

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

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ED HOWARD: As I mentioned there are floor mikes to which you can repair if you have a question you want to write down, finish writing it, hold it up, and a member of the staff will get it from you and get it up here.

Let me begin the questioning if I can seize the prerogative by picking up the thread of a couple of comments up here and also from one of the pieces in your materials. There is an excerpt from the Institute of Medicine Report actually requested by Secretary Thompson last year that lays out some potential state level demonstrations that would move us closer to universal coverage, if not to get us there. And I also note that in states as different as Maine and Maryland and even in California where there is a budget deficit the size of Orca the Whale, there are serious discussions about universal coverage plans of various kinds. I wonder if any of the panelists would like to speculate on whether or not that's merely campaign rhetoric or whether we're going to get somewhere with any of those, or more importantly whether there is anywhere positive to get with some of those initiatives. Len.

LEN NICHOLS: Well, I would start; I mean I want to avoid Orca as long as possible if I could, but I would start with the Secretary's initiatives to the IOM. It seems to me that a lot of people thought that was a very good idea to essentially offer the states cooperation with whatever the states wanted to do. To me that's consistent with the spirit of

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this entire endeavor and with a lot of others that are actually going on around town. To try to give the states a series of models that they might want to adopt. The problem is of course, and now we're back to Orca, the states are out of money rumor has it. All states are broke. Some states are more broke than others but at the end of the day what they're doing at the moment is trying to do triage on their own Medicaid programs. The amazing thing, at least from my perspective, is if they have managed to pretty much hold on to most SCHIP coverage, at least kids, they're cutting back some on parents, they are cutting back around the edges on Medicaid. In some places that edge is deeper than others. But by and large Medicaid has been relatively protected from the budget cuts compared to the magnitude of the state budget that Medicaid represents. Now that's all up to this year. I think next year it will pretty hard to hold that down.

But the point is there's no state money. Therefore all new money has to be federal and rumor has it federal government now is in more deficit than they were when Secretary Thompson encouraged that Blue Ribbon panel to go off to Woods Hole to come back with these ideas. So I think we're stuck in the absence of money of real coverage expansion alternatives.

As to what they're doing in California, talking about universal coverage when they have a thirty five billion dollar deficit I think it has to do with things that get smoked out

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there. I don't know what, what [Laughter]

ED HOWARD: Only if medically necessary. Anybody else? Actually one of our questioners has a comment on this topic quite coincidentally, a slightly different view. There have been numerous references to state based coverage expansion efforts. Many times this state approach is a way to avoid the use of federally mandated in terminology. Why continue an already erratic quilt of Medicaid and state run programs? Why not just do this once?

So a similar conclusion perhaps but maybe...

TOM MILLER: The simple answer is it's better to have fifty small mistakes than one really big one. [Laughter]

ED HOWARD: Well, oh, go ahead.

ELLIOT WICKS: Well, our view is that exactly consistent with the questioner's implication. We think that's the way it should be done. Inevitably, while certainly Tom is right that you have the danger of doing something bad all over, everywhere. But inevitably when you have states doing their own thing, you have huge inequities from state to state and it's bound to be affected by whatever happens in each state and states are more subject to economic swings than the country as a whole.

ED HOWARD: Okay. Yes.

GLEN PEARCE [MISSPELLED?]: Thank you.

ED HOWARD: Do you want to identify yourself and keep

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your question as brief as you can please?

GLEN PEARCE [MISSPELLED?]: My name is Glen Pearce [misspelled?] with the National Association of Free Clinics. Mr. Helms has referenced that history shows us that society when it takes on problems like this often has a three pronged approach with public, private, and non-profit issues and answers. Mr. Miller has also referenced the charitable care.

I'm wondering based on history, what the other two panelists see as the role for free clinics and charitable volunteer efforts in the community in trying to be a component of what you're doing. And if so wouldn't it be wise to begin to look at the issue from the beginning?

LEN NICHOLS: Well, maybe I would start just because of, my proposal's kind of closer to the spirit. I mean Elliot takes care of the problem with universal coverage.

Basically our view is Lord knows we need those many flowers to keep blooming. I mean our proposal was going to cover roughly half of the uninsured. We think we would pick up the sickest half. So the tremendous burden that you take care of for us every day should be reduced somewhat. But at the same time they would always be, in a world without mandates, you're going to have a lot of people who choose not to purchase health insurance coverage but they still will get sick. And when they get sick they do of course come to the safety net.

There are a lot of ways to think about strengthening

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that safety net, most of which I think can benefit from Bob's discussion of efficiency. We can do it better than other alternatives and I'm talking now about using appropriate primary care and not using the ER any more than you have to. But at the same time that too will require, as you know quite well, an infusion of dollars and in my mind at the moment those dollars have to be federal. So I would applaud the President's initiative in the budget to expand and strengthen the safety net community health centers, etc. but just note it cannot be the only answer or we're never going to get to full access to care.

ELLIOT WICKS: Let me just add, if you go to Canada or the UK or some people who claim to have universal coverage or even some of the other countries, you're still going to find a lot of effort by I think small community groups and so on. When people get sick a lot of people need a lot of help. And they don't always have families around to do it and that sort of thing. Churches everywhere I know play a big role in this and regardless, even if you have a system of universal health coverage I mean all that is, is a coverage policy. It's not a substitute for a lot of the kinds of things you know that you really see in communities.

TOM MILLER: I'd just add that the key role probably for the free clinics and the subsidized federal clinics is in primary care. And not only in primary care but providing an

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access to some special populations which may either not be as prone to or as comfortable dealing with the regular healthcare system. We've certainly see this with a good number of the recent immigrant population where having somebody you know and are comfortable with in your community will actually deliver more care to you than having a paper insurance card, which you may not know how to maneuver through. It won't deal with every type of complex life threatening illness, but it can clear out a lot of the necessary education, as well as initial care that's desperately needed at that level.

ANNE NEILL [MISSPELLED?]: Hi. I'm Anne Neill [misspelled?]. I work at Georgetown University's Center for Clinical Bioethics. And I'd like to have a little exchange between Mr. Nichols and Mr. Miller. I appreciate very much, Len, your starting out with moral principles because I think very much this whole health crisis issue and how we improve it is at it's heart a moral issue. And if I look at your first two moral principles can I assume that even a prior moral principle, implicit at least is that it is a good thing, it is a value for everybody to have ready access to healthcare and therefore they should have health insurance.

And I don't want to put words in Mr. Miller's mouth, but as I listened to you it didn't seem to me that that was a value or a principle that was at the basis of your proposal. And if I'm right, I would be interested in a little exchange

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on, a little moral discourse on that issue.

One seems to value universal access, ready access to all, for all people. One seems not to. Could you defend your respective positions?

ED HOWARD: If indeed those are your respective positions.

ANNE NEILL [MISSPELLED?]: I think moral discourse is real important.

TOM MILLER: I think I was starting with the idea that we should first have a system through it's many different branches and tributaries which allows healthcare to be as high value at as low a cost as possible without the multitude of policy distortions which have moved us away from that.

Now there are many ways to get healthcare. The primary one, which most people will rely upon is health insurance and that can vary in the degree to which you purchase that health insurance. There are other ways in which people can engage in a cash market, personal savings, access to charity care, which can provide that as well. Not as much as if you had more comprehensive health insurance. But there's a separate debate here which is how, what do we believe is the social minimum that we guarantee to individuals in terms of their command of resources that they don't have on their own. And I think we ought to determine what that is before we decide that anything called healthcare necessarily drives that forward before we've

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sorted out the initial proposition.

In general we've decided that not everybody in society is entitled to the same amount of money regardless of what they earn. We may decide that certain individuals are necessary, merit income support. But we went through welfare reform in the mid 1990's, which suggested that less might actually be more in that regard.

I think that the collective willingness of the public is to have other people pay. That's what the consensus is. Not that they're willing to pay for other's healthcare.

ANNE NEILL [MISPELLED?]: I guess I'm asking the simple question and maybe Len gets it and I don't have to say any more, but could you look at somebody who could not afford healthcare in the current situation, does not have ready access to it, and say, "Tough luck. You have to wait until the market makes it possible for you to have it." But Mr. Nichols you engage with me.

ED HOWARD: Let somebody else answer that. Thank you.

LEN NICHOLS: Well, great question. I think it is true that you have to think, start by thinking about what is your definition of a just society. I would go on and say, what's your definition of a strong society. What Isaiah was worried about by the way was the poor wouldn't fight for the king unless they all were taken care of, which is why I use the language defend the fatherless, plead the case of the widow. He

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was talking about sort of you know twenty four hundred years ago or something but that was the language he used.

The notion is people have a basic right to opportunity in our society. And I think it's true that healthcare access is an element of that fundamental core set of preconditions for realizing one's potential. Tom is surely right and Bob is too and I'm sure they're coming about as quickly as I can get off this mike that that doesn't mean you guarantee what you might call a Cadillac plan for every human being with no cost sharing. It does mean you guarantee access to primary care, access to appropriate secondary care, and access with appropriate incentives across the board. Actually these guys would agree with a lot more of that than you might think as long as we could do it efficiently.

I would submit though we have a first order problem to solve and that is to make sure that everyone has access to necessary care that is demonstrably clinically appropriate. And we haven't done that yet. We've done as good as you can do. The amazing thing when we go out there as we do in the Center for Health System Change and as Irv and other people have discovered, out there in the real world where real [unintelligible] exist, people are doing amazing triage every day. What you want to do is give more Saint Teresa's more money because they, they do such a good job of allocating money, you may be better off just giving them money and getting out of the

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But I would submit we don't have that guarantee when you have situations where forty million are without coverage. We basically start with coverage because we think coverage is the simplest way to guarantee access. It's not necessarily the most efficient. Not even necessarily the wisest. But it's certainly one that would start the conversation.

ED HOWARD: If I can sort of extend this in a very practical way from one of the questions on a card, a universal coverage system, the questioner writes, would have to have some type of standard benefit package. However, what type of benefits would it include? Who would decide that? With America's so called bleeding edge mentality and a consistent demand for the latest and greatest procedures and products how could a standard benefit package be palatable to American society as a whole? Can we do that? Elliot.

ELLIOT WICKS: What we suggested was that we start with the Medicare benefit package. Now everyone recognizes this is old, it isn't really up to date, and it isn't adequate. But our view was let's make it adequate and let's make it up to date. How can we justify getting a more comprehensive, a better package for people who are under sixty five than those who are over sixty five? If it's good enough for them why shouldn't it be good enough for the rest of the population? So we need to reform that system.

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But starting there also has a political advantage that you don't have to fight all the battles over again. We've already fought some of those once. So we suggest that that's a place to start. Obviously, it's not the place to end.

ED HOWARD: Tom.

TOM MILLER: Well, this exposes the thin and shallow consensus that we're all in favor of universal coverage except we don't agree on what it is and we can't kind of determine what the ceiling is as well as the floor, or maybe even the walls to either side.

There is an elasticity in the wrong way of what we call medical necessity. Today's necessary healthcare coverage is we can do more is going to climb up and up and up. There's also an interactive component in what Elliot is suggesting, which is if we define that minimum coverage is Medicare I'll guarantee you that Medicare coverage starts getting more attractive and more elaborate because as you, and in fact increase the lobbying for both sides to win although both want to cut and raise the level so that we have a great political difficulty in our society in setting political floors and political ceilings for social entitlements.

The other way to do it is to deal with in effect a categorical standard, which is if your life's in jeopardy, you've got a serious illness, we're going to treat you. We do that now. We did it before probably Hill Burton and before

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MTALA and we continue to do it in the future and then worry about how to pay for it later on.

We would also, if we relied upon a deeper tradition of civil society, we would recognize and most of us are pretty generous caring people when we're actually thinking about kind of our fellow citizens. But as soon as we route it through the political process where we think that someone else is going to take us off the hook and it's coming out of their pocket, that generosity is somewhat misguided from what our true heartstrings would tell us to do.

ED HOWARD: Len or Jack.

LEN NICHOLS: I would just offer that the benefit package is a difficult thing but that's precisely why I want clarity in what our subsidies are. Go back to my x percent and my y times; no human should have to pay more than y times the standard rate. Whatever society is willing to pay for is the level of benefits you should support. I would submit at the moment it's very difficult to elicit that understanding because our system is so Byzantine and our subsidies are so, so well hidden. And they're so well hidden they're disappearing I might add. Because fundamentally what's going on is a lot of the cross subsidies we've used have been hidden from people are becoming more and more expensive to maintain.

The fundamental problem here is that healthcare costs are growing faster than wages. And so an increasing fraction of

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our population, there's no other way around this, is finding it increasingly difficult to pay for what all of us would agree is a standard package of goods to which at least most of us have access now.

The Medicare package is actually quite parsimonious compared to what the employer sponsored average is. Because it doesn't have drugs and it doesn't have an out of pocket limit.

I would submit though you pick your subsidy scheme. I would offer mine up as a model but the notion is pick your subsidy scheme, what society will pay for that's what you guarantee and that's what you define but let's not quibble over the fact that you have to define it.

ED HOWARD: Jack.

JACK MEYER: Well, I've been listening to this interesting debate trying to reconcile these moral principles with some of the inefficiencies that Bob highlighted and as I think about it I think the rationale for a lot of these proposals is that if you look at our system today we have very inefficient tax subsidies, some hundred and forty billion dollars very poorly targeted to need. Then you look at programs like DISH which you know half of it I understand doesn't even go to healthcare, all supporting sort of the providers rather than the consumers. UPL, Universal, I mean is a sort of a cost based reimbursement this vestige, these are things we do, all of these things we do because we don't really have a system of

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providing basic coverage to all Americans and the thing, not to mention the cartels in the industry and all the inefficiencies as a result of that.

And it seems to be a good idea to try to think about how to capture some of that money, cover people at the front end, and use some of the savings by redirecting the money from those programs.

The moral thing that I was thinking about is we really do need to have a debate in this society whether we're going to continue to have twenty five year old healthy workers and other people cross subsidize sixty year old unhealthy people. And that's been a pillar of the health insurance principle for a long time. You know, just like it's a pillar that you pay into social security so that and take care of your elders so that somebody will take care of you. It's not a very well set up program but, but the morality of it is good.

And I think that that sometimes conflicts with the flexibility we want where we sort of design our own health policy. Well, I'm twenty five. I'd like to get more in wages and less in health. I understand that but I think there is a, an issue of taking care of other people in society because it could happen to you. And that's what the whole health insurance idea is about. And I think if we move some of those subsidies around we could cover a lot of people.

The District of Columbia spends one point five billion

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dollars on health care, which turns out to be about eight thousand dollars a person and it's way above the national average. Yet there's a huge number of people without coverage; a huge number of people without access to healthcare because a lot of that money is spent very, very inefficiently.

ED HOWARD: Go ahead, Bob.

BOB HELMS: Let me just add I hope this comes across as something that's more practical than moralistic. It seems to me that the Covering America project and all the details in this thing if you bother to look at it gives you lots of alternatives than actually trying to define this through a political process. I remind people that if you look at the benefit package from Medicaid it is an illustration of what happens when defining a benefit package becomes more political.

And I wrote an article several years ago where I tried to trace the history of the tax treatment of health insurance and the many economists have tried to survey the literature we had a very large subsidy for over fifty years and we shouldn't be surprised that it resulted in a benefit package even in private insurance that many people think is wasteful and excessive.

The point is that if you can get back to the right kind of incentives that some of these proposals do they try to let alternative ways of doing this to use the principles of actuarial equivalents for example. Not to, or let the state

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define it or, and so on.

So you don't have to adopt the Medicare benefit or to say that this is something that Congress has to define to do this.

ED HOWARD: Yes, at the microphone.

JOYCE FRIEDAN [MISSPELLED?]: Yes. Joyce Friedan [misspelled?] from Internal Medicine News. I was interested in Mr. Miller's prediction about when universal coverage would actually occur and I wanted to get some of the other panelists' thoughts especially since it's so much in the public discussion now at a time when they can't even agree on a Medicare drug benefit.

TOM MILLER: The pig is in geo-synchronous orbit at the moment. [Laughter] Let me, I am tempted to tell the old joke that everybody knows. I'll just say it's the Claude Pepper [misspelled?] joke in talking to God and God tells him, "You're not going to get national health insurance in my lifetime". Well I came to the conviction some years ago that we're not going to get it in my lifetime either.

But actually I don't think you'll ever get it for the simple reason that even the countries that say they have universal coverage, they all have problems of getting everybody to participate so, anyway.

ED HOWARD: Len.

LEN NICHOLS: I would submit we will not get it until

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we have a very different awareness of the, of the consequences and the risks of being uninsured. I'm not prepared to say we're going to get that awareness soon. I certainly wouldn't bet we're going to have seventy percent of the electorate get that awareness by November of 04 but I would submit that don't underestimate the power of a prolonged recession a little bit, a couple more years of health insurance cost growth and a little bit more cost sharing being shifted to workers to get people's attention. And I think therefore it's entirely likely that we will have a conversation about it in 04 and as we go forward.

I would tend to agree ultimately with Bob, we probably will adopt something that will be short of universal but it will be greatly expanded from where we are now and declare a victory because this is after all America. It's kind of hard to get a hundred percent of us to do anything. We don't even have telephones you know. So I mean at the end of the day we're never going to get there but we may get a hell of a lot closer than we are now if the middle class gets worried enough.

ED HOWARD: And if I can speak for Uwe Reinhardt, who when I talked to him this morning actually took a crack at this, not making this as a prediction but merely as a factual projection that if we don't change anything else and healthcare costs grow at even ten percent a year over the next decade at a time when the economy grows at four percent, which seemed to me

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very modest in both directions, we'll end up with total compensation being devoted forty percent to healthcare, which he thinks might trigger some action. So there's the doomsday scenario.

Yes.

BOB GRIST [MISPELLED?]: Bob Grist with the Center on Disability and Health. It seems like most of the models that are being discussed here are assuming that the marketplace actually is efficient or can be efficient. And the fragmentation that exists now I don't hear being discussed critically. In other words, the inefficiencies associated with the fragmentation, the differential benefits; the fact that people who have healthcare needs and are not getting appropriate treatment. I don't see that factored into the policy recommendations that are being proposed.

And sixty percent of total healthcare expenditures are public dollars. You wouldn't get that from the discussion that seems to assume that the market is really being generated primarily through private insurance.

We also know that health...

ED HOWARD: Bob, I want to, if you can keep it relatively brief so we can get a chance to get some comments back it would be helpful.

BOB GRIST [MISPELLED?]: Yes, you started Ed with the discussion of state models and that was dismissed as

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impractical because of fiscal constraints and yet I don't hear any proposals that deal efficiently with the fragmentation in healthcare delivery or the fact that healthcare services only account for maybe ten or twenty percent at the most of health status.

So we don't, we're losing the opportunities to be more efficient and effective in healthcare delivery and I don't see that being addressed by any of the models.

ED HOWARD: Okay. Panelists.

LEN NICHOLS: Remember we were only given eight minutes to describe our proposal.

But seriously the basic idea is certainly an, it's an important point. But the notion in our proposal anyway was to have this, this sort of what we call the pool, the home, the place to buy insurance, the haven, if you will. That place would be a place where a standard benefit package defined in some sense by some kind of political process would be applied to everyone because society as a whole is on the hook for the subsidy to cover the quote excess risk precisely for the population you think about representing. They're going to be by definition higher risk than average. Okay. They're going to be in there. They're going to have a social price tag to their participation.

What we are going to then I think engender is a process whereby there will be a more clear link between what we pay as

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society and what we're getting for it. It will be more clear what the value for dollar is. It's the same kind of goals that Tom talked about. Get value for dollar that Bob talked about. Get value for dollar but we can't get it until we get a process energized enough to empower the public buyer to do this efficiently, to engage the providers.

In no way do I mean just using payment policy to hammer on provider's heads. I mean to get providers working to a system that is indeed going to be more efficient for all concerned because the social willingness to pay is limited. At the moment, we have this competing, what I would call not shell game, but race, between who wins, who loses in a given year. And when one side wins we get more generous. The other side wins we get less generous and we never really attack the fundamental issue. And I, that's why I want to make the tax subsidies explicit so that we have to address the fundamental issue every single year, are we willing to pay this or not.

ED HOWARD: Elliot.

ELLIOT WICKS: I just think it's, it's important to understand that when we gave everyone this assignment we were actually asking them to address primarily the question of coverage. And yet a number of these competing proposals, people who did those spelled out in some detail what they would do to try to address the waste and inefficiency in the system. I mean there is a lot of concern about setting up monitoring systems,

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ways of measuring quality, and so forth. And those of us who neglected it didn't, wouldn't in any way disagree with the point you're making.

Also just to reiterate what Bob said, it's important to have incentives in the system that give people reason to be concerned about cost and value. And I think all of us would argue that these things have to be built in too. We just didn't, couldn't address everything in what we did.

ED HOWARD: And I think some of the other proposals do address some of the issues you're raising.

TOM MILLER: There are some other ways to deal with some of your issue beyond just the pure financing and the insurance.

First off, to the extent, you know Len was talking about empowering public buyers. I'd like to empower private buyers because those are the folks who are receiving the care and might have the greatest stake in knowing that the quality of it is coordinated and it's worthwhile.

But if you have a health system in which people are saving more of their money on a longer-term basis for their multiple long term care needs, they will actually kind of be more involved, intelligent buyers. They may be interested in having a steady source of insurance such as through individual insurance on a longer-term basis than simply the erratic episodes of who they happen to be working for to give in time.

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Which may or may not match with what their long-term needs are.

In addition, on the other correlations of health beyond health insurance, in other writings I've talked about, there's a much bigger payoff to improve the education than there is to expanded health insurance coverage. People are healthier if they have better education. They can use the healthcare system more effectively. The better educated actually get more dollars out of the approach.

There is also a better payoff to health outcomes if you are more actively involved in the self management of your own care and that extends beyond simply what you got out of the doctor's office but how you manage all of your healthcare.

In addition, to the extent we can improve people's broader socioeconomic status, which goes well before they step into a doctor's office, they'll be healthier individuals.

And finally you know the problem is not that people don't know per se about good quality care they don't know the price of it because they're not asked to kind of be active buyers. If they knew better the price of the various care options they had they might be better able to optimize the overall value of what they're receiving.

ED HOWARD: Okay. We have a couple of questions aimed at tax credits. Let me pass them both and people can respond to one or the other of them. One of the questions is directed to Elliott. Why repeal the income tax exclusion and replace it

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with a credit? Is the only rationale tax efficiency and targeting?

And similarly, or at least on the same general topic, a different aspect of it, a lot of proposals for expanding coverage include tax credits. How do we implement these credits without further complicating an already bewildering tax code?

ELLIOT WICKS: I, there is the main justification for eliminating the tax credit is that it is an inefficient way of using money and it's unfair. People who have high incomes are more likely to have comprehensive coverage, to have employers that pay a large proportion of the premium and therefore to benefit from it. They also have higher marginal tax rates so they get more of the advantage from being able to exclude it. So it is, it seems like a very inefficient and inappropriate way to provide subsidies. You need to decide who needs the most and provide subsidies in proportion to that. And that's what tax credits do. The other system does not.

Of course, there are political reasons to be concerned about being able to sell this idea and that's why we would have a credit for everybody so you don't lose all of the advantage that higher income people currently have.

ED HOWARD: Okay.

TOM MILLER: I'd be quite comfortable to deal with the tax exclusion by repealing it. The mistake though is what you then do to the rest of the tax rates. So it's kind of a strike

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and lift approach if I can borrow from Bosnia where you would strike the tax exclusion but then you would lift everybody's income up by offsetting adjustments in the marginal income tax rate. So you don't impose a tax increase on people in order to get rid of the distortions in the tax code that are caused by the tax exclusion.

The other way, the reason why I went the way I did with the individual tax credit to keep it simple as opposed to multi tiered phase outs and the usual games that they play with the code is, let's make an approximation. The thirty percent was to take in effect the lowest marginal federal income tax bracket, plus the payroll tax bracket and for most of the folks who'd be in play that would in fact be an equivalent substitute so you, and you make it for all purchasers. You don't kind of do distinctions. We do tend to over engineer the tax code as the way to slip through the code would indicate. And therefore less would be more effective than more.

ED HOWARD: And I guess at least with respect to the thirty percent estimate you would agree with the Dick Gephardt plan, right? [Laughter]

TOM MILLER: Well, since I don't have to pay off all the union members and state government employees for my primary campaign, it would be about half the cost of the current one and I wouldn't mandate it on small business men. But apart from that, it's a pretty good idea I guess.

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ED HOWARD: Well, actually, let me just address something that Bob Grist [misspelled?] really was, really was trying to get at I think very eloquently and that is compare your own plans, if you will to something that is admittedly simple and would admittedly save money on administrative costs like for example Medicare for all or a single payer system, which is actually something that got voted out of legislative committee in California while I was out there last week.

LEN NICHOLS: Well, Ed, maybe that's a good reason you shouldn't go to California so often but I would offer that you know single payer has always been a dream. It is likely to remain a dream. It may even be a good dream. But I just having lived through what I've through in the last twelve years, I don't see this nation ever going there because it limits choice way too much. At least it's hard to articulate a model that does not. Maybe there is one. And maybe that will be forthcoming.

So it seems to me what our proposal is about is precisely trying to take the goals and preserve as much choice as possible. We allow people to buy insurance on their own, outside of regulation if they're happy doing that. If you don't find that compatible you can come inside our pool. We make a haven for you. We subsidize you based on both income and your excess risk and we allow people to move freely back and forth.

We would have a center benefit package. We would define

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that benefit package if we ended up with control, which I doubt will happen. But if we do we would define it relatively parsimoniously, allow insurers to offer supplements above it so you don't have to have this one size fits all stuff. You can have lots of variation. But you've got to have a basic package as defined so insurers can bid, so you actually have market competition.

So to me the big difference in us and single payer is choice.

ED HOWARD: Okay.

ELLIOT WICKS: I would agree with nearly everything that Len said. I guess the additional element is that people who talk about the single payer system I sometimes think oversimplify it. You still, it seems unlikely that we would eliminate all health plans. That we wouldn't have insurers involved in some way. I mean we're trying to move Medicare toward that kind of thing. I just don't think it's nearly as simple as it sounds. And preserving choice I think is important in our system and it's probably unlikely that the single payer system could be sold.

JACK MEYER: Well, let me just add, I would go back and question the premise that somehow a single payer is administratively simpler. I mean if you have a dream maybe that's what you see. But it's very difficult for people who have tried to compare the administrative systems between so

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called, well single payer systems like Canada and the US, because it's a very difficult thing to do because a lot of the things that really go on in private insurance have to be done under public programs. They just don't get in the accounting. And so it's not at all, I guess I would go back and question even the first principle of that.

ED HOWARD: Okay. We may not sort this out all today but it is a question that we probably will come back to over the course of at least the next six or eight months since this does seem to be a subject that is, is raring it's ugly political head in a variety of forms.

Let me just ask you as you are packing up your things to pull out that blue evaluation form and fill it out before you leave.

I'd like to take this opportunity to just thank the Alliance staff, including Howard Eisenstein [misspelled?] who worked so hard on this program. The Robert Wood Johnson Foundation for its support of the Covering America project, Jack and Elliot and Stan Dorn [misspelled?] and the crew at ESIR for contributing the substance and so much of the discourse on this and finally in general to our panelists whom I would ask you to join me in thanking for what I think is a very useful and provocative discussion today.

So hearing no objection the meeting is adjourned.

[END TRANSCRIPT]