

The Pitfalls of the Public Option

By N. GREGORY MANKIW

IN the debate over health care reform, one issue looms large: whether to have a public option. Should all Americans have the opportunity to sign up for government-run health insurance?

President Obama has made his own preferences clear. In a letter to Senators Edward M. Kennedy of Massachusetts and Max Baucus of Montana, the chairmen of two key Senate committees, he wrote: “I strongly believe that Americans should have the choice of a public health insurance option operating alongside private plans. This will give them a better range of choices, make the health care market more competitive, and keep insurance companies honest.”

Even if one accepts the president’s broader goals of wider access to health care and cost containment, his economic logic regarding the public option is hard to follow. Consumer choice and honest competition are indeed the foundation of a successful market system, but they are usually achieved without a public provider. We don’t need government-run grocery stores or government-run gas stations to ensure that Americans can buy food and fuel at reasonable prices.

An important question about any public provider of health insurance is whether it would have access to taxpayer funds. If not, the public plan would have to stand on its own financially, as private plans do, covering all expenses with premiums from those who signed up for it.

But if such a plan were desirable and feasible, nothing would stop someone from setting it up right now. In essence, a public plan without taxpayer support would be yet another nonprofit company offering health insurance. The fundamental viability of the enterprise does not depend on whether the employees are called “nonprofit administrators” or “civil servants.”

In practice, however, if a public option is available, it will probably enjoy taxpayer subsidies. Indeed, even if the initial legislation rejected them, such subsidies would be hard to avoid in the long run. Fannie Mae and Freddie Mac, the mortgage giants created by federal law, were once private companies. Yet many investors believed — correctly, as it turned out — that the federal government would stand behind Fannie’s and Freddie’s debts, and this perception gave these companies access to cheap credit. Similarly, a public health insurance plan would enjoy the presumption of a government backstop.

Such explicit or implicit subsidies would prevent a public plan from providing honest competition for private suppliers of health insurance. Instead, the public plan would likely undercut private firms and get an undue share of the market.

President Obama might not be disappointed if that turned out to be the case. During the presidential campaign, he said, “If I were designing a system from scratch, I would probably go ahead with a single-payer system.”

Of course, we are not starting from scratch. Because many Americans are happy with their current health care, moving immediately to a single-payer system is too radical a change to be politically tenable. But for those who see single-payer as the ideal, a public option that uses taxpayer funds to tilt the playing field may be an attractive second best. If the subsidies are big enough, over time more and more consumers will be induced to switch.

Which raises the question: Would the existence of a dominant government provider of health insurance be good or bad?

It is natural to be skeptical. The largest existing public health programs — Medicare and Medicaid — are the main reason that the government’s long-term finances are in shambles. True, Medicare’s administrative costs are low, but it is easy to keep those costs contained when a system merely writes checks without expending the resources to control wasteful medical spending.

A dominant government insurer, however, could potentially keep costs down by squeezing the suppliers of health care. This cost control works not by fostering honest competition but by thwarting it.

Recall a basic lesson of economics: A market participant with a dominant position can influence prices in a way that a small, competitive player cannot. A monopoly — a seller without competitors — can profitably raise the price of its product above the competitive level by reducing the quantity it supplies to the market. Similarly, a monopsony — a buyer without competitors — can reduce the price it pays below the competitive level by reducing the quantity it demands.

This lesson applies directly to the market for health care. If the government has a dominant role in buying the services of doctors and other health care providers, it can force prices down. Once the government is virtually the only game in town, health care providers will have little choice but to take whatever they can get. It is no wonder that the American Medical Association opposes the public option.

To be sure, squeezing suppliers would have unpleasant side effects. Over time, society would end up with fewer doctors and other health care workers. The reduced quantity of services would somehow need to be rationed among competing demands. Such rationing is unlikely to work well.

FAIRNESS is in the eye of the beholder, but nothing about a government-run health care system strikes me as fair. Squeezing providers would save the rest of us money, but so would a special tax levied only on health care workers, and that is manifestly inequitable.

In the end, it would be a mistake to expect too much from health insurance reform. A competitive system of private insurers, lightly regulated to ensure that the market works well, would offer Americans the best health care at the best prices.

The health care of the future won't come cheap, but a public option won't make it better.