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## Session 61PD
## Access to Health Coverage

**Track:** Health

**Moderator:** THOMAS F. WILDSMITH
**Panelists:** GERALD G. SMEDINGHOFF
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**Recorder:** THOMAS F. WILDSMITH

*Summary: Panelists discuss the public policy issues regarding access to health insurance coverage. In particular, the speakers focus on the problem of the uninsured and on the debate of shifting from a primarily employer-sponsored financing of health-care coverage to an individual market system, or to even more heavily involved government financing. Panelists also discuss what future health-care reform efforts are on the horizon and what implications these proposals have on the access to health-care coverage.*

**Mr. Thomas F. Wildsmith:** This session is on access to health insurance. It's intended to address the millions of Americans who do not have meaningful access to health insurance, and some of the things that we might be able to do to help them out. We'll start with Dr. Kenneth Thorpe, then Gerry Smedinghoff and I will follow up on the tail end.

**Dr. Kenneth E. Thorpe:** Let me start out with some basic information that will be useful in all three presentations, in terms of who the uninsured are.

First, most of the uninsured are adults. On a typical month, there are about 43 million uninsured; 32 million of them are adults aged 19 to 64. Most of those are working. About 25 million of the adults who are uninsured work at some time during the year. Most of them work for small firms with under 100 employees or are self-employed, so it's a very specific population. Two-thirds of those workers are in firms that don't offer health insurance benefits, so most of them are in situations where they're either trying to find coverage through a spouse or they're relying on the individual market to buy health insurance.

The second biggest population of uninsured workers work for firms that offer benefits but the workers aren't eligible for them.



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**Note:** The charts referred to in the text can be found in order in the file 0lv61pd charts.pdf.

The third category is people who just turn it down. That's the smallest group. Only about three million workers that are uninsured actually have health insurance made available to them but actively turn it down for some reason. So that's actually a small part of the pie.

With these demographics and background in mind, I'll spend some time talking about what's going on in Congress right now and what the presidential candidates have put on the table. The first observation I want to make is that the most active sets of discussions trying to address the issues of the uninsured are really not happening in Washington; they're happening in state capitals throughout the country. The states, in many situations, have been very active in trying to look at solutions for covering additional populations. There have been some very substantial expansions of health insurance coverage that have recently been passed.

The most important and interesting case was New York, which just passed a very substantial expansion of health insurance coverage, which eventually will cover all parents up to about 150% of the poverty line, and all single adults and childless couples, through poverty. That's a very important change in terms of state direction because the bulk of the funding for this proposal is going to come from New York State itself. This is not going to be largely Washington dollars. New York State, through its tobacco settlement, is putting up a very substantial amount of money in order to provide health insurance coverage to single adults and childless couples. There are other examples. Rhode Island has been aggressive in pushing forward and covering parents of kids. The District of Columbia and Wisconsin are following in that direction as well.

There's a lot of interest in some states to expand coverage. The dilemma is that under federal laws, they're somewhat hamstrung in terms of the populations they can actually provide health insurance coverage to and get federal matching grants for. For example, Title XXI, the state children's health insurance program, allows states to provide health insurance coverage to children roughly up to 200% of the poverty line either through a Medicaid-type program or through private insurance. And if the state attempts to join this program, they get a federal match that is better than what they would receive under Medicaid. States can also provide coverage to parents of children through a simplified federal waiver—not a waiver process, just simply putting in a state plan amendment. They can provide health insurance coverage to the parents of those children, and get a federal match, this time at the Medicaid rate.

The issue the states face is that if they want to extend coverage to single adults and childless couples, they largely have to do it with their own money. There aren't federal matching grants available through the Medicaid program to expand coverage to those populations. I raise that because, going back to my demographics, of the 32 million uninsured adults, 18 million of them are single. That is the bulk of the population that is lacking health insurance. And it's exactly the population that states have very little ability to leverage federal dollars in order

to provide health insurance coverage expansion to those populations. That's the states' dilemma.

What's going on at the federal level to try to leverage some of these states to spring into action? President Bill Clinton put in play a proposal as part of his fiscal 2001 budget. Vice President Al Gore has a similar proposal that would allow states to provide health insurance coverage to parents at a fairly high level of income—in the Gore proposal all the way up to 250% of poverty—and get a federal match if states contribute. Both Clinton and Gore also provide other ways for single adults and childless couples to get health insurance coverage by relying on tax credits to reduce the price of buying into COBRA, or reducing the price of buying insurance if you're a small employer. The point to make with the Clinton and Gore proposals is that they're largely relying on the existing Medicaid in the Title XXI structure to build a base of health insurance coverage more broadly. That's an important tactical decision that they've made.

I think it's also an important fiscal federalism decision, because it keeps the states largely in the role of administering these two programs and building out from them. What it means is that a lot of the action—if those proposals were passed—would remain at the state level in terms of actually implementing health insurance coverage, administering it, and developing and setting payment rates for health plans. We've looked at some of the Vice President's proposals. Our sense is that overall, he could provide health insurance coverage to about 12 million of the 43 million people who are uninsured if his package was passed intact.

The other proposals on the Republican side largely do not rely on providing incentives to states to expand coverage through the Title XXI program and Medicaid. Rather, they rely on tax credits and financial incentives for individuals and/or businesses to purchase health insurance, so rather than providing federal matching grants to the states to enroll parents and single adults and childless couples into either a Medicaid program or private insurance program, these approaches are largely fully federally funded, relying on tax credits. How this is administered and what the roles of the states are, I think, are very much at issue.

The George W. Bush plan provides roughly a $2,000 tax credit to buy health insurance coverage. Obviously, that's not enough to buy a typical plan, but it would be enough to buy something that is a high-deductible plan. Our sense of that plan, however, is that it's much more limited than what Clinton and Gore put out. And as a result, it would cover about three million people in total, when you bring in all the different incentives that the Bush plan has brought to bear. It's a fairly modest effort, I think, in light of the growing problem.

One of the important things I see happening is that there are a lot of eclectic groups gathering around the table to push the politicians in Washington and at the state level to think a little bit more innovatively and realistically about putting some fairly substantial proposals on the table. There was a conference sponsored at the Robert Wood Johnson Foundation a couple of months ago. They had a very diverse set of interest groups. The Health Insurance Association of America (HIAA)

and Families USA were heading this conference, and those two are usually not on the same side of the health insurance issue.

But the thing that was interesting to me is that, of the seven proposals on the table, they seemed to coalesce around a single set of actions, which are really quite similar to what I outlined in the first part of my talk, which would provide a federal base of health insurance coverage for people living in poverty, largely through the Medicaid program or through the Title XXI structure. That was a very important development, at least in the preelection discussion. I hope that as we get into the presidential debate about this issue, these very diverse groups can push that agenda a little bit further and see if they can't get some action in Washington.

Where are things going to go this year in Congress in terms of passing health-care reform legislation to expand health insurance coverage? A lot of what's going on in Washington is bottled up in debating the Medicare drug benefits, Medicare restructuring and reform, and the Patient's Bill of Rights. If you look at the dollars available in the budget resolutions in the Senate and the House, you'll see that there really is no money set aside that could finance any type of substantial expansion of health insurance coverage. It will be very difficult, if not impossible, to free up some room for any types of substantial coverage expansion in this session of Congress. The only way that we'll see any type of minor expansions happening this year would be as a piece of the Patient's Bill of Rights legislation, where there is some opportunity to use that as a legislative vehicle to make some proposals that would expand health insurance coverage. That opportunity is there. But there's a lot of debate and confusion about exactly what the approach would be.

This is one of those issues that will be tremendous fodder for the presidential debates. Put your seat belts on for the debate that'll happen in the fall. I don't think it'll really take off until after the conventions. It's too hot of an issue and it's one that both candidates want to preserve until the public is actually paying attention, which is not right now, since it's the summer and you don't bring out your big-gun issues until the public is actually tuned in on this.

The interesting thing about it is that neither proposal on the table is one calling for universal coverage, at least right off the top. The Vice President has said that he would use his proposal as the first step moving toward universal coverage, and he's made that commitment. This is not 1992, when we were talking about not just universal coverage but single-payer employer mandates and so on. And neither of those proposals anywhere in Congress realistically are even being advanced. I don't know that in the Senate this year a single-payer proposal will ever be introduced, and that's very noteworthy because someone, someplace generally introduces it, in every session of Congress. Unfortunately, in terms of federal action, we'll see nothing in this session of Congress. Largely, the money's not there to do it, and Congress in terms of time, focus, and energy is spending all of its time on the Medicare drug issue and the Patient's Bill of Rights. There will not be legislative time to come back and refocus this.

But when we go to the fall debates we're going to see two very different visions of the future of how we should provide health insurance. The vision that Governor Bush has put forth is one that is going to rely largely on the private sector. It will not rely on the Medicaid Title XXI structure that has been developed. It provides some incentives for people to purchase insurance, meaning that the individual health insurance market will be relied on in substantial amounts to try to solve some of the problems of the uninsured.

Another vision is what Clinton and Gore put out, which says that we have a good program in Title XXI and we have a great agreement between the Congress and the governors on how to put together and administer this program. The states are getting experience in working with that program and enrolling kids. It's starting to bank up a little bit now. And the Democrats are going to want to use that as a structure for expanding coverage to adults in the future.

So again, that's a very different type of health-care system—one that's much more state-focused in terms of administration and how health plans are going to work with individuals as opposed to what the Republicans put forth, in which, in terms of the expansions, the states would not be a part of that equation. Rather, there would be individuals out trying to buy health insurance coverage on their own. And it's a little bit surprising, given the numbers of uninsured and how they've grown over time. Fortunately, the issue is not as bad as it otherwise would have been, because the states have very quietly along the way been pushing ahead in the absence of any type of federal leadership.

**Mr. Gerald G. Smedinghoff:** I'm no longer in the actuarial business. This presentation will explain why. What I'm going to do today is explain why trying to provide health care while ignoring or violating the laws of economics is like trying to run an airline while ignoring or violating the laws of gravity. Doctors and patients are no more above the laws of economics than pilots and skydivers are above the laws of physics.

The main reason for the slow collapse of our health-care system is that the primary means for delivering health care in our country, the HMO or the managed care health plan, does not exist anywhere else in our economy. Two companies have only tried it in the last 20 years: United Airlines and Sears. The reason the model doesn't work is that no company can cover a category so well that it can provide all products to all people in all places at all times at the highest quality at the best price.

Almost nobody remembers that United Airlines attempted to do this. I've been giving this talk all across the country and I've only found one person who remembers the name of the company United Airlines formed, which was what you might call a TMO or a Travel Maintenance Organization. Back in the early 1980s they formed a company called Allegis, and it was supposed to cover the traveler's every need from door-to-door: the flight, the hotel, the rental car, all the way on down. The reason nobody remembers Allegis is that the company lasted maybe 18 months and the CEO who came up with the idea was fired.

Sears tried the same thing with financial services, what you might call a FMO or a Financial Maintenance Organization. You all remember the Sears Financial Network. This was the world-beater combination of the Discover credit card, the Dean Witter brokerage firm, Allstate Insurance, Coldwell Banker, all the way down to the Kenmore appliances and the Craftsman tools that you would buy in the Sears store.
The only other place where you will see even a remote example of the HMO model in our economy today is the new car dealership. When you buy a new car, the salesperson will try to convince you to bring the car back to the dealer for all of your service needs. But since there's no comparable legislation in the car business like the HMO Act of 1973, what do we do? We get our oil changed at Jiffy Lube, we get our batteries from Sears, our tires from Goodyear, and our mufflers from Midas. Fortunately, we don't need to get a referral from our primary care mechanic, Mr. Goodwrench, to go there.

How many of you remember the energy crisis back in the 1970s? Remember all the long lines, the gas shortages, and the chaos? Back in the 1970s, buying gasoline was not as simple as pulling into the station and filling up. You had to consider a long list of what are called economic externalities. An externality is a factor that you have to deal with which has nothing to do with the transaction. For example, you had to ask yourself:

"Is the gas station going to even be open?" Back in the 1970s, stations started cutting their hours in the evenings and the weekends.

"How long do I have to wait in line? Maybe I should come back later when the line might be shorter."

"Are they going to run out of gas before I get to the front of the line?"

"Should I top off my tank now even though I'm still three-quarters full?"

And finally, probably the ultimate absurdity in economic externalities, you had to ask, "Is my license plate even or odd?"

Well, what about buying gas today? Nothing could be simpler and easier, especially with the credit-card-activated pumps. You simply swipe your card, pump your gas, and go. There's only one variable: the amount of the total sale, and that's within complete control of the customer. There are no interactions. You don't even have to talk with anybody at the gas station. And there are no economic externalities.

Well, what about buying health care today? It's a nostalgic throwback to buying gasoline in the 1970s. You have to consider a long list of externalities such as:

"Is my physician in the network?"

"What's the cost of going out of network?"

"Is the treatment covered?"

"Do I need a precertification or a referral?"

And, "What are the deductibles, coinsurance, and copays?"

Maybe you remember as far back as the late 1970s, when President Jimmy Carter declared our energy situation to be the moral equivalent of a war. Well today, for all practical purposes, our energy situation is the moral equivalent of a bachelor party. Since buying gas is very simple today, and since we've solved the energy crisis, it makes sense to ask these three questions:

Why was buying gasoline so difficult 25 years ago?

Why is buying gasoline so simple today?

And why is buying health care everyone's worst nightmare and only guaranteed to get worse?

There's a discipline of economics that's called public choice theory. Economists divide goods into two categories: public goods and private goods. With private goods, you can get exactly what you want in the way that you want it, such as food and clothes. We all wore different clothes here today, and we ate different things for breakfast. There are also what are called public goods, such as public roads where everybody gets the same thing in the same way.

The distinguishing factor of whether a good should be public or private is the answer to this question: Can different people satisfy their personal preferences simultaneously without any negative consequences? With food and clothing, the answer is obviously yes. No one suffered because of what someone else wore today or what someone else ate for breakfast. Obviously, with traffic laws, the answer is no. I can't drive back to the airport and simply ignore all the red lights. The economics of public choice theory says:

If everybody's going to get the same thing—as in back in the 1970s when AT&T was your only choice for long distance phone service; and

If your input is going to be ignored—if you were ever in the Army you probably remember they didn't ask you what you wanted for dinner every night. You got the same something-on-a-shingle as everybody else; and

If it doesn't pay to fight City Hall—meaning that even if you're Ross Perot or Steve Forbes and spending $50 or $100 million dollars can't get you elected.

If all these three things are true, then to maximize your personal wealth and your personal situation, you should choose a state that is called rational ignorance. Rational ignorance simply says, "I don't know and I don't care." With our health,

we all pretty much believe in the saying, "When you've got your health, you've got everything." Your health is one of the most important things in your life.

Yet take a very mundane category like motor oil. If you pull into a Jiffy Lube, the first question the guy who works there is going to ask you is, "Would you like Pennzoil 10W-30?" Well, most people are rationally ignorant about motor oil. Their attitude is, "I don't know and I don't care." Even though they're rationally ignorant, they get a choice of the motor oil they want.

Well, motor oil is not very important. Let's move up the scale of importance to the education of your children. How many people have the attitude with respect to the education of your children, "Ah, I don't know; I don't care." For many people, the education of their children is one of the most important things in their lives. Yet education is a public good. Everybody gets the same thing in the same way. You get the public schools in your neighborhood, regardless of whether you want them or not. If you want to go outside that public school system, it can be prohibitively expensive.

How about your life savings? That might be even more important. But everybody gets the same Social Security and Medicare by law, and everybody who works at your company gets the same pension plan. Well, if you move up all the way to the top of the scale of importance, your health is pretty much the same thing. After 65 everybody gets the same thing in the same way. They all get Medicare. And with respect to your employer, everybody gets the same health plan or the same set of health benefits.

The tragedy of our economic system and of our health-care system is that we have our priorities upside down. You'll notice we have the most choice with respect to the things that have the least importance (motor oil) and we have the least choice with respect to the things that are most important (health care).

So what are the consequences of public choice or of public goods? One of the consequences of our health-care system is that we are subsidizing wealthier, older workers at the expense of poorer, younger workers. Poorer, younger workers are not at risk for major health-care incidents or major health-care problems. They really don't use the health-care system. Obviously, young kids out of college have less discretionary income. They have more pressing basic needs.

One of the beautiful parts about an information economy with money is that we are able to transfer resources from people who have money and don't need it to people who don't have money and do need it. For example, when you're 18 you want to go to college. Very few 18-year-olds can afford it. But we can give you a loan to do that. And when you graduate you probably want to buy a car, but you don't have the money. We can give you a car loan to do that. But with our health-care system we're sabotaging the process. We're forcing everybody to have the same thing in the same way, and they're all paying the same price. So we're taking money from the younger workers and transferring it back to the older workers.

Let me dig down a little deeper into our health-care economy and show you how the financing of it works. Let's say that you started a business last year and you have ten employees. Each of these ten employees earns $45,000 a year. Let's say you had a good year and you have some extra money and you want to distribute it to your employees. How do you do it? If you give everybody a $5,000 raise, what's going to happen? The first $750 of that $5,000 is going to go to pay Social Security and Medicare taxes. The next $1,400 or 28% is going to go to pay federal income tax, and $350 or 7%, sometimes more, will go to pay state and local taxes. Your employees will end up with a $2,500 after-tax raise from the $5,000 that you allocated to them. However, if you decide to buy health-care benefits for your employees, none of these taxes have to be paid. Essentially, theoretically at least, you can double the amount of money you give your employees by buying health-care benefits for them instead of giving them a raise. (Chart 1)

What's the effect of this? Imagine tonight that the IRS takes over the largest shopping mall in your city. Let's say the mall didn't pay their back taxes. Tomorrow morning the IRS decides to reopen the mall but they have two new rules for anyone shopping there:

The first rule says that the IRS is going to double the amount of money of any shopper who walks into the mall.

The second rule says the IRS is going to confiscate half the amount of money from anyone who tries to leave the mall.

So if you go to the mall tomorrow morning with $500, the IRS will double that, leaving you with $1,000. If you walk around the mall and spend $900, you'll have $100 left. Of course, when you leave the mall, the IRS gets half that $100 left in your wallet, leaving you with $50. But the result of your shopping trip tomorrow is that you are able to buy $900 worth of goods with only $450 of what you left home with.

Now, obviously, with a situation like that, you'd probably want to shop there. Well, what do you think is going to happen when word of this arrangement gets around? Don't you think a lot of other people are also going to want to shop at that mall? As people flood the mall and as the IRS pumps mountains of cash into the mall, what's going to be the result? What's going to happen to the prices of the goods at the IRS mall? What is going to happen to the cost of the retail space at the IRS mall? Obviously, if you owned a business, you would want to set up shop in that mall. And, ultimately, what's going to happen to the value of the subsidy to the IRS mall shopper?

I'll give you a hint. What are the market similarities of health care to single-family homes and higher education? The answer is, these three categories—health care, housing, and education—are all subsidized by some form of tax exemption. They've all experienced inflation far in excess of the consumer price index over the past several decades. And they're all examples of what I like to call "Gold's Law." I call it

Gold's Law because the person who gave me the idea for this is an actuary named Jeremy Gold in New York, so I thought I'd give him the credit for it.

Essentially what Gold's Law says is that 95% of a legally mandated cost advantage will end up as waste. Or to put it another way, by doubling the amount of money you give to your employees, or by increasing their health-care spending by 100%, the insured employees will only get about 5% more health care, with the uninsured getting significantly less.

If you recall your Economics 101 days, you remember that the supply curve and the demand curve cross at a quantity Q and a price P. If you double the amount of money available, that does not double the amount of resources available. All you're doing is pumping more money into that mall. The quantity is not going to change. Essentially, the price is going to go from P to 2P. (Chart 2)

However, if you're one of the uninsured, if you don't get this subsidy, what does this mean to you? To buy the same quantity of health care, you have to work twice as hard and twice as long to increase your spending from P to 2P. When I gave this speech in Phoenix last month, somebody in the audience said, "So obviously 2P or not 2P, that is the question." (Chart 3)

Essentially, what we have is what I call a Jim Crow market for health care. We have a privileged class of people who gets access to this tax exemption, and we have a disenfranchised class who does not. Who's a member of that privileged class? They're employed on a full-time basis, generally upper income with stable jobs. Who is the disenfranchised class? They're largely unemployed, part-time, lower-income, and seasonal workers.

If you remember nothing else from what I say today, I'd at least like you to remember this. <u>Economics is not about money. It's about the allocation of resources.</u> That's so important I'll say it again. Economics is not about money. It's about the allocation of resources.

Table 1 shows what I call a borderless economy, where you only have four goods– food, clothing, housing and health care. Now you're all actuaries and you all remember those math textbooks, so I'll leave the case of N variables to the reader. But for now let's just go with four. If you allocate your resources equally among those four categories, what do you have to do if you decide you want more health care? You have to allocate some of your resources away from food, clothing, and housing and reallocate it toward health care. You do not create more health care by segregating these categories as we do with the tax code. We stamp dollar bills and we label them health care, housing, and education. And then we prohibit or restrict the movement of funds or the movement of resources among those categories.

TABLE 1
ECONOMICS IS NOT ABOUT MONEY

| Borderless Economy | Segregated Economy |
|---|---|
| 25% Food | 20% Food |
| 25% Clothing | 20% Clothing |
| 25% Housing | 20% Housing |
| 25% Health Care | 20% Health Care |
| | 20% Overhead –IRS, FSA, CPA,JD |

If you create a segregated economy, you'll end up with less food, clothing, housing, and health care, and you'll create this huge overhead category, which is staffed by IRS agents, actuaries, accountants, and attorneys. This is no different from going on a diet. If I want to lose weight, I have to reallocate some of my resources away from food. I can't lose any weight by lobbying Congress to get them to pass a law that says that anything I eat on my company's expense account doesn't show up on my waistline.

So, as I've said, segregation does not create wealth; it only creates waste. Again, let's look at a desegregated economy. You have 25% of your resources available to allocate toward health care. But what do we have? We have a segregated economy—what I call a Jim Crow economy. We have a privileged class that gets more health care and a disenfranchised class that has access to much less health care. People in the privileged class are the majority of the population. They look at the amount of health care they get and compare it to what the disenfranchised get and say, "Hey, this is a good system for me; we can't change it." What they don't see is what I call the border guards of our health-care economy, the 4 As: the IRS agents, the actuaries, the accountants, and the attorneys. They are adding a lot of delay, inspection, movement, and oversight—a lot of overhead in our economy which does not create any health care.

What's doing the most damage to our health-care economy is the Internal Revenue Code (IRC), which essentially segregates our money. We stamp our dollar bills "health care," "housing," and "education," so it's a form of segregation. ERISA is essentially segregation squared. Not only are we segregating our money and prohibiting and restricting the movement between it, but we are also segregating the fiduciary responsibility of it. It may be your money, but your employer decides when, how, and where you get to spend it.

My prescription would be to repeal the IRC and go completely with a flat tax. Once you do that, you can repeal ERISA, or ERISA essentially goes away. And I'll close by saying this: just as war is too important to be left to the generals, and just as the education of your children is too important to be left to the government, your health care is way too important to be left to your employer.

**Mr. Wildsmith:** What I'd like to share with you this morning is a proposal that the HIAA developed to address the 44-plus million Americans who lack health insurance

coverage. This was developed over a period of about six months. We had a committee made up of representatives of member companies. Candidly, I'm very proud of this proposal. I think it's a very pragmatic one. It was data based on research. And the one aspect that I am perhaps most proud of is that the group we were working with faced up-front that to make a meaningful impact on the millions of Americans who lack coverage is going to require spending a lot of money.

The time is ripe for action for a number of reasons. The number of Americans who lack coverage is increasing. And this is the best economy I've ever known! One projection shows that by the year 2008, one out of every four non-elderly Americans could lack health insurance coverage if the economy goes south. If the economy continues to grow at the rate it has so far, we could still have as many as 20% of Americans uninsured. We're also very fortunate that, at the federal level, we're beginning to see some budget surpluses that are quite substantial. And that should grease the skids for doing what needs to be done to cover people.

As Dr. Thorpe explained, the primary predictor of whether an individual has health insurance coverage is income. Over half the uninsured are in families with incomes below two times the federal poverty level. When we talk about these statistics, 150% of poverty, 200% of poverty, these sound pretty good: twice poverty. That's not a lot of money. For a family of four we're talking about something on the order of $16,500. The other thing that is a primary predictor of uninsured status is your employment status and the size of the firm that you're in. Income, however, is a predictor regardless of whether you work or not, regardless of firm size. Low-income individuals are much less likely to be covered than higher-income individuals.

HIAA believes very strongly that the current employment-based system should be continued and should be a building block that we work off of. More than half of non-elderly Americans are covered by their employers. Of those who have private coverage, nine out of ten are covered by their employers. And while the percentage of Americans covered through their employers dropped for several years, in the last few years that's started to pick up again.

Below 100% of poverty, the percentage of people who are covered by their employers is rising. Medicaid has been dropping but that may be part of welfare reform. Perhaps the statistic that argues best for continuing to rely on the employer-sponsored system comes from a recent study by the Center for Studying Health Systems Change. They looked at the percentage of employees offered health coverage who accepted it by income level. Of course, the acceptance rates rise with income, but even for employees earning less than $7 an hour, 78% opted for employer-sponsored coverage when it was offered, even though presumably many of these individuals would have been eligible for coverage through other sources.

There's no one single archetypical uninsured American. They come in different ages and different income levels. Some are employed; some are not. Some have

employer-sponsored coverage available; some do not. This argues for a multifaceted approach.

Now, the HIAA proposal, Insured USA, is a nice tag line. The dirty little secret is it was based on the available Web site names. We wanted to promote the program through a Web site and no one had taken Insured USA. But it's built from six primary components. The first provides a public safety net for the very neediest individuals. Those who are at incomes below the federal poverty level, in our judgment, have no meaningful connection with the labor force, and, quite frankly, are probably not in a position to make any meaningful contribution toward their coverage. Because of that, it makes sense to cover them through a public program such as Medicaid or the state children's health insurance programs. We are recommending that public coverage be made available to all Americans below the poverty line whether they're categorically eligible or not.

Categorically eligible, of course, is the magic term. You don't get into Medicaid purely on the basis of income. You have to be in a particular category. For the non-elderly and non-disabled, that means pregnant woman, children, or parents. So there are millions of Americans who are below the poverty line who aren't eligible for Medicaid. Part of that's due to politics in the past. Politically, pregnant women and children or families are a little more attractive targets of political largesse than are young, single men who are healthy but not working. Nonetheless, if you're going to make a real dent into the uninsured this is one population you need to address.

We see the working poor—and we define them for the purposes of our proposal as those with family incomes between one and two times the federal poverty limit—as being in a very different situation. They're much more likely to be employed and to have employer-sponsored coverage offered to them, and they're at income levels where you can start thinking about the individual or the family being able to make some contribution toward a premium. We believe it makes sense to get these individuals into the same private coverage that their coworkers and neighbors are in.

We're recommending a federally funded voucher set at 75% of the premium for the federal employees health benefits program, which would put you at about $2,000 per person. That is a very substantial amount. If you're familiar with the individual market, depending on your age and your health, for many people that might pay their entire premium. For others, it's going to make a substantial contribution toward it.

We suggested using a voucher rather than a refundable tax credit. There was a lot of debate over that for a couple of reasons. First of all, the tax code is a little more inflexible. You have to treat similarly situated individuals similarly. We feel that a voucher gives you more flexibility if needed to make demographic and geographic adjustments to support premiums that vary by age, gender, and geographic location. Also, the tax code, while there are some issues like the earned income tax credit where you can get a portion of it ahead of time, is basically oriented

toward going through the year and then truing up everything when you make your tax return. Funneling money to low-income individuals doesn't help them if they have a promise of receiving money next April. They need the cash in hand.

The feeling was that a voucher could be administered through the same state agencies that administer the Medicaid and SCHIP programs. They are already oriented toward tracking income-based eligibility on a month-by-month basis. To ensure access to those individuals who are in poor health, we are recommending federal matching funds for state high-risk pools. This is a relatively small segment of the uninsured population, but it's very important that every American have guaranteed access to health care through one mechanism or another.

We also recommend a tax credit for small employers, who are much less likely to offer health coverage than larger ones. We recommended a 40% tax credit based on the employer's share of the premium to encourage employers to offer the coverage. We would be targeting employers with ten or fewer employees. Of course, this would coordinate with the voucher in that lower-income employees could use the voucher toward their required share of the premium. We are also recommending that states revisit the mandates and their insurance regulations. We believe that could lower some costs. And we're also recommending some increased funding for the public health system.

I don't think, as Dr. Thorpe has mentioned, that anyone is currently pushing a plan that would cover all Americans. Politically, coverage mandates are not viable. The goal, and it's a practical one, is to make sure that everyone has meaningful access to coverage if they're willing to sign up. In particular, it was very important to us that everyone below two times the federal poverty level have access to subsidized coverage, and then provide tax incentives and deregulation to make coverage affordable for all Americans.

I should mention that we include deductibility for individually purchased insurance. And there's one other tax inequity that doesn't get a lot of discussion. If your employer offers a Section 125 cafeteria plan, you're able to make your required contribution on a pre-tax basis. This is much easier to do and much more prevalent among large employers. That's one other disadvantage that small employers labor under. We think it would improve equity if the employee contribution were made on a pre-tax basis, regardless of whether it was done through a Section 125 cafeteria plan or not.

Modeling these things is very difficult. It's more of an art than a science, and it inevitably reflects your worldview and your presuppositions. We project that if enacted in total, this could result in an additional 18 to 24 million Americans receiving coverage. The price tag would be very significant. We have not tried to claim credit for offsets for reductions and pro-Bonn care and charity care because, quite frankly, we're not sure how you can recapture that on the federal budget in a way that would directly offset the cost of these programs. So to be fair, we're trying to score this on a basis that would be similar to what the Congressional Budget Office would do. It looks as if the cost would be something on the order of

$57–80 billion a year, depending on who does the modeling and how the assumptions are done. It's real money. And I think, if you try to reach the hard-core uninsured you're going to find that any of the programs cost real money.

Politically, the odds of this being enacted as a whole, unchanged, are very, very slim. It is, however, structured modularly. The separate pieces can be enacted separately that would appeal to very liberal Democrats to very conservative Republicans. That was, quite frankly, not our goal. Our goal was simply to come up with a series of credible policy proposals that would address the needs of the uninsured.

**Mr. Dwight K. Bartlett, III:** All of the discussions about the uninsured proceed from the premise that there are adverse consequences to being uninsured, and I wonder if there have been any attempts to measure the negative consequences of being uninsured to the individuals who are uninsured, to the provider community, to insurance organizations, to taxpayers, and so on.

**Dr. Thorpe:** Right off the bat I would refer you to an excellent summary that the American College of Physicians put together. I think it's available on their Web site. It's quite comprehensive; a couple hundred pages that has documented all the empirical literature that has looked at the health status implications of having insurance and not having insurance. They do it for general populations, for specific diseases, and so on. It's an excellent survey. And the overwhelming bottom line is that it makes a substantial difference, particularly for populations such as kids, pregnant women, and so on.

On the financing side, it causes a lot of substantial dysfunction and distortions in the market. Of course, hospitals, like any business that treats uninsured patients who aren't formally compensated, treat it as a cost of business and have to finance that cost somehow. And that's generally in the form of either higher revenue intake coming from people with private insurance, which means that a piece of this is already being financed by people who have health insurance. It also puts a very substantial strain on localities, particularly in areas that have a high immigrant population—Texas and California being good examples—where those county hospital systems and the local taxpayers are basically paying the full price of providing health care for low-income populations who don't have health insurance in those hospitals.

So if you think about the equity and fairness of how we pay for it, I don't think it's a particularly pretty picture. One of the objectives as we think about this would be to come up with some way, in terms of how we finance care for low-income populations, that we can come up with a fair way that spreads the burden of this over a broader tax base, compared to the system we have today.

**Mr. Harry L. Sutton, Jr.:** Gerry and Tom, with respect to the population who doesn't have access to insurance, small group reform has been kind of a failure based on the results because it has forced the premiums too high to be affordable for small business. Gerry's talking about getting rid of the insurance industry or

getting rid of the employer as the mechanism for providing insurance. So we're down to enrolling a bunch of individuals or very small groups, though you can argue whether Health Insurance Purchase Cooperatives can work or not. But it seems to me most carriers feel that writing individual insurance—forgetting the uninsurable pools that exist, even if you could keep them—isn't feasible. None of the states are very big. Minnesota's as big as any, and it costs $50–70 million a year to subsidize 25,000 people, since the state dropped out of that.

How are we going to handle the enrollment of millions of individual families? And what are we going to use for underwriting rules? How are you going to entice a carrier to go into that market if they can't underwrite, since uninsurable pools would be an immense expense? How are you going to finance the deficits in those pools?

**Mr. Wildsmith:** First of all, we have intentionally left the employer-sponsored system alone. Our hope is that the bulk of these vouchers will be used for the required employee contribution to buy individuals into employer-sponsored coverage. In our modeling, we tried to look at what percentage of that population had employer-sponsored coverage available and what portion didn't. So while there definitely will be some people looking for individual insurance, we're hoping the bulk will be through the employers.

Part of the reason for that is, frankly, a wholesale shift from the employer-sponsored system to the individual system is quite attractive politically to some segments of the Republican Party. There's been some talk about tax credits and such that would accomplish that kind of shift. Several people have done some modeling and unless you have either a mandate to purchase the insurance or an incredibly high credit or voucher amount, you're going to get a net decrease in the number of people who are covered if you go to an individual system.

You're absolutely correct. The high-risk pools require a substantial subsidy and if you get down into the weeds of our proposal what we're recommending is federal matching funds that would be matched 50-50 to buy the premium down to 150% of standard. But you wouldn't get matching funds to take it below that. There would be an additional match for catastrophic claims to encourage lifetime maximum benefits of $1 million or more.

**Mr. Smedinghoff:** This gets down to public choice theory and whether health care is a public good or a private good. The problem we have is that health care is a public good. Everybody gets the same thing in the same way, and everybody's forced to pay roughly the same price. Obviously, we all have different health-care needs, just like we all have different needs for any other product or service. But essentially, we're all forced to buy the full array of benefits, and this gets to your point about underwriting. First of all, underwriting is essentially illegal. We need to change that. We need to increase the flow of information between buyers and sellers, just like we do with any other product or service.

We also need to allow people to buy just the coverages they want. As I said before, because the young and the old are essentially forced to buy this full array of

coverage, with all the state mandates and now with the federal mandates requiring coverage for things such as pregnancy or substance abuse if you allow different markets to develop, people would be able to buy scaled-down versions just for the specific risks that are appropriate to them.

As far as how do we handle the underwriting of all these individual families and all these individuals? We're able to do it with any other product or service. We're able to do it with auto insurance. If a market were able to develop, the underwriting would not be as specific as we know it. It would probably be some sort of derivative underwriting. For example, in auto insurance, they're not so much concerned with your driving record anymore as they are concerned with your credit history, because they know that people with good credit histories generally have good driving records. It costs a lot to get all that information that we generally get with individual underwriting. So insurers would probably move to some simpler form of derivative underwriting.

Getting back to Dwight's question earlier about the effect of the uninsured and just how bad that is, one of the things that we like to focus on in the health-care group that I'm involved in is, is there is a difference between insurance and access? Everybody doesn't need to be insured. The question is, do the uninsured have access to some form of health care? Because health care is essentially a public good—everybody gets the same thing the same way. We're pricing the poor out of the health-care market in a two-step process. First, we make them buy an entire array of health-care benefits, a lot of which they may not want, so we raise the price prohibitively high. Obviously, because the rich have more money than the poor, they're able to buy more. But since the poor can't afford to buy the complete package of health benefits, when they go outside the coverage system to buy health care on their own, we essentially double the cost for them.

**Mr. Steele R. Stewart:** Two questions. The first is, with regard to the HIAA's proposal, you mentioned that about 18 million would get covered if everything was enacted. But then there are 33 or 43 million who are uninsured right now. What about that other section, and who are those people?

**Mr. Wildsmith:** A good chunk of them are children, many of whom should be covered when states fully implement the state children's health insurance program. There are going to be some individuals below the federal poverty line, and there are working poor who have vouchers available to them who simply don't take advantage of it. Currently, there are lots of people eligible for Medicaid who aren't enrolled. All you can try to do is get better with your outreach. But realistically, in modeling what would happen, you can't assume that you would reach everyone who's eligible.

Beyond that, you have something on the order of 45% of the uninsured who are in families above two times the federal poverty line. And the tax proposals we have are partly intended to make insurance more affordable. They're also intended to address equity issues in the current tax code. All you can do with the tax provisions is encourage people to buy coverage. There are going to be a lot of

moderate and high-income individuals who still don't buy the coverage. We had to make a decision about what we were trying to accomplish. If the low-income have access to subsidies, we know they can afford it. If people who can afford a meaningful premium have guaranteed access to a high-risk pool and all the tax breaks to make it more affordable and they don't sign up, we decided we don't feel any guilt about it.

**Mr. Stewart:** With regard to the people who are currently uninsured, has anyone looked at what percentage previously did have insurance in the last year or two who have chosen to get out or dropped because of the cost of conversion policies and whatnot?

**Dr. Thorpe:** Well, it's a very dynamic group, but the statistics we have are looking at people at a point in time. We know in a typical week or a typical month that there are about 43 million who are uninsured, but the composition of that group is very diverse. There are about 10 million of them who are really long-term uninsured—people who haven't had health insurance in the last 18 months. And there's a number of them who have. The rest have been uninsured for shorter periods. The other part of the story is that people we're picking up as insured today have a chance of being uninsured next month. So it's a very diverse market, which makes some of these proposals difficult to lock in for long periods of time. But most of the uninsured are individuals who are uninsured for something less than 18 months. So there's a lot of churning in and out of the market. And the churning in will increase over the next couple years as the economy perhaps slows down a little bit and you have some swings in employment.

**Mr. Brent Lee Greenwood:** I believe a lot in the individual choice and we're moving toward that trend. But what other industry can you identify that costs five times the difference, between that young individual and that older individual based on their needs? For example, when I came to Las Vegas, I could buy an airline ticket for $500 or $2,000, depending on when I arrived. But that was at the point of sale; it wasn't based on my projected need three or four months ago. So I'm wondering when we're making our decisions before the event actually happens. How does this whole thing work and what are the industries that you feel are analogous to it? Because I think at some point we're going to need a uniform price within health care because of this large differentiation in order to avoid the segmentation that you're talking about. Because we might end up with older people being poor just because of the decision they've had to make and the cost being so high.

**Mr. Smedinghoff:** I would say pretty much any other industry. You can eat lunch at McDonald's for a few dollars, or you can go out and buy a very expensive lunch at a restaurant. Same thing with cars. You can get a Honda Civic or you can buy a BMW. Not to mention the clothes that we buy. We all have different needs, different desires, and different ways that we would like to allocate our resources. What was the second part of your question?

**Mr. Greenwood:** That was at the point of sale—when we're making those decisions, rather than when we have to make our decision a year ahead of time. We don't know that we may need open-heart surgery when we're making that decision. I see this big difference between buying a car versus buying what your needs might be a year down the road.

**Mr. Smedinghoff:** Well, I don't see open-heart surgery being any different from getting in an auto accident and totaling your car. We don't plan on that; we don't expect that to happen. That's why we buy insurance. Another major problem with our health-care system is we're trying to cover benefits, whereas benefits aren't relevant. What is really important is your personal financial situation.

One of the members of our health-care reform group did a study and found that the average person spends more owning and maintaining a car than on health care. Obviously, our health is more important than our car, and we're willing to spend a lot of money on our car. But when it comes to health care, people say, "I can't afford it." How do we think financially about our car? We're willing to spend several thousand dollars each year to own and maintain a car, but we only insure the risk above a certain amount. The same thing is true with health care. You have to spend a certain amount of money on your health every year. You might as well recognize that up-front just as you would with your car, rather than trying to get everything covered with a five or a ten dollar co-pay.

**Mr. Wildsmith:** I think there are analogous products, but they're all in one form or another an insurance product. Because what you're talking about is not purchasing a good or service right now for a current need. You're purchasing a financial protection against an uncertain future need. The key issues are how you price that, and whether the insurance purchase is voluntary or not. If it's voluntary, then each consumer has to make a decision. Is this economic deal in my own best interest? And that forces you to look at the premium versus what you expect your future needs to be. If you have a mandatory system where you have to purchase the coverage, then you don't have to worry about the person looking at the deal and saying, "I'm young, I'm healthy, I don't think I need this so I'm not going to buy it," and not participating in the risk pool.

At one time, our association, HIAA, advocated an employer mandate, requiring employers to provide health insurance. We don't do that anymore, not because we don't think it has merit, but because we don't think politically it's going to happen, and you don't do yourself any good advocating something politically that's a nonstarter.

I do think there are analogies out there and I think it's the voluntary nature of the system in the individual market that in fact forces companies to reflect risk in their pricing. There have been some academic studies of what happens in states when you do small group or individual market reform, particularly the guaranteed issue (GI) and the community rating laws. What typically happens when you do GI and community rating is you raise the price for some individuals who have lower expected needs. You lower the price for individuals and groups who have higher

expected future needs, and you change who decides to buy coverage. The people who are insured change. On average, you get more high needs groups or individuals and fewer low-risk groups or individuals. And you typically get a measurable decrease in groups and individuals who purchase coverage. The extent to which you change who's in the insured population and the extent to which you get a decrease in covered lives depends on the details of the proposal and just how restrictive those rating rules are.

**Mr. Smedinghoff:** Let me add one more point. I don't remember quite how you phrased it: "I'm not sure I'll need this," or "I don't know what my needs are going to be so many years from now or so many months from now." That's essentially what I talked about earlier—the state of rational ignorance. Everybody in our health-care economy is pretty much acting out of the state of rational ignorance. You are not going to get an efficient allocation of resources if everybody's walking around with the attitude, "I don't know and I don't care." People should be rationally knowledgeable about their current and future health-care needs. Otherwise, we're not going to make any improvement.

**Mr. Charles W. Edwards, III:** I was thinking about what Dwight said, and I think that one of the things that he was getting at was that there are a lot of uninsureds out there who don't care for coverage. They'll take it if it's free but they're not going to pay for it. A lot of the plans that you all have proposed indicate that you're thinking along the lines of moving more toward socialized medicine. Maybe not all the way there but moving more away from what we have right now, which is a very choice-oriented system and one that's capitalistic and kind of unique in the world in that regard. But I'm not convinced that there's a real problem.
**Mr. Wildsmith:** First, there is research out there that indicates that many of the uninsured are, in fact, receiving health care. The last thing I saw showed that on average the uninsured received about a half to two-thirds the amount of health care that someone with health insurance coverage receives. Sometimes, it's not as soon as they need. It may be in the wrong setting, and it may not be the most appropriate care. But they are receiving health care. There's a lot of pro bono and charity care out there. Nonetheless, there's also good research showing that when you look at symptoms that could be very severe or potentially dangerous, such as chest pain, if you don't have health insurance coverage, you're much less likely to seek care. I would recommend, again, the study by the American College of Physicians that Dr. Thorpe mentioned. It is excellent, and the consequences of not having health care range from low birth weight babies to higher death rates.

It's also important to decide whether we're going to have a socialized system or a free, private market. The association I work for represents private health insurers. We are absolutely in favor of a free, private market. That's what we do for a living. We have tried our best in this proposal to preserve it, enhance it, make it more affordable; and get some tax breaks to make it easier for people to buy. Nonetheless, when you look at people who are below the federal poverty level, they're not in a position to buy meaningful health insurance. They don't have a strong connection with an employer and they don't have an income. A private market really only works if someone can pay the price. Look at food in the U.S.

With grocery stores and restaurants, we have food readily available to everyone accessible at wonderful prices. There are still people who go hungry. Grocery stores don't help if you can't pay for the food.

**Mr. Thomas P. Carlson:** Gerry mentioned 2P as the effect of the government getting involved and causing distortions in the market. Has there been any research, papers, or discussions on how high the price would climb as additional government programs are implemented, especially with the advent of the baby boomers, the aging, into Medicare?

**Mr. Smedinghoff:** I'm not aware of any. The only study I know was research done by the Rand Corporation several years ago, which showed the willingness of people to spend money on health care when it's money out of their own pocket versus when it's money out of a third party, and I think the factor was 0.53 or 0.58. It was roughly a 2 to 1 ratio. People will take twice as much if they don't see the cost. But when they're spending their own money, they're much more efficient with the allocation of their resources. As far as research on the future, I don't know. All I know is, as I mentioned, you can draw the parallels between health care, housing, education, and pretty much any other market that you subsidize that way. I can't quantify it.

**Mr. Wildsmith:** There are a lot of economists in the public policy community who are concerned about third-party payment and how it creates inefficient utilization and excess utilization. Those were the theoretical underpinnings for medical savings accounts. On the other hand, if you look at any of the political debates running from the uninsured to the Patient's Bill of Rights, politically we're not concerned about people getting too much health care and too much health insurance. Where the political debate is about helping more people get health insurance and making sure they get more of it when they get it. So I think there's a bit of a disconnect from this academic concern to where we really are on the ground politically, which is helping people afford more health insurance.

**Mr. Carlson:** Right, and I guess my problem is that as the government gets more involved, there's more cost shifting, and the costs in the private sector just go through the roof.