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*CONGRESSIONAL TESTIMONY*

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# **Guidelines for Structuring Health Insurance**

**Testimony before  
Finance Committee  
United States Senate**

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My name is Stuart Butler. I am Vice President of Domestic and Economic Policy Studies at The Heritage Foundation. The views I express in this testimony are my own, and should not be construed as representing any official position of The Heritage Foundation.

The way in which Americans access health care is uniquely different from any other major country. As an immigrant to this country, I was immediately struck by the peculiarities of America's health care "system." The simple fact is that for most working-age Americans, health insurance is directly connected to their place of work. Which doctor you and your family sees – and often whether you can in practice see a doctor – depends on who employs you. This system did not come about as the result of a consensus vision or conscious legislation, rather because of a series of ad hoc regulatory decisions and IRS rulings stemming back to World War II. Since that time, structural weaknesses of traditional employer-sponsored health insurance have led to a steady erosion of coverage, especially for workers in the small business sector. Therefore, I'm convinced that America's health insurance system must undergo a steady, but gradual, evolution to reverse this trend. That has implications for reforming the tax code to make sure people without adequate employment based insurance get the same tax breaks as those offered such insurance.<sup>1</sup> It also has implications for how we organize insurance.

The goals that we virtually all share – such as reducing the number of uninsured Americans – could, in principle, be reached through a comprehensive federal reform of the health insurance system for working families. And some argue for a system designed

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<sup>1</sup> For a discussion of tax policy alternatives, see Nina Owcharenko, "Health Care Tax Credits: Designing an Alternative to Employer-Based Coverage," Heritage Foundation *Backgrounders* No. 1895, November 8, 2005, at [www.heritage.org/research/healthcare/bg1895.cfm](http://www.heritage.org/research/healthcare/bg1895.cfm).

in Washington. According to this view, health reform could come through a national restructuring of the insurance market. But I believe that strategy is inherently flawed. To be sure, it is important to set broad goals at the national level and to lay down parameters within which our values as a nation are preserved – such as our commitment to the disabled and the chronically sick. As almost all health economists agree, it is also important to fix the tax treatment of health care at the federal level to achieve greater equity. But in the case of insurance systems, and generally the organization of health systems, the best approach to achieve our goals is through a “bottom-up evolution” not a “top-down revolution.”

Last year as part of the Brookings Institution’s Hamilton Project I laid out a vision for health reform, a three-part proposal which included a component for states to reform their health insurance markets in part by establishing health insurance exchanges.<sup>2</sup> I envisioned state-sponsored insurance exchanges operating much as the Federal Employee Health Benefits Program (FEHBP) works for Members of Congress by setting broad criteria for portable plans, handling the flow of payments and subsidies, and providing information to enrollees.<sup>3</sup>

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<sup>2</sup> See Stuart M. Butler, Ph.D., “Evolving Beyond Traditional Employer-Sponsored Health Insurance,” Hamilton Project, May 2007, at [www.brookings.edu/es/hamilton/200705butler.pdf](http://www.brookings.edu/es/hamilton/200705butler.pdf).

<sup>3</sup> For a discussion of this comparison, see Robert E. Moffit, Ph.D., “State-Based Health Reform: A Comparison of Health Insurance Exchanges and the Federal Employees Health Benefits Program,” Heritage Foundation *WebMemo* No. 1515, June 20, 2007, at [www.heritage.org/research/healthcare/wm1515.cfm](http://www.heritage.org/research/healthcare/wm1515.cfm).

Some have criticized that state-based approach<sup>4</sup> and instead called for the creation of a national health insurance exchange. In fact, this later became a core element of the health plan proposed by Senator Obama.<sup>5</sup> But, in my view, there are three very clear reasons why such a “national” approach would not be advisable:

- 1) **The regulation of insurance in the private sector has primarily been, and should remain, a state function.** Some argue that a national exchange, or set of national exchanges, is better or more practical than state-level exchanges. Indeed, states do vary in their capacity to develop and implement innovative proposals. But any attempt to create a national exchange, or to introduce federally designed exchanges at the state level, would immediately be sidetracked into a debate over the federal preemption of state insurance laws and the form and structure of the new federal regulations that would be applied to plans sold through a national exchange. Also federalizing regulations—such as benefit mandates— would exacerbate problems that currently exist. For instance, while some states have driven up the cost of health insurance with costly benefit mandates,<sup>6</sup> that problem will only become more pervasive if regulation were centralized in Washington. Instead of focusing on fifty state capitols, industry lobbyists would have to make just one short ride from K Street to get a legislature to force Americans to use their industry’s services. Congress’s

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<sup>4</sup> For a discussion of a state-based approach, see Robert E. Moffit, Ph.D., “The Rationale for a Statewide Health Insurance Exchange,” Heritage Foundation *WebMemo* No. 1230, October 5, 2006, at [www.heritage.org/Research/Healthcare/wm1230.cfm](http://www.heritage.org/Research/Healthcare/wm1230.cfm)

<sup>5</sup> See “Barack Obama’s Plan for a Health America,” at <http://www.barackobama.com/pdf/HealthPlanFull.pdf>

<sup>6</sup> See “Health Insurance Mandates in the States 2008,” Council for Affordable Health Insurance, at [http://www.cahi.org/cahi\\_contents/resources/pdf/HealthInsuranceMandates2008.pdf](http://www.cahi.org/cahi_contents/resources/pdf/HealthInsuranceMandates2008.pdf)

history in designing the benefits for the Medicare program is instructive in this regard.

- 2) **National reform designs and federal regulatory structures would be inflexible and incapable of adequately addressing diverse local conditions.** Americans who would benefit most from insurance market reforms or the creation of an exchange are typically those employed in small or medium-size firms.<sup>7</sup> The circumstances and even values of those Americans differ in given geographic locations. A federal exchange, or system of federally designed exchanges, could not easily accommodate complex variations among, and even within, states. A state-based reform design would provide needed flexibility and is best able to practically address local conditions. Although certain general characteristics of an exchange are indeed essential if it is to achieve the goals of reform, there are many different ways to design the details to accommodate different local considerations. While the ease of a national approach to health insurance market reform might on the surface seem appealing, it clearly trivializes these very intricate and complex nuances of design.
  
- 3) **State experimentation with insurance market reform should continue because it is an important instrument to facilitate policy improvement.** Nobody, including me, can say with certainty what is the best way of organizing health insurance. It is such a complex system, where unintended consequences seem to be the norm after

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<sup>7</sup> See Edmund F. Haislmaier, "State Health Reform: How Pooling Arrangements Can Increase Small Business Coverage," Heritage Foundation *WebMemo* No. 1563, July 27, 2007, at <http://www.heritage.org/Research/HealthCare/wm1563.cfm>

any change, that we cannot possibly imagine constructing an arrangement that would work from downtown Brooklyn to rural Alabama. And even if, conceivably, we could do that, innovations and changing conditions would immediately begin to render ineffective in parts of the country. Consequently, it makes sense to set only broad parameters and goals in Washington. Allow the states to propose and implement the best ways they think instance should be arranged in an exchange system, and let us learn from the strengths and weaknesses as we compare their initiatives.

Moreover, given the already considerable variations that exist between states and the serious political and policy disagreements over the best practical approaches to insurance market reform it is both necessary and appropriate to foster state experimentation. It is generally easier to get important changes under way with an evaluation or demonstration project on a smaller scale, which would yield valuable experience and evidence that might shape broader national reforms later. This does not mean that every state must be an innovator. As with most state-based innovations in public policy in other areas, such as welfare and education, certain states would likely take the lead in designing exchanges while others would tend to follow. However, this is not all bad. Well-intentioned reformers will make mistakes and states will learn from the experience of others. State experimentation limits the consequences of any “glitches” along the way, which is comforting to the millions of Americans who say they want health reform but at the same time are hesitant to lose the health care they have today. These experiments enable comparisons between

approaches in order to spur continuous improvement in health policy—an area where serious uncertainty still remains. National reform designs, however, presume that the best answer to difficult policy considerations is known. The trouble with such an approach is not only that experts and politicians generally disagree but that if a consensus were miraculously formed and policies were enacted there would be no basis for comparisons to be made. Therefore, we would never know if we had the policy right.<sup>8</sup>

## **Recommendations**

### **Recognize that state-based insurance exchanges are the most promising vehicle to accomplish the goals of health insurance market reform.**

State-based exchanges create a framework for insurance plans to achieve more effective pooling, better spreading of risk, and portability of coverage. But the details of regulations to reach those goals is left to the states, on the grounds that they are best placed to develop rules for their particular situation and to experiment with new approaches. Of course, to arrange stable and affordable coverage, states must also experiment with ways to adjust for selection effects among plans within the pool.<sup>9</sup>

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<sup>8</sup> For a recent discussion of the importance of state experimentation, see Henry J. Aaron and Stuart M. Butler, “A Federalist Approach to Health Reform: The Worst Way, Except For All Others,” *Health Affairs*, May/June 2008, at <http://content.healthaffairs.org/cgi/reprint/27/3/725>

<sup>9</sup> For a further discussion of risk-adjustment mechanisms, see Edmund F. Haislmaier, “State Health Care Reform: The Benefits and Limits of “Reinsurance,” Heritage Foundation *WebMemo* No. 1568, July 26, 2007, at [www.heritage.org/Research/HealthCare/wm1568.cfm](http://www.heritage.org/Research/HealthCare/wm1568.cfm).

Once successfully designed, a state insurance exchange would ensure true portability of insurance within a state for workers who move between employers offering access to the exchange.

To achieve portability across state lines, states might draw up agreements to link their exchanges and to allow transfers between states. Alternatively, Congress could consider adopting legislation that reforms the individual health insurance market by allowing interstate commerce in such a way that does not preempt, undermine, or override innovative state health care reforms. The *Health Care Choice Act* (H.R. 4460 and S.1019) would achieve this goal.<sup>10</sup>

**Clarify the tax treatment of health exchanges in order to encourage the creation of state health insurance exchanges.**

The federal government has a critical role in facilitating state insurance exchanges by making it clear that employees obtaining coverage through the exchanges would enjoy the same tax breaks as employees with traditional employer-sponsored insurance. The federal government has already indicated that state exchanges meet the requirements of an employee welfare benefit plan, with the exchange deemed the plan administrator. That allowed the Treasury to indicate that money collected by an employer and sent to an exchange carries the same tax benefits for an employee as money for an employer-sponsored plan. Thus the federal government appears to treat a plan obtained through an

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<sup>10</sup> For a brief analysis an earlier version of the provision, see Robert E. Moffit Ph.D., “The Health Care Choice Act: Eliminating Barriers to Personal Freedom and Market Competition,” Heritage Foundation *WebMemo* No. 1164, July 17, 2006, at <http://www.heritage.org/Research/HealthCare/wm1164.cfm>

exchange much like one obtained through the FEHBP. But to remove any remaining uncertainty or ambiguity, either the Treasury should issue a clear ruling on the tax treatment of contributions to an exchange, or Congress should enact clarifying language.

**Enact “outcome-based” legislation which would enable states to apply to Congress for legislative waivers – a far more powerful instrument than administrative waivers – to develop innovative ways to foster coverage through state-level health insurance market reforms.**

State-based health insurance exchanges, or indeed any state health initiative, would take place in the context of other state and federal programs operating within the state’s borders. They should also be harmonized with national goals for reducing the number of uninsured without unduly restricting state flexibility and innovation.

A state-centered approach is compatible with proposals that would condition tax relief and federal health funding on plausible state action to make insurance available and affordable.<sup>11</sup> The approach is also compatible with bipartisan bills now before Congress that would encourage states to propose to the federal government a range of steps to reduce uninsurance within their borders, including congressionally enacted legislative waivers from existing federal laws and programs. Three draft bills propose state-based experimentation-- the *Health Partnership Act* (S.325), the *Health Partnership Through Creative Federalism Act* (H.R. 506), and the *State-Based Health Care Reform Act* (S. 1169). These bills would provide temporary waivers, and in some instances federal

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<sup>11</sup> For an earlier discussion of such a federalist approach, see Henry J. Aaron and Stuart M. Butler, “How Federalism Could Spur Bipartisan Action on the Uninsured,” *Health Affairs*, March 31, 2004, at <http://content.healthaffairs.org/cgi/reprint/hlthaff.w4.168v1.pdf>

grants, for an experimental period. Depending on how successful the state was in reaching agreed outcome measures that period could be extended. I have worked together with my good friend Henry Aaron of the Brookings Institution developing this bipartisan concept of creative federalism. Our proposal is designed to permit not only insurance exchanges but other innovative proposals as well, and to encourage reasonable ideas from across the spectrum to be tried and compared in order to find the best answers to the challenge of uninsurance.<sup>12</sup>

**Within an exchange – whether state or national – be wary of a government-sponsored plan competing with existing employer-sponsored insurance or other private plans.**

Some have argued that within an exchange there must be a default plan that will be a “safe harbor” for Americans whose medical history or circumstances means they cannot reasonably enroll in a plan currently available, and that plan should be a public plan – perhaps one modeled on Medicare.

There are several reasons why Congress should be wary of this idea.

To be sure, many Americans need special assistance or insurance rules if they are to obtain adequate, affordable coverage. But this could be done in various ways, including reinsurance markets organized by the state in collaboration with insurers.<sup>13</sup> The federal

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<sup>12</sup> See Henry J. Aaron and Stuart M. Butler, “A Federalist Approach to Health Reform: The Worst Way, Except For All Others,” *Health Affairs*, May/June 2008.

<sup>13</sup> Edmund F. Haislmaier, “State Health Care Reform: The Benefits and Limits of “Reinsurance,” Heritage Foundation *WebMemo* No. 1568, July 26, 2007.

government should encourage states to explore the best ways to do this and allow policymakers to learn from these experiments. Instituting a Medicare-type program would distort and even undermine those experiments.

It is also important to remember an old sporting adage – if the umpire works for one of the teams you should be suspicious of the score. The simple fact is that if the government is sponsoring a competition within an exchange, and also is responsible for one of the plans, there can be little doubt that the rules and regulations promulgated by the exchange will tend to advantage the government-sponsored plan. This will be compounded if, like Medicare, the public plan receives a large taxpayer subsidy.

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