DEBATE: WHO SHOULD PAY TO CARE FOR THE UNINSURED?

Moderator: ROBERT H. DOBSON
Panelists: PAUL J. FELDSTEIN*
JOHN A. MAURER
KENNETH R. SMITH
Recorder: ROBERT H. DOBSON

- Providers – as they do now
- The uninsured – at least what they can
- Employers of uninsured workers
- Employers through taxes
- Assessment on health insurance
- General revenues – state or federal

MR. ROBERT H. DOBSON: We've changed the theme of our title, "Debate: Who Should Pay to Care for the Uninsured" just a little bit to be broader in relation to health-care reform. Certainly the uninsured are a major part of health-care reform. I would like to introduce each of the three panelists and then we'll go straight to the presentations. We've geared it so we will have a lot of time at the end for questions and answers.

Going first will be Ken Smith. Ken is an actuary who recently retired from Towers Perrin. He currently is working with S&A Partnership, Inc. in Southfield, Michigan. He's been doing some work with the Inter-Religious Health Care Access Campaign, and has been heavily involved in heath-care-reform issues. He's going to be our first speaker and give an overview of the situation.

Second, we have Dr. Paul Feldstein. Paul has written four books and over 60 articles. One of those books is *Health Care Economics*. His most recent book is *The Politics of Health Legislation: An Economic Perspective*. Finally, he has sometimes taken leave from the academic life and has worked with the government with the Office of Management and Budget (OMB), the Social Security Administration and the World Health Organization. His paper, written with Mark Pauly, Patricia Danzon, and John Hoff and published in *Health Affairs*, was entitled "A Plan for Responsible National Health Insurance." I would commend it as excellent reading for any of you.

Our final speaker will be Jack Maurer, also an actuary. Jack is currently with Aegon Insurance Group in North Richland Hills, Texas. He has a paper being published in *Best's*. Jack, besides his position of Senior Vice President and Chief Actuary of the Health Division at Aegon, is also on the Executive Committee of the newly formed Council for Affordable Health Insurance. I think he will tell us a bit about that organization.

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MR. KENNETH R. SMITH: When Bob asked me to be on this panel, he asked me to take the token liberal position. And I'm not going to shun that role. I hope I can argue for some of the points that I think are valid in some of the more liberal positions. But I don't think it's the role that I'm most comfortable with personally. Maybe the role I'm most comfortable with is the actuarial role.

A pediatrician friend of mine has described me as an advocate for a rational approach to solving this problem, and I take that as a compliment because that is really what I am trying to do and trying to bring about here. Clearly our role as actuaries is first to substitute facts for appearances and demonstrations for impressions. Let me just give you some commentary on the Canadian system that I think illustrates that point. One of the appearances we get from some of the data that are cited is that the Canadian system has done a better job of controlling health-care-cost inflation than we have. The information cited to show that is the fact of Canada's rate of increase as a percentage of GNP has in fact been less than the United States. What those data do not indicate, however, is that it's Canada's increase in the GNP that has held that percentage down, not Canada's lower rate of increase in health-care costs. And the facts are that Canada's rate of increase in health-care inflation has been very comparable to the United States over the last ten years and even somewhat higher in the last couple.

Another side of this is we are left with the impression from a lot of the data that in fact Canadians are flocking to the United States for health care when in fact it's unavailable in their country due to the queues and so forth. But at least I have not seen any demonstrations of this. I think that's another thing that we're called to do is to provide the data behind some of these figures and not just buy into the popular mythology.

I'm going to be trying to set forth a basis for understanding the health-care-reform proposals, and our role in providing actuarial input. I'm very much in the camp of being in a position to say "yes, but," or "yes, and" to the various proposals. I think realistically we're not, as actuaries, going to have a major impact on the overall form of health-care-reform legislation. But I think we can have a major input into making whatever comes out of a political process better. To paraphrase a commercial, we won't make the laws, but we can in fact make them better.

The overall goal here is quality, cost-effective health care for all, supported by the vast majority of actuaries and the public in general. But within that overall goal, a lot of disagreement has been noted. For some, it's an ideal that we ought to be striving for but really too expensive or impractical to actually achieve. For others, it's a relatively easy problem, for example, the painless solutions that Congressman Rostenkowski made reference to in the General Session. But for many, if not most, major changes and major difficulties are going to need to be faced in order to address this issue.

I think of health-care reform really as a three-part problem, picking up on the Congressman's remarks about access and cost increases. I also think there's an issue we need to address, and that's being sure that quality health care is available. A lot of the debate on this issue has sort of taken that concept as a given in this country, that those who have access to care have in fact access to quality care. But there's a lot of data that also indicate that there are a number of unnecessary surgeries taking

place and wide variation in quality measures among providers of care within even the same geographic area. So there are some issues of quality that also need to be addressed as we address this issue. Certainly controlling cost increases is the key. I don't have to tell you the power of compound interest in working on that. One of the comparisons I developed is that a 2% reduction in the rate of health-care inflation will eclipse in just over five years the savings that would otherwise result from a 10% up-front reduction, let's say through reduced paperwork or administrative savings. That goes away in five years as compared to controlling the rate of inflation. Then, finally, is the whole issue of improving access.

I think because there are three parts to this problem, there also need to be three parts to the solution. We need to determine the health care to be provided. We need to look at reducing the rate of cost increases. And we need then to also look at reforming health-care financing. I think this is the logical order in which these issues ought to be addressed. They're interrelated, particularly the first two. What kind of health care you provide is going to be very related to how, in fact, you can control the rate of cost increases. One of the problems, however, is that most analysts' analyses of this problem have not clearly distinguished among these three different approaches. They have either looked solely at analyzing the financing reform alternatives, or to give an example from the recent issue of *Time Magazine*, February 17, 1992 the author describes what is called "three broad categories of proposals." One category was universal coverage, which I guess has to do with the health care to be provided. The second category was play or pay, which is, as we know, one of the financing alternatives. And then the third category was managed care, which is at least one of the approaches being suggested for reducing the rate of cost increases. But it's a real apples and oranges comparison, and I think that one of the things that we as actuaries can bring to this problem is some greater clarity about what exactly the issues are.

As I indicated, most of the proposals do focus on financing reform, and that's where most of the comparisons can at this point be made. The issue of the 37 million uninsured has gotten the attention of the politicians. It's easier to address financing reform, particularly if you can set aside the issue of inflation and say, "Okay, this is how my financing reform scheme would work in a controlled inflationary environment." And basically it's what gets the attention of the voters. All of the financing reform proposals genuflect at least to the other two issues. There are some health-care provisions or cost control features in them. But as I will comment as I go through, I think most of them really deal inadequately with that issue.

There are basically three types of financing reform: insurance reform or maybe call it more broadly "making health insurance more affordable," the employer mandate approach, and government financing. Virtually all proposals at both the national and state level tend to fall into these three categories, although in discussing this topic with my colleagues on the panel, I think what you're going to be hearing from them a little later may be slightly different. What I'm going to do here is just look at a broad description of each of these categories of financing reform, give you some legislative examples, and then raise some questions that we ought to be raising as actuaries, and that the public ought to be raising as we begin evaluating these proposals. Then I will conclude with the other two issues that I think need to be addressed and some of the points there, namely health care to be provided and controlling cost increases.

I'm not going to spend a lot of time on insurance reform. Not that it's not important, but I think it's the topic with which this group is probably best acquainted already. Many of you may be more aware of some of the nitty gritty of some of these proposals than I am. But it tends to focus on small employers. The statistic for example that the majority of the uninsured are, in fact, employed comes to play on that. One of the issues is coverage of preexisting conditions. The public has a lot of concern about that. "These are the people who really need insurance" is the kind of remark I think you often hear. Community rating is part of many of these proposals, and I think as actuaries we know some of the concerns and issues around that. And clearly to be workable as a means of gaining access, community rating would require a fair degree of regulation about requiring insurance companies to be in all markets and so forth. And finally, as one example, and there are many in President Bush's proposal also, some version of small group reform almost became part of the Democratic tax bill that Bush recently vetoed. I think the strategy was that if the Democrats included that, they could then point to Bush having vetoed a health-care-reform proposal. However, that did not become part of the bill.

I think we're fairly well-acquainted with employer mandate. Employers are given a choice of providing coverage, or playing, or paying a tax. It would replace Medicaid, at least in the Senate version, with something the legislators call Americare, which would be the coverage that was available if in fact you or your employer chose to pay. It would establish certain minimum coverage standards, defining certain benefits that would have to be provided in order for you to be considered a player. And the Senate leadership bill and, as we heard, Rostenkowski's own bill, both address the issue in this way. It's clearly the middle ground between insurance reform on the one side and government financing on the other. And because of its position, it's getting attacked from both sides. For example, in Bush's State of the Union Address, as you may recall, he basically outlined only two alternatives: insurance reform or government financing. He was essentially trying to eliminate the employer mandate from the debate. In my view, the Senate bill in particular is fairly weak in the area of cost control. I think Rostenkowski's may be somewhat stronger. Actually the strongest cost-control proposals from the advocates for an employer mandate come from the group called the National Leadership Coalition for Health Care Reform, which is a coalition of business, labor and some public interest groups. It is a fairly well-written and broad-ranging proposal that I recommend to everybody who wants to get up-to-date on this. One of the keys to the employer mandate is what's called the "all payer" concept. The concept is that all payers for health care would in fact pay the same rate, whether it was Medicare, there would no longer be Medicaid, but there would be Americare or private payers. Obviously that's designed to address the problem of cost shifting from one payer to another. It has actually been tried in the state of Maryland under a special agreement with Medicare to do that. And it's had some success there in controlling the rate of health-care inflation.

Finally, there's the alternative of government financing. The tax system would be used to collect the cost of health care. It would replace Medicaid and Medicare. Its other names are things like Single Payer, the Canadian Approach, National Health Insurance. Some of the supporters of that are Congressman Russo from Illinois in the House, and Senator Kerrey in the Senate. I think as most of you follow this, this is not the government providing the care but rather the government being the sole purchaser of care. That brings to mind other situations where the government is the

sole purchaser, under some of these defense contracts, with $500 hammers. But it also points to Medicare where the government has been fairly effective in controlling its costs. The question is, how much of that effectiveness has been due to the ability of the providers to then shift that cost to other payers? And would that same effectiveness work if that cost-shifting could no longer exist?

Different types of taxes could be used to finance this. There are some interesting implications of that: certainly the mix between employer and employee on the tax, and then whether we're talking about a wage tax or an income tax. One of the interesting aspects of that, if in fact we had an income tax, is the elderly in this country would end up paying a much greater share of our health-care dollar than they would under a wage tax, which of course, would not apply to them. It has some interesting political implications. I think most of these proposals for government financing are fairly weak on the cost control. They tend to rely very heavily on administrative savings and global budgeting without really addressing the cost-control issue. But that doesn't mean that that could not be addressed, for example, through some of the organized systems of care or managed care.

How do we evaluate some of these? Let me suggest that these are some of the questions we ought to be looking at: Does improvement in access really work? What is the impact on cost control? Who pays? How is that shifted from the current situation? What are the equity issues? What about the cost of the collection administrative procedure?

Does the proposal really improve access? I think that's something we need to look at. And let me just say as coming from Michigan right now, I can tell you that at least in that state, job-based coverage does not feel nearly as secure as it once did. I think there's going to be some perceptions around whether the access is really improved as well as the actuality of that. Is there some real impact on being able to control the cost? It doesn't seem to me that the insurance reform proposals have much leverage when it comes to this side of the issue. Government financing on the other hand has the greatest potential in both directions, I think, for not only controlling the cost but also for letting costs get out of control. Who pays and how much? That's going to be a function of the cost-control issue. But I think one of the things we need to look at is how whatever scheme we're talking about shifts the payment pattern from how it's paid currently. Certainly as a society, we would adjust better if there were minimal shifts in the distribution of how people pay.

I have some statistics on that. These numbers are always presented in different ways. This statistic includes in the individual and government piece, or business pieces, those wage taxes that are paid directly to cover health care, but does not include our own income tax. Under that scheme right now, 42% of the health care in this country is paid for by individuals and families, through premiums, deductibles, copayments and Medicare taxes; 28% is paid for by business; 16% by the federal government; and 14% by state and local governments. However, to look at it from *who's buying the care as opposed to where the money is coming from*, 42% of the health care in this country is purchased by governments, federal, state and local, which makes me not optimistic that we can develop any kind of solution where the government isn't at least part of the solution. Paul is going to be discussing the

whole issue of equity and who should pay and whether that should be more income related than in fact it is currently.

The cost of the collection and the administrative procedure is also something we need to look at. That's gotten a lot of play in the press and a lot of people like to jump on administration. That's sort of an easy target. Nobody's in favor of administration. But there's a lot of administration in the health-care system that I think does some good. It insures that there's proper payment for the care provided, and it provides the kind of data that we need to improve the system. What the public does not see any value in is the administration that determines whether your insurance company or my insurance company should pay. The public at least does not see that kind of administration adding value. And so, if you're going to have a proposal where that continues to be a part, that issue I think needs to be addressed.

Let me just make a couple of remarks about how we should also be looking at these issues of health care to be provided and controlling cost increases. One of the issues here in the health care to be provided is assuring quality of care. There are a lot of questions about that out there and all people, when they or their families are involved, want the absolute best quality. How are we going to address people's concerns on that if you believe, as I do and I think most do, that there are going to have to be some trade-offs in that area? Impact on cost-control -- do we provide benefits where it in fact promotes the controlling of cost, or do we provide benefits in such a way that inflation and cost increases are accentuated? That gets us right to the issue of patient cost-sharing. I think those of us in the actuarial profession have seen a lot of data that show that cost-sharing works. But I'm not sure our data necessarily go far enough. Cost-sharing works for employers. It works for insurance companies. But does it really work for the system as a whole? In other words, is unnecessary care being put off or is it just being shifted to employees, or the other side of that, are employees or individuals not getting care in the short term that they may need, and then having a greater impact on the health-care system later on? Next is the whole role of preventive care, whether we provide that through some sort of package or not. Maybe that's where this individual responsibility issue needs to be addressed.

Where long-term care fits in there is a very complex issue. And then there is the whole issue of rationing. It's a dirty word. I saw a survey taken back in the early part of 1992 where the various presidential candidates were asked whether they favored rationing. Both Bush and Buchanan said yes, and all of the Democratic candidates said no. But that's really almost the wrong question. I mean, we have rationing now. We're going to have rationing. The question is, how in fact should it be done? Should it be done on ability to pay, as it is now? Should it be done by medical judgment? Should it be done based on resources, for example, which is Oregon's approach, or some other factors, age, for example? I think actuaries have a role here in helping figure out how that can be best done.

We are concerned about issues in controlling cost increases and the impact on providers. They're going to be the front line in many of these situations. And with changes in rules, we need to take that into consideration. Does the impact of competition that really help in this kind of a market where there's not full information? Will in fact the cost control systems impact on quality? Added to that is the fact that there's a lot of good data out there that indicate that good quality medical care

actually costs less than poor quality medical care. So it's not like when you buy furniture and you can rely on the price as an indication of the quality and what's gone into it.

How important is freedom of choice? What can we give up in terms of that? And then consider the whole issue of managed care, organized systems of care, which is the new buzzword, because managed care has gotten so many negative things. I think managed care continues to hold potential.

Finally, in summary, I think there are four key points. One, we need to recognize that there's a problem. We need to look for the best solution in each of these areas: benefits to be provided, controlling cost, and financing, and not just focus on the financing. We need to get serious about cost control. There's no way that this can happen without that. The National Leadership Coalition for Health Care Reform proposals show savings per year by the year 2000, over where costs would be without control, of $600 billion. In other words, that's almost as much as we're spending right now, and that would be the annual savings by the fact that we brought it under control. And then, finally, no, it won't be easy. There are hard choices that will need to be made. Some people will end up paying more or getting less, both in terms of care and in terms of compensation, if you are part of the provider system. The transition from where we are now to where we will ultimately end up is going to have some bugs in it. It's not going to work right the first time. I think we need to be willing to accept that if we want to bring about real reform.

DR. PAUL J. FELDSTEIN: I'm very pleased to be here. As Bob mentioned, I'm an economist. And whenever I'm identified as an economist, I'm always a little mindful of what the late George Meany used to say about economics. He said, "Economics is the only profession where a person can gain great eminence without ever having been correct." So I worry about that. What I want to talk about is a plan for national health insurance. This is a plan that several of us have come up with. It's taken a number of years, and all the ideas are not new. Others have had the same ideas as well. We call it responsible national health insurance. Four of us prepared a paper published in *Health Affairs*. It's coming out as a monograph by the American Enterprise Institute in Washington, D.C. In the monograph, we've discussed the plan a great deal more in detail. We also provide a number of cost estimates of what the plan would cost based upon different characteristics of different aspects of the plan.

Now when we want to start with a plan for national health insurance, we don't want to start with something that's somebody's conception of what's politically feasible. We thought we'd start instead with what principles Americans believe in, and what we should try to adhere to. Those principles are that any national health insurance plan should be judged by whether it promotes two principles. These are efficiency and equity. By efficiency, we mean two things really. One is to minimize the cost of producing a given set of services. That seems fairly obvious to all. The other one is choosing an amount in quality of services valued most highly by consumers. In other words, we do not put some arbitrary expenditure cap on, but let the consumers decide how much basically they want to spend on health insurance. We say an efficient system is not necessarily the lowest cost system because you could starve hospitals, you could decrease technology, and you could lower cost. But it wouldn't necessarily be efficient. Further, we say that there's no arbitrary percent of GNP that

provides the correct rate of increase. There is no correct rate of increase that's tied to GNP. The right rate of increase in medical spending depends on the value that informed consumers with a quality and cost stake in their decision attach to new technology and the use of services. That determines the right amount to spend. What we want is a system that requires consumers to balance the value that they get from medical services and the cost that they have to pay as they do elsewhere. Currently, many consumers don't do that because employers pay the full insurance premium for about 54% of all single employees and the whole premium for about 34% of employees with families. So many of those employees don't make a cost-conscious choice, and the employer often pays a premium that's not related to the lowest cost plan. So employees don't have the incentive really to choose cost-effective plans.

When we talk about equity, we mean that, if you want to help those with low income, then the subsidy should come from those with higher incomes. It's not like an employer mandate where the burden eventually is shifted to the low-income employee. The current open-ended subsidy for employer-purchased health insurance should be phased out. Employer-paid premiums should be treated as taxable income. And this is for two reasons: because it's inequitable since the subsidy is greater for those with higher incomes, and it's inequitable because the subsidy depends on employment status, the size of the employer contribution and the person's marginal tax bracket. So you realize that if a person gets a $1,000 raise and you get it as cash, you have to pay federal tax, state tax, social security tax, and maybe you're left with 50%. Whereas if the employer buys you health insurance, you get $1,000 worth of health insurance premiums. And basically this is national health insurance for the middle class because it's worth $60 billion a year to those who have employer-paid health insurance.

We see that the tax exclusion for employer-paid health insurance distorts the incentives employees face between the cost and benefit of medical services. The tax subsidy lowers the value of savings from cost-containment programs, since such savings are taxed when returned to the employee, which the medical benefits are not. So that if you get the savings back and they're taxed, it's worth a lot less than the full amount going for front-end payments, copayments, and things like that.

Now the underlying assumption of our plan is it's an individual mandate. Everyone should be required to have a basic level of health insurance. Otherwise there's greater risk to the person if he or she becomes ill, and then he or she can't afford the needed care. Society should not have to pay the cost of that person's care. Society should not have to pick up the cost of free riders. The obligation to have insurance should be on the individual and not on the employer. This would not interfere with labor markets. It facilitates portability of coverage, employment mobility and ensures coverage even when you're not employed. And the employer wouldn't be influenced by the employee's health history or the number of dependents the employee has, and things like that, when the employer interviews somebody for a job.

The basic coverage, the core services, should be the same for everyone, but the out-of-pocket maximum should be related to income, so no one faces the risk of out-of-pocket expenses that are catastrophic. In other words, an income-related catastrophic policy is what we're favoring. High-income families would have higher

deductibles, copayments and stop-loss protection. Catastrophic insurance is determined by the income level. People can buy private supplements, but with after-tax dollars.

Individuals would have to indicate proof of purchase of an insurance plan meeting the basic coverage on their income-tax return. The government would provide a tax credit for the purchase of an insurance plan meeting the basic coverage. The size of the tax credit would be related to the cost of the basic coverage and the individual's income. The tax credit would reduce the person's income-tax liability. If the tax credit exceeded the tax liability, then the individual would receive a refund. The tax credit would decline as incomes rise, and the tax credit would become zero at some high level of income. At what point the tax credit becomes zero is really a political decision. How much you want to give to the middle class versus how costly the program will be is a political decision. What we say is that a low-income person would receive a refundable tax credit for the full cost of the managed care plan. If that person has no income-tax liability, the government would issue him or her a voucher that would cover the complete cost of the managed care plan. So in other words, if you have no income or very low income, you don't pay taxes. Then you would get a voucher that basically enrolls you in a managed care plan. If a person did not indicate proof of purchase of an acceptable insurance plan on the income tax, the government would deduct the cost of such insurance by increasing the person's tax liability and would assign the person to a managed care plan. So everybody should be covered by this plan.

Now, we would have the government take bids. In other words, we would establish a fall-back insurance plan. The government would solicit bids from insurers to provide the minimum required coverage in each area. The bids would specify the premiums for each rating category. In other words, we mean the out-of-pocket maximums by income level. And there are three reasons for the fall-back insurer. One, people may voluntarily join the fall-back insurer. It may be less expensive than other plans in the market. If people did not buy health insurance, then they would be assigned to the fall-back plan by the government, if they didn't indicate on their income tax they could be assigned to it. And the fall-back insurer would set the value of the tax credit. So that the poor with the voucher could receive care in some plan. In other words, if you want to make sure the poor are going to be able to join some plan, then there's got to be a plan there that they can join and that they can be paid to join that plan.

We would also eliminate current state mandates of which there are about 900 in all the states, which raise the cost of health insurance for the small employer. We also think that all insurers that agree to provide the basic coverage would have to guarantee renewability of coverage at standard rates. That would be a requirement. For financing, we would rely on a very visible and equitable method of financing, which is the income tax revenues as contrasted to hidden and inequitable employer play-or-pay mandates. The magnitude of the subsidies depends upon balancing the political cost of increasing taxes with the political gain of providing more general subsidies. The trade-offs between the size of the credit, the beneficiaries and the taxpayers should be obvious since they'd be discussed at congressional hearings. In other words, we think there should be open discussion of the trade-offs of how much you want to give a tax credit, to which income groups, and how many taxes will cause the greatest number of tax credits that you give.

On delivery systems, what we believe is that there should be competition among managed care plans. Reliance on a competitive health-insurance market is more likely to achieve an efficient and high-quality medical system than one controlled by the government and subject to arbitrary expenditure limits. We do not believe in an all-payer system where you can't have any possibility of price competition. It's really like a cartel among providers when you have an all-payer system. And we also think that Kaiser or other managed care plans can be as low cost as the government could be, however the government could reduce technology and access whereas, if Kaiser did that, people would go to other managed care plans. So what we believe is that the right amount that people would want to spend would be on a managed care system, not through some arbitrary expenditure limit.

Now as to how the program would operate, one group would be employed individuals and their families. It's likely the employer would continue to offer health insurance. The employer would merely mention it, or if you have the approved plan, that would be indicated on your W-2 form. Employers are likely to continue offering health insurance because there are economies of scale in large groups buying insurance. The employer is a more informed purchaser. It can screen different kinds of managed care plans. The employer would more likely be able to offer health insurance than it does now because it is not being required to offer health insurance. The employee is going to be mandated to have insurance, and in order to serve the employee, many employers are more likely to undertake offering insurance to provide a service to the employee. So we think more employers will offer health insurance because it's mandated on their employees, not on the employers.

The self-employed would get the same kind of tax deduction that the employer-paid gets. Right now the self-employed only get a 25% exclusion whereas those who get the employer paying it get 100%. The self-employed wouldn't be treated any differently. They could provide insurance on their own or through their own groups, or they could join the fall-back plan. But there will be a plan for them.

For those with low income and the unemployed, we currently have welfare offices that determine eligibility as they currently do for welfare programs. And they would issue vouchers for those who do not file tax returns. Those vouchers would be good for joining the qualified managed care plan. We would replace Medicaid. There would be no need to have it because it would be replaced by the tax credits and the vouchers. To have some money for the system, we would initially at least have the states maintain their current level of contributions to Medicaid, so that would add some funding for it. Eventually that could be phased out. Medicare could be kept separate or it could be phased in over time. We think it would be best to phase it in over time, but politically, you'd have to do it for those who are less than 55 years of age or something like that. That's a political decision, and it would be best if that were all together in the same system.

Now to give a summary, what we're doing is putting the obligation on the individual to achieve universal coverage. We would increase equity because we would tax employer-paid health-insurance premiums. The benefits of those go primarily to the middle- and high-income groups. Those funds could be used to subsidize the program. We would provide the subsidies to the poor and low-income people by income taxes, which is a most equitable way to assist the poor. We would encourage

cost-conscious choices because without the employer-paid health-insurance premiums and the tax deduction, people would realize the cost of what these different plans are, and think twice before choosing perhaps a fee-for-service plan as they would if they didn't have to pay anything. And there would be appropriate cost containment, and medical-expenditure increases will occur because reliance would be on a competitive market where purchasers have an economic interest in the selection of their health-insurance plans. We would also have, as I mentioned earlier, portability, since it would be on the individual. It would be guaranteed renewable, which a qualified plan would have to offer. There would always be an insurance plan which is the fall-back plan. It would preempt state mandates, and we would get the right rate of increase in medical expenditures.

Now, there are a few potential criticisms of our plan that have been offered. One is that it seems administratively complex: an income-related, health-insurance plan may be too difficult to administer. What we use though, is current bureaucracies. We don't start any new bureaucracies. We use the income tax system and welfare agencies to implement the plan. And some employers currently use income-related, health-insurance premiums. So we don't think it's that novel or that radical or that administratively costly.

Another problem that's been raised with our plan is that it's said that employers will now drop employment-related health insurance. We don't think, as I mentioned earlier, that that would happen because employers are trying to keep their employees happy in many types of companies. If the employees want it, it doesn't cost the employer very much to administer it. The employer would manage and look at other kinds of plans and act as an informed purchaser to the employee.

And the last potential criticism that's been leveled has been that individuals' ability to make choices is limited. And that's true. One of the things that distinguishes medical care from other markets is that we don't have very informed purchasers or consumers. That's why the only way to really get a more competitive market in medical care, I believe, is to have some large purchasers offer the choices and screen plans. If you can have competition among managed care plans, the employers can choose among those. The employers can get data on outcomes, on cost, and on performance of those plans. And the employee then makes a limited number of choices on the plans offered by the employer. We also assume that the government would be an informed purchaser when it sets up and takes bids for a fall-back insurance plan, that it wouldn't be in the business itself of delivering medical services, but it would solicit bids from fall-back insurers for those plans.

Now the one major criticism that I accept of the plan is that politically it may not be as feasible as some of the other plans. And that is, it gives very little to the middle class. In discussions with people at OMB and with some members of Congress, this is the main criticism we have heard, that all the plans try to give something to the middle class. We really don't give the middle class very much other than the fact that perhaps under a managed care competitive system, its costs won't go up as fast, that the system would be more efficient, that the middle class will get things such as guaranteed renewability, won't have state mandates, and things like that. But our plan doesn't really give the middle class big tax credit, because in fact, we take away the employer-paid health insurance, so the middle class loses something.

And if you give tax credits too high up the income scale, then that increases the cost of the plan.

But other than that, we think that our plan achieves efficiency and is equitable. We want to provide consumers with good information, with the right incentives, to choose what health plan they want, and to give the providers the right incentives to compete. We think that this would lead to an efficient, high-quality plan with the right rate of increase in medical expenditures, not some arbitrary increase.

MR. JOHN A. MAURER: The presentation that I'm going to deliver is taken from my paper "Sharing the Burden." Even though the *Best's* preprint is dated April 1992, I've been informed that it will actually appear in the May edition, not the April edition. Second, the views I'm going to present should be considered my own. They do not represent any particular group. You're going to notice a lot of similarity between what I'm going to present and what Paul just presented. I'll probably try to go through aspects of it maybe a little quicker because Paul's already gone over them, and that will leave us a little more time for questions.

Our current health-care-financing system costs too much for what it delivers. I usually don't get much of an argument with that. The question is, what are we going to do about it? There have been some proposals suggested. Let's see what some of them would do. How about improving access by buying coverage at the hospital door? That way you don't have to waste money while you're still well paying for insurance premiums. How about requiring small businesses to play or pay? A great idea if you want to shoot yourself in the foot. That is the most dynamic aspect of our economy right now. Who else picks up the downsizing results of our major corporations? One of my favorites is community rating. This makes insurance available to all by requiring a low-paid 20-year-old to pay the same premium as a highly paid 50-year-old with artery problems. It's real good thinking. None of these proposals can solve the basic problem. They all ignore insurance principles and individual responsibility. If you don't have to buy in before you get sick, insurance is not workable. Market forces can work, but only if the patient has a stake on the cost.

We need to preserve insurance principles and make these changes. First, create a level playing field for all payers. To be fair, it shouldn't matter who pays the bill. Payment to the doctor should be the same. Cost-shifting due to underfunded social programs is dishonest and counterproductive. Fewer doctors participate, and the participants become second-class citizens.

We should provide guaranteed coverage and portability for all persons who enroll in a qualified plan. Once you buy in, the plan is yours. Continue to participate and no new preexisting requirement will be imposed. Take it with you if you change jobs. It'll be there when you need it. Modify tax policy to insist and encourage the purchase of private health insurance. Let's help the low-income people with refundable tax credits. Let's induce higher-income people to participate with avoidable tax charges. Then, the industry can accommodate guaranteed issue.

Provide tax equity for individuals through individual health accounts. Current tax policy rewards corporations for spending money on employees' medical care. Current

tax policy penalizes individuals for looking after their own medical care. Current tax policy insulates the individual from the financial consequences of those health-care decisions. Is it any wonder we are faced with rampant increases in cost? In this financial wonderland, the more inefficient you are, the more money you make.

Our present system of health-care financing is commonly and mistakenly referred to as "insurance." Our current system is not insurance. Why not? Because to be insurance, the events insured must have these characteristics. They must be unexpected and undesired by the insured. Otherwise you have financial planning, not insurance. They must occur with relatively low frequency. If most everyone has a claim, you're just swapping dollars and paying a third party to do it for you. There's just no point to it. They must be outside the control of the insured. If the insured can control the event, insurance is impossible. The dollar amount of the potential loss must be so high that it cannot be budgeted for. Introduction of third parties to pay for budgetable items just adds unnecessary cost.

Let's see how these compare to our current health-care system. A major focus of current medical practice is properly on prevention and wellness. However, the cost for these measures are predictable and can be budgeted. They are not matters for insurance. Having the oil changed in your car is a good preventive maintenance measure. But I don't know anyone who buys insurance to cover it. Mandated benefits also violate insurance principles and make it more difficult to purchase true insurance at affordable premium rates. How many of those 35 million we keep hearing about would like to buy real protection but can't afford it? How many can afford but refuse to pay for Joe and Sally's attempts to conceive a child or for Bob who has to have a hair transplant to feel like a man? Sometimes it looks like the inmates have taken over the asylum.

What's the major result of violating insurance principles? Employers are trapped by escalating costs, and employees are trapped by fear of losing protection if they change jobs. In other words, the combination of counterproductive tax laws and misguided social policy has led to a system that pleases no one. What's needed? Here's a short list. We need individual awareness and concern with cost. This is essential if market forces are to be allowed to operate efficiently. We need the ability of doctors to practice cost-effective medicine without fear of financial ruin. Skyrocketing premiums for malpractice insurance and defensive medicine are major reasons for cost inflation. We need a level playing field and an end to cost-shifting and its pernicious effect on affordability. When costs are shifted to insured plans, fewer can afford insurance. The result is more uncompensated care. More cost is shifted to insured plans. And on and on. How about sensible tax policy? Let's give individuals and corporations the same tax treatment. Let's remove the bias in favor of the corporate purchase of medical services. This is a place to find funding for low-income subsidies. It makes no more sense to make medical expenditures 100% tax deductible than it would to make food expenditures 100% tax deductible. What do you think would happen to food prices if corporate spending for your food was 100% tax deductible? Everyone wants steaks; no one wants hamburger.

What will these things do? Well, Alice in Wonderland was able to make it back through the looking glass. Maybe we can, too. Let's give it a try. Let's free the individual from reliance on his or her employer, and free employers from burdens that

many cannot bear. Once in the system, the employee owns his coverage. Employers can contribute what they can afford. Let's free providers from fears of extravagant malpractice awards. It should have a major impact on affordability. Let's break the cost-shift assessment spiral. More young people will buy into the system. The spiral will begin to unwind. Let's allow the individual to choose his own mix of self-insurance and protection. Freedom of choice is fundamental to our way of life. With it comes involvement. With it comes competitiveness. And with it comes empowerment.

We need to fix our health-care financing system. Here are some ideas. Now these ideas were put together in an attempt to address all the important concerns that have been expressed. I view them more as a framework than as a blueprint. I also view them as a challenge to others to come up with something better. Define a quality plan. It should provide a minimum level of benefits and be broadly defined. It should provide a maximum of choice with respect to insurance mix. It should contain limited exclusions. And it must be exempt from state mandates and exempt from rate-filing rules. It would allow you to set up your own costs through the use of deductibles and coinsurance. It allows you to put your own limit on out-of-pocket cost in the form of a family resource amount as chosen by the insured. It will provide you with continuity and portability. It would allow just a 12-month limit for exclusion of preexisting conditions. And that's just at the outset. There would be no new preexisting condition period, in the event of replacement, as long as coverage has been continuous, with the option to suspend the individual plan if the employee elects to be covered by his employer's plan. He can pick it up later with no loss of any rights if he goes to another employer, becomes self-employed or whatever.

Establish tax incentives to encourage the purchase of private medical-expense insurance plans. Replace the fear of uninsurability with a desire for tax avoidance. A taxpayer computes additional tax on his 1040, based on income and family size. On the average cost of the qualified plan, tax grades down as income decreases and disappears at a predetermined level. If a taxpayer is covered all year by a qualified plan, the additional tax is not imposed. Those who are responsible and support the system will escape this tax. Allow deductibility of actual premiums paid for qualified plans. This is the same treatment as corporations currently enjoy. If individuals are going to accept the responsibility for taking control of their health-care needs, they deserve the same tax breaks as corporations. It's only fair. Low-income persons will receive tax credit based on income and family size to apply to the cost of the qualified plan. As the tax discussed above grades downward with decrease in income, the credit grades upward, such that the sum of the two remain constant. In this way, the ability to purchase insurance stays the same regardless of income level. Any excess revenue to the IRS would be earmarked to subsidize low-income individuals or used to offset uncompensated care. In this way, those who caused the problem will have their tax money directed toward the solution of the problem.

Establish individual health accounts (IHAs) as a funding option. This will provide a mechanism for you to save money to pay for preventive care and miscellaneous cuts and bruises. The IHA works like an IRA. As the fund builds, the individual can self-insure more of his needs. And as a result, the individual can exert more influence over the financial dynamics of the system.

Let's sweeten the deal a little further. If you make at least a minimum contribution to your IHA each year, and are also covered by a qualified plan, you are entitled to a stop-loss guarantee. This protects your assets against disastrous loss due to medical expenses. This would come into play primarily in two ways: if your policy maximum was exceeded or if your company went out of business. In this case, your maximum loss is the greater of your IHA account or the family resource amount that you have chosen, with the cost borne by an industrywide risk pool.

Limit the risk of malpractice awards for providers who agree to limit charge levels to prevailing rates, control utilization to normal medical standards, and charge the same price for their services regardless of payer. If these conditions are met, the provider is subject to compensatory losses only. Thus responsible practitioners will have a competitive edge, leading others to join in. Set up a special branch of federal courts made up of judges who are experts in tort law, who will have a responsibility to hear cases where pain and suffering are alleged. Pain and suffering awards for these providers would be paid from federal funds. This should bring stability into the system, establish standards for awards and lessen the effect of emotional appeals.

Companies would be expected to establish prompt pay programs with providers who agree to accept prevailing charge levels. The insurer would set his own rules as to the amount and nature of the qualifying charges. Patients would use an identification card as they would a credit card or debit card. The same fees would be charged to all for the same services. This is something that seems to be coming anyway, and I noticed a lot of articles on it after I had written this paper. And it seems to be kind of a wave of the future, and it may also be at least a partial solution to some of the criticism directed toward companies' administration costs.

Modify underwriting. All must be insured. There is an affordable premium rate for everyone. Companies will have to accept this if we hope to have an industry solution. Anything less will perpetuate the skimming criticism and lead eventually to a government solution that no one really wants. Abusive practices that limit access are not acceptable. Blocking, tier rating, and durational pricing are simply unfair and cause much criticism because they continually recategorize insureds who enter the group with the same risk characteristics. Companies will have to agree to avoid these practices in order to be certified as issuers of qualified plans.

Set up a nationwide risk pool. The government should enact enabling legislation and help fund the pool. The insurance industry can do the rest. State arrangements are too fragmented and too subject to political parochialism to work on a national basis. Only about half the states have pools and people do move.

With guaranteed insurability, when insurers drop out or when premium increases are extraordinarily high, you have somewhere to go. Once you buy into the system, you have the right to continue. You no longer have fear of being priced out of a system because you lose your job or a family member becomes ill.

To successfully redesign our health-care-financing system, we need two things: We need commitment and we need restraint from all the participants in the process. Politicians must prepare the field, act as referees, focus on incentives, fund social programs at prevailing charge levels. Providers must understand the financial

implications of their decisions and keep the system affordable. Providers also should expect prompt payment at going rates. Insurers must plan to include everyone regardless of health. The legal profession must support tort reform. Individuals must accept responsibility for their family health and assert control over their health-care needs.

Together, these proposals will result in an industry solution. Will companies step forward and take the challenge? Or will they insist on the same old idea of "We'll insure the best and the government can take care of the rest." If this attitude prevails, we'll see a move toward massive government control that will bring stagnation, delays, and service cuts, or in other words, a health-care deficit. The politicians will then decide how much money doctors and others deserve for their services. The politicians will then decide what constitutes cost-effective medicine. And we will no longer run the risk of making dumb decisions. The politicians will then be able to run an $800 billion industry in the same inimitable fashion as they run banks and post offices. Any takers?

We need to preserve our superior research experimentation and innovation capacities, as well as our freedom to choose, even if we do make an occasional dumb decision. That's what our way of life is all about. Let's redesign our unique private system so that it does what we want it to do. Let's create an American solution.

MR. DOBSON: I certainly heard a lot of good suggestions, a lot of similar comments. I've got a few questions for the panel. I think we should ask Ken exactly where the liberalism was in his views; I think we should ask Paul a little bit about the political feasibility, since everything sounded great until he said, "But the politicians won't buy it." Similarly with Jack, everything sounded good, but I wonder if any of the insurance companies will buy it. But given those guidelines, feel free to ask your own questions.

MR. WILLIAM J. SCHREINER: I'd appreciate it if the panelists would address the question of what the political and social imperatives are behind this issue at the present time. I would observe that Congressman Russo lost his bid for reelection. Senator Kerrey did not ride the medical care issue to the White House. Chairman Rostenkowski has reminded us that there's an incredible deficit out there that government is unable to meet and unwilling to tax the American public to meet. With this background, where does the issue of health-care reform fit?

DR. FELDSTEIN: I think there's really no consensus yet on health-care reform, because, as I mentioned, we have national health insurance for the poor -- that's Medicaid. We have national health insurance for the middle class -- that's the employer-paid, tax-free premiums. And we have national health insurance for the aged -- that's Medicare. And the only real change will come about when the middle class really feels the bite. And the middle class hasn't felt the bite yet because it still has tax-free health insurance. The middle class doesn't pay much out-of-pocket. And so it hasn't reached any consensus. But when it does reach a consensus, I think the principle it will follow is that it wants to get what it has now, which is free choice mainly of provider, without really paying much for the choice. The middle class wants to be subsidized in some way. And the only way it can do that is, I think, you'll have a small tax imposed on the working population, which will be

basically like the social security tax. Maybe a lot of low-income people will end up subsidizing high-income people. But right now the middle class is not that concerned about its own health insurance position.

MR. MAURER: Well, I think that there is an imperative, and I think that the political landscape is approaching a minefield. There have been a lot of proposals that have been suggested. All of them are of dubious quality. I think the reason why we don't have something going right now is because the political season is so hot and heavy. Bush is not going to buy off on a Democrat plan, and the Democrats are not going to buy off on a Bush plan. I am afraid that when the new congress is seated in early 1993, you will see a coming together and a solution put in the form of a bill that we probably won't like very much. So I think it's incumbent upon us to get our stuff together so that we can be prepared at that appropriate time to have an industry bill put together that does save the free enterprise approach to health-care financing.

MR. SMITH: I would agree that there is definitely a move out there, a political social imperative, if you will, for change. There's certainly no clear consensus as to what that change would be. And I think part of the reason is the point that Paul made, that the middle class, the vast majority of us who were covered by employer-paid insurance, is not feeling that. I think some of that is changing. For example, as your kids age out of your coverage and they're finding that jobs with full benefits are not nearly as available as they once were and that kind of thing, that's going to start to raise some of the consciousness. I think the other imperative is becoming increasingly economic. As we look as a society at international competition and see what a much larger percentage of GNP we devote to this particular cost as compared to our international competition, I think that's another thing that's creating an imperative here.

MR. JOSEPH W. MORAN: Dr. Feldstein, you threw into your description of your proposal something that struck a nerve: permanent renewability of coverage at standard rates. Once a person gets covered by any carrier, he or she has a right to get lifetime coverage at standard rates. Does that mean nobody pays anything other than standard rates and conversely that the standard rate becomes the highest cost rate governed by the population of health status of the risks that are covered by that carrier? Or is there a provision for variation in rates among groups, among individuals and among risks within that population?

DR. FELDSTEIN: It's a good question. It's a complicated question because we don't believe in community rating.

MR. MORAN: That's what I thought until I saw the standard rates for life.

DR. FELDSTEIN: No, we meant really what the percent increase would be. You said somebody has guaranteed renewability, but it could be at any rate, and you can easily write the person out by just having an exorbitant price increase.

MR. MORAN: But isn't there a maximum rate in your system? A maximum price level for any group?

DR. FELDSTEIN: Right, right. And that's basically what we're saying. So we would allow different experience-rated groups, but the annual percent increase would be limited to what it is for other groups. So you could come in at different rates and stay at different rates, but you couldn't exceed certain percent increases. You could come in less than that, but not exceed that. That's what I meant.

MR. MORAN: All right. And I wanted also in that same vein to clarify that the amount of imputed taxable income for somebody who's getting his coverage provided by the employer under your scheme would be based on what? The price that that carrier would charge? The lowest cost risk? How do you define that in a context where the individual might be able to buy coverage personally at a price lower than the average rate that the group is buying coverage at?

DR. FELDSTEIN: If I understand your question, you could always have the option of going on your own. If there's an insurer out there, fine.

MR. MORAN: Rampant adverse selection in other words, by age.

DR. FELDSTEIN: Well, the main question would be if you couldn't. And then if you could not, then at least you'd always have the fall-back insurer. In other words, if it's less expensive to go along with the employer group and it can negotiate a better deal, then you do that. But if you find that you can do something better, you have that option. But there is always something out there for people who could not do it on their own.

MR. P. ANTHONY HAMMOND: There are two main issues whenever we're dealing with these political questions: How many of the uninsured are going to get coverage, and what's it going to cost? And going along with that is, who pays for it? Can each of you address under your proposals, how many people would be covered or how many eventually would be helped, and what that cost would be?

MR. SMITH: Well, I didn't actually come up with a specific proposal. So that question I think is better addressed by my colleagues. Let me just comment on this. As I said in my remarks, I think the cost and coverage issues are very intertwined. And regardless of the option for providing universal coverage or universal access, it's unaffordable as a society unless we are willing and able to get the costs under control. So it seems to me that that becomes the key issue, finding ways as a society to control those costs that we find as a society unacceptable. And then if we manage that, I think there are a number of options for providing access that we could live with. What makes them unlivable is the uncontrollable nature of the cost.

MR. MAURER: I think we should realize that universal access is a given. It's just a matter of who's going to provide it. I'd like to see the private insurance industry provide it rather than the national government. When you talk about your 35 million or whatever, uninsured, you have to look at them in about four groups. You have your low-paid uninsured. You have your higher-paid uninsured. And within each of those, you have your insurable and your uninsurable. And I think you find that most studies have indicated that probably maybe 1% of the population is actually uninsurable by industry standards. So the question then becomes one of, how do you get the other part of these people who are insurable into the system? What I propose

here is a system of tax credits: I call them refundable tax credits and avoidable tax charges, so that the incentives are certainly there to buy in while you're still well. The uninsurable will have to be accommodated, and for those, I suggested that we would have a national risk pool to accommodate them. They probably should go in, at least starting off, at some higher rate than standard. I don't know exactly where that falls. I suggested it is probably somewhere between 150 and 200% of standard for the people to buy into the system and then be assigned to the risk pool.

DR. FELDSTEIN: As far as the number of people covered, I hope ours would be universal. But there's always a problem of the undocumented who fall through the cracks and get picked up late in the system, like for example, in California. But basically there are two groups to really supplement the medical coverage. One group is those on Medicaid who currently are inadequately covered. And the second group is the uninsured. As far as how much the coverage costs, it would depend upon what is the basic minimum level of services congress wants to give, how expensive that is. And then also how high up you want the tax credit to go? Do you want it to go up to give the middle class a tax credit, or do you want to end it earlier? Who pays? It would be the individuals' responsibility to pay, except if the individual is low income. And the money would come from really three sources. You would tax employer health-insurance premiums, which would raise about $60 billion. You would use current Medicaid expenditures. States would maintain their current level of effort. And then you would need, we figure, about $17 billion extra in tax monies to undertake our plan as we said. But you could come up with different cost estimates depending upon how high up you want to go with that tax credit, and how many middle-class people you want to get some of it.

MS. NANCY F. NELSON: First I'd like to say I was encouraged by comments made by several of you on what is insurance and an insured event in terms of health insurance, and the idea that out-of-pocket expenses perhaps should vary with income, and finally that tax changes are needed. I don't think any of those are discussed enough in the context of health-care reform. And with that as background, I'd like you to comment on two things. First, what proportion of income and/or assets is it reasonable to expect an individual or family to have at risk each year in terms of their medical expenses, which would include premium, out-of-pocket expenses and a tax if it would apply to their benefits? And then second, even though perhaps they're not insurable events, I think we could probably get a lot of agreement that certain preventative services such as immunizations for children are desirable. And how would you ensure that those are available to those who need them, if they're not insured?

MR. MAURER: Well, I always had this idea about taking care of children, and I think that's a very important idea. What I would really like to see is a system of community-based clinics attached to or along with the public school system. So that children, since they're there every day anyway, can have a staff of medical personnel necessary to do immunizations, testing and whatever else they need to do for the basic preventive-care-type thing. I think that would be an awfully good way to handle that particular problem.

DR. FELDSTEIN: I can just comment on what we've proposed. The amount that would be at risk for income and assets we said would be a varying level of income.

So you could go from like 5-15% of income. But that also is a political decision of how much Congress wants to do on that. We've come up with different cost estimates as far as how that goes. With regard to the preventive medicine, that's also political in a sense of what you want to be in the basic plan. One of the problems that we're all concerned about is that congress, once it starts developing a minimum benefit package, will throw everything into it. And that's a real concern because that increases the cost of the tax credit. My hope is that you won't overload the minimum plan. But there would be some preventive things that are known to have very high-cost-benefit ratios. My main feeling is that under a managed-care, competition-type framework, it would be in the economic interest of plans to decide what are worthwhile preventive measures to undertake, because it's in their interest to include them. And I think that's the way we would get the best kind of wellness programs and so on, if it turns out to be economically feasible to do that.

MR. SMITH: The 5-15% seems to me to be a fairly reasonable figure. I think the issue of preventive care is a difficult one in a sense because from an insurance point of view, it makes very little sense to pay somebody else to pay you back 80-90¢ on the dollar for those kinds of budgetable expenses. On the other hand, I agree with Paul. There are certain things as a society that we want to encourage in terms of health care. Certainly one is preventive care, like immunizations. Some of the data now on the health-care situation in this country are that immunizations are declining and rates of previously preventable diseases or immunized diseases are increasing. These are things we should be genuinely concerned about as a society. I think some sort of managed care organized system that carries your main vehicle does address that because there is a lot of incentive under that kind of system to ensure that people get adequate preventive care as well.

MR. JAY P. BOEKHOFF: In January 1992, the University of Minnesota released a report addressing health-care values. And the purpose of the report was that we're never going to have consensus on all the different types of financing mechanisms until we have some consensus on what we think the values are. And the preeminent value that they identified was access to a basic level of health care, which gets at what Reinhardt has expressed as, do we think of health care as we think of housing or as we think of education? That is, is it a uniform for everyone or is there a basic level of care for which we have higher levels going above it. I'm interested in the panelists' opinion about if we have a consensus on that fundamental question, and if not, if they have an opinion.

DR. FELDSTEIN: Well, I think there's no consensus because, once you put it before congress, everybody who's got a special interest in what should be included in a plan will be testifying. It would be very hard to say that's not necessary. But I think if you also include with that minimum level what the costs are of a plan, then I think it becomes obvious what the trade-offs are. I think there is no real consensus because it depends so much on how much you want others to have. Do you want them to have the same amount you do? But I think the best way to decide that is in an open forum in congressional debate.

MR. SMITH: I would agree. I don't think there is a consensus. We could identify health care as a basic value in our society, which people have done without getting

very specific about how they would do that, whether it was done on the basis of housing which, would be a minimal level with variation, or more like public education where everybody gets the same. To me, if we could as a society identify health care as a basic value and in fact then come up with the policies to implement it, whichever of those two approaches we would take would be a step in the right direction. I guess practically, my personal view is that the housing approach as opposed to the education approach would probably work better. But there are others who would argue the other side of that.