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State Employee Health Care as a "Public Plan"

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President Obama has proposed that Congress create a new public health plan to compete with private health plans in a national health insurance exchange.

The President says that Congress can create a "level playing field" nationwide to ensure a fair competition between the newly created public plan and private health plans and that Americans who like the private health insurance coverage that they have today will be able to keep it and pay less. This claim is simply not credible.

Loss of Coverage. In fact, independent analysis estimates that millions of Americans would be crowded out of their private coverage through the introduction of a public plan, depending on the level of payment and the size of the pool for eligible enrollees in such a new option.[1]

Moreover, with an employer mandate—forcing employers to offer a federally approved level or benefits or to pay a payroll tax—there would be powerful incentives for employers to pay a tax and dump employees into the public plan. The vast majority of working Americans under 65, after all, get their health insurance through employers. Those who do not have to buy health policies in the individual market are subjected to tax and regulatory penalties.

Some Members of Congress, such as Senator Charles Schumer (D–NY), are offering a compromise proposal to guarantee a "level playing field" by making sure that all of the rules that apply to insurance would apply equally to both the new public plan and the private plans. It is not clear under Schumer's proposal, however, that the new public plan would be permitted to fail without a taxpayer bailout.[2]

In a proposal by the New America Foundation, analysts say that the experience of more than 30 state governments in fielding a "public plan" for employees that competes with private health plans for the premium dollars of state employees is the proof that public plans can compete fairly and effectively.[3]

State Examples: A Big Stretch. Strictly speaking, there is no existing federal model of a "public" plan owned and operated by the government, with government employees performing the functions of employees of a private insurance company.

The Veterans Administration (VA) health program is, in fact, an integrated single-payer health care system, funded and maintained by special federal subsidies, where physicians are paid by the government, the price of medical services is set by government officials, and hospitals are owned and run by federal officials. The VA does not compete for enrollees on anything like a "level playing field"; it simply administers an entitlement for a special class of American beneficiaries.

Medicare and Medicaid are not health insurance plans like private health insurance plans.

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They are mostly bill-paying entitlement programs with detailed regulations governing eligibility and reimbursement.

The experience of state governments provides a good example of a "public plan" only if one is willing to stretch the meaning of a public plan well beyond all recognition. This is true for a variety of reasons.

First, state employees do not buy state-sponsored health insurance because it is a "public plan." So-called state "public plans" are really private health plans under contract to the state government. *The simple fact that a government agency contracts with a private firm does not transform that private firm into a public firm.*

Like many private employers, state government can determine, often in consultation or negotiation with public employee unions, how rich or lean the benefits package may be, or the terms and conditions of coverage. No state advertises the "public plan" to its employees as anything like a special vehicle to keep the private plans "honest" or provide uniquely accessible, affordable, and guaranteed benefits in *contradistinction* to any other health plan available to state employees.

In fact, the name of the health plan offered to employees is always, or almost always, the trade name of the private insurance company that is offering it. In some states, there is provision for higher employer payments for certain favored health plan options. Of course, this is the very opposite of a level playing field.

Second, no state owns or has state employees operate a health insurance plan. State government agencies do not carry out the normal functions of a health insurance company—negotiating contracts with doctors and hospitals, establishing provider networks, or budgeting for marketing and administrative costs.

States do, of course, administer Medicaid. But like Medicare, Medicaid is also not a health insurance plan but rather a bill-paying and regulatory agency for a federal entitlement. The Medicaid "managed care" plans that many Medicaid enrollees have been forced into by government officials are also private contractors for the government business and offer these special plans, benefits, and artificially low provider payments as authorized by government officials.

Third, merely because states offer self-insured plans to their employees, like many private employers, that does not mean that their plans are "public" plans in any normal sense of the word. Of course, state governments routinely contract with private insurance companies to provide coverage for their employees. They can bear as much or as little risk as they desire, and if they wish to self-insure, they can decide how much reinsurance they will secure to cover unanticipated costs and cover losses.

Most large private companies self-insure, often to escape state government insurance regulation, mandates, or premium taxes. Like self-insured private companies that offer health coverage under the Employees Retirement Income Security Act (ERISA) of 1974, a number of state governments also self-insure. This means that the state taxpayers, as the real employers of state civil servants, are directly liable for state employee and retiree health benefits, just as private employers are under ERISA. This simple fact of self-insurance does not render the contractors' insurance plans "public" health plans; it *does* mean that taxpayers as the ultimate employers are on the hook for the losses and liabilities of their employee coverage.

Big Taxpayer Burdens. States are also saddling their taxpayers with huge costs for their health plans, not only in the provision of generous current benefits but also in the form of growing unfunded liabilities.

1. See, for example, John Shiels, "The Cost and Coverage Impacts of a Public Plan," testimony before the Ways and Means Committee, U.S. House of Representatives, April 29, 2009.
2. Robert Pear, "Schumer Offers Middle Ground on Health Care," *The New York Times*, May 5, 2009, at *http://www.nytimes.com/2009/05/05/health/policy/05health.html?pagewanted=print* (May 27, 2009).
3. Len M. Nichols and John M. Bertko, "A Modest Proposal for A Competing Public Health Plan," New America Foundation, March 2009, p. 6.

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In a number of states, such as California, New York, and Maryland, these costs are large and growing. For retiree health coverage alone, state officials are saddling current and future taxpayers with unfunded health care liabilities upwards of $1.5 trillion.[4]

No Model to Follow. State employee health plans are really private health plans under contract with state government, and the simple fact that they are self-insured (like many private plans) does not make them public entities. Moreover, state experience is hardly a prescription for fiscal sanity at the national level, where current and future taxpayers must somehow cope with the recent explosions in federal spending and debt, as well as the trillions of dollars in promised entitlement benefits that are not funded.

If Congress creates a public plan, it is likely to be too big to fail, as is the case with so many other enterprises, thereby guaranteeing even greater burdens on taxpayers who are already faced with the seemingly insurmountable debt imposed by Social Security, Medicare, and Medicaid.

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4. 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.*