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Why a "Public Option" Is Hazardous to Your Health

by Michael F. Cannon

Executive Summary

President Obama and other leading Democrats have proposed creating a new government health insurance program as an option for Americans under the age of 65, within the context of a new, federally regulated market—typically described as a "National Health Insurance Exchange." Supporters claim that a new government program could deliver higher-quality health care at a lower cost than private insurance, and that competition from a government program would force private insurers to improve.

A full accounting shows that government programs cost more and deliver lower-quality care than private insurance. The central problem with proposals to create a new government program, however, is not that government is less efficient than private insurers, but that government can hide its inefficiencies and draw consumers away from private insurance, despite offering an inferior product.

A health insurance "exchange," where consumers choose between private health plans with artificially high premiums and a government program with artificially low premiums, would not increase competition. Instead, it would reduce competition by driving lower-cost private health plans out of business. President Obama's vision of a health insurance exchange is not a market, but a prelude to a government takeover of the health care sector. In the process, millions of Americans would be ousted from their existing health plans.

If Congress wants to make health care more efficient and increase competition in health insurance markets, there are far better options.

Congress should reject proposals to create a new government health insurance program—not for the sake of private insurers, who would be subject to unfair competition, but for the sake of American patients, who would be subject to unnecessary morbidity and mortality.

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Introduction

President Obama,[1] Senate Finance Committee chairman Max Baucus (D-MT),[2] and other leading Democrats have proposed creating a new government health insurance program as an "option" for Americans under the age of 65. This program would operate within the context of a new, federally regulated market—typically described as a "National Health Insurance Exchange." House Speaker Nancy Pelosi (D-CA)[3] and four House caucuses representing more than 100 Democrats[4] have stated that a new government health insurance program modeled on Medicare is the sine qua non of health care reform. Sixteen Democratic senators have signed a letter signaling their support.[5] Senate Health, Education, Labor, and Pensions Committee chairman Edward M. Kennedy (D-MA) has proposed legislation that would create such a program,[6] as have three key House committees.[7]

Others have suggested that Congress should adopt a different model. Senate Budget Committee chairman Kent Conrad (D-ND) and Sen. Charles Schumer (D-NY) have proposed that Congress create one or more health-insurance "cooperatives," although each endorses different structures and different levels of government support. Cooperatives are member-run health plans that already exist in many areas of the country; for instance, Group Health Cooperative already covers 580,000 Americans in the states of Washington and Idaho.[8] Schumer proposes that Congress spend $10 billion to create a single nationwide cooperative, which would be governed by a federal board and endowed with the power to use Medicare-like price controls.[9] Conrad proposes multiple cooperatives[10] with start-up subsidies in the neighborhood of $4 billion.[11]

Advocates of a new government health insurance program claim that government provides coverage more efficiently than the private sector. University of California–Berkeley political scientist Jacob Hacker writes:

> The public Medicare plan's administrative overhead costs (in the range of 3 percent) are well below the overhead costs of large companies that are self-insured (5 to 10 percent of premiums), companies in the small group market (25 to 27 percent of premiums), and individual insurance (40 percent of premiums).[12]

Supporters claim they are willing to put government to the test by having it compete against private plans in the context of a new government-run "exchange." President Obama claims that a new government program "gives consumers more choices, and it helps keep the private sector honest, because there's some competition out there."[13] The House Democrats' legislation would create a "public health insurance option" that would be "self-sustaining and compet[e] on [a] 'level field' with private insurers."[14] Columnist E. J. Dionne writes, "The public-option idea . . . would allow the United States to move gradually toward a government-run system if—*and only if*—a substantial number of consumers freely chose to join such a plan. The market would test the idea's strength."[15]

A full accounting, however, shows that government programs are less efficient than private insurance. Administrative costs are higher in government programs such as Medicare, because they avoid administrative activities that increase efficiency and incur other administrative costs that are purely wasteful. Government programs also suppress innovation, and thereby reduce the quality of care for all patients, whether publicly or privately insured.

The central problem with proposals to create a new government program is not that government is less efficient than private insurers, however, but that government can hide its inefficiencies and draw consumers away from private insurance, despite offering an inferior product. If the government plan's premiums reflected its full costs—and private insurance premiums reflected only their actual costs—there would be no reason not to let the government enter the market. As Dionne suggests, the market would test the idea's

strength. Yet government possesses both the power to hide its true costs (which keeps its premiums artificially low) and to impose costs on its competitors (which unnecessarily pushes private insurance premiums higher). It makes no difference whether a new program adopts a "co-operative" model or any other. The government possesses so many tools for subsidizing its own program and increasing costs for private insurers—and has such a long history of subsidizing and protecting favored enterprises—that unfair advantages are inevitable. This is in no small part because supporters of a new government program *want* it to have unfair advantages.

Literally Ousting Patients from Their Health Plans

In a speech to the American Medical Association, President Obama reiterated a promise that he has made repeatedly since the 2008 presidential campaign:

> No matter how we reform health care, we will keep this promise to the American people. If you like your doctor, you will be able to keep your doctor, period. If you like your health care plan, you'll be able to keep your health care plan, period. No one will take it away, no matter what.[16]

After the Congressional Budget Office estimated that as many as 15 million Americans could lose their existing coverage under Senator Kennedy's legislation,[17] the Associated Press reported, "White House officials suggest the president's rhetoric shouldn't be taken literally."[18]

Indeed, a new government program would literally oust millions of Americans from their current health plans and threaten their relationships with their doctors, as employers choose to drop their current employee health plans and as private health plans close down. A Lewin Group analysis estimated that Obama's campaign proposal would move 32 million Americans into a new government-run plan.[19] Lewin subsequently estimated that if Congress used Medicare's price controls and opened the new program to everyone, it could pull 120 million Americans out of private insurance—more than half of the private market.[20] The share of Americans who depend on government for their health care would rise from just over one-quarter to two-thirds.[21] Many of those millions would be involuntarily ousted from their current health plans—much like President Obama suggested ousting 10 million seniors[22] from their private Medicare Advantage plans and forcing them into the traditional Medicare program.[23] Yet even those who voluntarily chose a new government program over their existing coverage would do so not because the government program provides better value for the money, but because the government program would hide some of its cost.

A health insurance "exchange," where consumers choose between private health plans with artificially high premiums and a government program with artificially low premiums, would not increase competition. Instead, it would reduce competition by driving lower-cost private health plans out of business. President Obama's vision of a health insurance exchange is not a market, but a prelude to a government takeover of the health care sector. In the process, millions of Americans would be ousted from their existing health plans, and all would suffer the consequences of government-run health care.

Is Government More Efficient?

Supporters of a new government program note that private insurers spend resources on a wide range of administrative costs that government programs do not. These include marketing, underwriting, reviewing claims for legitimacy, and profits. The fact that government avoids these expenditures, however, does not necessarily make it more efficient. Many of the administrative activities that private insurers undertake serve to *increase* the insurers' efficiency. Avoiding those activities would therefore make a health plan less efficient. Existing government health programs also incur

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administrative costs that are purely wasteful. In the final analysis, private insurance is more efficient than government insurance.

Administrative Costs

Time magazine's Joe Klein argues that "the profits made by insurance companies are a good part of what makes health care so expensive in the U.S. and that a public option is needed to keep the insurers honest."[24] All else being equal, the fact that a government program would not need to turn a profit suggests that it might enjoy a price advantage over for-profit insurers. If so, that price advantage would be slight. According to the Congressional Budget Office, profits account for less than 3 percent of private health insurance premiums.[25] Furthermore, government's lack of a profit motive may not be an advantage at all. Profits are an important market signal that increase efficiency by encouraging producers to find lower-cost ways of meeting consumers' needs.[26] The lack of a profit motive could lead a government program to be less efficient than private insurance, not more.

Moreover, all else is not equal. Government programs typically keep administrative expenditures low by avoiding activities like utilization or claims review. Yet avoiding those activities increases overall costs. The CBO writes, "The traditional fee-for-service Medicare program does relatively little to manage benefits, which tends to reduce its administrative costs *but may raise its overall spending* relative to a more tightly managed approach."[27] Similarly, the Medicare Payment Advisory Commission writes:

> [The Centers for Medicare & Medicaid Services] estimates that about $9.8 billion in erroneous payments were made in the fee-for-service program in 2007, a figure more than double what CMS spent for claims processing and review activities. In Medicare Advantage, CMS estimates that erroneous payments equaled $6.8 billion in 2006, or approximately 10.6 percent of payments. . . . The significant size of Medicare's erroneous payments suggests that the program's low administrative costs may come at a price. [28]

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CMS further estimates that it made $10.4 billion in improper payments in the fee-for-service Medicare program in 2008.[29]

Medicare keeps its measured administrative-cost ratio relatively low by avoiding important administrative activities (which shrinks the numerator) and tolerating vast amounts of wasteful and fraudulent claims (which inflates the denominator).[30] That is a vice, yet advocates of a new government program praise it as a virtue.[31]

Medicare also keeps its administrative expenditures down by conducting almost no quality-improvement activities. Journalist Shannon Brownlee and Obama adviser Ezekiel Emanuel write:

> [S]ome administrative costs are not only necessary but beneficial. Following heart-attack or cancer patients to see which interventions work best is an administrative cost, but it's also invaluable if you want to improve care. Tracking the rate of heart attacks from drugs such as Avandia is key to ensuring safe pharmaceuticals.[32]

According to the CBO, private insurers spend nearly 1 percent of premiums on "medical management."[33] The fact that Medicare keeps administrative expenditures low by avoiding such quality-improvement activities may likewise result in higher overall costs—in this case by suppressing the quality of care.

Supporters who praise Medicare's apparently low administrative costs often fail to note that some of those costs are hidden costs that are borne by other federal agencies, and thus fail to appear in the standard 3-percent estimate.[34] These include "parts of salaries for legislators, staff and others working on Medicare, building costs, marketing costs, collection of premiums and taxes, accounting including auditing and fraud issues, etc."[35]

Also, Medicare's administrative costs should be understood to include the deadweight loss from the taxes that fund the pro-

gram. Economists estimate that it can easily cost society $1.30 to raise just $1 in tax revenue, and it may sometimes cost as much as $2.[36] That "excess burden" of taxation is a very real cost of administering (i.e., collecting the taxes for) compulsory health insurance programs like Medicare, even though it appears in no government budgets.

Comparing administrative expenditures in the traditional "fee-for-service" Medicare program to private Medicare Advantage plans can somewhat control for these factors. Hacker cites a CBO estimate that administrative costs are 2 percent of expenditures in traditional Medicare versus 11 percent for Medicare Advantage plans. He writes further: "A recent General Accounting Office report found that in 2006, Medicare Advantage plans spent 83.3 percent of their revenue on medical expenses, with 10.1 percent going to nonmedical expenses and 6.6 percent to profits—a 16.7 percent administrative share."[37]

Yet such comparisons still do not establish that government programs are more efficient than private insurers. The CBO writes of its own estimate: "The higher administrative costs of private plans do not imply that those plans are less efficient than the traditional FFS program. Some of the plans' administrative expenses are for functions such as utilization management and quality improvement that are designed to increase the efficiency of care delivery."[38] Moreover, a portion of the Medicare Advantage plans' administrative costs could reflect factors inherent to government programs rather than private insurance. For example, Congress uses price controls to determine how much to pay Medicare Advantage plans. If Congress sets those prices at supracompetitive levels, as many experts believe is the case,[39] then that may boost Medicare Advantage plans' profitability beyond what they would earn in a competitive market. Those supracompetitive profits would be a product of the forces that would guide a new government program—that is, Congress, the political system, and price controls—rather than any inherent feature of private insurance.

Economists who have tallied the full administrative burden of government health insurance programs conclude that administrative costs are far higher in government programs than in private insurance. In 1992, University of Pennsylvania economist Patricia Danzon estimated that total administrative costs were more than 45 percent of claims in Canada's Medicare system, compared to less than 8 percent of claims for private insurance in the United States.[40] Pacific Research Institute economist Ben Zycher writes that a "realistic assumption" about the size of the deadweight burden puts "the true cost of delivering Medicare benefits [at] about 52 percent of Medicare outlays, or between four and five times the net cost of private health insurance."[41]

Administrative costs can appear quite low if you only count some of them. Medicare hides its higher administrative costs from enrollees and taxpayers, and public-plan supporters rely on the hidden nature of those costs when they argue in favor of a new government program.

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Cost Containment vs. Spending Containment

Advocates of a new government health care program also claim that government contains overall costs better than private insurance. Jacob Hacker writes, "public insurance has a better track record than private insurance when it comes to reining in costs while preserving access. By way of illustration, *between 1997 and 2006, health spending per enrollee (for comparable benefits) grew at 4.6 percent a year under Medicare, compared with 7.3 percent a year under private health insurance.*"[42] In fact, looking at a broader period, from 1970 to 2006, shows that per-enrollee spending by private insurance grew just 1 percentage point faster per year than Medicare spending, rather than 2.7 percentage points.[43] That still omits the 1966–1969 period, which saw rapid growth in Medicare spending.

More importantly, Hacker's comparison commits the fallacy of conflating *spending* and *costs*. Even if government contains health care spending better than private insurance (which is not at all clear), it could still impose greater overall costs on enrollees and society than pri-

vate insurance. For example, if a government program refused to pay for lifesaving medical procedures, it would incur considerable nonmonetary costs (i.e., needless suffering and death). Yet it would look better in Hacker's comparison than a private health plan that saved lives by spending money on those services. Medicare's inflexibility also imposes costs on enrollees. Medicare took 30 years longer than private insurance to incorporate prescription drug coverage into its basic benefits package. The taxes that finance Medicare impose costs on society in the range of 30 percent of Medicare spending.[44] In contrast, there is no deadweight loss associated with the voluntary purchase of private health insurance.

Hacker nods in the direction of nonspending costs when he writes, "Medicare has maintained high levels of . . . patient access to care."[45] Yet there are many dimensions of quality other than access to care. It is in those areas that government programs impose their greatest hidden costs, on both publicly and privately insured patients.

Medicare and other government programs uniformly lag private insurers when it comes to quality innovations.

Government Programs Suppress Quality, Cost Lives

Supporters also claim that government programs outperform private health insurance on quality. On the surface, the quality of medical care in government programs tends to be similar to, or worse than, the quality of care under private insurance. This may be largely due to the fact that government programs uniformly lag private insurance in adopting quality innovations. Beneath the surface, however, government programs suppress the quality of care for all patients, whether publicly or privately insured.

Researchers estimate that patients receive high-quality, evidence-based care only about half of the time, regardless of whether they are enrolled in Medicare, Medicaid, or private insurance.[46] A recent Minnesota study found, however, "On eight of the nine statewide measures, performance in achieving high-quality care was significantly lower at both the statewide and medical group levels for [Medicaid and other government programs] compared with [private insurance]."[47] Patients with Medicaid coverage experience more unmet medical needs than similar patients with private insurance.[48] Studies have found that Medicaid patients suffer worse outcomes than similar privately insured patients when it comes to cancer,[49] unstable angina,[50] and coronary artery bypass graft surgery.[51] The Veterans' Health Administration appears to outperform private insurance on some dimensions of quality,[52] but exhibits serious deficiencies in others.[53] President Obama's secretary of Health and Human Services, Kathleen Sebelius, has called the government-run Indian Health Service a "historic failure."[54]

Nevertheless, supporters make the demonstrably false claim that government programs are more innovative than private insurance. Hacker writes, "Medicare has been slow to adopt quality innovations—though generally quicker than private health plans."[55] Peter Harbage and Karen Davenport of the Center for American Progress cite Medicare's policy on "never events"—severe medical errors that should "never" happen—as proof of government's superior ability to promote quality: "Witness steps such as Medicare's refusal to pay medical care providers for 'never events,' where a patient suffers a knowable and catastrophic mistake, such as having the wrong limb removed. This is something other major insurers are now adopting."[56]

In reality, Medicare and other government programs uniformly lag private insurers when it comes to quality innovations. For example, private insurers began experimenting with "pay-for-performance" financial incentives almost an entire decade before Medicare.[57]

"Never events" provide an even clearer illustration. In 2003, an estimated 181,000 severe medical errors occurred in hospitals alone.[58] Throughout its 43-year history, Medicare has actually *encouraged* such errors by financially rewarding health care providers when an error leads to more services, and financially penalizing providers who reduce error rates.[59] In October 2008, Medicare eliminated those perverse incentives for a short list of medical errors called "never events." That policy will

likely discourage *some* medical errors by forcing providers to pay for *some* of the associated costs. Yet the first private health plan to force providers to bear the *full* financial cost of *all* medical errors was offered by the Ross-Loos Clinic in 1929.[60] Kaiser Permanente has done so since the 1940s. Medicare didn't even play a leading role on "never events" among fee-for-service plans, as Harbage and Davenport claim. HealthPartners of Minnesota stopped paying for "never events" in January 2005.[61] Medicare merely followed suit.

Stagnation Costs Lives

Government programs are not merely slow to innovate, they are outright hostile to quality innovations. Government programs inject rigidity into health care markets that suppresses the quality of care for publicly and privately insured patients alike. The result is greater morbidity and mortality.

This can be seen most clearly in the way government suppresses competition between different methods of paying doctors, hospitals, and other health care providers. As noted above, Medicare financially rewards medical errors and penalizes error-reduction efforts because it pays providers on a fee-for-service basis. Fee-for-service payment, as the name suggests, means that providers collect an additional fee for each additional service they provide. Conversely, if providers deliver fewer services, they collect less revenue. Fee-for-service payment thus creates a perverse incentive: if low-quality care (e.g., a medical error, poor coordination between providers, insufficient attention to medical evidence) results in a patient requiring more services, then low-quality providers will receive more revenue than providers who adopt quality innovations. According to the *New York Times,* for example:

> Park Nicollet Health Services, a hospital and clinic system based in St. Louis Park, Minn[esota] . . . started . . . spending as much as $750,000 annually on more nurses and on sophisticated software to track heart failure patients after they left the hospital. It reduced readmissions for such patients to only 1 in 25, down from nearly 1 in 6. But the reduction has been a losing proposition. Although the effort saved Medicare roughly $5 million a year, Park Nicollet is not paid to provide the follow-up care. Meanwhile, fewer returning hospital patients mean lower revenue for Park Nicollet. "We've kept it up out of a sense of moral obligation to these patients, but we're getting killed," said David K. Wessner, chief executive of Park Nicollet. "We will totally run out of gas."[62]

Medicare suppresses countless quality innovations by making them "a losing proposition."

A free market would use competition from different methods of paying providers to keep those perverse incentives in check. Under "prepayment" or "capitation," for example, providers receive a flat fee to provide medical care for a given patient or group of patients. Group Health Cooperative is an example of an integrated, prepaid health plan. Prepayment *rewards* providers for avoiding unnecessary and harmful services: whatever money providers save by avoiding medical errors, for example, the providers get to keep. It is no coincidence that prepaid health plans, like Kaiser Permanente, lead the market in innovations such as coordinated care and electronic medical records, which help avoid unnecessary services. Prepayment also creates its own perverse incentive: providers get to keep whatever money they save by denying access to needed care as well. In a free market, however, competition from fee-for-service providers would force them not to stint on necessary care. By the same token, competition from prepaid plans would force fee-for-service providers to coordinate care, offer electronic medical records, and avoid medical errors.

Government health insurance programs—principally Medicare—block competition between different payment systems, and therefore dramatically reduce the quality of care. As the largest purchaser of medical services in the United States, Medicare accounts for two-

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thirds to four-fifths of revenues for many hospitals and specialties.[63] Medicare's influence is so vast that hospitals and other providers organize the delivery of medical care around the financial incentives it creates. Providers like Park Nicollet Health Services cannot stay in business by providing high-quality coordinated care, because that means less revenue from Medicare. Because privately insured patients use the same doctors and hospitals, that means Medicare suppresses the quality of care even for privately insured patients.[64]

The main reason that the U.S. health care sector lacks coordinated care, electronic medical records, and comparative-effectiveness research is that government rewards providers who avoid these quality innovations and penalizes providers who adopt them. The main reason that as many as 100,000 Americans die from medical errors each year is that the nation's largest health care purchaser rewards providers who tolerate medical errors and punishes providers who reduce them.

Congress cannot solve this problem by reforming Medicare's payment system, creating a new program that uses a different payment system, or attempting to incorporate such competition into a government program. All methods of paying health care providers create perverse incentives. If Medicare or a new program adopts the payment system used at Group Health Cooperative, Congress will merely trade the perverse incentives of fee-for-service payment (uncoordinated care, medical errors) for those of prepayment (less provider choice, greater rationing). Only competition between different payment systems can hold those perverse incentives in check. Yet government programs like Medicare and Medicaid stifle such competition. Medicare Advantage attempts to allow such competition, yet different health plans with different payment systems constantly lobby Congress for special advantages. Meanwhile, politicians, such as President Obama, propose eliminating such competition entirely.

Harbage and Davenport write that a new government program "will create incentives for effective performance just as today's Medicare program promotes quality care alongside cost containment."[65] That is precisely the problem. A new government program would suppress quality, just as Medicare has, by further stifling competition between payment systems. Sebelius says that making Medicare "a strong and sustainable program depends on our ability to fix what's broken in the rest of the system."[66] Sebelius has it exactly backward: Medicare *is* what's broken in the rest of the system.

We need not look to Canada to find horror stories about government-run health care. Estimates of 100,000 deaths each year in the United States from medical errors should be frightening enough.[67] A new government program, whether modeled on Medicare or not, would further suppress health care quality and cause additional morbidity and mortality.

The Fair-Competition Fantasy

President Obama admits, "I think there can be some legitimate concerns on the part of private insurers that if any public plan is simply being subsidized by taxpayers endlessly, that over time they can't compete with the government just printing money."[68] Nevertheless, supporters claim that Congress can create a new government program that competes with private insurers on a level playing field. The "Blue Dog Coalition" of moderate House Democrats has offered several criteria that a new program would have to satisfy in order to do so.[69] The Blue Dogs insist, for example, that the program would have to be completely self-sustaining (i.e., premium revenue would cover all costs), that the government not leverage its market power to favor the new program, and that government not enact any regulations that favor a new government program over private insurers. Supporters such as Len Nichols and John Bertko of the New America Foundation claim that a new program can satisfy those conditions.[70]

Yet the government need neither subsidize its own program with taxpayer money, nor newly printed money, nor must it do so "end-

lessly," to supplant private insurance with an inferior option. Indeed, government has countless other ways to prevent the true cost of a new program from appearing in its premiums, and to increase the premiums of its competitors. Moreover, government's long history of subsidizing, protecting, and bailing out favored enterprises shows that such special advantages would be inevitable. For example, Amtrak requires repeated taxpayer subsidies to stay afloat.[71] And Congress famously bailed out Fannie Mae and Freddie Mac.

Congress has made Medicare increasingly less self-sustaining over time. When Congress created Medicare in 1965, enrollee premiums covered 50 percent of the cost of physician services. Under pressure from Medicare enrollees, subsequent Congresses gradually reduced that share to 25 percent. The U.S. Postal Service is similarly unable to sustain itself. According to one critic:

> Make no mistake . . . the Postal Service is not self-sufficient. It is kept afloat by a number of hidden taxpayer subsidies. For starters, it has a monopoly on First Class and Standard mail. No private company can deliver a letter for less than $3 or twice what USPS charges, whichever is greater. . . . Meanwhile, USPS is immune from antitrust lawsuits and exempt from taxes on its massive real-estate holdings. . . . It enjoys power of eminent domain. And it doesn't even pay parking tickets.[72]
>
> It calculates the amount of corporate income tax it would owe if it were a private company—and then pays that amount to itself.[73]

Likewise, state governments have repeatedly crowded out private insurance in markets for workers' compensation insurance, crop and flood insurance, and reinsurance for medical malpractice and natural disasters, according to University of Pennsylvania economist Scott Harrington, because "the public sector is supported by various types of subsidies or special rules that allow it to compete with the private sector."[74]

Direct Subsidies

Among the many ways that Congress could favor a new government program is through direct subsidies—that is, real resources provided to the government program, yet withheld from private insurers:

- The federal and state governments finance Medicaid and the State Children's Health Insurance Program almost entirely through tax revenue. As a result, those programs crowd out private insurance among individuals who could otherwise obtain coverage on their own.[75] Likewise, taxpayer subsidies fund nearly 90 percent of Medicare spending, which helps that program almost completely crowd out private health insurance for the elderly.[76]
- Creating a new program around Medicare's existing infrastructure, as some supporters propose, would bestow start-up subsidies not available to new private health plans.[77] Senator Schumer has insisted that a government-sponsored "co-operative" receive $10 billion in start-up subsidies.
- The leading Democratic proposals would create a "risk-adjustment" mechanism that would essentially tax all health plans to compensate those that attract a disproportionate share of high-cost patients and/or that do little to reduce wasteful expenditures.[78] Whether a new government program proves to be more attractive to high-cost patients or does a poorer job of controlling unnecessary expenditures, the risk-adjustment program could easily become a tool for taxing private insurers to subsidize the government plan.
- When estimating Medicare's administrative costs, the federal government does not count the cost of activities undertaken by other federal agencies to support Medicare.[79] If the government fails to include such costs when calculating the premiums for a new program, that would constitute an implicit sub-

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sidy and enable the new program to set its premiums below its true costs.

To the extent that a new government program receives direct subsidies that are not available to private insurers, its relative cost would also be higher due to the deadweight loss of taxation, yet that added cost likewise would not appear in the government program's premiums.

Indirect Subsidies

To subsidize a new government program, Congress need not hand it bags of cash or use creative accounting when setting premiums. Congress can instead subsidize its program indirectly, whether by granting it special status or increasing its competitors' costs:

- The taxpayer subsidies and other advantages granted to Medicare give the federal government a degree of market power that private insurers cannot match. That market power in turn creates opportunities for Congress to grant other special advantages to a new government program. Many supporters propose that a new program should adopt price controls identical or similar to Medicare's, or that the federal government should require providers to participate in the new program as a condition of Medicare participation.[80] Sen. Jay Rockefeller (D-WV) proposes to let a new program use Medicare's price controls for two years, and to require doctors who participate in Medicare to participate in the new program for three years;[81] yet those time frames could easily be extended to four years, six years, or beyond. Leveraging the special advantages granted to Medicare would enable a new government program to achieve a level of provider participation at a lower cost than private insurers.
- Adopting Medicare-like price controls would also increase the prices that providers charge private insurers. Experts disagree about the exact mechanism that drives prices higher for private insurers.[82] Whatever the case, such price controls would increase the cost of private insurance relative to a new government program.
- Tightening the price controls that Medicaid uses to purchase prescription drugs, or expanding those price controls into either Medicare or a new government program, would likewise increase costs for the new program's private competitors. The price controls that Congress imposes on drug purchases through the Medicaid program have the effect of increasing prices for private insurers by an estimated 15 percent.[83] The Senate Finance Committee has suggested tightening this price control,[84] while House Energy and Commerce Committee chairman Henry Waxman (D-CA) has proposed importing those price controls into Medicare.[85] Either move would further increase costs for private insurers.
- Any new program would come with an implicit guarantee that Congress would bail it out if premiums proved insufficient to cover its costs. Hacker argues for an *explicit* bailout guarantee when he writes that reserve requirements "would not make sense for the public health insurance plan, which has the full faith and credit of the federal government behind it."[86] Even if the bailout guarantee were only implicit, that would enable the new program to set its premiums below costs. According to a 1996 Treasury Department report signed by Larry Summers, who is now President Obama's National Economic Council chairman, a similar implicit guarantee saved Fannie Mae and Freddie Mac an estimated $6 billion per year.[87] Meanwhile, private insurers would effectively face higher reserve requirements than the government program.
- Unlike many private insurers, government programs pay no taxes. The presence of corporate income taxes, invest-

Adopting Medicare-like price controls would increase the prices that providers charge private insurers.

ment taxes, etc., increases the price of private insurance relative to a government program. The CBO estimates that taxes account for 1.2 percent of private health insurance premiums, on average.[88] Government could further advantage its program by raising taxes on private insurers, such as through the special tax on insurance-company profits proposed by Senator Schumer.[89]
- Government can increase the effective cost of private insurance by imposing penalties on consumers who choose it instead of the government plan. Federal regulations penalize seniors who opt out of Medicare to obtain private health insurance by taking away their Social Security benefits, past and future.[90] That penalty exists in spite of a provision in the Medicare statute called, "Option to Individuals to Obtain Other Health Insurance Protection," which reads: "Nothing contained in this title shall be construed to preclude . . . any individual from purchasing or otherwise securing, protection against the cost of any health services."[91]

Even if Congress could create a new government program with no special advantages, a truly level playing field would require a credible guarantee that no future Congress and no future regulator would ever confer any special advantages on that program. Given the bailout craze of 2008–2009, it is not credible to suggest the government would not bail *itself* out if premiums were insufficient to support the new program's outlays. That public perception would itself create an implicit bailout guarantee, and redound to the exclusive benefit of a new government program. Moreover, today's Congress cannot bind future Congresses. Supporters of a new program know this, and they are already contemplating future efforts to secure special advantages for any new program that Congress creates.[92]

Medicare Advantage

Medicare Advantage demonstrates that the playing field between a government program and private insurers could never be level. The Medicare Advantage program allows private insurers to compete with the traditional, government-run Medicare program. The playing field shifts depending on whether the party in power prefers government or private insurance. In 2003, President George W. Bush and a Republican Congress adopted fairly high price controls for the Medicare Advantage plans. More recently, a Democratic Congress has sought stricter price controls. President Obama even proposed to throw private plans out of Medicare entirely, which is not so much a level playing field as it is a cliff.

Nichols and Bertko admit that the playing field isn't level in Medicare Advantage due to congressional interference, and they claim that such interference is "not inherent in public-private competition."[93] Yet when Congress creates a federal health insurance program and a federal bureaucracy to craft and enforce the rules of competition between that program and private plans, nothing is more inherent to such a scheme than Congress and its whims.

If wise philosopher-kings could somehow create a new government health insurance program and (permanently) deny it of any special advantages, *it would cease to be a government program*. It would be just another private insurer. If that is what supporters of a new government program want, there is no need for Congress to act. Supporters can gather investors and launch their own private health plan right now. The only rationale for having Congress construct a new health plan is to create socially harmful competition whose objective is a government takeover of the U.S. health care sector.

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Conclusion

A new government program would supplant private insurance, despite offering inferior care at a higher cost. The program would attract consumers not by virtue of its superior performance, but by government's ability to prevent the full cost of its program from appearing in enrollee premiums and its ability

If Congress wants to make health care more efficient and increase competition in health insurance markets, there are far better options.

to increase the cost of private options. As the new program's artificially low premiums crowd out private insurance, the government would exert even greater downward pressure on quality. Any new government health insurance program would shortly lead to a government takeover of health insurance markets—and the entire health care sector.

No one should be surprised. President Obama has repeatedly affirmed his preference for a single-payer, government-run health care system, such as exists in Canada.[94] Many people, including *New York Times* columnist Paul Krugman, support a new government program precisely because they believe it will lead to a single-payer system.[95] Hacker has quipped, "Someone once said to me, 'This is a Trojan Horse for single-payer,' and I said, 'Well, it's not a Trojan Horse—it's right there! I'm telling you: we're going to get there, over time, slowly.'"[96]

If Congress wants to make health care more efficient and increase competition in health insurance markets, there are far better options. Congress should let consumers—rather than employers or the government—control their health care dollars and choose their health plan. It should convert Medicare into a program that gives seniors a voucher and frees them to purchase any health plan on the market.[97] Reforming the tax treatment of employer-sponsored insurance with "large" health savings accounts would give workers the thousands of dollars of their earnings that employers currently control, and likewise free workers to purchase any health plan on the market.[98] Finally, Congress should expand competition by prohibiting states from denying market entry to health plans and providers licensed by other states—that is, by making clinician and health-insurance licenses portable across state lines.[99] Those reforms would reduce costs, increase innovation, and reduce the number of uninsured—without higher taxes or additional government spending.

Congress should reject proposals to create a new government health insurance program—not for the sake of private insurers, who would be subject to unfair competition, but for the sake of American patients, who would be subject to unnecessary morbidity and mortality.

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