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Congressional Testimony

Laying the Groundwork For Universal Health Care Coverage

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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.

Mr. Chairman, any observer of the American health care system is immediately struck by two of its central features.

Gaps and unevenness in coverage. Despite the huge expenditures devoted to the system, there are enormous gaps in the degree in to which it covers Americans and there are wide difference in the level and type of benefits available to people of similar circumstances.

Millions of Americans lack any insurance protection at all, and many of these are middle class. Many poor and non-working Americans are eligible for a wide range of benefits, while others struggle to keep their families just out of poverty yet lack any insurance. A worker may have coverage one week, arranged by his employer, yet lose it the following week because he switched jobs to a firm without coverage. Similarly, workers who are perhaps forced in to early retirement by economic conditions, or their health, are not eligible for Medicare or any other program and can find themselves suddenly in dire straits for lack of affordable coverage.

The level of benefits available also can widely differ. An elderly person who happens to qualify for veteran's benefits can obtain general support for their outpatient pharmaceutical needs. Yet an otherwise identical retiree in Medicare has no such coverage.

So our "system" is a system in name only. It is really a patchwork of public and private programs with widely differing eligibility criteria. And many people end up falling between the eligibility requirements of the programs and many others have benefits only loosely connected to their needs.

Multiple systems of health care. The second distinctive feature of the American system is that different parts of it are run on totally different principles of design and economics. The Veterans Administration health system, for example, has similarities to single payer systems in other countries, in that the VA maintains its own hospitals, pays its own staff, and decides centrally on the distribution of medical resources. Meanwhile another government program, Medicare, runs on other principles, with private providers reimbursed by government for the services they render to eligible beneficiaries. In Medicare, the primary package of benefits is decided in detail by Congress. Moreover, Medicare is actually two separate programs. The hospital insurance system functions as a traditional mandatory social insurance program. The other part of Medicare, principally covering physician costs, is a voluntary system with a subsidy for government-sponsored insurance.

Yet another government program, The Federal Employees Health Benefits Program (FEHBP), covers over nine million federal employees, their families and federal retirees, and operates on yet another approach. The FEHBP provides a direct subsidy which is used by eligible families to reduce the premium cost of the private plan of their choice, providing that plan meets basic requirements laid down by the government. The benefits in FEHBP plans vary significantly. Congress sets down only a very basic set of benefit classifications, and the actual content of each plan is determined by consumer demand in the competitive market place.

In parallel to these widely differing government-sponsored programs is the extensive private insurance system that covers most working age Americans. The primary component of this system is insurance sponsored by employers to cover their employees and families. The families obtaining health coverage in this manner enjoy an often very large tax benefit since the value of the employer sponsored component of there compensation is free of all taxes. Other individuals obtain private insurance by purchasing it directly from insurance companies, often because their employers do not provide such coverage. While some tax benefits are available for this form of purchased insurance the criteria for tax relief are so restricted that many in this market have no tax subsidy at all.

Our experience with this fragmented patchwork of programs should lead us to draw some important lessons as we ponder ways to achieve universal coverage in America. Among these lessons:

Lesson 1: The employment-based system, while successful for certain families, has severe weaknesses as the basis for universal coverage

The employer-sponsored system is often pointed to as a success story, despite the current concerns about escalating costs. In the case of coverage offered through larger firms, employment-based coverage does have advantages. For instance:

Pooling. A company with a large workforce obviously also has a large pool for insurance purposes. A large number of individuals can be grouped together and insured as a group for a standard premium, despite possibly wide variations in medical risks among employees. Large companies also have the economies of scale and the sophistication to provide insurance at a low administrative cost per employee.

Advantages for bargaining and administration. Larger companies also can bargain very effectively with insurers and providers, and so are able to deliver cost-effective coverage that is often tailored specifically for their work force.

Choice. Because of the size of their insurance pool and their sophistication, large companies can arrange a choice of health plans, making it more likely that workers will be reasonably satisfied with their coverage.

*Employment-based insurance is very convenient***.** When an employer provides coverage, it is normally very easy for an employee to take part in the plan. Premiums are paid directly by the employer, and the worker does not have to apply for a tax exclusion;

the W-2 form, indicating the worker's income for tax purposes, simply makes no mention of the value of the employer's contribution to his health insurance. Moreover, if the worker has to pay something toward the cost of his plan, this is usually done in the form of a convenient payroll deduction during each pay period.

Problems for Small Firms Sponsoring Health Insurance

While these advantages of employer-sponsored coverage certainly apply to workers in many firms, they are less likely to apply to certain specific categories of workers, especially those employed in small firms.[1] Among the reasons for this:

- Small firms by definition are small insurance pools. A retail store with a handful of employees is a dismal pool for insurance purposes. Hiring a new employee with a disability, for example, can mean a huge change in insurance costs for the employer. States and the federal government recognize this and are exploring various ways to group small firms together to form larger insurance pools. But the need for these efforts only underscores the fact that the place of employment is not a particularly good basis for the pooling of these insurance risks for employees of small firms.
- Small firms face relatively high administrative costs, and many small-business owners do not wish to organize insurance. Because they lack the economies of scale and the management resources of larger firms, small businesses tend to face high costs when administering plans. According to data collected by the Congressional Budget Office, overhead costs for providing insurance can be over 30 percent of premium costs for firms with fewer than 10 employees, compared with about 12 percent for firms with more than 500 employees.[2] Moreover, many small-business owners have little desire to engage in the demanding task of trying to organize health insurance that meets the often-varied needs of their employees.
- Small firms can rarely offer a choice of plans. If a small employer provides coverage, it tends to be a single "one-size-fits-all" plan. Small companies rarely offer a choice of plans. While 81 percent of workers with insurance in firms of 5,000 or more employees had a choice of at least three plans in 2000, only 2 percent of covered workers in companies with fewer than 25 employees had a similar choice of at least three plans. Meanwhile, 95 percent of covered workers in the smaller companies had only one plan available to them.[3]

These obstacles to employment-based coverage in the small-business sector help to explain the high level of uninsurance among families with workers in that sector. According to a recent survey by the Kaiser Foundation, 74 percent of the uninsured are in families with at least one full-time worker, and while 99 percent of large firms offer insurance, only 55 of firms with fewer than 10 employees do so. Among low-wage

[1]For a summary of the pros and cons of employer-sponsored coverage, see Uwe E. Reinhardt, "Employer-Based Insurance: A Balance Sheet," *Health Affairs*, Vol. 18, No. 6 (November/December 1999), pp. 124-132.
[2]Congressional Budget Office, *The Tax Treatment of Employment-Based Health Insurance*, 1994, p. 8.
[3]Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits*, 2000 (Menlo Park, Cal.: Kaiser Family Foundation, 2000), p. 57.

workers (defined as those who earned less than $7 an hour in 1996), 45 percent are not even offered insurance.[4]

Lesson 2: The primary method for subsidizing insurance for working families is inequitable, inefficient and fundamentally flawed.

Today we subsidize for insurance very efficiently. In fact, the current form of subsidy encourages an inefficient overuse of medical care by most non-poor Americans while providing little or no help to the lower-paid uninsured, and it actually exacerbates the problem of uninsurance for many Americans. This happens because by far the largest subsidy for insurance for working Americans is the tax exclusion for employer-sponsored insurance. The exclusion means that the portion of a worker's compensation devoted to employer-paid health insurance is not subject to federal or state income taxes, or payroll taxes. In aggregate this subsidy dwarfs even the value of the mortgage interest deduction. John Sheils and Paul Hogan valued the subsidy in 1998 at over $111 billion at the federal level and nearly another $14 billion in exemptions from state taxes.[5] In contrast to a subsidy aimed at those who need help the most, a tax exclusion provides most help to upper-income workers (who are in the highest tax bracket) with the most generous coverage. Sheils and Hogan have estimated the average annual federal tax benefits in 1998 as ranging from $2, 357 for families with incomes of $100,00.

But the exclusion is highly inequitable. Sheils and Hogan estimated the average annual tax benefit at just $71 for families with incomes of less than $15,000. Thus the exclusion provides little help to lower-paid workers, who often face hardship in paying for family coverage or out-of-pocket costs, and it is not available to workers lacking an employer-sponsored plan. It is hard to imagine a less efficient system of subsidies for helping people to obtain coverage.

Lesson 3: The Medicare program does not represent a sound structure for universal coverage.

The trust fund woes of the Medicare program indicate the financing dangers of a social insurance approach to health care. Similar to the experience of maturing social insurance programs around the world, Medicare is plagued with huge unfunded liabilities as political pressure for ever-larger defined benefits today mean ever-larger obligations on future generations. The 2002 report of the Medicare trustees provided a dire picture of the program's finances, with expenditures rapidly outstripping dedicated revenues in future decades.[6]

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[4]Kaiser Commission on Medicaid and the Uninsured, *Uninsured in America: Key Facts* (Washington, D.C.: Kaiser Family Foundation, 2000).

[5] John Sheils and Paul Hogan, "Cost Of Tax-Exempt Health Benefits In 1998," Health Affairs, vol. 18, no. 2, March-April 1999, pp. 176-181.

[6] The 2002 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Insurance Trust Funds (Government Printing Office, Washington, D.C., 2002), p.10.

But the structural problems of Medicare are not confined to its financing. When Medicare was created in 1965, its benefit package was based on the prevailing Blue Cross/ Blue Shield package for working Americans in large firms. As such, it was seen as state-of-the-art coverage. Since that time, however, the benefits for Medicare recipients gradually slipped further behind the benefits routinely available to working Americans. For example, Medicare provides no outpatient prescription drug benefit. It would be virtually unthinkable for a large corporation today to offer its workers a plan without at least some coverage for outpatient pharmaceuticals, or, for that matter, protection against catastrophic medical costs.

The main reason that Medicare's benefits package is out of date—despite the general awareness that it needs to be updated—is that all major benefit changes require an act of Congress. Consequently, discussions about changing benefits (especially about introducing new benefits by reducing coverage for less important ones) are necessarily entangled in the political process. Providers included in the package fight diligently—and usually effectively—to block serious attempts to scale back outdated coverage for their specialties. Meanwhile, talk of upgrading the Medicare benefits package unleashes an intense lobbying battle among other specialties that seek to be included in the Medicare benefits package. Invariably, the result depends as much (if not more) on shrewd lobbying than on good medical practice. The understandable reluctance of most lawmakers to subject themselves to this pressure further slows the process of modernizing benefits.

*Formula Payments***.** Medicare today uses complex formulas to determine its payments to managed care plans serving beneficiaries and payments to physicians and hospitals under the traditional fee-for-service program. Through legislation and regulation, the government tries to create a payment schedule that will work in all parts of the country and that takes into account local conditions. But as is typical of attempts by government to set payments by formula, these schedules rarely match the actual market, which constantly changes. As a result, policymakers and health care providers grumble constantly that the formulas systematically and wastefully overpay some plans and underpay others, and that many payments to physicians and hospital are far out of line with the cost and difficulty of providing specific services.

Bureaucratic Decisionmaking. Just as arcane and problematic the complex administrative process used by the Centers for Medicare and Medicaid Services (CMS) to modify benefits, to determine whether certain medical treatments or procedures are to be covered under Medicare, and to define under what conditions or circumstances services are to be delivered and paid for. This byzantine process is marked by intense pleading by medical specialty societies, and a degree of congressional micromanagement that makes efficient management of the program impossible.[7]

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[7] For a recent review of management problems arising from congressional micromanagement, see Sheila Burke *et. al., Improving Medicare's Governance and Management*, (Washington, DC.: National Academy of Social Insurance, 2002), pp. 39-42.

Moving Towards Universal Coverage

If we are to construct a health care system in this country that focuses resources efficiently to help those who need assistance to obtain health coverage, we need to take the following important steps:

1. **Agree on a health care social contract between society and individuals that is explicit and fair.**

Today there is a legal and moral obligation on society to provide some level of health care to those who become ill. Under federal law almost all hospitals must provide immediate health services to individuals entering the emergency room. In addition, physicians and hospitals routinely provide services to individuals unable to pay for these. A recent study by Jack Hadley and John Holahan estimates that as much as $38 billion is spent each year in public and private resources on health care services for the uninsured.[8]

This implicit "social contract" is both inefficient and unfair. It is inefficient because the method of providing services often means they are delivered in the most expensive setting. And because the services are not part of a comprehensive plan they are inefficient from a medical point of view. The contract is unfair because it discourages many families with the means to obtain adequate coverage from doing so.

The current social contract should be replaced with a more rational one. In a civilized and rich country like the United States, it is reasonable for society to accept an obligation to ensure that all residents have affordable access to at least basic health care – much as we accept the same obligation to assure a reasonable level of housing, education and nutrition.

But as part of that contract, it is also reasonable to expect residents of the society who can do so to contribute an appropriate amount to their own health care. This translates into a requirement on individuals to enroll themselves and their dependents in at least a basic health plan – one that at the minimum should protect the rest of society from large and unexpected medical costs incurred by the family. And as any social contract, there would also be an obligation on society. To the extent that the family cannot reasonably afford reasonable basic coverage, the rest of society, via government, should take responsibility for financing that minimum coverage.

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[8] Jack Hadley and John Holahan, "How Much Medical Care Do The Uninsured Use, And Who Pays For It?" *Health Affairs* web exclusive, February 12, 2003, available at: http://www.healthaffairs.org/WebExclusives/Hadley_Web_Excl_021203.htm

The obligations on individuals does not have to be a "hard" mandate, in the sense that failure to obtain coverage would be illegal. It could be a "soft" mandate, meaning that failure to obtain coverage could result in the loss of tax benefits and other government entitlements. In addition, if federal tax benefits or other assistance accompanied the requirement, states and localities could receive the value of the assistance forgone by the person failing to obtain coverage, in order to compensate providers who deliver services to the uninsured family.

2. **Provide support to people to obtain health care based on their need, not where they happen to work, or their eligibility for welfare, or their military record, or their age. Enable individuals and families to use this support to enroll in a seamless system of coverage according to their choice.**

The central public policy objective of a health care system is to use public funds in an efficient and economical way to enable every household to obtain at least an acceptable level of health care services and protection from large financial burdens associated with ill health. Whether a US resident is able to count on that commitment should not depend on their current circumstances. Moreover, resources should be used as efficiently as possible to provide help those who need it most to obtain coverage. That requires us to overhaul current subsidy methods to target funds more efficiently and to achieve horizontal equity between similar people.

An important step towards that would be to overhaul the tax treatment of health care, gradually ending the regressive tax exclusion for employer-sponsored health insurance and replacing it with a more progressive subsidy. That is the logic behind the various refundable tax credit proposals in numerous proposals for addressing uninsurance. These proposals would increase the subsidy to lower-income households relative to upper-income households.

The same rationale lies behind various approaches designed to alter the Medicare program to target a higher proportion of benefits on lower-income seniors, in contrast with the traditional social insurance vision of equal benefits regardless of income. And while there is fairly universal support for a residual safety net public program for indigent or dysfunctional households, replacing part of the Medicaid program with a refundable tax credit or voucher-like assistance is in line with the same goal.

It is also important to de-link financial support from household work status. In other words assistance for health care coverage should not be based on employment or retirement status, and it should be available for the cost of coverage from any reasonable source. Thus an unemployed person and his or her family should have the same degree of assistance as an employed household of similar income with employer-sponsored coverage. A worker with employer-sponsored coverage should get the same tax break or direct subsidy for coverage as a similar worker whose firm does not provide insurance. A

60 year-old early retiree should be able to count on the same help as a similar person who is still in the workforce.

The value of the assistance should also not differ according on the source of coverage. Thus a household should receive the same subsidy value were it to obtain coverage through an employment based insurance plan or by buying into a public program. On the other side of the same coin, an individual or household should be able to continue the same form of coverage throughout their life if they wish. Thus a worker with a private insurance plan should be able to continue that coverage into retirement, receiving "Medicare" benefits in the form of assistance towards the cost of continued insurance coverage.

3. **Make it possible for the place of work be the location through which most families can get coverage, without employers necessarily being the sponsor of coverage.**

Most people in America pay their taxes through a place of work. This is a very convenient system under which employers withhold income and Social Security taxes and send the money to the government. In addition, employees typically adjust their withholdings to take advantage of any tax breaks for which they may be eligible (for example, the mortgage interest deduction). This means that employers actually operate the basic income tax system; but they do not in any sense design the tax code for their employees or "sponsor" the tax system. They could more appropriately be considered a clearinghouse for tax payments.

The place of employment is likewise particularly convenient and efficient for handling health insurance enrolment and payments. Workers with employer-sponsored health insurance benefits typically sign up for the firm's plan when they take a job and arrange for a payroll deduction to cover premium costs for them or their family. With individual tax credits or other forms of subsidy discussed above, employers could carry out the critical clearinghouse role for plan choices, tax adjustments, and premium payments. Such employers would not required to organize or sponsor a plan for their employees to obtain tax relief or other subsidies for the cost of coverage.

In other words, smaller employers could handle the mechanical aspects of arranging for payroll deductions and premium payments (similar to their role in the tax collection system) without having to sponsor a plan. Thus, the employer could play a very important role in facilitating coverage without having to organize coverage. In this way the place of employment could be the "point of service" for selection and payment decisions, and for the receipt of subsidies, without the employee being restricted to coverage decisions made by the employer.

*Using automatic enrollment to boost coverage***.** Whether or not they sponsored insurance, employers could be encouraged to institute an automatic enrollment and payment system to make health insurance premium payments and to obtain health-related subsidies. This means that employees would automatically be enrolled in a health plan

unless they explicitly declined to do so, perhaps by signing a document indicating that they understood the possible consequences of not enrolling in a plan. Alternatively, a state could establish a default bare-bones health plan in conjunction with a private insurer, to which anyone not otherwise choosing a plan would be assigned.

Evidence from pension plans indicates that an automatic enrollment system for health insurance could have dramatic effects on sign-up rates.[9] This payment system is also very similar to the way in which the FEHBP enables a federal worker who may work in a small workplace, such as the local office of a Member of Congress, to choose from possibly dozens of plans.

4. Use "creative federalism" to discover the best arrangements for organizing health coverage.

Any approach designed to secure universal coverage, and perhaps especially one which seeks to encourage greater equity and freedom of choice in coverage, has to confront the challenge of organizing the system of coverage. There is no consensus on which structures are best to deliver health care. Some argue for government-sponsored plans. Others for individual insurance. Others still argue for various group arrangements. In addition, allowing people to make choices in health care, even within government-sponsored programs, raises such issues as risk selection. Moreover, views differ on how to achieve the right combination of subsidy and insurance regulation to secure affordable and efficient coverage for people of differing health status.

Perhaps the fastest way to discover the best methods of organizing health coverage under a universal system would be to institute a modified form of the idea of "creative federalism." Under this approach, federal-state covenants would be instituted to test comprehensive and internally consistent strategies at the state level designed to move towards universal coverage. Congress would provide federal funds to assist states to experiment with a chosen strategy for arranging health insurance and services. In contrast to a simple system of block grants, these federal-state covenants would operate within policy constraints designed to achieve national goals for achieving universal coverage.

The Institute of Medicine (IOM), one of the national academies, recently proposed a limited version of this strategy designed to stimulate and test creative methods of expanding coverage for the uninsured.[10] The IOM proposed that the federal government create a number of statewide 10-year demonstrations based on combinations

[9] A recent study found that automatic enrollment for 401(k) plans boosted participation rates from 37 percent to 86 percent for such voluntary pensions, with even sharper increases for young and lower-paid employees. See Brigitte Madrian and Dennis Shea, *The Power of Suggestion: Inertia in 401(k) Participation and Savings Behavior*, National Bureau of Economic Research Working Paper No. 7682, May 2000, p. 51.

[10] Janet M. Corrigan, Ann Greiner, Shari M. Erickson, Editors, *Fostering Rapid Advances in Health Care: Learning from System Demonstrations* (Washington, D.C.: Institute of Medicine, 2002).

of proposals, including federal and state tax credits, as well as Medicaid and SCHIP expansions partly financed by the federal government.

Congress should consider the IOM recommendations. But it could also pursue a more comprehensive strategy to trigger state experimentation. Under such a more comprehensive "creative federalism" approach the federal government would do four things:

1) **Congress would establish goals for universal coverage**. The goals could include a certain percentage reduction in uninsurance rates in each state over a period, and steps towards ending multiple programs and eligibility criteria. Congress would also establish boundaries in policies that could be adopted in reaching the goals (e.g. that no person could face unreasonable coverage costs as a result of their medical condition)

2) **Congress would enact a number of changes to provide an "*a la carte* menu" of federal policy options that would be available to states to help achieve the goals**. These options might include making a version of the FEHBP available within the state, allowing some Medicaid/SCHIP money to be used in creative ways, removing regulatory/tax obstacles to churches, unions, and other organizations providing health insurance plans, and the creation of association plans and other innovative health organizations that would then be available to states.

3) **Congress would provide an amount of funding.** This would be for two purposes. Part of the money would help states fund certain approaches. The other part would "reward" states according to how successful they were in meeting the goals.

4) **The federal government would enter into agreements, or covenants, with states to achieve the goals**. States would propose some combination of modifications of their current programs, initiatives with their federal allocation, and a selection from the federal menu. The states could also negotiate regulatory waivers to the extent allowed by law. The federal agreement would have to agree to the covenant before it could proceed and evaluation procedures would have to be included.

The goal of universal coverage is likely to remain elusive under our current health care system. Today we provide help to people to afford coverage in such an inefficient and inequitable way that it is impossible to help all those who need it to afford coverage. In addition, we have a patchwork of programs and subsidy systems with a multitude of complex eligibility requirements that guarantees people will fall through the cracks. Reaching the goal of universal coverage will be difficult. But it will be much easier if we rationalize subsidies for health coverage, enable people to pick the form of coverage that is best for them, and encourage state-federal experiments to explore innovative ways of organizing health care coverage.

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