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**Covering the Uninsured: Options for Reform
Alliance for Health Reform and Kaiser Commission on
Medicaid and the Uninsured
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ED HOWARD, J.D.: - eho lack health insurance. While we recognize that finding ways to cover the uninsured isn't the only goal of health reform, it's certainly one of the central reasons why policy makers are willing to take on one of the toughest tasks on this domestic agenda that's being faced.

The goal of today's program is not to convince you of a particular path to broaden the coverage that any of those options is the right one but rather we want you to better understand who the uninsured are, how they got to be that way. Then we hope to make you aware of the major options being discussed to address the problem and some of the pros and cons of each. This is decidedly a primer and we've asked our panelists to, as the bumper sticker used to say, eschew obfuscation, use as few acronyms as they can so that people who are smart but not as well informed as they need to be can follow this discussion with ease.

Our partner and cosponsor in this briefing, the Kaiser Commission on Medicaid and the Uninsured is a project of the Kaiser Family Foundation. Diane Rowland, who's the Director of that commission, you'll be hearing from in just a moment. We want to not only welcome you to this briefing but also to those congressional staff in state and district offices who are watching the live webcast on kaisernetwork.org, we want to give

you a better understanding of what that coming debate on the uninsured is all about. We want to thank you for tuning in.

Let me cover a couple of logistical items before we get to our program. In your packets, you're going to find a lot of background information including speaker biographical more extensive than you'll get from me in the time we have.

You'll also find there are PowerPoint presentations, which is going to be crucial since you'll see that the screen we have here on the right is very small. In fact, it's nonexistent. The audiovisual company is in the deepest part of Southern Maryland so they are still digging themselves out. Follow along with the versions of the PowerPoint that you have in your packets and I think you'll be okay. If you're watching on the webcast, you can find those PowerPoints and all the rest of the materials that are in the kits posted on the Alliance website, allhealth.org and on kaisernetwork.org.

In a few days, you'll be able to view a webcast, an archived webcast, of this briefing and later on a transcript. We'll try to let you know when that's available. At the appropriate time, those of you who are in the room can fill out the green question cards that you have in your packets. There are at least one mic. There are at least one mic to which you can come to ask a question in person when we get to that part of the program and eventually, we're going to ask you to fill

out those blue evaluation forms that are also in your kits so that we can make these programs better for you in the future.

I want to emphasize this is intended as a primer. When we get to the question period, you should not be constrained. There is no question too simple that you should feel embarrassed to ask it and given the level of sophistication of our panel, you can ask the most complicated question and not stump the panel at all. So we're very pleased to have, what I think is just an incredible group of folks to walk us through this discussion of the uninsured and what to do about them.

First up is Diane Rowland. As I mentioned, she's both our first presenter and in that instance, we're happy to note she is one of the country's foremost authorities on coverage policies. She's the Executive Director of the Kaiser Commission on Medicaid and the Uninsured. She's the Executive Vice President of the Foundation. She's been a senior professional staff on the Hill, key positions in the executive branch. Your task today is to give us a broad overview of this very important topic and we're very happy to have you setting the stage for us Diane.

DIANE ROWLAND, Sc.D.: Thank you Ed and thank you all for coming today. It's a pleasure to cosponsor these briefings with the Alliance and to try and provide some of the basics that can help underpin the discussions as we go forward. As Ed said, there's a handout in your packet that would normally be

these pretty color slides up on invisible board but instead, we'll work through them a little.

What I wanted to start with was just to remind us that 15-percent of the American population is uninsured today and that Medicaid and Medicare, the government programs that help provide coverage to the elderly as well as to some of the low-income population, comprise about 27-percent of coverage so that there already is a substantial public role in health insurance coverage.

About half of the population gets their coverage from employers so that as we look at options, we're looking at how to move that 15-percent uninsured slice of the pie to either employer-sponsored coverage, into public coverage, possibly into the private nongroup market but it's all about how do we provide for that pie to not have that chunk of uninsured there.

The other point, of course, is that when we think about our uninsured populations, it's about 36 million adults and about nine million children. That's at the last snapshot we have from census, which is about year 2007. There's some concern that obviously that number, with the economy in the shape it is in today, has grown markedly since that last snapshot.

If we think about the characteristics of the uninsured and what this may imply for coverage approaches, I think it's important to note that 81-percent of the uninsured come from

families with at least a part-time worker, 70-percent from families with a full or one or more full-time workers so that the attachment to the workforce is strong among the uninsured.

It is among that population though that offerings in the workplace are not available always for health insurance coverage. Most do not get an offer at their job. For some when they are offered coverage, that coverage is beyond the scope of their family budget in terms of their share of the premium.

That's because, as the second pie there indicates, two-thirds of the uninsured come from families with earnings at or below 200-percent of the poverty level. Today, that's about \$44,000 a year for a family of four. The other issue, of course, is that if you are trying to purchase coverage on your own, the average family policy today costs over \$12,000. So you could easily see that there is an issue there of how to make coverage affordable for the uninsured who are predominantly low-income and a need for talking about how to subsidize the cost of their coverage if you're trying to move them to broader coverage.

I point out the last one that 20-percent of the uninsured are children. They're largely been helped somewhat by the Medicaid and CHIP expansions. The reauthorization of the CHIP legislation will continue to make progress, hopefully, in reducing the number of uninsured children but we still have a major problem with uninsured adults.

The other point in figure three that I would make is that it's a national problem but it has very different impacts across the states and as those of you on the congressional staff know, there's always a lot of issues about how this fairs in your state.

You see that many of the states, 13 in the district, have less than 13-percent of their non-elderly population insured but 18 states have more than 18-percent so that one needs to think about the differences in the economies of those states where they're more likely to have small businesses rather than a manufacturing base, what's happening in some of our low, uninsured states that have large manufacturing bases that are eroding over time. So there are real challenges to how to provide for the employer-based coverage when there's differences across the country.

The other point is that we care about doing this and we think it's the right thing to try to move forward with broadening health insurance coverage because health insurance coverage matters. It affects how people use the health care system. It ultimately affects their health.

As a recent IOM report has concluded, being uninsured is hazardous to your health. Here you see that adults who are uninsured as well as children are less likely to have a usual source of care that connects them to ongoing preventive services as well as early treatment for conditions.

Many say that they needed care but did not get it due to costs, which can lead to adverse health outcomes and to, in some cases, more expensive care and hospitals and more expensive treatments because they didn't get their conditions diagnosed early enough or for many, especially those with life-threatening conditions like cancer, it could mean the difference between a stage one cancer diagnosis and a stage four. It could be the difference, therefore, between life and death.

If we think about moving forward on health insurance coverage, the figure five really shows you a different way of looking at the availability of coverage by income. You see there that those in the under 200-percent of poverty group are much less likely to have employer-sponsored or other private coverage than those at higher incomes.

They are more likely to depend on Medicaid coverage or SCHIP for the children or CHIP for the children but even in those groups, the coverage there for adults is very limited under Medicaid in most states and does not cover child as adults so that you still have very substantial levels of poor and near-poor individuals without health insurance coverage going uninsured.

The other factor that one needs to consider is that there would probably be little problem if insurance was not expensive but it is a very costly item for families and for

employers and an item that has been growing. The employer average premium for group coverage was under \$5,000 in 2008 for an individual and a little over \$12,000-12,680 was the average for family coverage.

That's a substantial cost increase from 2000 and has been one of the factors that has led many to think that as part of doing any kind of broader coverage reform, one needs to also consider how to also bring costs under control to make health care more affordable to all.

So the challenge we have going forward in figure seven is that if you think about the insurance challenge of getting to and aiming toward universality, you have to deal with the fact that we have a substantial uninsured population that is low-income.

The 14-percent of the uninsured who are low-income children, many are potentially eligible for the Medicaid program today and the state children's health insurance program. So there is an issue of broader outreach and enrollment to get these children into coverage but most of their parents and certainly adults without children are usually ineligible for public programs because their income is above the levels that make them eligible or in the case of adults without children, they're not technically eligible for federally Medicaid matching funds unless the state is able to obtain a waiver.

So there are challenges about public program coverage. There are challenges about affordability and there are certainly different strategies that may be applied to different parts of that pie, which I'm sure our other panelists will speak to.

In conclusion, I just like to say that the public is actually seeking action here. Many thought that given the serious economic problems facing the country, some might be adverse to moving forward and in all of our polling work consistently when we ask the public whether we can afford or not afford to take on health care reform now, nearly two-thirds of the public come back and say it is more important than ever to take on health care reform right now.

So I think the challenge is going to be how to do health care reform and how to move it forward and I hope that the remainder of this conversation this afternoon will help fill in many of the options and details that give you some ways to address this challenge we all have of making health insurance both affordable and available to all Americans. Thank you.

ED HOWARD, J.D.: That's terrific. Thank you Diane. We now turn to Jack Ebeler whose background I have on a sheet that's somewhere in this stack. Jack is currently an independent consultant on federal health policy. In some of his past lives, he's headed the Alliance of Community Health Plans.

He's directed the health care group at the Robert Wood Johnson Foundation. He was a senior official with the Department of Health and Human Services here in town and he's here today to help us lay out, in broad terms, the kinds of options under discussion as the reform debate heats up. Jack thanks very much for being here. I know you had to shovel that driveway to get out of your subdivision.

JACK EBELER: Thank you Ed. I'm a little worried, I thought it was illegal to give a presentation without PowerPoint especially in front of Congressional staff, I don't want to be accused of breaking the law here.

The purpose of this is to really provide a very simple top line overview. I'm a little embarrassed because there are people in the room who are far more expert than me but we're really just trying to ground us in the basics here. It's based on a publication that Jen Tolbert at Kaiser Family Foundation is lead author on.

This is in your packet and it has a lot more detail in it that again, the purpose is to provide the overview. I would note it does not address a whole bunch of other issues that are important in this debate, cost, quality, and the like. This is really just looking at options for coverage reform.

As you look at this, just sort of reanchor on the slide that Diane flagged about the sources of coverage by income where we see sort of most of the population under aged 65,

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benefits from employment-based coverage and particularly those at the higher income levels. Many others turn to public programs, Medicaid and CHIP in particular in these age cohorts and the uninsured obviously fall in between those two program areas and in particular at the lower income. You're more likely to be uninsured.

If you think of overall approaches in the simplest way to look at it, you can either build on the current base of financing structures that we have in the country, in particular the employment-based system and public programs or you can look at this and say it's not working and we should substantially replace some or all of those sources of financing and we'll look at those two models.

I will note when we get to the end, the public policy process, as you all know, typically doesn't necessarily pick sort of one or the other. You're going to typically look at a mix and match menu of choices as you go down this road.

So first of all, looking at the approach of saying well let's take what we've got and strengthen it, build on it for health reform, you first look to employment-based coverage. As Diane said, that's the dominant source of health financing for most people under aged 65.

You try to strengthen it either through a mandate or more typically in these days what's called a play or pay where the employer either has to provide health benefits meeting some

standard to its' workers or pay something that we would probably end up having to call a tax to some pool somewhere that would be a source of financing for coverage for that worker who doesn't get the coverage through the employer. So you basically would grow the employer system even more.

The second way to go here in building on the current system is the look of the public programs, Medicaid, CHIP in particular and see how to improve them probably in one of two ways. One is to improve the eligibility itself, in particular lots of low-income people, single adults travel as couples are not eligible for Medicaid. As Diane indicated it's also a very strong push to get people who are currently nominally eligible but not enrolled into the program. so you can build on those programs as well and typically aiming more to the low wage, low-income side of things as you use that tool to expand coverage.

In addition, there have been proposals, in the past, to look to Medicare to drop down to maybe individuals aged 55 to 64 and the Congress, as you all know, just put into place, subsidies for health benefits for the temporarily unemployed, again another use of public financing to try to buttress the current system.

Just by way of, we can get into it in questions, whether or not you have an individual mandate can fit within

just about any of these models that sort of sits there as a policy tool in a variety of frameworks.

The second big choice though is to say this isn't working and folks say, from a variety of different perspectives, that let's try something totally different. This can take you to the single payer, which is the easiest way to think about that is Medicare for everyone as one approach.

The alternative is to look at the employment-based system and say that the tax subsidy that's currently directed there either is not enough. We either think that that employment-based system is doomed to eroding so far that we can't buttress it or people look at it and say that is just not the right way to do health benefits and instead we should redirect that tax subsidy to individuals and drive health insurance through an individual health insurance market instead of the current mix of employment-based and private.

Within those two sort of big frameworks, there's a whole number of other issues you need to deal with and address, in the context of this debate, there's a whole bunch of sort of what tend to be subsidy and affordability policy levers that you confront. Subsidies, tax, otherwise for both the individuals in making coverage affordable and these are typically targeted obviously on lower wage, lower income individuals whom you try to encourage to purchase coverage.

They can be subsidies directed at employers. These are typically at the lower wage employers for whom health benefits might be expensive if you're requiring employers to step up here or they can be at smaller employers, again that's where the drop offs in employer coverage have been most severe.

You can also say well let's try to see if we can make the insurance products less expensive at the premium level, encourage high deductible products, for example. Massachusetts has a young adult product for the folks who are more likely to be uninsured but tend to be lower risk, again to try to keep those prices down. Again you have to be sensitive to the fact that you're attending to premium price there in ways that may well make receipt of health care pretty expensive for that person.

There have been proposals for reinsurance, some type of a government program of reinsurance of a high cost care that will help keep the premium cost more reasonable for the employers offering and/or the individuals taking up coverage.

You also have to attend to making sure that in coverage, products are actually available to people that you are trying to bring in to the market. We hear now proposals that try to give people access to some form of a larger purchasing pool. In Massachusetts, it's called a connector. These are typically driving towards getting people in the

individual market and a small group market access to some products that they might not normally have access to.

There are discussions of providing people access to the federal employees' health benefits plan that many folks in the room have access to but again, it's just it's a product availability mechanism for folks if you're leaning on the private market in this way.

Second, another option that has been put on the table is to make Medicare available not in a single payer model but as yet one of the options available to individuals and businesses in a community if you move to a mixed model approach. In addition, there have been discussions for many, many years about what used to be called the association health plans. I'm not quite sure of the current lexicon but these are ways to allow sort of clusters of smaller employers to make health benefits available to their members.

You move here towards trying to provide options available to people that allow regulatory approaches that cross state lines. You're typically moving towards options where you are making products less expensive by making things available for the regulatory structure in a less regulatory state and moving those around the country a little bit more.

In addition, there have been high-risk pools for years. These are typically state pools for people who are underwritten and excluded from private insurance, is a vehicle to make the

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coverage available to the higher-risk individual. You need to provide some form of subsidy in that model as you go forward.

Finally, as I said just to wrap it up and get to our next speaker, typically the policy choice is going to be to mix and match among these various models if you go back to the sort of last time Congress took a huge whack at this was Medicare and Medicaid in 1965. The big competing theories were let's do something just for the low-income.

Let's do a social insurance plan and let's do a voluntary premium-based plan. The answer was okay rather than choose among the three. The political process took a little bit of each and put Medicare A, B and put Medicaid into place. So I think sort of the mix and match menu and again in Jennifer's paper, there's a chart towards the end that sort of says how some of those options lay out today. So with that, let me stop and kick it back to Ed.

ED HOWARD, J.D.: Jack, one thing actually if you could clarify not everybody in the room may know what reinsurance involves and what does that do for you?

JACK EBELER: This idea that probably came around when we had a lot more sort of confidence in our financial institutions but the basic model is an employer is buying health insurance from an insurance company or an individual is buying health insurance from an insurance company.

Typically, the standard numbers you will hear is that about 20-percent of the enrollees incur about 80-percent of the costs. I mean health care is not spread evenly. That drives up obviously the total premium for everyone. The idea of reinsurance is to offload some of those exceptionally high costs to a larger federal program or you can even privatize that in some ways in order to keep the average premium at a much more reasonable level for the employer and individual enrolling.

ED HOWARD, J.D.: Okay. Good. Thank you. our final speaker is Brad Herring. He's on the faculty at the Bloomberg School of Public Health at Johns Hopkins. Brad's an economist PhD from Wharton. He's written on a whole range of health coverage-related topics. He's served a stint on the staff of the White House Council of Economic Advisors and today his job is to make sure we know some of the implications, pro and con, of some of the coverage options, which you've been hearing about. Brad, thanks for getting down here from Baltimore.

BRADLEY HERRING, Ph.D.: Thanks. Thanks. Thanks Ed. Thanks for having me and thanks to everybody for coming out on a wonderful spring day. Thanks also to the Alliance and Kaiser Family Foundation for putting this on. So what I'd like to do is spend some time building upon what Jack and Diane talked about and really focus in on these potential complications of the health care reform options that are out there.

So unless you came here without a dog in the game or without an opinion on how you think health care reform ought to go, I'm most likely going to say something that offends you. So have that in mind.

I'd like to begin by referencing what I think is a pretty telling story from the Kaiser Daily Health Policy Report. So if you haven't signed up for this and you're interested in health policy, I definitely encourage you to do so.

Several weeks ago, they referenced an article that talked about the Divided We Fail coalition. So if you'll excuse me, I'll just read from what the Kaiser Health Policy Report said. Members of Divided We Fail coalition led by AARP that includes the business roundtable, the National Federation of Independent Businesses, and the Services Employees International Union, and seeks to promote health care reform, have become and I'd emphasize here, divided over key elements of how to fix health care as they get down to the specifics, the AP Boston Globe reports. Yikes, right?

So Divided We Fail and it's coming out that they're divided on things. This doesn't bode well for us, does it? So the AP continues, although members agree that something should be done to revamp health care in the U.S. and have reached consensus on a vague set of general principles that include making coverage more accessible, affordable, and efficient, I

don't think anyone here is going to disagree upon those principles, they differ over important details including what roles the government and private businesses should play.

So let me spend a little bit of time talking about these potential differences, these potential complications. The first one's, I think, ideology. So you've got Republicans on the right, Liberals and then Progressives on the left who just have some fundamental differences about the role of government and the extent to which private markets can work in health care.

There's also issues related to special interests. So insurers, physicians, hospitals, drug companies, and both small and large business have some vested interest in what's going to happen. There's also this issue of redistribution of income. So I think fundamentally, we can all agree that a problem with the uninsured is that the premium they face is larger than what they're willing to pay for that coverage.

So if you think about trying to reduce the uninsured, you ought to think about trying to reduce that premium. So that's obviously going to take a fair amount of redistribution. One dimension is really transferring resources from high-income to low-income people. We also think about how this is transferring resources from healthier people to sicker people.

I've also made this note of an issue of how complex this is. So you can think about transfers of income that are

very straightforward, very apparent, or you can think about layers of taxes and subsidies that try and confuse a little bit in terms of what the final set of redistribution is.

So what I'd like to do in the remaining time is talk about these three political issues but then also maybe raise some non-partisan practical issues with the following four options, which seem to kind of be the dominant ones out there. So what I'll do is try and start on the left, go ping-pong over to the right and kind of work my way towards the middle.

So I'll start by talking about single payer, talk about the Republican vision probably best articulated in the McCain proposal, talk about the proposal that Candidate Obama put forward, and Chairman Baucus in this so-called White Paper and then the Wyden-Bennett bill. For each, I'll kind of just give a couple of seconds about the underlying appeal of this approach but then follow up with some of these potential complications or complexities.

First off, single payer, HR676, the underlying appeal of this is essentially that it's very elegant and simple. We pay taxes into the system and then in return you get the medical care that you need. Then also it's universal. So this is probably the only approach that's actually going to get us to having no uninsured left. So that's kind of your notion of universal, getting everybody covered.

This is probably the only that's going to do it but then moreover if you think about universal as having this system in which everybody's essentially got the same kind of coverage and we're all in the same boat together, single payer is really probably the only way we might get there.

Another thing that's underlying appeal about single payer is that there would be large reductions in the administrative costs. So Medicare has administrative costs between about two to three-percent whereas private insurance varies considerably across different markets but averages about 14 to 15-percent.

Potential complications, well if you look at the description of single payer and particularly on John Conyer's website. This kind of seems like a health care utopia. You get the health care you need, cost sharing is reduced. So right now, there's pretty significant cost sharing in the Medicare program. That's going to go away but I think many of us might agree that somebody's got to say no. We can't consume all the health care that we'd like. Somebody's got to be in place to say no. There's certain treatments that we shouldn't be receiving or certain patients that should receive certain treatments.

Taxes is a big issue. So I don't want to be hysterical. I actually think that taxes should kind of go up a little bit to address the fiscal situation we're in in the U.S. but many

people probably balk at the extent to which taxes have to go up to pay for single payer. HR676 includes payroll taxes increasing from about 1.5-percent to 4.7 and five-percent, which is both on the employee side and the employer side.

Repeal the Bush tax cuts, get in line. I think everybody's targeting these Bush tax cuts as a pay for. It's probably the single most popular pay for in history.

Then on top of that, the proposal would increase the marginal tax rates for the top five-percent and top one-percent of income, an additional five-percent for 10-percent respectively and then also include a tax on stock transactions.

The final thing I'll say about single payer is that it's most likely going to result in lower payments to providers. So if you look at the MedPac data comparing private reimbursements and public reimbursements are about 15 to 20-percent lower on the public side.

So let's transition into the Republican vision, which is probably best articulated by what McCain ran on, which involves tax reform, individual markets, cross-state purchasing. The underlying appeal here is really that tax reform can actually improve efficiency and equity in health care markets and maybe if there's time later in the questions and somebody's really focused on what the problems are with the tax subsidy can go into that but the appeal here is by having a push towards individual markets, allowing cross-state

purchasing, the theory is that increased competition might result in a competitive market for health insurance.

The difficulty here is that individual markets essentially discriminate against sicker people by either charging them higher premiums or denying them coverage. So the complication there is certainly that there'll be reductions in pooling across health status. So some sicker people are going to wind up paying more and then on top of that, some sicker people are going to be essentially uninsurable and we're going to have to have some high-risk pools to provide their coverage, which are either going to be, as I write here, either very expensive or underfunded.

This notion of cross-state purchasing is really an attempt to try and deregulate health insurance market. There's a concern on the right that benefit mandates are choking the insurance market but not all these benefit mandates are trivial things like hairpieces or chiropractic services but I mean not to put down that but there are indeed lots of these benefit mandates that are true consumer protections that would be stripped and then finally, the high administrative costs in the individual market.

So moving forward, so we got started off on the left going to the right, now let's get to the middle and consider what Obama talked about in his proposal similar to what Baucus has written about in his White Paper.

The underlying appeal of what they're talking about is really that it builds on the current system. So there's concerns that trying anything too dramatic is going to shake the apple cart and get the middle class upset. So the appeal of what they've done is focused on what we've got now with the least amount of upheaval.

I view this as a potential complication. I don't think anyone looks to the current health care system and thinks that it's a great system that one would design. It's very fragmented.

Another potential complication is building on employer mandates is potentially problematic because it doesn't necessarily provide for low-income subsidies for workers who will pay for those mandates through relatively lower wages.

I thought I'd maybe spend about 10 minutes, 15 minutes talking about the pros and cons of an individual mandate. No seriously, I think we had a lot of that during the debates between Clinton and Obama. So I'll move on but that too, with this approach, individual mandate, do you have one? Is it enforceable? As you move up the income level and expand Medicaid and SCHIP, crowd out is going to be an issue. As we saw with SCHIP reauthorization, which by all accounts was a great program, became hugely controversial in terms of this issue of crowd out in terms of the extent to which public is involved.

If we think that that was controversial, just wait until we have a debate about whether to have a public plan and an exchange. People kind of refer to this as a Trojan horse in terms of trying to sneak a public plan in there and hopefully it'll grow over time. I guess how you feel about a Trojan horse depends on whether you're a Greek or a Trojan.

Then finally is this bipartisan enough to pass? So can the approach that worked for the stimulus in terms of keeping all the Democrats together and getting two to three Republicans, can that work on health care reform? I conjecture no because you're going to have a significant number of Democrats on the left who are going to prefer single payer and maybe some of these blue dogs will get concerned about the public plan, potential concerns there.

So let me conclude here by talking about the Wyden-Bennett Healthy Americans Act. The underlying appeal here is that it's got bipartisan support. It might be a grand compromise, if you will, in which you give the Republicans their private markets. You give the Democrats their subsidies and regulation of the private markets and perhaps this is something we can all agree upon.

Another thing that's appealing about it is CBO and JCT estimate that it'll break even after a couple of years. Part of this is slower growth due to some better incentives in the plan but then some of it is also redistribution from high-income

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folks to low-income folks, which in turn is a potential complication. So just how willing are these high-income folks going to be to having some redistribution.

Another potential concern is that the Wyden-Bennett Bill takes a vulnerable Medicaid population and transitions them into private plans. That could be problematic for many advocates. Defining the basic benefit package is certainly going to be controversial. It's going to be controversial, I think, in any of these approaches but I wanted to highlight it here.

Then the final thing I'll conclude is on this, it doesn't seem like the Wyden-Bennett Bill is really anybody's favorite approach to health care reform. It just kind of seems to be like well this is perhaps the best we can really do in a bipartisan environment. So the concern here is that if the Wyden-Bennett Bill is everyone's second preferred plan, maybe we'll go somewhere but, if in the end, it's really somebody's third preferred plan in which the second preferred plan or approach is the status quo relative to their favorite one, that may not bode so well for us all. So with that, let me turn it back over to Ed and apologize for going over.

ED HOWARD, J.D.: No, that's very good. Thank you Brad. Brad was alluding to something that Stuart Altman of Brandeis takes credit, whether it's due or not, for coining, which is the observation that in the last health reform debate, everyone

had their perfect ideal plan as their first choice and their second choice was indeed the status quo. If you're in third place behind the status quo, you're not in very good shape.

We now have a chance for you to join this dialogue, multilogue, you can ask questions at the microphone. You can fill out a question on the green card and hold it up and someone will bring it forward. Alternatively if you're watching the webcast, remember you can go to the website, allhealth.org, click on the description of this briefing and you'll have instructions on how you can send us an email with your questions. I would urge you to take this opportunity to ask questions of some of the best folks you're going to have access to in the course of this debate.

Let me actually give you a chance to do that and clarify one thing. Brad was talking about special interests and it was those special interests last time around who were said to have the status quo as their second choice. You've heard a lot of speculation about different special interests being much more forthcoming in this debate and lots of meetings back and forth with various sponsors. I wonder if I could get your assessment or anybody on the panel's assessment of how the role of special interests might play out in this debate over health care reform with respect to the options that you heard described and talked about.

BRADLEY HERRING, Ph.D.: Well I guess I'll just first off say I mean I agree that it's promising that there have been these, I guess, not so secret meetings of these special interests coming to the Hill and meeting with key Congressional staff. I mean one of the things my research largely focuses on, on health insurance, private health insurance coverage.

So I think one of the things that has seemed appealing to me is that AHIP, American's Health Insurance Plans, have seemed willing to accept a notion of guaranteed issue and I guess there's a little bit of uncertainty whether they're willing to accept community rating but this notion of guaranteed issue so long as there's an individual mandate coupled with it.

So perhaps that's quite promising but I think in terms of provider groups, there's some potential concerns there. I mean on one hand, there's the appeal of getting everybody covered. So services that you previously provided for free you might now be reimbursed for but on the other hand, there's the concern that their reimbursements will go down. So it's really kind of weighing those two tradeoffs.

ED HOWARD, J.D.: Jack?

JACK EBELER: It's not just a question of sort of specialist interests in town. I think the issue is sort of the degree to which the debate gets framed in one way or in another and how that gets communicated to the public and how the public

then sort of turns to their elected representatives and either says slow down or do something. It just strikes me that it's the reading on Clinton health reform simply always was a special interest ran Harry and Louise ad and it died and it's a much more complicated equation.

I think particularly in today's world where we have much more ability to communicate and hear from folks out in the communities, we could see a very different debate than we're used to here.

DIANE ROWLAND, Sc.D.: Well I think it's always hard too though, everybody's for covering everybody when we ask them in the polls. That gets 90-percent, everyone should be covered but then when you start to look at how do you pay for it and what other details go with it, it's very easy for the public to get scared away from the concept of coverage if they think their own coverage is vulnerable.

So I think one of the things you see that's a lesson out of the Clinton plan in a lot of those who talk about improving on the existing system, that sort of middle range Obama as a candidate Baucus approach, is guaranteeing people that if you like the coverage you have, you may not have to lose it.

So I think a lot of the ways special interests are weighing in is to try and at least scare people if they think that this is not an approach they would want. I think it makes

an even bigger challenge on those who are moving to enact legislation to keep their message clear and to help the public understand that if they have something they like, they're not really at risk for losing that.

ED HOWARD, J.D.: Brad, you talked about one of the complications in this debate being the redistribution of income that might or might not occur and looking at one of Diane's charts that shows the uninsured rates by state, which implies at least a redistribution of another sort that always finds an interesting manifestation in the House compared to the Senate about the impact of various formulas, the impact of various policies from one state to another.

I wonder how big an obstacle the panel might think that will turn out to be. Speculation? I note for the record that there was a lot of talk during the stimulus legislation about the incremental increase in the federal matching percentage, which wasn't across the board but rewarded states with higher rates of uninsurance. That had a lot easier time going through the House than it did in the Senate I gather for reasons related to the distribution of the people who are uninsured.

DIANE ROWLAND, Sc.D.: Well one of the challenges has always been that if you're trying to do something, there are states that had moved ahead and have covered a state like Massachusetts, a majority of their population do you

disadvantage them in whatever you're doing by helping mostly those states that have very high uninsured rates.

We saw this clearly in the original State Children's Health Insurance Plans that Minnesota and other states had already covered many of these children and did you give them an extra boost. I think that's always a key issue as you deal with members and with Senators who come from and represent their state's interest to make sure that it's easier when you're expanding the pie for everyone than when you're trying to redistribute dollars within an existing pie.

JACK EBELER: The other policy variable just for everybody to remember you have in addition is the state opt-out. One of the issues that will inevitably come up in this debate regardless of the flavor it heads is provisions that say well gee my state does something different whether it's Massachusetts or something else. Can I opt out of that federal plan so long as I meet the objectives of the plan through my arrangements? I think you could expect to see that come.

ED HOWARD, J.D.: Yes? Go right ahead and identify yourself please.

DONNA SMITH: I'm Donna Smith with Reuter's News Agency. I was just wondering how you see current economic conditions shaping the debate and whether it is having an impact on who is now becoming among the uninsured.

DIANE ROWLAND, Sc.D.: A few months, we asked whether because of the economic downturn is it less important to try to do health reform or is it more important. Consistently, we're getting 62-percent of the respondents saying it's more important than ever to do health reform now given the current economic situation.

We just released our last poll earlier last week so that I think there is still a very big concern on the part of the public about health reform and about health care costs and about whether they're going to be able to afford their coverage or lose their coverage, which puts a reform prominent on their agenda.

The problem is that as we look at what's going on, the economy and the numbers that I showed you of the uninsured are from 2007. We know that with the economy and the loss of jobs, there are more people uninsured and probably therefore, a steeper climb to try and get everyone covered under health reform but I think clearly there is still very strong public sentiment that now health reform is a part of their economic security and they'd like to see it go forward.

BRADLEY HERRING, Ph.D.: I agree with all that and add on top of that that, as people lose their health insurance coverage when they lose their job, perhaps that's getting people thinking more and more about whether it makes sense to have something in place that's perhaps outside of the

employment-based system or at least something strong running parallel to it. So there's continuity of care when people lose their job or move between jobs.

ED HOWARD, J.D.: Yes?

COFFEY BROWN: It's been lamented that is countercyclic, by the way, the less money there is for health care reform, the more we need it. You teased it, I'm Coffey Brown [misspelled?], Talk Radio News, and Dr. Herring, you teased this question a little bit but I'm going to reach out and grab the third rail. In every possible form of health care reform including the status quo, there's going to be rationing. There is rationing now. There always will be. Can you say something about the way it would differ among the different choices?

BRADLEY HERRING, Ph.D.: Sure. Sure. So now under the status quo, I think you're right, the rationing is really income-related. Can an uninsured person afford to obtain the care they need. I mean of course there's also these forms of rationing in private insurance markets and public health insurance coverage.

I think the appeal of private health insurance markets in terms of rationing, as you say, is that if there are options available, different health care options available and those options are kind of clearly defining what benefit packages are available and we can all perhaps agree upon some minimum threshold of what's out there then in theory, people can make

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these rational decisions to kind of decide well which is the best rationing for me. So they work great in theory.

They have difficulties in practice but I think that's kind of the model in a private health insurance approach then whereas in a public health insurance approach, unless we're going to be spending tons, I mean there's got to be some decisions about what services get covered and there's then a push, which is positive in my mind towards this notion of comparative effectiveness in terms of thinking about what treatments are more beneficial than others and hopefully maybe it'll get pushed into even thinking about what treatments are beneficial for certain populations versus others but then that kind of gets you down this path of rationing across different individuals based on their characteristics, which is going to leave us uneasy but other thoughts?

JACK EBELER: We should also just keep in mind that we spend a good deal on health care in this country and there's pretty good evidence from looking at geographic variations and the like, the Dartmouth data a lot of you are familiar with, that we can slow the growth rate and spend a lot less without getting into the type of rationing that would be exceptionally negative. So your question is right but the citizens of Minnesota have not exactly revolted against a country and yet they somehow are getting terrific health care for a lot less than the citizens in Florida.

So there's a lot of policy tools that you've got available to you not just in a coverage debate but in other parts of this debate to slow growth rates in ways like comparative effectiveness and other things that will hopefully slow that growth in a sensible way.

ED HOWARD, J.D.: Yes? Go right ahead.

HAZIR HUSSEIN: Hi. My name is Hazir Hussein [misspelled?]. I'm with the American Muslim Health Professional Organization. My question is related to faith-based organizations. They have been part of the bedrock of health care both in public health as well as tertiary centers throughout the history of the U.S. I wanted to know what role faith-based organizations have played in informing and influencing health policy as it relates to coverage for the uninsured.

BRADLEY HERRING, Ph.D.: I can speak, I guess, a little bit to this on personal experience. Over the last year or so, I've been involved with a group called the Maryland Citizens Health Initiative, which is trying to enact reforms just at the state level. One of the elements that's been key in terms of that movement moving forward, there's a prominent advocate there, Vinnie DeMarco, and his appeal, his MO is really trying to build broad coalition across advocacy groups, large and small businesses, and the faith-based community.

So there's a number of ministers and church groups within Baltimore that seemed to really be pushing and supportive of health insurance expansions in the state. How it'll all play out? I don't know. It's not looking so good with this legislative session in Maryland but there's a hope that maybe in the future something will happen.

ED HOWARD, J.D.: Jack?

JACK EBELER: It's a good question. I think if you sort of look at the broad spectrum, faith-based organizations probably split a little bit in their views in much the same way that the body politic does but I think there's a lot of effort for mainline faith-based organizations to participate a little more in this debate.

Again if you talk to folks who were involved in the enactment of Massachusetts plan, there was a fairly broad-based coalition up there that came forward. To speak to what they saw as the ethical imperatives, and again you can come out in a variety of different places there but I suspect we're going to see that community be a little more involved over the next several years.

ED HOWARD, J.D.: Just as a very mundane supplement to what Brad and Jack have said, you ought to remember that the largest nonprofit hospital chains in the country are faith-based organizations. I think Ascension Health is the number one and the other members of Catholic Health Association are right

in the top 10. So there may be a variety of interests represented by faith-based communities. Yes, Joe?

JOE ONAKOWSTEF: Joe Onakowstef [misspelled?], just a question, why do employers and perhaps particularly small employers want to be in this business? It hasn't helped the auto industry. Small businesses are obviously struggling. In the old days, it was an enticement to your workers but now it seems to just lead to endless fights between labor and management each year on raising the deductible. Why do they want to stay in the game?

JACK EBELER: I mean one question is we're not sure that all of them do. I think it splits for smaller employers and larger employers. I defer to Brad but there is still a labor market and employers still want to attract workers and this is a presumed part of a benefit package. Some of the larger employers still believe that they can have a salutary effect on costs and quality.

They've been leaders in pushing the health plan community towards that but as I hear and read about what's in particularly smaller employers are saying, a lot of them are wondering why they're in this and particularly if you're an employer of a low-wage workforce, the incremental cost of health benefits is very significant. So I think it's a good question.

The other thing, the color I would add there is, which game, there's a question of health benefits for your current workers and their families and then there's a question of guaranteed health benefits for your retirees and if you sort of work through the arithmetic of what happens with retirees, that's a very risky business to get into as we see with the autos because you can make some promises to people in 1970 when you're one sector of the economy and you're paying for those promises in the year 2010 when your industry is another share of the economy.

So it's a very difficult economic deal to stick with. Only the government can back a deal like that. So I think you have to think of that slightly differently than health benefits for the current workers.

DIANE ROWLAND, Sc.D.: Well I also think if you look at sort of where businesses have been on this issue, they are more toward getting out of the game now than they were previously and that part of it is in our annual surveys of employer benefits, we find they're frustrated with their inability to really contain costs on their own. They're less concerned in bad economic times about retaining their workforce.

So we saw health benefits as something they wanted to offer when it was very competitive, get their workers but they know that that has been an obligation they may not be able to continue. I think, as Jack pointed out, the other issue for

low-wage firms is just employee turnover. Our system is extremely complex. So to sign someone up for health benefits and then three months later have that employee leave is a lot of difficulties.

So I think that streamlining our system and moving it out of having individual small firms have to negotiate has become more of a priority.

ED HOWARD, J.D.: Brad?

BRADLEY HERRING, Ph.D.: And I would just say totally agree with what both Jack and Diane said but also perhaps to try and address your question. I'll admit that I can't really. I don't really have a good idea of what employers want to do in terms of future health care reform but I can say pretty strongly that I think employers do offer health insurance benefits now and historically is to really take advantage of two things.

One is the sizable tax subsidy. So I, as a worker, can get heavily subsidized if I get my health insurance through my employer but I don't get heavily subsidized if I go and purchase it on my own. So I think employers are just kind of responding to employees' wishes of being able to get subsidized coverage. It's particularly heavily subsidized for those higher income workers.

Then the second thing is that both employers, particularly large employers, have a comparative advantage in

getting cheaper health insurance coverage than I can obtain in the individual market. So there's some appeal in having employers, particularly large ones, offer coverage to reduce administrative costs.

So long as there's not really an option outside of the employment-based system where I can get subsidized coverage or reduced costs insurance coverage with lower administrative costs. I think we're stuck with employers offering coverage to meet our desires.

ED HOWARD, J.D.: And I'd add just from some conversations with some of the larger employer representatives, they don't know who else can do it. They don't trust the government to do it. So here you are with no good candidate for replacement. Yes sir?

PARKER GRIFFITH: Thank you. Parker Griffith, a representative from Alabama fifth district. Just as an aside to your question on faith-based, Louisiana, French Catholic, we have a charity hospital in every major city, so it's a cultural thing in how we approach health care and whether we believe it's a privilege or a right of the citizens.

The thing that is interesting, to me, if we provide access to every American, who are they going to access? Less than two-percent of all medical school classes are going into primary care and a third to a fourth of all of our primary care physicians are 55 years of age and over. So we have got a

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system where we're trying to provide access but if everyone had a Blue Cross or a card in their pocket today, they could not see a doctor.

So the question is who are they going to see and are we willing to step outside the box and say that nurse practitioners, clinical pharmacists, nutritionists, in conjunction with physicians, must deliver primary care. The other thing that we haven't decided on is if we provide access, we still haven't solved the problem of distribution of health care into our underserved areas.

So these are things that we, for once I thank goodness, are beginning to discuss and even if you have insurance, it is no guarantee that you're accessing quality care because there's no follow up in our system today to know whether or not we're doing things right or wrong.

So it sounds like, to me, all the young people in this audience are going to make an assumption that they're going to have health care because they're going to see to it that we fix that problem but I do believe that the traditional deliverers of health care are going to have to take their restrictions that have grown up traditionally in our each state medical society and allow our certified nurse practitioners, our nutritionists, our physical therapists, those who are quite able to deliver care when we know that half of all deaths, in the next hundred years, will be lifestyle deaths.

They won't be deaths from cancer or infectious disease. They're going to be deaths from hypertension, obesity, diabetes, things that nurse practitioners and other health care deliverers are much better at delivering than a physician who is, and by the way I am one, a physician who is only trying to take care of an after-the-fact incident.

So I welcome this discussion. Kaiser has been a huge resource for me, by the way, thank you very much. We appreciate that we've got this aired out and for once, big business and health care reformers are on the same page. We're all making the same diagnosis over and over and over again. We need to decide on a treatment even if it's not perfect the first time. thank you.

DIANE ROWLAND, Sc.D.: Well certainly I think, as you point out, the experience in Massachusetts has borne out exactly what you're saying that everyone got a health insurance card but in Western Massachusetts, especially the lack of primary care there is really a challenge. I think that's why, as we talk about health care reform, we should be talking about more than just extending an insurance card to more people but to really how do we make the system better.

I think your suggestions certainly ought to be part of that debate especially around the use of extenders and the challenges of underserved areas.

ED HOWARD, J.D.: Other comments?

BRADLEY HERRING, Ph.D.: Yes. So two thoughts, one in terms of access to physicians overall, I think the potential for loan forgiveness programs to subsidize medical students to eventually practice in either rural areas or inner city areas might be a good thing to consider particularly and then thinking about the reimbursement rates for Medicaid often being less than those from Medicare and I think inner cities and rural areas have disproportionate numbers of Medicaid patients.

So I think there's thoughts or potential for subsidizing physicians to go practice in those areas to, perhaps, get more physicians there but in terms of this discrepancy between primary care and specialists, I agree, perhaps, that's something that Medicare B can address in terms of its' reimbursement of physicians.

I mean there is the tweak back in the 90s with RBRBS, which brought specialists down a bit and primary care physicians up a bit and a tweak with that further, I think you'd find physicians more apt to move into primary care on the margin. Then finally, I'd agree with the thought of thinking about other practitioners besides to get in the game more.

ED HOWARD, J.D.: Alright, Jack we're going to give you a chance to get the next one then, at least first crack at it. This is one of the questions emailed from one of the district or state offices and they're asking for a little more

discussion about the implications of the individual mandate briefly.

JACK EBELER: Anybody following the Democratic primaries saw some moderate discussions of this subject. Individual mandate has been an interesting historical piece of this debate. It arose in the 80s and early 90s in some ways in opposition to the idea of an employer-directed approach.

The question was why have employers do this? Why don't we do what we do in auto insurance and instead put the nexus of responsibility on the individual to have coverage and work from there. It has evolved since then to a tool that you've got to look at in the context of the overall plan. So if you have a, what again Jen Tolbert's paper and what Brad laid out, is sort of somewhere in the Obama-Baucus model.

You've got employer requirements. You've got enhanced public programs and at least in Baucus and not in the President's plan but another variance of it, you also have a requirement that you have an individual mandate. Massachusetts used the individual mandate as the nexus of reform. The questions that come up there relate to sort of the model you're operating in, the timing, what exactly is it you're requiring people to have. When are you going to put it in place?

I mean in sort of the debate between the President Obama and Senator Baucus, Senator, originally candidate Clinton. President Obama has said well we've got to make sure

that the products are available and affordable before we put the mandate into place. Others say you need the mandate in place in order to make them available and affordable.

The insurance industry, for example in some ways, is informally signaling we're willing to move to guaranteed issues and the type of regulatory requirements in insurance that might make a model like that work but only if people are forced to buy. If they're not, they worry about what's called free riders, are sort of folks waiting until they get very sick in order to buy their coverage.

So a lot of the debate on individual mandate is sort of do you see it as the primary vehicle for the plan Senator Wyden and Bennett used in mandate in their model or is it a supplementary vehicle that helps you do some other things within the plan. Then again, the real question is what are you mandating, how do you enforce it? What's the timing and how do you relate it with your insurance reforms and your cost controls?

DIANE ROWLAND, Sc.D.: This one is for Brad. Could you go into more detail on the difference between the Baucus plan and the Wyden-Bennett plan? Do both utilize exchanges?

BRADLEY HERRING, Ph.D.: Sure. So in short, yes, they both rely on this notion of an exchange. My read of the Baucus approach, and this is consistent with the Obama approach is to have a national exchange, kind of analogous to what's going on

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with the commonwealth connector in Massachusetts, the thought being here that the individual ones, small group markets now don't function so well. So getting everybody with access to a national exchange and perhaps result in a more competitive health insurance market.

I think the two, at least two, I guess three key differences between this Baucus-Obama approach and the Wyden-Bennett approach, one is where the exchanges occur. So the Obama-Baucus approach has a national exchange at the federal level whereas the Wyden approach is essentially to have 50s of these exchanges. I forget what they're called, I think Healthy Health Plans. I can't remember what they're called but basically 50 of these things in each of the states.

JACK EBELER: The thing is the technical health care term.

BRADLEY HERRING, Ph.D.: So one is, yes, the location, state versus federal. The other big difference is whether there's a public plan in that option as alluded to earlier. The Obama plan, in his candidacy, ran on that. That seems like something that's very, very important to people on the left getting this public plan offered in the exchange whereas on the right, it sure seems like this is a nonstarter for many Republicans having a public plan in there. So I think that's the second way in which the plans approach.

A third one I think is relatively minor and I think it signifies a switch that the Wyden-Bennett Plan had. Initially their approach was to say we're doing away with employment-based health insurance. Everyone's going to cash out and now we're going to move to this state-based exchange whereas in the more recent iteration where they unveiled it, they made a key switch, which again I think is really playing to the politics of this issue in terms of people being concerned about losing access to their current source of coverage. So now in the more recent iteration of the Wyden-Bennett Bill, retaining your employment-based health insurance is an option like the Obama-Baucus approach.

DIANE ROWLAND, Sc.D.: This question relates to the Nixon-Match strategy but how do we change existing coverage and it's a question about what do you think will happen to the people who currently at HSAs, while we are told that you can keep your current health plan, what if universal coverage comes into play and deductibles are lowered to a reasonable amount? Will they no longer be considered high deductible health plans and if so, they won't be eligible to have an HAS?

ED HOWARD, J.D.: And whoever tries that might explain what an HAS is.

JACK EBELER: Well let me, HAS is basically it's two features as we really talk about it. One is a health plan with a relatively high deductible. Second is some type of a tax-

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preferred account that you and/or your employer contribute to that provides funding to pay some or all of that deductible. It's a very brief description of a very complicated instrument. I apologize for that.

I think that would be a conscious choice. I mean it's fair to say it's sort of in a single payer model, if you go to one of the purists, if the single payer model, it's kind of maybe hard to see how it fits but if you go into any of the mixed models, one of the questions that you all are going to confront that Congress is going to confront is what's the definition of the health benefit plan that qualifies either to be offered in an exchange or qualifies for the tax subsidy in a Wyden Bill or meets the standards for an employer contribution.

That would be a legitimate choice. It's a little hard to see how it fits in a very, very comprehensive and rich benefit approach but one doesn't know whether it'll go down that path. So my sense is that it would tend to be an open question in the nuances of benefit design in that type of plan. Brad?

BRADLEY HERRING, Ph.D.: I agree with all that, just two points. One is which I'm not positive about this but I think the technicalities are is that you have to be enrolled in a high deductible plan in order to make a deposit into an HAS but you can use your HAS even if you switched to a different type of insurance down the road. So it's not necessarily the case

that under health care reform, these people who have health savings accounts are suddenly just going to lose all this money. It's going to disappear. I mean it's their account. They can keep it but so that's just the first point.

The second point is that for instance, the Wyden-Bennett Bill and also what I imagine would occur under the Obama-Baucus approach is that the minimum benefit package is not going to be an HAS-qualified plan. So the Blue Cross/Blue Shield standard plan that's identified as the minimum in the Wyden-Bennett Bill is not HAS-qualified.

So yes, I imagine you're going to have a number of people and I think it's a pretty small minority of people but those who are vocally advocating for high deductible health savings accounts are probably going to be a little upset with the resulting minimum benefit package under an Obama or Wyden type approach.

ED HOWARD, J.D.: Just go ahead and read the question. I just wanted to remind you that there are blue evaluation forms as we go through the Q&A session here that we would love to have you fill out as we finish up here. Go ahead Diane.

DIANE ROWLAND, Sc.D.: I guess one answer to everyone is that whatever happens to any of these issues depends on how it's drafted and that that is one of the things that goes into the legislative process. So they can decide rather to have a

special set aside for high deductible HAS plans and build them in as a credible source of coverage or not.

The question we have also involves variation. The panel's thoughts on allowing states to continue to serve as a laboratory for different approaches to health reform, are we really ready for a one-size-fits-all national approach?

BRADLEY HERRING, Ph.D.: Two quick thoughts on that. I mean one I guess is that the country was based on this notion of federalism and perhaps states should have discretion in terms of what they think the right approaches are. So I guess that's one thought.

I mean personally I don't really have a big opinion about federalism per say but then the second thing I'll point out is that it does strike me that we don't really know the best model for moving forward. So there is like a lot of appeal in terms of letting states experiment and seeing which ones have the successes and which ones don't pan out so well.

JACK EBELER: I don't want to speak against laboratories are democracy but I think we've had a fairly long experiment with sort of in the current structure having states sort of pursue what they can pursue. Unfortunately, Diane alluded to a map on state-by-state uninsurance rates. The current situation, in an IOM study that came out last week, you've got it in your packet, it's this green piece, you see sort of stunning increases in the uninsurance rates in many states.

So I guess my personal preference here, I don't know if we're supposed to be expressing these on the panel but I'm going to, is not necessarily to think of this as let's continue. Collect the states' experiment and hope there are more Massachusetts coming down the road but the set-up, at a minimum, a federal framework, a federal direction driving reform and federal financing, decisions about how one is going to allocate resources, whatever those are, if in that model a state can say gee I tried that a little bit differently.

It seems to me an opt-out of with an alternative of a strong federal framework is more promising than a wait and let states go. I know Brad is not suggesting that we wait and let states go. I would think of it more within a strong federal framework.

ED HOWARD, J.D.: Diane?

DIANE ROWLAND, Sc.D.: We had a question earlier about the economic downturn and the recession and what its' implications are and I think it also showed us so clearly that even states with the best intentions of trying to test new models, when the economy goes south, don't have the ability to sustain those models and to continue and that that is really why we're talking here more about a national solution, which is that in a downturn in the economy when states have to balance their budgets, health care is not something that can be sustained in many places and obviously that was part of the

economic stimulus. We have a questioner at the mic. So we'll go to him first.

MALE SPEAKER #1: Sure, on budget and policy priorities. Dr. Herring and the other panelists, so I was wondering if you could discuss the ability of all the various options to control costs in the health system, if health costs grow at their present rate, no insurance system no matter how well designed will be able to cover everyone because you won't be able to afford it. Thank you.

BRADLEY HERRING, Ph.D.: Let's see. So off the top of my head, I would think that the single payer approach yields the most promise towards reducing health care costs because it can essentially happen by fiat, right? The government can say this is what we're going to spend and if Congress is so willing to actually follow through on that, I mean kind of decide what we would want to spend.

I think the Republican vision of tax reform and getting people in individual plans has a lot of promise for slowing the growth in spending in the sense that people would face strong incentives to purchase cheaper plans with higher deductibles, less access to costly technologies, which will certainly reduce spending but taking a step away, you've got to ask is that really appropriate or is that where we want to go.

I think the Wyden Bill then in turn, I'd probably rank third in terms of its' ability to reduce the growth in

spending. I think for some of these reasons alluded to in the more Republican approach in which there's a system by which individuals are choosing across plans and making decisions to purchase basic versus more comprehensive plans.

Then finally, I think with the Obama plan and Baucus vision, I think the result is that yes, we might get everybody covered but it's still such a kind of wildly fragmented system that it might be really hard to control costs moving forward with these different things to kind of plug. Quick reaction I guess.

JACK EBELER: I think the cost question is obviously critical. I think just as people think about it, one you have to define what costs you're talking about. are you talking about government's costs, which is what we focus on intently in this town and it's CBO's obligation. Are we talking about the individual's share of costs for either the premium or the coinsurance? Are we talking about total health care costs or even to get crazy, total societal costs?

I mean one of the frustrating parts of the health care debate is always that we're bounded by the definitions of the National Health Accounts and stuff that happens when a kid doesn't go to school and a parent stays home from work is sort of both the cost and benefit of that equation is zero.

So there's really a definitional question. I think if you look at total, my sense is that the consensus view for, at

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least that I've seen, is that the folks really think it's wrapped up in a very, very intense focus on the delivery system that you really need to try to produce health care with a much more value, much more efficiency and higher quality, you then get the question is Brad getting to.

What's the lever you have to get to that? Is it through insurance purchasing getting folks to drive that equation through that or is it for other things, the tool that you also have obviously in town most readily is Medicare and using Medicare. I'm sensitive to that because I'm on MedPac and we spend a good deal of our time trying to think about doing things that not only make Medicare more sustainable but that drive the delivery reform that would appear to help make health care costs slow for everyone and make things like health reform more sustainable.

So my sense is as you watch this debate, you're going to see the Congress turn to its' insurance tools a little bit in these models but to its' paying programs a lot more in looking at trying to change these so-called bend the curve on costs.

DIANE ROWLAND, Sc.D.: One of the concerns that a questioner has raised is that if the single payer approach is actually one that may achieve greater cost savings yet it's been sort of taken off the table in the reform debate in the Congress is not a sustainable option or an implementable

option, shouldn't it at least be part of CBO's comparisons so that you could see what you're trading away or not obtaining by some of the other reform options.

So it's a question about modeling. We know that CBO mostly costs out proposals that are pending and submitted. It doesn't necessarily cost out the alternatives.

BRADLEY HERRING, Ph.D.: I don't know. Has CBO scored 676, HR676?

DIANE ROWLAND, Sc.D.: I don't know.

ED HOWARD, J.D.: Anybody in the audience a CBO person?

DIANE ROWLAND, Sc.D.: So I guess this questioner would like us to push CBO to at least score it.

BRADLEY HERRING, Ph.D.: We're not busy, right
[laughter].

DIANE ROWLAND, Sc.D.: The other question we have is an issue about the term universal and when we talk about universal and aiming toward universal coverage, are we including undocumented residents in or not and, if so, can we ever really get to a system that's leaving so many people uninsured who are undocumented. I would add another question to that. What does that imply about the need, potentially, to retain some form of a safety net in a health insurance proposal?

JACK EBELER: I noted in the President's eight principles that he released that he does talk about aiming for universality but I believe he uses the word Americans in that.

Those of you on the Hill, you know this is a red-hot issue. It's hard to think about exactly how you would include even if the political process wanted to, the undocumented person in a private health insurance arrangement simply because those individuals don't make a habit of making themselves available to a lot of bureaucratic processes and name taking nor should they and the political process hasn't been very amenable to that either.

My sense is that the policy lever Diane talks about is the one to think about here is that sort of no matter what we do in any type of a mixed market model that we're talking about here, there are going to be people who fall by the wayside for one reason or another, the undocumented are high on that list. You will still need some type of a robust safety net program to take care of that population.

ED HOWARD, J.D.: It's probably worth noting that most of the European systems that a lot of the folks who are universal coverage advocates point to themselves miss a percentage point or two in the course of trying to get everybody in for precisely the kinds of things we've been talking about.

I think we have tapped our panel and its' expertise. I want to thank particularly those folks who submitted questions from Congressional district and state offices. We got a large variety of those questions some of which were answered by some

of the questions that you wrote on the green cards here but some of which raised new things that are important obviously to that group of folks.

Let me just take this opportunity to thank you again for sticking with it on a tough day, thank the Kaiser Commission on Medicaid and the Uninsured for its' support and cosponsorship, and active and positive participation in a program and ask you to join me in thanking our panel for responding to a whole range of difficult questions [applause]. Now watch out for the wind out there. Thank you for filling out those evaluation forms.

[END RECORDING]