THE BROOKINGS INSTITUTION

NEW DIRECTIONS IN HEALTH POLICY: A DISCUSSION OF THE PRESIDENT'S TAX-BASED HEALTH INSURANCE PROPOSALS

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Panel 1: The Administration's Proposals

Moderator:

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Panelists:

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Panel 2: Where Should We Go From Here?
Health and Tax Policy for the 21st Century

Moderator:

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Panelists:

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P R O C E E D I N G S

MR. GALE: Good afternoon. Let's get started. We really appreciate everyone coming out on a Friday afternoon to talk about tax policy toward health insurance in the world of the Tax Policy Center. This is a fascinating subject, even more interesting than the alternative minimum tax, as my colleague Len Burman said a couple of minutes ago. So I would like to welcome you here to this discussion of health policy.

We all know that health poses enormous challenges as well as enormous opportunities for our country. Our goals today in this session are a little bit more modest than solving the whole thing. First, we want to understand and analyze the administration's new proposal for taxing health insurance. Second, we would like to discuss other current issues in health care focusing on what can or should be done in the next year or so, and we have two panels coming up, one discussing each topic. I suspect we will also hear mention of the longer-term fiscal issues involved with health policy, but I want to emphasize that is not the primary focus of this afternoon's event. On March 15th we will be hosting an event that deals exactly on that subject.

You have I hope picked up copies of the papers and bios that were outside on the tables. I will assume you have and will not provide lengthy backgrounds on the speakers. I would like to mention our lineup, though. We are as always honored and delighted to have Kate Baicker join us from the Council of Economic Advisers. She will explain the administration's proposal and how it works. And we will have comments on various aspects of that from Henry Aaron,

my colleague here, Linda Blumberg from the Urban Institute, and Len Burman from the Urban Institute and the Tax Policy Center. After that we will take questions from the audience. I will be your advocate throughout this exercise in keeping the speakers on time. I borrowed Bob Reischauer's meat timer which he used this morning at a budget conference. I am going to rechristen this a tofu timer because this is a health event. We will ask Kate to speak for 12 minutes and our discussants to speak for seven, and then we will have everyone come up and take comments from all of you. Kate? Thank you.

MS. BAICKER: Thank you all for coming, and thank you for the opportunity to attempt to explain the administration's proposal in 12 quick minutes. I have a number of slides and a number of ways of showing it, but I know this is not as easy as one would hope to explain, so I hope you will hold your questions until the end and we can get through some of the details, or not.

I do not think I have to convince anyone in the room that health care spending is growing incredibly rapidly. It is growing faster than inflation, it is growing faster than wages, and this poses a burden on all sorts of different people trying to get health insurance. It makes it more expensive to get health insurance on your own, through your job, it makes it more expensive to pay for Medicare and Medicaid, the public programs, and in fact, there is an additional burden on public spending through the subsidy of private health insurance programs. So we spend money on Medicare, we spend money on Medicaid, and we also spend money subsidizing individual and employer-based purchasers of health insurance, and I will argue that that is actually a big part of the problem for

why our health spending is both growing rapidly and why we are not getting our money's worth out of the system.

Are we getting our money's worth out of the system? I think that is the first question we should be asking because if we were spending a lot of money on health care but it was all going to things that were worthwhile, I do not think we would care what fraction of GDP was going to health versus other consumer products versus anything else we might be spending our money on, but I think there is ample evidence that we are not getting our money's worth out of the system. If you do international comparisons, we spend more than twice as much as a share of GDP on health care than a lot of our trading partners, but our outcomes do not look commensurately good. We also spend a lot of money on some places within the U.S., a lot more money than we spend on other places in the U.S., and the benefits to those people in those parts of the country are no greater than the benefits to people in the low-spending parts of the country. So it is clear that we are not allocating our dollars as efficiently as we could be. I am not going to spend a lot of time on that because I do not think that is hard to sell.

Why aren't we getting our money's worth? That is a harder question. We can all acknowledge that the system is inefficient, but there are a lot of different causes at the same time. On the public side through the Medicare program, we reimburse for quantity of care, not quality of care, and that is a whole separate context that I will not get into the details of now.

On the private side, the way that we treat the taxation of privately purchased insurance drives a lot of unfairness in the system and drives a lot of

inefficiency in the system. Our current tax code subsidizes the purchase of employer-sponsored health insurance, so if you get your health insurance through your job, that is with tax-free dollars, but it by and large does not subsidize health care that you purchase out of pocket if you just go to the doctor's and pay for it, or you get insurance on your own. If your job does not offer insurance and you buy private insurance, that is with after-tax dollars.

That is unfair in two different ways. It is unfair to the person who is trying to get health insurance on his or her own and is having to pay with after-tax dollars getting none of the tax advantages that the luckier people getting insurance through their jobs are able to take advantage of. It is also unfair because the policies that we are subsidizing the most are the most-expensive policies for the people with highest incomes. So people purchasing basic health insurance policies are implicitly subsidizing more the purchase of more-expensive policies that people are getting from the employer market. That is also unfair. So our current system is a really unlevel playing field for basic policies versus expensive policies, for individual purchases versus purchases through a job.

Unfairness is bad in and of itself, but it also drives a lot of inefficiency in the health care system because it forces people into or heavily subsidizes or pushes into first-dollar coverage insurance policies. What that means is if you get a policy that covers everything, even routine care, low-expense care that you would normally be able to afford to purchase out of pocket, you get it more cheaply if you get it through your employer plan than if you go out to get it on your own and that is why our health insurance looks nothing like

any other kind of insurance product we might buy. If you look at auto insurance, if you look at homeowner's insurance, none of those insurance products cover basic, routine services that are not very variable and you could afford to pay out of pocket because it is expensive to insure those things and it is not a very efficient way to purchase that product like an oil change or painting your house.

What insurance is for is for unexpected things, very expensive things, things that you want to insure against. It is about insuring against expensive risk. And health insurance that would look more like a basic policy, whereas the typical policies that people get from their employers are first-dollar coverage of even routine care, so it looks more like prepaid health care than it looks like a real insurance product, and that is the product of the tax code because you are at such a greater advantage in the price that you pay if you get it through your employer policy than if you get insurance on your own or if you pay for the care out of pocket. So that raises health care costs for everybody, it makes insurance harder to afford for people who are buying it on their own, and it drives the inefficient use of resources.

It means that people consume care without really evaluating the costs versus the benefits because they have already prepaid for it through their insurance package. That is largely invisible to most people. If you ask people how much does your health insurance cost if they are getting a plan through their employer, they have a pretty hard time telling you what their premium is. In fact, a lot of times they will answer with what they pay out of pocket which is a small share of what the total premium is because they do not know how much their

employer is paying. If you look at what the average employer policy is, it is about $11,500 for a family policy today. The average policy purchased on the individual market when people go out on their own is about $5,200, so that invisibility of how much your premium is may drive more expensive health care policies that hold down wages because we know employers pay total compensation, it is wages plus health insurance and if more of it is going to health insurance, less of it is going to wages, and it drives the inefficient use of health care in hospitals, from physicians, and in the long-run, the inefficient development of technology, it dulls the incentive to develop cost-saving technology. So it is not only unfair, but it also is driving up health care costs for everyone and driving an inefficient use of resources.

If you were sitting down to design a health care system, I do not think anyone would say, you know what, let's give the biggest tax advantage to people with the most-expensive plans and the highest income but only if they get it from their employer. That just does not seem like a fair system. Not only does that drive the inefficiency that I talked about, but it also holds down wage growth and puts increasing pressures on public programs and on taxpayers.

How do we fix it? How do we get higher-value health care, reduce the unfairness, and make sure that efficient, basic, affordable care is widely available? The president has proposed a three-part plan. First, there is a standard deduction for health insurance, and that is reforming the way that we treat the purchase of health insurance to level the playing field, make the system more fair, and bring costs down in the long-run.

The second part that I do not think I will have enough time to talk about in detail today is the Affordable Choices Initiative. That is a partnership between the federal government and the states to ensure that really hard to insure people, the chronically ill, the low-income people who do not have any tax liability at all, have access to basic policies and a risk-pooling mechanism at the state level. Those two pieces really work hand in hand. If you can reform the tax code to cover the easier to insure, much bigger portion of the population, that makes the problem at the state level of insuring the hard to insure, chronically ill population more tractable. And conversely, if you can fix some of the problems in the individual market and the barriers to affordable basic are at the state level, it makes the tax dollars go further. So they really work together, but I am going to focus pretty much on the first one.

The third piece is the continuation of efforts to make information more widely available to promote the use health IT, to open up options for consumers to purchase different kinds of health policies, and those because they have been discussed before I also will not focus on.

What I am going to focus on is the standard deduction for health insurance which seemed really straightforward, and I said I can explain that, no problem, and I realized I was completely wrong. The reason it is so hard to explain this I think is because our current system is so wacky that when you compare this proposal to the current system, the differences are very complicated because our current system is complicated. This is in fact pretty straightforward. It is a really clean way to eliminate the biases in the tax code to give the same

types of advantages to people who purchase individual insurance as to those who get it from their employer, and the same tax advantage to people who purchase plans as people who purchase more expensive plans.

How does that work? What is the magic bullet? It is a standard deduction for health insurance, for a family, $15,000, for an individual single person, $7,500. What that means is if you purchase any basic health insurance policy or better, you purchase at least a basic health insurance policy, you get to take $15,000 of your compensation tax free if you have a family policy, or $7,500 tax free if you have an individual policy. It does not matter where you get your insurance. You get the same standard deduction if you get it on your own or if you get it from your employer.

And this is the part that I think is hard for people to understand at first because it is so different from our current system, it does not matter how much your policy costs. If you get a basic policy, you get the standard deduction. If you get an expensive policy, you get the standard deduction. It does not matter what your premium is, it does not matter whether you are paying it or your employer is paying it; everybody with health insurance gets the standard deduction. It would be available to taxpayers who are paying the alternative minimum tax as well as taxpayers who are paying under the regular system, and it would apply to both income and payroll taxes. So low-income workers who do not have any income tax liability would still get to take advantage of the payroll tax liability portion of it.

It would replace the current tax preference reserved for employer-provided health insurance, so your taxable compensation would now be your wages plus anything else your employer was paying for your health insurance. But then in exchange for getting that tax, you would get the standard deduction of $15,000 for a family policy.

A side note: something that I think has been the source of some confusion, on the employer side nothing would change. Employers get to deduct their wages that they pay and the compensation that they pay from their taxable income as legitimate business expenses and they would continue to do so, so nothing would change on the employer side. This is all about the individual taxes owed. Although payroll tax applies to the individual portion and the employer portion of the payroll tax, nothing changes on the employer's tax return.

Let me give you a couple examples because, again, this is not so easy to understand in juxtaposition with the current system. Right now our system treats workers with the same compensation who do or do not get health insurance from their employer differently. Under the president's proposal, those workers would be treated the same. Let me give you two simple examples, I hope. John and Bob both get $60,000 in total compensation from their employer. John's employer pays $50,000 in wages and $10,000 toward health insurance. Bob's employer pays $60,000 in wages and Bob just goes and buys insurance on his own, assuming they are both buying a family policy in this example. Their taxable income is different. John is getting taxed on $50,000, and Bob is getting taxed on $60,000, even though they have the both insurance policy and they both

have the same total compensation and because John's employer was offering health insurance, John's tax bill is lower.

Similarly, Frank and Dave both get $100,000. Frank was getting $80,000 in wages plus $20,000 in health insurance, Dave was getting $100,000 in wages, and I have picked those examples so that one will be over the standard deduction and one will be under, so that is why we are doing this twice.

Under the proposal, your taxable income is your wages plus whatever your employer was paying for health insurance minus the standard deduction as long as you are covered by a policy. So John's taxable income goes down to $45,000, Bob's taxable income goes down to $45,000. The fact that one was buying insurance on his own and one was getting it from his employer does not change their tax bill, so we have leveled the playing field for somebody who did not have access to employer insurance and both of their tax bills have gone down. It is important to realize that about 80 percent of the policies offered by employers are under the standard deduction so most people would be in this situation.

As to Frank and Dave, Frank's policy was above the standard deduction, so Frank's taxable income is going to go from $80,000 up to $85,000, so his tax bill is going to go up. Dave's taxable income is going to go from $100,000 down to $85,000. So again, they will now have the same taxable income because they have the same compensation, and it turns out that Frank's taxes will go up a bit because Frank's policy was above the standard deduction. This was an attempt to just illustrate how the policy works.

Now let's think about what it does to different people. There it is in a graph, and people like graphs, but I am going to move on. It is a beautiful graph. Jonathan made the graph.

Let's think about how this affects different parts of the population. Think about the uninsured. Right now if you are uninsured and you do not have access to employer-provided insurance, you are buying insurance with after-tax dollars and it is a substantial chunk of your wages and maybe you do not buy it. Under this policy, if you get at least a basic policy or better, you get $15,000 of your compensation tax free. That is an enormous incentive to get health insurance.

Consider the example of somebody who earns $60,000 who would then be in the 15-percent income tax bracket and 15.3-percent payroll tax bracket. If that person gets any health insurance, that person's taxable income would go down to $45,000 which would reduce his taxes by more than $4,500. With no insurance, the tax bill is $4,500 more than if Gary gets any insurance at all.

I have just told you that the average cost of an individually purchased family plan today is about $5,100. That is the average. Imagine that Gary gets a $5,000 insurance policy. Under the current system, that costs $5,000. Under the president's proposal, taxes would go down by $4,500 while purchasing that $5,000 policy which would make the net cost of the policy only $500. That is an enormous discount on the price of the policy and an enormous incentive to get insurance.

Treasury estimates that on net about 3 to 5 million more people will get insurance because of this policy. Outside estimates by the Lewin Group and others are even higher. Lewin is estimating more than 9 million people would get insurance because of this, because now the price of insurance after taxes has dramatically gone down.

Individual purchasers, right now people who are getting insurance on their own are getting no tax relief. This provides important tax relief they did not have access to and makes them strictly better off. They were getting insurance before with after-tax dollars, now they are getting it with pre-tax dollars and the only thing that has changed is their tax bill goes down dramatically. There are some examples where people could even get free policies because a lot of policies are available at less than the tax benefit.

The last group, and I think the one that is the most complicated and the one we want to focus on the most because is the biggest is people getting insurance through their jobs right now. What happens to them? This removes the bias toward health insurance and against wages. So we would expect people to reallocate their compensation as labor markets evolve from health insurance to wages, but that would be their choice. Most people if they did nothing would see their tax bills go down because most people are under the standard deduction amount. Right now the average employer policy for a family is about 11-5, this policy would not take effect until 2009, so it would be higher, but Treasury still estimates that about 80 percent of policies in 2009 will be below the standard deduction. So for those people who did not change their behavior at all, the only

thing that would happen is the day the policy goes into effect, their taxes would go down.

That leaves 20 percent of people whose policies are above the standard deduction. If they do not do anything, even if they do do something, their taxes go up. It does not go up enormously. Imagine you have a $16,000 family policy. You would have to pay an additional amount of taxes on the $1,000 increment above $15,000. So if you are in the 30-percent tax bracket, that is for a year $300 more in taxes. People face that increase in taxes, but they do have options to reallocate their compensation that would not affect their tax but would make them better off in the long-run because right now they are being subsidized to get health insurance which is keeping wage growth down. We would expect people to change the mix of their compensation moving toward lower premiums and higher wages but, again, that is up to people and that is their choice.

Nothing else would change on the employer side. There is no penalty for employers offering insurance. So employers would continue to decide with their workers whether or not to offer insurance. Workers who got insurance through their jobs, most of them would see their taxes go down. Workers who do not get insurance through their jobs would have tax relief under the proposal that is not available to them now.

I think that I am winding now. One thing that I want to highlight is that this is not a regressive policy. People think this is going to hurt middle-income people. This is a graph of the distribution of changes in taxes as a fraction

of income. You see that the first four income quintiles see their taxes go down, while the fifth income quintile sees their taxes go up by a bit. There are a couple of reasons for this. Wealthier people tend to have higher premiums. That is not uniformly true. There is obviously a lot of variation in who has the most expensive policies, but by and large, the higher your income the more expensive is likely to be. Low-income people are also more likely to be uninsured and more likely to not have access to employer-provided insurance. So those first two groups that are all winners are disproportionately at the low end of the income distribution, and that third group that is mixed where some people's taxes go up, the people whose taxes go up are disproportionately at the high end of the income distribution.

I do not want to make too much of this in the sense that basically this is a fairly neutral proposal. It is revenue-neutral over 10 years, and it is basically distributionally neutral, but if anything, it is progressive. It is revenue-neutral over 10 years, it creates a significant incentive to purchase insurance which leads to millions of more people to be insured, and perhaps most importantly for everyone, it will slow the growth of health expenditures which affects people who are insured now, and it affects all taxpayers. There will not be an incentive anymore to purchase inefficient first-dollar coverage. The playing field will be leveled. People will choose the policy that is best for them. That means some people are going to get expensive policies, some people are going to get basic policies, some people are going to get HMOs, some people are going to get high-deductible policies. It is going to depend on how you value those

features and how you trade those off against your wages. So that will bring down the pressure that has been driving health spending up, and it will also increase competition among providers. And if you want to know whether that competition actually works, look at the case of Medicare Part D, and better yet, ask Mark about it later. You will see that in bids by plans came in substantially lower than people had expected and enrollees picked more cost-effective plans than people had expected, and that drove down the total cost of the program.

I will not talk about the Affordable Choices Initiative, but as I mentioned earlier, it really dovetails with this in an important way because there is a group of chronically ill uninsured people who none of these insurance programs will help with because they already have predictably high expenditures. It is hard for them to get an insurance policy that is not expensive because we already know their expenses are going to be high, you will need some pooling mechanism to deal with that and I as I say do not have time to deal with it in more detail. These proposals are all built on the prerequisite that people have good information about what health care costs, what the benefits are, what the quality of different providers are, so it is important to build on some of the president's other initiatives, allowing firms to band together to purchase insurance, allowing people to purchase insurance across state lines, and most importantly, making better information available to patients and to their physicians so they can work better to get the care that is most effective for them. The federal government can lead the way there as well both in promoting the use of health IT and in making information available to enrollees in federal health insurance; the federal

government can promote that better information availability throughout the system.

In the end, the goal of this proposal is really to arm patients, consumers, and providers with information and then level the playing field to let them use that information to choose the policies that are most effective for them, and the goal then is to bring down health care spending overall so that we are really getting high value for our health care resources and not caring so much about what fraction of GDP is comprises. I will stop there.

MR. AARON: Thank you very much. I think all health analysts agree that linking health insurance to employment just does not make any sense. Why on earth should you lose your health insurance if you leave your job? Health insurance premiums are excluded from personal income and payroll tax, which is the reason why health insurance is offered primarily through the workplace.

President Bush proposes to eliminate the differential between individually and group-purchased insurance. That is a step toward leveling the playing field. I would like to explain why that step by itself is not an improvement if that is all that is done. The reason is that it is going to nudge people away from employment-based health insurance to the nongroup market, and if that is to be a good choice, you have to have a well-functioning nongroup market. Currently the nongroup market for health insurance is a disastrous mess.

It is a mess because it does not adequately pool risks. An insurer who wants to stay in business simply has to charge each customer enough to

cover the costs of that particular customer plus enough extra to make a profit and cover selling costs. For a healthy 30-year-old, those costs are likely to be quite low. For the cancer patient in remission or the 60-yeear-old whose parents both died in their forties from heart attacks, those costs can be quite high, so high in fact that many people cannot actually afford them. Pooling is what makes health insurance affordable for the average person, and pooling is something that the workplace now does; it does not do it ideally, but it does do it adequately.

What is right and what is wrong with President Bush's tax plan? What is right is that it extends to individually purchased insurance a tax break similar to the one that is currently available on employer-financed insurance. Moreover, it does so in a way that does not add to the federal deficit measured over a decade, although it would boost deficits initially. Unfortunately, the plan perpetuates the current system's upside-down incentives. It continues to give bigger tax breaks to high earners than to low earners because the deduction is worth more to a higher earner facing a high tax rate than to a low earner facing a low rate, and most of the uninsured are low earners.

Much better than the current proposal would have been calling for a tax credit that offers the same relief per dollar of health insurance to people at all income levels. And better still would have been a proposal to turn the subsidy right-side up by offering larger credits to low-income households, the ones who need help, than to high-income households who by and large do not.

But there is a bigger problem with the Bush plan in my view. It does not assure that people who go shopping for insurance will actually be able to

find it at a reasonable price. The Bush plan if adopted would produce millions more such shoppers. Why? Because it will make it much easier and more attractive for employers who are bedeviled by rising premiums to simply stop sponsoring insurance plans. A generous employer might well give his employees a raise equal to what he has been paying for health insurance. Employer would be able to tell their employees you can get the same deduction by buying insurance yourself.

But many employees will not be able to find a plan that they can afford. Yes, it is true that the Bush plan would permit states to shift funds from a current grant program to this one to help subsidize high-risk patients. That is the Affordable Choices Initiative to which Kate Baicker referred. But I am going to assert now, and we can pursue further in discussion, that the financing for that option is inadequate and absurdly mistargeted across the states.

The issue is complicated and we can come back to it, but for now, the key point is that the Bush plan does not assure high-risk individuals that they will be able to find an affordable plan, and as a result, the plan is likely to leave old and sick people who now have insurance by grace of employer coverage uninsured and unable to find essential care.

The plan could have assured that insurance will be available. It could have authorized every working age American to buy insurance from plans that now cover federal employees at the same prices that federal employees now pay. Or it could have permitted them to buy into Medicare at a premium determined on a community-wide basis. One more step would have been

necessary for real reform, additional help for low earners to make insurance affordable. But here too the way ahead I think is reasonably clear as indicated by plans already enacted in the State of Massachusetts and one proposed in the State of California. Each offers ways to provide such incentives in practicable ways.

In my view, President Bush has offered a one-step plan that if enacted would cause the nation to step into a very deep hole. Three steps, not one, are necessary to reform the U.S. health care system. One is, as Kate outlined, a move away from employment-based insurance, but the second is a program to make the nongroup health insurance market work, a real plan with adequate funding to make it work.

The third step is to help low-income households in a way that makes health insurance genuinely affordable. My concluding appraisal is that nobody really should be satisfied with a one-step plan that makes things worse, or could, when taking two more steps would provide very much improved outcomes. Thank you very much.

MR. BLUMBERG: It is hard for me to follow Henry because it makes me want to just say what he said, but it also will help me in that I can make sure that I stay within my 7-minute allotment. What I want to do is start by talking a little bit about what I think are the main overarching problems with our health care system and kind of segue into what I think the president's plan could or could not do about them.

The first and most obvious is that 47 million people are uninsured in the United States today. And second, as Kate mentioned, is that the spending growth in health care has far outstripped the general price inflation and wage growth, and that means that vulnerability to losing coverage is even greater for more people in the future.

As spending growth climbs, one of the things that also is happening is that benefits are being decreased and cost-sharing is being increased as purchasers are trying to find ways to pull back on premiums and a greater share of the burdens of financing medical care are falling on individuals who are high users of that care. And fourth, as Henry already went into in some detail, is that individuals who do not have access to employment-based insurance who by the way make up 80 percent or more of the uninsured today and who are not eligible for public insurance really have no guaranteed location for buying health insurance because of the failings of the nongroup market.

In addition to the ones that Henry has already mentioned with regard to the fact that people who have very high medical costs may not be able to access nongroup coverage at any price, I will also mention that in some cases

individuals not only are fully excluded, but they have significant benefit exclusions and any policies that are offered to him, or as he mentioned, that the rates are unaffordably high, and this can happen not just to individuals who are at the very high end of the medical spending distribution, but analysis has shown us that even people who we might consider to have modest health care situations such as those with hay fever or other diseases that may require use of prescription drugs may also find that they cannot access nongroup coverage because of their medical profile. In addition, nongroup plans also carry very high administrative loads which means at any given level of benefits that you can buy in the nongroup market today is going to be at a higher price than what you would get in the group market.

In addition, these policies are notoriously difficult for laypeople to understand the details of and so it becomes very difficult for them to compare purchasers and to compare on their own differences in policies for equivalent price and benefits. Nongroup insurers also take demand for comprehensive health insurance policies as a signal that somebody intends to be a high user of medical care. What that means is it has become more and more difficult over time to actually be able to buy a comprehensive policy to cover all medical needs in the nongroup market, and those that do exist are extraordinarily expensive. All of this combines to mean that affordable policies in the nongroup market are going to require substantially higher levels of cost sharing, lower levels of benefits, and are only going to be available to a segment of the population.

The main problems in our system then as I see them can be summarized by saying that the number of individuals in the U.S. who have an accessible, affordable, and adequate health insurance policy is low and falling over time. So let's take a look at what the president's plan to address the core problems in the system, and as all economists will tell you, I agree that there is something positive to be said for limiting the current open-ended subsidy for employer-sponsored contributions to health insurance. But I think there is an important difference between saying that limiting that exclusion as the president's proposal does is an advance over what we have today and saying that it is actually going to have a significant effect on health care spending levels, on premium growth, and thus reduce the number of uninsured. The reason I do not think it is going to have an important impact is because when economists started warning us about what the dangers were of this open-ended subsidy, the health care system and health insurance in particular looked very different than it does today. Premiums were at a much lower level as a consequence of the intensity of medical services being much lower, insurance was dominated by indemnity coverage, fee-for-service coverage, and while the subsidies and incentives are still wrong to be sure today, the insurance system looks much different. The premium growth that we have experienced and that Kate talked about has really overtaken these negative incentives. The trend in benefit package design is not toward Cadillac policies and finding more and more comprehensive policies. Purchasers are looking for ways to pull the benefits out, to strip down what is going into the insurance costs and increase what individuals are paying who are actually users of

the medical care. So I think the importance of this issue is actually diminished over time because the premium growth has outstripped it.

It is also important to recognize that the engine of premium growth and spending is not the decisions that are being made at the low end of the health care spending distribution. Even if everyone in the country obtained a policy with health savings account-like deductibles at the $1,100 to $2,200 level and this resulted in some savings below those deductibles, this still would not have a significant impact on overall system-wide spending. The reason is because the lion's share of health care spending is attributable to individuals who have very high medical costs. In fact, 97 percent of total health expenditures are attributable to individuals who exceed even those higher deductibles, and 82 percent of total health expenditures in the U.S. are attributable to spending that occurs once those high deductibles have already been met, and so moving individuals into these kinds of policies is not going to have any impact on spending at that level, and that is really where the dollars are. If we want to be generating significant effects on premium growth over time, what we are going to have to do is have significant changes in how medical care is delivered and how we use medical technologies and the intensity of services that are being provided, and doing that in a way that is going to also maintain access to needed medical care for individuals who need it is no easy feat, and don't get me wrong, I don't think it is, but trying to reduce medical spending and hold down premium growth significantly over time by just pushing people into higher deductible health plans is really not going to touch the problem. And in fact if we are not careful and we do not put further protections

into place as Henry alluded to may actually hinder modest-income people's ability to access needed care.

The proposal also does not address, as Henry mentioned, and I will not belabor this, the issue that I always thought was the most obvious problem with the tax exemption, that it was built upside-down and has the greatest value going to those with the highest income. I have read certain commentaries and papers and heard it on the news that the president might be actually willing to consider placing the tax deduction or the tax credit that was progressive and had the greatest value for the lowest income, I would love to hear today that that was actually a door that was open.

The second change regarding the equity between the group and the nongroup market Henry has already discussed and so I am not going to go into it in great detail, but I feel very strongly that you do not put equity in place first before you have some way for protecting the individuals who are going to then be released from their employer-sponsored coverage and not have a reasonable alternative for purchasing adequate care.

In addition, while the president's proposal suggested that the states could take it upon themselves to reform their nongroup insurance markets to address these problems, there is no requirement to do so in the legislation and there is no guarantee that all or even most would or could. Having gone through the experience in the State of Massachusetts recently and watching that very closely, I can tell you that the political process is a very complex one and any of these kinds of reforms are no sure thing even in a state where it seemed like

everything was moving in the right direction. I will just reiterate that the funds that are offered to assist states in subsidizing their high-cost population and their low-income to purchase in the nongroup market are very unevenly distributed, not according to need, much more akin to the willingness of the states in the early 1900s to leverage dollars to their Medicaid programs from the federal government. That was the different states got different allotments for those dollars and really is no reflection of the relative need in those states. If the dollars are currently going toward the employer-sponsored tax exemption or added into that pot and able to be used in a progressive way and directed toward individuals with the greatest need, then you would have enough money to do something serious there, and so that is why I am hoping that that door is still open.

So summarize, the president's plan would limit our current open-ended subsidy, and we can all agree that that would be an improvement, but I purport that doing so would do very little to address health care spending and premium growth, and consequently not lead to a significant increase in health insurance coverage. Eliminating the inequity of the tax treatment between the group and nongroup markets might make insurance more affordable for individuals in excellent health, but the potential negative ramifications of doing so for those who have significant medical care needs means the inequity should not be eliminated yet. We do not want to make a tradeoff of more coverage for the young and healthy at the cost of less coverage for those with the greatest health care needs. And the move away from employer-sponsored coverage has to be accompanied by significant structural changes to how individuals purchase health

insurance relative to what it is today, otherwise we worsen a situation for those who are already most disadvantaged by the current system and I do not think anybody would consider that to be progress. Thank you.

MR. BURMAN: Here I am again at Kate's Amazing Medicine Show. Last year she went around and was talking about how great HSAs were and I was saying, no, they are not. She is an amazing salesperson. I will take mine in blue.

(Laughter)

MR. BURMAN: This proposal is fiscally responsible, it is creative, and it is fraught with risks. As it was proposed, it would cause millions of people to lose employer-sponsored insurance and many of them as Hank and Linda pointed out, especially those who have chronic illnesses and low incomes, would likely to without health insurance unless they are lucky enough to live in a state with a successful safety net. The good news is that I think the proposal could be fixed, and that is why I think it is worth taking seriously.

What should the government do? There are people who believe that all of the health insurance market's problems could be solved by simply letting market forces reign free, and although this is a good prescription for many markets like the market for cars, it is not the case for health insurance. Health insurance is a classic example of what economists call market failure, moral hazard; people with insurance spend too much on medical care because it is not coming out of their own packet. Adverse selection, healthier people value insurance less than less-health people, and insurers have a converse incentive to

try to find healthy people for their pools and exclude the unhealthy people. The free-rider problem, you do not want to pay for health insurance if you think you can get it for free, and we have a system where if sick people show up at the hospital, they have care. Asymmetric and incomplete information, Kate talked about getting more information to people so they could make better choices. That would be a huge improvement in the medical market and I think a lot of the problems come from the fact that people do not even know what they are paying for, and you can create whatever price incentives you want, but when a doctor tells you to do something, are they telling you because it is really in your best interest or because they have a vacation in the Bahamas planned?

And there is incomplete insurance. You can buy insurance when you are young and healthy, it is really not a problem even in the nongroup market, but there are serious problems in the nongroup market getting insurance that will cover you on affordable terms when you get sick, and those things need to be dealt with. Without a subsidy there would be way too little insurance. There really is a role for government here. If it were just left up to the market, there might not be any insurance at all. There is a famous paper by Rothchild and Stiglitz that shows how there could be a kind of death spiral where the people who prefer insurance are the ones who are least healthy and that pushes up the premium for insurance, so even healthy people who would like to be protected against the risk find that insurance is too expensive, they drop out to push up premiums more, and eventually there might not be a market at all.

The question is what do you do about this? The current system is employer-sponsored insurance and it is a mixed bag. We provide a subsidy for insurance provided at work and little or no subsidies for other kinds of insurance. What this chart shows is the upside-down subsidy that exists under current law. The line that is going downward, the pretext premium burden, premiums as a share of income, and you can see that low-income people, and these are people with health insurance at work so they are the relatively fortunate ones, their premium as a share of income is huge for low-income people, and it falls to almost nothing for very high-income people.

Then we have a subsidy scheme in place, and the subsidy scheme provides the largest subsidy to people who least need help. That is what the current employer-sponsored system does. It does encourage people to get insurance at work. Most working-age people who have insurance get it through their employer, so in that sense it is effective. Large employers are an effective pooling mechanism. But as Hank and others have pointed out, and as Kate pointed out, there are a lot of problems with tying insurance to work as well, and there is an equity issue that people are paying for insurance themselves and they do not get a subsidy.

The solution is to encourage people to get insurance but not overly generous insurance. The proposal would do that pretty well. To encourage the development of effective cost-containment strategies. It is less clear on that score, but it certainly gives people an incentive to pay attention to the cost of care. To encourage effective pooling arrangements, and there is not really enough detail in

what has been released by the administration so far to tell whether that work would, and there are certainly reasons for concern about that. To align insurers and providers and patient incentives together to be sure that if your provider is telling you you need treatment, it is not because they want to go to the Bahamas, but because it is the best thing for you. And to aid the poor and the vulnerable.

The proposal would encourage people to get insurance but not too much insurance. It could be very effective in restraining costs. It removes all marginal incentives to get more expensive insurance. You just get the subsidy if you get insurance. If you spend more, you do not get a bigger subsidy. For the first time people will know what their employer-sponsored insurance costs and that could actually be huge, much bigger than what shows up in economists' models. Probably most people in this room and certainly most people out in the real world do not know what their employer is paying toward their health insurance even though virtually all economists believe that it comes out of people's wages.

The proposal is not so good at encouraging effective pooling arrangements at least given the level of detail that has been released so far. There has been a lot of talk about the problems with the nongroup market. Hank said that the employer group market is adequate, and I suppose it depends on how you define that, but one area in which it is weak is for small- and medium-size employers. Under this proposal, small- and medium-sized employers would stop offering health insurance in almost all cases. They do not have a huge cost advantage over the nongroup market. Right now if you are an employer and you

want tax-subsidized insurance for your family, you have to offer it at work; otherwise you cannot get the tax break. Under the proposal, you could buy the insurance yourself to get a $15,000 tax deduction. And the healthy people in the workplace would say do not give me insurance, give me the wages and I will buy that $5,000 plan that Kate is selling, so that would be a problem.

Kate mentioned the administration estimates, the Lewin estimates, that there would be a lot more people with insurance under the proposal. Nobody really knows, but there certainly would be a lot of people who would lose insurance at work. John Gruber is reported to have estimated because of that effect, even though a lot of people would get insurance in the nongroup market, more people would lose it, and that is certainly plausible. And the subsidy is still upside-down. The purple according to our estimates is what the subsidy would be under the proposal. By the way, we are measuring the subsidy as the income tax part and the Medicare tax part. We are leaving out Social Security because as I think Kate mentioned, when people stop paying Social Security, it also affects your benefits. But even if you include Social Security, there would still be this upward slant of the line. So the proposal is not as bad as current law, but it is not a huge shift.

Kate cannot talk about this, but there are obviously good political reasons why the administration did it that way. It is not raising taxes on 80 percent of people as a sensible subsidy would do, but it also makes it less effective at helping the people who really need help to pay for health care.

The proposal is a mixed bag for encouraging cost containment. It would level the paying field, but it retains and actually would expand tax benefits for health savings accounts. The whole idea of health savings accounts was to level the playing field between high-deductible health insurance and comprehensive insurance. Before HSAs were put in place, you had a strong tax incentive to get more expensive health insurance. Under this proposal you do not. And actually there is an example in our paper showing how the president's proposal with HSAs would take the distortion that used to favor comprehensive insurance over HSAs and flip it over exactly, the exact same distortion would exist, but now it is in favor of high-deductible health plans. That may not be a good thing, you basically want to let the market determine the most-effective way to constrain costs, and the way to do that is to give people the same incentives and let them choose the option that works best for them.

The proposal does little for low-income people. Saving payroll taxes is not worth much to them. There was a distribution table that Kate showed, our estimates are a little bit different, and I do not know fully why the differences exist. These are based on estimates and very unreliable data and so I do not know if these differences are significant, but the main point is that the proposal is, as Kate said, progressive in the sense that the first four quintiles give more of a tax break to people at the top. The chart also shows that by 2017, those are the gray lines, most people would be paying more taxes at least on average within each group, but it is not actually changing things hugely.

Hank and Linda have both said that a refundable tax credit would make a lot more sense as a way to encourage pooling and help low-income people, but the fundamental thing is fixing problems with the nongroup market. The proposal would be a lot more convincing if more thought were, and I know Kate cares about this, but in terms of what is actually proposed by the administration, you need to think about how to make sure that those nongroup market reforms occur. For a couple of ideas that are fleshed out a little bit more in the paper, one is condition the tax subsidy for nongroup insurance on the availability of an effective pooling mechanism within the state. In Massachusetts where everybody can get health insurance, you can buy subsidized insurance in the nongroup market. If other states choose not to do anything about it or do not do enough, the subsidy ought not to be available; you should still have people on employment-based health insurance because despite its flaws, it is the best way of pooling without fixing the problems in the nongroup market.

There could be voluntary market reforms, and we talk about those in the paper. You could say if insurers want to play in this market, they will have to figure out a way to offer renewable insurance in such a way that if you get it when you are healthy, you get low premiums forever as long as you keep continuous coverage. We talk about that in the paper. But the point is that you are providing an additional subsidy, you might as well use that as an opportunity to provide an incentive for insurers to actually do something to deal with this problem. Thank you very much.

MR. GALE: We are open for questions from the floor. Be sure to use the mike and be sure to state your affiliation.

QUESTION: Thank you. I am a retired physician and I have a couple of comments. First, I found it disturbing to hear that health insurance is comparable to automobile insurance, and I will tell you why. A car is a very sophisticated instrument, but the human body is far more complicated. If you do not maintain your oil in your car, a red light comes up to warn you. But if you have cancer of the prostate, the red light is going to be blood in your urine and by then you are heading to the morgue. If the car breaks down, you can replace it. If you due, that is a human tragedy. So you cannot establish a system that allows the patient to decide that he is not going to give himself maintenance because after all of these $100 checks, I am normal last year, why should I bother. And by the time that the warning signals which we call symptoms, you are in a lot of trouble.

The other point is that no one has mentioned one of the big busters in the economy of medicine which is the multibillion-dollar liability problem which the president has addressed, but the Congress has refused to address. This is killing the physicians because the insurance companies are paying under-cost and high-risk specialties such as obstetricians and neurosurgeons are simply dropping out of the system, and we are going to wind up like we have wound up already with the nursing situation where we are recruiting nurses all over the world because American men and women are not going into the profession in large numbers. And let me tell you that it is very scary when I pick up the phone

at 1:00 in the morning and I have an ICU nurse talking to me which I cannot understand, and she cannot understand me.

MR. GALE: Point taken. Let's see if there are any responses.

MR. AARON: Let me just say one thing, I do not think any of us up here disagrees with the proposition that human beings are different and more important than automobiles. I also do not think there is anybody up here on the stage who would disagree with the proposition that incentives matter and we want to get those incentives better than they now are. We may not agree on exactly what reforms would on net be beneficial, but we all I think share the view that current incentives are all screwed up and that improvements can be made.

MR. GALE: Thank you. Are there other questions?

MR. LIGHT: I am Bob Light (?) from the Congressional Research Service. I have a question for Kate about the president's proposal. Does it terminate Flexible Spending Accounts? The budget documents were ambiguous.

MS. BAICKER: Let me clarify. With Flexible Spending Accounts, people who work for firms that have set these up can sometimes pay for either some of their premiums or some of their out-of-pocket expenses with pre-tax dollars. This would eliminate the pre-tax treatment so you could still use the mechanism for ease of payment, but spending out of the Flexible Spending Account for health would be subject to taxation in the same way that premiums would and you would instead get the standard deduction.

MR. SAMUELSON: Bob Samuelson, Newsweek. This is for Kate Baicker. I do not understand how as a practical matter this proposal would

work. In other words, if you are an employer, let's suppose you have a workforce of 1,000 people, you have employer-paid insurance for all 1,000 people, how are you going to attribute the cost of that insurance to each employee? You have a 25-year-old making $30,000, probably really does not have any medical costs at all; you have a 45-year-old or a 50-year-old making $80,000 who has substantial medical costs. Are you simply going to average it? If the employee says I am a 25-year-old employee, you have just put $10,000 taxable income on my tax form here, but you have not given me a penny, you are just giving me health insurance which I do not want, are you going to require the employer then to offer the employee the cash equivalent of the insurance? How does it work?

MS. BAICKER: Thanks. I think the practicalities are not so hard to work out as it turns out, and people at Treasury have given a lot of thought to the details of this would be implemented, so I will give a quick answer and then I can give more detail if people want it, but I know we do not have an infinite amount of time, and there is an infinite amount of detail.

If you are getting insurance from an insurer, so if you are not self-insured, then it is easy, the insurer has already an obligation to tell the employer the amount of the premiums broken out per person. But the real problem group I think you are getting at is if it is a self-employed employer through ARISA so they just have a giant pot of money they are using to insure all of their employees and they do not have to have broken out the premiums. Actually, they do have to give the employees an employee premium if the employees want to leave and want to purchase COBRA continuation coverage, so there is already an

established methodology for attributing individual premiums to a self-insured big firm. So that mechanism already exists and nothing would change that and you would just use the COBRA premium which they already have to calculate.

How would this show up on your tax return or on your pay stub? Each pay period the employer would add that amount of taxable income to the employee's pay stub but would subtract the prorated amount of the standard deduction. Most big firms, and even most small firms, use payroll services; they do all sorts of addition and subtraction all the time for dependent child care, for contributions to charities, for all sorts of stuff, so this is an extra line that does not really pose an administrative burden. For people doing it by hand who are looking things up on withholding tables, the withholding tables would be adjusted to reflect this so you would be looking up a different number, but the Treasury would put out a set of tables that incorporated the standard deduction and all you would have to do is add in the premium.

So there are clearly a lot of logistical details to work out. I think those are surmountable without too much extra administrative complexity for anyone involved, so the proposal really hinges on what you think about some of these bigger-picture issues about risk pooling and whether you want to have a level playing field or not and all this different things, but the administrative burden I do not think is the issue here.

MS. GOULD: This is a question for Len Burman. Linda Gould with the National Association of Realtors. Certainly, representing self-employed individuals as our organization does, we have given a lot of thought to the

challenges in the individual group market. You referred to voluntary reforms as one of the solutions in the individual group market. If that market did not reform itself voluntarily, how might you structure some nonvoluntary reforms? In other words, how do you get at that marketplace?

MR. BURMAN: The proposal that I actually worked out with Amelia Gruber a while ago is that the idea was in the spirit of people who think that there should be a market solution to give incentives to the insurance industry to figure out how to solve these problems itself, essentially, adverse selection is not in the insurance industry's interest as an industry. They sell a lot less insurance than they would if they could get healthy people to buy insurance, but for each individual insurer, there is a strong incentive for them to get a healthier-than-average pool.

In terms of the nonvoluntary solutions, actually, there are two or three people on this panel who know more about this than I do. Linda, do you want to comment on that?

MS. BLUMBERG: There are a number of ways you could go about it. I would say that I would suggest that in order to solve the problems that we see in the nongroup market, we need some government involvement as well. Letting the market fix itself I do not think is going to work because of the risk-selection and segmentation issues.

For example proposal that we have developed which is not all that different than what is going on in the State of Massachusetts is the notion that each set up could set up a purchasing pool where individuals would all have

guaranteed access to insurance coverage, private plans could offer coverage. You might also have a plan that is kind of a self-funded so to speak government plan that would have specific rates that it would pay as a kind of competitor to the private plans that were available on the market. All individuals could then have access to purchase those plans. You would provide subsidies for low-income people to be able to afford plans. In addition, our suggestion to the approach is to also have subsidies explicitly directed toward individuals who have high health care needs.

Part of the problem with a voluntary system such as what we have is that if you open up the doors and you let everybody in to the nongroup market, then what happens is that costs on average go up and individuals who are healthier tend to exit when they have the option to do that. What you want to do is create some sort of mechanism where pooling is much broader than just the group over which the premium is being determined. So if you can either pool risk for those in the employer market with those in the nongroup market, shifting some of the costs of the higher-costs people to the much broader population or have government subsidize the high cost so that the cost for healthier individuals in the nongroup market would not skyrocket to the point that they would voluntarily exclude themselves.

MR. GALE: Bob? Last question.

MR. REISCHAUER: Bob Reischauer of the Urban Institute. This is just a footnote on Bob Samuelson's point. I think Kate's answer is right in that employers will not have a hard time at all. They charge premiums now to provide

various classes and you can just add those to workers' wages depending on what your particular categories are. Of course, the categories that the tax proposal suggests are not the same categories as one has at the workplace. At the Urban Institute we have single people, we have a parent with a single child, a couple with no children, and families, and you might have some sort of transition kinds of problems.

I also think that this whole effort will bring increased transparency, and by increased transparency you will also get increased divisiveness when it is clear to my research assistant, a single healthy 22-year-old, that he is getting added to his income the same as the 55-year-old single diabetic, and that is going to be kind of a problem.

There is another little wrinkle here for employers, and that is the calculation of where to get your insurance is going to change for many people. Right now, something like 65 percent of the Urban Institute's employees get their insurance through the Urban Institute, 35 percent from a spouse's policy. That is not maybe going to be the same and for some institutions you might get increases in the numbers of people who are getting insurance through that firm and therefore a burden on the firm in the short-run to others' relief. In the great scheme of things I do not think these changes are very much, but it does not take much to stop things in their tracks.

MR. GALE: I think that was a question for you.

MS. BAICKER: Maybe I will say one thing and then I will let you bring us home, which is the reality of the way health care markets are operating

today is that employers are stopping offering coverage, small employers in particular are stopping offering coverage. We have seen a fairly substantial erosion in the fraction of people getting insurance from their employers, and that trend is going on in the absence of any policy change. What this policy would help to do is give the people who are thrown into the individual market some tax help in going to get their policies. I do not think that the policy can stem that tide that exists now, but it can throw a life raft to the people who are thrown out into the individual market.

And I think that this policy would work with the Affordable Choices Initiative or other initiatives to make the nongroup market function better because part of the reason the nongroup market does not function very well right now is that the group market is so heavily subsidized relative to the nongroup market that people will not stay in the nongroup market very long if they can help it, so lots of reasonable insurance premium profiles that would get people in when they are healthy and then keep them in as some of them get sick and some of them do not are not really available now because that market is not subsidized at all and people try really hard to get out of it. So if you could level the playing field, that would open up some policy instruments to you to make the nongroup market function better that simply are not available right now. So these initiatives I think could work together to make both the group market function better and the nongroup market function better.

MR. AARON: Just two points. Kate had some charts indicating the effect of the administration's proposal by income class. This is a town that

loves to look at distributional tables by income class. With respect to this proposal, however, I think they are not on point. The real issues here are not between rich and poor; they are between old and young, and sick and well. I have not seen any tables done breaking down by health status, class, or by age. Those should be done and I think they would be interesting, and I believe they would be troubling, but we should wait and see what they say.

The final point is a number of us have referred to the affordable choices aspect of the proposal, but we have been rather Delphic, and I think it would be useful just to add a little flesh to those bones. I hope I am going to be accurate in my characterization. My understanding of the proposal is the funds currently granted to the states under the disproportionate share program which a supplementary grant provided ostensibly to hospitals in states that serve a disproportionate share of low-income households. It is an adjunct to Medicare and Medicaid. A program I must say is really quite dreadful and has been terribly abused by the states, no good words to say for it. That said, if that is the source of funds, we are in real trouble.

I tried to find out for state distribution those funds and I admit the numbers I am going to give you are pretty stale, but they have not qualitatively changed. The numbers were for the year that I was able to find information, five states received more than $1,000 per uninsured person in Medicaid disproportionate share grants, five more states got between $800 and $1,000 per uninsured person, 17 states got less than $100 per persons, and one state got nothing at all. What that means that as a source of funds to underwrite a program

that really should apply fairly equitably across the United States in order to make access to insurance real, the distribution is wrong and the total amount of money involved in my view is not adequate and that could be supplemented from other sources.

MS. BAICKER: May I give one point?

MR. GALE: I think you should respond, yes.

MS. BAICKER: You are raising a very important point that the disproportionate share hospital payment program through Medicaid is quite inequitably between the states and is driven in large part by which states were the early ones how to leverage the most money out of the system. That is only one potential stream of funding for the Affordable Choices Initiative. It would need to be balanced against other potential streams of funding that could perhaps balance out that inequity in the way that they were allocated. And you are also raising the important point that it is not particularly specific right now, and that is on purpose because the president directed the secretary of HHS to work with the states to figure out which streams of funding were easiest and most fruitful to move, and to work with Congress to figure out which streams of funding were easiest and most fruitful to move. There are a lot of different choices.

The overriding principle governing that should be redirecting funds from institutions to individuals because right now we are doing a lot of ex post funding of uninsured people. People who are not insured show up and get charity in care in a way that is not particularly good for their health and is not particularly efficient for the system. If you could take those funds that are going to reimburse

hospitals and providers after the fact, instead directing them to insure those people beforehand so that they could get more efficient care that is better for their health and more cost-effective, then you could really get more bang for the buck out of those dollars. The disproportionate share hospital payment stream is just one example of money that is not being spent particularly well to cover uncompensated care, there are lots of others, and as we choose among them, you want to think about which ones could most improve health and which ones would be most equitable across people and across states.

MR. GALE: Thank you all very much, in particular Kate for a very articulate presentation. We are going to change sessions now and ask Bob Reischauer to come up and introduce his session, and we will continue in just a second.

(Recess)

MR. REISCHAUER: Why don't we get started? Can the Senators milling around in the hall there sit at their seats or leave? When I came here I thought I had been invited to a forum on tax policy as it relates to health expenditures, but having heard Kate Baicker and Linda Blumberg speak, I now realized that I was at the final competition for the 2007 Tom Skully Fast Talker Award. The title of this panel, if I have enough light to see, is "Where Should We Go from Here." This title suggests to me at least that the president's policy is not going anywhere. That might be an appropriate political if not an appropriate value judgment, or it could suggest that the president's proposal is okay for the interim, but if we are thinking longer-term, we should think in different ways.

I for one would say that if we are thinking long-term we should start by asking what it is about health insurance that warrants special treatment in the tax code. Of course, that is a question we should also ask of housing, mortgage expenditures, property taxes, retirement savings, and a lot of other tax preferences. If we assume that we do want to use subsidies to encourage insurance coverage and we want to look out over the long-, long-, long-term, I think we should be asking whether we should focus those subsidies on something more than just do you have health insurance, or how much does your health insurance cost, the former being what the president has proposed, the latter being what we have today.

The two big problems this nation faces going forward are the rapid growth of spending, and quality that is well below what we as a nation should expect. Those are not separable, they should be joined together, and so my candidate for looking forward would be to begin thinking about what we can do to encourage those two goals together. We know that not all types of health insurance hold out the same promise for dampening the growth of health care spending at the same time as they improve quality, and we should begin gathering the information that might allow us in the future to focus our tax subsidies on the joint product thereof.

We have a first-rate panel here to discuss these and other issues. We are going to start off with a presentation by Mark McClellan, move on to Mark Duggan, Jeanne Lambrew, and Gene Steuerle. So in that order, let me present Mark.

MR. MCCLELLAN: Thank you all. It is very good to be with you this afternoon, and having been in a position like Kate was in today, I got to tell you it is more fun to be on the second panel, I think. Let me see if I can get this started.

Kate did a very nice job of presenting some of the key features of the president's plan, and I do think this is an important step, an important proposal for moving forward the whole debate about how we are going to get to better health insurance coverage, and as Bob said, a better system for getting high-quality care to ever person in this country, and I think it is going to be very hard to do that. I have four key points to make about moving forward on getting more people covered and getting to more affordable and sustainable health care.

Number one, as the president's proposal does, we have got to provide more meaningful help and greater equity for the growing number of Americans who do not have the luxury of coverage through their job right now. This is a growing number of people. It accounts for most of the uninsured today. They are working people who are getting almost no help at all from the government in getting health insurance and no wonder so many of them are unable to afford coverage. We had some discussion on the first panel about the importance of linking steps to provide new financial help to that group with steps to improve the function of the nongroup health insurance market, and I am going to come back to that.

The second key point is pay-go. We are operating now in a very tight financing environment, and even if you are one of the people who thinks the

president's tax cuts should not be extended and that somehow that is going to lead to more funding for new health initiatives, even so, we have got to take steps to redirect spending to achieve more coverage and more financial sustainability for our health insurance programs if we want to keep Medicare, Medicaid, the tax subsidies for health insurance, the other new forms of help that may be coming to support affordable health care. If we want to keep all of that sustainable for the future, we need to find ways to get more for what we are spending, not just add in new money. The problem in our health care system is not that the government or the private sector is not spending enough already.

Third, we want to limit and crowd out of existing coverage particularly the good coverage many people prefer through their employer, but I want to emphasize that if you are doing something about this first area and the second area, you are not going to eliminate any kind of crowd-out effects at all, we are just making these alternatives to employer coverage more attractive, so there is going to be some crowding out and just need to deal with that, be aware of it, and plan for it in going forward with reform proposals.

Finally, and I cannot emphasize this enough as Bob just did, we have got to take steps fundamentally to improve quality and efficiency of coverage, put much more emphasis on increasing value in health care, not just paying more for more services, more emphasis on prevention and care coordination, and I am going to come back to that as well.

Looking at new ways to assist people without employer coverage, I frankly do not see how you are going to get there unless you reform the employer

tax exclusion perhaps along the lines or at least building on the approach that the president has taken. One reason I do not see any other way to get there is because proposals from Republicans and Democrats over the past 20 years that have made a serious effort at addressing this problem have all involved one way or another reforming the employer tax exclusion. The Clinton plan's rate proposals from President Reagan and the first President Bush before that, all of them involved taking steps to take the current system which is not progressive at all, and as Kate said, as assistance concentrated in some of the wealthier groups and people with the most generous plans and reforming them. The president proposed a flat exclusion which as Bob said would give everyone a much stronger incentive to get at least basic health insurance and would be an important step for covering more people without spending more money. If you think that is too tough on providing adequate assistance, there are a lot of modifications, some of which came up on the first panel. You could index the increase in the exclusion to average health care costs rather than CRI; you would still have the incentive for people to purchase a basic health plan at the lowest feasible cost. You could do a cap deduction. You could do a tax credit so that you could have even more progressivity. But all of those involve reforming the employer tax exclusion, and it is a big service that the president has done by getting that issue on the table.

Second, we can link these reforms even more explicitly than the president's proposal did with reforms in the nongroup market. There are many approaches to doing this, and I think it is very important to come up with constructive approaches to build on the president's plan for solving this problem

because we are going to have to deal with this in order to get more people covered.

Finally, even if we are not going to see more action on this at the federal level, many states are taking steps to do this right now, redirecting funds and taking advantage of some new federal funding sources as well. I want to talk briefly about some of the things that are going on in the states that I think in many ways are very promising.

There are a lot of reasons why states are acting now. I think it is not just that they feel like they are fed up with federal inaction on this, and there has been federal inaction on issue of uninsured for 20 years plus now. For one thing, there has been a lot more flexibility in Medicaid waiver approvals in the last few years. If you look at some of the major reform proposals that are being implemented now with the intent of increasing insurance coverage without spending a whole lot more money, Maine, Vermont, Massachusetts, Arkansas, the list goes on and on, that is a direct result of flexibility in how the Center for Medicare and Medicaid Services and HHS are enabling states to redirect funds, provide new kinds of benefit packages, new partnerships between employers and the like, that had not been used much in Medicaid programs in the past and is making a big difference now.

The second key point is the flexibility in benefit design that was created by the Deficit Reduction Act. Again, in Medicaid, most of the money that is going to help low-income individuals get health insurance now is through Medicaid and S-CHIP. Under the DRA, states have a lot more flexibility in how

they can spend that money. If you talk to folks in California, that proposal is a direct result of the DRA, the proposals that they were able to put together.

The third important factor is slower Medicaid spending growth. This has been going on for several years now. In the past year, 2005 to 2006, Medicaid spending went up at about the lowest rate I think in the last couple of decades, just a few percent with a big slowdown in prescription drug growth, as well as other areas of cost growth, and I think all of these issues are related, the flexibility for states to adopt innovative approaches, et cetera.

The fourth factor is favorable economic conditions, relatively speaking, for the states. All of those are very favorable for further action by states to address the problem of the uninsured, but it does not happen with the states alone, you have to have a supportive Medicaid/S-CHIP/federal funding program.

Many states are now taking steps to improve coverage options such as setting up purchasing pools, Linda and others mentioned that earlier, and providing subsidies for their low-income working population without coverage. Almost all of these proposals are about redirecting institution-based federal and state funds, and that includes DSH as Henry mentioned in his comments, but that is about $8 billion a year in DSH and Medicaid funding alone, so it is a lot of money, but it also includes other sources. For example, some states like Massachusetts had hundreds of millions of dollars tied up in other types of charitable programs. Arkansas, a state with very little DSH funding to begin with was able to fund their program to help small businesses provide insurance with a

subsidy up to 200 percent of poverty by redirecting state institutional funds. So this is a common feature of all the state reform programs that are going on now.

Massachusetts and California get all the press. Lots of other states are doing this, too. A couple of points to mention in these proposals as they come together, things to watch, one is the cost of the insurance plans that are emerging from the state nongroup market reforms. In California, for example, they think they can provide coverage for about $225 per individual per month. Massachusetts was aiming for something like that, but it turns out their proposal is looking considerably more expensive. States like Tennessee, in order to make sure they come up with an affordable policy, are focusing on the bottom-line costs. In Tennessee, they are aiming at a cost of $150 per month. The plan has to provide basic insurance and catastrophic protection, but the competing plans bid on what the benefits are that they can provide within $150 a month rather than requiring a whole bunch of potentially costly coverage mandates.

The other key problem for states doing these approaches is of course that the incremental cost of the coverage expansion, the more that you can redirect money and avoid new taxes or other new sources of mandated revenues, the easier it is to implement the programs. This is where California may have a little bit of difficulty in that proposal. Even as it stands now, there is a 4-percent payroll tax on employers who do not offer coverage, and that amount to be a pretty substantial cost.

S-CHIP reauthorization is up this year. This is an important step that the federal government can take to help states reduce the uninsured. Instead

of simply reauthorizing the program, maybe it is time to consider mandates for children's coverage, maybe it is time to consider new financial incentives for reducing the number of uninsured low-income children, have a performance measure built into the S-CHIP reauthorization. Maybe it is time to look at successful approaches that states have been able to take to use ASHIP funds to set up an infrastructure so they can provide more affordable coverage to low-income families and adults working with employers and working with private insurance plans. It is the best opportunity we have I think at the federal level this year.

Finally, this would emphasize that if the president's tax reform proposals are implemented along with the Massachusetts, and the California, and other plans, it would make those state initiatives much, much easier to pull off successfully. In the problem of affordability of health insurance in Massachusetts, for example, was going to be a big deal for families who do not get much of a subsidy over 200 or 300 percent of the poverty line, those costs go way down if they get this new flat-tax exclusion.

Some people have said that the individual insurance market cannot work. This would emphasize that we have had this problem and tried to address this problem in Medicare already. The key steps in the competing plans that are available to Medicare beneficiaries are, number one, everybody gets significantly subsidized coverage, so almost everyone participates, and of course, an individual mandate could achieve the same kind of goal. There are local, regional, and national plans that are competing that meet some minimum standards but have a lot of flexibility in how they can design their benefits and provide services within

that with guaranteed issue and no underwriting, and I think a very important point increasingly in the future in making competitive markets work well in health insurance is risk adjustment of the payments to the plans. Risk adjustment encourages a concentration of efforts of where the costs are, again, risk adjustment of payment plans not based just on demographics, but on the health characteristics, the predictable expenses of individuals in the pool. A number of state Medicaid programs are already doing this as well. In Medicare I think the experience in the last couple of years since these steps have been implemented is that it is working. The Medicare new spending on health plans is being extremely concentrated on beneficiaries with chronic illnesses and predictably high costs. Plans are now competing by offering new and innovative benefits that are attractive to these patients, additional drug coverage, care coordination and management services to address some of the huge gaps in quality of care for treating chronic illnesses. The result is now better access measures, better satisfaction measures than with the traditional Medicare fee-for-service program particularly for beneficiaries with chronic illnesses, and substantial savings for beneficiaries, averaging about $90 a month across all beneficiaries, but much higher for those with chronic illnesses. In fact, some of the fastest growth in Medicare in the past 2 years has been in so-called special needs plans. These turn the traditional view of HMOs on their heads. These are coordinated care plans that only accept membership from people with serious chronic illnesses. Why? Because they are providing services like nurse practitioners, electronic records to support care coordination, additional wellness benefits for people with chronic

diseases, and it only makes sense when you are treating the highest-cost patients. So this competitive choice approach is getting new, innovative benefits that are improving care coordination and access for beneficiaries with chronic diseases. And again, states are doing the same kinds of things now. Minnesota, Arizona, and others are using private insurance programs in pools to get insurance to offer up-to-date benefit designs that work well for people with chronic diseases.

Finally, I want to emphasize that the reforms have got to address the huge gap in health care quality and efficiency. We have talked around these issues today, but I just want to emphasize that first of all we have got to do a much better job of measuring quality and cost, there are a lot of efforts underway to do that now, and that if we want to keep costs down, it is important to focus not just on trying to reduce prices, but also on getting the quantities right. Cost is price times quantity, and a lot of our big problems in the health care system today are in the wrong quantities, the wrong treatments, overuse of some procedures, underuse of many drugs and chronic care management and preventive techniques because we are not providing enough support to promote the right care for each patient.

In our system this has to involve public-private collaboration on developing consistent measures and on developing ways of supporting getting to better quality of care. That means moving from fee-for-service to fee-for-value in payments to providers, it means getting consumers much more involved in their own treatment decisions. Again, as I mentioned earlier, this can work for people who are chronically ill as well. In fact, that is where some of the most important

benefits of getting patients involved are because people with chronic illnesses have a pretty good idea of what works best for them and, therefore, can help drive us to a better designed health care system.

We need to provide more support for informed personalized care decisions. This has been a big deal in Medicare's choice programs working over the last couple of years. I want to emphasize that choice and competition I think are a key part of this well, not that I have anything against government-run health care, but it is not clear today what benefit packages and what types of services are going to work best in the coming years particularly for people with chronic illnesses. What we know is that the existing programs do not do a very good job of dealing with prevention well and of keeping people from preventing costly complications of chronic diseases very well. The treatments, the drugs, the services that work for certain chronically ill patients will not work for others, and one-size-fits-all is an increasingly poor fit.

In terms of action this year, I think the president's proposal has done a great job of promoting a lot of attention and debate and hopefully action on this issue. I do not think it is sufficient to criticize the president's plan on an issue so urgent as providing more affordable coverage and better quality health care particularly for people without insurance. Let's see some specific alternative proposals and move forward on this whole process. Certainly the candidates are all going to have them, but I would be even more optimistic about prospects this year if we saw not only criticism of the president's proposal, but good, solid

alternatives. The state actions are absolutely going to continue in 2007 for all the reasons that I mentioned.

Finally, at the federal level, I think you can expect to continued administrative support for major state reforms. There are at least a dozen states that are seriously considering such reforms to approve access to coverage for people who cannot get good coverage through their jobs now. With S-CHIP reauthorization, that presents some opportunities not just to reauthorize the program, but to take further steps to encourage reducing the large number of eligible but unenrolled, particularly low-income, children and providing more infrastructure to support affordable, good-quality care options for more people. More emphasis on quality measurement and payment will certainly be involved in Medicare legislation this year, and with FDA legislation particularly around drug safety we have an opportunity to put in place a much better system for supporting better evidence development particularly in the postmarket setting on medical treatments which in turn can help lead to higher-quality care through more informed decisions. Thank you all.

(Applause)

MR. DUGGAN: I was a bit intimidated when I heard this morning that there would be in the neighborhood of 200 people here, and now after hearing Mark talk so fluently about the nooks and crannies of many different federal and state initiatives, a little more so, but hopefully I will get some momentum here.

I am very honored to be a part of this panel and to follow Mark and to talk to all of you today. I think like everyone here, I am very much hoping that in the next few years we will not continue to see the number of uninsured in the U.S. go up to 48 million, to 49 million the year after that, to 51 million the year after that. I think all of us here hope that federal and state policies will interact to produce a real dent in that number. I want to give a bit of background. Some of what I am going to discuss unfortunately has already been mentioned, but certainly not all of it.

As we have heard many times now, the tax subsidy to health insurance up to now has really only been available to folks who were offered group coverage. Essentially, if you look at data, and here I am looking at data from the Kaiser Family Foundation, it is virtually all high-income individuals are either getting employer-sponsored insurance at work or have a family member who is, but less than a third than those in poverty are. Many people have talked about the higher marginal tax rates and thus the higher subsidy for those with high incomes, but it also arises from this very differential access to employer-sponsored insurance.

I think it is true that this regressive tax subsidy contributes to the income insurance gradient that we observe in the U.S.. If one looks at the data, about 37 percent of noneligible individuals who are in poverty who do not have health insurance, versus just 6 percent of their high-income counterparts, and that sort of gradient has all been attributable to the tax code, probably not, but I think that most of us would agree that a considerable share of it is.

I think one thing that I would like to step back and talk a bit about is the idea of what consequence does it have for a person to be without health care insurance. I think today there has not been much discussion about that, there has been a bit more on people forego preventive care and they end up going to the emergency room and that ends up costing more, but I would like to point to one recent study which in my view is the best evidence that is out there on the consequences of being uninsured for people who are in very bad health, essentially the study by Joe Doyle who is a professor at the MIT Sloan School of Management. He has unbelievably detailed information on every auto accident that occurred in I believe Wisconsin and what health care individuals received after these auto accidents when they were taken to the hospital.

The idea behind the paper is that at a hospital, if two patients are admitted, a person with health insurance and a person without health insurance, they are going to likely incur large loss if they treat the uninsured person intensively. So he finds consistent with this pretty persuasive evidence, controlling for every characteristic of the care accident, uninsured people who end up at the hospital in trauma care get much less health care than their counterparts who have health insurance and that this results in much higher mortality rates for the uninsured. To my knowledge, if we aggregated up all causes of death among people under the age of 40, I think this is number one. It depends exactly what the year is, but it is right up there. So this is a real consequence. I mention this partly to point out that I think there is a real urgency to grab a bull by the horns on this issue and really try to tackle it.

The question that I have is similar to the one that many have raised, whether tax subsidies are somewhat of a weak instrument. I certainly agree that the plan that has been put forward by the president makes two very important improvements. The first is that it makes the playing field more level in the sense that those without access to group health insurance can potentially get this tax deduction. On top of that, it encourages more efficient purchases of health insurance. So on the margin, people are trading up a dollar of health insurance with a dollar of other kinds of compensation, so those are good things.

But it is not obvious that it is going to make much of a dent; it is likely to make some dent in the number of uninsured, but even with the proposal, health insurance is going to be much too expensive for families, many of the differentially poor, or low-income individuals who are without health insurance. As Kate mentioned, the average family policy today costs about $11,500, and this will still be too large a share of potential wages for many workers to make it optimal for them to purchase it, and so they have to make this very gut-wrenching decision of do I get health insurance, especially if they have kids, or not, and live in a tiny place far out from the downtown. In any case, I think I would say that the proposal makes two important steps, but I am going to encourage a bit more of an effort on that front on the next slide.

It is also true that fewer firms are offering health insurance, and I think many of the people who have talked today based on what they have said and what others have written, it is plausible that the share offering health insurance will continue to decline, perhaps accelerate, but it is hard to know. It is very hard

to predict the effect of these policies, but this is something that we will want to be aware of. I think the thing that is lurking in the background is that the number and percent of people without health insurance continues to increase, so this light have a level effect on the number of uninsured, but what are we going to do about this steady growth in the fraction who are uninsured?

What I am going to say, I do not have the benefit of dozens of people to analyze every consequence of the policies, but I want to throw out some ideas, and I have not thought through all of the economic impacts of this, but one could be a bit more aggressive about changing the tax subsidies that are inherent in our tax code by essentially eliminating them for high-income individuals, or significantly lowering them. I think it is in a sense unconscionable that the federal government and my state government are subsidizing my insurance by $4,000 or $5,000 a year for my health insurance and my family's health insurance, and contributing not at all for some family's health insurance for a family let's say making $20,000 to $25,000 with a couple of kids. I think we could reduce the subsidy for high-income individuals and substantially increase it for low-income. We have seen that the subsidy goes in the opposite direction. I think that we could flatten it or we could even tilt it the opposite way so that the subsidy fell with income. There are many complicated factors to work through here, so perhaps eliminate, perhaps they would only get half the subsidy that they currently have, but it seems like the revenue raised from eliminating it for high-income individuals could perhaps be used to increase subsidies for lower-income

individuals so that we could make more of a dent in the number of people without health insurance.

In doing this, it will be important to address the various problems in the nongroup insurance market that have been raised. One is that there are different load factors; this is what economists refer to in thinking about the costs of insurance policies. The load factor refers to the access of premiums over expected benefits, and load factors in general are much, much higher among individual or small policies than they are among a policy purchased by a very large firm, so it is possible.

Another alternative would be to consider expanding Medicaid coverage to more groups, and this would be a potential alternative to or complement with the tax subsidies. In doing this, it would be important to work out the various incentive effects. We would want to design it, as Mark said, in such a way to keep in mind crowd-out type issues. I am not saying that Mark advocating this, but just worry about the crowd-out issues, that if you extend Medicaid, perhaps many people will drop their private coverage and it will end up costing more than you expected.

It is true, actually, that there have not been many horse race studies of Medicaid coverage and private health insurance for the same person. I actually did one little-noticed study a couple of years ago looking at what it costs when we move a person from the Medicaid program into a private health insurance plan, and I found for the state that I studied actually a substantial increase. That may not generalize to other states, but I think it is not obvious to me that expanding

Medicaid or a program like Medicaid is an important part of what we ought to be doing.

I think though that slowing health care expenditure growth is an important thing for us to be focusing on, otherwise the fraction of people without health insurance will continue to rise. Basically it is 16 percent of GDP now and rising every year. I guess I would push, and Mark and others have alluded to this a little bit, for us to be a little more aggressive about thinking about, we have talked about accountability in education, why don't we think about accountability in health care? In 2005 the U.S. economy spent $2 trillion on health care, $903 billion spent by federal, state, and local governments. The average household in the U.S. spent $8,000 in taxes for federal, state, and local health programs. What is the return of that spending? We are not doing nearly enough to try to figure out how much is health improving as a result of this spending, trying to wring out spending that is not efficient, and direct more money to things that are. In doing this, it is crucial to differentiate between the average effect of some treatment and the marginal effect, and arguably the most influential study to have done that is a paper by Mark, Joe Newhouse, and Barbara McNeil in The Journal of the American Medical Association.

In doing this, I think there are really three key considerations, the price of health care treatment, are we paying too much for a given treatment given how much it improves health; are we treating too many, perhaps too few people with a given treatment; and then administrative costs. How much of our money,

if we follow where the money goes, how much is going to medical care versus the various overhead and administrative costs.

I guess what is a surprise to me in the private sector when a company like Wal-Mart is trying to do things more efficiently, they may try to learn from Target, their competitor, and Target may do many things wrong and some things better, but it is surprising to me that we a nation do not want to try more to learn from what other countries are doing. There are many problems with Britain, France, Germany, and others, but we spend 120-percent more than Britain per person, and our health outcomes are actually slightly worse. It is complicated, maybe we have more inequality, we have more obesity, et cetera, but still that is a striking number to me and something that I am personally, and I think many here, are not too happy about.

If I were to do any one thing in health care in the U.S., I think it would cost virtually nothing relative to the rest of the federal budget or other government spending, would be to create an agency to try to estimate the effect of health care in the real world, to really go after all this money we are spending on these things, let's see if it is working. FDA trials do this very early on to look at safety and efficacy, but I think this would provide very valuable information to consumers, insurers, providers, and policymakers, and it would be a sort of public good that could improve quality and lower costs in the U.S. health care system. Thanks very much.

(Applause)

MS. LAMBREW: I have a couple challenges. One is that I do not have slides, and two is I think we are running late. So I am going to try to talk as fast as the fast talkers have before me.

What I would like to do is actually talk about this issue of eliminating the tax exclusion as part of health reform and start by saying that there are a lot of areas that we agree on. I think we all have to agree that it is a regressive form of taxation, and we all agree that the employer-based system is not sufficient in this current health care system. In fact, as part of my work with the Center for American Progress, we were part of a coalition that includes Wal-Mart, SEIU and other kinds of strange bedfellows to say by the year 2012 we need to move to a system that is beyond the employer-based system that includes everybody.

But I do think there are a couple of important points I would like to try to make. I do not think we can eliminate the exclusion before we have universal coverage or even as part of a plan that creates a universal coverage system. I think we have to first get the system in place and then eliminate the exclusion, and let me explain why.

One of the things that we have heard about are some of the negative effects of this employer exclusion on the health insurance system, but there are also some positive effects. We heard Linda Blumberg earlier talk about the importance of pooling where the group system really allows for pooling across income, across age, and across illness. We really have a de facto pooling system which we discussed already. But one of the kinds of inverse aspects of the

employer system which is in some respects a negative is the invisibility of its prices. We can debate whether or not this price transparency of premiums will help people be better shoppers and lower the price of health care in the U.S., but there are a couple of things we do know. We know the fact that the vast majority of low-income people who have access to employer-based coverage actually take it. So even though they are getting a small subsidy, a tax subsidy that is very low in the big scheme of things, they take up employer-based coverage beyond where you might expect them to. And vice versa, we also know that people who have access to free health insurance through Medicaid or the Children's Health Insurance Program often do not take it up.

The truth is, health insurance participation is about more than money, and I think we need to kind of take our lessons from the pension world where we have learned that default enrollment, automatic enrollment and making things behind the scenes as possible is important to participation in health insurance which we think is a public good. So at the end of the day, giving that pooling mechanisms and this participation effect of our employer-based system, I would have to agree with analysts like John Gruber who think that this proposal that the president has put forward could actually cause more people to become uninsured on net than people who gain coverage. I think it is an important thing. We are talking about a proposal that may go in the other direction from where some people think we should be heading at this point in time. I think the analogy is like thinking about a leaky dike. The employer system is clearly leaky, it has gaps in it, but you would never try to repair that by first blowing it up and then

trying to build a dam after all the water is gone. We just cannot blow up the employer-based system until we have some alternative in place.

Could you do that as part of a universal coverage plan, put it in with the policy to create universal coverage? I think there are two challenges that that type of proposal would face. The first is it takes time to build alternative insurance systems. When you think about all other areas of social policy, when we try to think about Social Security reform, we usually phase it in generations at a time, cohorts at a time. When we thought about the Medicare drug benefit there was a subsidy to make sure that people who had access to the employer-based coverage could actually keep that coverage even though Medicare was providing the benefit. I think it is going to take time to have an alternative system to the employer-based patient and, frankly, if you are trying to do this all in one fell swoop and do it with a transition, the money is just not going to be there to adequately fund the low-income subsidies that you need in a universal coverage system. So I am not sure it is possible to do even when you are looking at a proposal to cover all Americans.

I have, like many people, have a health insurance proposal that was published a couple of years ago in which the way we would do it, which is very similar to what Linda described earlier, to what Massachusetts has done, to what actually California has done, and frankly, to what the Health Security Act was about a decade ago, keeping employer-based coverage and public insurance programs, create alternative group options so that people are placed to get health insurance, make critical investments in areas like information technology and the

comparative effectiveness research that Mark was talking about with information so we really know what we are doing, truly progressive subsidies so we make sure that when we are spending money on premium assistance it goes the most to the low-income crowd, and lastly, to require all Americans to have it. We need to have a system where we create the place for people to get it, the subsidies for them to afford it, and then the expectation that everybody is in the system. That is the sort of plan that I think is a common-denominator plan that would propose. You could begin to curtail the employer exclusion as part of that as you are moving to this new system, but at least we proposed a couple of years ago that we should look at a value added tax or some new source of revenue to really begin to move into this new system.

We do not have time to debate the merits of a value added tax, and believe you me, I have done that many, many times. We chose it primarily because it is a broad-based revenue source. It is comparable to how our competitor nations finance their health and social insurance systems. And if we can think this through in the long-term, over time once we get everybody in hopefully by the year 2012, then what could happen is we can gradually move away from the exclusion toward a broad-based financing system, and I would argue, bring in Medicare, bring in the whole entire system because clearly we have an irrational system and we need to think of a way to get to something that is more rational.

I will end by saying that I think when we talk about the tax exclusion, it is fun to do the math. We all love to do our math examples. But as

somebody said earlier, this is really a very serious issue. People's health and their lives effectively are at stake when we talk about health insurance, so we cannot do this carelessly or quickly, and I would argue that we all want to get to a point where we can eliminate the exclusion in the tax system, but we need to do that on a pathway that is responsible. Thank you.

(Applause)

MR. STEUERLE: At one point I considered joining Bob and Ray's Slow Talker's Club of America. It was a great skit, but I do not think that would work too well for today.

I probably should retitle my talk Health, Tax, and Budget Policy for the 21st Century because my focus is mainly on the budget aspects of the president's proposal, how I think we have to move in that direction, and how I am very dissatisfied with the notion that if we do not get everybody's perfect reform that we are not going to take undertake some of the things that he has suggested. By the way, I agree with most of the modifications people suggested in terms of risk pools and making this more credit based and everything else, but I object to he notion that doing nothing is something that does not have to be defended, and that is largely what my talk is about.

If we are going to spend this much more on the tax exclusion or on Medicare or something like that, the people who are advocating doing nothing are just as responsible for talking about those incremental expenses that are going to be spent however unfairly and inefficiently as they are for part of the reforms.

Let's suppose we had a program and we went outside Brookings here and we started throwing money off the roof and the money was available for people to buy health insurance, and all of a sudden Mark comes in and says I think we are going to stop doing this program. People would say cannot stop doing that, there is a little old lady across the street and she has got good health insurance and the distribution of benefits is not perfect but I am not sure what your substitute is, I do not think you have to be a genius to decide that this is not a program you would want even if we are not sure of the program we want in its place.

Joe Theismann once was talking about what it meant to be a genius, and he said you do not have to be a genius to play football. He said a genius is someone like Norman Einstein.

(Laughter)

MR. STEUERLE: My view is that health reform is a continual issue, it is one-sixth of the U.S. economy, and it is growing perhaps to one-fifth. None of us know how to control that part of the economy. As Len Burman mentioned earlier, it is changing rapidly. In fact, it is changing so rapidly that 5 or 10 years from now, half of what we spend is going to be totally different than what we are spending on it now. Reform not only must be continual, but it is always going to be controversial because we are talking about a huge, huge portion of the economy. So I do not accept as an argument that we do not know or we do not agree on what to do, therefore we cannot reform because I think a lot of what we do as analysts when we do it well is we find boundaries, we find

borders around which we just should not operate and these borders are where you cannot justify the policy on the basis of any principle, it violates in some sense all principles.

I would say that much of current policy particularly with respect to the tax exclusion that I would even argue also if we had time with respect to aspects of Medicaid, they are not sustainable, they are not efficient, and they are not fair from almost any perspective. Mostly importantly from a budget perspective, they involving decisions for increasing spending every year in an inefficient and inequitable way, and the incremental spending is actually even more inefficient and inequitable than is the baseline spending that we undertake.

This graph here shows you just how we are now spending revenues, not just revenues that we have now, this is the increases in revenues that are due to the American tax system under current law. Under current law, revenues of the United States government will increase by about $344 billion over the next 4 years. These are Congressional Budget Office numbers converted to real dollars. If you look quickly at that set of numbers, you will see that over half of the increase in revenues going to the United States government has already been determined to be spent on health care. So those of you who think we can live and operate in this world until we can agree on reform are deciding this is how you want to spend the money, you do not want to spend the money on children's programs, you do not want to spend the money on community development, you do not want to spend the money on a lot of other things that I would argue might be equally useful to society. And also you do not want to let

policymakers decide how to spend the money; you want to leave this an open-ended subsidy.

Just to show the level of cost in the role government plays, this adds in the tax subsidies to the other subsidies in the system and see government now, depending on how you do the calculations, comes up with 55 to 60 percent of the health budget, so they cannot sit on the side and say we are going to wait only for private-sector reform. In fact, government at all sources by my calculations are spending about $1.3 trillion, and if you divide that up by individuals, it actually comes out to be about $11,000 per household, that is, total spending per household if you take estimates of national health care spending done by Health and Human Services and you divide it by the number of households, you come to a number already that is about $19,000 per household, government is already spending $11,000, and we sit around and say we just cannot agree what to do, we just do not have enough money, or we have to get to reforms.

Let me get to the increments. If you take the increments, the estimates HHS comes up with, just in the next 4 years we are going to spend another $2,000 on health, but we are not going to spend it in any way we have decided. $2,000 per household, by the way, is enough to buy a very, very decent health insurance policy for all children. No, cannot afford that because we have to keep the existing tax exclusion, we have to keep the existing growth in Medicare. Or if you believe we ought to be spending it on other programs and investments in children which are often for young people like education, we also

say the money is not there. So I do not accept the notion that we cannot or should not do something about capping the exclusions.

By the way, for those of you who are baby boomers in this audience, and I cannot but help but always show this slide, your are scheduled to get somewhere between three-quarters and a million and a million and a quarter dollars in benefits as a couple in Social Security and Medicare because if you look at the numbers closely, you know that all of the government is aiming for us, but that is our legacy to our children.

What are the first steps we need to take? I think from a budget policy perspective, you have to cut off automatic growth in the inefficient and unfair tax subsidy, and I would argue you should cut off default growth in Medicare. And for those of you who are interested, there is a paper outside that Rudy Penner and I did that actually is almost exactly what OMB put up and adopted this year as a proposal on how to slow down Medicare growth. These are not proposals for what health care should look like. These are proposals on how you have to cap the growth in spending so we force it into a decision-making process. Growth is still possible; it just has to be on a discretionary basis and with a level playing field.

Having said that, I will grant that there are some very tough second steps, and this is where we start to disagree more, but I think we would agree at least to the following, that we should be spending the saving at least on health subsidies that are likely to increase rather than decrease coverage, and I have argued, and I think some others have taken up this argument, that the incremental

amount spent on the tax exclusion right now decreases coverage because of its influence on health costs. I am not talking about the average amount, I am talking about the incremental amount, we are spending more to decrease coverage, and we do not want to do that. We certainly do not want to bias the health care spending against innovation, and I would argue that we are also doing that in many ways because, as Mark if anybody would tell us, we are spending a lot on acute care, we are spending a lot of chronic care, and there are incentives for providers and technology firms to emphasize that type of research because there is a lot of money in there. There is less incentive or relative incentive to have cures that might not be quite as profitable.

I think we have to recognize that our system does not empower decision-makers; we do not like the fact that government is making decisions; we do not like the fact that individuals make decisions, we do not like intermediaries making decisions, but somebody has got to make some decisions here and reform has to do that. Of course, several people have talked about dealing with adverse selection.

To conclude on an optimistic note, a pessimist is someone when he smells the scent of flowers looks around for a casket. I think if we are willing to try to gain control over this health cost growth, we could get greater coverage fairly easily, we could get better use of technology, we could certainly devote more money to health research, and I think we could have a growing instead of a declining children's budget, and I think, by the way, we could do such things as health insurance for children. Thank you.

(Applause)

MR. REISCHAUER: I realize that we are running over here, but we will have a few questions. As before, please raise your hand, wait for the microphone and identify yourself. We also have an interesting problem here because we have two Genes and two Marks, so if you want to be more specific, add a last name.

QUESTION: I want to take the discussion down to more of a street level and that being that I work for the federal government and I am finding many retirees are staying in the group of their federal employer so that would prevent any increase in the nongroup coverage that you were talking about. I do not know if you talked about veterans as they come out of this war, how they may have some kind of increase in the nongroup. Also I see that when both sides for the president and against the president are fighting right now, what could happen is we could tackle the reality of abuses in the programs, that being doctors who overcharge and what have you. There is no enforcement in that. I am not saying that it is a bad thing, but you could keep those doctors to a point in which they would give back to the medical community by helping low-income folks. But there is a lot of abuse and we know it, and I do not know if that is being addressed.

There is one more thing I had right here. There is a lot of politics in the Medicaid system here. Locally, and all I can speak to is locally, D.C. has experienced a $300 million decrease in their budget due to it cannot get reimbursement for Medicare and that is because of a couple -- contracted out

neighborhood housing facility that took care of mentally challenged adults and there is an ongoing investigation in which the former mayor and the city administrator gave wrong information to the judge. So as a punishment, the federal government is saying that we are going to hold back your reimbursement until you give us a full and complete story about those deaths at that contracted house. So this is politics right now, and as the guy was saying that we are paying $8,000 per household to provide state and city health care, so with this $300 million you have to divide that amongst the population of D.C. so that $8,000 will increase because we have not been reimbursed for that $300 million. So that is the politics locally.

MR. REISCHAUER: I think that was directed at you, Mark, because you are the most recent person to leave the federal government and you must be the guy who withheld the money from the District of Columbia.

SPEAKER: On the point about the Medicaid spending, it is actually common or too common for disputes to arise between the federal government and the states about whether the Medicaid dollars are being spent for their appointed purposes. I think that that is one reason that some of the proposals recently in the Deficit Reduction Act that gives states more flexibility in how they spend the money within a broad overall spending level are actually a good thing. It will help reduce these fights, it will also help states and the District of Columbia spend the money more effectively.

On this broader point about differences in people for and against the president's plan, yes, there are some differences, and my version being an

optimist, I at least heard a lot of interest in trying to if not accept the president's proposal wholesale, at least trying to build on it and realize that we need to do something now, we cannot afford to wait, and there are some steps that states and the District are taking to make more affordable coverage available, and there is a lot that the federal government can do right now to support those efforts.

MS. PIERCE: I am Olga Pierce with UPI. My question is, I do not know if anyone else had this response, but Bush's plan is supposed to help cover 3 to 5 or maybe 9 million uninsured people. I am just wondering if this sort of tax reform offers hope for the other 40-plus-million uninsured or if it is really just something that will work at the margin.

MR. REISCHAUER: Since Gene expressed the feeling that it would lead to greater uninsured?

MS. LAMBREW: Also I am sure other people will respond, but I think that Henry Aaron actually said that it is very -- as well. It is always the question of winners and losers. There will be some people who will lose employer-based coverage and some people who will gain coverage because of the new tax treatment maybe through the employer-based system, but most likely in this nongroup system, and the question is about behavior. What is going to happen with small businesses, what is going to happen with large firms, what will happen to those early retirees that that gentleman talked about?

I think it is a big question mark and I think without a lot of good research and some existing kind of tie-ins of what we see, without the tax incentives, will employers really continue to do what they are doing today?

Probably not. Will that mean that people who are middle-income or low-income who are either older or have some kind of health risk can find coverage in the individual market? Probably not. We did not talk about the statistics much, but in 35 states there is no guarantee issue meaning you are required to get insurance; the company has to give you an offer, there are rating reforms that are pretty weak so that you can get an offer but have to pay a lot of money. So there will be a change as Henry Aaron said not just in numbers, but who is uninsured because it will be potentially a shift so that some people will gain coverage, some people will lose coverage, and the losers in this case will probably be higher illness older people because of just the nature of the market. That could potentially fixed but, frankly, until that is on the table, I think we have to be looking at a question of which direction that the policy is going to go in which is not a good place to be I would argue.

MR. REISCHAUER: Mark?

SPEAKER: I was just going to say that it was that exact issue that caused me to mention higher subsidies at the low end than are in the president's proposal, and combining that with a proposal to expand whether it is an S-CHIP or a Medicaid-type program that is carefully targeted so as to minimize crowd out. An important problem with expanding government health insurance programs is that as you expand them, people will optimally choose to drop their private coverage, but if you can manage that, I think you could make a much bigger dent than 3 to 5 million in a revenue-neutral way.

MR. REISCHAUER: Gene?

MR. STEUERLE: I think you have to divide the president's proposal into parts and again I am not defending the whole proposal myself. The notion of capping the subsidy and converting to a more level amount per person, those like myself, I think most of the people here said they would prefer to go more towards a credit-based system, actually a voucher-based system, get outside the tax system. That clearly I think moves in the direction of increasing the number of insured people by itself.

The question as to whether there would be more uninsured people gets to the issue of supposing now to expand the subsidy to the nonemployer market. If you really believe expanding to the nonemployer market by itself causes this increase in uninsurance, you could comprise a proposal well let's just convert the employer-based subsidy to a better subsidy. It is not perfect, but that would be an incremental step.

When it is all said and done, and I am not sure that that will go, my motion is that this issue of how to deal with nongroup insurance and individuals is an ongoing and continual issue. That is why we have got to involve the states. We are not going to resolve it. And if we leave the current system we are having more and more people drop out of the employer-based system anyway, so we have got this issue to deal with anyway, and we do not know any one single solution. I think we will all agree that we have got to put some subsidies into the high-risk insurance pool, we do not really in all honesty any of us know how to do it perfectly and so we have got to have some experimentation. We should take the

steps we know how to do, for the ones we are less sure how to do, let's leave ourselves some maneuver room.

SPEAKER: Just as a final comment, this is the flat exclusion, so a $15,000 deduction from your tax liability to get insurance is a pretty strong incentive to buy health insurance within the tax code, and you get that same deduction whether you buy a basic policy or a more comprehensive policy under the current system, and you only get the deduction until you spend money on health insurance and you get it through an employer. I think that is why most of the analyses that have been done suggest a significant reduction in the number of uninsured as a result of the president's policy. You can clearly build on it to perhaps get more people, the steps that have been discussed drive more affordable and widespread availability. Good plans in the nongroup insurance market would sure help with that. I think many of the supporters of the president's policy believe in a demand push, if the subsidies are there then there is going to be more attention to making those markets work better, but there are a lot of many states are doing that the federal government can support to make lower-cost plans available more widely in the nongroup insurance market, so that would help.

If you pair this with the reforms that many states are undertaking in their Medicaid and S-CHIP programs already so that people with low incomes get direct subsidies, remember, it is not the federal government that provides those subsidies directly, it is the federal government that subsidizes state programs to give people money toward buying their insurance plan. If you put those together, then you would have a really powerful impact. The president's proposal plus

something like Massachusetts even without a mandate is a pretty powerful approach to getting many more people insured.

MR. REISCHAUER: That was not the last word. As Gene said, we really do not know whether the president's proposal as it is will lead to a reduction in the uninsured, an increase in the uninsured. These estimates depend on a lot of assumptions, and the range of plausible assumptions is really quite wide here and important ones really relate to employer responses and we really do not know if there could be co-linearity between the employer responses. So I would not put much faith in plus 9 million, minus 5 million, whatever you want.

A much more important thing I think given the strong incentives that Mark pointed out is that depending on what the administration's definition of qualified plan is, it could lead to a situation where many people feel they are underinsured, that they buy policies that seem okay when they are healthy, but one never knows when one is going to become unhealthy and then they will be very unhappy campers. You can say that is tough, the same thing with what car you purchase. You think it is a great car because you are just zipping around town, but now you have to drive to the West Coast and you wish you had a different car, but this is the kind of thing I think you should focus on. Are there other questions?

MR. SMITH: Bruce Smith, and I have a question for Mark McClellan. I wonder if we could focus a little more on the Medicaid side, and could the federal government somehow have the authority to mandate coverage under Medicaid and mandate a connector of the Massachusetts style? If we went

that way first, presumably that would force everybody to have insurance if it works. I have heard a number of things on the Massachusetts, including your thing at AEI, I am not sure that it is going to work, but could the federal government work on that end of it first, on the Medicaid side and the connector side and some kind of mandate?

MR. MCCLELLAN: Good question. I think what the federal policies over the last few years have done is give the states a much broader invitation to try new approaches in how they spend their Medicaid and S-CHIP dollars to get more people covered and a recognition of the fact that Medicaid as on the books was designed as a program to provide health insurance to people on welfare, not to deal with the main problem that we are facing today which is working Americans, particularly those with low to moderate incomes not being able to afford health insurance and it really is a different and broader population that you want to target. Many states are doing that under the flexibility around now.

Some steps that the federal government could take without mandating a particular approach would be to further encourage what might be things like having performance-based payments in Medicaid and S-CHIP. For example, instead of just matching state spending, the way it works now, you spend more money on your programs and you get more federal dollars, maybe look at some performance goals related to that, have you as a state made progress on reducing the number of uninsured below 200 percent of poverty without putting a lot of caveats on how exactly how it is done, has the state been able to

take steps to improve some important measures of quality of care, that kind of emphasis on what we are getting for what we are spending that really has not happened in a health care system where the federal subsidies are really based much more on how much you are spending, not what kind of value you are getting for it. So that might be an intermediate step.

But even without the federal government providing a lot of specific guidance, many states are taking steps in the direction of making more affordable options are available to people outside of the group insurance market. Again, Massachusetts and California get all the press, but Arkansas, New Mexico, Michigan, many other states are either implementing or seriously considering reforms that move along the same lines. I do not know that the federal government needs to do a whole lot more there except to continue to support what the states are doing.

You asked also about mandates. That is something that has not been done at the federal level, but when you look at coverage for kids now where over 70 percent of the uninsured children in this country are already eligible for existing public programs, you wonder whether there is more that we can do to focus on getting enrollment of eligible kids up, that is what would make the most difference, not again just plowing more money into the current system which is clearly leaving a lot of kids uninsured.

MS. LAMBREW: If I could just say a word about the reforms real quick. One thing about demonstrations is that I wish at the federal level we were better at using the results of demonstrations and actually encouraging states to

truly demonstrate. But at least in my experience having also been in a position of looking at waivers at OMB, states are often using them to circumvent federal rules to access federal funding. There are state options we could use to allow states to have the resources to do it. I think we ought to be taking what we see in all these states not necessarily as the solution to our health problems, but a signal that we need national reform. We have an economy that cannot support 50 different health insurance programs, so I actually take the right lessons of what we are seeing at the state level.

MR. REISCHAUER: Last question?

MR. MATNAMAR: Ken Matnamar (?) with a question for Mark. You gave a California projected at about $250 per individual. What is the Massachusetts number? And did you say that under the president's proposal there is going to be a repeal of the Ferguson so you can shop nationally?

SPEAKER: Under the president's proposal, one element of this connecting would be enabling people to buy plans across state lines, and that has been pretty controversial, but it is another step intended to be in the direction of giving people more affordable health insurance coverage options that maybe do not have so many mandates.

In the Massachusetts plan as it was finally implemented, it did include some significant proscriptions from the state as to what had to be in the actual plan, and the state has gone forward with trying to get bids from insurers on providing that coverage. I do not have the exact number, one of you might know,

but I think they have come in significantly higher than what the initial projections were.

California seems to be, or at least as the governor has proposed it, on a somewhat different path. They are aiming for a particular actuarial value of around $225 a month and they intend to stick to that. How did they get that number? They look at the cost of plans available, they had some expert consultants do analysis of what a basic insurance plan would cover, and this would involve a significant deductible, it is not gold-plated coverage, and that is what they are aiming for. In the legislative process in California there will no doubt be some pressures to increase the generosity of the coverage and to put in more mandates. The downside of doing that is that you drive up the cost per person covered and that makes it much less easy to get the general public to accept any kind of coverage mandate. You are telling me that I have to go out and buy a health insurance plan that is going to cost me $500 a month?

The opposite extreme which I mentioned briefly is what Tennessee is doing where they said what we think what people are willing to spend is about $150 a month on their coverage so we are going to ask plans to bid on what they can do within a $150 a month premium. They have to meet that limit, but within that they have a lot of flexibility, they have to provide catastrophic coverage, so they have a lot of flexibility in what other benefits they can provide. I think my point was just that you need to take steps to make sure that you are keeping the cost of coverage down, and too many mandates can get in the way of that.

MR. REISCHAUER: Thank you. I thank the panel here, and I thank the audience.

(Applause)

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