Federal Trade Commission

A Healthcare Triptych

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Competition to Believe in

The health care debate has devolved into a shouting match between proponents of a "public option" and proponents of a "co-op option." Each side touts its preferred option for universal coverage as the best way to "keep private insurers honest" and "bend the curve" (i.e., slow the growth rate of health care costs). Both sides are missing the boat. If those are indeed the objectives, the best way to achieve them is to spur robust competition among private insurers.

That competition does not exist now. According to the AMA, private insurers have a monopoly or duopoly in some portion of all 50 states. Consumers in those markets are essentially beholden to the prices and products offered by one or two insurers. The federal Sherman Act does not provide a remedy because it does not reach firms merely because they have monopolies where they have come about their monopoly or near-monopoly power honestly. Enter the public and co-op options. Through both proposals, proponents intend to inject "competition" by creating a government funded or subsidized competitor. But government-funded "competition" is a red herring.

Economics 101 teaches that real competition exists only when the low-cost provider – i.e., the solvent provider who keeps costs the lowest – can prevail. "Costs" in this context refer not only to the cost of providing goods or services, but also the cost of capital and taxes. If and to the extent a public insurer or co-op insurer receives subsidized or free capital from the federal government (which happened repeatedly during the recent financial crisis) or does not have to pay taxes (because it is tax-exempt), there is a thumb on the scales in their competition with for-profit private insurers. The government-backed entity's costs will always be lower than any participant who must compete without government support. Real competition cannot and will not occur.

Indeed, the federal government can subsidize public or co-op insurers more subtly just by defining what "basic" and "emergency" care those options will cover in such a way that only those insurers will have the government-backed resources to provide that level of care. Even worse, the federal government may define those levels of care so that only those entities plus the private insurers that are well entrenched and endowed can provide that care. That would maintain the monopoly or near monopoly that currently exists among private insurers in some markets – a fact that may explain why some of the major insurers are cheerleaders for the current reform plans.

Beyond that, basic economic theory also predicts that if and to the extent that public or co-op insurers are subsidized, they will lack the same incentive to keep the lid on providers' costs that unsubsidized private insurers have. That is because the latter must compete with other unsubsidized private insurers to be the low-cost insurer. To do that, those insurers can and do "steer" their insureds to hospitals and physicians who are willing to provide health care on an efficient basis (by judicious use of co-pays and deductibles). Thus, introducing real competition

among private insurers instead of subsidized "competition" from a public or co-op insurer provides the best way (if not the only way) to "bend the curve" on health care costs.

Some, on both sides of the aisle, have suggested that there can be no real competition among private health insurers so long as the McCarran Ferguson Act, which gives states their own monopoly to regulate the "business of insurance," remains in force. In other words, critics claim that the McCarran Ferguson Act is responsible for the monopolies or duopolies that now exist. Indeed, Anne Bingaman, Assistant Attorney General for Antitrust in the early 1990s, testified to that effect in support of former President Clinton's health care proposal. But repeal or modification of the Act would certainly be a daunting task. There are arguably show-stopping arguments against judicial repeal, and there would be many opponents of legislative repeal, including those who champion states' rights.

In any event, the virtues or vices of the Act are relative: they depend on the federal system that would replace it. So long as unsubsidized private insurers are confronted with a federally subsidized public or co-op option, it can be predicted with certainty that the benefits of real competition will not occur (and that the true costs of introducing universal or near-universal health care cannot be accurately determined).

In short, the best way to achieve universal health care while "bending the curve" would be to introduce more real competition among private insurers to provide universal or near-universal health care instead of subsidizing public or co-op options to pay for that additional insured care. This could be done by paying the millions of new insureds directly on the condition that the recipients use those funds to buy health insurance from a private insurer. And this would have the added virtue of enabling the true cost of universal or near-universal health care to be determined more accurately.

Universal Coverage: What Will It Really Cost?

To date, the health care debate in Washington has focused on the cost of reform and how to finance a plan. A largely neglected but critical point in the debate thus far, however, relates to the scope of the health care insurance that will go to the millions of new insureds. The definition of that "Coverage Floor" must occur upfront before legislation expanding coverage is enacted. To be sure, there seems to be agreement that the Coverage Floor will include "Basic" and "Emergency" coverage components. But what does that mean? To date, neither the President nor Congress has explained what is in the basic or emergency bundles of products and services. Like most things, the cost of what is bought depends on *what* is bought; it is critically important that Americans know before the government enacts health care reform into law what the cost of those bundles will be.

That is so for several reasons. First, if the government or co-op option is adopted, a Coverage Floor that includes all of the health care bells and whistles may mean that the government and co-ops alone – with considerable financial aid from the federal government – will be able to provide that coverage. Indeed, even if those options are not adopted, that kind of Coverage Floor may be beyond the means of all but the most well-entrenched and well-endowed private insurers to provide – a fact that may help explain why certain large private insurers are major cheerleaders for health care reform. If the goal is to create real competition among insurers, the government should be setting up a system that ensures more competitors are able to participate in the market for the insureds, not less.

Second, whether members of Congress will admit it, the cost of universal coverage will almost certainly be reflected in federal tax policy for years to come. America already has a very large budget deficit. As a result, there reportedly has been serious talk in Washington that the

tax pledges that were made during the Presidential campaign may have to be treated simply as goals. Higher deficits fueled by a high Coverage Floor will almost certainly transform that threat into reality. Indeed, if the government does not provide sufficient subsidies and minimum coverage for the uninsured (at taxpayer expense), the problem will not have been fixed.

Third, a high Coverage Floor will result in one of the biggest wealth transfers in American, if not world, history. All countries must ration health care because they can't afford to give all things to everybody: some countries do it by denying the most expensive therapies to some people; some by requiring people to wait in lines; but they all must do it one way or another. Like it or not, America has rationed on the basis of means: he or she who has the means to afford expensive treatment has gotten them; he or she who does not have the means has not. If America is not to be bankrupted, the latter can only get everything if some of those with the means to buy insurance are willing to pay higher premiums to achieve that objective. We have been told they are willing to make the sacrifice – that's what the last election was about. Maybe so, but maybe not. Certainly the amount of the sacrifice was not defined, and it should be.

In short, to properly value what Congress is providing (and whether reform is worth it), the Coverage Floor must be defined upfront. Recent history has shown that broad coverage is politically easy to give, but mighty hard to take away – a fact that states like Oregon, Massachusetts, and Tennessee, which have tried to introduce universal health care, have discovered as they have tried to rein in costs. More importantly, however, Americans deserve to know what universal coverage will cost them in both absolute and relative terms. As matters now stand, they are asked to buy a pig in a poke.

Some Healthcare Myths

Republicans have been excoriated for propagating myths about pending legislation seeking to introduce universal health care insurance in America. Properly so. The assertions that the legislation would create euthanasia "death squads," pay for abortions, or cover illegal aliens were incorrect. To be sure, bills have been introduced that do not contain enforcement mechanisms that would prevent these results, but that's the most that can be said about them truthfully. On the other hand, some Democrats have propagated other myths that have thus far mostly gotten a free pass.

The first myth is that a public option is essential to guarantee that private insurers will be competitive. That gets things backwards: not only will a public option not guarantee competition; it will guarantee that there will *not* be competition. That is because true competition exists only when the most efficient competitor – i.e. the one with the lowest costs and best products – can win. A public insurer would certainly receive substantial federal subsidies whenever necessary (just as the banks and others received during the financial crisis). The competitive scales therefore would always be tipped in a public insurer's favor, regardless of its true costs and the quality of its unsubsidized insurance.

This is not to say that private insurers compete with each other on a level playing field now. Some of the big insurers have entrenched positions and resources that they came by honestly. Others (for example, some of the Blue Cross entities and some co-ops) are subsidized as a result of their non-profit status because they don't have to pay the taxes that their for-profit competitors do. The remedy for the latter is to require all private insurers to pay taxes. The remedy for the former is to level the playing field over time by using the billions of dollars the federal government will pay to achieve universal coverage to buy health insurance from the most

efficient insurers. If that choice cannot be made by the consumers themselves, the choice can be made on their behalf using objective criteria.

A second myth is that every American who is satisfied with his or her health insurance can keep it. That promise assumes that today's private insurers continue to exist. If a public option is embraced, it is hard to see how all of the private insurers out there now will continue to exist. Over the long run, some private insurers will be run out of business by the subsidized public insurer. As a result, some insureds will have to buy their health insurance from another private insurer – and that insurance may or may not be as satisfactory to them as what they have now.

A third myth is that there is no chance that grandma (or grandpa) will be denied the health care coverage that she or he needs in a ripe old age. Of course there is a chance that this will happen: in fact, it is almost an inevitable consequence of having an "expert" panel decide what health care is sufficiently beneficial to be included in the package insured by the federal government. To date it has been contemplated that that panel would make such decisions for the Medicare program (in order to wring some cost savings out of Medicare to help pay for universal coverage). That would put seniors squarely in the panel's sights.

If the panel were to determine what health care should be included in the Basic and Emergency care components of the coverage offered to the millions of new insureds to be offered universal coverage, that might expand those affected by the panel's decision to younger people who are currently not insured, but the panel's decisions would affect the elderly who are currently uninsured as well. The only way to avoid that result would be to include all health care in the universal coverage package, and that would be prohibitively expensive.

A final, and arguably the most pernicious, myth is that it is essential that universal health care insurance legislation be enacted this year, regardless of its costs and other consequences. Indeed, some claimed that it was essential to enact legislation before the August congressional recess. The claim might be understandable if there were a good chance that a political sea change might occur before next year. But one political party controls both the White House and Capitol Hill – a fact that will not change until November of next year at the earliest.

The only excuse for such haste is that delay will impede the dissemination of facts and the development of non-ideological legislation. But those are not legitimate reasons for haste. Americans who end up being surprised and disappointed by health care reform that is not well thought out will undoubtedly revolt by means of the ballot box in November of 2010.