

Current Health Reform Proposals: No Government Takeover of American Health Care

Timely Analysis of Immediate Health Policy Issues

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Summary

Current national health reform proposals would not cause “a government takeover of health care.” Pending legislation would leave in place the country’s largely private medical care system, in which more than 90 percent of doctors are in private practice and 84 percent of all hospital admissions are to private facilities.

Reform proposals would not give the federal government new authority to intervene in private health care decisions. Rather, legislation would mainly extend two current responsibilities of the public sector: to fund health coverage for low-income, uninsured Americans and to regulate health insurance so that it meets consumers’ needs. In fact, reform proposals would substantially *increase* health plan choices for many people, including workers covered by small firms. While 73.2 percent of these employees are offered just one plan today, pending legislation would let them choose from among multiple, diverse health plans available in a new health insurance exchange.

Some predict that including a public plan in such an exchange would cause private health insurance to unravel, ultimately “removing the medical sector from the free enterprise system.” However, under the original version of the House Tri-Committee proposal, the Congressional Budget Office (CBO) estimates that, by 2019, 12 million people—just 4.3 percent of Americans under age 65—will be in the public option. Private insurance will cover 191 million people, according to CBO, or nearly 16 times the number in the public plan. Further, it is the consumer who chooses whether to enroll in public or private coverage offered through the exchange—a key detail sometimes obscured by arguments against reform. Finally, even if the public plan fully replicates Medicare’s basic structure, it will simply pay private health care providers for furnishing covered services. Using this approach, Medicare has achieved high levels of beneficiary satisfaction, wait times below average levels under private insurance, and a choice of physician that equals or exceeds that available through private coverage. Former Senate Majority Leader Bill Frist (R-TN) recently acknowledged that Medicare is not socialized medicine; the same would be true of a public plan based on Medicare.

Many claims about government-run health care are based on hypothesized future scenarios that go far beyond current proposals. Such speculation can easily prove unfounded, as illustrated by confident predictions in the early 1960s that enacting Medicare would eventually lead to the conversion of American medicine into a socialized system for all residents.

With the debate over national health reform heading into a critical, perhaps determinative phase, reliable and objective analysis needs to focus on the details of current proposals and their likely results. Based on this standard, it is clearly mistaken to claim that proposed health reforms would lead to a government takeover of American medicine.

Introduction

At this critical juncture of the national health care reform debate, decisionmakers and their constituents need clear and objective information about the content and implications of the proposed changes. This is not easy,

given the emotional arguments now being made on all sides as well as the subject’s complexity.

This paper focuses on one central claim in the debate —namely, that proposed reforms would represent “a government takeover of health care”¹ that promotes a “socialized

medicine agenda,”² with “bureaucrats making the health care decisions that should stay with doctors, patients, and their loved ones.”³ In examining these assertions, we do not mean to suggest that any one side in the debate has a monopoly on unfounded claims. For example,

proponents of reform now attack the insurance industry's role in the national debate, even though the industry has agreed (assuming that reform legislation fits certain parameters)⁴ to end preexisting condition exclusions and similar practices.⁵ Some reform advocates likewise suggest that increased preventive care automatically lowers overall health care spending, despite much evidence to the contrary.⁶

In addition, it is clear that supporters of the current reform bills face legitimate questions. How many low-income uninsured will use Medicaid and new subsidies to obtain coverage, given the proposals' individual mandates and enrollment systems? Are the subsidies large enough to mandate enrollment or will many people need to be exempt due to affordability concerns? Are the proposals to slow the growth in health care costs adequate?⁷ Are there risks to moving low-income children from current public programs into private insurance?⁸ Will slower growth of some Medicare payment rates create access problems for beneficiaries?

We do not attempt to address the full range of such questions or to analyze the advantages and disadvantages of proposed reforms' many facets. Instead, this paper builds on a previous exploration of what is meant by "socialized medicine" and assesses what seems to be emerging as the primary public argument against reform.

Previous analysis

In April 2008,⁹ Dorn and Holahan analyzed claims that proposals being advanced during the presidential campaign represented

major steps towards "socialized medicine" or "government-run health care." The authors explained that socialized systems provide health care through government-employed staff operating in government-owned facilities. That paper concluded that most of the proposals¹⁰ advanced by Democratic candidates did not involve socialized or government-run health care, since they continued the central role played by private health care providers and insurers, leaving considerable decisionmaking authority in private hands. Dorn and Holahan suggested that claims about a "government takeover of health care" were a distraction from the more important issues of how reform proposals would affect cost, access to care, quality, and consumer choice. Over the past 16 months, little has changed regarding the meaning of "socialized medicine," but the issue warrants reexamination given the specific reform proposals now before Congress.

Current health care reform proposals

We focus on the reform proposals passed by four congressional committees and under consideration in a fifth.¹¹ While details vary, the proposals share a remarkably similar basic structure:

1. *The low-income uninsured would receive subsidies.* Medicaid would cover the poorest uninsured, and new federal subsidies would assist people with incomes too high for Medicaid but too low to afford health insurance without help.¹²
2. *A health insurance exchange would offer diverse health plans.* People without access to employer-sponsored insurance could buy coverage through the exchange, which would feature competing plans offering a variety of benefits, deductible and copayment options, provider networks, and premiums. Consumers who select more costly plans would pay the associated higher premiums. Small firms (and possibly other companies)¹³ would have the option to cover their workers through the exchange, but each employee would choose his or her own plan.
3. *Consumers buying coverage in the exchange could select a publicly-administered health plan.* Depending on the proposal, such a plan may resemble Medicare, with a federal agency paying private providers, or it could be a consumer-owned cooperative. In both cases, each consumer would decide whether to enroll in the public plan or in coverage offered by private insurers through the exchange.
4. *Individuals would be required to obtain health coverage, unless they cannot afford it.*
5. *Employers above a threshold size would be required to help finance health care, by either buying coverage for their workers or paying a tax to the federal government.*
6. *New requirements would apply to health insurers.* Insurance companies could not exclude the treatment of preexisting conditions or engage in similar

practices.¹⁴ Health plans would also have to follow new minimum benefit rules, such as required coverage of preventive care without copayments.¹⁵

7. *Various policies would attempt to slow the growth in health care costs.* Medicare pilot projects would test promising innovations, such as new payment methods that “reward value rather than volume.” If these experiments succeed, Medicare could expand them. Private insurers could also apply successful Medicare innovations, as they have done in the past.¹⁶ A separate cost-related measure would sponsor research into the comparative effectiveness of alternative medical treatments.
8. *Increased costs would be fully funded by new revenues and policies that slow the growth of Medicare and Medicaid spending.* While proponents of reform all articulate this goal, final scoring from the Congressional Budget Office has not yet demonstrated whether this goal would be reached, and pending proposals vary in how they raise revenue and reduce projected spending on current public programs.

In the main, reform proposals simply extend the public sector’s current roles in funding low-income health coverage and regulating insurance. The most significant new public responsibilities involve coverage mandates imposed on individuals and employers, but such mandates do not seem to be the primary concerns raised by those warning of a “government takeover of health care.”

The overall structure of proposed reforms

A typical criticism of the pending reforms states: “The Obama health care plan would allow, and even require, the government to take over and run every aspect of the American health care system... For doctors, surgeons, and specialists, this also involves a substantial loss of control over their practice of medicine. Their clinical judgment would be increasingly displaced by the diktats of faraway government bureaucrats who don’t even know their patients.”¹⁷

Rather than expand government’s role as the direct provider of health care, current proposals leave the practice of medicine firmly in private hands. Fewer than 3 percent of the nation’s physicians are federal employees working for the military, the Veterans Health Administration, or the Public Health Service.¹⁸ Among nonfederal, patient-care doctors, only about 5 percent are employed by a city, county, or state government.¹⁹ All other such physicians are full- or part-owners of their practices or employed by a privately owned entity. Similarly, 84 percent of all hospital patients were admitted to private facilities in 2006.²⁰ The remainder were treated at hospitals run by state and local governments or the Veterans Health Administration. Although Medicare is a government-run program, its beneficiaries were no more likely than were the privately insured to be admitted to a government-run facility.²¹ Nothing in pending proposals would increase the proportion of care provided in publicly owned hospitals or by publicly employed physicians.²²

Equally absent from current proposals are attempts to vest the federal government with direct control over medical decisionmaking. Presently, both private and public insurers define the limits of covered services, and doctors and nurses attempt to meet their patients’ needs, subject to these definitions. This same approach would continue under proposed legislation, without any new federal authority that circumscribes the practice of medicine.

Instead of mandating or forbidding any particular service, the proposed expansion of comparative effectiveness research would simply provide patients, physicians, and insurers with better information about the treatments that are most effective for particular medical conditions. This element of reform extends the tradition of federally funded health care research exemplified by the National Institutes of Health and the Agency for Healthcare Research and Quality. Gail Wilensky, who ran Medicare and Medicaid for President George H.W. Bush, supports comparative effectiveness research as “providing objective, credible information on the likely clinical outcomes of different strategies to treat the same medical condition. The information produced and disseminated would be intended to better inform clinical decision making and to help design sensible reimbursement strategies.”²³ To insulate this potentially valuable research from allegations of rationing, pending legislation specifies that the agency conducting comparative effectiveness research has no authority to impose “coverage,

reimbursement, or other policies for any public or private payer.”²⁴

A central feature of pending proposals is the variety of choices offered to consumers and to businesses. By letting consumers choose from among diverse, competing health plans, with new protections for patients with preexisting conditions, the exchange will dramatically increase coverage options for many people. For example, 73.2 percent of workers covered by companies with fewer than 50 employees were offered a single health plan in 2008.²⁵ These are the very workers most likely to obtain coverage through the exchange under reform proposals. By the same token, small firms will gain a new option to insure their employees through an exchange that, by purchasing coverage collectively on behalf of numerous individuals and companies, can apply substantially increased leverage to get better deals from insurance companies than small businesses now obtain on their own. At the same time, employers and individuals will remain free, if they prefer, to purchase coverage directly from insurers, without going through the exchange.

Critically important, current proposals would shift the locus of health plan choice. Today, employers typically make health insurance decisions for employees and their families. Under the proposal, by contrast, consumers in the exchange would choose their own health plans, taking into account personal financial resources, available subsidies, and their families' health care needs. Those who select more costly plans would pay more. Compared to the status quo, buying health insurance

through the exchange would be more like shopping in a traditional marketplace, where consumers balance the positive features of each product against its price, and sellers' desire for market share drives innovation and competition. This market-oriented approach to health coverage seems at odds with claims that proposed reforms represent steps toward socialized medicine.

Notwithstanding those options, current proposals would also impose important new responsibilities that would constrain some choices. Individuals would have to buy insurance if they can afford it. Medium-sized and larger employers likewise would be required to contribute to their workers' health care costs. Insurers would need to cover preexisting conditions and to offer benefits that meet minimum requirements.²⁶ Proposed reforms thus involve a straightforward exercise of traditional regulatory authority.²⁷

Pending proposals likewise spend federal funds to subsidize health coverage for low-income Americans. Similar fiscal arrangements in the past have not turned American medicine into a government-run enterprise. Examples include President Bush's investment in community health centers, which created or expanded more than 1,200 such centers;²⁸ the establishment of the State Children's Health Insurance Program (SCHIP) in 1997; and the creation of Medicare and Medicaid in 1965.

Some contend that any significant increase in the federal government's role represents a dangerous step toward a government-run, socialist economy.²⁹ From this perspective,

the “government takeover” label could have been attached to the creation of Social Security and Medicare, the Environmental Protection Agency, the federal highway system, and the National Park system, each of which extended the federal government's authority into a new sphere of American life, but none of which led to a socialist economy.

During the debate over reauthorizing SCHIP in September 2007, Senator Grassley of Iowa made comments that may fairly apply to many of today's arguments against broader reforms. He noted that “screaming ‘socialized medicine’ during a health care debate is like shouting ‘fire’ in a crowded theater. It is intended to cause hysteria that diverts people from looking at the facts.”³⁰

The public plan

Critics of reform argue that “a government-run insurance option” will “slowly erode existing private insurance plans to the point where the so-called government option is the only option,”³¹ thus causing “lower quality of care” by “removing the medical sector from the free enterprise system.”³²

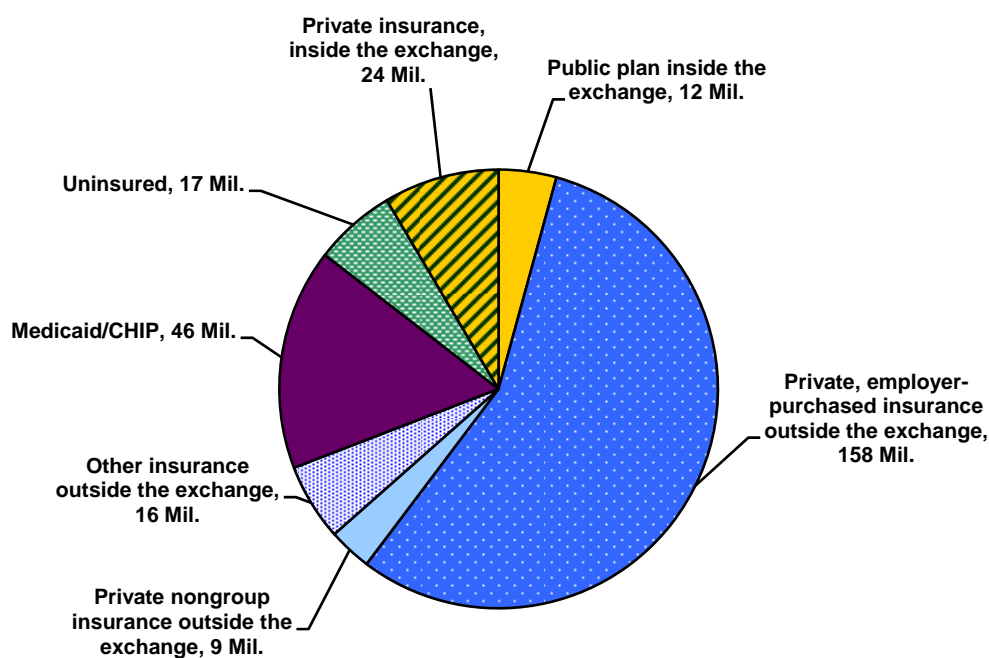
This argument has three serious flaws. First, including a public plan as an option in the health insurance exchange is highly unlikely to end the private health insurance industry in America. The original Tri-Committee House bill included the most aggressive public health plan provisions of any major reform proposal.³³ The Congressional Budget Office recognized inherent uncertainties but estimated that, under that proposal, only 12 million out of 282 million nonelderly Americans, or 4.3 percent, would

enroll in the public plan by 2019.³⁴ CBO estimated that private insurance would cover 158 million people through employers' purchase of insurance outside the exchange, 24 million in private plans offered through the exchange, and 9 million

consumers purchasing nongroup coverage outside the exchange, for a total of 191 million privately insured, or nearly 16 times the number of public plan enrollees (figure 1). Other forms of a public option, such as a consumer-owned

cooperative or the amended version of the House bill that passed the Energy and Commerce Committee, involve a public or quasi-public plan with even less capacity to compete effectively with private insurers.³⁵

Figure 1. Congressional Budget Office projections of FY 2019 health coverage under the original specifications of the House Tri-Committee proposal (millions of people under age 65)



Source: Authors' calculations based on estimates by CBO, July 17, 2009, and July 26, 2009.

Notes: "Other insurance outside the exchange" includes various systems of coverage that include Medicare for people under age 65 and care offered to active-duty military and veterans. "Private insurance inside the exchange" includes 20 million individual enrollees and 4 million people whose employers provide coverage through the exchange. "Public plan" members include 10 million individual enrollees and 2 million people whose employers provide coverage through the exchange.

CBO anticipated that only companies with fewer than 50 employees would be allowed to buy coverage through the exchange. According to 2008 survey data, this would exclude from the exchange 81.6 percent of all workers whose employers furnish them with health insurance.³⁶

CBO also concluded that the proposal, rather than lead most firms to drop coverage and let their workers buy insurance through the exchange, would cause a small net *increase* in employer coverage. Among other reasons, current federal tax advantages would continue to favor employer payment of insurance premiums, medium-sized and larger firms would face a financial penalty if they dropped coverage, and employers would be pressured to help their workers meet the individual coverage mandate. CBO's analysis is consistent with experience in Massachusetts, where the combination of subsidies, a health insurance exchange, and an individual mandate caused a nearly 3 percentage point increase in employer coverage.³⁷

CBO further determined that, among the estimated 36 million Americans receiving coverage through the exchange, one-third would choose the public plan. This is consistent with experience in California, which runs the nation's largest health coverage system for public employees outside the federal government. California offers state workers 10 health plan options, 3 of which are run by the same public agency that provides health and retirement benefits. In 2008, 29.3 percent of state employees and retirees chose a public option.³⁸

In a different analysis, The Lewin Group estimated (assuming full implementation in 2011) that the public plan could cover 103.4 million people, considerably more than forecast by CBO.³⁹ Lewin's analysis has been cited as evidence that an exchange with a public plan would dramatically reduce private insurers' role, helping lead to "a government-run, single-payer monopoly, with all private plans driven out of business."⁴⁰

However, as the Lewin analysts made clear, their estimate assumed that the exchange would be available to all employers, which is not required by current legislative proposals or believed likely by CBO. In addition, Lewin's calculations assumed that the public plan would pay providers at Medicare rates and have considerably lower administrative costs than those incurred by private insurers (although higher than Medicare administrative spending), resulting in public plan premiums 30 to 40 percent below those for comparable private coverage. If such a sizable cost advantage materialized, many people would select the public option. However, CBO determined that the likely premium differential would be closer to 10 percent, taking into account factors not considered by Lewin.⁴¹ When the Lewin analysts calculated the effects of a 10 percent premium differential and assumed that only small employers and individuals could use the exchange, they estimated that 17 million people would enroll in the public plan—a number quite close to CBO's projection, given the uncertainties inherent in all of these estimates. This lower estimate suggests a strong and ongoing role for private health insurance.

The claim that an inherently inferior public option would replace most private health insurance has a second major flaw—namely, it is individual consumers who decide whether to enroll in the public plan or in private insurance options offered through the exchange. If problems emerge with the public plan, consumers can vote with their feet and move to private coverage.

The distinction between an *option* to select a public plan and *mandatory* enrollment into publicly administered coverage makes a dramatic difference to popular support. A survey of likely voters in January 2009 found that, while 73 percent supported giving all Americans a choice between public and private health plans, only 9 percent supported a proposal that would enroll everyone into public coverage.⁴² The power of individual consumers to decide whether to enroll in a public plan thus seems to be a critically important element of current proposals. Nevertheless, some opponents of pending legislation charge that reforms involve a "massive, forced dislocation of currently insured individuals" who would "involuntarily lose their coverage due to a government-run plan,"⁴³ and that "millions more Americans will be forced onto a government-run plan."⁴⁴ This perception is at odds with the clear legislative language and CBO's analysis of pending proposals and their clear legislative language.

Third, the public plan would not "remove medical care from the free enterprise system," even if the public plan was based squarely on Medicare. While programs like the Veterans Health Administration (VA) furnish care through publicly

owned health care facilities and publicly salaried medical staff, Medicare pays private doctors and hospitals who provide covered services, and such providers exercise considerable flexibility in determining the care they furnish. As former Senate Majority Leader Bill Frist (R-TN) recently acknowledged, “Socialized medicine is not Medicare. Socialized medicine is you [i.e., the government] own the hospitals, you own the doctors... The VA is socialized.”⁴⁵

Medicare gives beneficiaries a choice between enrolling in a private health plan and seeking care from private providers whom the program reimburses on a fee-for-service basis. There is considerable evidence that Medicare beneficiaries are quite happy with the program. More than 90 percent of beneficiaries report good access to care.⁴⁶ In fact, when compared to privately insured individuals age 50 to 64, Medicare beneficiaries are less likely to experience waits for either routine appointments or urgent care.⁴⁷ Despite Medicare’s potentially open-ended cost-sharing obligations, only 15 percent of elderly Medicare beneficiaries have any problems paying medical bills, compared to 30 percent of adults with private coverage.⁴⁸ In addition, Medicare beneficiaries are significantly more confident than older adults with employer coverage that they can get high-quality, safe medical care when they need it.⁴⁹ In giving enrollees their choice of physician, Medicare nearly equals the flexibility offered by private Preferred Provider Organizations (PPOs) and exceeds the options available through private Health Maintenance Organizations (HMOs).⁵⁰

The eventual consequences of proposed reforms

Most of the claims that reform would impose federal control over the health care system involve alarmist speculation about future events. For example, although the statutory language of current proposals as well as CBO projections suggest that, in the short run, proposed reforms will not turn American medicine into a publicly administered enterprise, a recent Heritage Foundation paper predicts that events will unfold differently. The public plan “would be a wholly owned subsidiary of Congress,” so “if the exchange became a powerful regulatory agency,” Congress would have “powerful incentives to set the rules to the advantage of its own plan,” causing “the deck [to] be stacked against private-sector players in a game that is rigged from the start,” thus “ensur[ing] the eventual triumph of a single-payer system of national health insurance run by Washington.”⁵¹

A second example of such extended extrapolation involves comparative effectiveness research. Despite the above-described statutory language and the bipartisan origins of this policy initiative, Conservatives for Patients’ Rights sees it as “a first step towards rationing care in the U.S.,” anticipating the ultimate outcome as “injecting a government bureaucracy between patient and doctor in the name of cost,” which “can only lead to sacrificing care for those whose perceived life value cannot meet the government’s cost/benefit standards.”⁵²

Such projections of the future that go far beyond the legislative proposals do not enjoy an impressive track record of success.

One noteworthy example is Ronald Reagan’s prediction in the early 1960s about federal legislation that later became the Medicare program:

*First you decide that the doctor can have so many patients. They are equally divided among the various doctors by the government. But then doctors aren’t equally divided geographically. So a doctor decides he wants to practice in one town and the government has to say to him, you can’t live in that town. They already have enough doctors. You have to go someplace else. And from here it’s only a short step to dictating where he will go.... All of us can see what happens once you establish the precedent that the government can determine a man’s working place and his working methods, determine his employment. From here it’s a short step to all the rest of socialism, to determining his pay. And pretty soon your son won’t decide, when he’s in school, where he will go or what he will do for a living. He will wait for the government to tell him where he will go to work and what he will do.*⁵³

Reagan further claimed that the backers of Medicare subscribed to a “foot in the door philosophy” through which the creation of Medicare “for this particular population” would later expand into a system of “socialized medicine for every American.”⁵⁴ None of these predictions came true. If reform legislation passes in anything like its current form, opponents of today’s proposals may not prove any more accurate in their forecasts.

Conclusion

The late Senator Daniel Patrick Moynihan cautioned that “we are all entitled to our own opinions, just not our own facts.” That warning is

well-taken for everyone involved in helping the public understand the complex undertaking of national health reform and assess its potential risks and benefits. Given

where we are in the legislative process, reliable and objective analysis needs to focus on the details of current policy proposals and their likely results. Based on

this standard, it is hard to conclude that health reform legislation would lead to a government takeover of American medicine.

Notes

¹ House Majority Leader John Boehner, *Americans Concerned about Impact of Dems' Health Care Plan on Taxpayers, Families, Seniors*, August 6, 2009, <http://republicanleader.house.gov/News/DocumentSingle.aspx?DocumentID=141038>.

² FreedomWorks, *FreedomWorks Leads Grassroots Fight against ObamaCare*, July 21, 2009, <http://www.freedomworks.org/publications/freedomworks-leads-grassroots-fight-against-obamac>.

³ Newt Gingrich, "Deal Bites Dogs," *Washington Examiner*, July 31, 2009.

⁴ America's Health Insurance Plans (AHIP), the industry trade association, has agreed that, if legislation mandates the purchase of health coverage, practices such as excluding preexisting conditions can be outlawed, since consumers will no longer have the option of delaying the purchase of insurance until they get sick.

⁵ For example, insurers would be forbidden from limiting benefits or raising premiums based on the individual medical condition of each consumer; and premiums could vary by no more than a specified ratio based on such factors as age, gender, industry of employment, and area of residence.

⁶ Congressional Budget Office, letter to the Honorable Nathan Deal, August 7, 2009, <http://www.cbo.gov/doc.cfm?index=10492&type=1>.

⁷ See Robert Pear, "House Committee Approves Health Care Bill," *New York Times*, July 16, 2009, discussing CBO Director Doug Elmendorf's concerns about proposed legislation's impact on cost growth.

⁸ See Genevieve M. Kenney and Stan Dorn, *Health Care Reform for Children with Public Coverage: How Can Policymakers Maximize Gains and Prevent Harm?* Prepared by the Urban Institute for the Robert Wood Johnson Foundation, June 1, 2009.

⁹ Stan Dorn and John Holahan, *Are We Headed Towards Socialized Medicine?* Prepared by the Urban Institute for the Robert Wood Johnson Foundation, April 2008.

¹⁰ The one exception involved a proposal advanced by Congressman Kucinich. While the Kucinich proposal would preserve the private sector's role in furnishing care, the federal government's authority would be so expansive as to represent the functional equivalent of socialized medicine. Among its other features, the proposal would make it illegal to provide almost any health care services outside a greatly expanded Medicare program, place all capital investment decisions related to health care in the hands of the federal government, and forbid the for-profit provision of health care.

¹¹ Reform bills have been passed by the Senate Health, Education, Labor and Pensions (HELP) Committee and the House Committees on Education and Labor, Energy and Commerce, and Ways and Means. The Senate Finance Committee has released an outline of policy options and is working on a legislative proposal for potential action in September.

¹² The upper end of subsidy eligibility varies from 300 percent of the federal poverty level in the proposal under discussion in the Senate Finance Committee to 400 percent in the bills adopted by the other committees.

¹³ For example, the House Tri-Committee bill leaves it to the exchange administrator to determine whether large employers can participate after the first two years the exchange is operational.

¹⁴ Plans are likewise forbidden from engaging in medical underwriting—that is, assessing individual enrollees' health risks to determine the coverage that will be offered or the premiums that will be charged—or rescinding coverage if an illness arises.

¹⁵ As another example, some proposals forbid lifetime or annual limits on the amount of covered services.

¹⁶ For example, most private insurers pay physicians based on a multiple of Medicare's fee schedule; and when Medicare changed hospital reimbursement to pay based on each patient's Diagnosis-Related Group (DRG), most private insurers followed suit.

¹⁷ Peter Ferrara, *The Obama Health Plan: Rationing, Higher Taxes, and Lower Quality Care*, The Heartland Institute, August 2009.

¹⁸ American Medical Association, *Physician Characteristics and Distribution in the US, 2003-2004*, Chicago, IL, 2004.

¹⁹ Based on tabulations from the 2004-2005 Community Tracking Study Physician Survey.

²⁰ Authors' calculations based on data from: (1) American Hospital Association, *AHA Hospital Statistics: 2008 Edition*, Health Forum: Chicago, IL; and (2) Personal communication with staff at the Veterans Health Administration. Hospitals operated by the Veterans Health Administration are public facilities and admit approximately 800,000 patients each year.

²¹ Medicare Payment Advisory Commission (MedPAC), *A Data Book: Health Spending and the Medicare Program*, page 73, June 2009.

²² If anything, the proportion of care furnished privately may increase; some reform proposals fund health insurance subsidies through reduced payments to safety-net hospitals and could lead to the closure of public hospitals.

²³ Gail R. Wilensky, "The Policies and Politics of Creating a Comparative Clinical Effectiveness Research Center," *Health Affairs*, July/August 2009; 28(4): w719-w729.

²⁴ New Social Security Act Section 1181(h), added by H.R. 3200, Section 1401(a).

²⁵ Agency for Healthcare Research and Quality, Center for Financing, *Access and Cost Trends. 2008 Medical Expenditure Panel Survey-Insurance Component (MEPS-IC)*.

²⁶ House Tri-Committee bill includes standards that seek to prevent discrimination by insurers based on health status (H.R. 3200, Sections 111-116) and that require health insurance to include certain “essential benefits” (H.R. 3200, Sections 121-124). State insurance regulators would enforce these minimum federal standards, but they could set more demanding standards. If states did not enforce these rules, federal enforcement would occur. The goal articulated by congressional sponsors is to require insurers to treat people fairly by making them accountable to a transparent set of rules. In the end, there would be more uniformity in insurance rules across states than currently exists.

²⁷ Under current law, the federal government regulates some aspects of insurance markets. For example, employers cannot exclude preexisting conditions for new workers with prior, continuous coverage, and states must prevent certain types of discrimination based on health status when people transition from employer-sponsored insurance to non-group coverage. Mila Kofman and Karen Pollitz, *Health Insurance Regulation by States and the Federal Government: A Review of Current Approaches and Proposals for Change*, prepared by Health Policy Institute, Georgetown University, April 2006, <http://www.allhealth.org/briefingmaterials/HealthInsuranceReportKofmanandPollitz-95.pdf>. However, the states, rather than the federal government, currently set minimum benefit requirements, which do not apply to self-insured coverage. As explained above, proposed legislation would expand the federal government’s role in this area by setting a “floor” below which state benefit standards could not fall, and these new national rules would apply to self-insured plans.

²⁸ The President’s 2009 Budget for the U.S. Department of Health and Human Services, <http://www.gpoaccess.gov/usbudget/fy09/pdf/budget/hhs.pdf>.

²⁹ As noted in one news article, “Republican opponents say [President Obama’s] commitment of huge sums to try to revive the ailing economy is driven by a philosophical belief in greater government intrusion in many areas, from healthcare to education, dubbing it socialism.” Tabassum Zakaria, “Resistance Grows to Obama’s Bigger Government,” *Reuters News Service*, March 22, 2009, <http://www.reuters.com/article/newsOne/idUSTRE52L0J820090322?sp=true>. As one example, on May 5, 2009, Lou Dobbs commented on his radio show, “For the first time in the history of the United States, the federal government has supplanted sales, property, and income taxes at the state level as the biggest source of money for state and local governments,” adding that “so socialism has arrived in the first three months of this year, folks, and it is—well, it is what it is, and it’s not going to change, I’m afraid, for a little while.” Media Matters, “Mr. Independent” Dobbs repeatedly smears Obama, progressives as “socialist,” August 6, 2009,

<http://mediamatters.org/research/200908060012>. In his only public speech since leaving office, George W. Bush indicated openness to this line of argument. According to CNN: “Bush was asked what he thinks about conservative pundits who claim the Obama administration’s fiscal policies are opening the door to socialism. ‘I’ve heard talk about that,’ he said. ‘I think the verdict is out. I think people are waiting to see what all this means.’” Peter Hamby, “Bush: ‘The information we got saved lives,’” *CNN Political Ticker*, May 29, 2009, <http://politicalticker.blogs.cnn.com/2009/05/28/bush-the-information-we-got-saved-lives/>.

³⁰ John K. Iglehart, “Fate of SCHIP—Surrogate Marker for Health Care Ideology,” *New England Journal of Medicine* 357, no. 21 (November 22, 2007): 2104–2107.

³¹ Conservatives for Patients’ Rights, *Say No to Government-Run Healthcare*, undated on-line petition, <http://www.cprights.org/no-government-run-healthcare.php>.

³² Conservatives for Patients’ Rights, *All Roads Lead to Government-Run Healthcare*, http://www.cprights.org/pdf/GovRunHC_85x11.pdf.

³³ For example, payment rates are set at Medicare levels for the first three years of plan operation, with a 5 percent increase for providers who also accept Medicare; Medicare-participating providers automatically participate in the new public plan, unless they opt out; and federal funds help capitalize the public plan, amortized over 10 years of premium payments. House Ways and Means Committee, *America’s Affordable Health Choices Act Section-by-Section Analysis*, July 14, 2009, <http://waysandmeans.house.gov/media/pdf/111/sbys3200.pdf>.

³⁴ CBO, Letter to the Honorable Charles B. Rangel, July 17, 2009, <http://www.cbo.gov/ftpdocs/104xx/doc10464/hr3200.pdf>; CBO, Letter to the Honorable Dave Camp, July 26, 2009, <https://www.cbo.gov/ftpdocs/104xx/doc10400/07-26-InfoOnTriCommProposal.pdf>. In the former document, CBO estimated that 30 million people would receive coverage through the health insurance exchange in FY 2019, and 164 million would receive ESI. In the latter document, CBO made several important clarifications: its estimate of 164 million ESI recipients included 6 million people whose employers would buy them coverage through the exchange; and these 6 million people were not counted in CBO’s estimate that 30 million people would be covered through the exchange. As a result, we concluded that 36 million would receive coverage through the exchange. CBO further explained that, whether they reach the exchange as individuals or through employer sponsorship, one-third of exchange participants would choose the public plan. We accordingly calculated that 12 million

people would enroll in the public plan, given CBO’s estimates.

³⁵ The Senate Finance Committee proposal appears likely to include, not a publicly administered health plan, but a health insurance co-op owned by consumers. The House Energy and Commerce Committee, after negotiations between House leadership and “Blue Dog” Democrats, approved a bill that eliminated any linkage between Medicare reimbursement rates and the public plan, applied to the public plan various legal requirements that also govern private insurance, facilitated the establishment of state-level rather than federal exchanges, and supported the development of health insurance co-ops owned by consumers. See *Amendment to the Amendment in the Nature of a Substitute to H.R. 3200 offered by Mr. Ross of Arkansas, Mr. Hill of Indiana, Mr. Matheson of Utah, Mr. Space of Ohio, Mr. Barrow of Georgia, Mr. Gordon of Tennessee, and Mr. Melancon of Louisiana* (AINS-EC_001), July 31, 2009, 6:40 pm, http://energycommerce.house.gov/Press_111/20090731/hr3200_ross_2.pdf.

³⁶ Authors’ calculations from Agency for Healthcare Research and Quality, 2008 MEPS-IC.

³⁷ Sharon K. Long, “On the Road to Universal Coverage: Impacts of Reform in Massachusetts at One Year,” *Health Affairs*, Web Exclusive, June 3, 2008. Subsequent surveys show that employer-sponsored coverage continued to grow after the one-year period documented by Long. Massachusetts Division of Health Care Finance and Policy, *Health Care in Massachusetts: Key Indicators*, February 2009.

³⁸ A similar proportion, 27.9 percent, chose a publicly-administered plan in 2003, the earliest year for which data are available, suggesting a relatively stable level of enrollment into public coverage, rather than the rapidly growing percentage some observers (but not CBO) foresee under federal reform proposals. Authors’ calculations, California Public Employees’ Retirement System (CalPERS), *Preparing for Tomorrow: Comprehensive Annual Financial Report, Fiscal Year Ended 6.30.08*, December 17, 2008; Authors’ calculations, CalPERS, *Comprehensive Annual Financial Report, California Public Employees’ Retirement System, Year Ended June 30, 2003*, December 17, 2003. On the general issue of state-administered plans for state employees, Moffit argues that such self-funded forms of coverage are not analogous to the kind of public plan included in reform proposals, since these state plans typically carry the trade name of a private insurer, and states, rather than perform as an insurer, simply contract with third-party administrators to handle claims payment and similar functions. Robert E. Moffit, *State Employee Health Care as a “Public Plan,”* The Heritage Foundation, May 28, 2009. In California, the former concern is not well-taken. The publicly sponsored plans are named “PERS Choice,” “PERS Select,” and “PERSCare,” after CalPERS, the state agency that provides public employees

with health and retirement benefits. And while CalPERS contracts with a third-party administrator to perform key administrative functions, the same is true of Medicare and would doubtless be true of a public option under reform proposals.

³⁹ John Sheils and Randy Haught, *Analysis of the July 15 draft of The American Affordable Health Choices Act of 2009*, prepared by The Lewin Group for The Heritage Foundation, revised July 23, 2009, <http://www.lewin.com/content/publications/LewinHouseBillAnalysisHeritageRev.pdf>. The same findings were released several days later as John Sheils and Randy Haught, *Cost and Coverage Impacts of the American Affordable Health Choices Act of 2009: The July 15th draft*, Staff Working Paper #8, July 27, 2009, <http://www.lewin.com/content/publications/LewinAnalysisHouseBill2009.pdf>.

⁴⁰ Ferrara, *The Obama Health Plan*. See also House Minority Leader John Boehner, *Detailed Analysis: House Democrats' Government-Run Health Care Plan Breaks President Obama's Promises*, August 24, 2009, <http://republicanleader.house.gov/News/DocumentSingle.aspx?DocumentID=142197>; Conn Carroll, *Myths and Facts About Obamacare*, The Heritage Foundation, August 24, 2009, <http://fixhealthcarepolicy.com/in-the-news/myths-and-facts-about-obamacare/>.

⁴¹ CBO, Letter to the Honorable Dave Camp.

⁴² Lake Research Partners, *Voter Attitudes on a Public Health Care Plan*, January 26, 2009.

⁴³ House Republican Conference, "Healthcare," *GOP Solutions for America* (undated) <http://www.gop.gov/solutions/healthcare>.

⁴⁴ Senate Republican Policy Committee, *What We Know So Far from CBO about the Democrats' Health Care Plan*, July 30, 2009, <http://rpc.senate.gov/public/ files/HealthCareFactSheetHealthFactsWhatWeKnowSoFarfromCBOabouttheDemocratsHealthPlan.pdf>.

⁴⁵ "Healthcare Reform with Dr. Howard Dean and Dr. Bill Frist," *The Charlie Rose Show*, July 29, 2009, transcript at http://www.charlierose.com/view/interview/10524#frame_top.

⁴⁶ MedPAC, *A Data Book*, page 53.

⁴⁷ MedPAC, *A Data Book*, page 55.

⁴⁸ Karen Davis, Stuart Guterman, Michelle M. Doty, and Kristof M. Stremklis, "Meeting Enrollees' Needs: How Do Medicare and Employer Coverage Stack Up?" *Health Affairs*, Web Exclusive, May 12, 2009.

⁴⁹ Davis et al., "Meeting Enrollees' Needs: How Do Medicare and Employer Coverage Stack Up?"

⁵⁰ The percentage of physician practices accepting new patients, based on such patients' source of coverage, is 96.7 percent for Medicare, compared to 98.3 percent for private PPOs and 86.3 percent for private HMOs. MedPAC, *A Data Book*, page 57.

⁵¹ Robert E. Moffit, "A Federal Health Insurance Exchange Combined with a Public Plan: The House and Senate Bills," Heritage Foundation, July 30, 2009.

⁵² Conservatives for Patients' Rights, *Is Congress Importing Health Care Rationing from Britain?* Undated White Paper, <http://www.cprights.org/2009/05/is-congress-importing-health-care-rationing-from-britain.php>.

⁵³ Larry DeWitt, "Operation Coffeecup: Ronald Reagan's Effort to Prevent the Enactment of Medicare," September 2004, <http://www.larrydewitt.net/Essays/Reagan.htm>.

⁵⁴ A recording of the entire Reagan speech is available at <http://www.youtube.com/watch?v=fRdLpem-AAs>.

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