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Government-Run Health Care Even Without the Public Option

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One of the most-discussed issues in the health care reform debate is whether to include a government-run, "public option" health plan. President Obama says a government plan is necessary to "keep insurance companies honest," but opponents—and even some proponents of the public option—say that a public option will reduce competition and choice and become a step on the road to a single-payer health care system.

But both sides seem to be ignoring a much larger issue: Regardless of whether a public option is included, the reforms under consideration in Congress would impose such rigid control on *private* health plans that it amounts to a government-run health care system—even if the insurance companies remain technically under private ownership.

Government Control of Private Health Plans. Both the Senate and House bills give unprecedented levels of control to federal bureaucrats to pre-empt patient choice and block competitive innovation. The House bill would create a new federal office—a "Health Choices Commissioner"—to make health choices for the entire nation, specifying precisely what services health plans must cover, may cover, and (perhaps) must not cover.[1] The Senate bill would direct the Secretary of Health and Human Services (HHS) to define precisely the services that health plans must cover.[2]

The Senate would permit only four categories, or levels, of plans that would differ only in the levels of deductibles, copayments, and coinsurance ("actuarial value"). The House would permit only three levels. In both cases, the package of covered services and the conditions under which each service would be covered would be identical for all plans from all companies. Except for a limited range of financial options, individuals and families would have no flexibility to choose health plans that meet their particular needs.

Furthermore, the House bill also empowers—actually, requires—the Health Choices Commissioner to determine the premiums private health plans can charge: "The Commissioner shall, based upon a review of such bids including the premiums and their affordability, negotiate with such entities for the offering of such plans."[3] Of course, the term *negotiate* has to be understood in light of two factors:

1. The commissioner has the absolute authority to determine whether the plan will be offered—meaning that if the commissioner does not like the plan or its premium, the plan cannot be offered; and
2. The next clause states, "The Commissioner shall deny excessive premiums and premium increases," and nowhere does the bill define what "excessive" means.

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If one of these bills passes—even without a "public option"—the U.S. will have government-run health care that is merely administered by private companies. With all benefits and coverage conditions specified by government regulations, there will be no room for people to choose what is right for them—and no room for health plans or providers to innovate and find more efficient and cost-effective ways to deliver higher quality health care.

All of the inefficiencies of the current system—inefficiencies often described in detail by the President himself—will be locked in permanently, and many more inefficiencies will be introduced. Americans will still pay providers to "do procedures" rather than keep them healthy, the health care system will still be fragmented with little accountability, and the payment system will still penalize providers who provide high-quality care and subsidize those who make mistakes.

It is important to note that the federal government would be essentially running *private* health plans—individually purchased plans starting in the year 2013, and employer-sponsored plans starting in 2018. In other words, every insured American would have government-run health care, *even if there is no "public option" plan*.

Single-Payer Could Be Imposed by Bureaucrats. Because the Health Choices Commissioner could determine what health plans cover and what premiums they may charge, it is quite possible that the commissioner could define a package of "essential" health benefits that is very expensive to provide and then define the premium required to support that benefit package as "excessive" due to lack of "affordability."

In this worst-case scenario, every health plan would be faced with two choices: go out of business, since the commissioner would not approve a premium high enough to break even, or go into bankruptcy. In either case, the result would be no private plans—and post-hoc "justification" of the "necessity" for a public "option" that would be the only plan actually permitted to operate.

In short, while the House bill does not actually impose a single-payer, Canadian-style health care system, it does give federal bureaucrats enough power to impose precisely such a system without any further congressional action.

Medicare Law Could Be Rewritten by Bureaucrats. The House bill calls for the Institute of Medicine—a quasi-private entity—to recommend changes to Medicare law to limit coverage to procedures defined as "high-quality care."[4] While this sounds good in theory, the definition of "high-quality care" is defined in such a way that it could end up excluding treatments that are the only effective options for a small percentage of patients. In essence, the provisions could exclude treatment of patients for whom "one-size-fits-most" care is not effective.

The institute's recommendations would become law by default—unless both houses of Congress pass, and the President signs, a law rejecting them completely. Failing that, the bill authorizes the HHS Secretary to rewrite the Medicare laws passed by Congress in order to bring the law of the land in compliance with the recommendations of the institute's panel. Allowing appointed bureaucrats to rewrite laws passed by Congress according to the instructions of an unelected panel of "experts" is certainly rare, if not unprecedented. And it is certainly undemocratic.

Medicare Coverage Options Could Be Drastically Reduced. Furthermore, options for Medicare patients will be substantially reduced, as the House and Senate bills both propose cuts in Medicare Advantage—the "private option" for seniors that is disproportionately chosen by minority seniors and those with lower incomes.[5] The Chief Actuary of the Center for Medicare and Medicaid Services estimated that the House bill would force 8.5 million

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1. The Affordable Health Care for America Act, H.R. 3962, 111th Cong., 1st Sess., Title II, Subtitle E, pp. 131–39.
2. America's Healthy Future Act, S. 1796, Section 1504, 111th Cong., 1st Sess., pp. 256–57; Section 1201, pp. 124–127.
3. The Affordable Health Care for America Act, H.R. 3962, 111th Cong., 1st Sess., Title III, Subtitle A, Section 304(a)(2)(B), p. 173.
4. *Ibid.*, Title I, Subtitle C, Sections 1159–1160, pp. 502–20.

Medicare Advantage enrollees (of the 9.9 million) out of the health plan they have chosen and into the government-run health plan they have rejected.[6] In other words, about 85 percent of Medicare Advantage patients would not be able to keep their current plans, even if they like them.

Paying More and Getting Less. To add insult to injury, the U.S. would pay vastly more for this new system—a system that is even less responsive to patient preferences and choices than America's current system. Americans would face higher premiums and higher taxes. Both the House and Senate bills penalize employers for hiring workers, especially workers from low-income families—the people who need help the most. And the bills impose taxes on medical devices and (in the case of the Senate bill) prescription drugs and health plans—taxes that would burden the very people who need those products. In effect, the bills would tax those who need health care to pay for health reform.

But at least all Americans would be covered, right? Wrong. According to estimates from the Congressional Budget Office, between 18 and 25 million Americans would remain uninsured. And under these bills, they would have to pay heavy tax penalties to punish them for their misfortune.

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5. Adam Atherly and Kenneth E. Thorpe, "Value of Medicare Advantage to Low-Income and Minority Medicare Beneficiaries," Emory University, September 20, 2005, pp. ii and 7, at *http://www.bcbs.com/issues/medicaid/research/Value-of-Medicare-Advantage-to-Low-Income-and-Minority-Medicare-Beneficiaries.pdf* (October 29, 2009).
6. Richard S. Foster, "Estimated Financial Effects of the 'America's Affordable Health Choices Act of 2009' (H.R. 3200), as Reported by the House Ways and Means Committee," U.S. Department of Health and Human Services, Center for Medicare and Medicaid Services, Office of the Chief Actuary, October 21, 2009, at *http://republicans.waysandmeans.house.gov/UploadedFiles/OACT_Memorandum_on_Financial_Impact_of_H_R__3200_.pdf* (October 29, 2009).