

Statement of

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Health Reform in the 21st Century:
Proposals to Reform the Health System**

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United States House of Representatives**

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Mr. Chairman and distinguished members of the committee, thank you for inviting me to share my views on the Tri-Committee's health reform draft proposal. The views I express are mine alone and should not be attributed to the Urban Institute, its trustees, or its funders.

The proposal has many strengths and I applaud the committee for the thoroughness with which it approached its development. In many respects, it builds upon the successful health reform enacted in the state of Massachusetts. It provides for a Medicaid expansion to 133 percent of the federal poverty level (FPL), a set of income-related subsidies between 133 percent FPL and 400 percent FPL, a national health exchange, and extensive insurance market reforms. It contains an individual mandate, which is essential to providing universal coverage. It provides for a competitive framework within the exchange by requiring individuals to pay more if they want more comprehensive coverage. The plan improves access to primary care, including increasing payment rates to primary care physicians in the Medicaid program. It also provides for a cap on total out-of-pocket spending, an essential protection for those with high medical expenses in a given year. Finally, it includes a public option, which I think is essential for several reasons that I will discuss below.

I want to focus my testimony on a few specifics of the plan: the individual mandate, the public plan option, the Medicaid reforms, and the employer pay or plan mandate. First, an individual mandate is essential for providing universal coverage. Numerous studies and the leading microsimulation models have shown that voluntary efforts, even with generous subsidies, will fall well short of universal coverage.¹ An

¹ Linda J. Blumberg, John Holahan, Alan Weil, "Toward Universal Coverage in Massachusetts." *Inquiry* 43 (2006): 102–21; Danielle Holahan, Elise Hubert, and Cathy Schoen, "A Blueprint for Universal Health

individual mandate with subsidies that make coverage affordable is a fair way to get to universal coverage. Voluntary efforts will tend to extend coverage to those with the most serious health conditions. As a consequence, adverse selection into a new guaranteed source of insurance coverage would likely lead to unstable insurance pools. A requirement for everyone to participate eliminates this critical problem. Also, the government's cost of extending coverage via an individual mandate to those who would not voluntarily enroll is relatively small because this group tends to be healthier and, therefore, lower cost. Further, without an individual mandate and universal coverage, it is impossible to reallocate dollars now being used to support safety net providers that care for the uninsured. This is an important source of financing that is only possible with an individual mandate.

Second, I think it is important that the committee has included a public insurance option in the plan because having a competitor to private plans, under a fair set of market rules, will provide more choice and place substantial cost containment pressure on the health care system. The arguments made in the public plan debate too often ignore the fact that a public competitor would not be introduced into a well-functioning health marketplace. Many health insurance markets, as well as provider markets, are simply not competitive today. As a result, the markets are not providing the benefits one would expect from competition, including efficiency and control over the growth in health care costs. An extraordinary amount of concentration in the insurance and hospital industries has taken place over the past several years. This concentration has been a significant contributor to cost growth.

Insurance Coverage in New York” (New York: The United Hospital Fund and the Commonwealth Fund, 2006).

According to a 2003 study, 34 states have had values of the Herfindahl-Hirschman Index, a measure of market concentration, that exceed guidelines set by the Department of Justice and the Federal Trade Commission and should trigger antitrust concern.² Another study has shown 94 percent of 314 large metropolitan statistical areas (MSAs) were highly concentrated.³

Provider markets, particularly hospital markets, have also become increasingly concentrated in recent years. According to a 2006 study, 88 percent of large metropolitan areas were considered to have highly concentrated hospital markets.⁴ Studies have shown that hospital rates are as much as 40 percent higher in more highly concentrated markets.⁵ While much of the hospital sector is not-for-profit, the lack of competition often means increased revenue that can be devoted to the purchase and diffusion of new and higher-cost technologies and procedures.

The impact of consolidation on health care spending depends on the particular market. In markets where there is little concentration among insurers but a concentrated

² James C. Robinson, "Consolidation and the Transformation of Competition in Health Insurance," *Health Affairs* 23, no. 6 (2004): 11–24; The Federal Trade Commission and U.S. Department of Justice, Horizontal Merger Guidelines, issued April 2, 1992, and revised April 8, 1997, www.ftc.gov/bc/docs/hmg080617.pdf. The Herfindahl-Hirschman Index is calculated by summing the squared market shares of each competitor in a given market.

³ American Medical Association, "Competition in Health Insurance: A Comprehensive Study of U.S. Markets" (Chicago: American Medical Association Division of Economic and Health Policy Research, 2008).

⁴ William B. Vogt and Robert Town, *How Has Hospital Consolidation Affected the Price and Quality of Hospital Care?* (Robert Wood Johnson Foundation Research Synthesis Report 9, 2006); see also Federal Trade Commission and Department of Justice, *Improving Health Care: A Dose of Competition* (Washington, DC: Federal Trade Commission and Department of Justice, 2004), http://www.usdoj.gov/atr/public/health_care/204694.htm.

⁵ Alison Evans Cueller and Paul J. Gertler, "How the Expansion of Hospital Systems Has Affected Consumers," *Health Affairs* 24, no 1 (2005): 213–19; C. Capps and D. Dranove, "Hospital Consolidation and Negotiated PPO Prices," *Health Affairs* 23, no. 2 (2004): 175–81; Cory Capps and David Dranove, "Competition and Market Power in Option Demand Markets," *RAND Journal of Economics* 34, no.4 (2003); Emmett B. Keeler, Glenn Melnick, and Jack Zwanziger, "The Changing Effects of Competition on Non-Profit and For-Profit Hospital Pricing Behavior," *Journal of Health Economics* 18, no. 1 (1999); R. Krishan, "Marketing Restructuring and Pricing Behavior," *Journal of Health Economics* 20, no 2 (2001); L. Dafny, "Estimation and Identification of Merger Effects: An Application to Hospital Mergers," Mimeo, Northwestern University, 2005.

hospital market, there is little ability to negotiate. Where there is a dominant insurer, it is possible to do better and obtain discounts from hospitals, but they still have little negotiating power with dominant hospital systems. In some markets, dominant insurers have no real incentive to be tough negotiators because they have no real competitors. Small insurers lack bargaining power with providers and thus cannot significantly compete with larger insurers on premiums. Finally, there is no real competition in many hospital markets because smaller hospitals have no ability to challenge the dominant system.

The public plan can help with the problem of cost containment in the United States. First, it is likely to have somewhat lower administrative costs, though not as much as some have argued.⁶ The public plan can also establish and negotiate provider payment rates at lower levels than private payers are able or willing to negotiate today. The plan can pay lower rates than do commercial plans but higher than current Medicare rates. It may be necessary to require providers who participate in Medicare to participate in the public plan, at least in the short term. But participating in the public plan is not a requirement to see large numbers of patients. Much more important is that the program makes participating economically worthwhile. A program that pays higher rates than Medicare does today should result in many providers being willing to participate voluntarily. MedPAC should have a role in advising the Congress on the payment rates to ensure access to sufficient numbers of providers and to avoid adverse effects on the financial viability of institutions.

⁶ Merrill Matthews, "Medicare's Hidden Administrative Costs: A Comparison of Medicare in the Private Sector" (Alexandria, VA: Council for Affordable Health Insurance, 2006).

A number of aspects of the public plan are important to ensure fair competition. The public plan should be legally and administratively separate from exchanges. It should abide by the same insurance market rules as private plans. It should offer the same benefit packages and have the same levels of cost sharing and caps on out-of-pocket liabilities. The income-related subsidies should apply in the same way to all plans within the exchange. The plan should operate on a level playing field with regard to maintaining reserves. Initial start-up capital will be needed. The public plan should be required to set premiums high enough to build up adequate reserves and to pay back the government over time for the initial start-up funds.

On the other hand, the public plan may well get a disproportionate share of high-risk enrollees. A level playing field means that a public plan should be compensated if it ends up with populations with higher medical needs. But risk adjustment is not perfect, and the public plan could have somewhat higher premiums as a result.

However, the presence of the public plan should have a significant cost containment impact both directly by providing a lower cost option and indirectly by creating incentives for private insurers to become more efficient. The House proposal calls for individuals to have a choice among plans within the exchange and for subsidies tied to a mix of the lowest-cost plans in the area. If the public plan is one of the lower cost plans in an area, as we expect, it will bring down subsidy costs significantly. In a paper being released this week, we estimate that subsidy costs would be lower by \$200–400 billion relative to a plan with only private insurance options.⁷

⁷ John Holahan and Linda Blumberg, “Is the Public Plan Option a Necessary Part of Health Reform?” (Washington, DC: The Urban Institute, forthcoming).

We also believe that the public plan will not destroy the private insurance market. In the same paper, we have estimated that the number of people losing private coverage will be relatively small. While a number of those currently in the nongroup and small-group market will purchase coverage through the exchange and many will choose to join the public plan, there are close to 50 million uninsured who will newly obtain coverage. Many of these will take up employer coverage outside the exchange; others will purchase coverage within the exchange and will choose both public and private options. On balance, we estimate that the number of people with private coverage will fall from about 177 million to 163 million.⁸

One issue ignored by many in this debate is that the private market will respond to the presence of a public option. There are many insurers that do an excellent job of managing care. This is particularly true of integrated health systems. But it is also true that Blue Cross plans and others that have substantial market share can reduce costs. Plans with limited leverage are likely to be at risk, but private plans that can develop strong management systems and negotiate effectively with providers will remain active and successful competitors in the new market place.

Thus, we conclude that the public option will help lower the costs within the exchange, and even with possible spillover effects to plans offered outside the exchange. Private insurers will respond to this competition, and health care costs will be lowered as a result. The number with private insurance will not be too different than it is today due to the expansion of coverage overall, and the savings to the government in lower subsidy costs will be substantial.

⁸Holahan and Blumberg, "Is the Public Plan Option a Necessary Part of Health Reform?"

Third, I applaud the committee for the Medicaid provisions in the bill, particularly the proposal to increase payment rates for primary care physicians. I would encourage the committee to consider increasing payment rates for specialists as well. However, I also believe that the provision that pays 100 percent of the cost of new enrollees should be reconsidered. Such a policy would provide a large amount of money to states with low levels of coverage today and provide no relief to states that have already covered populations to these levels. Now is an opportunity to restructure parts of Medicaid financing to make it more equitable among states. The legislation could have the federal government pick up state responsibility for Medicare premiums and cost sharing and eliminate the prescription drug claw-back. It could increase matching rates on acute care services. This would provide some fiscal relief to all states and help address some longstanding Medicaid financing issues. This would not fully address all the needs of lower-income states. The remaining gap in their funding for new enrollees could be met with a short-term matching rate increase that would be phased out over time.

Fourth, the provision for an employer mandate with a payroll tax of 8 percent of payroll should be reconsidered. It is true that some believe an employer mandate is necessary to keep employers from dropping coverage. However, there is considerable research evidence, as well as actual experience in Massachusetts, that employers are unlikely to drop coverage.⁹ Most employers in the United States offer coverage to their workers without a mandate; they do so to compete for workers. The current tax exclusion of employer contributions to health insurance provides a strong incentive to provide some

⁹ Sharon K. Long and Paul B. Masi, "How Have Employers Responded to Health Reform in Massachusetts? Employees' Views at the End of One Year," *Health Affairs* 27, no. 6 (2008): 576–83; Jon R. Gabel, Heidi Whitmore, Jeremy Pickreign, Will Sellheim, Shova KC, and Valerie Bassett, "After the Mandates: Massachusetts Employers Continue to Support Health Reform as More Firms Offer Coverage," *Health Affairs* 27, no. 6 (2008): 566–75.

form of compensation in the form of health benefits. There is nothing in this legislation that would change these fundamental incentives. The Massachusetts experience has shown that, despite the very small penalty on employers, employer coverage has actually increased. This is because in order to comply with an individual mandate, workers are more likely to take up employer offers of coverage. Further, employers in competition for workers find it advantageous to offer coverage to help their workers satisfy the mandate. One possibility is to assess a tax rate that varies with worker wages: 2 percent on those whose wages are less than \$20,000, 4 percent for those with wages between \$20,000 and \$60,000, and 6 percent for others, up to a cap.

Finally, while there is not a cost estimate for this bill, the CBO estimates for one of the Senate bills last week was \$1.6 trillion over 10 years. This may seem an alarming number but it should be viewed in context. Over the ten-year period, 2010–2019, the amount of gross domestic product produced in the U.S. economy will be \$187 trillion dollars.¹⁰ Even a number as high as \$1.6 trillion is less than 1 percent of the amount of GDP being produced over this period. The \$1.6 trillion does not account for the savings to business and individuals because of subsidies and new coverage options, and states and localities because of less uncompensated care. The new societal cost, net of these savings, is closer to \$1.0 trillion. We will spend \$33 trillion on health care over this period, even without reform. We clearly need to gain control over this spending. It is important to pass a good plan—not one that is meant to achieve an arbitrary budget goal. It is important that health reform be fully paid for. There are many ways to achieve this.

¹⁰ Congressional Budget Office, “A Preliminary Analysis of the President’s Budget and an Update of CBO’s Budget and Economic Outlook” (Washington, DC: CBO, 2009), <http://www.cbo.gov/ftpdocs/100xx/doc10014/03-20-PresidentBudget.pdf>.