the "competition" would be rigged, with the government plan enjoying a number of advantages.

As a result, the government plan would likely capture a large percentage of the insurance market, marginalizing and undermining private insurance. For example, the Lewin Group estimates that the America's Affordable Health Choices Act,[2] the health reform bill currently under consideration in the House of Representatives, would reduce the number of Americans with private insurance by 83.4 million and that the new public plan would cover 103.4 million people.[3] Coupled with the federal regulatory system that the legislation would impose on the remaining private

Talking Points

- Contrary to advocates' claims, the America's Affordable Health Choices Act would not create a level playing field on which the government health insurance plan would complete fairly with private plans.
- Unlike private plans, the government plan would be exempt from a broad variety of federal and state requirements, such as taxes, antitrust laws, and licensing requirements.
- The bill appears to give the HHS Secretary and the Health Choices Commissioner broad discretion in interpreting its many ambiguous provisions to benefit the government plan.
- A government plan would benefit from the imprimatur of the federal government, which can change the rules of the game by passing a law or bail out the plan with taxpayers' money if it becomes insolvent.
- Creation of a federal insurance plan would be a giant step toward a single-payer, nationalized health care system much like those in Europe and Canada.

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plans, this would clearly by itself constitute a government takeover of health care.

Even worse, the federal takeover would accelerate. The private plans' relatively small market share would likely render them increasingly uneconomical and lead to a death spiral in which private insurance would serve an ever-decreasing share of the market.

In short, the federal insurance plan is a giant step toward the single-payer system that the President has admitted that he prefers. The single payer would be the federal government. This would create a nationalized health care system much like those in Europe and Canada.

Tilting the Playing Field

The President and his allies in Congress have attempted to allay fears about how the government plan would affect Americans' private insurance system by saying that it would merely provide them an additional choice and would compete on the same terms as the private plans offered through the new Health Insurance Exchange. To that end, the House bill even contains a section entitled "Ensuring a Level Playing Field."[4]

However, the actual terms of Section 221 do not live up to the title. Private insurers and the government plan would not compete on a level playing field. The provision that is touted as "ensuring" a level playing field fails to do so in three respects.

Tilt #1: Provisions for leveling the playing field are limited to the requirements of the bill.

Most important, the scope of Section 221 is limited. It requires the "public health insurance option [to] comply with requirements that are applicable under" Title II of the bill to other insurance plans offered through the Health Insurance Exchange, including those that are related to consumer protections, benefits, cost-sharing, notices, and provider networks.[5]

Disregarding the grammatical conundrum of how an "option" can do anything, Section 221 makes the government plan subject only to the requirements that are imposed by Title II. It does not impose on the government plan the broad variety of other federal and state requirements with which private insurers must comply, such as taxes, antitrust laws, and licensing requirements. Undoubtedly, other requirements would quickly become apparent if the legislation were implemented.

Depending on their tax status, private insurers must pay federal and state taxes, including premium taxes, property taxes, and income taxes. The government insurance plan, which would be run by the U.S. Department of Health and Human Services (HHS), would not pay these taxes, and Section 221 does not change this. Nor would the government plan be subject to the federal and state antitrust laws that regulate the operations of private insurers.

Moreover, the bill is unclear on whether the government plan would be required to meet state licensing standards and obtain state licenses. Section 204 contains a general requirement that a plan offering insurance through the exchange must be licensed under state law for each state in which it offers coverage,[6] yet state laws do not apply to the federal government unless federal law provides that they do. The general language in Section 204 and Section 221 may not be sufficiently explicit to require the government plan to obtain state insurance licenses. If not, the government plan would

1. Harry Reid, in *Congressional Record*, June 11, 2009, p. S6482. President Obama has since taken up the same argument. Barack Obama, speech at town hall meeting, Portsmouth, N.H., video file, August 11, 2009, at *http://www.youtube.com/watch?v=5XTi-WdOu2s* (August 20, 2009).
2. America's Affordable Health Choices Act of 2009, H.R. 3200, 111th Cong., 1st Sess.
3. John Sheils and Randy Haught, "Analysis of the July 15 Draft of the American Affordable Health Choices Act of 2009," memorandum to Stuart Butler, revised July 23, 2009, at *http://www.heritage.org/research/healthcare/upload/Lewin_public_plan_National_all.pdf* (August 19, 2009).
4. America's Affordable Health Choices Act of 2009, § 221(b)(2) (capitalization changed to title case).
5. *Ibid.*, § 221(b)(2).
6. *Ibid.*, § 204(b)(1).

avoid state solvency and other requirements that private plans must meet.

Similarly, the language is unclear on whether the government plan must provide specific benefits and include providers as required by state laws. Section 203 specifies that such state mandates "shall continue to apply" to plans offered through the exchange,[7] but it is unclear whether this is a "requirement" within the meaning of Section 221 that would apply to the government plan. If not, the government plan would avoid the expenses that private insurers incur in complying with the extra benefit requirements imposed by the states.

Whether these general provisions would require the government plan to comply with state law is complicated by Section 225, which explicitly makes state law applicable to the government plan's selection of providers. It specifies that the government plan can include only providers that are licensed or certified by the state. The absence of similarly explicit provisions in other sections would suggest—according to the rules of statutory construction—that the government plan would not be subject to state laws in other aspects of its operation.

The government plan would be shielded from the high costs of tort litigation that private plans face. Unless exempted by the Employee Retirement Income Security Act as an employee benefits plan, a private insurer can be sued for a variety of torts, including actions for consequential and non-economic damages for death and injury resulting from a wrongful denial of coverage. Yet the government plan, as an arm of the federal government, would probably be immune from tort liability. The federal government can be sued under the Federal Tort Claims Act (FTCA), but not for discretionary actions of its agents, and a coverage decision would probably qualify as such a discretionary act.

Even if suit could be brought against the government plan under the FTCA, it could not be heard in a state court or before a jury, and the government plan would not be liable for punitive damages. Furthermore, the FTCA imposes strict caps on attorneys' fees, which significantly reduces economic incentives to stir up suits against the government, which is certainly not the case in litigation against private parties.[8]

Tilt #2: Even with the requirements imposed by the bill, the field is not level.

Because the bill does not spell out the scope of Section 221(b)(2), it is unclear precisely which "requirements…are applicable under" Title II.

Title II requires plans to submit bids to the newly created Health Choices Commissioner, who would review the adequacy of their provider networks and presumably would make demands on price and service before accepting a bid and entering into a contract.[9] Provider networks are briefly mentioned in Section 221 as one of the applicable requirements,[10] but the commissioner's obligation to enter into contracts with plans and the process for doing so are not mentioned. The bill is unclear on whether these requirements are applicable under Title II and therefore whether Section 221 gives the commissioner the authority to require bids from the government plan and to negotiate contracts with it.

Even if the bill does give the commissioner this authority, the structure of Title II makes it unclear what requirements the commissioner could impose on the government plan. The commissioner is required to develop standards on various aspects of plan operations in order to carry out the requirements of Title I. Even if the government plan is expected to negotiate with the commissioner as other plans do, it is unclear whether a requirement under Title I that is embodied in the commissioner's

7. *Ibid.*, § 203(d). The provision requiring compliance with state mandates is effective only if the state agrees to compensate the government for the amount by which the mandate increases the federal tax credits to help people buy insurance.
8. The bill authorizes HHS to contract with companies to provide administrative functions for the government plan (but not to bear risk), as is done under Medicare. Administrative contractors operating at the direction of the government would likely enjoy the same protections against suits as the federal government enjoys.
9. America's Affordable Health Choices Act of 2009, §§ 201, 203, and 204.
10. *Ibid.*, § 221(b)(2).

standards is a requirement applicable under Title II with which the government plan must comply.[11]

The bill does not explicitly require the commissioner to treat the government plan the same as it treats the other plans. In the absence of such clear direction, it is unlikely that the government plan would face the same bidding and contractual process (which, in essence, will be the foundation of a costly regulatory regime) that the private plans face.

In fact, despite the language of Section 221(b)(2), other language in the bill leaves open to interpretation whether the government plan must meet any of the requirements of Title II or Title I. Section 100 states that the HHS Secretary, in connection with the government plan, "shall be *treated as*" offering an exchange-participating health benefits plan and that "the term 'qualified health benefits plan' means a health benefits plan that meets the requirements for such a plan under title I and *includes* the public health insurance option."[12]

This language could be read as requiring private plans to meet certain requirements under Title I but not requiring the government to do so. Because "treated as" and "includes" are used to describe the government plan's status, it might be argued that the government plan is not required to meet those requirements through the operation of Title II or even those requirements included in Title II, notwithstanding Section 221(b)(2). This language could be read as giving the government plan a free pass to qualification.

In addition to creating the illusion of a level playing field, Section 221 is drafted craftily in other ways. It introduces the ambiguous requirement, discussed above, that the government plan comply with the provisions imposed by Title II with the qualifying phrase "consistent with this subtitle [Subtitle B]." Importantly, Section 221 also states that HHS's "primary responsibility" in creating the government plan is to create "a low-cost insurance plan."[13]

The qualification that the level playing field must be consistent with the subtitle could embolden the Secretary to claim exemptions from costly requirements of the bill on the grounds that the exemptions are needed to carry out the mandate for a low-cost plan. These ambiguities could also support claims that the government plan is not required to submit bids, have its premiums approved by the commissioner, enter into a contract with the commissioner, submit to state mandate laws, or obtain state licenses.

The bill also seems to give the government plan the ability to obtain proprietary information about competing private plans. It confers on the Health Choices Commissioner unspecified and virtually unchecked authority to collect data from plans, including the government plan. The commissioner is required to collect the data needed for carrying out his or her duties,[14] and plans are required to report "such information as the Commissioner may specify."[15] The information collected could include the health status of each person covered by insurance plans and which services were obtained from which providers. It could also include information on the terms of providers' participation in plans, how much each provider is paid by the plan, the profits earned by a plan, and other information relevant to plan operations.

Disturbingly, the commissioner is authorized to "share" this information with the HHS Secretary, the operator of the government plan, without any restriction on the Secretary's use of the informa-

11. Interestingly, Section 143 requires the commissioner to "consult" with state insurance commissioners "as appropriate" and to act in "co-ordination" with them. *Ibid.*, §§ 143 and 201. The division of responsibility between the commissioner and state authorities is ambiguous, and the vague language makes it unlikely that the bill would be interpreted as subjecting the federal government plan to state regulation.

12. *Ibid.*, § 100(c)(20) (emphasis added). Further muddling the question, the HHS Secretary is designated as the sponsor of the government plan, just as an insurance company is the sponsor of a private insurance plan. *Ibid.*, § 100(c)(19)(C).

13. *Ibid.*, § 221(a).

14. *Ibid.*, § 142(c).

15. *Ibid.*, § 204(b)(2).

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tion.[16] Thus, the government plan may obtain extensive data about the operations of competing private plans, but private plans will not have access to this information about either the government plan or each other.[17]

Tilt #3: A government-operated plan has other inherent advantages.

The government plan would have a number of other advantages. It would be marketed with the imprimatur of the federal government, and that status itself would be persuasive to many potential enrollees. In addition, the government could use its ongoing contacts with the citizenry to market its insurance plan. Nothing in the bill would explicitly prohibit the government from including promotional materials in mailings or as an electronic message accompanying automatic deposit of government benefits, such as Social Security checks and tax refunds.

The bill requires the Health Choices Commissioner to set "uniform marketing standards" for all insurance plans selling through the exchange.[18] Whether these standards would apply to the government plan is unclear. Nor is it clear whether the government plan would be subject to the same information-disclosure requirements as private plans.[19] These provisions are contained in Title I of the bill, and, as discussed, Section 221 explicitly imposes only the Title II requirements on the government plan.

The government plan would also have the advantage of having law-making authority behind it. The bill would make reimbursement rates for doctors and hospitals under Medicare applicable to the government plan.[20] These are unilaterally imposed by the government—a power that no private plan would have—and are lower than what private plans have been able to negotiate in the market. Even if this is changed to require the government plan to "negotiate" reimbursement rates, its larger size and clout would give it bargaining advantages that no private plan could match.

In any event, neither of these reimbursement methodologies would likely be the last word. The bill gives the government plan blanket authority to establish reimbursement rates for providers unilaterally as long as they are "innovative."[21]

Finally, in competing with private plans, the government plan will enjoy one overriding advantage: Because the government can force the taxpayer to make up any shortfalls, the government plan can charge premiums that do not cover its costs. The bill requires the government plan to charge premiums as necessary to meet its costs, plus a margin for contingencies.[22] However, political realities and the pressure to provide "affordable" insurance could result in this being disregarded or fudged.

How costs are calculated will undoubtedly be complex and controversial. The government plan could charge less than its costs because the U.S. taxpayer—initially, lenders to the federal government—could be tapped. Private plans do not have the ability to lower prices below cost and tax the taxpayer to make up the difference. The resulting taxpayer subsidies to the government plan could easily make Fannie Mae and Freddie Mac look like careful and disciplined actors in the mortgage market.[23]

16. *Ibid.*, § 142(c).
17. The commissioner is also required to audit plans. *Ibid.*, § 142(b). Whether the information derived from such an audit may be shared with the HHS Secretary is unclear.
18. *Ibid.*, § 131.
19. *Ibid.*, § 133.
20. *Ibid.*, § 223.
21. *Ibid.*, §§ 223(e) and 224.
22. *Ibid.*, § 222.
23. The House Energy and Commerce Committee added the Stearns amendment to Section 222 to prohibit the use of federal funds if the government plan becomes insolvent. However, this cannot prevent a future Congress from bailing out an insolvent government health insurance plan.

Furthermore, unlike the proposed government plan, they were not even government agencies when they were bailed out.

Conclusion

In a number of ways, the America's Affordable Health Choices Act would fail to "ensur[e] a level playing field." It is unclear whether the government plan would be subject to a number of requirements that the private plans would be required to meet. It would appear to give the HHS Secretary and the Health Choices Commissioner the discretion to decide these ambiguities in favor of the government plan and to find that various requirements do not apply to the government plan because of its overriding mission to offer a low-cost plan. However, even without including these potential advantages, the government plan would clearly be free of a number of requirements and expenses that private plans face.[24]

Happy talk of creating a level playing field between the government insurance plan and private plans should be viewed with strong skepticism and even disbelief. The government plan would be heavily favored, leading to the marginalization of the private insurance market and the creation of a *de facto* single-payer system—a nationalized health system.

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24. It is perhaps telling that the House Energy and Commerce Committee rejected an amendment proposed by Representative George Radanovich (R–CA) that would have required the government plan and private plans to comply in the same manner with a number of the state and federal requirements discussed above.

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