Exhibit 13

HEALTH REFORM IN THE 21ST CENTURY: INSURANCE MARKET REFORMS

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Prepared Statement of Uwe E. Reinhardt, Ph.D., James Madison Professor of Political Economy and Professor of Economics and Public Affairs, Princeton University, Princeton, New Jersey

My name is Uwe E. Reinhardt. I am Professor of Economics and Public Affairs at Princeton University, Princeton, New Jersey. My research work during the past several decades has been focused primarily on health-care economics and policy.

I would like to thank you, Chairman and your colleagues on this Committee for inviting me to present a statement on the problems of structuring a market for individually purchased health insurance in the United States.

After some remarks on the interface between social ethics and health reform, my statement will focus for the most part of ways of reforming the market for health insurance.

I. INTRODUCTION

Any modern health system, regardless of its structure, must perform the following five major functions:

1. **FINANCING** health care, that is, extracting the requisite funds for the health system from individuals and households, who ultimately pay for all of health care. (Government, employers and private insurers are merely pumping stations in the flow of funds from individuals and households to the providers of health care).
2. **POOLING RISKS** for the purpose of protecting individuals and households from the uncertain financial cost of needed health care.
3. **PURCHASING** health care from its providers (doctors, hospitals, and so on), which includes negotiating or setting the prices to be paid for health care and determining the set of goods and services actually needed for the efficient, evidence-based best treatment of given medical conditions (including disease management and chronic care).
4. **PRODUCING** the goods and services required for the proper treatment of given medical conditions, including their diagnosis.
5. **REGULATING** the various clinical and economic activities involved in the operation of the nation's health system so that it works consistently towards socially desired ends.

As I understand it, this hearing is about the allocation of the first three functions between the private and the public sectors. The fifth function, of course, is the natural preserve of government, especially after the financial markets have demonstrated at such great cost to the rest of the world that private markets cannot be trusted to be self-regulating and working in society's interest, a point now grasped even by economists, including libertarian Alan Greenspan.

The allocation of the first three functions between government and the private sector, however, is not so clear-cut. It depends crucially on the social goals society wishes to posit for its health system, including how the financial burden of ill health is to be allocated to members of society and how care is to be distributed among them. I shall therefore offer a few remarks on that facet of a health system.

II. THE SOCIAL GOALS OF HEALTH SYSTEMS

Most industrialized nations in the OECD, along with Taiwan, seek to operate their health systems on the *Principle of Social Solidarity*. It means to them that health care is to be viewed as a so-called "social good," like elementary and secondary education in the United States. That perspective, in turn, implies that the financial burden of health care for the nation as a whole should be allocated to individual members of society roughly in accordance with the individual's ability to pay, and that needed health care should be available to all members of society on toughly equal terms.

If the health system is to operated subject to this distributive social ethic, it requires that government either operate the financing, risk-pooling and purchasing functions directly (as is the case in Canada, Taiwan and the UK, for example) or that government tightly regulate all three functions, even if they are actually performed by private institutions outside of government proper (as is the case in Germany, the Netherlands and Switzerland).

Unfortunately, the United States never has been able to evolve a widely shared consensus on the distributive social ethic that ought to govern the U.S. health system. The bewildering American health system reflects that lack of consensus.

At one end of the ideological spectrum, many Americans appear to believe that health care ought to be treated as a private consumer good that should be distributed on the basis market principles. This means that the financing of health care ought to be viewed primarily as the responsibility of the individual, and only the

poorest members of society ought to be given public assistance in procuring a bare-bones package of health care. In other words, these Americans believe that, for the most part, health care should be rationed among members of American society on the basis of price and ability to pay, like other basic consumer goods, such as housing, clothing and food.

At the other end of the ideological, just as many other Americans share the ethical precepts of other nations in the OECD. These Americans, too, believe that our health system ought to be operated on the *Principle of Social Solidarity*, that is, that health care should be viewed a social good. If rationing of health care there must be, then it ought to be on principles other than price and ability to pay.

In between these distinct but coherent views reigns massive intellectual confusion.

To illustrate, the same citizens and politicians who look askance at "socialized medicine"[1] reserve the purest form of socialized medicine—the VA health system—for the nation's allegedly much admired veterans. A foreigner may be forgiven for finding this cognitive dissonance bizarre.

Similarly, there are many Americans, who believe that government does not have the right to impose on them a mandate to have health insurance, all the while considering it their moral right as Americans to receive even horrendously expensive tertiary health care in case of critical need, even if the recipients have no hope of financing that care with their own resources. Foreigners may be forgiven for shaking their heads at this immature and asocial entitlements mentality, which would be rare in their home countries.

Finally, a good many citizens and politicians who accept with equanimity the rationing of health care by price and ability in this country openly deplore the rationing of health by administrative means in other countries, perhaps not realizing that textbooks in economics explicitly ascribe to market prices the role of rationing scarce resources among unlimited want[2] Why the latter form of rationing is superior to the former is not obvious.

A much mouthed mantra in our debate on health policy is that "we all want the same thing in health care, but merely quibble over the means to get there." Nothing could be further from the truth. That debate has been and continues to be a tenacious ideological fight over the social ethic that ought to govern American health care; but we camouflage it as a technical debate strictly over means.

My plea before this Committee and to the Congress is that any health reform proposal put before the American people be preceded with a preamble that clearly articulates the social goals our health system is supposed to pursue and the social ethic it is to observe. Policy makers in other nations routinely do so and accept the constraints that this preamble imposes on their design of health reform. It would be helpful to have a clearly articulated statement on the social ethics for American health care as well.

With these preliminary remarks, I would now like to turn to the structure of the market for health insurance.

III. THE MARKET FOR PRIVATE HEALTH INSURANCE

The value a health insurance system offers society is the ability to pool the financial risks faced by individuals in order to protect members of that risk pool from uncertainty over the financial inroads of high medical bills in case of illness. In return for receiving that value, individuals make a financial contribution to the risk pool, in the form of taxes (e.g., payroll taxes) or premiums.

Many economists view this risk pooling as the sole proper function of health insurance *per se*. To them, for example, the segmentation of a free market for private health insurance by risk class, with relatively higher insurance premiums charged to patients expected to be relatively sicker over the insured future period, is not only an inevitable outcome of such a market, but is viewed perfectly acceptable. Such

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[1] The formal definition of "socialism," according to my American Heritage Desk Dictionary, is a system in which *government owns the means of production*. "Socialized medicine" thus is a system in which government owns, operates and finances health care, as in the VA health system. It is not the same as "social insurance," which merely is an arrangement under which individuals transfer financial risks they face to a larger collective body, often the government. The limited liability shareholders of corporations enjoy, for example, is one of the oldest forms of social insurance, as is the Federal Government's assistance to states struck by natural disasters, as is the many guarantees government extends to the financial sector and as is, of course, Medicare and Medicaid.

[2] As two well-known authors put it: "*Bread must be rationed somehow; and the price system accomplishes this in the following way: Everyone who is willing to pay the equilibrium price gets the good, and everyone who is not, does not.*" See Michael L. Katz and Harvey S. Rosen, *Microeconomics*, (1991): 15.

premiums are called "actuarially fair." On this view, if society wants greater equity in the financing of health care, then government should provide risk-adjusted subsidies toward the purchase of actuarially priced private insurance.

As a practical matter, however, most people seem to believe that both private and public insurers should not only protect individuals from the variance of their own health spending likely to be incurred by that individual over time, but also incorporate in its premium structure hidden cross subsidies from chronically healthy to chronically sick members of society. Most health insurance systems in the world actually do that, including the Medicare and Medicaid programs in the United States and the private employment-based health insurance system.

A. Employment-Based Insurance

In the market for employment-based group health-insurance, the insurance premium paid the insurer by the employer typically is "experienced rated" over the group of employees being insured. It means that the premium reflects the *average expected (actuarial) cost* of the health care likely to be used collectively by all of that employer's employees, plus a markup-up for the cost of marketing and administration and profits.

In effect, then, the bulk of the risk pooling for employment-based health insurance actually is performed by the employer, not the insurer. The insurer bears only a small fraction of the total risk, a fraction that varies inversely with the size of the insured group.

This is even clearer when the employer overtly self-insures, as most large employers in the United States now do. In that case, the employer bears all of the financial risk of the employees' illness, and private insurance carriers are engaged by the employer merely perform the purchasing function (the third function above) on behalf of the employer-run risk pool, including claims processing.

Economists are persuaded by both theory and empirical evidence that, over the longer run, the full cost of the employer's contribution to the employees' group health insurance is shifted back somehow to employees in the form of lower take-home pay or a reduction in other fringe benefits. The arrangement typically does force chronically healthier employees to cross-subsidize chronically sicker employees, because the reduction in take-home pay within a given skill level is independent of the individual employee's health status.

In a sense, then, employment-based insurance is a form of "social insurance." One may call it "private social insurance," especially for larger employers, as distinct from government-run social insurance. It is one reason that the employment-based system has such strong support among people who would like to see American health care governed by the *Principle of Social Solidarity*. The feature of employment-based insurance that attracts them is the pooling of risks in that system.

A problem, of course, is that this principle is vastly eroded, the smaller the number of employees is over which premiums are experience-rated. For very small firms, employment-based insurance approximates individually purchased insurance.

B. The Market for Individual Insurance

In the market for individually purchased insurance, risk pooling necessarily must take place at the level of the insurance company.

As is well known from a distinguished literature in economics, a price-competitive market of individually sold health insurance will naturally segment itself by risk class. By economic necessity—and not a mean spirit—insurers in such a market have no choice but to engage in "medical underwriting" if they want to survive.

This means that private insurers must (a) determine as best they can the health status and likely future cost to the risk pool that an individual prospective customer will cause and (b) charge the individual a premium that covers that anticipated cost (the "actuarially fair premium") plus a mark-up for the risk pool's cost of marketing and administration and for desired profits. The size of this mark-up is constrained through price competition. As the Lewin Group estimated in a recent report, this mark-up averages 31.7% for private insurers in the individual market.[3]

The general public and the media that informs the public seem insufficiently cognizant of the horrendously complex product insurers sell. A health insurance policy is a so-called "contingent contract" under which the insurer is obligated to pay the insured a specified amount of money—or, alternatively, to purchase for the insured specified medical benefits—should that contingency arise.

The problem has always been to define that "contingency" so that it does not trigger disputes on whether or not the contingency has occurred—e.g., whether a med-

[3] The Lewin group, *The Cost and Coverage Impacts of a Public Plan: Alternative Design Options,* Staff Working Paper # 44, April 6, 2009.

ical procedure was called for on clinical grounds. Furthermore, it should be clear that *both* sides to the contract—the insured and the insurer—have the opportunity to cheat on the contract, if they are so inclined. It is the reason why these types of contingent contracts typically are subject to penetrating government regulation and oversight.

There is a tendency among the critics on the private health insurance industry to vilify it. I find that unfair and unproductive. The important question is whether that industry, as it is currently structured, can serve the social objectives American society may wish to posit for it and, if not, what regulation of the industry would be required to make it march toward the desired social goal.

C. Marrying a Purely Private Insurance Sector to the Principle of Social Solidarity

If the social objective of our health reform is to make health insurance available to all Americans on equal terms—as President Obama's campaign statements clearly imply—then the current private market for individual insurance has three major shortcomings.

The first is the practice of *medical underwriting,* that is, the practice of inquiring deeply into the personal health status of individual applicants for insurance and basing the quoted premium on the individual's health status. This practice could be eliminated by forcing every insurance company to charge the same premium to every one of its customers, with the possible exception of age. Every insurer would charge so-called *community-rated premiums*, although these could vary competitively among insurers.

A second practice at odds with the President's stated social goal for American health care is the practice of denying health insurance to anyone whose expected future medical bills exceed the premium that can be charged the individual, or to rescind insurance *ex post* when medical claims have piled up and he insurer cancels the policy over some flaw belatedly found in the original application for insurance. This practice can be eliminated by imposing *"guaranteed issue"* on the industry. It means every insurer must accept all applicants seeking to buy coverage at the insurer's quoted community-rated premium and may not cancel policies *ex post*.

But as both the theoretical and the empirical literature on this market clearly demonstrate, imposition of *community-rated premiums* and *guaranteed* issue on a market of competing private health insurers will inexorably drive that market into extinction, unless these two features are coupled with a third, highly controversial requirement, namely, a *mandate on individual to be insured* for a at lest a specified minimum package of health benefits.[4]

A mandate upon the individual to be insured, however, is likely to be disobeyed by large numbers of low-income individuals unless the government is willing and able to grant those individuals sufficient public subsidies toward the purchase of health insurance. One way to assess the adequacy of these subsides is to reach a political consensus on the maximum percentage X that the individual's (or family's) total outlay for health insurance premiums and out-of-pocket health-care spending takes out of the unit's discretionary income (disposable income minus outlays for other basic necessities, such as food, housing, clothing, etc.). That maximum percentage X probably would have to rise with income. Its proper size is a political call. It would be helpful if Congress could agree on such a number.

With these four features—*(1) community rating, (2) guaranteed issue, (3) mandated insurance* and *(4) adequate public subsidies*—a private, strictly monitored health insurance market for individually purchased health insurance probably could be made to march fairly closely in step with the distributive social ethic professed by the President and by many Members of Congress. It would require very tight regulations and supervision of the industry, however, most likely through the National Health Insurance Exchange provided for in the President's health-reform proposal. Within their ranks of enrollees, both the Medicare Advantage program and the Medicaid Managed Care program are tightly regulated and supervised in roughly this fashion.

IV. THE POTENTIAL ROLE OF A NEW PUBLIC HEALTH PLAN

During his presidential campaign, President Obama firmly and quite explicitly promised not only to reform the market for private, individually sold health insur-

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[4] For a report on how private insurance markets implode when the mandate to be insured is not imposed in a community-rated market with guaranteed issue, see Alan C. Monheit, Joel C. Cantor, Margaret Koller, and Kimberley S. Fox, "**Community Rating And Sustainable Individual Health Insurance Markets In New Jersey:** Trends in **New Jersey** 's Individual Health Coverage Program reveal troubled times for the program," *Health Affairs*, July/August 2004; 23(4): 167–175.

ance—along the lines outlined above—but to include among the insurance options in this market a new public plan for non-elderly Americans. This public plan would have to compete with private health insurers for enrollees.

A. Why might a Public Plan be attractive to Americans?

One could imagine a sizeable latent demand among the American public for such a public health plan, even in the absence of any significant cost advantage that such a public plan might have.

In recent years, Americans have seen retiree health benefits once promised them by private corporations melt away. They have seen their 401(k) savings in the private sector similarly melt down severely and the value of any other private pension plan vastly eroded. They have lost their employer-based health insurance with their job or, if they have not yet lost it, they fear of losing it. They have seen once revered and seemingly indestructible American corporations stumble toward bankruptcy and extinction, either at the hand of global competition or as a result of mismanagement. Finally, they have seen the once revered leaders of the financial sector behave in so irrational and destructive a manner as to make a mockery of received economic theory, with its instinctive belief in the economic superiority of private markets[5].

After all of this turbulence, destruction and self-immolation in the once hallowed private sector of the economy, many Americans may now seek the comfort of permanence that a fully portable, reliable and permanent government-run health insurance plan would offer them, side by side with the possibility of choosing a private health insurance plan instead. To deny them that opportunity would require a compelling justification.

Advantages of a Public Plan: A public health insurance plan for non-elderly Americans could offer society a number of advantages.

First, it would be likely to have the advantage of large economies of scale. Therefore, it could economically use expensive and powerful health-information technology to simplify claims processing, lower the cost of prudent purchasing ad quality monitoring, and engage in disease management, if it were allowed to do so.

Although a few large private insurers dominate the market in many areas, overall the market for private health insurance remains remarkably splintered, with many insurers carrying on somehow with very small enrollments, often below 20,000 insured[6] It is not clear how such small insurers can harvest the economies of scale of marketing and administration, and especially the benefits of health information technology. One must wonder what features in this market have allowed them to survive to this point. Presumably, the market for private insurance would have to consolidate significantly in a reformed insurance market.

Second, a public plan would not have to include in its premiums an allowance for profits and probably have low or no marketing costs. The previously cited Lewin Group sees that as a significant cost advantage of the public plan, reducing administrative costs as a percent of medical claims to about 13%, relative to 31% for private insurers. That advantage, however, may be exaggerated if private insurers offered their policies through a formal insurance exchange, reducing the cost of commissions to insurance brokers.

A third advantage could be the ability of a public plan to innovate in paying the providers of health care. Medicare already has been remarkably innovative on that front. The case-based DRG system for hospital payment, now being copied around the world, is Medicare's creation, and so is the development of the Resource-Based-Relative-Value Scale (RBRVS) which now forms the basis of negotiations over fees between physicians and private health insurers.

The next step in payment reform has to be a move away from the time-honored but inefficient fee-for-service system that dominates in both the private and public insurance sectors, and round the world, towards bundled, case-based payments for evidence based, clinically integrated care[7] Along with Medicare, a new public plan for non-elderly Americans could play a role in the development of this payment method as, of course, could private insurance plans.

Finally, government has already contributed substantially to the measurement of the quality of health care and websites that disseminate such information to the

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[5] See, for example, George A. Akerlof and Robert J. Shiller, *How human Psychology Drives the Economy, and Why it Matters for Global Capitalism,* Princeton University Press, 2009.

[6] See, for example, Allan Baumgarten, *Texas Managed Care Review* 2006 (available at http://www.allanbaumgarten.com/images/presentations/TX_ManagedCareReview_2006.pdf) and similar reports by that author for other states.

[7] See, for example, the website of Prometheus Payment® Inc., http://www.prometheuspayment.org/

market place and has fielded demonstration projects for disease management, once again side by side with the private sector.

Problems with a Public Plan: As I see it, the main problems with the addition of a public health insurance plan to a menu of competing private insurance options are political, rather than technical.

There is in the realm of politics the overarching question whether government should perform functions that the private sector could also perform, even if the private-sector would use more resources—be more costly—to achieve the same end. We see that question debated now in connection with student loans[8] which, according to the Congressional Budget Office[9], cost taxpayers considerably more when channeled through the private banking sector than when loans are made directly by government to students. The outcome of the current debate over student loans may be an augury for the course of health reform.

But even if the answer to the previous question were "Yes"—that government may indeed intrude as a competitor on economic turf traditionally held by the private sector—there is the question of what would constitute a level playing field in a proposed competition of private insurers with a new public plan.

Private insurers argue that if they are forced to compete with a public plan that can piggy-back its payment system onto the administratively set Medicare fees, they are forced to play on an uneven playing field tilted unfavorably in their direction. This suggests a scenario in which the private insurance plans would be pushed to the wall until eventually the U.S. ends up with a single-payer system. The long queues in Canada for certain types of health care, the low fees paid doctors and tight budgets for hospitals there, along with and the much sparser endowment of Canada's health system with certain high-tech equipment are cited as the inevitable destination of a single-payer system.

At this stage, this scenario is mere conjecture, and I have some difficulties following it.

In Canada, private insurance for services covered by the government-run system is prohibited. It would not be in the United States. Thus, if a public health insurance plan for non-elderly Americans really began to deprive American patients of what they desire in health care, the private insurance industry offering superior benefits at higher premiums would not melt away or, if it had, it would quickly be reborn, just as we now see providers starting to refuse the allegedly low fees paid by large private insurer and resorting again to the indemnity insurance model. Markets work that way.

There does, however, remain the issue of the level playing field, which I would not brush aside so easily. In what follows, I shall offer some comments on that issue.

V. DEFINING A LEVEL PLAYING FIELD

Two major facets define the evenness of the playing field on which insurance companies compete with one another: (1) the risk pool with which the insurer ends up and (2) the level of fees at which the insurer can procure health care from its providers.

Risk Pool: At this time roughly two thirds of the American population obtains health insurance from private insurance carries; but collectively private insurers account for only slightly more than one third of total national health spending. It is so because through its Medicare and Medicaid programs, government covers much higher risks on average than do private carriers.

It is not clear how the allocation of risks to private carriers and a new public plan would work out in a market for individual insurance. Chances are that a somewhat sicker risk pool would gravitate toward the public plan, which by itself would put it at a competitive disadvantage *vis a vis* the private plans, other things being equal.

Whatever the case may turn out to be, this facet of the playing field should be recognized in the debate on health reform. To mitigate any tilting of the playing field by that factor, one would ultimately have to install a differential-risk compensation mechanism, such as those operated in Germany, the Netherlands and Switzerland.

Payment Levels: The previously cited report by the Lewin Group projects that, if a new public health plan for non-elderly American paid Medicare fees, and if the overhead of such a plan were less than half of that experienced by private competi-

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[8] http://www.washington monthly.com/archives/individual/2009_04/017728.php

[9] http://studentlending analytics.typepad.com/student_lending_analytics/2009/03/cbo-significantly-ups-cost-savings-estimate-from-eliminating-ffelp-.html

tors, then the premiums of the public plan would be 21% below those charged by the private plans.

Assuming a premium-elasticity of the demand for health insurance of −2.47 (meaning a 1% decrease in the premium of the public plan vis a vis the premium of private insurers would trigger a 2.47% migration from private to public insurance), the Lewin Group simulates that some 119 million Americans would shift from private insurance to the public plan, a large fraction of whom would be Americans hitherto covered by employment-based insurance in smaller firms. In fact, the Lewin Group estimates that if the public plan were forced to pay at what it calls "private payer levels," enrollment in private insurance would decline only by 12.5 million, rather than 119 million."

Any such simulation, however, is merely the product of a computer algorithm into which researchers feed assumptions that largely drive the predictions. I, for one, believe that the assumed differential of administrative overhead may be too large, if private insurers sold their policies through an organized exchange, rather than through brokers. Furthermore, research based on the Dutch and Swiss experience suggests considerable stickiness of insurance choices, suggesting that the premium-elasticity assumed by the Lewin Group may be too high. In Switzerland, in particular, very large differences in insurance premiums charged by private insurers for the same package in the same Canton exist with only minimal switching by consumers among plans in response to such differentials. A similar experience has been observed in the Netherlands.[10]

Be that as it may, there is the question what the Lewin Group means by "private payment level." Is there actually such a thing? If so, how is it defined and measured?

Table 6.3 below, taken directly from the *Final Report of the New Jersey Commission on Rationalizing Health Care Resources* (2008),[11] illustrates the variance of actual payments made by one large health insurer to different providers for a standard colonoscopy. Table 6.4 exhibits the variation in actual payments made to different New Jersey hospitals for identical hospital services. Finally, table 6.5 below exhibits similar variances for the same procedures paid by a different, large insurer to different hospitals in California.

Table 6.3:

Large New Jersey Insurer's Payment for Colonoscopies Performed in Hospitals and Ambulatory Surgical Centers – Minimum Cost Per Procedure versus Maximum Cost Per Procedure

Cost per Colonoscopy	In-Network Minimum to Maximum Range
Physician	$178 to $431
Hospital	$716 to $3,717
ASC	$443 to $1,395

[10] See http://www.commonwealthfund.org/~/media/Files/ Publications/Fund%20Report/2009/Jan/The%20Swiss%20and%20Dutch%20Health%20Insurance%20Systems%20%20Universal%20Coverage%20and%20Regulated%20Competitive%20Insurance/Leu_swissdutchhltinssystems_1220%20pdf.pdf

[11] http://www.nj.gov/health/rhc/finalreport/index.shtml

Table 6.4:
Payments by a N.J. Insurer to Various Hospitals for Four Standards Services, 2007[a]

	Normal Delivery[1]	CABG[2]	Appendectomy[3]	Hip Replacement[4]
Hospital A	$2,178	$26,342	$2,708	$3,330
Hospital B	$2,787	$32,127	$2,852	$3,444
Hospital C	$2,906	$34,277	$3,320	$4,200
Hospital D	$3,187	$36,792	$3,412	$4,230
Hospital E	$3,276	$37,019	$3,524	$5,028
Hospital F	$3,629	$45,343	$4,230	$5,787

[1] Mother only, case rate.
[2] Coronary Bypass with Cardiac Catheterization (DRG 547), tertiary hospitals only.
[3] Surgical per diem (DRG 167) with average length of stay of 2 days.
[4] Surgical per diem for Total Hip replacement, average length of stay 3 days.

Table 6.5:
Payments by One California Insurer to Various Hospitals, 2007 (Wage Adjusted)

	Appendectomy[1]	CABG[2]
Hospital A	$1,800	$33,000
Hospital B	$2,900	$54,600
Hospital C	$4,700	$64,500
Hospital D	$9,500	$72,300
Hospital E	$13,700	$99,800

[1] Cost per case (DRG 167)
[2] Coronary Bypass with Cardiac Catheterization (DRG 107); tertiary hospitals only.

Cost Shifting: Medicare and Medicaid stand accused of shifting costs to private insurers by paying providers, especially hospitals, low prices, often below costs. In a study commissioned by the insurance industry, published in December of 2008, Milliman Inc. estimated the size of this cost shift for 2007 at $51 billion for hospitals and $37.8 billion for physicians, for a total of $88.8 billion.[12]

Although the phenomenon of the cost shift seems real to hospital—and insurance executives, it is less obvious to many economists who have debated the existence of the cost shift for decades among themselves. Indeed, with appeal to empirical data bearing on the issue, Congress' own Medicare Payment Advisory Commission (MedPAC) has cast doubt on the existence of a cost shift before this very Committee in a *Statement for the Record* dated March 2009.[13]

But even if one agreed that there actually were such a cost shift from the public to the private insurance sectors, Tables 6.3 to 6.5 presented above that there must be an even larger cost shift within the private insurance sector among private insurers. It raises the question whether the playing field is level even within that sector.

[12] Will Fox and John Pickering, "Hospital and Physician Cost Shift: Payment Level Comparison of Medicare, Medicaid, and Commercial Payers," (December, 2008) http://www.milliman.com/expertise/healthcare/publications/rr/pdfs/hospital-physician-cost-shift-RR12-01-08.pdf

[13] See also MedPAC, Medicare Payment Policy: MedPAC's March 2009 Report to Congress: 57–67 available at www.medpac.gov.

As Michael A. Porter and Elizabeth Olmsted Teisberg rightly observe on this point in their book *Redefining Health Care*:[14]

"Within the private sector, patients enrolled in large health plans are perversely subsidized by members of smaller groups, the uninsured and out-of-network patients. . . . The dysfunctional competition that has been created by price discrimination far outweighs any short term advantages that individual system participants gain from it, even for those participants who currently enjoy the biggest discounts."[15]

What, then, is the Private Payer Level?: Any proposal to force a new public health plan for non-elderly Americans to pay providers at "private payer levels"—the words used by the Lewin Group—would immediately run into the problem of the rampant price discrimination within the private sector, that is, and the huge variation in fees this price discrimination begets. Every insurer pays vastly different fees to different providers for the same service, and every provider bills different insurers different fees for the same service.

What in the chaos begotten by this system would the "private payer level" be to which a new public health plan should adjust. Would it be the average or the median of the prices paid by private insurers? Would they be simple or weighted averages and medians? If the latter, weighted by what? Over what geographic areas would these averages or medians be calculated?

Finally, if the public plan would have to pay such average or median fees, would it not by sheer arithmetic endow private insurers below that average or median with playing field tilted in its favor?

VI. MAKING THE PUBLIC PLAN FUNCTION LIKE A PRIVATE PLAN

In a recent position paper, Len Nichols and John A. Bertko of the New America Foundation have gone to some length to design a level playing field for private insurers and a new public plan.[16]

Nichols' and Bertko's proposal is inspired by the thirty or so state governments that offer their employees a choice between (a) traditional private insurance plans and (b) and a self-insured public plan operated by the state. The authors would subject the competing private and the public plans to exactly the same rules, monitored by an entity other than the government itself. The public plan would have to be actuarially independent and not get any public subsidies not also available to the private plans. Like the private plans, the public plan would have to negotiate its own fees with providers.

Presumably, unlike Medicare, it would be allowed to exclude particular providers from its network of providers and would be allowed to engage in disease management and other strategies designed to enhance value for the dollar.

The advantage the authors can claim for that proposal is that it might find bipartisan approval. A drawback, however, would be the high administrative cost of forcing the new public plan to negotiate fees with each and every provider.

Furthermore, this approach would perpetuate the rampant price discrimination that should, at some time in the future, be replaced with a more efficient and fairer payment system—perhaps even an all-payer system, such as those used in Germany and Switzerland. As Michael Porter and Elizabeth Olmsted Teisberg[17] and others have argued, it is hard to detect any social value in the chaotic price-discrimination that now characterizes the private health insurance market in the United States.

VII. A MARKET COMPOSED SOLELY OF PRIVATE INSURERS

In the end, the idea of the promised new public plan may be sacrificed on the altar of bipartisan political horse trading. In that case, if one wanted to offer Americans the stability and permanence they are likely to crave and run the market for health insurance on the *Principle of Social Solidarity*, one might structure the market for individually purchased insurance along the lines now used in Germany[18],

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[14] Michael E. Porter and Elizabeth Olmsted Teisberg, *Redefining Health Care*, Harvard Business School Press, 2006: 66.

[15] For a proposal to begin to reduce this price discrimination see Uwe E. Reinhardt, "A More Rational Approach to Hospital pricing," http://economix.blogs.nytimes.com/2009/01/30/a-more-rational-approach-to-hospital-pricing/ and Uwe E. Reinhardt, "**The Pricing Of U.S. Hospital Services: Chaos Behind A Veil Of Secrecy,**" *Health Affairs*, January/February 2006; 25(1): 57–69.

[16] Len Nichols and John M. Bertko, "A Modest proposal for a Competing Public Health Plan, The New America Foundation, (March 11, 2009) http://www.newamerica.net/files/CompetingPublicHealthPlan.pdf

[17] Michael E. Porter and Elizabeth Olmsted Teisberg, *Redefining Health Care*, Harvard Business School Press, 2006: 66.

[18] See http://www.commonwealthfund.org/~/media/Files/Resources/2008/Health%20Care%20System%20Profiles/Germany_Country_Profile_2008_2%20pdf.pdf and http://content.

the Netherlands and Switzerland [19], all of whom seek to marry the Principle of Social Solidarity with a system of private, non-profit insurance carriers (Germany and Switzerland) or a mixture of non-profit and for-profit insurers (the Netherlands).

As already noted in the introduction, in these systems the first two functions of a health system—financing and risk pooling—is basically under the control of government, either directly or through tight regulation. The purchasing function, however, is delegated to private, competing entities, albeit under tight regulation as well.

In Germany and Switzerland these systems operate on the basis of an all-payer system, in which fees are negotiated, at the regional level of the state (*Land*) between associations of insurers and associations of providers, where after the negotiated fees apply to all payers and providers within the region. In the Netherlands, fees paid can vary among insurers; but the variance across plans is relatively small by American standards.

VIII. CONCLUSION

Even the opponents of a new public health plan for non-elderly Americans will probably concede that the private market for individually purchased health insurance remains underdeveloped and needs a restructuring before it can serve the needs of the American people better than it has heretofore.

As was argued in Sections III and VII above, even if Congress in the end decided not to permit the establishment of a new public health plan, a rather daunting set of new regulations would have to be imposed on that market to meet the social goals posited for our health system by President Obama. It would also require a mandate on individuals to have basic coverage, a proposal eschewed by the President during the election campaign, albeit not by his Democratic rivals.

Chairman RANGEL. Thank you, Doctor.

We would now like to hear from Bill Vaughan. I join with Chairman Stark in congratulating you and Consumers Union for the contribution you have made to our Congress over the years. And we would like to hear you.

STATEMENT OF WILLIAM VAUGHAN, SENIOR POLICY ANALYST, CONSUMERS UNION

Mr. VAUGHAN. Well, thank you very much, sir, and thank you for inviting us to testify. Consumers Union is the independent, nonprofit publisher of Consumer Reports, and we don't just test toasters. We try to help people with health issues, and we are big, big fans of comparative effectiveness research, which we are using to save people, we think, millions of dollars in getting the most effective, safest, best buy drugs out there.

If Dante were alive writing about the independent health insurance market, it would be in the eighth circle just above where the uninsured are stuck. And it is exhibit number one for what is wrong with American health care.

I was going to go into that, but I think the opening statements of Mr. Camp, Mr. Stark, that is coals to Newcastle. Our statement documents why it is all goofed up, and has some very moving,

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healthaffairs.org/cgi/content/abstract/27/3/771?ijkey=DsTX9syExLZLc&keytype=ref&siteid=healthaff

[19] See http://content.healthaffairs.org/cgi/content/full/27/3/w204) and (http://www.commonwealthfund.org/~E/media/Files/Publications/Fund%20Report/2009/Jan/The%20Swiss%20and%20Dutch%20Health%20Insurance%20Systems%20%20Universal%20Coverage%20and%20Regulated%20Competitive%20Insurance/Leu_swiss dutchhltinssystems_1220%20pdf.pdf and http://www.allhealth.org/BriefingMaterials/JAMA-Uwe-1183.pdfhttp://content.healthaffairs.org/cgi/content/full/27/3/w204) (http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2009/Jan/ The%20Swiss%20and%20Dutch%20Health%20Insurance%20Systems%20%20Universal%20Coverage%20and%20Regulated%20Competitive%20Insurance/Leu_swissdutchhltinssystems_1220%20pdf.pd and http://www.allhealth.org/Briefing Materials/JAMA-Uwe-1183.pdf

wait to be called. And that goes for all of you, but especially your organization that has such a wide membership.

Linda Blumberg, Dr. Blumberg, who is a senior fellow at the Urban Institute. Thank you for being with us.

STATEMENT OF LINDA BLUMBERG, PH.D., PRINCIPAL RESEARCH ASSOCIATE, THE URBAN INSTITUTE

Ms. BLUMBERG. Mr. Chairman and distinguished Members of the Committee, thank you for inviting me to share my views on health insurance markets and health care reform. The views I express are mine alone and should not be attributed to the Urban Institute, its funders, or its trustees.

Current health insurance markets suffer from many shortcomings. I am going to focus my remarks on three that I believe are central, and what I think we might be able to do under reform to address them.

First, private health insurance markets are not very organized, making it difficult for individuals and employers to effectively compare options based on price, benefits, and quality of service.

Second, individuals and employers voluntarily participate as purchasers. But too often, those who would like to buy coverage face barriers to doing so, including problems of affordability and discrimination based on health status.

Third, there is little competition between insurers, a consequence of a substantial amount of consolidation among insurers and health care providers in recent years, fueling the growth in insurance premiums.

Insurance market reforms and subsidies to make coverage affordable for the modest income population within the context of a more organized health insurance market are essential strategies to address these problems.

A health insurance exchange can be developed to organize the insurance market and to provide guidance and oversight in achieving reform goals. Making a public health insurance option available to purchasers can further promote competition in insurance markets, and could be an effective strategy for slowing health care cost growth.

Competition in private health insurance markets today focuses largely on obtaining the lowest-risk enrollees. Insurance market regulations are required to prevent risk-selecting behavior by insurers. States allow insurers to risk-select to varying degrees today so that they can protect themselves from the inherent nature of a voluntary insurance market, where individuals who expect to use significant health care services are those that are most likely to seek coverage.

However, the consequences of allowing insurers to use such strategies are that many who need coverage cannot obtain it, and many who have some type of insurance may not have adequate coverage to meet their health care needs.

In the context of a health care system that is universal, where everyone is insured all of the time, there would no longer be any reason to allow discrimination by health status, and coverage denials, benefit riders, preexisting condition exclusions, and medical

underwriting can be prohibited, with the costs of those with high medical needs spread broadly across the population.

In such a context, an exchange can penalize or exclude from participation companies that violate insurance market regulations, establishing market conduct rules to prevent evasion of regulations. An exchange can also provide for risk adjustment to account for any uneven distribution of risk across insurers.

Exchanges can also be designed to efficiently deliver health insurance subsidies, an essential element of reform intended to make coverage affordable for all incomes. Centralizing into a single agency, such as an exchange, the subsidy determination and the payments of subsidies to insurers would be a much more efficient approach to administration that under the HCTC experience we are having today. The exchange could exclude plans not meeting minimum coverage standards, ensuring that all have access to meaningful coverage.

Exchanges can also play an important role in cost containment. The lack of competitive pressures in the current insurance market leads to higher prices and less cost-efficient practice patterns. An exchange can be given the authority to negotiate with health insurers over premiums.

Other cost-containment strategies would include requiring similar benefit packages be offered within an exchange to make it easier for consumers to compare prices for like policies, providing improved information materials, and incentives to choose lower-cost plan options. An exchange could also reduce administrative costs due to lower churning across insurance plans.

Adding a public plan option to those offered within an exchange would significantly increase the cost containment potential of reform. A public plan could be modeled after the traditional Medicare Program, paying providers based upon the payment systems Medicare uses, but with different cost-sharing rules and possibly some differences in covered benefits. Payment rates could be set between Medicare and private rates.

Medicare payment policies have been shown to reduce cost growth relative to private insurers. A public plan could create competitive pressures necessary to induce private insurers to be tougher negotiators with the providers and their plans.

The public plan could also be an innovator in the development of other cost-containment mechanisms. It would also create a lower-administrative-cost option for purchasers, putting pressure on private insurers to hold down their own costs.

I do not believe that a public plan option would destroy the private insurance market or lead to a government takeover of insurance, as some fear. Those plans that offer high-quality services and good access to providers would survive. Those that innovate and offer limited networks may even be able to offer lower-cost plans than the public option.

I consider the public plan a very promising catalyst for cost containment, and one that I think would be considerably less of a dramatic change than other effective options, such as having the exchange negotiate rates on behalf of all participating plans, or moving to an all-payor rate-setting system.