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Health Coverage Revisited: Exploring Options for Expansion
Alliance for Health Reform and Commonwealth Fund
March 19, 2007

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ED HOWARD: Hi. I'm Ed Howard with the Alliance for Health Reform and on behalf of our Chairman, Jay Rockefeller, our Co-Chairman, Susie Collins, and the rest of the Board; I want to welcome you to a briefing on how best to deal with the growing number of Americans without health insurance. Our partner today is the Commonwealth Fund. A century old philanthropy based in New York City, which has done as much work as anybody on this topic and find quality work indeed. You'll hear from Karen Davis, the President of the Fund in just a moment.

As Paul Simon, the singer not the Senator, might have said, "There must be fifty ways to cover the uninsured." As a matter of fact, I can think of a few governors who would agree with that precise formulation. And you have in your background materials information about many of those approaches and included, you should have a copy of the brand new report from Commonwealth, laying if not fifty, at least a sizeable number of those approaches; some national, some state based, some market oriented, some were heavily governmental, some proposed by republicans, some proposed by Democrats. It's a very good jumping off point for our discussion today and I hope we can do that.

A couple of logistical items for those of you who haven't been part of these briefings before. In your

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packets, as I mentioned, you'll find a lot of information including a much more detailed biographical information that I'll have time to tell you about our speakers. By tomorrow you'll be able to view a web cast of this briefing on Kaisernetwork.org and I believe Commonwealth is putting together a special package in a couple of weeks that will allow you both to hear the presentations and see the slides at the same time. Technology marches forward. There will be a transcript available next week on both our website and the Kaisernetwork.org website. Pod cast, if that's your method of obtaining information these days.

Let me just say once again, blue and green. We'd love to have you fill out the blue evaluation form that you'll find in your packets and there is a green question card for the Q&A session, which is always the heart of these discussions. So we have an extremely extinguished lineup of speakers today. So if you would turn your cell phones to vibrate or whatever setting that is that won't disturb the discussion, we'll get started.

I mentioned that the Commonwealth Fund is the co-sponsor of this event and representing the Fund today and serving as our lead off speaker is the President of the Fund, Karen Davis. She's headed Commonwealth, it seems like just yesterday but, she's been there for twelve years, she's an economist by profession, she's taught; she's been a senior

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official in what is now the Health and Human Services Department. In fact, she was the first woman to head a U.S. public health agency and she's co-author of the Legislative Report that's being released today by Commonwealth. So Karen thanks for being here and we'll look forward to your comments.

KAREN DAVIS: Thank you, Ed and thanks to the Alliance for Health Reform for this opportunity to share information with you on some of the very exciting legislative proposals introduced in the Congress over the period of 2005 and so far in 2007. We're very pleased to be a sponsor of these events and appreciate all of you joining us for today's session. When we first started talking about featuring a session on universal coverage there was a question about whether the time was right and whether there was an interest in this topic.

The fact that this session was sold out an hour after it was announced by the Alliance for Health Reform I think answered that question. But there has been an up tick, a major up tick, in interest in this issue precipitated in part by the growth in the numbers of uninsured from 40 million in the year 2000 to the 47 million today and the growing financial squeeze on the middle class at a time when people are sickest and perhaps most deserving of our compassion.

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They have the worry about whether they can obtain needed care and pay the bills that they are incurring.

The New York Times issued a poll recently confirming that health insurance coverage is high on the public's agenda and furthermore, that the public is willing to pay additional dollars to ensure that everyone has affordable health insurance coverage. President Bush, as we'll learn just a bit later, made a new strategy for health insurance coverage, a key feature of his State of the Union Address and Budget. Presidential candidates are beginning to advance proposals and as Ed alluded to, governors are stepping up to the plate with their own strategies for coverage.

We're particularly pleased to release the report an analysis of leading Congressional health care bills. This is the first of a two part series, this one focusing on insurance coverage in particular thanks to Sara Collins and Jennifer Kriss [misspelled?], who did the bulk of the work on these reports and also to the Lewen Group [misspelled?], we're joined today by John Shields and Randy Ho, who produced the cost and coverage estimates for the report. And to Health Policy R&D that produced the legislative side by side analysis in the report.

There are three different types of proposals in the report. Those that are fundamental reforms of insurance coverage that I'll focus most of my remarks on, but of the

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more than a dozen bills analyzed in this report some are expansions of public insurance coverage, building on SCHIP or on the Medicare program to cover more older adults, others with strength in employer based coverage. So I commend those provisions to you as well. I think you will find of interest some of the findings on employer mandate. For example, the Representative Pallone Proposal that covers 12 million people without costing the federal government anything by having employers provide coverage and it saves the federal budget by 43 billion. But as you'll note in the fine print, increases cost to employers. Other proposals around Association Health Plans and purchasing tools.

But let me turn to four major proposals in the report as well as briefly allude to a proposal that has been advanced by Senator Edwards. Most of these proposals have the following building blocks that aim to cover all Americans. They require individual's to have health insurance coverage. They require employer's to share in the financial responsibility for coverage, if not actually providing coverage. They expand public programs and expand subsidies for lower income families. They have different mechanisms for risk pooling. Some would use private, regional risk pools, others would pool risk by having people obtain coverage through Medicare.

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Some, like Senator Edwards, would use a combination of regional private insurance pools, but also require a Medicare-like option to be offered to everyone under that pool. Most have comprehensive benefit package. All of them have some type of measures to try to improve quality and efficiency. The number of uninsured varies across the proposals from 9 million estimated uninsured to receive coverage under President Bush's proposal, at least in the initial year, to almost complete coverage for all.

There are kind of two ways of thinking about the costs of these proposals and I particularly want you to focus on what it does to total health system spending. A lot of time we focus on federal budget spending and the first question is whether the proposal saves money in the total health system. And some of these proposals, particularly Congressman Stark's Americare Medicare for All proposal, as does the Widen bill and the President Bush's proposal, but do so in different ways. And then we also have estimates that the federal budget impact of these proposals.

Just to give you a sense of how these proposals affect the distribution of insurance coverage; currently 52-percent of all Americans are covered under employer plans. Under Senator Wyden's Healthy Americans Act, nearly all employer coverage, as well as Medicaid, would be replaced by new, private coverage administered through regional pools

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called "Health Help agencies." By contrast, under Congressman Stark's Americare Medicare for All bill, a new form of Medicare called "Americare" would replace most employer coverage, as well as replace most Medicaid coverage, although it retains dual eligible coverage for Medicare and Medicaid beneficiaries.

President Bush's proposal also shrinks the employer market, reducing it from 52-percent to 49-percent. About 12 million people lose employer coverage under the President's plan. And over time there could be more shift out of the employer market and into the individual market and less comprehensive coverage under that proposal. Some of these proposals achieve near universal coverage, while reducing total health system spending. Again, just to focus on the four major alternatives in the approach, the number of uninsured covered would be 9 million under President Bush's proposal and that ranges up to 47.8 million under the Representative Stark's Americare bill.

I should note that the federal state partnership model, that is included here, is not the same as the bill in the House or the bill in the senate. Senator Bingham and Avoinavich [misspelled?] bill, Congresswoman Baldwin represented a price and tyranny bill in the House, in that those bills do not have sufficient details to model cost estimates. So what is included in the report is an example

of how a federal/state partnership might work if fifteen states participated with plans similar to a combination of the California and Massachusetts proposals and if the federal government provided matching funds for low income; children below three times the poverty level and for low income adults, below the poverty level.

As you see looking, these have very different affects across payer sources. Under Congressman Stark's bill, a 155 billion in new federal spending, but you also see that states save money, employers save money. So partly, that could be financed through greater maintenance of effort provisions. Under Senator Wyden's bill, the net cost to the federal government is 24 billion, but it would be 165 billion without provisions that require employers to cash out health benefits and, therefore, be subject to income and payroll taxes on those cash earnings in lieu of health insurance benefits.

On health system costs, most of the savings come from lower administrative costs. For example, in Representative Stark's bill it achieves administrative savings of 74 billion by covering virtually everyone under Medicare. It also requires the government to negotiate pharmaceutical prices for the entire U.S. population, not just Medicare beneficiaries, at a savings, total system savings, of 34 billion dollars. And there are some Medicare provider payment savings of 62 billion. Those savings, more than

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compensate for the induced utilization of extra care received by the uninsured and underinsured, paying for uncompensated care and some additional administrative costs from administering subsidies for low income individuals.

By contrast, President Bush's proposals total system savings come largely from reduced utilization as people have somewhat less comprehensive proposals. To summarize the effects of these four strategies for coverage, they would improve coverage anywhere from 19-percent to a 100-percent of the uninsured. They would, for the most part, achieve total system savings. They differ markedly with regard to their affects on low income. With the Stark proposal having relatively greater benefits for low income than for high income and they contain a variety of provisions to improve efficiency. And all have the potential to ensure long, healthy and productive lives by improving access for care. Thank you.

ED HOWARD: Thank you, Karen. A very good setup. And now we're going to hear from Katherine Baicker, whose also an economist. In fact, she's a member of the President's Council of Economic Advisors, making her the object of respect and adulation among those of us who have only undergraduate economics degrees. She's been on the staff of the Council as well and is on the faculty at UCLA's

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School of Public Affairs. And thanks very much for being with us.

KAREN BAICKER: Thanks so much and thank you for hosting this event. It's a great opportunity to compare a lot of different approaches to solving a common set of problems. I don't think we need to convince anybody in the room that we really need to get health care spending under control and expand access to affordable to the millions of people who don't have insurance and to keep care affordable for the millions of people who do. So that's why I view the goal of any policy reform not just as expanding coverage to the uninsured, which is surely one of the most important goals, but also of bringing health care spending under control so that it remains affordable for the people who have insurance now. And so the problem of the uninsured doesn't return with just as strong a vengeance as soon as health care costs start to rise.

So I'd like to focus on policies that will both expand access to affordable care and bring the cost of care down, or at least stem the rise of health care spending that we've seen growing at two or three times the rate of inflation or wage growth. That's simply not sustainable, no matter what system we have for covering the uninsured. So the goal is first to get higher value for our health care dollars. I don't think you're doubting the idea that we're

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not getting as much out of the health care system now as we could. If you do international comparisons, if you compare our health care spending to that of our trading partners, we spend almost twice as much of our GDP on health care and our outcomes do not seem commensurately better.

If you look within the U.S., the parts of the country where we spend the most on health care are not the parts where people end up with the highest quality health care. They're not the parts of the country where people start off sickest. They're just areas where we spend on more intensive care that doesn't seem tied to better outcomes in the end or even better patient satisfaction. So I think there's evidence both across countries and within the U.S. that we could get more for our money. And reforms that we do to get us more for our money will reduce in equities in the current financing of the health care system.

Make the system more fair and then we'll also make the system more affordable for the millions of people who don't have insurance now and bring down the strain that health care spending is putting on both public and private budgets. On private budgets, through the purchase of health insurance or through not being able to afford health insurance and then paying for care out-of-pocket on public budgets through Medicare and Medicaid that are already straining federal budgets. And on the subsidization of

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private health insurance that we do now through the federal tax code.

So let's think just for a minute about why our health care spending is rising so much and that, I hope, holds some of the keys to the solution to bringing that spending down. It's not just that we're spending a lot of money on doctor's office visits or hospital visits; we're spending a lot of money on intensive technology while we're there. And we're spending on inefficient forms of insurance. First dollar health care coverage that doesn't necessarily get people high value care that they would choose if they weren't being pushed in one direction by the tax code.

So I mentioned before that we subsidize private health insurance consumption through the tax code. That sounds like a second order, not that important, kind of a thing to somebody who hasn't spent way too much time thinking about the tax code, but in fact, it's very important. We spend more money on the tax code subsidizing private health insurance consumption than the federal government spends on Medicaid. More money subsidizing private health insurance, then we spend on Medicaid. This is an enormous tax expenditure. It's growing more rapidly than any other tax expenditure in the budget. It's the biggest expenditure in the budget and that expenditure has been rising dramatically at the same time that we've seen increasing ranks of the

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uninsured, that we've seen decreasing employer offering and that we've seen rapidly rising health care spending. So that subsidizing that we're doing through the tax code is not buying us what it should be and we need to fix it as an important part of a solution to bringing health care costs under control and to spreading the burden of paying for health care more equitably across the population.

So there are two biases that are built into the tax code right now. Our current system subsidizes the purchase of employer provided health insurance, but it doesn't subsidize the purchase of health insurance bought outside of employment. So if you go buy insurance on your own because your employer doesn't offer health insurance, you get no help through the tax code right.

It also subsidizes the most expensive policies purchased by the people with the highest income the most. So if you're a low income person with a basic policy, your tax bill only goes down by a little. If you're a high income person with a really expensive policy, your tax bill goes down by a lot. So that seems wildly unfair on a couple of different dimensions. If I were to standing here now and proposing such a system, you would rightly boo and hiss and throw your lunch at me. So I'm glad most of you have finished eating. But that's a ridiculous system to have now, we need to change that. It's not only unfair, but it's

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inefficient as well. It subsidizes the most expensive insurance policies on the backs of people who don't get insurance from their employer and who are purchasing basic policies and that drives people into inefficient insurance coverage.

So fixing this system is an integral part of any solution that's going to get the health care system rationalized. So the President has a two-part proposal that builds on existing proposals that I don't have time to go into now, but one that I've talked about so far is reforming the tax treatment of health insurance, the standard deduction for health insurance. And in fact, that's the one that was focused on in Karen Davis' slides and it's focused on in the report. It's only one part. There's a second part of the President's proposal, the Affordable Choices initiative, which has as its goal to pick up the people who might fall through the cracks of the standard deduction. To partner with states to ensure very difficult to insure populations, such as the chronically ill who are uninsured now, or low income people with very limited tax liability.

Those two pieces must work together and the costs that you saw for the President's proposal and the number of uninsured picked up, I think were for primarily to the first part. But I'd like you to consider both pieces together and that's the way they were designed. So how would the standard

deduction work in 23 seconds or fewer? Right now the tax treatment of health insurance is favoring only employer provided health insurance. If you get insurance from your employer it's tax free. If you buy it on your own or if you buy health care out of pocket, you're paying with after tax dollars and that's a big difference. For the average person that's 30 or 40-percent difference in the price when you think about payroll taxes and income taxes.

Under the President's proposal if you have health insurance from any source, no matter how much it costs, you get the standard deduction of $15,000 for families, $7,500 for individuals. It applies to income and payroll taxes and that's important because low income people may have no income tax liability, but anyone with any positive working income has payroll tax liability. So the President's proposal would direct extra resources towards people who are below the payroll tax cap. It would apply to people on the regular tax system and the alternative minimum tax. But nothing would change on the employer side. So there would be no reason for employer's to stop offering health insurance.

Their tax bills would not be going up, but anyone with an employer policy that's under the standard deduction would get a tax break. Anyone purchasing insurance on his or her own would get an enormous tax break. The uninsured would have an enormous incentive to get insurance because the cost

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of insurance for them would go way, way down. Because the tax preference for the current system leaves them out, they would see the biggest advantage.

So what does that mea in the aggregate? And then hopefully during Q&A I can go through some more of the details because I know that was very quick. First of all, this is designed to revenue neutral over ten years. The standard deduction is above the average premium now; it would rise with CPI, average inflation. So it would be revenue neutral of the ten year window. Millions more people would be insured because they'd be getting access to help through the tax code that they don't have access to now. It would slow the growth of overall spending because we would no longer be subsidizing the heaviest, least efficient insurance policies the most. We would be spreading the benefits more evenly and that would remove a bias in the tax code that pushes people into inefficient insurance.

Overall it would be progressive. That's because the current tax code favors people with employer provided insurance and that tends to be higher income people and it favors people with the most expensive policies the most, and they also tend to be higher income people. The uninsured are most likely to be low income people. They're the ones who get the biggest advantage from this relative to the current system. So Treasury estimates that overall the top income

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quintile would see a very slight tax increase, the bottom four quintiles would see a tax decrease.

So overall it doesn't change the distribution within the tax code that much, but it makes it somewhat more progressive. Now the second piece that I only have just a minute to talk about is the Affordable Choices Initiative. Now the people who might fall through the cracks of this system that I have described, the standard deduction, especially during the transition from the current tax treatment to the new tax treatment would be, for example, people with chronic illnesses who are uninsured right now. It's hard for them to get an affordable quote for insurance because their already sick. Their expenses are predictably high and so there's little insurable risk left.

Insurance is about uncertainty and those people have certain high expenses. What they need is extra resources. They need a transfer and the federal government can partner with the states to make more resources available to ensure the hard to insure populations. People with very low income, but who don't qualify for public insurance. People with maybe higher income, but commensurately higher health insurance expenditures. The state should have the freedom to roll over funds that they're currently using to subsidize the charity care of the uninsured into an insurance program that would get people in for care earlier when it was most

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advantageous for them, for their health, and when it was more cost effective. By redirecting funds from institutions to individuals we can cover even more people and that's an integral second part of the President's proposal that maybe I'll get a chance to talk about in more detail.

So I think there's some common questions that arise when thinking about this that I've tried to address a little bit, but that might also be fodder for your questions later. This will help low income people both through the Affordable Choices Initiative and through the payroll tax component of the standard deduction. It will help sick uninsured people, especially in partnership with the states. It won't undermine employer provided insurance, it will merely provide help to people who are currently getting no help through the tax code and struggling to get insurance on their own. And it will make health insurance more affordable by a eliminating a buys in the tax code that is spending enormous public and private resources on insurance that is not high enough value. Thank you.

ED HOWARD: Thank you very much, Katherine. We continue our march down economist's row with Henry Aaron, but to say that Henry is just another economist is like saying that Henry Aaron was just another outfielder. Our Henry Aaron comes to us from The Brookings Institution where he ran the economic studies program for many years. He's also

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served in high government and non-profit and academic positions. His thought provoking article done with the Heritage Foundation's Stuart Butler a few years ago on how best to move toward broadening coverage, has in fact triggered the kind of bipartisan legislation that Karen referred. Embodying that proposal in the both the House and the Senate and he has some ideas about health reform that I hope he's going to share with us now. Henry?

HENRY AARON: Thank you very much, Ed and thank you for having me here. Since he mentioned Henry Aaron the baseball player, I have to tell you that I am the owner of a letter from Phyllis George inviting me to play in a celebrity golf tournament. Unfortunately, I do not play golf and consequently I told her that she had the wrong person, but I was willing to come anyway. She withdrew the invitation!

In selecting a title for my comments today, I tried to draw inspiration from the current season, which is that of Easter and Passover. So I chose two titles. This is one of them and that is the other. Actually, given my background I found greater inspiration in the first title. And so I'm going to ask the four questions, although I fear I'm not the youngest male in the room. The first question brings to mind a thought that the era of large tax cuts may be over, but I would ask you whether it is likely that the era of large increases in government expenditures is at hand?

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The chief feature of the federal universal coverage plans is that they entail massive increases in the share of the economy that is under direct federal control, large increases in deficits in some cases and large increases in taxes in all. Please remember that vast resources that can be brought to bear to criticize and yes, misrepresent such plans and the size of the economic interests that can be mobilized against them. We are Washingtonians, even more important we live in a Washington centered town. But wakeup and look around at this vast and diverse nation.

The states are not only ready to move, some have moved. With modest financial support and active cooperation from the federal government and fashioning methods to extend coverage, many more would be prepared to do so. Indeed, if there is some significant financial help on the table, pressures for most states to act would be irresistible in my view. So here is what I am suggesting. That Congress create a bipartisan commission to review state plans for extended coverage. That this commission recommend a menu to Congress of states to be approved under fast track procedures that are guaranteed to force a speedy decision. If the federal government offers financial help and regulatory flexibility and under some variance, significant financial help. Benefits for the Medicaid population should be protected.

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My personal preference is that any financial help that's offered be calibrated on a "pay for performance" basis. That is, if the states make progress in reducing the number of uninsured they get the help. If they don't, they don't'. Again, the key point here is that the states are acting and more are ready to move ahead. Look at the materials in your package summarizing the number of states and the bipartisan leadership of those states among those who are trying to extend coverage.

Some advocates of state action regard this initiative as an experiment. A way of gathering information about what works, about what problems will arise in implementing plans and what solutions can be found. We will re-live the welfare reform experiments, or so it goes, proceeding national action. I suppose there's something in that view. But if the states act, it is not mere experimentation. It is much, much more. It is action. Six hundred and fifty thousand people in Massachusetts are uninsured. Six million people are uninsured in the State of California. If the plan enacted under Republican Governor Romney and now being implemented by Democratic Governor Patrick succeeds, if the plan advanced by Republican Governor Schwarzenegger that will have to be passed by democratic legislature in California succeeds, the uninsured population in the United States would drop by millions.

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They and other states would show that covering everyone can be done and here's the beauty part, they're going to make mistakes. Tensions will arise between the states. Industry will insist that inconsistencies be ironed out. My own view is that that will make national action inescapable. But suppose I'm wrong. Suppose all that happens is that 5 or 10 or 30 billion people who are currently uninsured come to have it. Would that be such a bad outcome?

The premise of the state partnership strategy is that one party action to extend coverage cannot possibly succeed. That bipartisanship is necessary in this nation, at this time. That's a necessary condition for success politically. There's a house bill to achieve the general objectives I've described, co-sponsored by democrats Tammy Baldwin of Wisconsin and John Tierney of Massachusetts. Two pretty liberal members of Congress and by Republic Tom Price from Georgia, a pretty conservative member of Congress. This bill has 58 co-sponsors, which isn't terribly impressive as house co-sponsorship goes.

But of those 58, 31 are democrats and 27 are republicans, and that, I believe, is impressive. Not so many co-sponsors on the senate bill of Senators Bingham and Avoinavich [misspelled]. But there's another one going that will soon be introduced I believe, co-sponsored by Senators

Russell Feingold and Lindsey Graham. You see the bipartisan pattern in all of this.

So at the risk of going where no economist should dare to go, into the dark space of political advice, I'm going to offer the following. To democrats I say that encouraging the states to act now is the thing to do. Extend coverage, grab some low hanging fruit and go for encourage state action. To republicans I say, you can put your principles, those of federalism, to work on behalf of a goal that you cannot permit democrats to take away from you, so do it.

My final comments are addressed to those who, like me, yearn for effective action to extend health insurance coverage to all Americans. It is just and it is a precondition to effective cost control. But we should keep in mind the warning that my Brookings colleague Charles Schultz gave fifteen years ago when President Clinton put forward his health reform plan. "Do you realize…" he said, "…that they want a remake with a single piece of legislation, an industry as large as the entire economy of France." Well, in the last fifteen years, since that plan did not succeed, U.S. health care has had a better run than France has. In fact, U.S. health care is now as large as France and Spain combined.

My point is that health care financing is too vast to be remade in a single bill. It will come, but gradually and over time. We have a lot of states ready and willing to begin that process. Let's not blow that chance by trying once again to do something that no democracy ever has done in peace time. Particularly not one with the constitutional devices marvelously fashioned to frustrate bold actions, unless large majorities support them and important minorities do not oppose them. The first condition may be satisfied at the present time, the second one, no way.

My final comment would be, let us not repeat past mistakes.

ED HOWARD: Thanks very much, Henry. What is this fascination you have with Charles Schultz's, of various kinds? Both of them.

HENRY AARON: Well, you're fascinated with Henry Aaron!

ED HOWARD: We have our final speaker, Dallas Salisbury, who is the President and CEO of the Employee Benefits Research Institute. Now Dallas may not claim to be an economist by training anyway, but Ebry's Economic Analysis I dare say is among the most widely respected and quoted in this town and around the country. And if you've heard those radio commercials that urge you to choose to save, this is the guy that wants you to save, whether it's health care or

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your own retirement. So we're very pleased to have you with us Dallas.

DALLAS SALISBURY: Thank you very much and congratulations to the folks at Lewen and the Commonwealth Fund for this excellent analysis, and for the overwhelming interest in the subject that Henry wishes to send back to the states. As Karen reviewed, as does the study, the affects on both employers and individuals of aggregate coverage and aggregate cost, so I won't go back over that.

Henry highlighted in his closing the dominance of the employment based health insurance system in the United States and that, in spite of one of the documents in your package starting and then repeating two or three times in the document, that employment based coverage in the United States is "crumbling" is the word that's used repeatedly, the absolute numbers covered by that system clearly contradict any such notion.

Kathy pointed out the importance of the tax system, to the development and the maintenance of that employment base system. And it is irrefutable that the presence of tax preferences has dramatically influenced the structure and what employers have been willing to do as well as what employees have wanted. Our research over the last twenty-eight years, and surveys, indicates very clearly that

individuals have a primary preference for getting health insurance through their employer.

When asked in our most recent surveys if individuals, if given money in lieu of the insurance they would then purchase insurance, 52-percent say probably not, they would need the money for other things. And while Kathy has stated boldly that President's proposal would not undermine employment based coverage, our research for what it's worth suggests that it would do a pretty good job of potentially decimating the system that currently provides protection for the largest segment of the American population, outside of Medicare and Medicaid.

If we move to the issue of not employers who don't have coverage where essentially the primary implications of all of these proposals relate to administrative burden, what it would take for them to comply, as well as the cost relative to no current cost explicitly for health insurance provision. And if one thinks back to 1992 and one looks at the reform efforts in numerous states, as well as many things that have failed to passed Congress in the thirty years I've been in town, it has been small business opposition to changes that would bring administrative costs just for all employers that has kept many, many health reforms from being enacted. So that type of opposition could be anticipated to

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many of the changes and many of the approaches that we'll review today.

Moving instead to the bulk of employers, those employers that do provide coverage today, is the dispersion of concerns would be almost as broad as the number of employers that exist. To this slide, one might add variation in the income, the education; the hours worked of individual employees, as well as add to the size of the employer. Whether they be the fifteen employee enterprise like mine that provides comprehensive health insurance, or individual enterprises of a much larger size. Many different factors come into play in what would determine the direct impact and how individual enterprises would react to whether or not they wish to provide coverage.

For those with plans as well, there are many issues that fall into the analysis and what individual employers would think about these programs. I would put one footnote in related to the President's proposal, that is one of the reasons the Congressional estimates of the amount of revenue that would be raised by the federal government by the President's proposals are quite high. And that is because one of the features of the President's plan that has received relatively little media attention is that in addition to the $15,000 and $7,500 caps applying to the cost of the health

insurance, they would also roll into that any money that is currently going into so called "flexible spending accounts."

Flexible spending accounts allow up to $5,000 to be set aside for the payment of co-pays, deductibles and premiums. Federal employees have that available, very widely used in state and local governments as well as private employers. I emphasize that since flexible compensation, so-called "cafeteria plans", came into play some years back in the early 1980s. It is the presence of flexible spending accounts that have actually facilitated much of the redesign of employer health programs aimed at increasing the stake that the individual has. And if one adds that mount in the FSA to the employer premium, nearly every federal employee will find themselves paying income tax on the value of their insurance packages; not to speak of very large numbers of private sector workers, including those who do not think they have Cadillac coverage.

So employers looking at mandates, looking at many of these issues, really are evaluating what will the real effect be. They end up looking at a favorable side to some of the proposals. Employers have been desirous of moving health information technology, of moving more towards evidence based medicine and other issues. There is a hope on the part of employers that many of these reforms would have the effect of accelerating those movements and allowing for broader

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efficiencies in the employment based health system. One of the concerns, however, is the second bullet, those proposals that would be a movement to Medicare and might well require the employers to the equivalent of supplemental coverage as currently happens in the Medicare marketplace. And really, the question over time of what would be that balance of what the government provides and what would be demanded by workers in that supplemental marketplace.

If we move to those proposals, that last point on Medicare for all, then the designs between the Widen bill, which uses an FEHB standard. So a much more generous benefit in terms of payment of the person’s average individual’s health expenses as opposed to the current Medicare program. Those concerns about supplementation might well be mitigated. Under the Stark proposal there is less of an increase of the value of Medicare and the issue of, in essence, that Medigap market, the affects of it, the demands for it could be quite substantial. So unless Medicare is enhanced, employers concerns on this principally relate to what kinds of long term tax burdens they might anticipate on themselves and their employees coming from different reform alternatives.

And then finally, there’s a change taking place which can be underlined by a survey that was released by MetLife a week ago. Three weeks before that another survey came out about employers and it was telling against one issue. In the

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last 6 to 7 years survey after survey has found that the primary health care issue of concern to America's employers was cost and how much they were spending on health care. These two surveys found this year for the first time in the series of years, that cost is no longer the major concern. That the long talked about labor force shortages and tightness that began to be talked about in the year 1990 and then with the release of Workforce 2000 and again with Workforce 2020 are beginning to show up.

Employers have now said that their primary interest and concern in the health area is using health care to be a best in class employer in order to attract and retain the technical employees and others that they need. And that that ability to design a program aimed at attraction and retention, even if it means it must be Cadillac, is taking over and dominating a question or a concern over concern. So reform costs are an issue here, individual employer concerns about labor force will become an increasing concern and as this debate goes forward the clearest thing is given the diversity of the employer community in America anticipating that employers will have a common position on any of this falls into the highly unlikely category. Thank you.

ED HOWARD: Thanks very much, Dallas. A rich background. We're also happy to have join us for the Q&A part of our program, Sarah Collins from the Commonwealth

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Fund. She's the Assistant Vice President there for the program on the future of health insurance. She's also an economist, of course, and the principle author of the report on health care legislation that you have before us. Sarah thanks for being with us to answer all those tough questions that everybody else can buck to you.

Those of you who would like to ask in person, there are three microphones that I see – two in the back and one up here in the front. If you want write your question on a green card, someone from the staff will take it from you, just hold it up. And I see some being held up. Let me take advantage of a card here and a question addressed to Dallas. "To what extent does the preference for getting coverage through their jobs reflect simply as an aversion to change among most workers?"

DALLAS SALISBURY: The survey's data would indicate that it's not about change, it's about trust and confidence in their ability to negotiate and in they're feeling currently about the individual insurance market. And most individuals that have a serious need for health insurance find it very difficult in today's individual market to find affordable coverage.

One of the concerns individuals have is the pricing. If you go to, for lack of a better example, the Care First website here in the District and start filling out the

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material, what you find is the premiums are both experience rated and aged based. So the older you get and the more serious the health condition, the more you pay. So the dynamic appears to be a feeling very strongly stated in the surveys of a belief that the employer is in a much stronger position than the individual to get them a good deal and to sort through the system in ways that they do not want to sort through it themselves.

ED HOWARD: Call on the folks at the microphones. I would ask you to identify yourself and try to keep your questions as briefly as you can. Tom?

TOM MILLER: Thanks, Ed. Tom Miller, American Enterprise Institute. Kate was talking about kind of value on the margin, whether you look at international comparisons, whether you look at regional variation in the U.S., even the marginal return on tax subsidies. The suggestion is, as you spend more on health insurance you don't get as much back in return for it. Let me ask you about some recent data that just came out in an article in Jama [misspelled?]suggested maybe going on to the other end of the continuum as well, at the low end of the uninsured.

Jack Hadley had a piece last week in the Journal of American Medical Association. Jack would probably reach different conclusions. Let me just give you his numbers though and let you think about this. He was looking at folks

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who were either uninsured and had an accident or had a new chronic condition. And the question is who gets care in that situation? I was surprised at the small numbers of the uninsured that those who are less likely to receive any medical after an accident, 78.8-percent still get some medical care and the insured get 88.7-percent of the get medical care.

How about getting any medical care with the onset of a new chronic condition? Those less likely to receive any medical care, if they're uninsured, 81.7-percent still get medical care, and if they're insured, 91.5-percent. That's about a 10% differential. There's another differential, which is for those who are as likely to get the recommended care. Now the point there was maybe it was twice as likely that you won't get recommended care if you're uninsured. But the actual differences are 19.43-percent are not likely to get any recommended care if they have an accident, of course if you're insured it's 9.2-percent, again a 10-percent differential. It's a 10-percent differential on the other side for those with chronic conditions.

Here's the point. It's about a 10-percent differential in whether you get any care, yet the uninsured supposedly are consuming about 50 to 55-percent of the care that the insured are. It suggests a real bargain to be

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uninsured. You get care anyway, even though you pay less for it. Could you sort that out a little bit?

KATHERINE BAICKER: Well, not addressing all the facts and figures and not familiar with that particular study, I think you're raising a couple of very important points. The uninsured do consume a fair amount of care and the insured pay for that through higher premiums, the taxpayer pays for that through uncompensated care. About half of the uncompensated care in the country is financed by federal dollars, about 25-percent by state and local dollars, about 25-percent by private dollars and then the uninsured consume a bunch of care out-of-pocket as well.

It's not particularly efficient care, it's not good for their health to get care only when they're sick enough to go into the emergency room and it's not good for the system. It's much more expensive to treat somebody with pneumonia in the emergency room than to give them a pneumonia shot when they're healthy. So the fact that they consume care makes the system less efficient overall and less good for them.

On the flip side, if you look at people with consumer directed or high deductible health policies, they reduce their use of emergency rooms in discretionary settings but not in emergency settings. So somebody with a higher deductible policy is more likely to seek primary care instead of going to the emergency room where somebody who's uninsured

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is likely to get less efficient but costlier emergency room care. So both of those sets of facts I think suggests that getting people insured ahead of time rather than waiting until they're sick enough to consume uncompensated or charity care would be good for them and good for system and both of those were accomplished in this proposal.

ED HOWARD: Henry?

HENRY AARON: I'm not sure it's a cause of celebration or that we should relax, "I'm going to turn your numbers around," because of those who develop serious disease, 12-percent of those who are insured do not receive care, but 30-percent of those who are not insured do not receive care. That doesn't strike me as a testimony to the irrelevance of insurance coverage.

ED HOWARD: Karen?

KAREN DAVIS: You have in your packets a report by our Commission on a high performance health care quite not the best, and on page 17 it indicates that only 49-percent of the U.S. population is up to date with preventive care that ranges from 31-percent for the uninsured to 52-percent for those who are insured all year; so there is a difference. But what I conclude from this is we're far from giving perfect care, even to people with insurance and we need to not only cover people to eliminate those differentials, we really need to work on incentives, whether those are pay for

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performance or the way we organize care if we're going to improve quality, improve preventive care, improve management of chronic conditions. So that's one point. Insurance is not the only factor that's impeding people's ability to get care. And then some of the proposals I mentioned, some of them require people to have a medical home to hold those physician practices accountable for seeing that people get recommended care, recommended preventive care.

The second point I would make is that cost sharing is not a good way of steering people toward necessary or recommended care. The studies that have been done coming out of, for example, the Rand Health Insurance Experiment show that cost sharing reduces of essential and discretionary care. So again, there's a better technique than simply financial incentives to guide people to appropriate care.

ED HOWARD: Yes? In the back.

DAN ADCOCK: I'm Dan Adcock with the National Active and Retired Federal Employees Association. My question is for Katherine and anyone else that wants to answer it. The assumption in the Administration's health tax proposal is that the higher the amount of the employer contribution for that plan the more generous that plan is. But what if you're dealing with an employer who has a plan that's efficient but is very high cost because it has many more people because of

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the way they use health care drive up the cost of those premiums.

KATHERINE BAICKER: That's a very good point. There a lot of different factors that drive up health insurance premiums. Certainly holding all else constant in more generous policy with less cost sharing has a higher premium, but you can hold all else constant. Premiums are driven by the characteristics of the insured population, but also by say the state regulatory environment that people are operating in or by the competitiveness of the provider market or by how small the group is. So there are a lot of different factors. Some of those factors would be able to adapt under the new policy.

So for example, individuals can choose different types of policies but also states can change their regulatory environment. Some states have policies that drive up premiums for everybody and reduce coverage amongst the healthy they could reform those. Small employers could be able to ban together to get better rates for their groups than they currently can. Especially in a lot of state markets where small employer groups are risk rated, but large employer groups aren't. So getting people into risk pools is clearly important for bringing premiums down overall. And that applies in the employer market, but it also applies in the individual market where it's important to get people

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insured while healthy so that you then have a big group of people whose premiums can't go up because of their individual health experiences and the system that we have now really keeps people out of the individual market who might otherwise participate and get in while they're healthy.

So if we can provide an incentive for people to get in that's great. The President's standard deduction applies only if you have coverage. So there's an enormous discontinuous incentive to get some coverage and then no discrimination about which plan you get once you're covered by at least the basic policy. So hopefully all of those policies together – and I didn't get a chance to go into some of the individual insurance market reforms that would help with small groups will work together to get everybody to get into a big risk pool at the beginning.

ED HOWARD: Yes. I'm sorry; you're not standing at the microphone! If you were, you could ask a question. Fortunately or unfortunately we do have a bunch of questions that have come forward. This is a pretty broad gauged one that I think any of the panelists comments would be welcome on.

These proposals described today are based largely on economic arguments. Many health care providers would argue that the delivery system is what's in crisis. Does the panel believe that changing the way we pay for coverage should come

before, at the same time as, or after reforming the delivery system?

Karen, you want to take a crack at that?

KAREN DAVIS: Well, I think the point is well taken. We've got a lot of problems with our delivery system. It's fragmented, it's uncoordinated, people don't have a medical home. People have been with their physician a lot less longer than in other countries, which do have medical homes. So there's a lot we need to do on the delivery system. Should we hold the $47 million uninsured, the $16 million underinsured, hostage until we fix all of the ills of the healthcare system? I would argue.

I think it's important to build in to coverage proposals some of these provisions that would move us toward medical homes, that would provide financial incentives to providers to reach high quality targets on providing recommended care. Providing preventive care that would move us forward in terms of IT and using a modern information system, but I would not hold hostage the uninsured addressing that until we totally reform the U.S. health care system.

Sarah may want to comment on this. What's coming through in these estimates is the big health system savings are on the administrative expense side. If we can establish broad risk pools, whether those are state purchasing pools or opening up Medicare to the entire population, having

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insurance market reforms, we could achieve significant administrative savings. So I definitely think as we assess these proposals we should be looking for those that will get away from a lot of the efficiency, the fragmentation in our insurance system. Sarah, I don't know if you want to add that.

SARAH COLLINS: I think it's important just on that point of risk, to look at these proposals with that in mind. I think the small group market was just discussed a few minutes ago and there really are serious issues in terms of trying to get small employers access to affordable coverage that really are illustrated in the two proposals or three bills, two that which we modeled, that try to reform the small group market. And the same issue you see come up, again in President Bush's proposal that would move more or given incentives to get coverage through the individual insurance market. So the risk pooling is really an important factor in what we find in a lot of these bill modeling exercises.

ED HOWARD: Henry?

HENRY AARON: In direct answer to the question, both and, not either/or, and not one before the other. As Karen said, two numbers to keep in mind, if you wanted to pick a single number out of the air as to the extra cost of health care that would be consumed by the currently uninsured if

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they became insured. It's something in the vicinity of an additional $100 billion dollars a year, plus or minus 30-percent or more.

But that's what might be the central estimate. We currently spend $2.1 trillion on health care. Surely, it is worth thinking hard about how to spend $2.1 trillion to get a higher level of health care services for the 85-percent of the population who are insured. At that same time that we think about how best to spend some additional money for services perhaps offset by savings in other areas of those who are currently insured.

I'd like to also use this opportunity to make a comment about the numbers in doing an associate's estimate. I know John Shields; he's as good a person with these kinds of estimates as there is. Good people, as good as there are, disagree frequently, particularly when they are estimating the consequences of institutional change as massive as that contemplated by these health care forms.

In the jargon of economics, all of these estimates are way, way out of sample. We don't really have specific experience to estimate what the impact of many aspects of the plans that are under consideration would be. So what have in these numbers is a single digit as part of a very flat and broad distribution of possible outcomes. In fact, the savings could be a great deal larger than those estimated

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from administration that are contained for a couple of these proposals. Look at how CBO and the CMS actuaries fell on their faces about the estimates of the drug bill. They were far lower; the numbers came in far lower than either of those estimates. But there would be a precipitated changes in behavior and norms, access to care, the ability to fund screening tests that might unearth more illnesses than certainly exist that we would want to have taken care for.

I'm simply suggesting that when you look at numbers that are estimating what's going to happen, if you turn on it's ear a sixth of the U.S. economy modesty is in order and we should recognize these as good faith estimates by highly trained professionals, but not put a lot of reliance frankly on the point estimates.

ED HOWARD: Actually, if I could just followup on this general topic of savings and numbers. There's a question directed at Karen and you, Henry. I wonder about your response to the premise of the question and then the substance. Most of the savings, it says, attributed to the Stark plan seemed to come from price controls e.g., imposing Medicare administered prices on all providers, single purchaser of drugs and so forth. How realistic is this in a market based economy like ours?

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And I might add if anyone has comments on the desirability of that kind of arrangement, those would be welcome as well. Karen?

KAREN DAVIS: Again, I'll invite Sarah to join in this. But the bulk of the Stark savings come from administrative savings. Some Medicare runs 2-percent administrative overhead, group insurance around 10-percent, individual insurance anywhere from 20 to 45-percent. So whenever everybody gets covered under the Medicare program you get the advantage of the Medicare administrative costs. You also have statements from people not moving in and out of coverage, enrolling, disenrolling, and different administrative costs on providers.

So the Stark bill estimates include $74 billion in administrative savings. They do include $34 billion in prescription drug prices. That's about 15-percent prescription drug spending and about $62 billion from provider savings for physician and hospital services. On the other hand, they assume there's some push back by providers, particularly in the Medicare Advantage plans that they charge higher rates to compensate for the fact that they're being paid at Medicare rates for a larger percent of the population. But whether, again as Henry cautioned, you believe those exact numbers, the point is there's $150 to $170 billion of savings. The net effect was $60 billion

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savings because of the induced utilization of services and some additional paying for uncompensated care that's now rendered free and the additional administrative costs of administering subsidies for low income individuals.

The bulk of the savings around the administrative side, not on the provider payment side, but there are savings there as well. Other countries have been willing to use the power of government to negotiate fees, to negotiate pharmaceutical prices, achieving savings for their systems and what you get from these estimates is somewhat of a sense of what kind of savings could be achieved if those principles were applied more broadly in the U.S.

ED HOWARD: Anybody else?

HENRY AARON: Let me just not answer this question directly at all, but say that I think if we moved in the direction of something like the Stark plan where essentially everybody was covered and the federal government had a large function as a financial intermediary through which funds went on their way to providers, inevitably sooner or later you are going to have increased premiums or other forms of cost sharing in order to hold down the tax hit, the size of taxation, that would be necessary to fund those benefits. And inevitably as those charges increased, they're going to vary based on income. They would have to be in order to avoid being too high for low income people or yield too

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little revenue to serve the purpose of minimizing the size of total tax collections.

Income testing is administratively expensive. If one moves in the direction of cost sharing related to particular services, recent research indicates that you darn well better have different cost sharing for different services if your objective is to hold down costs because the cost minimizing, cost sharing for some services is negative. You should subsidize people to use certain pharmaceutical products because the increased drug costs are more than offset by reduced physician and hospital charges later on. And that gets administratively expensive. So I doubt very much whether over the long haul the current Medicare administrative share is going to be sustainable as the cost of health in the aggregate grows with the menu of beneficial interventions.

ED HOWARD: Kate?

KATHERINE BAICKER: Not to pile on, but just to build a little bit on what Henry was saying. That kind of flexibility in pricing to subsidize things that are cost effective, especially for health in the long run, that's not the kind of flexibility you expect to see through an administered pricing system and it's very tempting I think to say I know how we should spend more money on healthcare, let's just spend less money on health care; done, lower the

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prices, insist that those are the prices you're going to pay and look at the pile of money that accumulates.

The problem is that the Medicare Part D drug benefit illustrates two important shortcomings of that strategy. First, it took forty years for Medicare to have a drug benefit because Medicare was first designed drugs were not a particularly important part of the way we all consumed healthcare. There just weren't that many pharmaceuticals and they weren't very expensive so they weren't built in and it took that long to get it in because Medicare is an enormous and inflexible program.

And so do we want to stifle future innovations, do we want to have the wrong pricing structure? That's very dangerous in reducing everyone's access to cutting edge technology, then the enormous stack of prices that comprises Medicare prices is thousands and thousands of prices differing by thousands of counties it's this much paperwork. That kind of inflexibility has led to some of the wasteful misallocation of spending that we see in the Medicare program where certain parts of the country are twice as expensive as other parts, even once you control for how sick the population is, for how much health care they get, for how healthy they are at the end, for how happy they are at the end.

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The price structure encourages more consumption, not higher quality or higher value consumption. Then look at the Medicare prices in Part D prescription drug coverage. The prices came in 40-percent lower than people had forecast. So already if we had set the prices at the forecast level we would have lost money, not gained money. Not only were the prices lower, but the benefits were more to people's likings. The original benefit had the doughnut hole and a big deduction up front. The policies that people bought filled that doughnut hole because that's what they preferred and achieved cost savings in other ways.

So I think adding more flexibility to the system, not less, is the way to encourage higher quality care that meets the needs of a changing population and adapts to rapidly evolving medical technology.

ED HOWARD: Dallas?

DALLAS SALISBURY: Ed, at the extreme of flexibility though and the extreme of Medicare for all, would be a much heavier reliance on the individual market as opposed to the group mechanism and the primary cost differential between the 10-percent approximately for a large group and the 35 to 50-percent cost in the small group market is almost totally attributable to marketing costs and commission payments. And it adds up to a tremendous add on relative to what the individual receives in value. So it just underlines the

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tremendous need and any approach that moves to gain greater coverage to have some type of a very, very efficient pooling mechanism.

Most of the experiments that have been done, there's a big experiment and program in Rhode Island. There have been them in Denver and many other markets, the equivalent of association health plans by a slightly different name. Almost all of those have ended up finding that they have not created a net increase in the number of insured. They've simply been moving around the deck chairs by taking business elsewhere, but at very high marketing costs and at very high administrative costs. So I think it's trying to find a way to dramatically bring down the cost of individuals obtaining coverage as opposed to the individual mechanism if we do anything that serves to undermine the employment based large group marketplace.

KAREN DAVIS: Just one clarification. In the Stark Medicare For All, I don't want to convey that it's all public. First of all, it's a Medicare For All with employer opt out. So if any employer has comparable coverage that they want to provide privately they're permitted to so. So that differentiates it from Senator Kennedy and Representative Dingelsbill [misspelled?].

The second point I would say, when I say "Medicare For All" I don't mean Medicare Fee for a Service for All. It

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would keep the Medicare advantage options in Medicare. So those would be provided to people but personally on a level playing field, unlike the situation that we have now.

ED HOWARD: Thank you. Question for Kate and actually also Henry Aaron. Please address the concern that low income workers could end up with reduced social security benefits due to the President's health proposal because they'd be paying social security taxes on lower incomes. It would also lower the amount of dollars going into the trust funds.

KATHERINE BAICKER: So let me take first stab at that. So there's the question of what happens in the aggregate to the social security system and then there's the question of what happens to individual people where there's a different effect for people at different points of the income distribution. So let me quickly address both.

What happens in the aggregate is that the solvency of social security is improved. In the same way that this is in fact revenue neutral over the ten year window, but revenue gaining in out years. This would be revenue neutral for social security and the social security system over ten years, but revenue gaining in the out years. So this in no way undermines the solvency of social security.

Now, what about individual people? There will be some people whose taxable income goes down because right now

they're getting no help through the tax system. Under the President's proposal they would get to exclude some of their income from both income and payroll taxes to help them purchase health insurance. That means they're taxes go down. If they're taxes go down for their whole lifetime, then their social security benefits would go down for their whole lifetime because your social security benefits are based on your taxes.

Well, that's what happens today for anyone who gets health insurance from an employer. So if you're getting health insurance from your employer, if you had instead gotten it as taxable income, your social security taxes and benefits would be higher. You have the option to say, "You know what, I'd like to pay taxes on that." Pay higher taxes now and get higher social security benefits in the future. Most people choose not to do that because the return on those benefits aren't so high. So most people would say, "You know what, I would rather not pay extra taxes right now just for the sake of having higher benefits in the future.

So for the small group of low income people whose lifetime taxes would go down because of that and who therefore would have lower lifetime benefits, although there is a floor on social security benefits so it's a fairly small group of people who might be in that circumstance. They always have the option of saying, "No thanks. I'd rather pay

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the higher taxes and have the higher benefits." But there's no reason they shouldn't have the same choices that people who get insurance from their employer's have today. There's no reason their choice should be more restricted and they should get less help through the payroll and income tax system towards purchasing health insurance.

ED HOWARD: Henry, anything? Okay. This question goes to actually making some of these plans work in the real insurance world. What role do you think risk adjusted payments – this says from government to payers, but by any mechanism, will have in the anticipated move toward universal coverage; will have, should have, can have?

KATHERINE BAICKER: I think that there are a number of ways that states could work in partnership with the federal government to get hard to insure people under the insurance umbrella. And what I have in mind is people who don't have insurance now, but have some pre-existing medical conditions, who have high expenses, who have a very low income. One strategy that some states use is state high risk pools which subsidize insurance for that group of people.

Another strategy could be risk adjusted payments made to those individuals who could then go purchase any insurance they wanted. That's another really promising strategy for states to help transfer more resources to high expenditure people. Because again, those high expenditure people I think

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people have an idea that we should design the insurance system around making sure those people get insured, but they're not really insurable. They have predictably higher expenses. Predictably high expenses aren't something you can insure against, they're just something you can have transferred against. Society can give you extra resources to help you get health care, but once you have predictably high expenditures, it's hard to ensure against a situation where there's no risk.

So that kind of health status adjusted payment could go a long way towards getting those people into private insurance markets. But it's just one strategy of many and Henry has emphasized, letting the states experiment with those different strategies seems like the lowest risk, most effective way of expanding access to affordable healthcare.

ED HOWARD: Go ahead Karen.

KAREN DAVIS: I think it will be interesting to watch the Massachusetts Connector to see if they get risk selection into certain products and whether this becomes a big issue. Obviously, for a state like Massachusetts that has community rating within age bands. They're saying to all insurers you have to charge the same premium to everyone who's the same age. In principle, that pools the risk that it could be under a multitude of products that are offered. Sicker people tend to pick certain plans, healthier people tend to

pick other plans and if so, the State Connector may have to do additional adjustments to avoid leading to spiral upward in the premiums of those plans that happen to attract higher risks.

ED HOWARD: As we go into the last block of question time, I would ask you to pull that evaluation form out and start filling it out so you can hand it in as you leave. Yes, sir. Would you want to identify yourself?

FRANK CLEMENTE: Sure. Frank Clemente of Change To Win. In the state reform model I'm wondering if yourself and other panelists could say that relatively how successful at controlling costs do you think states will be as opposed to a Medicare for all type nationally?

ED HOWARD: Henry you want to start?

HENRY AARON: I'm not sure how successful Medicare For All will be in the long haul. What I would expect to see from state initiatives is an extremely wide range of approaches tried in different places. The motivation, you can't get the diversity of sponsors for the kinds of bills that have been put forward without a framework in which all sides can be confident that their favorite plans will get a fair hearing and will be tried somewhere.

The bills do that I think in all cases by specifying that the commission that would approve state proposals for particular plans, the commission would have to approve by a

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super majority and the membership would be chosen to assure bipartisan representation so that members of both parties would have to have their fingerprints in order to get approval you would need a wide range of different proposals as part of the menu that was submitted to Congress for being underwritten and for regulatory flexibility.

That means that you're going to get different answers to your question I think and from different places. Some would emphasize cost control and probably relatively lien coverage, relying on the individual market. We'd find out whether Kate Baicker's belief in the health care reforms that are going to work actually would. Some would be about as near as ERISA would permit you to get to universal coverage through something approximating a single payer or at least with a good deal of state regulation. Some of the plans might even go for ERISA waivers in there as part of their application. And there you would have something near to Senators Wyden, Kennedy or Representative Stark's proposal and we'd get a chance to see whether their approaches were particularly effective. I would expect them to have broader coverage and probably tighter regulation over costs.

The idea here is that we do not have yet and we are not, let's be honest, on the verge of a national consensus about which of those models will work and we are not close to the prospect of being able to get 60 votes in the Senate and

a Presidential signature for such a proposal. After all of the lobbying and questioning that would hit any hard edge proposal that could be run through John Shields model would generate. We're going to have a lot of disagreements. So the idea here is we can insure some people, we can learn something, the states are ready to move, let's turn them loose to do so.

ED HOWARD: Yes. Sarah.

SARAH COLLINS: I just want to underscore the point that Aaron made earlier about the point estimates not being the thing that we should focus on. But even when we're thinking in terms of the effects of particular state proposals, it's really the dynamics that occur in a particular proposal that are important. So it's the direction of change.

I think things that I didn't expect to see, such as there's a mandate for large employers that's modeled Representative Pallone's proposal and it requires everyone who's provided an offer of health insurance from an employer, even those who are currently covered in public insurance programs should take up that employer coverage. So what you get is a big decrease in federal and state expenditures for health care and a big increase for employers.

The other thing that occurs is that you get an increase in the cost of administration because the cost of

administration on employer based healthcare is higher than it is on their public plan. So it's things like that come out of the modeling that are the most important, I think, take away from these rather than simply the point estimates.

ED HOWARD: Yes?

MALE SPEAKER: Got a question for Karen Davis.

ED HOWARD: Actually, before we do this, there's a late entry Henry following up on something you just said. They want to know why universal coverage, and they put this in quotes, I don't know if it's verbatim – "Why is universal coverage a precondition to effective cost control."

HENRY AARON: I've said this a number of times and people have disagreed with it or asked for an explanation. So let me see if I can make the case. Maybe I'm wrong, but it seems to me that as long as coverage is incomplete efforts to squeeze to achieve cost control with respect to the insured population will generate social and health consequences that none of us would find tolerable.

In that situation there would be strong buyers and weak buyers. The strong buyers would remain as they are today, the insured. The weak buyers would remain as they are today, the uninsured. Providers confronted with cost pressures will react I believe as they do in every single market. They take care of the strong buyers first. That's a long winded way of saying that the cross subsidies that

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uninsured now enjoy would be squeezed and it would give the state of being uninsured a whole new and terrifying meaning. I believe confronted with that we would all back away.

So what I'm arguing is yes, universal coverage I believe is right on grounds of equity access to care, but also it is also in the self interest of the well insured to achieve it because it will enable us to set up regulatory frameworks or competitive frameworks that you can get these goals through different means. It will enable us to set up frameworks through which effective cost control becomes politically feasible and sustainable.

ED HOWARD: Okay. The question was asked: In working to develop a new healthcare aimed at covering the uninsured, what would be the most successful at reducing widespread, racial health disparities in our country? Kate you talked a little about that in your presentation. Do you want to take first crack at that?

KATHERINE BAICKER: Sure. And it draws a little bit on some of the areas of research I worked in wearing my academic hat. So let me try to fish that back out. I think one of the main drivers of disparities that we see in health care, both along racial lines, income lines, all sorts of different measures, is that there are people in certain parts of the country that get very low quality care and that low quality care tends to be focused in poor areas, areas with

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more minority residents. So that drives the disparity not so much the variation in what people at the top are getting, but the very low quality that a lot of people at the low end of the quality distribution are getting.

So efforts that target raising the quality at the low end of the quality distribution will reduce disparities along racial dimensions, income dimensions, etc. And dramatically improve the health of those at the low end of the distribution. How can we do that? Well, the Medicare program is a major purchaser of health care and it has some tools at its disposal to implement, but can go even further in rewarding not just quantity of care but quality of care. Creating centers of excellence, paying hospitals, if and only if they provide the standards of care that we should expect from our system.

There are other tools available to the federal government to make information more widely available about which hospitals are really lagging behind in providing high quality care and we've seen examples from public and private partnership that just revealing that information can be enough to bring the low quality providers up to meeting clinical standards. So those are two roles that the federal government can play. And then on the private insurance side you would want insurers to be able to take advantage of better information to reward high quality providers more and

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to steer their patients towards higher and hopefully people would choose insurers based on that information being available and on having a higher quality network available to them.

So eliminating those disparities would be a great goal of a lot of these different policies.

ED HOWARD: And I might also commend to you the work of the Commonwealth's commission on a high performance health system, which focuses on some of the very questions Kate was laying out. As we mentioned, Dallas Salisbury is a member of that commission. Karen, we've got a question addressed to you.

Could you briefly discuss the impact of proposals that would allow 55 to 64 year olds, if not everyone, to buy into Medicare?

KAREN DAVIS: Just before I leap into that, which is covered on page 23 of the report. Let me just make a plug for our second report, which we expect to release in April, which is an analysis of bills that are more focused on quality and efficiency and that includes Senator Lieberman's Fair Care bill specifically aimed at reducing disparities.

But in terms of the opening up Medicare to older adults, Congressman Stark has a Medicare early access bill. What Lewen Group estimates is there are about 30 million people ages 55 to 64 and about 5 million of those are

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currently uninsured, about 1½ million have coverage through the individual market at 2.7 million are early retirees and get coverage through their employer, others obviously are active workers that get coverage through the workplace.

Their assumption is that everyone's whose — and the Stark bill has a 75-percent premium subsidy. In other words, 75-percent of the cost of coverage would be paid by the federal government. So they assume that all of the 3.5 million out of the 4.8 million who are uninsured would buy into Medicare. Everyone who now buys coverage through the individual market, 1.5 million, would buy in. And 2.1 million early retirees who now have employer coverage would buy it through Medicare employee's round coverage. In other words, about 7 million new people would be covered through Medicare, including about half of those who are currently uninsured.

This is an expensive option, it increases federal outlays by about $27 billion. There are savings to employers of about $10,000 billion. Obviously, there are ways to refine that proposal to reduce the premium subsidies or to target it more on lower income individuals. But I would say while we're used to proposals to expand the state children's health insurance program and children tend to be low cost per person covered. Well, these older adults are high cost per person. This is the group that's really in the most

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desperate situation right now. Many of these individuals are unable to qualify for coverage in the individual market because they have prior health problems or even of the 1.5 million who are purchasing coverage in the individual market as we noted earlier. That market age basis premiums so they pay very high premiums.

So it's a group really looking for some relief and very precarious position and the thought of being able to get into Medicare early, which is going to be their source of coverage at age 65, makes a lot of sense.

SARAH COLLINS: The only thing also to keep in mind about these is allowing people to come in, we didn't model this, but allowing people come in at 55 rather than 65 if they have a serious health condition obviously might save Medicare costs over the long term as peoples may be somewhat healthier entering Medicare at 65 than they would have otherwise.

ED HOWARD: Good point. I think we've covered the questions that you had before us and I'd like to end this program by asking our panelists to offer a one minute speech from before the House and Senate that we look to for enlightenment. Start with Dallas if we can.

DALLAS SALISBURY: Thank you Ed. I'd just conclude with the notation of on all of these I think the primary necessity is trying to find a balance between doing no harm

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while simultaneously finding a way for expansion of access and coverage. One of the proposals that's in the long paper for example is one that would deal with many of the uninsured by allowing access to purchase into the federal employee health program by small employers and individuals. Which against these issues of administrative costs, market ability and other issues is and approach that would provide for relatively cost efficiency in a proven program, which to consider relative to the individual market.

Another factor which I know employers are continuing to find challenging as they focus on design of programs is just the data reality that about 80-percent of their costs are attributable, depending on the employer, to between 12 and 17-percent of their participants is most of the expense in the system is expense that is not going to affected by co-pays and deductibles. And that reality in design comes home very frequently with employers.

The third factor is the one that Henry mentioned in passing. Which is the Employer Retirement Income Security Act and the fact that that federal law of 1974 created preemption for self insured health plans from state initiatives and state regulations. That is where a tremendous amount of private coverage comes from and it is a factor that is not always addressed in these proposals and probably would need to be addressed specifically.

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And finally just one note, vis a vis even the large market, that when one looks at large and small employers, one finds that one of the reasons there's substantial cost is there's dramatic turnover in who the insurers are for large and small enterprises. One of the things from the survey is that causes employees to think not kindly of employment based coverages, even though the insurer that is servicing that large company may change rapidly. It ends up the employer insulates the individual from much of that change.

If you think about the feedback from Medicare where for certain plans in the private program dropped out and Medicare beneficiaries find themselves forced to find coverage. That happens very frequently in the individual market. It's another consideration just in the design of how to do these programs.

ED HOWARD: Okay. Kate?

KATHERINE BAICKER: Thanks. Just to sum up. Turn on its head the question that posed to Henry Aaron, I would say that getting the fundamental cost drivers in our system under control is a necessary pre-condition for covering the uninsured. But if we don't do that, no system that we design today will be affordable tomorrow. So by addressing the fundamental cost drivers in a way that makes the system more equitable, we can also make insurance more widely available. I agree that employers will contin to want to offer insurance

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to their employees, especially in a increasingly competitive labor market. People want to get their insurance from their employer because of the returns to scale, the lower load factors, the bigger risk pools. I can't imagine a quick erosion of the employer market. It's just important for people who don't get access to the employer market they not be penalized by getting no help in getting insurance on their own.

ED HOWARD: In keeping with the Reliance tradition of moving toward the center, why don't we start with Sarah.

SARAH COLLINS: I just wanted to say that on these proposals the federal — I think I missed your question. Did you have a question? Just a comment? My one minute? Okay.

I think what's really important is that the particular measures of the bills, even as we look toward state proposals really do matter in terms of overall costs and how those costs are shared across stakeholders. How their costs are shared across households by incomes. Whether there are premiums that are subsidized, whether there is a standard deduction that is the same across all income categories, whether the proposals would pool risks broadly, these are very important questions, very important features of the plans to look at as we consider proposals that going to come out of it over the next couple of years.

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And then also thinking forward in terms of the quality issues, whether we're structuring the health system in a way that we can most efficiently and strongly improve the quality of care on a system wide basis. And I just would add too, as we look at the costs of these proposals keep in mind what the Institute of Medicine estimates that people who are uninsured each year lose in terms of lost health and productivity in the order of $65 to $135 billion dollars a year. So we really do have to think in terms of those costs as well.

ED HOWARD: Henry?

HENRY AARON: Much of what we've said today has sort of moved back and forth between what might happen over the next four or five years and what might happen this. I'd like to end by focusing on this year. I think there are three major events that could come together to give us a shot at really major action at health care reform.

One is the fact that the President has put on the table a major health proposal. Like Kate, I'd like to emphasize the proposal to give states the additional resources to expand coverage and to improve risk pooling within their borders not, I might add, by the funding mechanism that was floated by the administration. But the idea is on the table, the President put it there, and if he's genuinely behind it is an important development.

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The second is that we have to re-authorize that state child health insurance program. There's bipartisan support for significantly increasing the resources behind that program. Karen has raised a question I think explicitly of the relative importance of covering 60 year old, chronically ill person at the poverty level versus additional children at 300-percent of the poverty level.

I don't know the answer to that necessarily, but I think it's something that's worth discussing and just maybe we ought to leave it to the states to decide on the priorities within their own boarders for that.

The third major development is the veritable explosion of proposals from a large number of states and in support within Congress to encourage states to try to expand coverage on their own. These three developments lifts the prevailing political climate permits could coalesce into large scale action. That If is huge. The Administration of President Bush is, to put it mildly, in some political distress at the present time and the capacity of the President to play an active role on this domestic issue may be seriously compromised.

If he is able to do that and if the democrats can see around the very fat targets that they have, which are very seductive for political reasons, and are willing to work

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with the administration. Then that could bring about I think quite fundamental legislation.

ED HOWARD: Karen?

KAREN DAVIS: Thanks. I guess what I take away from this session is that universal coverage is doable. We do need to extend universal coverage to the uninsured and it is key to achieving a high performance health system that has better access in quality and greater efficiency.

I think what's helpful about seeing the specific estimates prepared by Lewen Group is it's clear that to finance coverage for all we will need a shared responsibility with employers contributing, with states contributing, but also with federal government funds required, even states I think will learn as we go along can't do it alone without additional funds from the federal government.

Third, I think it's important to focus on total health system costs and not just on federal budget outlays we have a tendency because of scoring, because of things like Peco to focus on the federal government impact. But it's important to look at the total costs of any proposal and the interaction among sources of funding; federal outlays, state outlays, employer outlays, and household. So I hope you will take the time to dig into these estimates in more detail and understand some of the dynamics that Sarah has stressed.

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Fourth, we have a mixed public/private financing system. In my view we're going to continue to have a mixed public/private financing system for a long time. But what I take away from this report in this session is that we need broad risk sharing and we need a framework, whether you call it regulation, whether you call it a connector, whether you call it a health insurance exchange, whether you call it a regional health market or a help agency where those offerings are available and where we avoid segmenting risks into separate sources of coverage for those who are healthy and those who are sick.

So I do hope you will stay tuned for part two on the bills that look at quality and efficiency, including those that try to move forward on pay for performance, information technology, transparency, public reporting, patient safety, medical liability, disparities, those are among the bills that will be included in this report.

I hope you find helpful what we've offered today. It is the first time that there has been a systematic analysis of Congressional health insurance bills. For those of you writing those bills and assisting your members with ideas, we plan to do this again in another year. So we're eager to follow new proposals, do keep us informed about those or about modifications you plan to make to proposals as they are re-introduced.

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So finally, thanks to The Alliance for Health Reform for this session. But my particular thanks go to the Congressional staff and to their members who have developed these bills and in doing so have moved the debate forward. I think I can speak for Sarah and others who've been involved in this project. It's actually been a fun project because of the richness of the ideas that are on the table. As we looked at the bills that were there they often said introduced, referred to committee, and read twice and that was the end of it.

So we hope to give life to many of these fine ideas and to really overcome the sense that there is no solution to the nation's pressing health problems by seeing the array of proposals that are there and the implications that they have. Thanks.

ED HOWARD: Thank you Karen. Very quickly, let me just turn that around and say thanks to all our friends at the Commonwealth Fund for their support and sponsorship as well as the contributions to the intellectual product that has been on display here. One last pitch for the evaluation form. I don't know when we've had such a thoughtful and thought provoking discussion and I'd like to ask you to help me thank the panelists for that discussion.

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