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*CONGRESSIONAL TESTIMONY*

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**Policies for Congress To  
Expand Health Coverage  
Through State Reforms**

**Testimony before  
The Subcommittee on Health  
Committee on Energy and Commerce  
United States House of Representatives**

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Mr. Chairman and Members of the Committee, my name is Robert E. Moffit. I am Director of the Center for Health 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.

Given Washington's gridlock on health care policy over the past few years, it is not surprising that many states are taking the lead in health care reform. It is also not surprising that the American people are supportive of states taking the lead role in reform. According to a Dutko Worldwide poll conducted in January 2007, 74 percent of voters prefer to give more power to state and local government, and 72 percent prefer that state and local government experiment with strategies for expanding health care.

The states differ markedly in the range of their problems and their internal capacities to cope with them. States vary radically in their demographics, their economic profiles, their level of employment and poverty, the strength of their employment-based health insurance, and the functioning of their individual health insurance markets.

Most states are struggling with a number of common problems: Top among them is the problem of Medicaid costs and the functioning of the Medicaid program itself. Low reimbursement rates discourage doctors from taking new Medicaid patients. Meanwhile, Medicaid obligations have been consuming a far greater portion of state budgets, squeezing out other priorities. The National Governors' Association reports that Medicaid has surpassed education spending in many states.

Beginning this year, states are faced with a new fiscal challenge. The Government Accounting Standards Board will require states to begin calculating and disclosing the expected future costs of their retiree health benefits, just as the Financial Accounting

Standards Board requires such disclosures for private companies. State retiree benefits are often more generous than private sector benefits, and that means that many states are going to be faced with large unfunded liabilities for state and local retiree health benefits. This will impose new pressures to raise taxes or to reduce other budget categories. Failure of state officials to act will hurt state bond ratings.

Beyond that, state officials are wrestling with rising employer costs, and increasing access problems, especially for low-income working people. Health insurance markets in many states are also deeply flawed, resulting in less competition, more market concentration, and excessive government regulation.

### **The Nature of Insurance**

As a practical matter, health insurance problems are heavily concentrated in small businesses, where employers often cannot afford to offer their employees a policy and where the administrative costs and tasks of securing a policy are particularly daunting.

The professional literature on the uninsured shows that the problem is not simply a difficulty with people having access to affordable coverage; it is more a difficulty of people keeping it once they have it. Perhaps the best single analysis of the data on the uninsured was conducted by Pamela Short and Deborah Graefe of Pennsylvania State University and published in *Health Affairs* (2003). In their analysis of the Census Bureau data over the period of 1996 through 1999, they found that only 12 percent of the uninsured population was uninsured over the entire time. In fact, the overwhelming majority of the uninsured were persons in and out of coverage; getting coverage, losing it, often with a change of employment. So, in effect, the vast majority of uninsured

Americans are people who are transitioning in and out of an unstable health insurance market.

The policy problem, then, is how to make the insurance stick to the person, not the job. That policy problem is acute for persons who work for small businesses.

There is another facet of this problem. Can employees get the specific kind of coverage they want or need? Small firms that do offer coverage usually offer workers and their families no choice of coverage. If a worker tries to buy health insurance on his own, he must pay for it with after tax dollars. This could end up adding between 40 percent to 50 percent to the cost of a policy for the same level of benefits that the worker might have been able to get through his employer.

The federal tax code, then, is not neutral about where persons get their health insurance. If one gets health coverage outside of conventional employment-based arrangements, one is punished with a heavy tax penalty.

### **The Concept of a Health Insurance Exchange**

In order to tackle these related problems, a number of health policy analysts have suggested the creation of health insurance exchanges: new markets for health insurance for small businesses employees that ease their access to coverage, reduce the administrative costs for small businesses owners, and allow individuals to own their own health insurance policies.

In the initial stages of the health care debate in Massachusetts, former Governor Mitt Romney invited me and my colleagues at Heritage to provide advice and assistance on the creation of a health insurance exchange as part of a comprehensive reform of the health care system in that state. In response to that request, we helped the Governor and his staff design an

entirely new market for health insurance that would get around the current limitations of the federal tax code, which undercuts both the choice and portability of health insurance coverage, particularly for employees in small businesses.

The model for this approach was the stock market, and the new market was designed to work like a consumer-based market for stocks, bonds, equities, and securities: a single place where one could buy the product that one wanted and keep it regardless of changes in life circumstances and employment. The concept of the stock exchange was thus grafted onto the health insurance market as an “insurance market exchange.” The Massachusetts legislature renamed it “the Connector” and significantly modified its authority beyond what we had originally proposed.

It is vital to understand what the health insurance exchange, as proposed by my colleagues at Heritage, is not. It is not a regulatory agency; it is not purchasing agent, buying health plans on behalf of individuals or businesses; it does not negotiate the rates and benefits of health plans like the federal employees program; and it does not enforce a comprehensive standardized benefits package for health insurance. Its functions are purely administrative: It simply processes premium payments, government subsidies for low-income persons, and the paperwork for small employers.

The role of employers would be retained, but changed. Instead of the traditional defined benefit approach to employees’ coverage, the model would encourage defined contributions, particularly for smaller firms that do not have the financial wherewithal to participate in today’s employer-based health insurance system. So the new market would function through defined contributions to the health plans of the employees’ choice.

Former Governor Romney added another feature to the exchange: If an employer did not want to contribute anything to an employee's health insurance, the employer nonetheless would be required to offer a flexible spending account, a Section 125 plan, so that the employee could make tax free premium payments and benefit from the generosity of the federal tax code.

In the exchange, individuals, not employers, purchase health insurance plans. The exchange will ease access to health insurance coverage for many workers in non-traditional jobs, including part-time and seasonal employees, contractors and sole proprietors, and individuals with more than one job. Small business employees would be able to pick and choose health insurance plans, including health savings account plans.

Because employers will be able to designate the Connector as their employer plan for the purpose of the tax code, all of the premiums for health plans offered in the exchange will be *tax free*, and the benefits for the employees will also be tax free, just as under conventional employer-based health insurance. The achievement, then, is that the Connector will provide *for broad employee choice of health plans without compromising the tax-free status of health insurance coverage*. Employees would be able to pick health plans of their choice, have a property right in their insurance policies, and take their coverage from job to job without a tax penalty. Personal ownership and control of health insurance policies would thus characterize the new market. This is a major structural change in health insurance.

### **Helping Low-Income Workers**

For years, health care economists have been debating the best way to integrate low-income individuals and families into the private health insurance market, as an

alternative to rising uncompensated care costs or Medicaid expansions. On a bipartisan basis, many policymakers have proposed refundable tax credits—basically vouchers—to help people buy private health insurance.

Within the \$2.2 trillion in national health care spending, there is a great deal of cost shifting, including reimbursements from both the private sector and the public sector for uncompensated care. One thing that states could pursue, especially in cooperation with the federal government, is a policy that would use *existing* government funding for the uninsured to provide them with the means to secure private coverage. Once again, in Massachusetts, policymakers pursued this approach and redirected, with waivers from the U.S. Department of Health and Human Services, hundreds of millions of dollars in existing government subsidies to provide coverage for the uninsured through a sliding-scale voucher program.

Massachusetts's taxpayers spent \$1.3 billion in 2005 on hospitals and other institutions to provide care for the uninsured and those who did not pay for it. Federal law, of course, requires hospitals to care for persons entering the emergency room regardless of their ability to pay.

The new Massachusetts law transforms these subsidies into direct financial help to individuals, in the form of “premium assistance” for the purchase of private health insurance. Subsidies will be available to individuals and families with incomes up to 300 percent of the federal poverty line. Eligibility, in other words, broadly tracks an earlier Bush Administration proposal for a refundable health care tax credit program for low-income families that would phase out at \$60,000 per year. This also is a major change in health care financing.

The Massachusetts compromise reflects the political coloration of Massachusetts. There is plenty of room for criticism of the Massachusetts law on strict policy grounds. How it will work is another matter. But it is well to remember that it is in the early stages of its implementation, which will continue for another three years. In any case, it is far too early to make definitive evaluations.

What Massachusetts does prove is that with the political will, compromise at the state level is possible. Unsurprisingly, other states are looking at this very carefully, and they should be.

### **A Supportive Federal Role**

There are a number of steps Congress could take to aid state experimentation in health care reform. First, Congress could help states cope with the uninsured in one simple step: provide tax equity in the purchase of health insurance. There are a couple of ways to do this. President Bush has proposed a universal standard deduction, which would go a long way toward eliminating the current distortions in the tax code and providing fairness in the tax treatment of health insurance. Others have proposed refundable tax credits. At the very least, Congress should provide tax breaks or subsidies to people who do not or cannot get health insurance through the place of work. A combination of the universal standard deduction and a system of refundable tax credits would be the best solution.

Second, states could aid state experimentation with special grants. There are two promising approaches. The first is congressional assistance to the states through the enactment of broad goals to reduce the uninsured, the provision of policy tools to

accomplishing this objective, and special grants to enable states to achieve coverage expansion using their preferred policy approaches. This approach has broad bipartisan support and is embodied in the Health Partnership Act legislation, sponsored by Representatives Tammy Baldwin (D-WI) and Tom Price (R-GA). Similar legislation is sponsored by Senators Jeff Bingaman (D-NM) and George Voinovich (R-OH).

Another approach is being advanced by the Administration. The Bush Administration has signaled its intention to provide grants to the states—known as the Affordable Choices program—to help them cover the uninsured. This is an Administration priority and a real opportunity for states to enter into an agreement with the federal government to address this pressing policy problem.

The Founding Fathers designed the federal system as a way of allowing a diversity of options in a very diverse and dynamic country, the most revolutionary society in the world. We can improve our health care system, and we can do it because of the opportunities afforded by our unique federal constitution, the product of the Founders' peerless political wisdom.

Thank you. I will be happy to answer any questions you may have.

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