IMPLICATIONS OF SENATE BILL 5526 FOR EMPLOYER-SPONSORED INSURANCE

Statement of
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*The views expressed are my own and should not be attributed to the Urban Institute, its trustees, or its funders.

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Members of the Committee, thank you for inviting me to speak to you today about Senate Bill 5526. The opinions I express here are mine alone and do not necessarily reflect the views of the Urban Institute, its trustees, or its funders.

Whenever the nongroup insurance market changes, there is potential for interactive effects with employer-sponsored insurance coverage. This possibility raised concerns before the implementation of the Affordable Care Act's coverage reforms in 2014 and before implementation of the Massachusetts reforms of 2006. In both cases, the reforms provided significant subsidies for the purchase of nongroup insurance coverage that lowered the premiums enrollees with incomes below an income threshold would have to pay for the coverage. All else being equal, one might expect that such a price drop would pull many people out of employer-based coverage and into nongroup coverage.

Except, all else was not equal. And, consistent with our analyses before each of these reforms was implemented, the number of people using employer-sponsored insurance coverage did not drop. [1] If anything, it increased, particularly among occupations with lower average pay.

The effective price change resulting from introduction of a private insurance plan using Medicare rates in the Washington exchange would be much smaller than the introduction of either the ACA or Massachusetts comprehensive reform. Therefore, we would expect to see even smaller effects on employer-based coverage. In fact, our recent analysis of a number of incremental reforms indicates that introducing a change similar to what is being proposed in Cascade Care would decrease employer coverage by less than half of 1 percent.[2]

Why don't workers flood out of employer-sponsored insurance even when premiums in the nongroup insurance market decrease?[3] Because most workers would continue to prefer employer-based insurance, and because employers want to attract and retain the best workers, with few exceptions, employers would continue to offer health insurance and the workers would continue to enroll in it.

Employers deciding whether to offer insurance coverage must balance a complex array of financial incentives and preferences that vary across their workers. But, the largest financial incentive to offer coverage through the workplace is the tax exclusion of employer-based health insurance premiums. For all but low-wage workers, this tax subsidy creates a powerful incentive to seek out employment in a firm that offers health insurance coverage.

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[1] Fredric Blavin, Adele Shartzer, Sharon K. Long, and John Holahan, "Employer-Sponsored Insurance Stays Strong, with No Signs of Decay under the ACA: Findings through March 2016" (Washington, DC: Urban Institute, 2016); Anuj Gangopadhyaya, Bowen Garrett, and Stan Dorn, *How Have Workers Fared under the ACA?* (Washington, DC: Urban Institute, 2018), table 3; Gary Claxton, Matthew Rae, Michelle Long, Anthony Damico, and Heidi Whitmore, *Employer Health Benefits: 2018 Annual Survey* (San Francisco: Kaiser Family Foundation, 2018), page 45.

[2] Linda J. Blumberg, John Holahan, Matthew Buettgens, and Robin Wang, "A Path to Incremental Health Care Reform: Improving Affordability, Expanding Coverage, and Containing Costs" (Washington, DC: Urban Institute, 2018).

[3] Linda J. Blumberg, Matthew Buettgens, Judith Feder, and John Holahan, "Why Employers Will Continue to Provide Health Insurance: The Impact of the Affordable Care Act," *Inquiry* 49, no. 2 (2012): 116–26, https://doi.org/10.5034/inquiryjrnl_49.02.05; Thomas Buchmueller, Colleen Carey, and Helen G. Levy, "Will Employers Drop Health Insurance Coverage Because of the Affordable Care Act?" *Health Affairs* 32, no. 9 (2013): 1522–30, https://doi.org/10.1377/hlthaff.2013.0526.

A second sizable incentive is that large-firm, employer-based insurance carries lower administrative costs than does nongroup insurance, another price and value advantage for employer-sponsored coverage. And since employers use health insurance benefits to attract and maintain desired employees, they try to tailor coverage to their workers' preferences. This adds to the appeal of employer coverage for workers.

For all these reasons, employers dropping employer-sponsored insurance run a real risk that their workers will seek out employment elsewhere, where they can obtain their desired mix of wages and benefits.

In the case of Cascade Care and Washington specifically, the effect on the employer-sponsored insurance market will likely be small for one other important reason. The state's large population centers already have strong competition between multiple marketplace insurers, and at least some of those insurers are likely paying rates in the neighborhood of Medicare's payment rates already, and some may be paying even lower rates. Cascade Care will likely have little impact on nongroup market premiums and provider payment rates in those areas. It will likely have its greatest impact in less-populated areas of the state, where no lower-cost insurers are currently offering marketplace-based coverage.

Another fear that some still hold is that lower provider payments paid in one sector—say, Medicare or a public option—will lead health care providers to increase prices in other sectors—say, the private market. While such fears are commonly held, there is strong empirical evidence that such "cost shifting" does not actually occur.[4] In fact, the body of research over the past six-plus years shows the opposite: when public programs reduce payment rates to providers, premiums also fall in the private sector.

Cost-shifting fears are wrought of a misperception that health care providers, especially hospitals, essentially face fixed costs of providing care. However, this is not the case. What the evidence indicates is that when providers are faced with lower payment rates in one sector, such as Medicare, they find ways to lower their underlying costs, creating efficiencies that then also provide savings in the other sectors of their business, such as private insurance. In just one example of recent research, analysts found that a 10 percent reduction in Medicare payments to hospitals was associated with an 8 percent reduction in the prices hospitals charged to private insurers.[5]

As a result, the decision to reduce provider payment rates under Cascade Care—a change that will likely be felt in only those parts of the state where price competition doesn't already exist or is weak—should not raise concerns of premium increases in employer-sponsored insurance markets.

I am happy to answer any questions you might have.

[4] Austin Frakt, "JAMA Forum: Hospitals Don't Shift Costs from Medicare or Medicaid to Private Insurers," news@JAMA, January 4, 2017, https://newsatjama.jama.com/2017/01/04/jama-forum-hospitals-dont-shift-costs-from-medicare-or-medicaid-to-private-insurers/.

[5] Chapin White, "Hospital Payment Rates for Inpatient Care Lead to Lower Private Payment Rates," Health Affairs 32, no. 5 (2013): 935–43, https://doi.org/10.1377/hlthaff.2012.0332.