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CONGRESSIONAL TESTIMONY

Coverage Issues in Health Reform

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My name is Stuart Butler. I am the Vice President for Domestic and Economic 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.

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There is broad agreement on the broad goals of health reform. We all want to achieve significant progress this year towards the vision of an America in which everyone has coverage that is adequate, accessible, and affordable – to households and to the nation – and portable.

Coverage Issues to be Resolved

Two major landmines on the road to consensus. Those of us who agree on the goals are making good progress towards resolving the "engineering questions" to achieve the agreed objectives. I will discuss some of these together with a broad outline of how I believe Congress can achieve a broad consensus for action on coverage. But I am very concerned about two proposals that have entered the picture: a "competing" public plan and a federal health board. These are like nuclear landmines on the road to broad agreement. They could be lethal to the prospects for consensus and even to the passage of any significant legislation.

Some say that within an exchange there must be a default plan that will be a "safe harbor," and that plan should be a **public plan** – perhaps one modeled on Medicare. But it is 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 the owner of one of the plans, there can be little doubt that the rules and regulations promulgated by Washington will favor the government-sponsored plan. A "competing" public plan as a choice will inevitably become a public plan for all, and is unacceptable. Fortunately, as I note below, there are alternatives to achieve the same stated purpose.

A powerful **federal health board** could also undo any consensus. It's one thing to have a body to spur and distribute cost-effectiveness research, as the new Federal Coordinating Council for Comparative Effectiveness Research will do. It's quite another to have a board, as others have urged, that is not really answerable to anyone and starts to determine how medical care is to be provided. To be acceptable, any such board must not be a monopoly of information – other clearinghouses should be established in the private sector. And it must not promulgate rules for coverage and professional conduct in the private sector.

There are other coverage issues to be resolved, where I believe agreement is quite possible.

A benefits package. If we are to assure Americans of adequate coverage, we must of course define in some way what that level and type of coverage actually is. That leads some to insist that future coverage, and perhaps existing plans, must include a specific, federally determined comprehensive benefits package. But others point to the dangers in that approach. There will be provider pressure on Congress to add services to the mandatory package, for instance. And many Americans will face the sticker shock of plans that contain expensive benefits they do not need or want.

The solution would be to copy the approach used in the program covering members of Congress. The Federal Employees Health Benefits Program (FEHBP) not only does not include a public plan, but it also does not have a standard benefits package. Instead it simply requires plans to include broad categories of coverage, such as emergency care and major medical, and allows plans to offer a variety of benefits within these categories. This approach can and should be the basis of any subsidized benefits package developed by Congress.

A Health Insurance Exchange. There is broad support for the concept of a health insurance exchange to improve the functioning of a competitive market for plans. Such an exchange would, among other things, aggregate premium payments to simplify and reduce the costs of insurance transactions, set broad marketing rules, and provide a source of standardized plan information to help facilitate plan choice. (These are all functions carried out by the FEHBP). In addition, exchange operations would dovetail with state actions to organize **insurance pools**, including perhaps high-risk pools for expensive enrollees, and with **risk adjustment** or **reinsurance** systems as methods to distribute risk and reduce adverse selection. In keeping with this model of an exchange, it should not set benefits, payment rates or premiums.

But should an exchange be at the national level, or at the state level, and should there be overlapping exchanges?

A national exchange may seem attractive but it is accompanied by many problems. In particular, there could be a mismatch between national rules and the pooling, risk pool and even existing exchanges (e.g. in Massachusetts) at the state level. It would also be difficult for states to explore creative approaches for delivering efficient coverage if they always had to comply with national rules.

The solution would be for the federal government to do two things. First, set out broad objectives for exchanges, and allow states to propose designs for state or regional exchanges to be certified by the federal government. That would enable a state like Massachusetts to continue its Connector, and other states to develop exchanges that best fits their situations. And second, the federal government could provide technical assistance and perhaps develop a plan information system to be used by all states.

While single risk-adjustment mechanisms would have to arranged to cover particular geographic areas, that is not true of exchanges. Since exchanges provide a set of services

to enrollees, permitting competing exchanges would sharpen customer service. But even if Congress or a state chose to set up non-overlapping exchanges, it is important to allow organizations offer "Expedia-style" navigation, advisory and enrolment services tailored to the needs and preferences of Americans. Thus even if an exchange has monopoly status, it should be required by law to provide plan information and access to the enrolment to such organizations.

Mandates. The issue of coverage mandates has become increasingly divisive. Some argue that the only way to achieve near universal coverage is to make people buy insurance, and others claim that the only way to maintain a stable insurance pool that includes healthier individuals is through a mandate. Another line of argument is that employers should pay their "fair share" towards coverage through a mandate to provide some specified level of coverage.

Both forms of mandate are problematic and pose threats to a consensus on coverage. An **employer mandate** is damaging because it continues the illusion that employers actually pay for a worker's insurance. But in reality health insurance is just one element of total compensation and "employer-provided" insurance just means there is more compensation in that form and less employer-provided cash income. So an employer mandate is nothing more than a hidden way of making employers pay for their own coverage. It is not a true subsidy, and it is regressive.

An **individual mandate** also poses problems. Even those who agree in principle that individuals should take responsibility for their coverage worry that individual mandates force people to buy something they may not want and cannot afford. They also worry that such a mandate will open the door to requiring a government-designed coverage.

The solution would be to encourage voluntary coverage in two ways, and to see how close to full coverage we get before we consider prosecuting people for not buying insurance.

The first way to do this would be to reform the subsidy system as part of overall reform. The inability to afford available coverage is the major reason working families are uninsured. Policy analysts, as well as members and staff on both sides of the aisle, recognize that the current tax benefits for coverage provide large subsidies for affluent Americans and little or no help for lower-paid working families. The **capping** or **elimination of the tax exclusion** and replacing it with **tax credits** to help lower-income taxpaying families better afford coverage, is thus a critical step.

The second step would be to make **automatic enrollment** in private plans the default for working families**.** In this arrangement, working families would be automatically signed up to the employer's plan or to one of a group of plans chosen by the state and would have to actively decline coverage if they did not want it. It turns out that default enrollment sharply increases sign-ups for pension plans. Inertia is very powerful. According to John Sheils at Lewin, auto-enrolment with more rational subsidies could

boost insurance sign-up rates to above 85%. Peter Orszag has also raised the importance of this feature of behavioral economics in the health field.

The Future of ESI. There are huge gaps in the employer-sponsored insurance (ESI) system. Many smaller employers do not even offer coverage. So we do face a momentous policy choice. Do we try to expand coverage by somehow encouraging or forcing more employers to provide coverage, such as though mandates (with the problems noted above) or subsidies to firms? Or do we rethink the future role of employer in health care, at least in the case of smaller firms?

I believe the right foundation for wider coverage in the future is not employer-sponsored insurance. There is a reason America is unique in trying to maintain such a system – it does not work for an increasing number of Americans. Artificially tying the sponsorship of insurance to the place of work (which is kept in place mainly by the discriminatory tax exclusion) means a family's coverage depends on the preferences, knowledge and economic fortunes of the employer. And it inhibits portability of coverage. If we were starting anew, we would never tie this crucial part of family well-being to the place of work.

The solution, however, does not mean overlooking some advantages of employment-based insurance, nor does it mean closing down successful employer-based plans. Instead, it means two things.

First, it means creating a parallel system of plans available through health exchanges, with the same tax benefits available to those enrolling in such plans as are enjoyed by those with traditional ESI (ideally with the tax reforms described earlier). To avoid any damaging disruption to existing, successful ESI plans, each employer currently offering insurance would decide if his/her workers would continue with their ESI or obtain coverage through the exchange. Workers not offered ESI could choose from the exchange plans.

Second, all employers in the future would function as **facilitators** of insurance. In other words, people typically would sign up for coverage at the place of work – even though many employers would not sponsor coverage – much as they sign up for tax withholding or make contributions to 401 (k) plans, or congressional staff sign up for their chosen FEHBP via their member's office. In most cases employers would institute a payroll deduction system and send premiums to the exchange for distribution to the chosen plans (much like the mechanism used in the FEHBP). If an automatic enrolment system were in place the employers would administer that for most working-age families.

State innovation. Our system of federalism is intended to allow states to determine the best ways to achieve objectives we share as a nation, as well as to innovate, thereby appropriately limiting the role of the central government and fostering creative diversity. We value that principle of federalism in such areas as education and welfare. It is important to utilize it fully in health care. But to do so we would need to marry the

national goals we set with a procedure to enable states to try innovative approaches to reach those goals.

The solution is for Washington to identify the broad goals of a health system and to encourage states to devise the best ways to achieve those goals. That can be done in a bold way by making it possible for states to obtain congressional approval for significant changes in existing laws and programs – i.e. by granting the states **waivers from federal laws**, not just from regulations – so that they can restructure programs and try creative ways of expanding affordable coverage. Three bipartisan bills were introduced last year to permit such 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 grants, for an experimental period. Depending on how successful the state was in reaching agreed outcome measures that period could be extended. I worked together with 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.[1]

Charting a Way Forward

How might these elements come together in a health strategy this year to achieve substantial progress towards portable coverage that is adequate, affordable, and accessible?

The Federal Role

- Congress establishes the overall national **objectives of coverage**, including the general categories of coverage. These would serve as the benchmarks for state action.

- The federal government establishes a set of **metrics to guide state action** and to **evaluate their success**. These would include such measures as the reduction of uninsurance levels among categories of residents, and mileposts for quality and affordability improvements.

- The federal government establishes a default or **fallback coverage** mechanism for states that chose not to design a plan to meet the national goals, or whose proposals or performance fell short. This might take the form of allowing residents in these states to obtain coverage through the national FEHBP plans, using a separate pool. In

[1] 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.

addition, as an alternative to a public plan, the federal government and state officials could negotiate with the national FEHBP plans or other major insurers to offer **benchmark private plans** in each state. But the aim is to encourage states to take action, and so adopting the fallback should not mean states merely transfer costs to the federal government.

- The federal government provides technical assistance and start-up grants to facilitate **state exchanges** and **risk adjustment mechanisms** to reduce adverse selection while making affordable premiums available in the state.

- The federal government provides a modest tax credit for smaller firms to set up a payroll reduction, premium payment and **automatic enrolment** system for their employees. Firms could use this system either for employer-sponsored insurance or to enroll employees in a state-designated default plan or a chosen exchange plan.

- The federal government establishes **"creative federalism" procedures** to permit a state to propose ways of achieving the national goals for coverage through an alternative strategy involving the suspension or alteration of existing laws and programs.

- The federal government enacts a tax reform/subsidy system to completely or partially replace the current tax exclusion and Schedule A deductions for health care insurance. A **non-refundable credit** would be available to taxpayers, financed from limiting the exclusion and deductions, and a **refundable credit or equivalent subsidy** for others financed by savings in programs.

The State Role

- States design approaches, or accept the federal fallback, to meet the goals of **accessibility** (including underwriting and issuance rules to achieve continuous coverage); **adequacy** (the FEHBP benefit categories); **affordability** (including a negotiated FEHBP or other benchmark plan); and **portability** (including an exchange or similar mechanism).

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