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Can Tax Credits Be a Linchpin for Health Reform? Lessons from the Factory Floor
Urban Institute
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BOB: —are an opportunity for the Urban Institute to showcase some of the interesting and policy relevant research that is going on at the institute and have a discussion with other experts and practitioners who have different experiences and different perspectives on the topic.

Today's topic is tax credits for health insurance and it is being informed by a recent analysis by Stan Dorn of the Institute entitled Coverage, Tax Credits: A Small Program Offering Large Policy Lessons. Now the report is part of an ongoing series of timely analysis on immediate health care issues that has been funded by the Robert Wood Johnson Foundation and we are grateful for their support.

As all of you know the current tax code subsidizes health insurance by excluding employer-paid premiums and contributions into health savings accounts from taxable income and by allowing employees to reduce their pay through deposits into flexible spending account. And also allows people who itemize their deductions to deduct the amounts over 7.5-percent of income attributable to health expenditures out-of-pocket.

This structure, as all of you also know, is inequitable in that it provides no real benefit to those whose employers don't offer premium support for the health insurance of their workers. And it provides subsidies whose value is inequitably

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distributed in the sense that it is related to one's marginal tax rate. So for an individual who has no tax liability it is basically worthless while for those who face a marginal tax rate of 35-percent over a third of the premium represents a tax subsidy.

Given our current system, it's no wonder that most of the candidates who have suggested significant reforms in our health care system have suggested that we change the nature of this subsidy from a deduction into a tax credit of one sort or another. The fact of the matter is that we know very little about how such a tax credit might work. The problems that we might have implementing it. What this discussion will do is draw on the experience we have had from this small program, Health Coverage Tax Credit, and try to extrapolate to what might happen in a larger context.

To start us off we have Stan Dorn of the Institute who's a senior research associate here. And previously to joining the health policy staff at the Institute he was a senior analyst at the Economic and Social Research Institute and Director of Health Consumer Alliance and the Health Division of the Children's Defense Fund before that.

Commenting and adding a different perspective to the issue we have Roy Ramthun who is the President of HSA Consulting Services, which is a health care consulting practice

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that specializes in health savings accounts and consumer-driven health care products. Prior to forming this consulting practice he was a senior health policy advisor to President Bush and also was at the Treasury Department, or helped the Treasury Department implement health savings accounts. Roy also, I believe if I'm not wrong, served on the Senate Finance Committee staff when I was also working at Congress. So we seem to have sort of taken that off the bio. [Laughter]

RAY RAMTHUN: That's okay.

BOB: Maybe at your request, I don't know. Following Roy will be Janet Trautwein who is Executive Vice President and CEO of the National Association of Health Underwriters. She's worked closely with state legislators, regulators, governors, and others to implement purchasing options for workers who are eligible for the existing tax credits. In 2001 she was appointed to President Bush's Health Advisory Transition Team and helped to start the new administration off.

JoAnn Volk will follow Janet and she has been at the AFL-CIO Health care lobbying organization since 2001. Prior to joining the AFL-CIO she was a senior analyst for the AFP Associates doing research on state efforts to cover the uninsured and state high-risk pools. She's also worked as an aide to the speaker of the New York State Assembly and so has a lot of experience with the state perspective on these issues.

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This is a terrific panel and it will be moderated by Gene Steuerle. Gene is a senior fellow here at the Urban Institute and co-directs the Urban Institute Brookings Tax Policy Center. He's also a columnist for Tax Notes and the editor of 11 books and countless articles. And I commend to you his most recent book, "Contemporary U.S. Tax Policy," the second edition of which will be issued by the Urban Institute Press in a couple of weeks. Gene also was Deputy Assistant Secretary of Treasury for Tax Policy in the late 1980s. So with that let me turn it over to you, Gene, and get the discussion underway.

EUGENE STEUERLE: Thank you, Bob. I do have to interrupt this discussion however, for an important announcement. Apparently the White House and Speaker Nancy Pelosi's office have come together on an agreement to establish a tax credit that will help promote universal health insurance along with a mandate. They've decided that they're going to put aside all partisan bickering over this issue and the Clinton, Obama, and McCain campaigns have all come together and decided that health policy will no longer have to be an issue in this campaign.

Meanwhile Bill O'Reilly and Ann Coulter have both announced that given the lack of controversy in this town they will stop pontificating for at least one day. Now that may be

a bit of an April Fool's joke but not entirely. I think actually as we see momentum on the tax credit issue for health care we actually see a lot of different proposals that I think to many analysts are a lot closer together than they may appear to the politicians. And indeed it may be an area that in which we could see momentum, but whether we do or not is something I hope our panelists will soon address.

But just by way of further background, you know, we have had tax credits for health care. We certainly had a Bentsen tax credit. It was a small one. It didn't work very well, but it was enacted back in the early part of the 1980s. We have a trade adjustment assistance credit that is available now, but it's not just for trade adjustment assistance, but as Stan reminded me it's also for a PBGC recipient as well.

We certainly have the president's recent proposal, not to establish a tax credit although he has indicated he might move towards a tax credit relative to his exclusion. And we have tax credit proposals in the McCain and the Clinton campaign proposals. I'm not quite sure where Obama is on that although he has indicated some indication to think about mandates.

So as we can see this is an extremely active and important policy topic and a lot of people are moving in similar directions but not exactly the same, and partly because

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of the issues that our panelists are going to discuss in some depth. And since they've already been introduced I will say nothing more than I think it's just a superb panel, really. Not just in terms of the expertise that they bring to the issue but I think the range of expertise we have today really makes this an exciting discussion.

Our panelists will spend about eight minutes each teeing up the issue and then we will open the floor to discussion among them and then with you as an audience. So to lead off is Stan, please.

STAN DORN: Thank you very much, Gene and Bob. I'm going to begin by building on Gene's observation that tax credits as a mechanism for health reform enjoy unusually broad support across the political spectrum. This is very important I think because we may have another shot at health reform in 2009 and legislation is much more likely to be enacted if it enjoys bipartisan sponsorship. And in an area of policy that's been extraordinarily divided along ideological and partisan lines, tax credits are one of the very few mechanisms that have enjoyed broad support.

So it behooves us I think to examine the experience with the Health Coverage Tax Credit, the HCTC, to ask what does this teach us about the ability of tax credits to play a major role in larger reform efforts. And what does this teach us

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about how to structure tax credits if we want to use them to subsidize coverage for the uninsured? To help answer those questions I'm going to talk about three things.

When I was learning public speaking as a kid they always said you should talk about three things. I am convinced this rule has its roots in Christian theology, but even though I'm Jewish I'm going to follow it. I'm going to talk about some of the accomplishments of HCTC, some of the challenges of HCTC, and some lessons for the future.

In terms of accomplishments the most important of course is that tens of thousands of people receive health coverage thanks to the subsidies provided by HCTC. In many cases these are folks who would have been uninsured without the credit. It's a critical accomplishment. It's the most important thing that HCTC has done.

The most important thing that HCTC has not done represents a second accomplishment. That is that the credit has avoided the problem of insurance marketing fraud, a problem that was very serious with the earlier Bentsen tax credits which we've seen with Medicare recently and which we saw with Medicaid-managed care when it was first getting going.

Now to be clear, I'm not — the insurance industry as a whole is an honorable, reputable industry, but there are con artists and shysters in those ranks along with every other

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rank. And when consumers get the government's money to spend on any insurance they want that becomes an almost irresistible target for opportunism unfortunately. And now the problems have been not evident with HCTC because the credits can only be used for qualified coverage which basically means COBRA coverage offered by former employers and state-qualified plans, private health insurance plans arranged by the state.

And so because you haven't had the kind of wide-open free wheeling enrollment process that you've had with other credits and with other programs, the program has avoided the problem of insurance marketing fraud. So a lot more to say about other HCTC accomplishments, but to stick within that eight-minute frame that Gene mentioned I'm going to stop there and move on to two issues, two challenges facing HCTC.

The most famous of which, of course, is that many eligible individuals do not participate. In my view it's impossible to come up with a valid single take up rate estimate for HCTC, but I think it's fair to estimate that no more than 15-percent of eligible individuals benefit from the credit in either its advanceable form or its year-end form. And the surveys that have been done of beneficiaries and state officials working on this program give the same answer about this main obstacle, its affordability.

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Most of the eligible workers can't afford 35-percent of premiums. And that should come as no surprise. If you work, on average you spend 15-percent of the premium for worker-only coverage and it's not realistic to expect that somebody who loses their job is going to be able to more than double the amount that they spend for health insurance.

But there's a cash flow problem as well. Typically you have to spend — before advance payment begins with HCTC people have to spend money out-of-pocket for full, 100-percent premium payments unsubsidized. Lots of people in this eligibility group simply don't have that amount of extra cash sitting around in household budgets.

Now a number of states have been clever and creative and circumvented this problem by using Department of Labor grant funds to provide essentially a mini-HCTC, a 65-percent subsidy for the months before IRS begins the advance payment process. But that's a minority of states and that's not a very sensible way to run a railroad and it raises serious questions about moving forward on a broader scale.

The second obstacle that I'm going to talk about is administrative costs. About a third of federal dollars related to advance payment go to administrative cost. To some degree it's because non-group coverage can qualify as coverage for which the credit can be used and we know that of all forms of

insurance, non-group coverage is the type where the smallest percentage of the premium dollar goes to actually buying health care.

But there's also an issue of IRS administrative costs. For each $4 in advance payment delivered to health plans the IRS has to spend about $1 in administrative costs to make that possible. Now, why is that? The way advance payment works IRS first of all invoices the beneficiary each month for their 35-percent premium share. They track that 35-percent payment. They then give it to the financial management service of the Treasury Department.

With us today are some folks from IRS, I'll no doubt make some mistakes and I hope they won't correct me. No, I hope they'll correct me during the question and answer period. Of course I do. Provides to FMS, FMS couples it with a 65-percent HCTC, sends that 100-percent premium payment on to the health plan along with identifying information about the individual enrollee. It's about a half a dozen transactions per month for each beneficiary. That is very expensive.

Now it was structured this way for good reason. The IRS and the Treasury Department were worried that health plans wouldn't participate in the program. Not that many beneficiaries nationwide and in some ways the rules for the

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program differ from those in other pre-existing health insurance markets.

So to avoid the problems of health plan nonparticipation they said, "You know what? We're going to make sure that each plan gets one premium payment from one source in time for its regular monthly billing cycle." As a result that government made that happen and lots of plan participate.

A survey a few years ago found that on average five options are available, state-qualified options in the median state. But that came at a price and the price was hefty administrative costs for delivering a subsidy. So these are a few comments about the accomplishments and the challenges.

What are the lessons going forward? Well one lesson is you have to pay attention to marketing fraud. You need to think about enrollment. You need to think about what plans qualify. If policy makers say we're just going to give a tax credit and use it wherever you like in any licensed health coverage that is inviting disaster in the form of marketing fraud in my view. Lots of different answers are possible but you need to think about it.

Second lesson is the size of the subsidy is critically important particularly if you want to reach the low income uninsured. And remember two-thirds of the uninsured are poor

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and near poor with incomes below 200-percent of the federal poverty level. This is no surprise. I mean, we've known from Medicaid, from SCHIP for decades that relatively small costs imposed on low income beneficiaries mean very low participation just because there's not that much extra money in household budgets. So the credits need to be quite large if you want to aim them at low income uninsured population.

The final lesson that I'll mention is that administrative details matter enormously. And I think change to the administration could have a profound impact overcoming some of the problems HCTC is experiencing. For example, why do people have to pay monthly premiums in full before advance payment starts? It's because there's no mechanism to apply for an individual determination of eligibility unless you're already enrolled.

In other words, you have to be enrolled in qualified health coverage in order to get a determination of eligibility. Well there's an answer to that. Establish an alternative mechanism through which consumers who want to can seek an individual determination of eligibility and then with a finding from a certificate from IRS saying, "I am eligible for the tax credit," at that point the consumer can go out, find a qualified plan and pay only their share of the premium not the full 100-percent premium.

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We do this with Medicaid and SCHIP already. If there are forms of coverage where premium payments are required you don't have to enroll and start paying 100-percent premiums. First you go to the Medicaid agency or the SCHIP agency; you get a determination of individual eligibility. Only then do you enroll in coverage and the only amount you pay is what you owe, not the full premium amount.

A second example of why administration matters. Think about administrative costs. Instead of having half a dozen monthly transactions for each enrollee there is a better way to quote that great bipartisan sage, Jesse Jackson, "There is a better way." You could have the health plans bill the beneficiary for their share of the premium and then invoice the IRS for the health credit paying the remainder.

Now this is also something that's done today in Medicare Part D. Medicare Part D plans bill subsidy-eligible recipients only their share of the premium and at the end of the month they settle up with CMS, with the federal government, for the remainder of the premium. Well we could do that with tax credits, too. And in that way instead of having half a dozen transactions per month per beneficiary you would have one transaction with a health plan for all of its enrollees per month. And you could even do it once per quarter if you're willing to compensate health plans for the float.

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So you could redesign HCTC in a way that would substantially reduce the administrative costs. Not to mention that a much greater program would benefit from economies of scale.

So in short it's no surprise that HCTC has had problems. It's had accomplishments that are often overlooked, but it's the first time in our country's history we've tried to use a refundable advanceable tax credit to subsidize health coverage. It's no surprise that it's had some problems. You try something new you always encounter problems.

Now think about how often Medicare and Medicaid statutes get changed. Not quite as often as my kids change their underwear, but nearly. Just about on an annual basis these statutes get changed. It's been since 2002 and the HCTC statute hasn't been changed. It's clear. Every problem with HCTC can be solved. And now with TAA reauthorization Congress has a chance to do so. Whether they will in fact solve the problems is another question entirely. Thank you very much.

GENE STEUERLE: Thank you, Stan and I have to compliment you because in order to stay within your time limit you converted three conclusions with mid-ration to a Jewish equivalent of 12. [laughter] So it was very effective. Next we're going to have Roy.

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ROY RAMTHUN: Thank you. There's one point of clarification in the papers that were on your seat today when you came in. There is a health coverage tax credit fact sheet which has my name on it but I want you to know that I was not the source of these facts. This is information that I asked to be submitted on behalf of the Internal Revenue Service who keeps track of all of the facts of the program. And these data points are as of January of 2008 so these are the most currently available information from the IRS regarding participation in the program. So I did not make up these numbers. That's what the IRS is reporting.

In my introduction one thing that was omitted was when I was actually at the Treasury Department I was also involved with the implementation of the Health Coverage Tax Credit Program. So we had monthly steering committee meetings and I know a fair bit about how this program was designed and implemented.

And I would agree with Stan that it's very important to understand that this is really the first time that we've ever tried a refundable and advanceable tax credit for health care. During my days on the Senate Finance Committee in the early to mid-1990s what was impressed upon me as a health policy staff person is that there's a very different world of tax policy that we are trying to bridge here. And I would imagine that

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most of the people in this room actually consider themselves more experts in health policy than tax policy.

And JoAnn and I were talking before the presentation. There is a different language that is spoken in the tax policy world and it's important for the health policy people to understand that. The tax staff ended up writing most of the provisions in the TAA bill when it came to the tax credit. They were informed and involved with some of the health policy staff, but at the end of the day that process is controlled by tax policy experts and it's important to keep that in mind as we're looking at how we're going to get these policies correct.

During my days on the finance committee the only experience that I had heard about with tax credits up to that point were the Bentsen Child Health Insurance tax credit. Again, all we heard were about the marketing fraud with that program. And the other program was the Earned Income tax credit program which, again, the only thing I heard about was that the participation rate was about 200-percent.

So when you come to a program that involves a tax credit and you're then designing it for health care, you have these two large black clouds kind of hanging over you wondering what kind of experience is this program going to have? And clearly it has had a very different experience than either the Bentsen tax credit or the Earned Income tax credit. And for

anyone who knows whether there is more recent analysis of the Earned Income tax credit, I do not; I think it might be instructive for how we look at how we design tax credits for these programs going forward.

I think it's also important for everyone to understand how a refundable tax credit actually works. The easiest thing to do would be to file something on your tax return at the end of the year and claim a credit for the amount that you are eligible and relate that to your tax liability or to your income. A lot of people when they look at tax credits don't understand that they reduce your tax liability rather than your income. So if you have tax liability of $1,000 and you have a refundable tax credit of $1,000 then your tax liability is zero. It does not reduce your taxable income by $1,000, but depending on what tax bracket you're in it could have a varying effect on the amount of tax liability that you have to pay.

The advanceable part of this tax credit I think is extremely important because from a health policy perspective if you are trying to help people maintain insurance coverage knowing that some may have cash flow issues, this was part of the design so that people would not have to wait until the end of the year to actually claim their tax credit although they could adjust their withholding if they're still working, but these people generally by definition are not working, having

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recently lost their jobs. That may work for other credit designs but it doesn't work particularly well for the health coverage tax credit.

Making it advanceable meant that we had to come up with an infrastructure to help make that money available to people on a monthly basis, not unlike how Medicaid and other programs do periodic eligibility determinations. This doesn't involve the same level of determination of whether people have income and resources and those kinds of things, but it does require a determination of whether you have an insurance policy that is qualified and whether or not that policy then is eligible for a subsidy and you write your check to the IRS and the IRS forwards on your payment plus the government subsidy on to the insurance carrier.

As Stan said, it does not have to be designed that way but that is the way that it was designed and because of that I think it has become more costly than maybe it needs to be.

So looking over the course of the past several years I think that we have successfully demonstrated that a refundable, advanceable tax credit can work for health insurance. We can all debate whether the current model is appropriate for broader use for refundable tax credit as we look at expanding coverage to more uninsured Americans.

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I think HCTC has achieved some level of success but obviously the enrollment and participation in the program has been disappointing. Initially estimates suggested that perhaps a half a million people might be participating in this program. And what we have found is much smaller numbers than that. In many states it's only a couple thousand people and in some states it's only a couple hundred people and so we've had to understand that this program is serving a very, very, very small niche of people. And we are asking that program to operate under sometimes slightly different rules than the rest of the world operates.

There are many people who are potentially eligible for this tax credit but don't have the right type of insurance to actually use the credit. I think that's a mistake. There are many that I think could probably find much more inexpensive coverage but they're not allowed to use the tax credit. And I understand how important it is to have appropriate consumer protections to make sure that everybody who is potentially eligible for the credit and qualifies for it could actually use it for some coverage.

But by limiting people's choice when there are sometimes better options available for them is a mistake in my view. The rules that apply to these individuals are different

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from HIPAA so for a very tiny population you are asking the insurance industry to abide by a different set of rules.

I think it's very interesting looking at the options that people have potentially when states are making their choices of what types of plans would qualify for coverage. One of the plan options that was made available was state employee health insurance benefits. So those types of plans that state employees participate or programs that are similar to that.

And for those who think that using the federal employees health benefits or even state employee health benefits programs as an option to provide to uninsured Americans, and I think that it's very interesting that no state has chosen that choice over the last four years, yet it would be one of the simplest options available to them. We don't know why they have made those decisions but they have. We also don't understand why so many states have chosen high-risk pools as the only option available to individuals.

We don’t really have any reason to believe that these individuals are of worse health status, although I do understand that the majority of the population by definition is in an older age group, 55 to 64, because they qualify through the piece of eligibility under Pension Benefit Guarantee Corporation and must be within that age up to Medicare. Clearly those on the TAA side of this program don't necessarily

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fall in that age group and when you look at their average age it is definitely much younger than those in the pre-retiree area.

I do agree with Stan that the administrative costs are probably higher than they could be or need to be, but we also need to keep in mind that the infrastructure that was built was designed to handle 500,000 people. And unfortunately we've built this ballpark and nobody came and so we have a lasting legacy of infrastructure that right now is maybe being underutilized.

I also want everyone to understand though that much of the costs that have been incurred by the program have been something that has been a positive aspect for the program beneficiaries and that is in the marketing and outreach areas. Letting people know that this credit does exist, that they have options to use with their health insurance and there is this credit that can help them pay for their insurance.

There is probably next to zero fraud in this program so while people may laud the low administrative costs of Medicare we have $50 billion worth of fraud in that program. So there clearly has to be a balance between administrative costs and potentially fraud. The IRS also is very concerned of maintaining taxpayer privacy so that makes other challenging issues that have to be addressed. If there was a broader

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population I believe a lot of these costs would be spread over that larger population and would make the cost ratios much lower.

Finally, I believe there's not very much evidence to date to suggest that the administrative costs would be any lower if this were a direct subsidy program administered by the states or by HHS. So that is something else I think we need to ask ourselves, is this relatively equal in cost? Relatively better or relatively worse compared to other types of subsidy programs? And finally the cost of being uninsured is much greater than the cost that the government is bearing to keep these people insured, so all points that we need to keep in mind as we look at fine tuning this program.

GENE STEUERLE: Thank you, Roy. You reminded me when you referred to your Senate finance days of a discussion I once had. It was either a Senate Finance staffer or joint committee on taxation staff person who made note that if I thought that sausage making was interesting when you wrote tax legislation I should see what happens when they write health legislation. Janet?

JANET TRAUTWEIN: Yes, I'd like to focus my remarks today on the purchasing options. Most of our work with the TAA program has been in working with states to get options up and running because in fact if a person has a tax credit and has no

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place to spend it, it doesn't really do them much good. And I want to focus a little bit specifically on what we've seen as some of the impediments with some of the purchasing options as they're structured.

There are actually 10 different purchasing options and I'm not going to go through each and every one of them except to group them a little bit by categories. There are two or three options that we would categorize as kind of automatic options. The state doesn't need to do anything in order for those options to come into play.

And then most of the options require the state to do something, as Roy said, any of the states could have allowed people to buy into their state employee program but none have done that and there are a lot of reasons why I think they didn't do that, which I won't get into here. States can set up a variety of different soft of private programs and then coverage can be available through a state high-risk pool and those are kind of the basic categories that things fall into.

Some people really hang their hat on the fact that COBRA is available and I would just point out that COBRA is one of the automatic options. People can continue their employer-sponsored coverage through COBRA or if their employer is a smaller employer 39 states have state continuation programs. But that requires their employer to still be in business.

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And if you look at the nature of this particular tax credit many of these employers have been impacted by U.S. trade agreements and didn't just downsize; they just shut their doors. And so if the employer is not in existence any more neither is their COBRA option or their state continuation option and so that is not a real option to them.

One of the other things that I wanted to mention is that we do have, and I believe I have this count correctly, now 12 states that only have the option of a state high-risk pool. Now for those of you that are not familiar, a state high-risk pool is a very important component of a good functioning individual health insurance market, but it was never intended to insure healthy people.

State high-risk pools were intended to insure people with health problems, yet we have 12 states who in addition to the automatic options of COBRA and state continuation only have a state high-risk pool. And that would be a very good explanation as to why people may not be covered in those particular states because state high-risk pools are more expensive than traditional coverage. And so it's not a very cost effective means of having a purchasing option if that in fact is your only option.

Now you might wonder why is that? Why do 12 states only have this option through a state high-risk pool? Well the

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requirements, and this is very important, the requirements of each of the options, all 10 options, each one is required to meet certain guidelines of the law distinctly. Not in combination with another option; each one separately on their own. And so here are the things that any plan that the state sets up has to do.

So any individual who has less than a 63-day break in coverage has to be issued on a guarantee issue basis, no pre-existing condition waiting period, and they have to have benefits and premiums that are pretty much consistent with what a non-TAA eligible individual would have. Now even in states, and I want to just clarify this, even in states that have implemented both state high-risk pool option and a health plan option, both of those two options have to separately meet this guarantee issue requirement, no pre-existing conditions, and they can have any number of people coming into these programs at any time.

I would just tell you that this is very, very different than the way that these insurance companies operate in most states. And the individual health insurance market, which is where these buyers are buying into, normally in the majority of states, there is medical underwriting and then if people don't pass the questions, if they're more ill than that, then there is some sort of a safety net and all but a couple of states the

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most common safety net is a high-risk pool. And the high-risk pool backs up the individual market, but it's not separate and distinct like it is in this program and it's just kind of strange the way that it's put together like that.

So this is really a lack of flexibility and I guess that would bring me to pointing out some things that could be done a little bit better. If it was a perfect world perhaps we would have some really strong fraud controls and people would just be able to purchase coverage that was available and had been approved by their State Department of Insurance in their state. But let's just admit that it isn't that world and that's not the world that we're in.

What could we do with the purchasing options that are already there which have proven to be helpful in combating this fraud issue? Well one idea that we've had is taking the options and combining them rather than each of the options serving distinctly on their own, what if you combined a private health plan option with a high-risk pool option, and you would have many, many more insurers participating in this, the cost of coverage would be dramatically lower. It would be affordable for many, many more people.

And the people that are in states that have only a high-risk pool as an option would have a much more affordable option. And one last thing that I would like to mention in

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that regard is when people who are insured under this program, when their 35-percent is higher than it should be, well guess who's paying the other 65-percent? It's the federal government.

And that means the government is paying way too much for the coverage under these programs and it's not necessary at all. It would be very simple to combine these options together to achieve the exact same goal that we're looking at now and provide better affordability and more coverage choice for many more people. I think we'd see a lot more take up in this program if they just had a reasonable and affordable place to purchase their coverage.

GENE STEUERLE: JoAnn?

JOANN VOLK: I'm going to start by trying to answer the question put to the panel today. Are tax credits a linchpin for health care reform? And I think no, they are not. I think that overstates the value of tax credits and their role in health reform. I think you need to think about this as one piece of a broader effort that must address insurance market reforms and making sure people have a place to go for comprehensive coverage.

So in some respects we're looking at one little piece here, but I think it is worth noting that there is broad agreement that we need to do subsidies of some sort in an

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expansion. The question is how? And this gives us an interesting look at one way to do subsidies, the Health Coverage Tax Credit. But it is also an interesting look at some of the true barriers to getting health insurance because the other pieces I would argue here are not addressed adequately and so we've seen this very limited take up.

I would say on a positive note that the Health Coverage Tax Credit tried it's best to be as much like a direct subsidy as possible with the advanceable, assignable and refundable features. And I think appropriately provides for a-percent of the premium so you don't have a flat dollar amount that would disadvantage higher cost and lower income people. But beyond that I think it fails some key tests. It does not provide enough help to make coverage affordable. It is not linked to meaningful coverage that people think will provide them access to care. And it does not pass the test of simple enrollment.

On the first point on whether they're adequate, I think you've heard plenty here about how the 35-percent does not go far enough. And I just want to remind folks that the average UI benefit, unemployment insurance benefit, is about $1,200 a month. And the average PBGC benefit for this population is about $700 a month. So 35-percent does not get you very far when you have other household needs to meet on your limited income, and it's certainly a far departure from the coverage

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subsidies they enjoyed when they were working, which we know are far higher.

And then of course there is the other complication that Stan mentioned that you have to actually pay the full cost for one month or more and then at this point wait for a refund at the end of the tax year for that amount which again, on a severely reduced income whether your pension benefit or your UI check, is just not doable for too many folks.

The coverage should be tied to adequate coverage and it was not done so here. I think the intent in legislation was to limit the use of the credit in the individual market to those who had coverage there in the 30 days prior to their layoff or retirement. That is not the way it's acted in practice. In practice the arrangements with insurer designation or option has come to look like the individual market for all practical purposes. There's medical underwriting and so people experience wide variation in premiums based on age, gender, and health status.

And then finally enrollment is not at all simple. I would just point to the last page of the papers that were on your seat. I borrowed a page from the GAO report in 2004 that outlines the process for both the HCTC people and the PBGC people. You have to clear a lot of hurdles to finally pop out at the other end with an advanceable credit in hand.

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So for example you have to first meet the eligibility guidelines of TAA or PBGC or this other thing called ATAA. You have to then be a qualified individual, meaning that you had three months of coverage prior to seeking to enroll in a plan, which is another area that's been interpreted differently than I think Congress intended. They're looking at that point far down the road where you seek to enroll in one of these plans you probably didn't have coverage in the previous three months. They meant when you lost your job, when you retired, did you have coverage in the previous three months?

And then finally you have to have qualified coverage, you have to be enrolled in qualified coverage. And there is that list as well. So you can see that there's just an enormous number of hurdles to clear here to be considered HCTC-eligible. It involves two different federal agencies, a number of state agencies, health plans, and a lot of back and forth. And that begins with just a petition for the TAA certification which itself is a very complex and technical process.

And then there is currently the linkage to the trade readjustment allowance which is what TAA benefits are called. And there is an automatic 60-day delay built in there. This has the effect of contributing to more delays and reducing the eligible population for the HCTC. There's a fix that can be made there that just brings it back to the original TAA and not

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trying to link it to TRA which gets into whether or not training spots are available if you're enrolled and so forth.

And then I think generally there's been agreement and GAO cites this in the report that there are between three- and six-month delays that have nothing to do with the worker, yet they are expected to maintain coverage with a break of no more than 63 days in order to have the consumer protections they need to actually be able to get coverage with the credit they finally qualify. So there is no way that you can construe that this as simple or effective.

So I think it really does point out the true barriers to getting health insurance. Timing absolutely matters. To get or keep coverage it has to be affordable, it probably isn't affordable without a subsidy, but you can't get the subsidy unless you've had coverage. And then, too, I think we've seen that people want meaningful coverage.

One of Stan's earlier reports said that people said that they absolutely wanted meaningful coverage even if it meant that it would cost them more. There is just no good economic reason for a laid off worker or a retiree whose pension was just slashed to elect to pay premiums that they probably had to scrape all their money together to buy and then get into a plan that had a big deductible that required them to pay for a lot of care out-of-pocket before the coverage even

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kicks in. That's just not a realistic option for these people. So I think these are the real lessons. You can look at making the enrollment process simpler. You can make the coverage-percent a higher percent, but you also have to address whether or not people can access the coverage and once there, whether it's meaningful and provides them access to care.

GENE STEUERLE: Thank you. This is a very, very interesting discussion and before we turn to questions I'd like to give the panelists a chance to react to each other if they'd like to make comments on each other's presentations?

STAN DORN: Well I wanted to react to a comment made by Janet about the need to make sure that there's a reasonable and affordable place to buy health coverage. I think that's absolutely well taken. And I think Janet deserves a huge amount of credit, personally, for the fact that there are state-qualified options all around the country.

I know that soon after the legislation passed she was going all around the country encouraging state legislators to make sure that they offered a form of state-qualified coverage. And it was really an extraordinary accomplishment and I think she deserves a huge amount of credit for it. And one reason I'm glad she's here is it gives me a chance to say that.

I agree with her that there's a need for a place to — it's not enough just to give people a credit. You have to make

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sure that there's a place they can use the credit to obtain health coverage, and coverage that they value. I think that JoAnn's point is absolutely right that people tend to prefer more comprehensive benefits, even folks who have been recently laid off, even people who are PBGC beneficiaries who don't have a lot of money.

If you look at the plans in which they enroll they tend — given a choice between more and less comprehensive plans — people tend to pick more comprehensive plans. The question I would raise though is, is the non-group market the right place for a reasonable and affordable place to buy coverage? I have questions about that. If you're an older person, if you have prior health problems, the premiums you pay are much higher. You may be denied the services that you need. In North Carolina for example, it was tragic.

There was an incredible amount of work done by the governor, by Blue Cross Blue Shield, by the unions, when the Pillowtex textile mills closed, one of the biggest lay offs in the history of that state. They got thousands of laid off workers to come and apply for health coverage from Blue Cross Blue Shield. Blue Cross Blue Shield knocked off the top two risk tiers. It was a medically-underwritten coverage and they said we're going to have five risk tiers instead of seven.

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And yet once people got those medically-underwritten quotes back, three-quarters of the folks said, "I can't afford this." I can't afford to spend — 35-percent of the premium is thousands of dollars. And as JoAnn said, some of the people — I'm going to spend money I don't have for high deductible coverage that doesn't pay for the prescription medicine that I need every month? Forget about it.

And huge numbers of people failed to follow through. So now I think there are other ways. I think Roy's point about making sure that the coverage is less expensive is a good one, but there are other ways to do that. You can have health insurance exchanges where everybody pays the same premium regardless of age, regardless of health condition.

You can make sure there's a range of benefits that are available so that you can pick between more and less comprehensive coverage. So I think that the points that were made were well taken, but I think there are better solutions than the non-group market.

ROY RAMTHUN: I want to draw your attention on the HCTC fact sheet that has my name associated with it. On the second page there's a little paragraph that says monthly premiums. The average was approximately $750 per month. Now I know from having seen other data from the IRS that the average is somewhat skewed here because you have single individuals and

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you have families claiming the credit. My knowledge of the premiums that are paid under the program and this is the total premium not just the government share or the employee's share, for single individuals is about $500 a month.

That's $6,000 a year. That's about average in the market. So to say that these policies are a lot more unaffordable than anything else that they currently have I don't think is true. The employee's share would be 35-percent of that $500. For family coverage the average is about $1,000 a month. So $12,000 a year, that's right in line with what the Kaiser HRET survey tells us every year it's about $12,000 for family coverage is the average, so not widely unusually high coverage.

But we also know that a lot of people are shocked and think they're being overcharged when they go on COBRA because they have no clue how much their premium actually is. All they see is what they pay from their own paycheck and so they suddenly think that you're ripping them off even though by the law the employer can't charge more than 102-percent.

On the eligibility side there have been proposals that would greatly simplify eligibility by tying the tax credit to the receipt of unemployment insurance. And to the extent that people understand how the unemployment insurance process works in qualifying for benefits, if you're eligibility to this tax

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credit were tied to the unemployment system I would think eligibility would be a rather simple proposition, maybe a few less handoffs.

However, if it is tied to unemployment insurance you're almost by definition talking about individuals who may have unemployment benefits that last 13 weeks, longer with extensions and those kinds of things. The nature of the insurance that might go along with a temporary benefit then is not the same type of insurance. It's almost like temporary insurance on the health side which is a little bit different and has its own issues.

So this becomes somewhat of a balancing act here I think. Clearly if we were to look at using tax credits, refundable tax credits for broader populations we wouldn't need all the specific minutia of how you qualify for HCTC under the TAA rules, the ATAA rules, or the PBGC rules so presumably we could figure out a better way.

GENE STEUERLE: Janet?

JANET TRAUTWEIN: And I think it's just important to note that the $500 average premium is for the people who cleared the medical underwriting. The three-quarters of the people at Pillowtex who never even signed up for the $1,000 a month or more coverage would have driven up the average. They

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could have been able to afford their share and enroll. So that's a little skewed picture I think of the average.

RAY RANTHUM: But we have no data here.

JOANN VOLK: Yes, I'd like to add one thing to that. But if in North Carolina we had been able to combine these two options together and they didn't have the high-risk pool at the time, but they've got one that's being formed right now, the only people in the private plan pool would have not been — those high risks wouldn't have been there.

And so only the higher risk people would have gone to the high-risk pool and the coverage automatically would have been affordable for more people there. This dual option is really a viable option that we should really look at because it will reduce the cost of coverage for a lot of people. And that's important because of something Stan said.

I take it that you'd like to have group options instead of non-group. But the thing about a group option is that group option's not magic. It has to do with who's in the pool. So if all we have in the pool are older and sicker people your costs will be just as high as they are in the options that we already have. We've got to figure out how to get some real affordability in and some participation by a broader range of people into this program and then we'll have more affordability for everybody.

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GENE STEUELE: I feel a little bit like one of Jim Valvano's players down at the basketball season. I don't know if you know, but once he asked to be excused from basketball practice because his sister was having a baby and he didn't know whether he was going to be an uncle or an aunt. So I'm kind of trying to interpret what I consider really useful comments about the existing tax credit into the implications for broader scale tax/health reform.

I see there's some question because it's not clear to me that it necessarily has to operate through the tax system at all, but a lot of the proposals essentially do that. So for instance the issue of eligibility, Roy you mentioned that if you went to something like unemployment insurance system you might have a simpler way to determine eligibility to solve problems. But what would that mean if we went to a more universal system?

For instance I work sometimes on the question whether you can really income condition a credit too much because the Earned Income credit we really have great trouble getting to the population because they don't know they're eligible until the following year. Or the questions of non-group market, what are the intentions in terms of what we're learning about the non-group market here if we actually try to create a broader

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voucher credit for people? Or how about the number of transactions?

I mean all of you have mentioned the problem of the transactions that are created. How can we keep them down? And our risk pools? What do we need to worry about on risk pools and what do we need to worry about when we go, from your experience to the states, we're going to let the states have sort of 1,000 flowers bloom in the states? What are the implications? What are the lessons here from this tax credit if people really try to apply it on a more universal basis? And you've addressed some of this but I wonder if you just might briefly go back to that and maybe give us some comments?

RAY RAMTHUN: Well, first of all tying the tax credit to the insurance begs a number of questions. One, do you have insurance and two, how do we know whether you actually have insurance or you just say you do?

Second if you have a requirement that you can only use your tax credit for a certain type of insurance then we have to do another round of checking to make sure that you're on the approved list of insurance rather than the unapproved list your insurance. And then thirdly what do we do with you if we find out that you don't have the insurance that you claimed?

So there are a number of mechanisms that get built in depending on how complicated you want to make this. And it's,

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in my opinion, it's nice to say you can only get the credit if you buy this type of coverage, but we have to admit that that adds layers of complexity that wouldn't be there if it was usable for basically any type of insurance that you wanted.

GENE STEUERLE: Anyone else?

STAN DORN: Well, you asked a lot of questions. Letting 100 flowers bloom? I think one of the lessons is that if policy makers want tax credits to achieve a particular type of coverage outcome they need to specify that and the HCTC statute says that states can come up with qualified plans and there's no rules for benefits.

So quite a number of states have nothing but high deductible plans, a few states have no high deductible plans, some offer a choice, a number of states use a non-group market, a surprising number of states use community-rated coverage, so the type of coverage that you want you need to specify. And so that's one, I think, one important lesson.

I think another lesson in terms of risk pooling and what would happen with a larger program, I think with a larger program, Roy's right. You could make things a lot simpler, but in terms of means testing which is a question that Gene asked, that isn't necessarily going to be simple in the context of a tax system. And yes, the IRS is the master of the universe

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when it comes to income measurement, but that's last year's income measurement.

People need subsidies based on current contemporaneous income and the IRS doesn't have a mechanism for testing that. Now there are solutions, you know, you could do things, for example you could do what Medicare Part B does and say last year's taxable income is going to presumptively determine the level of subsidy that you get. Or you could say if you got an EITC last year you qualify for a full level of subsidy this year.

Or you could, say, do what Medicare Part D does where they say if you got Medicaid last year you automatically qualify for low income subsidies for Medicare Part D this year. So you could say if you get food stamps, if you get other means tested assistance you automatically qualify. You could establish a residual means testing program in Social Security Administration offices. They do means testing right now for purposes of SSI administration.

So a lot of – these are complicated issues and often people tend to say we'll take care of it, we'll do means testing, we'll have bigger premium subsidies. But if you don't get the administrative details right, if you don't make it easy for the beneficiary, if you don't make sure there's somebody to help that beneficiary through that process, you're not going to

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get much enrollment. So I think there are all kinds of nitty gritty lessons that are important to take into account.

I guess the final point I would mention is that I think that a combination of non-group coverage and high-risk pools is worth thinking about, particularly if it's a high-risk pool like the one that Maryland offers or the one that Minnesota offers where there's a lot of state subsidy that reduces the price of the premium. While the other ones are pretty tough for people to get through; the premiums are awfully, awfully high in a lot of states.

But really I think another option worth serious consideration is combining tax credits with health insurance exchanges, purchasing pools, where you have a diverse range of health plans that are available that could function like a market but you can have nondiscrimination in premiums. It's easier for people to negotiate because they know where to go. You can avoid fraud because there's an enrollment mechanism that's distinct from the operation of each insurer. So I think that approach has a lot of promise and is worth serious exploration.

GENE STEUERLE: Janet or JoAnn, do you want to add? I know you talked about this to some extent already, but—

JOANN VOLK: Yes, and I think I would piggyback on what Stan said and you can make it simple. You can ensure better

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spending of federal resources and ensure that people are getting coverage that allows them to access care if you do designate a good source of coverage and say you go here. Your credit can be used. We can settle up, as I think Stan said, at the end of the month with the Treasury. And I think it provides for better health care for the workers, lower funding and resources for the feds to have to subsidize reasonable coverage. It makes a lot of sense.

JANET TRAUTWEIN: I think I do want to comment about the exchange because I think the exchanges, the proposals that we're seeing are an interesting way to get subsidies to people but they don't really address the affordability issue. The fact that we put coverage together in a pool does not always make it less expensive. It depends and seriously that's a very big issue.

But I just want to point out something that's sometimes we overlook the simple and we make things much more difficult than they really need to be. And I would just point out an example of the State of Oregon. The State of Oregon has an assistance program to people who meet certain income qualifications. And most of the coverage that the state approves in the individual and the group market is eligible for coverage under this particular program.

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There is a very, very small administrative staff that administers the whole thing. Agents and brokers and others that connect people with insurance know about this program. And when they find someone eligible they send them back through it and it's just a very simple not tax-related subsidy that subsidizes the coverage that's already out there. It works very well. It's been working for a really long time.

I mean, Oregon is not exactly a bastion of conservatism, they're a pretty mid-range state and a lot of people get coverage through — it's the Family Health Insurance Assistance Program. And it works quite well. It's also administered by the same people that administer their high-risk pools so if some one doesn't qualify, they're an individual market buyer, if they don't qualify there then it's easy for them to be converted over to the high-risk pool coverage which is one of the affordable states by the way. Oregon's coverage is quite affordable, one of the best. And the whole thing works very smoothly.

And so it's not a tax credit, but it is a subsidy program. And like you, Gene, I'm not convinced that we have to do this through the tax system although we have this great infrastructure built. I wish and I hope that we could use it effectively. It actually is a pretty sophisticated system.

GENE STEUERLE: I know. I —

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RAY RAMTHUN: [Interposing] Just one last comment. This tax credit we also need to remember it is a flat percentage tax credit so there's no variability for people with lower income to get more assistance than they would. And presumably somebody, although they may have lost their job could be the spouse of somebody on Wall Street who doesn't need a subsidy, yet they could potentially be eligible for that.

So presumably we wouldn't do that if this were a broader population. We would make some variation in terms of the value of the subsidy. It would be higher for those individuals who fell into a lower income range. The tax system is not the easiest place to go and say I just lost my job. Please re-compute my income for tax purposes. We don't do things that way. We kind of wait until the end of the tax year and see how things shake out.

But if you're going to make it refundable and advanceable you have to think about how we would actually do that to make it worthwhile to people so that they maintain their coverage like we want them to and not go without coverage and then potentially be left out of the system later.

GENE STEUERLE: I was reminded literally yesterday of how the complexity of these issues plays through in the real world families. I had a lady call me somewhat randomly from Minnesota. She was divorced. Her husband's former wife was

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disabled. One of the children from their marriages was also disabled. They were attempting to qualify for DI SSI for these people.

This particular family, the husband had just moved to making $31,000 a year so he had just moved out of Medicaid eligibility for that family, but the child was eligible through SCHIP and she didn't know how to negotiate the system. And I couldn't imagine that I would be able to try to figure it out either.

We're going to turn to the audience now. And I'd like to ask you to identify yourself before you ask your question. I'd like to ask you to please ask a question. You may precede the question with a very, very brief statement if that helps you clarify the question, but please, please make it a question. And please also wait for the microphones. We have a couple of microphones here that will come around to you. So would someone like to start? We have a question right here.

BARBARA SMITH: Hi, I'm Barbara Smith. I'm a health policy consultant and I just wanted to precede my question with a reality check of sorts, a personal story. My husband's firm converted all of their professionals from employees to independent contractors and we then had to go out into the individual market, everybody in that category did. Insurance premiums in that market for what was basically a healthy

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population with no serious catastrophic illnesses ranged from $26,000 per family to $36,000 per family. No catastrophic illnesses, problems from seasonal allergies to migraine headaches. So this is basically what the reality is for people out there.

My question is in terms of bringing this to scale for health reform, why would it be necessary to segment this population separately from the population as a whole at all if you couldn't have pools that had employers participating, that had individuals participating, that had, you know, all the streams in the health insurance able to go to the same pool so that you could basically aggregate the risk as much as possible.

And then the second thing is that if you make it seamless, as Stan was talking about, where you basically have people where the credit is paid into the pool or whatever the financing source is and then the individual pays only what they owe on a net basis. Why would that tax credit structure be any different than from just a sliding scale subsidy?

STAN DORN: I wanted to answer the end of your question, Barbara, by quoting that great sage, Stuart Butler, tax credits are just money that republicans can vote for. [laughter] Barbara's question was why a tax credit? Why not just a break on the premium? Why not just a subsidy

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administered by HHS? And I think the answer is if you want to have health reform that has bipartisan support you need to think about is there a way to make tax credits work?

JOANN VOLK: And I think on the coverage options I think it did take some efforts in some states. There's some states that were hit hard right away and Pennsylvania comes to mind and I have a colleague here who used to be with the steelworkers at the time, that they really dug in with the governor and the heads of the four different Blues plans and figured out the coverage that people could get into and minimize the gaps in coverage and everything else.

But in other states where there isn't a political will or there are fewer people affected, the incentives are not there to come up with a whole different structure. I don't know what Janet's possible explanation would be for why somebody went to high-risk pools, but there were mechanisms that were in place. There was seed money in the TAA bill also to help states with their administrative costs run or to set up new pools so there was perhaps an additional incentive there for those.

But it is a little bit of a chicken and an egg. If there bigger numbers there might be more willingness in states to come up with something, but just adding more eligibles to the list of people who can get this without addressing the

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fundamental flaws that affect take up rate, you're not really in reality growing the program in a way that commands more political support for better options in the states due to their action.

JANET TRAUTWEIN: Yes. I would just comment about why, to answer your question about why it was difficult. I was really shocked I have to tell you. We thought that it would be much simpler than it was. And some of the states that were most difficult were quite surprising as to who they were.

And in general what the problem was is that it did require some pretty heavy lifting on the part of the state primarily because the rules for this program are completely different than every other market rule in any market that they already had. And so it was reinventing the wheel for a potentially very small number of people. And they just couldn't get a lot of takers for it.

And so the political will wasn't there for such a small group, but just financially making it an attractive enough option that anybody wanted to do it. So I think, you mention why couldn't we just put everybody in the same pool? Well, I think it would be nice if everyone in the state had the same rules basically, particularly in certain markets. If they're an individual buying there are these rules and it doesn't matter if you're eligible for a tax credit or you're not.

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It would be nice if everyone was subject to the same rules. We would have avoided many of these problems if that had been the case. It was because of having to set up these separate systems for a small number of people, but even if you were doing it for a larger number of people it's just not as efficient. And so if we could have had the same rules it would have worked out a lot better.

RAY RAMTHUN: Just one final comment to note that if everyone who did not have employer-based insurance could deduct the cost of their insurance from their income today, like those of us who have employer insurance could do, they would receive a much greater subsidy than even under the HCTC.

BOB ROSENBLATT: Thank you. Bob Rosenblatt, freelance writer. All of you mentioned affordability as being a real problem why the people in North Carolina didn't take it up. And I wonder if you could relate this to the presidential campaign where I think affordability will be an issue. I'd like to ask each of you, whether based on your research or anecdotal discussion with workers, what your number is for people to be able to afford health care insurance? Is it 1-percent of income, 3-percent, 5-percent or 10-percent of income? A level at which you can expect people to buy and afford health insurance.

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STAN DORN: Well, I think it depends on your income. I think it depends on your income. I don't think you can say, to pick a number randomly, that everybody pays 10-percent. Some people have that much disposable income, some people don't, and if you want to focus again on the low income uninsured where most of the uninsured are, under 200-percent of the federal poverty level, only very small payments are consistent with the high level of voluntary participation, very, very small payments.

JOANN VOLK: And I think perhaps more or at least as important as the-percent of income that you might set it at is what counts towards that. It should not just be the premiums but all out-of-pocket costs because again, in a day of high deductible plans, just subsidizing a premium for coverage that doesn't actually get your doctor bills paid for is a problem.

GENE STEUERLE: Bob, I'd just remind you that if we're spending 16-percent of GDP on health care and well over 20-percent of personal income on health care, not everybody can only spend 10-percent, although again, that's not just insurance. I'm counting everything such as nursing home and Medicare, but the percentage is not just what we think people can pay but we have to cover the cost of —

STAN DORN: [Interposing] Right, but remember. Most of the health care spending is on a tiny fraction of the

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population, the sickest fraction of the population. So what people can afford out-of-pocket is something quite different.

JILL WECHSLER: Jill Wechsler with Managed Health Care Magazine. You mentioned some reauthorization legislation this year. Is there any viable possibility that any of these issues will be addressed in legislation this year or is this something that's really just going to be part of the long-term ongoing health care reform debate?

STAN DORN: Oh, I think it's very much up for potential action this year. The House has already passed the TAA reauthorization bill that would increase the percentage of the premium covered by the credit to 85-percent. It would end HCTC after 2009 because I think there are a lot of folks in the house that think that this has just been a failure and we should ultimately end it, but in the meantime let's raise the percentage.

In the Senate, Senator Baucus has introduced a bill, S-1848 I think is the number, that would also raise the premium percentage up to 85-percent. Senator Rockefeller has introduced a bill that would raise it to 95-percent. Both bills make other reforms as well and I wouldn't be surprised to see the Finance Committee marking it up over the next month or so because Senator Baucus has made clear to the administration that he doesn't plan to consider trade deals until TAA gets

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reauthorized. So I think there is actually a good chance of action on this, this year.

RAY RAMTHUN: Although the administration has threatened to veto the House-passed bill, so I don't know where that —

STAN DORN: [Interposing} They sure have.

RAY RAMTHUN: — leaves things in terms of actually getting it enacted.

GENE STEUERLE: I wonder also if any of you detect that there's going to be some conflict over who would be covered, certainly if the number of unemployed go up, is it a question of do you only get it if you're unemployed through something called trade adjustment assistance?

STAN DORN: yes, that's right, that's right. And the last time we had an economic downturn a huge question was would the stimulus package include help for displaced workers to buy health insurance? And they couldn't work out a deal. The President proposed a 60-percent tax credit. The Democrats in Congress proposed a Medicaid expansion and a COBRA subsidy and they could never bridge that ideological gap. I would hope they could have more success this time.

GENE STEUERLE: I think he's over here. I always miss the people in the corners.

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SUZANNE HAVILAND: This could be a — I'm sorry. I'm Suzanne Haviland from AFSCME and this could be a two-part, or could be for JoAnn or Janet, but one is that you mentioned that a lot of states had the option to buy into the state employee health plan and you said that there are reasons and you didn't want to go into them necessarily, but if you could specify what you think may be some key pieces there.

And a corollary question for Stan which was you talked about the fact that it would be potentially better for there to be more specification as to what kind of plans and how would that be done? Obviously there were some guidelines or some things that were set up, but those aren't necessarily working and I can imagine what some of those would be, but I would be interested to hear that.

JANET TRAUTWEIN: Well, I'll go ahead and start first. So basically a state employee plan or the federal plan for that matter, is an employer-sponsored plan. So that's the first premise that you go from. And any employer-sponsored plan the risk characteristics within the group are driven by the employees that work there.

They have a certain time that they're eligible for coverage. They can come in during annual enrollment or when they're first hired. They have a large employer contribution paying part of the premium. And so these things mitigate

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overall losses in any employer-sponsored plan, including a state employee program.

So any employer plan that has this amount of control over what the risks are because they're paying a lot and also because they can control who goes in and who goes out is very reluctant to let an unknown risk come into it. The state programs are no different than any other large employer plan which would have the same issues. And that's why it is.

Now some people have said, well, the way you get around that is you set up a parallel pool for these people. But keep in mind, and I know I've said it three times and I'm going to say it again, the costs within the pool are only as good as who's in the pool. And that if the pool is comprised primarily of people who have higher health risks or they're older, unfortunately as we get older our expenses are higher, then it really won't help with the costs that you sort of attach to them in the pool.

And so that's why the states haven't done it. It's just this basic reason they don't want — if they let these unknown risks in the pool they're concerned that it will drive up costs for the people who are already in their pool over which they have a little bit better control.

JOANN VOLK: I would guess, too, that the health insurers themselves would not, I mean they sort of get a —

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they'd certainly maintain more control in the mostly medically-underwritten options arranged with an insurer now, but I think they would have, if they put them in the state employee plan everyone would get the same premium. This allows them in the current situation more control to set prices according to who they think they're getting then at least the cross subsidization that you'd get in those pools separate or the same.

STAN DORN: And to answer your second question, I'll tell you what I would think about if I were trying to find a bipartisan solution to this issue given how much disagreement there is on what a health insurance plan should look like. You have some people that are passionately committed to high deductible plans. There are other people who believe that private coverage like what employers offer their employees is needed to provide good access to health care. You can tell from the objective and impartial way that I've put it which side of the divide I fall on, but recognizing that there is that divide I would think about saying why not require each state to make at least one plan available in each of those categories?

And if a state chooses not to do so have the federal government step in and make a plan in that category available. That way, workers in each state with the tax credit would have

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access to both high deductible and more comprehensive coverage. That's in the context of HCTC. More broadly I think it's worth thinking about an insurance purchasing pool with a range of different benefits from which people can choose. And with tax credits that are based on income that subsidize benefits and make comprehensive coverage affordable but to ask people to pay more money if they pick more comprehensive, more costly coverage.

RICK CURTIS: Rick Curtis Institute for Health Policy Solutions. Janet has mentioned a couple of times and it's just fact. The costs of people in a pool depends on what their risk profile is —

GENE STEUERLE: Pick up just a tiny bit.

RICK CURTIS: Okay. Oregon was referenced. They have a very well-run program which does run both a risk pool and a premium assistance program. The cost per capita for the premium for the people who are bought into the individual market are inexpensive because 20-percent of the applicants get referred to the risk pool.

And the reason is it's still very cheap for those people to participate in the risk pool because the percentage subsidy of those very high premiums is high. The total per capita is not low and that brings us around to the point of who does pay for the high-risk people? Now so far the comments

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seem to be oriented on what are the lessons for a voluntary market? And I'd like to ask whichever of the panelists wants to comment, what are the lessons for a market where we're covering everybody and where the low risks have to participate? So if any of you have a different observation about what the lessons are and how you would design it I would appreciate it.

STAN DORN: Well, if low risk people participate then the premiums come down for everybody. And so it's beneficial to encourage lower risk people to participate whether by mandate or by automatic enrollment mechanisms where you have to opt out if you don't want to get covered. There's a lot of ways to skin that cat but I think you're right and I think Janet's absolutely right. If you have a high-risk group of enrollees, not matter how you divvy up the premiums it's going to be pretty darn costly. So you need to get the good risks in there, too.

GENE STEUERLE: Stan, one of the issues that's been raised there is whether low income young people should subsidize high income older people for instance. How far do you carry that?

STAN DORN: Yes, of course. [laughter] As a high-risk older person I say, yes. [laughter] Your knees don't ache you can help pay for mine by golly. And it's interesting, the public opinion polls show people think you shouldn't be paying

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different premiums based on how old you are, how young you are, how healthy you are, how sick you are. I think people understand, number one have the sense that a market good — if insurance is a market good you should pay a certain amount for it regardless of who you are.

But second there's a sense of solidarity. I was once young, now I'm an old geezer and I'll soon be an older geezer, God willing, and by coming together we make life easier for those points in the life cycle when it would be pretty tough to do it on our own. So, yes.

JOANN VOLK: I've heard, I just have to say, we in our world have Taft-Hartley funds which are these funds that collect money from employers that are subject to the union contract and they jointly administer the funds to provide health insurance with labor and employer representatives. And whenever a young person stands up in those meetings and says, "Why are my premiums going up to pay for these older people?" Someone says, "Because your father's in the same plan," or "Your father retired from the plan," or "Hopefully you'll be retired from this plan in 20 years or 30 years." So solidarity may be hard to achieve more broadly but we get it at least in our Taft-Hartley funds.

GENE STEUERLE: Because we're running out of time, if you've had your hand raised, and what I'm going to try to do is

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go around. I think there are about two or three and let all of you ask your questions real quickly and we'll see how much we can get in the way of answers but I don't want to cut it off. If you had your plan raised already please give us your question real quick. But please try to keep it very brief.

RYAN OLSON: Thanks. Ryan Olson, Americans for Tax Reform. A quick question I wanted to throw out there is the way that these refundable credits score. They score out as both a revenue loss and an outlay. That creates a problem if you offset it with let's say capping the employer exclusion. Let's say you could end up with a net tax increase even though it looks like it's revenue neutral at first. That could be a deal breaker for a lot of Republicans. And if this is going to be a linchpin for trying to get health care reform through that's one thing that could really derail it. I wanted to comment on that.

RYAN HESS: Ray Hess with the Employment and Training Reporter. Some might argue that the health care tax credit exists as a training support enabling workers who have skills that are of diminishing value in the economy to engage in training during a period of unemployment so they have more valuable skills. I was wondering when you're talking about expanding health coverage looking at this model, how you would address that in a political argument?

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GENE STEUERLE: Did you already have your hand raised? Right here. Have I missed anybody?

MALE SPEAKER: I couldn't let the comment pass. We the younger generation are supposed to subsidize the, I don't want to point to anybody here, but —

STAN DORN: [Interposing] The old farts. [laughter]

MALE SPEAKER: Yes. So does that mean that the IRA that I've already started setting up I don't really need that any more because Social Security is going to be around in 50 years? I mean, you're telling me that I'm going to get the benefit of it but as far as I'm concerned I don't see any benefit 50 years from now. There's no guarantee on that and frankly I don't trust you guys. [laughter]

GENE STEUERLE: Panelists, please respond if you can. Did I miss anybody here who had their hand raised? Okay. So please respond to either of these questions or any last comment you want to make. We'll just go across the way.

RAY RAMTHUN: I'll just quickly — I think the comment about the potential concern on the budget side is real for some Republicans and that may be a factor that has to be addressed.

GENE STEUERLE: Janet, anything? Any last comment?

JOANN VOLK: We need to work on you, Paul. Basic social insurance concepts, right Paul? Yes.

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JANET TRAUTWEIN: Well I would like to comment to the last person because I think the whole issue of community rating, although it's the most wonderful idea that we can all ever hear of in fact we have — it doesn't work. The states that currently use it have significantly higher cost because people don't want to be in the system. And if we thought that we could really enforce an individual mandate and make everybody be in it might work, but I'm not convinced that we have a mechanism to enforce an individual mandate yet.

We haven't been very good with our auto insurance mandate, so I need a little bit more convincing in that area. And so in the meantime what I've observed over many years is that markets that do this the costs are significantly higher and the young people drop out. And I worry about that because it doesn't achieve the goal of what I think we need to do which is get everybody in.

STAN DORN: Well, we have community rating in a couple of contexts. You're right. In the individual market in a voluntary individual market it can be problematic. You're absolutely right, Janet. But 61-percent of non-elderly residents get their coverage from employers and we all pay the same premium whether we're young or old. Do you get your health insurance coverage from your employer?

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MALE SPEAKER: Yes, I do but for the four months after I graduated from college and before I got a job I was uninsured.

STAN DORN: Right. Right. Now during those four months you could have gone out into the individual market and gotten a, you look like a young, healthy guy, you could have gotten a pretty reasonable premium but you didn't. And now you're — and the employer — you're actually paying for the old geezers at your company because you and the geezers are paying —

RAY RAMTHUN: [Interposing] Don't make him drop coverage.

STAN DORN: — the same premium rate. Pardon me?

RAY RAMTHUN: Don't make him drop coverage. You completely ruin your argument, Stan.

STAN DORN: Yes, but you know what? If life goes well for you someday you'll be old with gray hair like me and you'll want younger people to be involved in that same insurance system. So the question is if we over time, if we can all say we're in this together and we're going to support one another then the thing can work. But if people say I'm dropping out right now then you'll be in trouble too when you get older.

GENE STEUERLE: Wait, what we'll do at the end of the session is we'll put the young people over here. [Laughter] The

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old people if they can make it we'll put on this side of the room here. [Laughter] And we'll continue the discussion. I'd like to thank our panelists. I think they did an extraordinarily well job and thank you the audience. [Applause]

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