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Alliance for Health Reform and ERSI:
Roadmaps to Coverage – Exploring Options for the Uninsured
Presentation
Monday, May 19, 2003

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ED HOWARD: Today we're going to look at something that I'm pleasantly surprised to note seems to be getting more and more attention these days, which is ways we might get all Americans or almost all quality, affordable health insurance. And the Alliance certainly has no higher priority than to help to foster this discussion.

Last Friday yet another democratic presidential aspirant, John Kerry announced his plan, his blueprint for expanding coverage. That puts him with several rivals in the company of having a comprehensive plan showing how they would respond to meet this pressing domestic challenge.

We explored a number of approaches that have attracted policymakers' attention in our program two weeks ago on this subject right here in this very room. And today we're going to let the analysts and experts, at least several very prominent ones, have a crack at the same topic. One of those panelists on May 5th pointed out that more Americans are worried today about paying for healthcare than are worried about paying their rent or mortgage or about losing money on the stock market or about terrorist acts. The question is will that concern translate into policy change.

Now our panel to help us explore that question is first rate and I'm really looking forward to that dialog. And I'd like to start by recognizing the President and Founder of ESRI, one of the most respected health economists in the country, Dr.

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Jack Meyer. Jack.

DR. JACK MEYER: Thank you, Ed and thank you and the Alliance for arranging for and hosting this fine event.

Three years ago my non-profit research institute got a grant from the Robert Wood Johnson Foundation to launch a program that we call Covering America. The purpose of this program is to lay out comprehensive, detailed blueprints to reduce the number of uninsured and increase access to health coverage, healthcare for many Americans and to do that across a wide spectrum representing the full range of philosophical and political thinking in this area. It's a non-partisan exercise.

In addition to commissioning these proposals, which resulted in the two books you saw as you came in and a third one will be published in September, we've also instituted a series of design briefs with the different components or building blocks of any health reform plan and published a series of papers on that. And some issue briefs that are timely that represent our commentary and technical assistance in areas that the Congress and the Administration are working on.

For example, we were very involved in some background briefings and issue briefs on the trade adjustment assistance healthcare tax credits that were enacted last year and continue to work in that area.

So we try to lay out comprehensive visions of long term reform, but also help Members of Congress and their staffs and

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people around the country in the states as they work on incremental reform. This project is guided by a fine advisory panel and many of you know some of these folks like Judy Feder and Mark Pauley [misspelled?] and Alice Rivlin and two of our panelists, Len and Bob and several others who have sat with us for three years and helped guide the work and review all the proposals.

The final point that I want to make is in many ways the most important. And that is we have been working with and the Robert Wood Johnson Foundation commissioned the Lewin Group in general, but more specifically John Shields to model all of these proposals, at least the first ten that appear in volume one and determine their impact on coverage. How many people would be newly insured? What would be the cost of that? How is that cost distributed, distinguishing between the federal government's costs, costs imposed on state governments or savings, and costs in the private sector. Now this would be probably the most heroic and ambitious example of trying to subject such a wide range of proposals to reduce the number of uninsured to the discipline of good modeling. And we anticipate coming out with John's volume in the next few months and making it available to people on the Hill and in the Executive Branch and around the country.

So again I'm looking to the dialog. I thank Ed and both senators for their hosting of this and thank you for including

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us.

ED HOWARD: All right, Jack. Thanks very much. I should point out there is in your materials an excerpt from the, I guess it's from volume two of the papers that Jack was referring to, the Green Reform Plan comparison. There is a chart that I find one of the most useful tools that I have come across in trying to figure out what the differences are between different approaches. What their strengths and weaknesses are. What you really have to come to grips with if you are going to talk about this in anything but vague generalities.

So let's get to our, to our panel. I apologize in advance both for the time we've allotted to them to expound on fairly complicated proposals and for the briefness in the introductions that they're going to get. There are biographical sketches in your materials that I commend to you. And I also want to send along the regrets of Uwe Reinhardt who is nursing something his wife is very relieved to report is just a very bad cold. Many of you know of the annual conference that he and Stewart Altman [misspelled?] host at Princeton each spring. This year it was last Thursday and Friday and Uwe was nowhere in sight at his own conference. And I talked to him this morning. He wanted all of you to know he was very sorry to miss the discussion. He also wanted me to pass along his conviction that until more people vote who are either uninsured or worried about being uninsured, mounting some sort of comprehensive

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solution is going to be very, very difficult. And, of course, he said that in ways that are much more memorable and eloquent than I can capture. But I thought I wanted to get that idea across and we wish him a speedy recovery.

Our first speaker is Elliot Wicks who is a Senior Fellow at the Economic and Social Research Institute and a Senior Consultant with Health Management Associates, a Michigan based consulting firm. Elliot specializes in the analysis of policy reforms to help bring affordable health coverage to more Americans, especially workers in small firms. He's an expert on arrangements of pool purchasing of health coverage. He recently directed a project to investigate the barriers of success, barriers to success, rather, of health purchasing cooperatives. He's got a wide range of experience in both private and state governmental sectors. He holds a PhD in economics and social policy from Syracuse University. And we'll hear from him not only about healthcare, but whether or not Syracuse ought to join the ACC. [Laughter] Right, Elliot?

ELLIOT WICKS: That's right. Thanks Ed.

I want to describe to you a plan for universal coverage that was developed by me and my colleagues, Jack Meyer and Sharon Silow-Carroll at the Economic and Social Research Institute. In developing this proposal we had certain objectives in mind. First of all we wanted to assure that we really had universal coverage and we see that as having two

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elements. First, we want to make sure that nobody is ever without coverage. And secondly, sort of a corollary to that that all providers get paid for all necessary services they provide. There is no uncompensated care in this system.

We also wanted to retain the best elements of the present system. For example, most prominently we wanted to build on the employer-based system that we already have. And we wanted to also use private health plans and competition among those health plans as a way of ensuring that we have some control over cost.

And finally, we wanted to improve the horizontal and vertical equity of the present system. The present system gives people different levels of benefit, that is those who are subsidized. Different levels of benefits depending on what state they are in, what program they are eligible for, and we view this as being highly inequitable. And we also wanted to ensure that the system was financed in a way that was fair. And we think that we have come up with ways of achieving both of those objectives.

The first task is how to make coverage affordable. Clearly that's the key problem for most people who don't have coverage. And we propose to do this through tax credits. These credits would be available to everyone, but the [unintelligible] of the credit would be based on income.

For example, those people below the poverty level would

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have a credit sufficient to buy the equivalent of current Medicaid coverage. People above the median income would also get a credit even though one could argue they don't necessarily need it but we're proposing to do that because we're going to take away something else that you'll see in a minute. We would give them a tax credit equal to the amount that they, that the average person above the median income now gets in the way of a tax relief by not having to pay tax on a premium contributed by the employer. That approximates a couple of years anyway ago; it did when we wrote this, seven hundred dollars for an individual and fifteen hundred dollars for families. So that would be the credit for the people above the median income. And then those that are between the poverty level and the median income would have graduated credits, gradually going from what they get for Medicaid equivalent coverage to what the median income people get.

Now because, in order to make this really truly affordable, you, you have to make sure that people have the money when they need to pay the premiums and we would, that would mean that we would make these tax credits advancable, that is be paid not at the time you pay your tax but over the year. And they would also be refundable so that if the amount of tax liability is less than the credit, people would still get the full amount of the credit.

As I suggested earlier, we would also change the

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present subsidy program that's available to everybody, that is the exemption of the premium paid by the employer from taxation, so we would make all premiums paid by employer taxable as ordinary income to the individual.

Because this program is designed to give credits to everyone sufficient to afford coverage, we would essentially eliminate the main components of Medicaid and the SCHIP programs because they're no longer necessary. Now obviously some elements of Medicaid would need to be retained. The long term care portion and other elements to deal with those who have special needs but the subsidy just to help people buy coverage would be eliminated because it's replaced by the credit of the, through the income tax system.

The second, after assuring affordability, the second task is to ensure availability of insurance. Therefore, to facilitate this we would require that employers offer coverage. Not that they pay for coverage that would be their choice just as it is currently. We would expect many to do so. But the requirement would be that everyone offer coverage. Since most people get coverage at the workplace this would make sure that everyone who is employed could get coverage through their workplace.

We would also require states to establish what others have called insurance exchanges. We've adopted that language because the language we used was not very, very felicitous. But

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essentially these are like purchasing cooperatives or health marts or other similar organizations that are, that contract with health insurers and then offer coverage through this entity, which facilitates the process of marketing and paying premiums and so forth, collecting premiums and then paying the insurers.

We would require that certain firms participate; namely the smallest firms, those with fewer than ten employees. And there are several reasons for doing this but the most, one of the most important is that these are the firms that are least likely and able to do a good job of purchasing on their own and this process allows them to have the kind of information to make better choices. And also because we need to make sure that we don't suffer from the problems that purchasing cooperatives have had in the past. They've never been big enough to really have critical mass to negotiate well and to be a presence in the market. And by having it all firms under ten we would ensure that happens.

We would also allow individuals to participate but they wouldn't have to. We would anticipate that many would chose to do so and we would also anticipate that many small firms not required to do so would also participate through the insurance exchange.

Large employers would be permitted to buy coverage through the purchasing exchange but they would be separately

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risk rated to ensure that the exchange doesn't become the victim of adverse selection by having just the high-risk large employers participate.

We would also require that insurers offer a, two, at least two kinds of insurance packages. One that was the equivalent of Medicaid and the other that was the equivalent of Medicare coverage with some additions that I'll speak of in a moment. And the reason for that will be clear. They would also be required to participate in the exchange if the state decided to include them. That would be the option of the state. They could negotiate and could exclude some if they wish to.

We would also require that all small group and individual market be subject to community rating of the purest kind. That is the only basis for charging rates different to families and individuals would be on the size of the group being insured. That is whether it's a small family or a larger family and the richness of the benefits. And this, the community rating would apply inside and outside the purchasing exchange to all, in the small group market – under one hundred employees – and to the individual market.

Now because we've eliminated the possibility for our insurers to rate on the basis of risk, we would need a risk adjustment system to ensure that those that got higher profile, higher risk enrollees didn't lose out on the process. So there would be a risk adjustment system to measure risk of the

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enrollees in different plans and then to compensate those plans with higher risks by having money transferred and those with lower risk profiles.

We would also have a centralized system for administration of this process and that would include at least the following functions - determining eligibility and for coordination of benefits.

Now the next question is how do we ensure universality of coverage. Well we would do this by having an individual mandate first. Households would be required to buy coverage and that would have to be equivalent to Medicare coverage but augmented with at least well baby care and a prescription drug element.

But we know that in spite of whatever we do to have mandated benefit, some people are going to fall through the cracks. They'll be between jobs or they just don't sign up. And we want to have a fallback system to ensure that these people actually have coverage. And we would, we suggest doing this with Medicare. That if you don't have any other private coverage you're automatically covered by Medicare. Now this could be FEHB or any other kind of mechanism you set up but we chose Medicare. And what would happen is, if you show up at the doctor's office or in the hospital emergency room or anyplace else for a covered benefit and you don't have a card that shows you belong to Aetna or Prudential or something else, then your

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provider is going to be paid by Medicare. And you, while you're not enrolled in Medicare, you're paid for by Medicare.

Now we want people not to just fall back into Medicare. We're not trying to get in Medicare for all on the back door. So we would require that anyone who is not covered for private coverage at the time they pay their income tax, have to pay a premium that's equivalent to the actuarial value of this Medicare coverage. And you pay that whether or not you use services or not. So you can't show proof of private coverage, you're going to pay for Medicare coverage at the actuarial value.

In addition we would impose a ten percent penalty above and beyond that actuarial value to ensure that people don't just choose this as their, as their source for coverage.

Well, this, these elements ensure universal coverage. No one ever doesn't get covered and all providers get paid. How would we finance this? Three things – first there would be some savings resulting from the elimination of Medicaid and SCHIP, both states and the federal government would achieve savings through that. We would also have the new taxes that result from the fact that employer paid premiums are now taxable income to the employee. But undoubtedly this would not be sufficient to cover the full cost. This is expensive. We need to just admit that. And we would propose to finance the rest of it through general revenues.

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We think this plan has a number of virtues. It's relatively simple. It's easy to understand. It provides mainstream care for essentially everybody. We do away with Medicaid and SCHIP. It has elements that should appeal both to conservatives and, and to more liberal people. And finally it achieves universal coverage.

ED HOWARD: And within your time limit, this is going to be easier than I thought.

Next up is Len Nichols. Thanks very much Elliot. Len is the Vice President at the Center for Studying Health System Change. At the center a major part of his responsibility is to make sure that the center's research actively informs the policy process in a timely and non-partisan way. He also conducts his own research centered on private health insurance and healthcare markets. He's held posts at the Urban Institute, at OMB. He's chaired the Economics Department at Wellesley College. He coordinated cost and revenue estimation for the Clinton Health Security Act and its congressional successors. And I'm pleased to say he has also graced a number of Alliance agendas much to our benefit. Len thanks for doing it again.

LEN NICHOLS: Thanks Ed. And I also want to thank Jack for talking the foundation into making this possible.

I will start by simply saying that you may have noticed we are all looking for something new and the basic rule is if you can't think of a new idea put new in the title. [Laughter]

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So what we have here is a new approach. We actually do think we do have a new idea and we'll try to, we'll try to convey it. And I want to make clear it's a joint product. This was started as Jack said three years ago. John Holahan, Linda Blumberg and I, colleagues at Urban at the time [unintelligible] and basically we've added Yu Chu Shin [misspelled?] along the way as the program got more complicated as we went along.

I want to remind you of the assignment. Covering America told us to think outside the box and dream big. When you get as old as me you can really dream. And it turns out at the end of the day this was being done at a time when our nation had large surpluses, which health policy analysts were salivating over with great glee. And so when you see the price tag on these things don't forget, we were looking at it at a time when we thought this actually might be affordable. It may yet be, keep dreaming.

The proposal is based upon three key elements. There are three key moral principles. It may be odd for an economist to use the word moral. I'll say two things. One – I don't have time to tell you about Isaiah but Ed's heard that lecture so I'll give it to you later.

And second, actually economics used to be called moral philosophy. When Adam Smith wrote, he taught moral philosophy. It may some day come back to that in another couple of hundred years.

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Anyway, the second concept here we have is realism about insurance markets. We think we understand them reasonably well and we'll go through why we think our proposals will work.

And third again the point, we expect there to be substantial new federal subsidies along with continued states subsidies; essentially the reflection of a collective willingness to pay for coverage that, of course, does not exist this morning. But as Ed pointed out in his opening remarks, there is increasing conversation about that and some day, some day, some day we may get back there. Okay.

The key moral principles on which we based our proposal are three. No person should have to pay more than x percent of income for their health insurance. Now we can argue about x. In fact, it's fun to argue about x. And we can argue about x for the rest of the day. But the point is there is some level at which in fact we all agree. It's just that at the moment we agree in kind of inconsistent and arguably stupid ways.

We agree, for example, that children shouldn't have to pay up to a pretty high-income level. We agree that women while they're pregnant shouldn't have to pay up to a certain level. But we don't agree about childless adults. We agree that medically indigent people; that is people who are really, really sick and have spent all of their money should be allowed to get coverage.

The point is, what we're searching for here is clarity.

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As you get as old as me you start thinking about simplicity. You start thinking about clarity. And fundamentally if we agree in principle that poor people shouldn't pay for healthcare, then I think we can agree in principle, there is some x percent of income below which people should pay nothing and some sliding scale should take that into account.

The second principle, and here is what I think is kind of a new thing but again I will submit it's an articulation of an old idea, no person should have to pay more than y times the standard rate. Now the standard rate in insurance parlance is not average. The standard is a rate that would be charged to your proverbial very healthy person. So the point is we think you can make the case that no human should have to pay more than certain multiples of that.

Again, we have that in place now in very inefficient and kind of patchwork ways. We have high-risk pools in twenty nine states, which is a principle that says basically if you get uninsurable we'll take care of you to some degree. We have again the medically needy program inside Medicaid which is again is a recognition of this notion. All we're saying is let's make it clear, let's make it simple, let's make it across the board, let's agree as a society what y is and for whom y should apply.

And the third moral principle is no one should be forced into any kind of health insurance arrangement against

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their will. And I didn't put here, but I should, by the federal government. Okay. We thought, we were actually asked to think about politics for a couple of hours in the development of this proposal. And a couple of us had lived through the Clinton experience, as Ed told you and there's a little bit of scar tissue remaining and so we basically thought, maybe it would be a good idea if we didn't propose federal mandates if we let Elliot propose that and let him take all that flak. Okay.

The operational principles are fairly straightforward. If you're going to try to do something like this, that is to say, full subsidies up to a hundred and fifty percent of poverty with a sliding scale to two fifty and the basic idea, if you go back to my principle of x percent, no one should pay more than x percent, what that gets you to is that no person should, would pay more than twenty percent of their income. If you take two hundred and fifty percent of the federal poverty level, that's about forty six thousand dollars, today a family health insurance policy costs about ninety two hundred dollars. That means if they had to buy it without subsidy, as they would under our proposal, which by all accounts would be considered a generous proposal, they would be paying nineteen point eight percent of their income for that.

So what we're doing here may sound radical. In fact, by today's standards, it's quite generous. But it still leaves people at two hundred and fifty percent of poverty paying

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twenty percent of income.

The second operational principle is to create a pool. We think of it as an insurance home, a place in which all people may buy an insurance policy at the community rate. The trick here, and here's our new idea, don't impose the community rate on the whole society. Just guarantee access to coverage at the community rate by using essentially general revenue funds to subsidize that what we call excess risk, that amount above which you would be charged by an insurer, but we don't want to force other people to have to subsidize that. So we don't impose community rate elsewhere in the society.

The third operational principle is federal share of subsidies would be enhanced. The basic notion here is to not force any state to go along but to offer them a deal we think they probably wouldn't refuse. And the deal is if you participate, we'll give you the SCHIP match. So fifteen percent bump up in your matching rate for all of Medicaid, which puts all that long-term care money, a lot of money into the system. And then you get the federal match for all coverage expansions that occur as well. So fundamentally one match rate, a whole bunch of federal money coming in, strong incentives for the states to play, and the states can then set up approval and run it according to their local preferences, which they would. We think the most natural mechanism would be to allow people to buy through the state employee plan, which exists in every

county, which already has a mechanism for collecting money, for accepting bids from insurance plans, etc. etc. etc. And is easily adaptable to small business and individuals who would want to buy.

The fourth operational principle, and I want to emphasize it, is in our view equity trumps target efficiency. The notion here is that if you deserve a subsidy, that is you make income below say a hundred and fifty percent of poverty, if you happen to be buying it now we think you should be subsidized. And this proposal would do that. It turns out, hello; this is a big surprise that costs money. It costs real money and we'll talk about that in a minute.

Okay let's talk about realism.

First point, of course, no mandates, no federal mandates. Again, we allow states to impose a mandate if they chose to. In fact, we would encourage them to do obviously through this kind of subsidy mechanism but no federal dictate will exist for the purpose of dodging all those bullets. We allow those who would prefer to do so to buy insurance outside our created pool. So again we give freedom. We give choice. If you can do better on your own, go do it. The trick though, if you want a subsidy for either income or excess risk, you're going to have to come inside the pool. We only give subsidies inside the pool. We only give subsidies where we can control the benefit package at a standard rate and only give subsidies

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where we can monitor all that stuff. We do not add regulations outside the pool so outside the pool you're on your own and we leave existing tax subsidies alone. Okay.

And the [unintelligible] that comes out as Jack pointed out; the Lewin Group is going to be releasing estimates of all of these plans relatively soon. But of course we and my colleagues at Urban are fairly impatient and so we couldn't wait for that. And we have a model after all designed to do this sort of thing. And so we played around a little bit and here's what we basically found.

About half of the uninsured would get coverage. About half of the people with coverage would enter, would choose to enter our pool that means half would stay out. About a third of the population that would be covered would end up getting this excess risk subsidy. That is to say they would be getting a subsidy for their risk above the average in the society. Most of the subsidy dollars would go to the already insured. And perhaps a point that's important to emphasize that I didn't get on here is the remaining uninsured would by and large be extremely healthy people. They would be people who voluntarily choose not to buy. They would be plenty well access to subsidies if they want them, choose not to take them therefore we must assume their willingness to pay is very low so we think the uninsured in our world would be very healthy, which has got to be the best group to leave uninsured.

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You would have a society with moral principles in place. You could realize that and feel good about yourself. And federal taxes would have to be raised, there's no question about that. [Laughter]

ED HOWARD: Excellent. Thanks very much, Len.

Our final presenter today is Tom Miller. Tom directs a research program at the Cato Institute that emphasizes expanding healthcare financing and purchasing options for consumers and for purchasers. He's written for such varied publications as the Wall Street Journal and USA Today, the Reader's Digest, and Health Affairs. And before joining Cato Tom spent fourteen years at the Competitive Enterprise Institute as Director of Economic Policy Studies and Senior Policy Analyst. Before his incarnation as a policy wonk, Tom was that lowest of low things, a trial attorney. Those of us with law degrees…

TOM MILLER: Plaintiff's attorney as well as defence I might add, malpractice cases.

ED HOWARD: We may have you back on another panel. He was also a radio broadcaster, dear to my heart, and a journalist. He holds a Bachelor's degree in political science from NYU and a law degree from Duke. Tom, please.

TOM MILLER: Thank you, Ed. I would mention that Duke originally voted against including Syracuse in the ACC. [Laughter]. Now since we don't compete in football anyway I

suppose we could bring the football program over to the Big East and then match up accordingly.

Once again I'm in the position of offering my common sense consensus proposals after these two radicals next to me. [Laughter] But I'm talking primarily about improving access to healthcare, not necessarily health insurance, by improving the value of the healthcare that we purchase. So I'll just provide some of the low lights and the details are in the chapter.

The core focus is on consumer driven healthcare, to rely more on that and to allow consumers to actually go in small terrain vehicles, which will be allowed to go off the regulatory road. This is based upon reducing third party payments, less early dollar coverage, and the core policy principles are tax parity, early savings targets, and more deregulation rather than greater regulation.

How do we get there? Incentives rather than mandates, market driven affordability, if we're going to have subsidies, let's have them out in broad daylight and be more transparent and I think we should target them because we don't have, we can only do so much harm and we ought to limit it.

There are some clear tradeoffs between relying upon greater safety net care, which has some reduction in demand for health insurance as opposed to some of the offsetting costs of subsidized coverage in terms of net welfare losses. So both of those have tradeoffs on either end, as well as positive

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upsides. But the basic idea is to move toward some evolutionary principles rather than revolution in order to fit in with our broader political culture.

So that's the basic roadmap which would steer consumers toward market driven healthcare, as opposed to going around in the circles of traditional tax and regulatory subsidies because, as my healthcare policy guru would always say, Laurence Peter Berra, otherwise known as Yogi, if you don't know where you're going you might not get there.

Financing always starts with tax policy. And the core reforms here are to move toward tax parity. You never get exact parity but you can get a lot closer to it. I'm talking about more horizontal equity. Not vertical equity because the healthcare elevator will always stop at different floors. There, however, is a need for a binary option, not to blow up the employer-based system. So you basically have a choice. If employer provided coverage is available to you, you continue to take the tax exclusion under the tax code. But as an alternative either for folks who have access to that coverage or those who don't have that coverage, a thirty percent individual tax credit could be applied against the cost of your purchasing health insurance. It would be a proportional tax credit without a fixed dollar cap on it. That tax credit can be used to leverage other reforms with a bit of a bias toward catastrophic coverage and also some other tax reforms would be

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involving boosting some individual savings vehicles to fill in the holes around the insurance coverage, whether they're MSA's, FSA's, HRA's, VC's – name your letter in the alphabet. The idea is to put them on a common platform and treat them the same to incentivize savings for your long-term healthcare.

Why not refundable fixed dollars tax credits? Well I have some concerns about the implications of that for overall tax policy and welfare policy. And besides at the time I was writing this Mark Pauley [misspelled?] and some others had already ploughed that field about as well as it could be done. So as Yogi would say, if you can't imitate them don't copy them.

The insurance reform tie ins, I operate in a bit of a parallel universe in this regard so that I would not bend the prime directive of libertarianism, which is don't just do something stand there while the market and civil society works their wonders. So instead you can kind of tie this additional tax credit, without disturbing anybody's prior choices, to insurance, which would have the option of preempted state mandates, out of state regulatory reciprocity treatment. I'll have more on that at the next slide, and also some greater flexibility for the right kind of voluntary purchasing pools.

Those voluntary purchasing pools are needed to give people somewhere to go if they are not going to an employer sponsored health plan in a market which may not be pure

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individual insurance but will be another way to kind of group people together. The key element in there is to get away from the bias of always community rating these type of pools upfront but instead to allow some front end risk rating for the first couple of years until the durational effect wears off, and then provide a longer term risk redefinition protection for those who stay within that pool.

You can go at this a couple of ways in terms of either long-term contracts with exit disincentives to keep people in the pool. Or the alternative is to; if you're willing to stay with the same insurer, go in the direction of kind of what is called incentive compatible guaranteed renewability protection. It's kind of a two-tiered insurance premium, which does a lot of that protection against risk redefinition.

But there's a clear tradeoff here. If you want to have a broad shopping market you can go from one insurer to another every year. It's going to be harder to provide that type of long-term protection against risk redefinition without a lot of complexity and side payments.

Now I mentioned before the deregulatory competition, which is sometimes called competitive federalism. Ernest Fletcher, the Congressman from Kentucky has a bill from about a year ago on cooperative governance, which isn't quite as Darwinian as I would like, but it's pretty close. The idea is to have Reagan product regulation allowed to be done by another

state for consumers in a different state. You would keep consumer in the home state of the person buying the insurance. This is to have in effect market driven competition in state regulation and as I like to think of it, a race to the market top rather than a dive to the rent seeking, regulatory bottom.

There are a couple of ways to do this, whether it's through a straight legislative provision, which has some political side effects or to have some contractual fixes, primarily relying on choice of law and choice of forum clauses.

Now what about everyone else who hasn't bought their health insurance? Well, this is a time to in effect defend and bolster the healthcare safety net. Again, there's a tradeoff. There's a slight reduction in the demand for health insurance if you have access to safety net care. But it's not that tremendous. It tends to affect more of the offer rates by insurers and the take up rates by the uninsured. And again you're balancing this off against some of the welfare loss effects of over subsidized insurance coverage in terms of raising the costs of health insurance for the people who don't have as many resources.

The other thing is, when you look at the market for free care and some work on this. There's a lot of parallels between charity care and what in effect is a means tested, high deductible insurance policy. Since I like that in general it seems like let's have more of the same through the safety net

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if we can't get through it another way. So that's kind of making a virtue out of necessity.

Now we need to bolster the safety net and I say put it both on steroids and also do a little surgery to prune the excesses around it.

Len mentioned the high-risk pools and they certainly can be strengthened. That's primarily a matter of money. Since I wrote the original proposal the feds have dived in with a little bit of money, about a hundred million through the Trade Adjustment Assistance Act. There's a danger of attaching too many conditions to it but in general we need to get some revenue into play on this. What, by having those high-risk pools, you allow the rest of the private health insurance market to operate more efficiently and do what it does best while in effect carving out the subsidies for those who are the uninsurable.

The other way to cut and bolster the safety net with a wild card is to adopt what I call citizen appropriations. These are in effect redirecting your tax payments through tax credits so that you can send them to, in effect, providers of charitable healthcare for the uninsured. It would have to operate through third party non-profit broker so you can designate your own designated beneficiary. But this is somewhat of a bolstered, a bigger model of what's been done in Arizona in education through tuition tax credits that can be done in

effect through charitable individual contributions.

And in effect I'm saying it's a put up or shut up. If we cared that much about the uninsured and it's not going to cost us that much as taxpayers to redirect the federal spending, let's go ahead and let people vote with their own tax payments to do it. If it turns out they don't want to do it then I suggest the political demand for this type of subsidy may not be as great as it's assumed.

We also need to kind of in the safety net rethink a bit about MTALA. I don't have a lot of time to go through that so I'll skip on. But it allows me to at least get in my two blind from Yogi on the next slide, which is about emergency room care. Nobody goes there anymore, it's too crowded. [Laughter]

Now Medicaid reforms, the idea is to get into more patient directed Medicaid. It will be a slow process. I've talked about some opt out waivers or vouchers as a way to get in that direction. We've seen some early signs of this being a positive way to go in the more limited area for disability with the cash and counselling waiver experience. And it needs to be expanded to other areas of Medicaid. We want in effect a private crowd in of the market for healthcare out of Medicaid into the private sector as opposed to the exact opposite way it tended to occur in a lot of the 1990's. And it might allow the flexibility for some types of incentives that are not allowed under the traditional Medicaid coverage to in effect allow the

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low income uninsured who get the alternative to Medicaid to optimize their coverage and save some money for the long term.

The real issue I want to get with is why to do this. What are the politics of access to care and the uninsured? You have to recognize that even if there's a momentary surplus a couple of years ago, it will be a deficit in the future and it is now. There are resource constraints, and not only that but that's a bunch of dollars that are flying elsewhere. The money for the uninsured is long since gone away. I had an original version of this with a dancing deutschmark, which I took out for, since Uwe wasn't here but my one attempt at competitive PowerPoint but I couldn't get it to spin around.

Public subsidies are the other part of this, no matter how much money you throw in, in terms of public subsidies they don't catch up with the rising cost of healthcare and in fact some of those public subsidies boost that cost even higher. There are old studies of price and welfare effects and subsidies for healthcare merely to a lower base but you're talking about twenty to thirty percent in effect being put into the cost of the care rather than its improved value or the quantity available. And in addition, it's important to remember that as those costs go up the folks who get hurt the most on the margins are the low income people who can't afford to pay the highest priced care that you may set in motion by throwing more dollars at the same issue.

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In addition, those middle class minimums, which were done on the regulatory side, price out the marginal lower income buyers. It makes us feel good in the middle class. We don't have to sort through inferior and better healthcare, health insurance but it's a lot tougher for folks who don't have many dollars to spend.

The rest of the politics – you know, we are still seeking some cost containment alternatives in the post-managed care world. Since we've run out of remedies on the supply side for the moment I am suggesting let's take a look at the consumer demand side.

We also have to kind of in setting those priorities for what we're going to do with out limited healthcare dollar; it's time for a bit of a triage. We need to first deal with the most urgent medical needs and that ends up being the folks who have a serious condition and need care right away.

Second down the road are the chronically uninsured, but well below that in effect the folks who would just like some dollars in order to buy some healthcare – a limited benefits policy you may have seen profiled in the Wall Street Journal last week. That was my alternative proposal for universal coverage, which is five dollars a year for everybody; they're at a thousand right now. But those don't really do much although if you ask the folks who are low income, they'd probably prefer to have the bird in the hands in the more

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catastrophic coverage without assets to protect.

But in all of these types of proposals you have to keep in mind that there are limits on trying to do a lot of good, which is if you coerce that compassion too much in a voluntary market it short circuits and in effect people drop out of the insurance market.

So will any of these proposals go anywhere? Well, we'll at least try them out with two parting observations from Yogi. The first is we don't know whether they'll take it but they should at least take a chance to look at it. And then also by aiming lower we might hit more of the target.

Now in summary on terms of what I'm proposing, key is to separate income redistribution goals from goals of improved insurance market efficiency and better value, to leverage market based reforms to make limited coverage more affordable, and new competition out there in the field for both employer sponsors so that the employees who may not want what they're offering can go somewhere else without having, paying a tax penalty, and competition for state regulators, no longer a geographical monopoly in bad state insurance regulation. But the political rule most of all is you strike the cost, you join the poor but feed the middle class first.

So in parting, when will we achieve this magnificent goal of universal coverage? My prediction would be [Laughter]. Thank you.

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ED HOWARD: Okay. Tom, you've given us a lot to think about. And…

LEN NICHOLS: Can you make a pig up there? I think that's good. Make a big pig.

ED HOWARD: If I can, Bob will bear with me, I wonder if I could actually ask Tom to, to circle back. We made you go at about, you know, mach two to get through that presentation. There are at least a couple of things that I think some of us would not mind having a little clarification about. So if you could do it briefly.

One of them is risk redefinition protection.

TOM MILLER: Basically when you're young and healthy you say I don't need that much of a policy. It doesn't cost me very much. That's what I want to buy right now. However, there's the uncertainty that at some point in the future, it could be near, it could be far in the future, your health will change. That's why you would like to have it. Well, sometimes it's done through guaranteed renewability. The other way is to in effect have a second element to your premium, which says you are buying true insurance protection against the unexpected, the uncertain case that your healthcare cost would suddenly be much greater than you envision today.

ED HOWARD: Very good and secondly, MTALA.

TOM MILLER: That's the emergence. No, I was going to say…

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ED HOWARD: You don't need to come up with the words but what does it mean?

TOM MILLER: Emergency Medical Treatment and Active Labor Act. It's the act of labor that always made me wonder what the passive version was. It was passed in the mid-1990's, I guess that must be a think tank person would be passive labor. It's in effect a mandate that if you present yourself at a hospital, just about every hospital, it's largely through Medicare dollars, that they required to screen, stabilize, and treat if it's extreme. It's gone a little bit far on the regulatory mandate and, from what the original goals were.

ED HOWARD: Okay, thank you. Thanks for that clarification. If you have other questions we are going to have some, a vigorous and generous Q and A session time reserved so we'll get back to that.

Let me turn now to our commentator for today. Bob Helms is a resident scholar and Director of Health Policy Studies at the American Enterprise Institute. He's written and lectured extensively on health policy and health economics and pharmaceutical economic policies. From '81 to '89 he was Assistant Secretary For Planning And Evaluation and Deputy Assistant Secretary For Health Policy at the Department of Health and Human Services. He holds PhD in economics from UCLA and in Uwe Reinhardt's absence; he's volunteered to offer comments on the uninsured from both his and Uwe Reinhardt's

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point of view. [Laughter] Right?

BOB HELMS: I did?

ED HOWARD: All right, Bob thanks for being with us.

BOB HELMS: And thank you, Ed. I am the economist that on the original schedule was scheduled to follow Tom Miller and precede Uwe. You know, that's not something anybody would wish to happen. But anyway let me just start out, as you all know, I'm no Uwe Reinhardt when it comes to public speaking. But I will tell one story about Uwe. It was back in about twenty years ago in the 1970's. He came to an AEI conference. It wasn't one of my conferences. It had to do something with economic policy. And I don't think he particularly wanted to be there. And so he said he wanted to quote that great American, Benjamin Franklin who said, "A conference missed is a day earned". [Laughter] So all of us that attend all these conferences, I thought would appreciate that.

Let me also say that I've enjoyed serving on the advisory committee for the Covering America project these, has it been three years Jack? I guess it has now. And I've learned a lot from a lot of smart people. A lot about the details of this and it was even more complicated than I thought. All of these proposals, what you've seen today is three out of thirteen that have been developed in the Covering America project. And all of these are intended in one way or another to expand coverage to a larger proportion of Americans that are

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now without health insurance. And to illustrate a range, not just a range of philosophy, but a range of tools and so on that can be used to increase this coverage.

But they also illustrate a range of objectives. In other words, different people want to get to different places with this.

And so I want to raise some issues about, I hope it's directly related to the three presentations you've heard, but I want to raise some issues about objectives and sort of where we are headed with this.

The word roadmap is as you know in the news this week. It seems to be both domestic and foreign policy. And I am a person that loves maps. I think they give you a perspective about where you are and where you are going and so on and they can be a lot of fun to work with. But all of us have the experience you know when you have a good map and you know where you're trying to go that you have these tradeoffs. I mean you can take the most direct route, the fastest route, the most scenic route or in a certain sense the most efficient one. And we're used to making these tradeoffs. And I think in a sense we have a kind of similar problem with health insurance.

But my concern here is that the politics of healthcare I think is going to prevent us from achieving the kind of health reform that I think would be best for patients and for the country. And I'm glad that Tom Miller reminded us that the

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objective is not just health insurance, it's the health well-being of patients that we're, and the population that we're concerned about.

Now let's look at the objectives of health reform. When you look at the political activity around health reform it, you can classify it in several different ways. I see a lot of advocacy for coverage with the emphasis on the poor, the sick, and those without health insurance. Our good friend, Karen Davis always reminds us of this every program she's on. We see a lot of concerns about equity and fairness. And even Uwe has raised these issues in the past among others. And you will also, especially in the Congress, see a lot of concerns about the cost and the federal government in fairness to taxpayers and other people who are getting benefits from the federal budget.

Now all of these are, I think are legitimate issues. My assessment is that the Covering America project has provided Congress with the tools for designing new health policy. Whatever we want to do there is a lot of good information there about how to do it. And so the politics of this is primarily now I think an issue of commitment. As Len said, we started this thing when there was a lot of surpluses and that's not the case now. But I did hear a Republican pollster a couple of weeks ago comment that in all of his polling and focus group work and so on, he saw that instead of this being a dying

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issue, just the fact that all of the Democrats are going to run on trying to expand coverage is going to mean it's going to be an issue in the presidential election. Now I'm not a political expert. I'm just telling you what other people are saying.

But I am an economist and what I want to really say is I think that something's getting lost in this debate. In other words, I want to remind people it helps to know where we're going if we're going to use this roadmap. And that concept is what I would call economic efficiency. Now all the economists in the room are groaning because they know where I'm going with this. And it's understandable that that's sort of getting lost in the debate because it's hard to define it and not even economists can agree on just what it is. But I do think most economists are trained to have a basic understanding of what's meant by the concept of economic efficiency.

And I might add I was expecting Uwe to be here. He's written a quite thoughtful article about this, raising some issues about why economic theory is not decisive about sort of defining economic efficiency.

But again I would argue that I think we know enough about how to get the economic efficiency to keep it in mind as a concept that we should achieve here.

So basically I would define it in a very crude way is saying what we are trying to do is create the right incentives for all the players in the market or if you don't want to call

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it healthcare, a market. All the players that participate in this activity in any way you want to define it.

And I would break those down to consumers. We are trying to create incentives for consumers to seek value when they are purchasing healthcare. Now this does not mean they're just out there looking for the lowest cost. They're looking like they do in every market, cars, TV sets, whatever or personal services, you're looking for value. The things, the people, the commodities and so on, the services that you want and those that provide you with value. So that's a combination of both quality and price. And it gives consumers strong incentives to seek good information about choices and the ability to make these choices in the marketplace.

Now the providers, and here we're talking about physicians, hospitals, all the companies who supply materials to this market and so on including the specialized forms of labor, nurses and so on. Here the incentives to should be I think to first of all strong incentives for those providers to respond to consumers like we have in most other non-health markets. Incentives to compete on the basis of value, meaning the quality of medical care and the quality and convenience of the service provided, and also the incentives to do research, I don't mean pure research but market research in some cases about what's medically effective and what's cost effective. And of course let's don't leave out insurance companies, these big

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third party payers and so on that they have incentives to design efficient types of insurance and efficient risk pools and so on.

So if we get the incentives right we're going to create markets more like those that we see in the non-health markets so that consumers have lots of good choices and the suppliers are focusing on producing what consumers want and the competition protects the consumers from monopoly pricing and you have strong incentives for suppliers to use the inputs efficiently and strong incentives for those people to do research.

But I'm the first to admit that healthcare markets are different from other markets. There is, I like Len's term, the collective willingness of people to provide healthcare for others. I do think there's a strong desire on the part of many voters to protect the poor and the sick. This was a historical role of the church long before the governments got involved in this and I think it illustrates its collective willingness. There's a large role for insurance and third party payers that, as Tom Miller was talking about and this of course is a large government role which introduces a lot of political incentives for politicians that run counter to economic efficiency. And then you have a number of different types of provider cartels and market power that raise prices and prevent the protection of market, for market entering competition.

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Now there's little chance that we're going to eliminate the politics from health policy. But keeping the objective of economic efficiency in mind I think could help achieve those other objectives of coverage, equity, and fairness. And to do that I think we have to adopt plans that increase choices of consumers that eliminate some of the distorting influences of tax policy. In other words, the way we have the tax exclusion. I could talk more about that but there's not time. That increase real economic competition in the provider markets, and that take the reward away from politicians who want to use healthcare, quite frankly, as a way to buy votes. And, in other words, return these decisions to the competing private entities rather than government agencies. In my view government regulation is inherently arbitrary and subject to political influence. And it will never really, it's almost impossible to promote true economic efficiency just through government regulation.

So there's no superhighway to economic efficiency but having a better idea about where we think we should be going I think will make the roadmap a lot more useful. Thanks.

ED HOWARD: All right. Thank you Bob. Let's, let's get to a discussion.

[END TRANSCRIPT]

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