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Is Tax Reform the Key to Health Care Reform?

Edited by Stuart M. Butler

The Heritage Foundation

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Introduction

Mr. Truluck: Good morning, ladies and gentlemen, and welcome. I am Phil Truluck, Executive Vice President of The Heritage Foundation.

We have a very busy day today. Today's conference will address the crisis of the U.S. health care system and what we believe is a highly innovative strategy to deal with it. Health care costs consume over 11 percent of America's GNP. We are spending an average of over $2,000 each year for every man, women, and child in America. Yet, even with this, 90 percent of Americans in recent polls say that a major overhaul of the system is needed.

The reason people should be concerned about this issue is that still over 30 million Americans are without health insurance today. Moreover, costs are running far ahead of the average inflation rate. There is also widespread dissatisfaction with increasing red tape and restrictions in both private and public insurance.

Last year here at The Heritage Foundation we unveiled what we consider a bold strategy to address these concerns and to create what we call a "national health system for America." Not a national system based on the shortages and continuous budget problems of, say, a Canadian-style system, or one that simply hands the tab to the business community, but one based on reforming the basic tax treatment of health care to give help where it is really needed and to introduce real incentives for sensible economies.

The purpose of this conference, this working conference, is to subject this proposal to intense scrutiny, to test its central elements, and to refine it. That is why we hope you will join us in participating in that.

The panels that we have assembled to analyze this plan certainly are not cheering sections, and they are not intended to be that. This is a real working session. We hope to have comments from not only the panel, but from you in the audience as well.

The Bush Administration and Health Care

Mr. Truluck: At the same time that we have been developing our plan here at The Heritage Foundation, the Bush Administration has been conducting its examination of options for health care reform. That effort is being conducted by the Department of Health and Human Services, and it is headed up by our first speaker this morning, Under Secretary Constance Horner. The report is not complete yet. Connie, we are not asking you to give us any secrets today, but we would like to ask you to discuss the general problems and the issues that the Administration is examining.

I think all of you probably know Connie already. But just to give you little bit of background: Since May 1989, she has served as the Under Secretary for Health and Human Services, which I guess now is the fourth largest budget in the world behind the United States, Soviet Union, and Japan.

Ms. Horner: We used to be ahead of Japan.

Mr. Truluck: Yes. Another problem with Japan. HHS has slipped into fourth place. Prior to her appointment at Health and Human Services, she served as Director of the U.S. Office of Personnel Management, and during the Reagan years, served in a number of positions, including associate director of the Office of Management and Budget, director of VISTA, and acting associate director of Action. Of course, a lot of us wish she were still at the Office of Management and Budget. But that is another story.

We are delighted to have Connie join us to give us some opening remarks about what the Administration is doing on this issue.

Ms. Horner: Thank you, Phil. I think that this conference reflects a rare but important Washington event. That is the interjection into debate and deliberation of an idea that serves the interests of no particular interest group. As far as I know, there is no interest group that is determined to put all its forces behind the Heritage concept of how to resolve the problems in our health care financing and delivery system.

This idea has, instead, surfaced and grown strong on its merits, because of the compelling strength of the ideas – that is, the proposal to replace the current employer-based tax subsidy of health benefits with a system of individual tax credits or vouchers, with greater subsidy for those who have greater financial need. I want to compliment especially Stuart Butler and Ed Haislmaier for the work they have done. This is not an endorsement of the idea. I have to make this very precise, succinct distinction. I'm going to be enthusiastic about some of the attributes of this proposal without endorsing it. I think we can all do that with respect to any number of proposals.

In the early days, this proposal was sort of a stepchild. It did not have much legitimacy in the health policy groupie discourse around town, and it took a while for this idea to make it into those matrixes of proposals that those of you who are health policy groupies are now seeing. But *Modern Maturity* has a cover story just out that identifies the Heritage proposal as one of the *four* major proposals that are under consideration: the Canadian-style proposal, the Heritage proposal, the Kennedy proposal, and the Pepper Commission proposal. That represents a very significant event, when an idea reaches that status without, as far as I know, a committee chairman's support and impetus, and with no big company or consortium behind it – just the power of the idea.

I would like to spend a few minutes this morning talking about why I think this idea is powerful, not to endorse it but to indicate why it is commanding increasing attention. It is like every other proposal that is being discussed. It has its virtues, and it has its flaws. The reason I want to talk about some the virtues of this proposal is that I think that it interacts with some economic and social changes that are going on in this country in interesting ways. We need to consider what those ways are, not as a means of supporting this particular proposal but as a means of identifying for ourselves some of the significant social and economic changes going on in the country. These changes form a context in which we have to evaluate any proposal that we, as an administration, or we, as a government, or we, as influential opinion molders, are likely to confront.

There are a number of changes going on in American life which are going to escalate and grow more powerful in the next two decades and which impinge directly on how we insure ourselves against the cost of health care. These changes are the product of prior interwoven social

and economic change. I'd like to identify four that impinge on our thinking, or should impinge on our thinking, as we evaluate any health care reform proposal, but which the Heritage proposal highlights and brings forward for attention.

One is the increasing geographic and occupational mobility in the country. The second is the miniaturization of work organizations. The third is the empowerment of people as consumers and citizens brought about by the development of instantaneous and global telecommunications. And the fourth is what I believe is a coming redirection of publicly controlled wealth.

Let me get more specific on each of those. First, geographic and occupational mobility. Our geographic and our occupational mobility are both increasing, and they represent the strengthening of a trend that has been underway for several decades in this country. Americans are not only continuing to move more and move farther from home, and in the high professional and managerial classes, even to live for a time outside the country; they are also changing jobs and careers many times in a lifetime. This is now what a young person grows up to expect – to have many different job locations, even many different careers. With the increasing internationalization of economic affairs, people expect to live some time out of the country. They expect their children, even when dependent and being schooled, to live away from them for a time.

This has a tremendous impact on how we identify our needs in terms of financing health care. What it means is that portable benefits of all kinds, health and life insurance as well as pensions, are something we need to look at to support this work style. That is one strong appeal of financing systems which attach in the first instance to the individual or the family, rather than only to the work organization. This is not to exclude the work organization, of course. It is significant and will remain, I am sure under any system, extremely significant. But in the first instance, a very occupationally and geographically mobile society needs to be able to attach financial decision-making to the individual and family unit as much as possible and still meet other needs.

In such a mobile society, people also increasingly seek out alternative structures than their workplace to attach themselves to. The American Enterprise Institute, in the early Eighties, did some work on what is called "mediating structures": the union, the church, the

The third change I see is the power of consumer choice that has been brought about by instantaneous global communications. What do I mean by that? I think back to last December when the Berlin Wall came down. Anyone observing that event could see that it represented both the fruition of massive communication among people outside the control of their government, and by its communications power it lent power to the ideas represented by freedom to those who had not yet seized their own freedom. In addition to these very large events that give great power to individuals through the knowledge they provide of what is possible, there are many small events in our lives that are occurring as a result of the vastly expanded information we have available through the computer, and through television, and through satellite communications. When individuals either as citizens or as consumers get that kind of information within their own individual control, they can see what is possible, they can compare among competing possibilities, and their desire for something better is strengthened. Therefore they are less dependent on the old hierarchical large organization, whether it is a union, a corporation, or whatever, to do the deciding for them.

This movement toward individual choice and control is very strong in our culture today, and it is growing stronger. A health financing system that puts control into individual hands, and so broadens individual choice, is, I think, going to have considerable political appeal. Any proposal which is viewed as removing choice, distancing decision-making from individuals, is going to have considerably less political appeal. This is all happening because of the technological revolutions.

Finally, on a more mundane note, I would like to say something that may strike you as counter-intuitive. In the last year, two events have caused major political brouhahas surrounding the question of health benefits. One was the passage and then the repeal of catastrophic health insurance. The other was just in the last few weeks, the discussion surrounding Medicare budget cuts.

Now, both of these arguments raged for a while, and then one proposal embedded in each of those arguments was rejected. That was the proposal for means-testing. Our body politic has rejected means-testing in Medicare and rejected it in catastrophic health insurance. In spite of that fact, I think we are going to see a move toward more means-testing in government programs. What we have just seen is the

beginning of the last gasp of an attempt in this country to use the powers of government to collect large sums of money and redistribute them, regardless of personal need – in other words, the social insurance concept. I think that the hostility that exists among members of Congress right now toward those who forced the rejection of the means-testing idea will lend force to a counter-movement toward greater means-testing in government programs.

This will lead to a national discussion on the subject that is going to go on for quite a period of time. It is going to be a discussion about several questions: What do we want to spend money on? Where do we want to draw the line? Is it possible to create new systems which build in clear, strong incentives for cost containment? The deliberations so far have focused on the need for an intrinsic design which elicits cost containment behavior from people, rather than relying simply on attempting cost containment by fiat, because fiat is not working very well right now.

If that is, indeed, a future trend, it is meeting up with another trend – a very, very important one which the Heritage proposal again highlights. That is the increasing trend toward a national commitment to health care, adequate health care for every citizen. I think that has always been an implicit desire on the part of the American citizenry. All our extraordinary efforts at the federal level, local voluntary efforts, charitable efforts, municipal subsidies, county programs – all of those represent an attempt to move closer to fulfilling the aspiration for adequate health care for everyone.

What we are seeing now is that those multitudinous systems are not fulfilling our aspirations. However benign their intent, they are not doing the job as well as they need to.

If we are going to use public resources to assure an adequate level of health care for everyone – and I believe we are – we are going to have to confront the question of how much, and to whom, and how. We have to look at things like our employer-based tax subsidy, which this year will cost the Treasury $58.6 billion. We have to look at tax credits. We have to look at vouchers. We have to look at the questions of direct service and direct appropriations. We have to look at the incentives not only built into our financing but also into our delivery systems, as well as issues of malpractice, medical effectiveness, and so on.

So there's a huge range of items that we have to confront. This conference today will help commence a process of information sharing, opinion sharing, and insight generation, which then needs to ripple out around the country. We should be prepared when that happens, not for a ripple back but for a potential wave.

Mr. Sullivan: I am Sean Sullivan from New Directions in Policy. Connie, can you say one thing about what your group is studying? Are you focusing more on the expansion of coverage or on cost containment, or are you trying to keep those two goals equally balanced?

Ms. Horner: We view it differently. Our goal is expanded access. We cannot begin to attempt to achieve that goal until we design systems that contain costs because we cannot continue in our current cost escalation.

For instance, on Medicare, if we continue at the current rate, in thirteen years we are going to be spending more on Medicare than we do on Social Security. That is too much. We cannot just expand access at the current cost. So, we are working on both of those.

Mr. Haislmaier: Ed Haislmaier, The Heritage Foundation. Looking from the outside, particularly at the last budget round, I get the sense that Congress has not quite reached the point where it understands that the only way out of these increasingly frustrating exercises, such as the one they are going through now, is to sit down seriously and overhaul these programs from top to bottom. Do you sense any move, any increased awareness? I sensed a bit after catastrophic, that there were more members of Congress who thought that we really need to get in there and redo the whole program.

Ms. Horner: It is all over the lot. Congress has become dispirited as unsound ideas which had previously generated great enthusiasm have come under attack and been squelched. They are frustrated because they cannot do employer mandates, and they cannot have a Canadian system. They say: What are we going to do? The people hate us. Every time we try to do something, the people do not say thank you, they do not appreciate it.

So, right now, lawmakers are mad and they are discouraged. But they are not quite to the point where most of them are at all receptive to serious new thinking, because the emotion levels are running very

high. Now, they are going to go home. The ones who get reelected will feel good. They will relax a little bit. They will come back in January. At that time, I think if they have had a chance to think upon the wreckage scattered across the political landscape right now on these issues, that they will be receptive. I think that is a good time to open up a very large discussion.

Mr. Quay: David Quay with Senator Symms. When is the Administration coming out with their health proposal on reform?

Ms. Horner: There's a two-track process when you want to make a reform. One track is intellectual, the other track is political. We all know that it is not difficult to come up with an array of intellectually sound options which could do some good. We all know that, given the prospect for wrenching change to the disadvantage of one group or another often implied by such proposals, the political track is much more difficult.

Since we do not want to have another catastrophic health insurance situation, what we are doing is beginning a series of what Secretary Sullivan calls "conversations with the American people on health care." This will focus on what people want and what they want to pay for it. We are going to spend some time laying out the facts as we see them.

The reason we have to do this is that we have to see if the general public sees the facts the way we do. If not, we have to have a discussion in which either their thinking or ours is modified. I do not mean to portray it as "us" and "them" It is an interwoven civic process. We are going to do that over a period of months. Then we are going to say, what can we do? At that point, we are going to bring forward proposals. I cannot tell you with any precision when that will be. We have done a lot of intellectual work, and we have done a lot of study: who is uninsured, what is the economic condition of the American elderly, and so on. We have done a lot of intellectual work, but we need to do what I would call political (in the good sense), political work before we come forward with anything specific. I hope you all will help with that. Thank you.

Mr. Truluck: Connie, thank you very much. That got us off to a good start. Thank you for joining us.

The Heritage Foundation Proposal

Mr. Truluck: We would like to turn the discussion now to the Heritage proposal itself. I am going to call on Dr. Stuart Butler to do that. The study that we released last year was co-edited and largely written by Stuart Butler and Ed Haislmaier. Ed has been a very valuable part of our team in pulling this proposal together. He has done an outstanding job in this area and in the several other issue areas that he covers.

Following Stuart's remarks, we are going to ask Gene Steuerle of the Urban Institute to provide a few comments. Gene is a senior fellow at the Urban Institute and a weekly columnist for *Tax Notes* magazine. He has also been a fellow at the Brookings Institution and American Enterprise Institute. Between 1987 and 1989, he was the Deputy Secretary of the Treasury for Tax Analysis. Earlier, he was one of the Treasury's top specialists designing the 1986 Tax Reform Act.

He has written on the idea of individual tax credit for health expenditures – which is the core of the Heritage proposal – and he will subject the idea to the sharp eye of one of Washington's most highly regarded tax analysts.

Stuart is our Director of Domestic Policy Studies here at Heritage and has been with us for over ten years. He has written numerous books. Among them, in 1987, was a major book on welfare reform, *Out of the Poverty Trap,* and last year, of course, with Ed Haislmaier, our health care monograph. Stuart has established himself as one of the leading thinkers in this town and is regarded as someone who has to be consulted on these kinds of issues, as well as some of the other economic issues we face.

Dr. Butler: Thanks very much, indeed. The nub of what we are to address today is the strange paradox of the American health care system. In the United States we have the best quality and the most technologically advanced health care system in the world. It is a system on which we spend more than any other country – over $600 billion a year, or over $2,000 per person. So there is no question about the commitment to health care and the extent of care availability in this

country. Yet, 90 percent of the people in this country think that the system requires major change. That is a strange paradox. It is a paradox that we try to address, as Phil mentioned, in our study, *A National Health System for America.*

What I would like to do is take a few minutes to try and sketch out the thinking behind our approach and some of the key elements in it.

When you look at the causes of dissatisfaction regarding the health care system in this country, people tend to point to some very specific things. One of most obvious is that as many as 37 million people in this country lack health insurance at some time during the year. They do not necessarily lack access to health care, but they lack financial protection for the cost of health care.

In addition, all of us who do have insurance are acutely aware of the increasing red tape associated with health coverage in this country, both by insurers and by companies. There seems to be a never-ending and irritating expansion of very detailed requirements, exclusions, and so forth that accompany everything we do in the health care area.

Anybody in business acutely recognizes another source of frustration: the rapid escalation of the cost of health care in this country, now running at roughly double the underlying rate of inflation throughout the economy.

When we looked at these elements of dissatisfaction, Ed Haislmaier and I, like many others, recognized a number of peripheral causes of the problem. These include the malpractice issue, which doctors tend to focus on, as well as the increase and improvement of technology, which requires higher costs for better services. There are a number of issues like that.

But our conclusion was that if you look at the underlying reasons why there is a mixture of very high costs and a rather large volume of unnecessary health services, while also uninsurance and problems of that nature, the best explanation is the perverse incentive system within the tax structure as it treats health care.

For most people, indeed virtually for all Americans, the primary method available to obtain some kind of tax benefit for health care is through the tax exclusion that applies to company-based health care plans. There are other tax incentives and tax breaks available for those who itemize their deductions and incur very significant costs, and for the self-employed who run small businesses themselves. But really, for

almost everybody, we are talking about just one tax break, which is that when you get health care benefits through your place of work, they don't appear on your W-2 and you do not pay tax on them. That is the one tax break most people have for health care.

That lax treatment certainly has led, over the years since the Second World War when this exclusion was enshrined in tax law, to a rapid expansion of health insurance in this country. That has been a very positive development in the sense of more and more people were able to be covered by health insurance. But the tax exclusion has also led to some very unfortunate side effects that we feel explain the dissatisfaction, the gaps, and the cost escalation endemic in the U.S. system.

The first effect is that a tax exclusion for a company-based plan gives the maximum tax relief to the affluent, who are at the maximum marginal tax rate and generally have the most generous health care plans. So, if you are lucky enough to be a senior executive in a corporation with $6,000 or $7,000 worth of health care benefits, and you are in the top bracket, you will get thousands of dollars of tax relief at the federal level, as well as at the state and maybe even the local level.

On the other hand, if you happen to be a part-time floor sweeper in a car dealership and you are covered under a minimal company plan, you get little tax benefit because you are at a low marginal tax rate. Worse still, if you have no company plan whatsoever, then in almost every case you also have no tax help whatsoever for buying services directly or for buying insurance on your own.

It should come as no surprise, then, that we have a situation in the U.S. of very heavy uninsurance among people who are working in firms without health plans, particularly in smaller firms or part-time, or are dependents of people who are working but are not granted family coverage under company plans. If you look, in fact, at the complexion of those who are uninsured, you do see about three-quarters of these people are working people or are dependents of working people.

So, in the way the tax treatment now operates, we have the exact opposite of what one would assume government should be trying to do: the code currently gives most tax assistance to those who least need help in buying health care, and least assistance to those who need it most.

By having most health care delivered to most people through company-based plans paid for by the employer, you have another perverse

problem: the illusion of the free service. As far as the employee is concerned, the company is paying. You, the employee, do not see the real cost for the most part. You may have a deductible. You may even have a co-payment. But generally speaking, it is the company that is paying the bills. Therefore, it is understandable that Americans have less inclination to question costs when they have an insurance package paid for through the place of work. Their incentive is to get as much as possible. I am not suggesting people go out and break a leg in order to get free medical care. But they do not have much incentive to say "no" to an expensive test, or to question the cost of a service, or in general to seek out the best value for money in medical care.

It should be no big surprise that when consumers of services have very little concern in most instances regarding the cost, and when providers of services recognize that their patients do not care about cost, it is a recipe for inflation within the health care system. So, if you look at the tax treatment of health care in this country, it seems to me quite predictable that you would see rapid escalation of cost, because nobody really sees the price at the point of consumption of health care services. The only people who see the price are the people in the business sector who are paying the bills.

There are a number of ideas floating around in Washington to try to deal with this issue. One broad category of approach is seen in either the Canadian-type system or the proposal to mandate all employers either to provide health care for all of their employees or to contribute to some fund for those who are not covered under company plans. Both of these approaches fall into the category of legislating access to health care, and then requiring certain individuals or organizations to pick up the tab. It is the government in the case of the Canadian system, business in the case of mandated benefits. But these approaches really do not do anything to address the perverse incentive structure among patients and physicians themselves.

In both the Canadian and the mandated employer-paid system, you do not really create the exchange that needs to take place in the hospital itself or in the physician's waiting room between the physician and the patient. For costs to be brought under control, patients need to ask: "Is this test necessary? What is the cost? Do I want to look somewhere else for a better health care package?" In neither of those cases do you encourage such questions.

That is why we believe, together with many people who criticize the Canadian system and the mandated benefits system, that those approaches necessarily will have to lead to more and more control and regulation of consumer decisions to limit access and supply of services, since the consumer will have no incentive to economize. In these cases citizens would have a "right" of access to health care, but then government or employers would place some limit on what they can have.

Such approaches do not do anything about the problem of perverse consumer incentives and do not introduce basic consumer incentives. So they are doomed to shortages and waiting lists in the case of the Canadian system, because of overstretched government health budgets, or to more and more of the regulation by insurers and companies that could you see in private employer-provided approaches today.

The Heritage approach adopts a very different strategy. It does aim to create a national health system in this country. But by that we mean a set of programs and approaches that will lead to everybody in this country having affordable access to at least a basic package of health care. So, in that sense, we have the same goal as someone like Ted Kennedy – although that is about the only thing with which we agree with him in this particular area. Where we depart from him, however, is on the process to achieve it. But we do agree that a universal system is something that should be the objective of all health care reform proposals.

Our approach is based on trying to deal with the perverse incentives by stimulating consumer choice to constrain prices, by encouraging a really competitive market in the delivery of health care, and by trying to use consumer choice as a way of allocating resources, rather than controlling people's choices and access through the government or private sector. We try instead to use consumer choice as a method of economizing and regulating access and efficiency, rather than resorting to more red tape.

In addition, our approach would restructure existing tax assistance, using that tax assistance mainly for people who need most help in obtaining health care. The Congressional Budget Office estimates that in 1991 the tax exclusion for company-based plans will be worth about $48 billion in tax subsidies. As I mentioned, that support is skewed to the top end of the income spectrum. What we want to do in our proposal

is distribute that $48 billion in a different way, to help those who need it most.

There are two key elements in our strategy to achieve this general goal.

The first is a tax reform strategy which would change the basic tax treatment of health care in this country. What we would do, over a period of years, is phase out the tax exclusion for company-based plans. That does not mean that companies would have to shut them down, although many might. What it does mean is that the value of benefits paid for by the place of work would appear on your W-2 at the end of the year, and it would be part of your taxable income. If you have a $3,000 package, then $3,000 would be added to your W-2 and it would be subject to normal taxation. That is the bad news. The good news is that we would phase in a system of individual tax credits in the personal income tax code, for the purchase of health insurance and for out-of-pocket expenses.

This tax credit would have certain very specific features. First of all, it would be an above-the-line credit. In other words, you would not have to itemize your taxes to claim this credit. So it would be available for those filing the short form. Second, it would be refundable. By this we mean that if, when the credit was calculated, it exceeded your tax liability, you would, in effect, get a check for the difference from the IRS. Thus for people faced with high costs compared with their normal tax liability, it would be a voucher to obtain health care and health insurance.

The size of the credit would be based on the ratio of your anticipated health expenditures, direct or in the form of insurance, compared with your income. The higher that ratio, the higher the percentage credit would be. So, in other words, if you were faced with very high medical or insurance costs compared with your income, you would get a higher percentage credit than somebody who had low medical costs compared with their income. This necessarily gives a bigger credit to those on low incomes that are facing normal medical bills or those on moderate and higher incomes facing unusually high medical costs.

We envision the credit for most people at around 20 percent. But that would rise, perhaps to 80 or 90 percent, for those facing unusually high expenditures compared with their income. Maybe the credit

would be phased out completely for those who have very high incomes compared with their medical bills.

The second element would be what we call a "health care social contract." We would include a mandate in our proposal – not a mandate on employers, but a mandate on heads of households – to obtain at least a basic package of health care insurance for themselves and their families. That would have to include, by federal law, a catastrophic provision in the form of a stop loss for a family's total health outlays. It would have to include all members of the family, and it might also include certain very specific services, such as preventive care, well baby visits, and other items.

The other side of the contract is that government, either through the credit system that I've outlined or by access to existing public programs such as Medicaid and Medicare, would guarantee heads of household the ability to obtain that coverage, either in the private sector or, if necessary, through the public sector itself. So, there would be a two-way contract between government and citizen.

This two-pronged strategy would lead to some very important effects in the way health care would be delivered in this country, and it would have a very profound impact on the current problems we currently face.

The first is that by changing the tax assistance in the way I have outlined, and by introducing the health care social contract, we would be able to finance a universal system of health care coverage for all Americans, irrespective of their place of work or, for that matter, if they were even employed. The credit system has nothing to do with where you work or if you are employed.

Second, the size of the credit you would get through the tax code would be based on your expenses – insurance or out-of-pocket – compared with your income, and not your marginal tax rate. It would be designed to provide the most help to those who need it by virtue of their health expenses – a very different system of health care financial assistance than we currently provide.

Third, we believe the credit approach would stimulate efficiency and cost control within the health care system by introducing a powerful system of incentives and other tools to stimulate consumer choice.

There are several reasons why this would occur. One is that under our system, people would buy insurance and medical care directly. The employer would not be doing it. This means that any savings people

achieved by getting a more efficient basic package, or through more careful use of their own doctor, would go into their own pocket, not that of their employer.Thus they would tend to act just like anybody else in any other sector of the economy, making sensible economies by shopping around wisely rather than buying without thinking about price.

Today, of course, if when I go to the doctor and I am kind enough to say "no" to an additional test,The Heritage Foundation saves money, not me. If somebody at a large corporation does the same thing, the corporation gets the lion's share of the savings, not the employee. Under our approach, because individuals would get the savings, they would have a powerful incentive to question the cost of insurance and services.

In addition, costs would be brought under control because people would no longer be locked into company plans. They would then have an incentive to look at an alternative group or a plan that might have rather different features than their current company plan and to choose the one with the best combination of price and service. They would no longer be locked into whatever the company and union negotiates.

In addition, our plan would tend to discourage excess utilization – today's "use-it-or-lose-it" approach to medical care. Many employees buy an extra set of prescription sun glasses at the end of the year simply it is allowed under the company plan. You would have a powerful incentive for people to cut back on such wasteful spending under our proposal by choosing less generous plans with lower premiums.

Fourth, by introducing consumer choice as the principal method to bring about greater efficiency and a more rational allocation and use of resources, you have an alternative mechanism for accomplishing that purpose. A consumer-driven tax credit system would begin significantly to reduce the overhead cost in insurance and in the company-based plans we have today.The reason for this is that a great deal of insurance administrative costs are those associated with actually trying to stop customers buying health care. Insured individuals have a perverse incentive to overuse services or to use an expensive provider rather than a less expensive one. So, insurance companies introduce complex procedures to curb use and to question claims. Under a consumer-based system, the consumer has the incentive to use resources economically.Thus, we believe that there would be a significant reduc-

tion in the overhead costs of medical insurance by basing a system on consumer choice instead of the command and control mechanism that applies today.

For those of you from the Senate Budget Committee or OMB, I will shock you by saying that a fifth feature of our proposal is that a national health system could be budget neutral. It would be budget neutral because we are talking about restructuring existing tax assistance, not adding on a new layer of spending or tax breaks.

The Congressional Budget Office estimates that if we were to replace the entire tax exclusion for company-based plans with a 20 percent credit with certain limits, the Treasury would be ahead by about $18 billion a year in terms of tax revenues. That, we believe, would be a good margin for financing a bigger credit for those that really needed it, and to provide a credit or access to Medicaid for those who currently have no health insurance whatsoever.

Sixth, we believe that our approach also would deal with some of the problems we currently face with those who are currently on welfare. Consider the single mother who is unsure whether to leave welfare and take a job. Today, that person can face an enormous financial risk. After a phase-out period she loses Medicaid coverage for her family, and in most instances she will not receive health benefits at her place of work. And if she pays a doctor directly for services, she receives no tax relief. Under our proposal, she would become immediately eligible for a large, refundable tax credit after leaving welfare. That would tend to reduce some of the huge disincentive for moving from welfare to work.

Let me now touch on some of the common concerns expressed about our plan. The first is the question: Are people informed enough to make these kinds of decisions? Many blue collar workers and even many sophisticated professionals are not knowledgeable about health insurance and medical care. The argument is often raised, then, that health care is very different from some other type of service, and so a consumer-based system cannot work. In fact, that concern is well addressed under our proposal.

In our proposal, people would have to obtain a basic package of health insurance which would have very specific things in it, many of which are sometimes lacking in even the most financially generous health care plans today at the place of work, such as catastrophic

coverage. So, the consumer would not have to look for all kinds of obscure exclusions from his or her basic coverage under our type of proposal.

In addition, we believe consumers would, in most instances, simply join a group to make detailed decisions for them, and to obtain economies of scale in bargaining with providers or insurance companies. That group would also assist consumers in making trade-offs among costs, access, choice of doctor, and so forth. Today, because of the tax treatment of plans, the only people who can do that for you are company health care benefits managers. Under our proposal, you would be able to join other groups and get all the tax benefits associated with that. We imagine that unions, for example, would quickly expand in this area to manage benefits for their members. I think a lot of union members today would much prefer to have the union making detailed health care decisions than to have the employer making those decisions.

We also feel that other informed organizations – such as churches school organizations, and farm bureaus – would emerge to act on behalf of the consumer. Yet even with this help, it is the consumer who makes the basic choices. Is he satisfied with the group and the services it organizes for him? Does he think that it represents his interests? If he does not, he can go somewhere else. Today, he is either in the company plan or he is paying in after-tax dollars himself.

Another problem, some people argue, with this kind of approach is what in the health care area we call "adverse selection." Everywhere else, we call the same thing "consumer choice" and we think of it as a good thing. Strangely, we call it adverse selection – a problem – in the health care area.

Free consumer choice in health care is a problem today because of the way we cross-subsidize health care costs. In the employer-based group system, what we do is essentially to apply equal premiums to everybody, while recognizing there are some people who use far more health services than others. Thus some people are paying far higher premiums than they need to cover the services they use, while some people are paying lower premiums than are needed to cover their services. Equalizing premiums within each company plan is the method we use to cross-subsidize the less healthy. If we allow the healthy to opt out of a company group and buy lower costs insurance, that

"adverse selection" leads to much higher costs for companies to cover their less healthy employees.

We would still cross-subsidize in our proposal, but we would do that through the tax code rather than through trying to engineer equal premiums. Under our approach, we would allow premiums to reflect the market situation. Some people thus would face much higher premiums under our proposal, but they would also gain access to large tax credits to offset these costs. We believe this is a much more precise and equitable method of cross-subsidization and avoids this perennial task of trying to force everybody into a group at the place of work and then finding enormous problems if the characteristic of the group changes in some way.

Finally, some people argue that a credit system is technically very complicated compared with just having company plans. Wouldn't it be very hard, they say, for people to understand the credit system and to use it? We feel that the answer is "no." For most employed people, the credit would be provided to them through the normal withholding process. They would go to the payroll department and the credit would be blended into their normal withholding, just as if they bought a house they would take extra exemptions to take account of deductible interest payments.

In addition, we feel that you could simplify the operation of this system even further for people in larger companies by requiring larger companies to make a regular payroll deduction on behalf of the employee and to remit it to the insurance company of the employee's choice, much as people do today for 401(k) plans. The company thus would be doing the paperwork and making sure that regular premium payments were being made.

In addition, under our proposal, when you filed your tax returns you would have to provide a statement from your insurer saying that you did, in fact, have the basic package throughout the whole year. We think that fairly simple method would assure the compliance of most people.

Finally, consider the politics of this approach. Even though we do not have demonstrations outside saying "Support the Heritage Plan," we do feel that in these particular times there is a powerful dynamic behind the proposal.

One reason for this, as I mentioned earlier, a proposal that provides universal coverage in a budget neutral way has certain distinct ad-

vantages over one, such as the Pepper Commission, that needs to raise $80 billion in taxes every year to "solve" the problem.

In addition, the problems with other approaches are becoming more appreciated. People are beginning to look a little bit more closely at the Canadian system, for example, than simply relying on Dan Rather blathering about the Canadian health care utopia.

We are also finding that combining a credit with first a cap, and then with the eventual elimination of the tax exclusion of company plans, is the kind of package deal that blunts the normal resistance among employers and unions to the idea of a change in the taxation of fringe benefits. The concept of capping company plans is not new. But it has generally been put forward simply as a way of taxing people to reduce the deficit. Understandably, most people do not like that. But proposing some limit on how much is excludable, in order to finance a credit to cover their spouse or kids who are not now covered, or for additional services they need that are not covered, is a very different package for the blue collar worker who instinctively would tend to resist the idea of any cap.

We are also finally seeing some movement within the Administration and on Capitol Hill in this direction. We do not know what is going to happen with the budget debate yet. Obviously it could change any moment. But right now, there is within the agreement a provision, already passed by the Senate and sponsored by Senator Bentsen, the Democratic chairman of the Finance Committee, to give a 50 percent refundable tax credit for the purchase of insurance by low income families for children not covered under a company plan.[1] This is a first step toward our proposal being put forward by one of the most powerful Democrats on the Hill. We are seeing, in other words, the notion of giving very specific credits to cover groups not covered under company plans beginning to acquire momentum among those that really matter in Washington. We feel that will continue and that the momentum will strengthen.

1 This provision subsequently became law.

I have tried in those remarks to lay out some of the main elements of our proposal. I know there are a lot of aspects of it that probably still are puzzling and no doubt some problems we need to address.

I would like now to ask Gene Steuerle of the Urban Institute to comment on the Heritage proposal.

COMMENTS ON THE PROPOSAL BY EUGENE STEUERLE

Mr. Steuerle: There is a notion in Washington that eventually all think tanks merge into one. You may know that at one time the Brookings Institution was considered very conservative, until the advent of the long Roosevelt era converted all advisors to the government into advisors to Democratic administrations. I am here today to congratulate Heritage on its transition as well. This is probably the first time we have heard Stuart advocate a more progressive income tax!

In fact, his proposal has merit for that very reason. As Connie Horner mentioned earlier, this type of proposal really does gain support across the political spectrum. My comments here will support that premise.

The government at this time is in a stalemate with respect to health policy. Of the $600 billion that we are spending as a nation on health care, approximately $300 billion, or about half of that, comes from the government. That number is a little higher than the ones you may hear normally, because I am adding all the direct expenditures of the federal, state, and local governments, as well as tax expenditures. The tax expenditures that Stuart wants to reform are on the order of, perhaps, $60 billion. The figure for tax expenditures depends on the year in question and whether Social Security tax losses are also counted.

During the Reagan era, the major expansion of the government was not defense but health care. Despite all the rhetoric on both sides, what we saw during the Eighties was that health care was the dominant program expansion.

Whether conservatives or liberals, almost everyone now agrees that the health care budget is simply out of control. The budget is not determined legislatively. It is open-ended. And not only is it open-ended, but in some sense it has become so large and dominant that it derails other efforts on education, on the environment, and on other issues on which as a nation we may have started to reach some consen-

sus. It is growth in the health care budget that is swamping much of what we are trying to do throughout the rest of the budget.

But on the other side, there are also legitimate concerns – very legitimate concerns. We have over 30 million non-elderly Americans (perhaps 35 million, or 36 million, depending on how one does the counting) who are uninsured. Among the elderly, we also have a perverted system that disproportionately favors acute care over chronic care. Thus it is very difficult to get long-term care under Medicaid, yet up-front coverage under Medicare is automatically available.

On the one side, we are afraid to cut back on the existing system because we have these gaps. On the other side, we are afraid to expand the system because it is so large and growing so fast that we feel it to be out of control.

It seems to me that in this type of environment, as difficult as it may first appear, we have to look for budget-neutral types of strategies. Budget-neutral strategies are not very popular. At least until about the mid-Eighties, they were not the way to achieve reform. Throughout most of the postwar era, when we talked about legislation, we talked only of winners. Reform would be paid for only through a tax cut or an expenditure expansion. The way we paid for these changes was through hidden devices or, if not hidden, at least devices that didn't cause much controversy. We let Social Security rates go up. We let inflation gradually increase income tax rates. And, of course, we have been spending the decline in the defense budget for quite a number of years.

All of those sources of revenues, whether we like it or not, now are coming to an end. We have moved into an era in which we simply cannot have legislation that only identifies winners. If we are going to move forward and set new priorities, we have to identify both losers and winners. It is difficult to do. I do not think our institutions in either the executive branch or in the Congress have yet fully adapted to this requirement. But this new era is now upon us. It seems me, that in such an era, the type of proposal advocated by Stuart has to be taken very seriously.

I commented earlier that I thought the proposal described in the Heritage publication, *A National Health System for America*, could be favored by all parts of the political spectrum. Let me state why I think this is so. First, the proposal enhances equity or fairness among in-

dividuals. Second, it improves efficiency. Third, it actually makes the tax system more progressive. Fourth, it provides an element of budget control. Finally, it even gives us some potential for dealing with some Medicaid issues. Since Stuart has made similar arguments, I'm going to restate them very briefly, with perhaps a slightly different flavor.

There is a principle of equity that purportedly is behind our tax system, as well as our expenditure system. It is a powerful principle of equity. It is one that dominates most decisions with voters. The principle is simply that people should be treated fairly. If I am equal with you for all intents and purposes, then I should get equal treatment by the government. I shouldn't pay more tax than you or less tax, or I shouldn't get an expenditure unless you get it.

The current tax subsidy for health care simply does not operate in that fashion. It is a very inequitable device. It is one we would never enact if we were to start from scratch. We know that the subsidy does not provide equal treatment between those who have health insurance and those who do not have health insurance. It does not provide equal coverage or equal tax breaks between those who get health coverage from an employer and those who have to pay out of their own pocket for health coverage because they don't have employer-provided plans. It is not equal between those who get very generous health plans and those who get health plans that are not very generous.

This subsidy does not provide for equal treatment among different socioeconomic groups. For instance, women often end up to be working for plans that are less likely to provide health coverage. So, women in some sense are discriminated against relative to men. The same discrimination occurs against certain minorities, especially if they are poor minorities, because they, too, are less likely to get tax subsidized health coverage under their plans than are other groups.

For all these reasons, the system is just not fair. It does not provide equal treatment of equals. There is no way, it seems to me, that one would want to maintain or retain that type of feature in the tax code. Converting this tax subsidy to a tax credit, on the other hand, does move us in the direction of greater equity.

Secondly, this type of proposal improves efficiency. It can be designed to avoid subsidization of the last dollar of health care. I have one caveat about the incompleteness of the Heritage proposal in this regard, which I will mention in a minute. But, in general, there is a

substantial economics literature that argues that we should not subsidize the last dollar of health care. If we want to provide health care, it would be better to subsidize the first dollar, when we are less likely to interfere with the choices made by the consumer.

This point has been raised by a number of people. Alain Enthoven was one who pushed it most strongly over a decade ago. I, too, have made several proposals along the way. The Treasury Department has actually proposed capping the current employer-provided benefits three different times: once in 1983 as a means to get the budget under control, once in 1986 as a means to provide greater tax rate reductions to individuals, and then once again at the beginning of this year in a report called *Financing Health and Long-Term Care: A Report to the President and Congress.* So, three different times, the Treasury Department has come on board supporting this efficiency argument. (Since I was involved in making all three of those proposals, sometimes the wording tended to be the same.)

I would next argue that a Heritage-type proposal would enhance progressivity. Again, Stuart has spoken to that point. The proposal provides more benefits and is more helpful to people who are less well off. This change enhances the progressivity of the tax system.

Fourth, this type of proposal over the long run offers us greater potential for budget control. When we talk about "entitlements," and particularly our inability to control expenditure entitlements, we should remember that we have entitlements on the tax side of the budget. But "entitlements" is not a good term. The problem we have with many programs is that they are open-ended: They have tremendous built-in growth that is not subject to budget control every year.

One great advantage of setting a tax credit is that if we want it to grow – if we think this is the way we want to subsidize people – we can vote for it to grow. If we decide there are other needs in the economy that have higher priority, we can vote for them instead. With an open-ended tax exclusion, we keep spending more and more every year without being allowed to decide. The cost of the existing tax subsidy is growing at a rate much faster than GNP, and we have no control. By setting a tax credit, by controlling the financing, and by defining the program in terms of the size of the credit, rather than open-ended benefits, it seems to me we have some potential for budget control.

Finally, one of the nifty parts of a tax credit proposal is that it provides us a mechanism by which to attack a major Medicaid problem. Today, if those persons on Medicaid earn one more dollar, all of a sudden, they can lose several thousand dollars of health insurance.

If the federal government provides a health insurance base through a credit that is available to everybody, then we can supplement that credit at some rate related to income. That is, state and local governments, along with the federal government could adjust Medicaid to provide an additional subsidy of X to help people buy more health insurance. The amount of additional subsidy could be made dependant upon income level.

Here, then, is a way of merging the tax credit proposal with a reform of Medicaid. We could avoid a tax system that assesses several thousand dollars in tax for earning one more dollar of income. I hope some of the later speakers might get to this issue.

I do have one major difficulty with the Heritage proposal. Actually, I have several. But I am going to emphasize one here because I hope it will be discussed later. I do not agree with the notion that if we are going to provide a tax credit, it should be at a rate of 20 or 30 percent. When we addressed this issue in the Treasury Department, I finally concluded that it would be better to subsidize the first dollars of health insurance rather than the last dollars – hence, to give a credit at a rate of 100 percent on a smaller base of expenditures for health insurance. A 100 percent credit up to some dollar amount, say, $200, $400, $600, would be paid for by the cutback in the existing tax exclusion.

You might ask, "Why give a broad 100 percent credit, rather than a credit at a rate of 20 or 30 percent?" One reason derives from experience with individual retirement accounts and proposals for individual health accounts. Evidence indicates that at best only 10 or 15 percent of the population usually make use of these accounts, despite the generosity of the tax break. Individual retirement accounts are extraordinarily generous. Yet, the vast majority of people with under $50,000 of income do not buy these accounts, even though they are eligible to buy them. As a voluntary matter, we then would not see people opting into this system at a credit rate of 20 or 30 percent.

If we give a credit rate of 100 percent, on the other hand, it seems to me that people have a very strong incentive to get into the system. They have a powerful inducement to buy at least some health insurance.

Some of these people who do not buy health insurance – we do not know how many – seem not to buy it just because they have not taken the trouble. Now they would be foolish not to take some trouble.

Some of these may decide they are going to supplement credit-based insurance with more health insurance. We could reduce substantially the people who are not covered by insurance and provide easy opportunity for them to make further insurance transactions.

Another reason we favored a 100 percent credit rather than a 20 or 30 percent credit is that we wanted to subsidize the first dollars rather than the last dollars of health care – the very efficiency issue that Stuart talked about.

Finally, I doubt we are going to be able to solve our problems by imposing a mandate on people to buy health care. The Heritage Foundation proposal would mandate that everybody buy health insurance. That is how they get around the problem of only 20 percent of the uninsured population opting into the credit. I am not sure how that mandate would work, or what enforcement mechanisms are realistic. I question strongly whether the population would really accept an enforcement mechanism that says that individuals are going to pay a huge penalty if they do not go out and buy health insurance.

The avoidance of a mandate is another reason why I tend to favor a 100 percent credit rate. We do not need the enforcement mechanisms or penalties when the subsidy is great enough to get almost everyone into the market. But those caveats, however important, are still caveats. Even if we adopted a 20 or 30 percent credit rate, I think the system would still be better – more equitable, more progressive, and more efficient – than current law.

Let me take two more minutes here and talk about some of those who would oppose this proposal.

First, there is the group of people who simply note that we cannot solve all problems with this type of proposal. And I agree with that comment. One of the difficulties in changing anything in medical care is that we already have a system in which we are spending $600 billion. Even shifting around $30 billion, $40 billion, or $50 billion is not going to solve all our problems. Yet I do not think we are ever going to solve all our problems in health care or in welfare as long as people can die, be sad, or be wanting in some good or service. There is a point at which

we have to admit that we can only deal incrementally with these problems. We are trying to improve the system rather than cure all ills.

Those who object that this proposal would not do enough often favor national health insurance. If incrementally a credit is the right way to go, however, then it seems to me that the lack of perfection is not a legitimate economic objection. And national health insurance raises its own enormous set of costs.

The second group that tends to worry about this type of proposal are those who favor existing insurance arrangements and simply fear a new world. It is clear, as Stuart has mentioned, that there would be shifts the ways people buy health insurance. And we really do not know how all the shifts would work out. There is some fear that those shifts may involve turns that we may not like. In truth, some of those shifts probably would not be desirable. Some of the adverse selection that would take place probably would be not be advantageous. But the existing system is so inequitable and so inefficient that it is hard to make a case that we should maintain a system that is that bad merely because we are afraid of some unknown shifts that might take place down the road.

Third, we certainly would hear objections from those getting the most tax benefits under the existing system. But that problem is inherent in any budget-proposal because we are going to have losers as well as winners. We simply have to face that political problem right from the start.

Finally, there are some technical problems on which I am not going to go into detail: for instance, how the credit could be made refundable, and how to deal with a multi-employer insurance and other insurance plans where the individual value of the insurance is not well calculated. These are among the important technical details that would have to be worked out. While I do not think that they are going to be easy to deal with, I do think that they are amenable to solution. For that reason, I cannot reject the proposal on those grounds, either.

As a bottom line, if we were to start from scratch, we would clearly favor the type of proposal put forward by Heritage – and by Enthoven, myself, and others – over the existing law. For that reason, all of the important caveats are insufficient to reject the proposal. Thank you.

Mr. Truluck: Thank you very much, Gene. We appreciate those comments. Stuart, thanks to you as well.

The Industry Perspective on Health Tax Credits

Dr. Butler: In this first panel, we will examine the broad idea of tax credits for health care from three different, but somewhat overlapping, perspectives; one looking at it from the business side, the kind of people who administer the company plans, or work with organizations that face the cost of such plans. Our second panel, this afternoon, will look at the same idea from a medical and insurance point of view. Then bringing on some of our Washington insiders, who have to deal with these issues in a political sense, the last panel will try to look at some of the politics of the idea.

Our first panel has three individuals representing different aspects of the broad business community. Our first speaker is Jim McDivitt, who is senior vice president for government operations of Rockwell International. Jim has had a long, distinguished career in the corporate sector. As many of you may know, he was also with NASA and commanded Apollo 9, the earth orbital flight in 1969. He is somebody dealing with industry issues such as health care costs, and who well understands the government affairs aspects of these issues.

Our second speaker comes from what one might call the other end of the spectrum in terms of business size. Bill Dennis, or "Denny" Dennis, as he is known to many of us, is with the National Federation of Independent Business. NFIB is the largest small business organization in the country, with over half a million members. He is a senior research fellow at The NFIB Foundation. Besides bringing a perspective from the smaller firms that have to address the health care issue, he also brings to the table a larger body of data on what actually goes on in the small business sector. Denny conducts very extensive analyses of individual small businesses and their views on the issues they face – including on health insurance.

Finally, we have Karen Brigham, who is manager of health care policy at the U.S. Chamber of Commerce. She deals with health care issues for Chamber members and works closely with the various organizations at the U.S. Chamber dealing with health care. Karen also

was with the American Legislative Exchange Council, which is an organization that represents state legislators.

So, we have three speakers who, while all representing an industry perspective, have very different standpoints. I think it will lead to a very useful discussion about what the Heritage proposal would mean to the business world generally.

Mr. McDivitt: Thank you, Stuart. I have done some things other than fly around in space. I worked as an hourly worker and belonged to both the United Mine Workers and the United Stove Mounters Union of America when I was younger, and I have negotiated a bunch of labor contracts when I joined management. So, as an industrialist, I feel a lot of the things that we are talking about here fall into the area where we bargain between management and the employees for the benefits – as opposed to imposing them by law. I have an inherent lack of trust about trying to move these kinds of issues into the bailiwick of law. Let me talk about how I see the problem. I am not an expert on health care, although I have spent fifteen or eighteen years dealing on the periphery of it, trying to hold corporate costs down.

I see three issues: the cost of the health care, who pays for it, and who has access to it. Let us look at these from the Rockwell standpoint for just a moment. Who is covered? Who has access to it? Well, we have 109,000 employees, and all of our employees are covered. They do not all have the same coverage because we bargain with the UAW for some of our plans, and that coverage is what we agree to with the union leadership, with both sides knowing what the benefits are and what the costs are. So, we reach the best agreement that we can with those people.

We have a lot of other labor contracts, for example, with the electrical workers. We also have some plants that are nonunion, and we bargain with those people. One-sixth of our employees are engineers. So, we have a lot of white collar workers and we have plans for them. The plans for the white collar workers are broken down in three or four different areas. But all of our employees are covered. If we are talking about access at the worldwide level or at the U.S. level, maybe everybody does not have access. But of our 109,000 employees, they all have access.

Who pays? In general, both the company and the employee pay. We have some incentives to hold down costs. We are very, very conscious

of cost. We have adjusted the health care plans probably five or six times in the last eight years. We finished adjusting them again within the last six months. We are trying to hold down the costs. But we know who pays. We all pay.

Then there is the cost growth issue. That is a major concern to us. It has been going up at an unbelievable rate. We have tried a lot of things. We have a lot of gate keepers that you have to go through for certain types of insurance coverage. We have second opinions required for certain types of coverage. We have cost sharing. We are doing all the kinds of things that we need to do to contain those costs.

But let me tell you how I think our employees would view something like the Heritage proposal. They would look at it as a significant decrease in their pay. All of a sudden, we would give them this money, which we would have to calculate, and then it would immediately be taxed. So, they would view it as a tax increase or a loss of take-home pay. That is the way I look at it.

I think that if one is looking at the political aspects of how one deals with all these solutions offered to problems of those without coverage, we ought not to forget the people who are currently working and are covered under company plans. As our first speaker indicated, we have both technical issues and political issues. I think we are talking a lot about those people who do not have access and face high-cost individual insurance plans, and how we are trying to get them to feel politically more comfortable. But do not forget that most people in the United States actually do have health care coverage. I believe they will feel politically uncomfortable with this Heritage plan. I think that is how it would be viewed by our employees.

Let me put aside my corporate hat and just put on my personal hat. I feel that the real issue is a cost issue as we see it in industry. I had a big freight car plant that reported to me at one time when I was the president of Pullman Standard. I had this group of machines that was located in one part of the plant, and this fellow came to me who was running that part of it and said he wanted to move the machines over to the other part of the plant. I thought that was odd. So, we carried on a dialogue for awhile, and finally I found out that the reason he wanted to move the machines was that the overhead in the other part of the plant was less than it was in his part of the plant, just because we divided it by department. So, he wanted to get on the other side of the aisle

where the overhead was less. He wanted to spend a lot of money to move from point A to point B to get this overhead down.

Well, of course, the overhead really was not any different. The overhead was what the plant had, and it was distributed by an accounting process to get it in one place or another. He would have ended up with lower costs, but everybody else would have ended up with higher costs. So, it really did not do much.

That is sort of the problem I see with some of the approaches to health care regarding who pays and who has access. What we are trying to do is to change a lot of things around, but when we get all through, we have not really changed significantly the cost of health care.

I applaud Heritage for going after the whole health care issue. I do think that there would be a smidgen of improvement here in the cost of health care if the plan were implemented because there would be some incentive for people to contain the cost if it were their own money. But for those people who are already covered, there is almost always an incentive to contain the costs to companies that provide that coverage – I am talking about company coverage now. The companies who provide coverage have some cost sharing up front to try to keep those costs down. Those people who have individual health care with Blue Cross and Blue Shield normally may not always try to do it, but if they want to continue their coverage at some rate in the future, there should be some incentive there to hold the costs down.

So, I think what we really need to do is spend a lot more time dealing with the cost issue instead of who is going to pay for it. I am not an expert in this area, so I cannot really help much. But I do recall being at a meeting about a year ago, held by the National Association of Manufacturers. They had a doctor running a program on why health care is so expensive. He talked about a study that they had done using Boston and, I think, it was Hartford, Connecticut, on a number of diseases. They looked at what it cost to cure somebody of disease A in Boston and compared that to Hartford. They would then go to disease B and find out what in Hartford it cost to cure, and compare it with in Boston. It went back and forth like this.

Being a businessman, I would like to find out what causes the cost and then go to the cause and get it fixed so that we do not have these high, high costs. There has got to be some reason that it costs a lot more in Boston to get cured of a disease, only a few miles from Hartford –

and vice versa when you get to a different disease. There is a cost problem in the United States. It is not just a problem of who pays. I do not have a solution for it, and I do not think this program has a solution for it.

I think personally – with absolutely no data whatsoever – that the cause is the litigious nature of the society that we live in. We sue everybody over everything. I think that doctors protect themselves with an excessive number of tests and you have the malpractice insurance costs doctors have to contend with.

I believe also that there is an overcapacity of capital equipment. For example, when I have a plant, I do not buy fifteen or twenty lathes if I only need two. But I think that there is a tendency in the health care industry to buy a lot of new machines. If you have got fifteen CAT scanners and only have enough people to keep two of them occupied, people are going to charge to recover the cost of those fifteen CAT scanners. That is just straight business. These doctors and health care providers are not idiots when it comes to business. So, I would like to see us spend a lot more time on health cost containment instead of who pays for it.

I was really surprised when I read the proposal because of all the people in the world that I did not think would propose a progressive tax increase, it was Heritage. And this is nothing but a progressive tax increase. Stuart and I have had many discussions about that already.

I think that the proposal also does not really deal with what happens with poor people in rural areas. They do not have any money, and there is no public health care available to them, either. So, how do you force this head of the household to take care of his or her family?

In the proposal, there was some discussion about the idea that people who have specific diseases could get together with other people who have the same disease and group their medical payment money for service in that area. But it has been my experience that families do not tend to concentrate on one disease. They get sick across the board. If you have a family that has a person with a diabetes problem and a kidney problem, it makes it more difficult. The idea of spreading costs by group is what we do in group insurance, so there is really no difference. It just makes the group bigger.

Stuart, I did not like the way you compared the senior executive to the part-time floor sweeper. The proper comparison is one of a cor-

porate employee who has coverage who is making $5 an hour and a man who is making $5 an hour who is not covered. Those are the proper comparisons. It may be that the business not covering this $5-an-hour floor sweeper does not have the money to do that, and if you loaded that requirement onto the business, they could not do it. In the other company, that may be part of his compensation. If you take the health care away and give it to him in the form of money, I wonder what the sophistication of that man is to choose the proper health care.

That is one of the things that concerns me as an industrialist. What happens to the employees of these companies who are now thrown out to sift and pick out health care insurance? Well, if they go to the union, as was suggested, the union already participates in what the health care coverage is, especially if they are in a bargaining unit. You would not be joining a union health care plan unless you were in a bargaining unit, so I think those services are already bargained for.

There was also discussion about how one holds the head of the household responsible for providing that health care coverage. Quite frankly, I have no idea how one enforces that, especially if you have a poor family head of household, and they do not take out insurance. What do you do? Do you put them in the debtor's prison? That just does not make sense to me. I do not know how one would do that.

Another negative thing I find is that in the proposal it seems like we are creating an incentive to not work, when we provide health coverage to people who work and also to people who do not work. Do we change an incentive to work for an incentive to contain costs? I do not know how one looks at that. But if you start paying nonworking people for their health care, is that an incentive for them to not work? I do not know. As I mentioned earlier, I do not see how a lot of our employees would automatically become sophisticated enough to select the right health care. I do accept that there are a lot of people today that buy Blue Cross and Blue Shield insurance, and so they must be sophisticated enough to do that – or maybe they just buy whatever those insurance companies offer them.

Let me end with something I have said earlier. Probably the biggest problem that was not addressed here is the political impact that this proposal is going to have on all those people who do work and who are covered today. The problem also applies to the Canadian plan and

some of the other reform plans. There is not in existence today a good alternative plan for people who are covered workers.

I do want to end on a higher note, though. I think this is an issue which really requires a lot of very thoughtful effort. I do not think there is going to be an approach in the next decade that truly will solve the problem. I am pleased to see Heritage sticking their neck out to go after the problem.

Dr. Butler: Denny?

Mr. Dennis: Small business has drawn unusual attention during recent health policy debates. The reason is no mystery. Two-thirds of the 32 million Americans without health insurance either are employed or are dependents of people who are employed. Three-fourths of uninsured employed are attached to a small business. And, two-thirds of the group attached to a small business are attached to a smaller, small business -- firm size 1 to 25 employees. Adding one and a half million non-insured self-employed, small business is associated with over half of uninsured Americans and smaller, small business with about 40 percent of them.

Small business owners share public concern about the American health care system. In a national survey, the cost of health insurance was identified as the most important business problem of the 75 evaluated -- more important than finance, taxes, sales, etc. That may not surprise you given recent premium increases and the attention focused on health care. But if I told you the survey was conducted five years ago, you might begin to appreciate the impact health insurance cost increases have had on smaller firms.

The principal health care problem small business faces is cost. Last year 90 percent of small business owners polled believed that health insurance was becoming "prohibitively expensive." The figure has, if anything, increased over the intervening months. As a result, it is not difficult to forecast that barring major change, the number of uninsured attached to small business will increase in the future as it appears to have done in the recent past.

Small business is clearly not the only group to feel pain. Thirteen percent of employees reject coverage under an employers' plan (half that number have alternative coverage) and an unknown number select employers who substitute higher wages for health care. The tears of

Mr. Iaccoca and Mr. Crandall before Senator Kennedy's committee attest to the fact that large employers also face cost pressures. However, there are aspects of the health insurance market which affect small employers particularly.

Small businesses by definition are small groups for purposes of health insurance. (Industry-wide arrangements or geographic groups such as in Cleveland are exceptions to the rule.) Costs are relatively higher for a constant dollar of coverage in small groups. Small groups are prone to adverse selection and insurer costs of marketing to them are comparatively higher.

But small groups are not the only source of differential costs. Small businesses and individuals who are not self-insured -- and that's just about all of them -- must purchase health insurance subject to more costly regulatory and tax requirements than are those who can self-insure. The reason is state mandates and taxes levied on health insurance sales. Gail Jensen and Jon Gable estimate individual mandates can raise costs as much as 12 percent. Blue Cross-Blue Shield has suggested that the total additional cost in some states the amount is substantially more. Tax on insurance sales runs in the two percent range. As a result, the same coverage will run about 10 percent higher for a individual in a small firm plan and more than 20 percent higher for a family. Discrimination against self-employed people in the tax code only makes matters worse.

Is direct cost the only small business problem? No. Owners of new firms cannot obtain group coverage for at least the first year and sometimes not for the first two. The reason is adverse selection. Also, there may be owners willing to provide health insurance, but minimum wage laws prevent them from passing the cost back to the employee in the form of a lower wage. High turnover, typical in many small firms, creates administrative hassles as well as raising administrative costs. So, all in all, the current environment for health insurance creates relative disadvantages for smaller firms and works to impede small business owners from providing employee health benefits.

The Heritage proposal has two primary attributes that recommends it to owners of small businesses. The first is that the proposal rationally alters current market incentives to achieve desired outcomes. The second is that the generic alternatives to the market approach are terrible. In effect, the Heritage plan or some modification of it

provides small business owners the best opportunity to obtain the results of a quality health care system that both they and their employees can afford.

The Heritage proposal recognizes several important ingredients that are necessary to achieve a health care system which has high quality, universal coverage, and reasonable cost. The first is that the proposal puts markets to work for us rather than against us. The principal problem with the current system is that the individual receiving health care services does not pay for them directly. "Service is free." There is no incentive for either the provider or the consumer to consider cost in the many important health care decisions.

How many of you have heard that the health care market has broken down? Most of you? Think about it! The health care market has not broken down. It is working very well. The fact that we don't like its outcomes merely indicates that the wrong incentives are built-in. Some would argue that health care is inelastic -- that costs are irrelevant in health care decisions. That is true when someone has just been hit by a bus. Yet, we know empirically that about the only things that have affected the "service is free" behavior are deductibles and co-payments -- pure market incentives. Since we can't repeal the market, our only choice is to alter the incentives. Thus, the Heritage proposal deals with the problem of escalating costs in the only rational manner.

The second positive aspect of the Heritage proposal is that it is not bound by old shibboleths. In particular, it is not wed to the employment-based group. There is no divine requirement that an employment unit act as the basic health insurance unit. The employment-based group does have advantages. But, think of the problems it creates: not everyone is covered; despite COBRA, it reduces labor mobility; the employee in all but a few cafeteria plans must take the benefits the employer or the majority of employees want; and, many employees are in relatively small employment groups escalating their relative costs. The Heritage plan facilitates the collection of individuals into groups who prefer similar benefits and in which the individual's participation is "portable". Heritage, therefore, provides opportunities for non-employment based plans which will allow many small business owners and their employees to escape the small group problem.

The third attractive aspect of the Heritage proposal is that government subsidies are directed where they belong -- to the indigent and to those with extraordinary medical expenses. There is no intellectual justification of which I am aware to subsidize first-dollar coverage for wealthy individuals while providing no help to the working poor for the most basic health insurance coverage. Only tradition and raw political power preserve the existing arrangement. I recently heard an incredulous proponent of mandates comment that the tax portions of a market-based proposal were more progressive than any other approach to health care! The coffee is brewing and some are beginning to smell it.

Fourth, the Heritage proposal puts the responsibility for health insurance coverage where it belongs -- on the individual. Employers are being badly "yo-yoed" by government these days. On the one hand, they are asked to take care of their employees -- provide them the benefits that the government thinks they need rather than benefits that they choose. On the other, their authority to enforce acceptable workplace behavior is increasingly eroded by case law. The Heritage proposal would change the decision locus from what some now consider an employer responsibility, i.e., purchase of a predetermined health insurance policy, to what is essentially an employee's right, i.e., how to spend his earnings. Thus, individual choice -- particularly for those now in small and medium sized plans -- would govern personal decisions about health care.

Finally, the Heritage proposal provides universal coverage. Many small business owners and their employees currently without coverage (over 15 million of them) will have insurance as will many others. I expect that cracks will develop in coverage. Every individual with a serious "precondition" may not be able to obtain insurance even with the subsidies provided. But, these situations can be handled separately.

Are there elements of the Heritage proposal that bother me? Yes, though in most instances my concerns snipe around the edges or are not inherent to it.

My greatest concern is that the proposal will not be taken as a whole. I fear that politically popular stimulants to increased demand, i.e., tax credits, will be decoupled from politically unpopular demand depressants, i.e., elimination of some exclusions. The result will be a boom in

demand and an accelerating rate of health care and health insurance cost increases. In turn, families will find the health care portion of their budgets even larger. Thus, while we will be better off in terms of people covered, we will be much worse off in terms of total health care costs.

Critics of the market approach charge that consumers cannot make rational choices among health care providers and the procedures they employ. Therefore, the price mechanism implicit in the market approach cannot work. This elitist view is betrayed by operations of the market elsewhere. Consumers, for example, seem to be able to choose universities and courses of study without being college profs. They seem to be able to discriminate among cars without being automobile engineers or mechanics. Every consumer does not make an objectively rational decision on these or other purchases. But we don't need every consumer to make an objectively rational decision to make markets respond.

More and better information than is now available would improve market performance, however. In particular, information on costs and outcomes are critical to the success of a market-based strategy. The Heritage proposal does not address either issue directly. I think it should, if nothing more than to say the market will create a demand for such information and the market will fill the demand.

I also think the market-based strategy is far enough along so that we can begin to attach numbers to the concepts. How much is the credit for whom? Etc.

The most controversial element of the Heritage proposal to me and the one I swallow hardest on is compulsory coverage. Inclusion of the provision assumes that society will provide some level of health care services whether an individual is financially responsible or not. Therefore, the proposal faces a classic "free-rider" problem and handles it in the classic statist way. Moreover, compulsory coverage assumes minimums, i.e., a minimum level of coverage to qualify as having insurance. (Tax credits for purchasing health insurance, with or without mandates, also implies minimums.) Minimums are, of course, mandates which can be relatively modest, e.g., catastrophic coverage only, or extensive. Though the initial objective will be to keep minimums minimum, provider groups will exert enormous political pressure to create a laundry list of new compulsory benefits. That's a serious problem.

My dilemma is that I don't know how to avoid the mandate. Tax credits, market forces and bare-bones plans will lower costs, making the purchase of insurance more attractive -- with or without compulsion. Yet, today about 20 percent of those without insurance have family incomes of $30,000 or more. This suggests reasons beyond cost for the lack of coverage. Moreover, human nature is such that there will always be a group who will refuse to purchase insurance. The "young invincibles" are the most likely. And, who pays when a young invincible gets hit by a bus, or more likely, who pays when he hits a bus?

Should there be any doubt left, I like the Heritage proposal a lot. It's good for small business; it's good for small business employees; it's good for the country. Unfortunately, that enthusiasm is not yet shared on Main Street. Markets in health care are new to them and aspects of the proposal make small business owners nervous. The most serious is change in the current tax exclusion. They see this as just one more attempt to increase taxes. Reversal of Mr. Bush's campaign pledge and the debacle small business owners have witnessed on Capitol Hill over the last few weeks only reenforce their cynicism.

So, there is missionary work to be done. But, I think it is very doable.

Dr. Butler: Thank you, Denny. Karen?

Ms. Brigham: Thanks, Stuart. I think the question that we are all asking is, does the Heritage proposal have any merit? I would say that it must. And Stuart is not making me say this.

We have been talking about it for more than a year. Think about it. Think about all of the health care proposals that have come out over the past two years. How many of them are we still talking about? From my own anecdotal evidence, in talking to members, there is a great deal of interest and a degree of support out there for the Heritage proposal recommendations. I think it has merit if for no other reason than it is different from the other proposals that we have seen. Thank goodness, it is not another pay-or-play mandate approach. This is a fresh perspective on a very difficult issue. So, I think it is a serious proposal that cannot be dismissed out of hand and should be discussed. So, I commend you, Stuart and Ed, for assembling this program today. I have to give the same caveat that Connie Horner did – that this is not an

endorsement of The Heritage Foundation proposal. But I think one thing that it has done is fostered debate, certainly in our health care policy committee and around town also, on the issues of tax incentives and the health care system.

I would like to talk about some of the issues from the business perspective. I think that the basic question that health care analysts everywhere are examining is how do you change the perverse incentives, which Stuart talked about earlier, that are inherent in our health care system. These are the incentive for individuals to choose the richest plan, and bargain for the richest plan, because they are tax-free compensation and the incentive for these same individuals to over-utilize the system because they are insulated from the cost of that system by a third-party payment system.

There is also an incentive, as a result of the structure of the health care system, for providers to over-treat and over-prescribe. We have seen questions being raised about the appropriateness of some of the care being provided and studies showing wide variations in care with no clear medical explanation. But I think for business, it comes down to the cost of health care. So, as we discuss how can we get health care costs under control, we seem to look in three directions.

The first is that of trying to change provider behavior through some kind of a regulatory scheme, similar to the physician payment reforms in Medicare, Part B, that were enacted last year with fee schedules, limits, expenditure targets, volume performance standards – trying, in other words, to control costs in a regulatory mode.

Another approach often discussed is trying to change provider and consumer behavior through increasing cost sharing and through managed care programs. That is what employers are doing right now. They are increasing cost sharing not so much because it decreases the total amount that they are spending on health care, but because it emphasizes to the employee the true cost, at least in part, of their health care coverage. Managed care is another important tool that they have for trying to control costs, to encourage more rational behavior among health care consumers.

I think that Denny raises an important issue in saying that one thing that we need if we are ever going to have a market in the health care system is better information. Better information on outcomes, better

information on costs. We need better information if there is going to be a market in the health care system.

The third option discussed in looking at ways to control costs is changing individual behavior through tax reform, giving the individual a financial stake in his or her own care. That is what we are talking about today.

These are the debates and discussions that are going on within our health care committee and around town. Let me tell you that my constituency is not speaking with one voice. My constituency ranges from the mom and pops through to the Fortune 500. We have 180,000 members, businesses of all sizes and descriptions. We are not all singing off the same song sheet when it comes to what should be done to reduce health care costs.

I will focus on the tax reform issue, because that is what we are here to talk about. Taxation of health benefits as an initiative has been around for a long time. It seems to surface at least annually. It is an approach where business, organized labor, and the insurance industry traditionally have stood shoulder to shoulder in opposition. I would emphasize that the U.S. Chamber of Commerce opposes taxation of benefits. I think the primary reason that this issue comes up year after year is due to the revenue loss involved, which will be $48 billion next year. I think there is a suspicion among many employers that if they were to favor an approach that would tax benefits, Congress would latch onto half of that equation and they would happily tax benefits, but you would never see tax credits on the other side. It would just be a revenue raiser.

I think that suspicion is compounded by our recent experience with Section 89, which most of my constituency viewed as a back door attempt to tax benefits. It was cloaked in the social goals of ensuring that benefit plans did not discriminate against lower paid and part-time workers. But I think most viewed it as simply a way for Congress to get at a piece of that revenue, namely health benefits.

Another issue employers would consider in looking at this proposal is that it would increase their payroll costs. As health benefits become taxable income, that is an increase in payroll taxes. Over time, that may go down because health care costs now are certainly growing faster than wages. But that would be a consideration. Some members of the business community have begun talking about the whole issue of the

tax exclusion and whether it should be limited or reduced all together. There have been talks over the years, and in the pre-tax reform days, of some kind of a tax cap, a dollar level for benefits. Today, we are hearing more talk about design based tax caps, where the design of the health care plan would determine whether or to what extent the health benefit would be excluded from taxes. So, the debate over taxation of health benefits has changed some.

There is also a question of whether or to what extent eliminating or changing the tax exclusion would change behavior. Is it too far removed to have an impact on behavior? Or would it, perhaps, have an impact on which plan an individual would choose? But, on the other hand, would it provide the incentive for that individual to use that health plan to the fullest extent? In other words, tend to encourage overutilization. From my own perspective, I have a flexible health care spending account that sets aside an amount of pre-tax dollars for certain out-of-pocket health care expenses. I certainly want to make sure that I spend every last dollar that I set aside, because I would otherwise lose the amount in the account. So, there is something of a question on how much this would change individual behavior.

There are a couple of other obstacles to employer support. One is an issue that Denny raised. An individual mandate is certainly one of them. It would be very difficult for an organization such as ours, which has strenuously opposed employer mandates, now to come out in favor of an individual mandate. That is certainly a problem.

The issue of government determining a benefits package is also of concern given the experience that we have at the state level, where providers and interest groups have been very successful in lobbying the state governments. These require that health insurance benefits sold within that particular state must include their services. That causes some concern.

Finally, I would just strike a note of political pragmatism. I do not think anybody favors the status quo when it comes to health care. Costs are going out of sight. Questions about quality are increasing. We have a large number of individuals who do not have health insurance. So the question becomes: How do we reform the system, and what is the likelihood of structural systemic change? The U.S. Chamber of Commerce supports what could be termed an incremental approach, a recommendation targeted at what we see are problems within the

health care system. They fall into three broad categories: addressing the factors that are driving health care; making it easier for businesses, particularly small businesses, to offer health insurance coverage; and, finally, ensuring that the public sector programs, primarily Medicaid, are meeting the needs of their target population.

This incremental approach acknowledges the political and budgetary obstacles that we face to enacting reform. On the political side, you have a large number of players in this debate – very powerful and very diverse. You have business, organized labor, organized medicine, hospitals, other providers, the insurance industry, consumers, the elderly – a very powerful subset of consumers – and government at all levels. As I said, we all agree that something has to be done about health care, but at this point in time there is certainly no consensus on what that solution should be.

The budgetary side also creates a problem in solving the health care problem. A budget neutral proposal, such as that from Heritage, is certainly attractive from that perspective. Given the fact the spreading of risk would be done through the tax code rather than as it currently is, across groups purchasing health insurance coverage, there is some question as to how long the proposal would be able to remain budget neutral. But I think that it has provided an excellent addition to our health care debate, and I thank you for inviting me here today.

Dr. Butler: Thank you very much, all the members of the panel. I would like to take a couple of minutes to respond to some of the points made. Jim raised some very important points about the proposals, and I take them in the spirit they were intended. Some, however, I would disagree with, although I think he does raise legitimate concerns.

Let me first address the progressive tax issue in several ways. The first is what they call in the White House "plausible deniability." What they are talking about is not raising people's taxes but the tax base itself. What do you include as income for tax purposes? I feel there is a big distinction between saying that something which is clearly income, namely health benefits, shall be treated like any other element of income, as opposed to saying we are just going to raise everybody's taxes.

The second point I would make in talking about the tax exclusion is that unlike many people in Washington, D.C., we at least recognize that when you provide new benefits to people, somebody ends up having to

pay for it. Unlike some of the other reform proposals, we open the question about how do you introduce equity, and how do you finance an approach that tries to provide assistance for the uninsured.

I would just mention in passing that when you look at, say, some of the studies that have been done recently about the Canadian system, these point out that many of the unions now strongly supporting the Canadian system would discover that their own members would lose substantially by an approach that would raise the income tax or payroll taxes and then provide a similar package to everybody in the health care system. So, at least we are talking about it, unlike some proponents of other proposals.

I would say, thirdly, that it is also by no means clear that we are talking about a situation where those who currently have benefits, whether it be at Rockwell or somewhere else, necessarily lose under this type of proposal. For example, I am sure that at Rockwell there are many people – the young invincibles that Denny mentioned – who get perhaps $6,000 worth, or maybe less than that, of benefits that they do not use. They are not paying tax on them, but they are not using them either. They would probably much prefer to have $2,000 worth of benefits and get the rest in cash, even taxable cash. I think you would find that a lot of people who currently have very generous benefits would see it in their financial interest to exchange that employer - based system for one in which they can choose what they want – particularly those who feel that the generous company plan actually does not cover some of the things that they think are important while providing services they do not need or use.

So I think the whole progressive tax issue, and who is paying higher net tax, is not as clear-cut as Jim suggested.

He and others also mentioned the issue of: how do you enforce a mandate on individuals? I suppose, in the last resort, we *are* talking about debtor's prison. But it seems to me that if you have a requirement that you have to show insurance coverage on your tax form, you can gently indicate to somebody that they are not complying without throwing them in jail. IRS examinations make everyone nervous.

Remember also, we are talking about a situation where the people who would not comply would be those who, despite a generous refundable tax credit system to help them offset those payments, and despite a legal requirement that they must avail themselves of a basic package,

are still determined to evade the law and not to get themselves and their families covered.

Quite frankly, I wonder what responsibility we have to those people. If the young invincible is a sky diver and refuses to get himself covered insurance, and then he gets hit by a bus, then do we really have quite the same obligation to force him to protect his finances and his health as we would for somebody who does not have his children covered under a plan?

So, in terms of enforceability, I am not sure that the number of people who are determined to evade the law would be that large. Even if there were a significant and troublesome number, there would be some categories of evaders that we would be more determined to deal with than some others, namely, those who put at risk their own family members.

I accept Denny's point, that it is extremely important that you take an idea like this as a package. I also accept both the political difficulties of doing that and the necessity of it. That is why we have argued strongly, as you heard in my introductory remarks, that we must talk about a tax reform strategy. We put the emphasis on the word "reform," meaning a reorganization. I think that we are politically better placed today to do that than we would have been a few years ago. The very pressure of the deficit issue makes it much harder simply to give a huge credit and do nothing else, because of the tax revenue implications of that action. So, while I accept the problem, I would argue that we are in a better position to move forward with a uniform package today than we might have been some years ago.

In addition, as a good conservative, I, like Denny, am very concerned about the notion of compulsion. We have received a good deal of criticism from our friends on the libertarian end of the conservative spectrum emphasizing this concern: What right, they say, does society have to force anybody to do this?

I think it all boils down to your answer to a simple question. Imagine you come across somebody seriously injured in the street, someone who has not obtained health insurance. You might be a doctor or an individual trying to help this person, and the person says, "No, I do not have any health insurance. I made a decision to take a risk and not to obtain insurance." Are you prepared to say to that person, "Fine. You

have made that decision, so we are not going to help you unless you can pay for it"?

The fact is, I do not think we as a society or as individuals are going to do that. I do not think we are prepared to do that. Given that, it seems to me that a mandate on individuals, and the assignment of responsibility to individual citizens in the first instance to protect themselves financially is the second best solution, in an intellectual sense, to the worry about the infringement of liberties.

Another issue brought up – I think Karen and Jim made this point – is faced generally by employers today, namely the problem of even measuring output costs and trying to compare value in medical care. Groups of employers around the country engage in various kinds of strategies – "buy right" strategies, as they are sometimes called – to try to develop a data base that means anything in terms of these kinds of comparisons.

I agree that it is necessary, whatever else you do, to have a better method of evaluation. I feel that by simply allowing, indeed encouraging, groups other than employers to form groups and engage in this kind of data collection activity, our proposal would very much enhance movements in the direction of improving data.

I also recognize strongly the political point that employers and employees have about sliding down the road of taxing fringe benefits. While it may seem very nice and self-contained in the Heritage proposal, I agree it can be seen as becoming a little pregnant by taxing something which has been off the table. It just seems to me that you have got to look at the alternatives and the risks they carry. As much as there are dangers associated with our proposal from a political point of view, there are far more severe dangers associated with other approaches. That is not the perfect answer, I know, but it seems to me that is the kind of political risk conservatives have got to consider just as employers have to consider, as Karen said, the difficulty of opposing employer mandates for years and then saying we are in favor of employee mandates when it comes to availing themselves of insurance.

These are all issues that we at Heritage recognize and we understand the political dimensions. But as Karen also said, you have got a certain political climate now. The notion of trying to move forward with something that reorganizes the subsidies you currently have under the tax system, rather than adding a new expenditure or simply a new tax

break, may have a lot more going for it today than it would have had ten years ago.

I would be very happy now to have very specific direct questions either to me or to members of the panel or a statement you would like to make.

Mr. McDivitt: Stuart, I have one that is a technical question. Would you propose that the income allocated to individuals be the total premium for the corporation divided by the number of employees and then given to the people, or would you have it allocated on an actuarial basis? The young guys who are not getting sick very often would get significantly less money than the old guys who are getting sick a lot?

Dr. Butler: That is a very good question. It is one that has been raised before. Under the current employer-provided system, the actual benefit to one person may be very different from that to another. What do you do in terms of making that taxable?

My reaction would be to divide the total premium equally among employees and make that taxable. I say that for a couple of reasons. One is that it is simpler to do that. That is a pretty big reason.

But secondly, think through what the impact would be if you were to give an equal extra cash benefit to all employees in lieu of the health benefits. On its face, that would be very inequitable in terms of the total value of the compensation. But then each individual would be subject to a tax credit based on expenditures and income. So, the person that is today using far more health services than his premium pays for would get less extra money in his pocket than the value of the employer-paid benefits. But he would be eligible for a larger credit because of his comparatively high costs compared with his income. Meanwhile, the healthy person that would receive more cash than his premium level would not be eligible for such generous credits. So, if you look at it that way, in a rough and ready way, it comes out the same in the wash in terms of the extra cash income net of the credit. If you try to really assign actual costs, it would be complex, and I doubt you would really end up much different than if you gave equal amounts of cash.

Mr. Haislmaier: Can I comment on that for a minute and then ask a question? One of things that Stuart and I sought to achieve in develop-

ing this proposal was simplicity as being a virtue; that if we could make it simple, people would be more inclined to support it.

Now, there are places where we are happy to make it a bit more complex, if that is what is needed to support it and it does not diminish the overall advantages. For example, it has been suggested that rather than expecting people to take deductibles and get tax credits for out-of-pocket expenses, perhaps people should have tax relief for saving up a tax-free savings account, for example, to pay for out-of-pocket expenses. It is a bit more complicated, but it does get around the problem of, say, incurring $300 in up-front costs when you do not have $300 on hand.

Similarly in this case of providing employees with the cash value of their premiums. You can see where we are coming from. When you got into the legislative stage, it would be something decided on the basis of input from business and labor. From our, if you will, theoretical framework, it does not really much matter. There are some differences in the end. But it does not much matter from the theory of it whether you do it on an actuarial basis or you simply divide it. Simply dividing it is simpler. But if unions and management feel that it is fairer to do it on an actuarial basis, I would consider that a friendly amendment if I was sponsoring a bill in Congress. I would not have a problem with that.

The question I wanted to bring up to get the reaction from the business panel is this: We, too, have struggled, as Stuart mentioned, with the issue of mandates. The best answer I have been able to come up with for our libertarian colleagues is first to admit that yes, you are right; any time we have to government mandate something, there is always a danger of that expanding. But then I argue that the political dynamic surely is more favorable if it is a mandate on individual voters than if it is on a mandate on a nonvoting distant entity, such as an employer or an insurance company. In other words, you are more likely to see the government or the legislatures expand a mandate, or a tax or anything else, if it is on one of those "thems" out there that cannot really fight back. When you try to impose a mandate on the average citizen, eventually it will lead to a backlash if it is excessive. So, my argument is that, politically, it would be more difficult to impose an excessive mandate on individual voters. I would like your reaction to that, if you think I am right, or off base, or what.

Mr. Dennis: Politically, it would be more difficult. There is no doubt about it. It would be more difficult because you are dealing with individuals rather than employers. It would also be more difficult than it is today with state mandates because you are not even dealing with all employers. You are only dealing with employers that purchase insurance. You are not dealing with self-insured employers. And self-insured employers tend to be the largest and most powerful. So, I think that from a political perspective, there is no doubt what you say is correct. It still makes you really nervous, however.

Congressman McCrery: Jim, I appreciate your remarks because I made basically the same remarks when I first talked with Ed about this proposal some months ago after I first read the proposal and started thinking about it. However, since then, I have examined the alternatives to a free market approach in trying to bring down the costs of a health care system. It seems to me, Jim, that if we just put blinders on and try to nip at the edges of our current system and try to fill in the gaps, so to speak, we are just going to exacerbate the problem. We are going to probably hasten the demise of what free market we have left in our medical system, and we will end up with a nationalized health care system or, probably along the way, mandated health insurance for all employers.

I do not like those alternatives. So, I am hopeful that the business community, and particularly big business, will examine the alternatives and see that for the country's benefit. It may be best to take off the blinders and see if maybe we could not approach something like the Heritage proposal. From a political standpoint that would be a very vast undertaking, no question about it. But it is one that deserves your attention and your type of business's attention because sooner or later, it may not affect your bottom line, but it will certainly affect the morale of your employees, I think, and the way that Americans do business in general. So, I hope you will think about it some more.

Now, Stuart, a question for you all. I am sorry I was not here for the earlier presentation. You may have said something that I did not pick up in reading your program or talking with you before. But comment, if you will, on the framework for employer-provided insurance that you foresee if your proposal were enacted. I keep hearing comments about taxing the benefits of employer-provided insurance. But it seems to me

that under your proposal, employer-provided insurance would not be as attractive as it is today. So, what do you foresee employer-provided insurance becoming under your proposal?

Dr. Butler: We would expect to see employer-provided insurance shrinking under our approach. I suspect that some employers would continue to provide it, even though it would be a taxable benefit, because of special circumstances that they felt would give a competitive advantage in recruiting certain individuals. So I would imagine it would continue. But I think, in general, employer-provided insurance would decline across the board. You would, however, get the emergence of other types of groups, as I mentioned. Many unions, and maybe other collective groups, would instead begin to act as brokers for plans.

I would emphasize that if an employer did decide to end benefits under our proposal, they would be required under law, at least until the next bargaining round, to give the same in cash as they had previously provided in health benefits so they could not just change the total compensation midway. Next time around, it would be up for the normal negotiation.

Mr. McDivitt: I would think that management employees, and non-union employees, would probably stick with the corporation. They have the best bargaining position today. They are the ones who are working, I believe, hardest to contain costs.

To go back to what I was talking about earlier, I think costs are the major problem. Corporations today are taking a lot of actions to contain those costs. If the corporations really get out of the insurance business, I do not see that pressure to contain costs going someplace else. It is not a free benefit. It may be free to the employee, but it is a cost to the corporation. And we work very hard in the bargaining we do with our employees, and in benefits we give to the non-bargaining employees, to keep those costs down.

So, if that pressure on the health care industry goes away, I can see the costs going up. Maybe I am oversimplifying it, but I really do think they would increase. I would think that our employees, at least on the management side, probably would stick with the company's plan. Each one of the union plans is different because that is what they bargained for. Whether they would elect to continue with the corporation or just have that money flow to the employees, and then into the union, that

would vary. Some unions have very, very strong central plans, and others do not. So, I think that would vary a lot.

Mr. O'Dea: Jim, you had mentioned earlier about dealing with a managed care type program. I know there are two types of managed care. One is modelled after PPO managed care, but there is the other one now with the gatekeeper approach. To me, that is the scariest approach of all because we are talking about rationing health care. There is no doubt that we will get some controls on cost if the insurance company can just say we will pay for this and we won't pay for that. That is where we are headed if we do not have a proposal like The Heritage Foundation's. Could you just comment on what employers think about rationing care?

Mr. McDivitt: We are not rationing care to keep the truly sick people out of the hospital; we are trying to keep some cap on the costs. We use gatekeeping in Rockwell for things like psychiatric treatment, drug problems, alcoholism, and other things like that. We use second opinions for surgery and other activities like that. There is no answer to this thing, to go back to what Congressman McCrery said. I do not see a better proposal. I do not see any good proposals anywhere right now. I think that employees who are covered think that their plan is fine because they have all these benefits. I think there is going to be a big political problem when you tax them all or whatever you do. I am just trying to reflect reality. I think that most of the people in the United States are covered. Is that right?

Mr. Haislmaier: Eighty percent.

Mr. McDivitt: Eighty percent of the people in the United States are happy; 20 percent are not.

Mr. Haislmaier: Well, wait a minute. I didn't say they are happy!

Mr. McDivitt: Those are your numbers. I think most of the people in the United States are covered and most of those people are happy. If you tax their benefits and do these other things, I think there is going to be a major problem. I do not have a better plan, though.

Mr. Davis: Ed Davis, Eli Lilly & Company. To get off the dime in terms of your Hartford-Boston connection, would you in small business agree – if one could identify a reasonably self-contained community, where you had small business and could get professional, medical, and governmental agreement – to a laboratory model experiment to compare consumer behavior, professional behavior, and business costs of health care?

Mr. McDivitt: I think that we need to understand what makes health care costs so different all around the country. I am not sure that we will ever do that. We have some enclaves in certain parts of the country where we really provide a lot of service because we are the dominant employer in that area. We probably employ 80 percent of the people who work in Cedar Rapids. We have our own pharmacy because we can cut the costs down by about 80 percent of what the costs are if we just let the people go to the local pharmacy. In an area like that, we have members of the boards of directors of the hospital, and we can help work with them to not overbuy things like CAT scanners and other very expensive machines. So, we do influence what the costs of health care are in Cedar Rapids, Iowa. We do not in Los Angeles where we have maybe 45,000 employees. We are not dominant at all, so the prices just go up.

I do not really have an answer to this whole thing. I think that you cannot solve the problem unless you know what the costs are. If this was a business problem and I saw my costs going up, I would start analyzing it. Is it labor? Is material? Is it overhead? Is it variable costs? That is the kind of approach I would take. I see more effort in trying to distribute the cost than finding out what is the cost problem and addressing that.

As I mentioned earlier, I think it may be the litigious nature of the universe in which we live today. I think, Congressman McCrery, that is your problem. Change that for us, will you? Seriously, that is a societal problem. I do not know how we deal with it. I think that there is a total lack of coordination between purchases of equipment in the medical industry. There are a lot of other things like that I do not have a solution for.

Mr. Dennis: The fundamental problem with looking for costs, as Jim wants us to do, is that only a few people are looking for them. When you do not have any incentive to watch costs, why should you do it? We need 240 million Americans watching costs. That's a lot better than having a few guys from Rockwell out there, who only have partial control over the whole situation, looking after costs. It is helpful, but it clearly cannot be a solution.

Mr. Sullivan: Sean Sullivan, New Directions For Policy. This issue of costs is a troublesome one, but I do not think 240 million consumers are going to solve it, either. We have just completed a detailed analysis of the forces driving costs in the American health care system. One of the forces is the expectations of the American people as to what kind of health care they are entitled to on demand. That helps to fuel what is called the high tech nature of American medicine. The gentleman's question about rationing is most apropos. If we really want to reduce the rate of health care cost increases significantly, there are forces that lie outside our discussion today that will have to be addressed, and quite frankly the rationing of health care is one of them. Unless we are prepared to face those issues, we can reduce the curve somewhat, but I do not think we are going to change it an awful lot.

Other countries have chosen another way of trying to deal with this, namely the method of putting lids on spending. That, of course, is just suppressing costs. But they are beginning to see the same kinds of increases now that we are seeing, albeit starting from a lower level. So, I think we are going to have to expand our discussion, if we are really concerned about costs, beyond what we are talking about with just this proposal.

Mr. Wicks: Elliot Wicks, Health Insurance Association of America. I have strong reservations about moving from a system that depends upon employers making cost effective choices about what kind of plans to buy to one that would place that onus on the individual, primarily because of the problems of adverse selection. It is much easier to give people low cost plans by choosing people who have low risks than it is by making the health care system more efficient. It would be a very strong incentive for all people selling plans to try to get people who

have low cost health care expectations. And people would be drawn to those.

I should think small employers would be particularly concerned because they have been the people who have borne this, badly in some instances. The solution that Mr. Butler gave in response to this thing, I think, is inadequate. To say that the answer is simply let people charge to the tax credit the higher premiums that they pay because they are a group with high risks means that it is impossible to place any burden upon plans to be efficient, because you cannot tell whether a plan is high cost because it is inefficient or because it is insuring people who have higher risks. So, if I choose an inefficient plan, I get higher credits, even though the incentive is to try to get me to choose an efficient plan.

Dr. Butler: That is a very important point. I certainly would agree that if we merely suggested that people should be able to select out of company plans into other kinds of plans, then the mechanics you lay out would, indeed, take place. There would tend to be intense competition for the low-risk person. But, of course, competition of that nature would cut prices and profit margins and force efficiencies in that area of the market. In addition, as you argued, you would see high cost people facing high premiums and getting large credits to offset that.

You are right to say that it is hard to distinguish between an inefficient plan and one that is just expensive. But that is also true in almost every other area of the economy. You can buy a very expensive car that is no better than less costly cars. Yet we all know that consumers do tend to look very carefully at quality and price. I do not see any reason why, with the kind of credits we suggested, that people would go out of their way to pick inefficient plans that give poor quality services and maybe less choice of physician, and so on, for the same price as some other plan. I just do not see why you think that would occur to any significant degree.

We would imagine the same kind of intense consumer scrutiny, no matter what the price and level of service. I would agree that the person who has the lowest credit, in other words the least amount of his premium offset by a tax credit, is going to be rather more ruthless in examining the various options than one who is eligible for perhaps a 90 percent credit. Generally speaking, those with 90 percent credit are going to be poor people and/or people with higher medical bills. I do not think there is any way around of a tendency for excess utilization

for those that you are trying to subsidize most. You always have to strike a balance in this area. You want price to be something that encourages people to shop around efficiently, but you do not want price to be something which is a barrier to those needing most medical care. I think our proposal recognizes that and tries to strike the right balance. It would not lead to the kind of effect you mentioned, of people just ignoring value for money simply because they got a credit. Everybody would still have the same incentive to get the best value for money, no matter the price level of the insurance package they were looking at.

Mr. Schmid: Stuart Schmid, HHS. I think you are probably right that efficiency would make itself felt. But is it not possible that this market could function so well and the selection could be so refined that the whole cross-subsidy that works in the private sector now would break down? Thus your budget neutral solution, with its $18 billion in available funds, might not be nearly enough to cover the credits that would be necessary to funnel to the people that got stuck in the high cost plans.

Dr. Butler: No, I do not agree with that because, one way or the other, you are still trying to lump all the different risks under some kind of mechanism to pay for them. A mandated employer-benefits proposal tries to lump them all under an employer-paid group premium. We are trying to do exactly the same thing by lumping all risks under a system that is cross-subsidized through the tax code. The same medical risks are there under our approach as under any other kind of approach.

If you got the ultimate extreme segmentation of the market, where everybody was assigned a premium actually reflecting every single service they were provided, our credit strategy would still provide the greatest help to those who were paying the most for those services. The person facing the highest costs for medical care would receive an even bigger credit than if he were part of a group with lower risk people.

So, I think that the selection effect is not a significant problem under our proposal. On the contrary, a proposal that provides cost subsidies and direct assistance to individuals through a refundable tax credit mechanism is a far more precise and effective way of subsidizing people than trying to forcibly lump different risks into one group.

Mr. Alexander: Alec Alexander, with Congressman Jim McCrery. With regard to enforceability problems, Mr. Steuerle earlier suggested

making the credit 100 percent at the outset. Would you comment on that? Also, with regard to care, would you comment on the importance of a good, firm data base in health care. California recently considered – I do not know whether they implemented – a plan that would have done that. As a peripheral concern, what effect will it have? What is your analysis of the California legislation, if you are familiar with it?

Dr. Butler: Would it be wiser to give 100 percent credit to the first dollars of necessary care for individuals? I can see the attraction of that. But I think there are some downsides that ought to be considered. One, of course, is that if you are subsidizing anything to 100 percent, you do remove some of the incentives to shop wisely or to choose wisely. There is no direct financial benefit of choosing wisely, even though you might get better services. That would be one concern I would raise with it.

Another concern is that we do not necessarily want to subsidize everybody to 100 percent in the first several dollars. Therefore, at least having some kind of credit which is different for different income and groups might be sensible. I do not feel myself that somebody who earns $5 or $6 million a year necessarily needs any benefits to provide themselves with health care. So, it is not that I am vehemently opposed to that notion, but I think there are certain trade-offs.

I am not really familiar with the California case, but I am broadly familiar with various pieces of legislation and approaches to try to get better data. That is an issue raised often, spurred by the fear that people just do not know how to make these comparisons. But I would point out that here in the Washington area we do have the federal system. I know there are a lot of problems with the open enrollment plan, but I think one might argue here that the problem is that you are saturated with information, rather than having too little information. I would suspect you would find a lot more advertising on the basis of value for money under our kind of approach than you tend to get today – these days advertising often centers on such things as getting gourmet meals in the hospital if you choose our plan. Because the company is paying for it, hospitals are not competing on the basis of price.

But certainly any progress toward improving the reliability and accuracy of data in the area of value for money, and quality of services, is a benefit to our proposal, as it is to everybody else's. Even an employee-mandated system is going to work better if you have better

information than if you do not. So, those strategies to improve data are going to be extremely advantageous, whichever route you go.

Mr. Steuerle: I want to pull together a couple of things. One, I am not so sure that the employers would drop out of the market very much. That is partly because the big employers are very efficient administrative units. So, I think you should try to sell your proposal on the notion that it is nice for groups, but I would not try to sell it on the fact that employers are going to drop out.

Secondly, in terms of the administration of the Heritage proposal by employers, I do not think that they would actually administer a limit or a cap on the current tax exclusion. They would not send the employee statements saying that you have $300 worth of taxable benefits, or $3,000 for that matter. What would happen is that they would operate very much like the government plan now, or any plan where the employee makes a contribution. Here is the plan, they would say, and here your contribution. The employee would get $10,000 in wages, pay off $1,000 as their contribution to the plan, and see a taxable income statement of $10,000. You do not necessarily need to go through the rigmarole of having the employer saying you have a taxable income statement. All you have to do is require the employee to pay out of his pre-tax income for the premium.

My final point is something that I want Denny to address. My sense is that if we really go with this type of world, there will be some regulation to prevent adverse selection. That is, there will be attempts to say we want a plan where small players can come in without having to go through elaborate testing or something else to see if they are eligible. That is, in fact, how adverse selection would often be dealt with. There would be regulations. You may not want regulations, but there would be regulations saying that this credit or whatever is available if you have plans that meet certain criteria, and those criteria are among those that would prevent adverse selection. Have you thought about this, Denny?

Mr. Dennis: Yes. This is not a new situation. About ten years ago, when Enthoven came out with his plan, he argued that in order to avoid this adverse selection, you would need a geographic or community base of some kind.

Yes, I thought a little bit about it. You now see people who must drop plans because they happen to hire someone who has a precondition such that it makes the whole plan too expensive. Employees would them be either helped or directed to specific groups. So, under the Heritage approach, varying medical characteristics would not be a particular problem any more to the employer but one that would devolve to the employee.

Whether or not there would be some type of regulation, per se, to handle the question of adverse selection among those employer groups that still remained, I have not thought about adequately. A risk pool mechanism, designed to handle individuals or small groups, is one obvious possibility.

Dr. Butler: I think we will have to make that the last question in this session. Many of these issues will flow over into this afternoon, where we will look at the proposal again from the perspective of insurers and medical people and then from the perspective of political people.

Issues Raised By A Tax Credit Strategy

Dr. Butler: I am very pleased indeed that Gail Wilensky is able to join us to make some observations on the issues in the health care area. I have known Gail for a good while, and she has been very helpful to us as we develop our ideas here at Heritage. She does not necessarily agree with them all, but she has always been extremely helpful.

Gail was sworn in as Administrator for the Health Care Financing Administration in February of this year. When her nomination was announced, there was praise for Gail from right across the political spectrum, from those in the technical area of health care as well as those in the policy area. We at Heritage felt that in Gail, the Bush Administration picked somebody who had the technical knowledge, the openness to ideas, and the sophistication necessary for that demanding position.

As Administrator, Gail oversees both the Medicare and Medicaid programs, now amounting to $155 billion in fiscal 1990-91. She is a nationally known expert in health care finance and health policy issues and features prominently in numerous conferences in this area.

She came from Project HOPE, which has for many years been very active in the health care area. She is well known to many of you, and I am delighted that she is here this afternoon to share with us some of her observations on the health policy debate, and to make some observations on the health credit strategy for dealing with the problem of uninsurance and general health care.

Mr. Wilensky: I have been following some of the ideas that are raised in the Heritage plan for some time. There are ideas that we health economists have discussed with each other and the people at Heritage. I am pleased to have an opportunity to share with you some observations I have about what is going on in general in this area and about this plan in particular.

I think it is important to note at the beginning that while the concept of tax credits as a fundamental replacement for our current strategy which primarily relies on tax exclusions, at least for the employed

population and for the public insurance program of Medicaid for the poor population, is not fundamentally a new idea, it is an idea that has been discussed by health economists and other economists in one form or another. In fact, a version of capped tax exclusions, which is a close cousin to tax credits, came up during the Reagan Administration on at least a couple of occasions.

What is important, however, is the real interest that the idea that The Heritage Foundation's ideas have sparked now relative to earlier incarnations. I regard that as a very important comment on where we are now. The Foundation's proposal, along with several other ideas is attracting increased levels of interest, that should not be overlooked. It is a very important proposal.

Some of these concepts using a tax credit, particularly a sliding scale refundable tax credit as a primary way to subsidize the purchase of health insurance, are getting attention now that they did not get in the 1980s or in the 1970s. We need to understand what that is saying something about the interest, knowledge, and probably the frustration that is exhibited in the health care area right now.

Clearly, the current rate of increase in national health care expenditures is widely regarded as unacceptable, something that cannot and should not be allowed to continue into the indefinite future. Our current estimate for health care expenditures is over $600 billion. If it continues to grow at the rate it has been growing, HCFA estimates the number will top $1.5 trillion early in the next century. These are very big numbers.

Medicare will grow from around $98 billion this year to something not very far from $150 billion in the next five years.

At the same time we worry about rates of increase, we are also worried about making sure that we provide access to populations that need access to health care, that we do things that preserve the quality we have come to know and expect in our system, and, at least as important to most people in this room, that we preserve choice. We do not want to do something that will cut out the choice that has always been a very important part of the American health care system.

I cannot say enough in agreement with what Secretary Sullivan has said, which is that a nationalized health care system is not the way to achieve these goals. I assume that there are probably very few people

who would regard the nationalized systems we see in Western Europe or Canada as something that is appropriate for the United States.

There are two elements of the current health care debate that I am finding particularly interesting. One is that there is so much interest now in the area of access, cost containment, and what we are going to do about our health care system. This interest is coming from so many different fronts. The second is the fact that while reform proposals such as the Heritage proposal are in some ways very different from what we have now, in many other ways you can argue that there are lots of antecedents to what is being proposed. So in some ways the proposals are not all that different. We are not yet to the point where we are likely to see imminent change. The consensus that we find is mostly a consensus of frustration, a sense of what we do not want, and not consensus about where Americans want to find themselves. Still, the consensus is very important.

This is really a difference from what I believe has been occurring in the last 20 years, and one that we cannot emphasize too much. It means we are getting to a point where there may be a willingness to take some action. It is hard to tell whether we are in a period like that of the early 1960s, when the country was getting itself ready to make the kinds of significant change that Medicare and Medicaid represented, or whether we are now at a point somewhat like the 1970s or 1980s, when ideas would bubble up for a while and then die down and nothing really would happen. I hope that this period is one where we are ready to start seriously thinking about some change. What we cannot do is to ignore the level of frustration, if for nothing else because some unhelpful ideas spring up during these times of frustration.

As you know, in the Department we are looking at these issues in a very serious way. I am working with Connie Horner, working as a vice chair of her work group in the Department. We are also working with the Domestic Policy Council and looking at these issues.

I would like to talk a little bit about some of the issues raised by the tax credit idea. I am sure that Ms. Horner gave at least as many caveats as I am about to, in terms that we in the Bush Administration have not come to agreement about the direction we will recommend in terms of changes in health policy. In particular, to the extent that you are talking about tax policy changes, we would work closely on with these issues with our friends at the Treasury Department.

into an HMO without penalizing the HMO by paying them on the basis of what was paid in the fee-for-service community. Why were they previously penalized? Because HMOs used hospitals much less. If they were paid on a per diem basis at the fee-for-service rate for hospital use, but used hospitals a lot less, they would end up not being compensated for their different ways of providing services. That was the basic idea behind a per capita amount.

But that was not the most important principle. The most important principle was the allowance made for an HMO to offer more services than the Medicare amount and to charge the individuals more for those services. So, it was the supplementation that was built into the HMO Act that provided a very important precedent – that is, the notion that there is a certain amount that the government would pay to cover a certain benefit package of services. If people wanted more and if the HMO wanted to offer more, it could. The HMO could either accept the payment from Medicare as payment in full, or they could ask the individual to supplement the payment with some amount of money per month, typically much less than is normal under Medicare. The notion of a government-set amount of money that is designed to cover all or some portion of a set of benefits, to which people are free to add their own money to buy more services, was in my opinion an absolutely critical precedent built into that program. While probably that was not realized by most observers, it was an important step for those of us who might want to consider this as an important precedent for change in the future.

While there are many things about this system that we would like to improve upon, as I will mention, it represents a very important version of this whole notion of being able to supplement an amount that the government provides that is supposed to pay for some set of services.

The second area where I think we see some important precedents that could be used for expanding our ideas in the future has to do with the Arizona Medicaid program. It is a case that I have cited on a number of occasions when I speak because I think it provides important precedents in a number of ways.

Arizona is a case where you have a state entering into contracts with competing plans to provide services for Medicaid eligible people. It is one of the advantages that you see happen when you have a late adoption by a state of a program. Arizona was the last state to provide

Medicaid services for its poor population so it entered the program in the early 1980s being able to take advantage of some of the learning that had occurred about different ways to provide health services, and has done so in a way that incorporates at least what I would regard as many highly desirable features. There is, for instance, negotiated bidding with regard to the price being paid, and individuals are in coordinated care systems, HMO-type facilities.

Now, this does not, as far as I am aware, have some of the features that you see in an HMO in which you can add to the amount that the government is willing to pay for the set of services that it covers. So, it does not have that same feature that we allow the elderly to have in their HMOs. I believe we can say, however, that it probably would not take an awful lot of imagination to see how you could get there, keeping the same concept but allowing people to have that amount and augment it, just as they can in HMOs for the over-65. That is not a concept we normally allow to happen anywhere in our Medicaid program. In fact, for the most part, we prohibit it from happening.

This notion of saying government will pay for what we regard as the minimum set of services, but you can, if you wish and are able to, buy more and get more services is not something that we have worked into our program for the poor. It is something that obviously follows, however, from the idea of having a refundable tax credit for individuals, as raised in the Heritage plan.

Our ability to expand the idea of TEFRA HMOs for our Medicare population has worked well in a limited way. We have about 1.3 million of our elderly enrolled in this kind of plan. Relative to the almost zero base we started from a few years ago, that is respectable growth, but clearly not as much as we want. It represents about 9 percent of those who have an option available, so it is not quite as low as it looks because there are a lot of places where that option is not available. In terms of the value it represents, the choice it makes available, and as a way of having good access and quality, it is an approach that we are very interested in trying to promote. You will see us making efforts in that direction over the next couple of years.

But we also are very interested in the kinds of experimentation which states like Arizona have shown in terms of a different way to organize health care for their poor population. It has now been in existence for about eight years, and the evaluations that HCFA has sponsored

shows, in fact, that this is a way to provide acute care with the same quality of care that you get elsewhere, for slightly less cost than you would see elsewhere. But the fact that it represents the concept of choice, and potentially of being able to augment choice, is at least as important.

There are some similar concepts in both systems. One is, the notion of a basic benefit package; something that, when you talk about refundable tax credits, has to be either implicitly or explicitly in the back of your mind, and it is something that will need to be addressed if you are thinking about a system where everyone has access to some kind of health insurance.

Among the other issues addressed in both of these programs is that some kind of adjustment for health status and a geographic adjustment built into the payment system. That is again something that either implicitly or explicitly needs to be addressed in a tax credit system.

What I would like to do just before I close is to raise a couple of the issues that come to mind when we think about a tax credit system.

One is the issue of mainstreaming. It is something that we often hear raised when we talk about Medicaid, and usually talked about with some sense of frustration. The issue with regard to a tax credit is, to the extent that the credit is covering some basic benefit package or some share of a basic benefit package, it probably allows for mainstreaming to occur in a relatively easy way. But it assumes that a tax credit is set at a level which, at least for the very poorest population, will cover the kinds of services that are needed. So, it assumes that there is not cheating down at that bottom end, that the credit really is sufficient for the very poorest; however, you want to define that group, to cover services that that group needs to have provided.

The issue about how well mainstreaming will occur in the process is as much an institutional one as a conceptual one. But as to the question: Can you easily achieve mainstreaming through a tax credit way? The answer is, "yes." You can if you set a price that will allow it. So, the issue of affordability is really the most important caveat that you can offer.

Now, would a tax credit be enough? Well, that is obviously going to depend both on how you set it for the poorest populations and how you introduce a sliding scale for other populations. It will turn out to depend in a very major way on the size of the minimum benefit package,

the size of the credit, and how those start to relate to each other. The real critical question that arises is whether or not supplementation will be allowed at the poorest level and what kinds of choice you are really willing to consider in this kind of system.

Traditionally, for our very poorest populations, we have not really been willing to allow for the kind of choice we see permitted in our elderly population. I do not know whether or not we really want to change seriously the way we think about choice for the poorest members of society.

There is also some concern as to whether or not we might get a segmentation of the market, with some plans specializing in low-cost minimum benefit packages. That is a real concern. It is probably one of the very big concerns that gets raised, and that leads me to the second broad issue, which is one of biased selection or adverse selection, depending on how you want to look at it.

Whether or not a tax credit system can cope with the issue of biased selection, in which people who have a different expectation of their use of health services – based either on their health status or on their inclination to use health services – choose certain kinds of health plans and therefore drive the cost up or down, is probably one of the major problems that we face in designing payment systems for the HMO world we now have.

There is one easy way, however, to try to remove concerns about biased selection. It is called *not* giving people choices. You will see movements in this direction from time to time, with people throwing up their hands and saying that there is no way we can control for biased selection and that the way to make sure that you do not have it is to have either a very limited choice or no choice. That certainly is one way to cure biased selection. But many of us would say that may be a little higher price than we are willing to tolerate.

The question then becomes: Can you make adjustments that, if not perfect, are close enough, so you get around some of the most serious distortions? These adjustments would have to ensure that the same amount of money is not going to buy the same minimum benefit or share of a minimum benefit for all individuals. Either because of very strong differences in the cost of services that are being provided, or because of health status differences, it will cost different amounts and we must be able to figure out how to adjust for that in a reasonable way.

For someone like me, at least, the answer is that the costs of not doing so are too great. While we are not going to have a perfect system, we can have a system that makes some real improvements. We will be trying to push forward on this as we try to continue to promote choice and coordinated care systems. To the extent that it will help folks like those in the room who are trying to move forward with their ideas, we are pleased to have that happen.

Again, I think that the issues being discussed here, and being discussed in the Heritage proposal, are very important and very exciting. These issues take us forward and push our thinking in new directions at a time when I personally believe there is as much serious interest in trying out other ideas as I have seen in a long time.

When we look back over the recent period, we have seen a movement where you have significant expansions in terms of government setting prices for health care services and significant expansions of micromanagement of utilization. This is not surprising in a fee-for-service à la carte system in which you do not really have much in the way of incentives for either consumers or providers to be minding the store.

The best direction in which to try to go as an alternative is, in my view, some notion of getting people into coordinated plans and trying to have incentives for people and service providers both to use the services efficiently and to provide services in an efficient way.

I believe the thinking that is going on here, the types of reform being raised in the Heritage plan and elsewhere are very important. It is going to take a good while for us to get the American people to think seriously about the kind of health care system they would like in the future. What are the things that are important to them? What are the things that they are willing to give up if they are going to have a lower rate of cost?

To my mind, issues of quality and choice and access are very critical. How you achieve those, and the trade-offs between them, is what the fight is going to be about for the next several years.

I am very pleased at the work that Ed and Stuart have done. I hope this session has been a good one and that you have had lots of provocative questions thrown at you about how do you take what is clearly an interesting and intriguing idea and think about it operationally.

There are lots of problems. As somebody who has spent the last 20 years worrying about policy ideas and is now faced with the operational issues of running some major public programs, I can tell you it is a large

step between having good policy ideas and trying to carry them out. But I think you are taking a very important step by raising the issues that you have raised. I assume it is people like this in the room who will push you farther to make sure that you think about all of the operational steps needed to get from here to there.

Thank you.

Dr. Butler: Thank you very much, indeed, Gail. I can assure you, the questions have already been provocative, searching, and critical in some cases. Gail has time for a few questions.

Mr. O'Dea: Mike O'Dea, PHCC. One issue in the Medicaid payments for a nursing home that has always concerned me is that of money being manipulated by wealthy families to get their wealthy parents to qualify for the Medicaid system. No controls really seem to have been put on that, other than maybe a time frame. Is there anything more being looked at?

Ms. Wilensky: I think we are rightly concerned that we have set up a system that has some perverse incentives. If you can divest yourself of assets, you can find a way to have the government pick up the cost of the nursing care. We should be concerned about that. The information about how often that happens is much less clear. There certainly are lots of horror stories.

My sense is that our dealings with the long-term care population are going to be even more difficult than our dealings with the uninsured population. The reason is because they force us to address even more fundamental questions about the role of government and the responsibility of government – and for whom should the government feel responsible? In the case of the uninsured, there are some questions about coverage, and degree of support for different kinds of populations, but not quite the deep emotional issues as with the elderly.

Thus long-term care will force us to think very seriously about what the responsibility of the government is for the non-poor – for what, for whom, at what point? Those issues are so much more difficult that I think we will see them coming even after we have dealt with the issues of the uninsured population.

What I am very concerned about, and try to raise it whenever I have an opportunity, is that it is very important that we not do things now

that send out bad messages to the private sector, which has been developing approaches recently in this area. One of the important issues will be whether or not there are alternative financial strategies at hand in this area. We are seeing them start to develop. It is very important that government not send out either direct or even implicit signals to suggest that is not a good area for the private sector to develop, because if we do, we can kill off something that has started in the last few years and is growing very rapidly.

Ms. Fritz: Debbie Fritz, of the Pharmaceutical Manufacturers Association. Gail, could you just comment a little bit on the task force at HHS and where it is on the process, the timetable, and any inkling about what recommendations they are moving toward?

Ms. Wilensky: You know I am not going to answer the latter part. We are moving ahead just fine. The real issue is, at what stage the recommendations will go forward. There are a lot of different parties that we need to deal with. There are really two different levels of activity going on. There are those inside the Department, as the Department has its own ideas about options and preferred strategies. And then there is the relationship with the Domestic Policy Council, which is being led by Dr. Sullivan.

There is coordination between these levels. Connie Horner is chairing both the task force internally and heads the work group of the Domestic Policy Council. I serve as her vice-chair, and I am also on the working group of the Domestic Policy Council.

Now, regarding timing, there is some slippage, and I think that will probably affect the workings of the group. The Advisory Council on Social Security, which was going to release some preliminary statements about health in September, and a final report in January, did not release preliminary statements on health in September and is now scheduled to release its final report somewhere between March and June. Meanwhile, the National Governors Association is set to release its final report in June. Since the Domestic Policy Council working group has been directed to review not only the recommendations of the Department, but also other recommendations like those of the Advisory Council, that means that although I think the material from the Department will start percolating through the Domestic Policy Council and its work group early in 1991, I would be surprised if there

are any recommendations that can take all of these other proposals into consideration until mid 1991.

Mr. Helms: Bob Helms, American Enterprise Institute. Gail, this is really a political question. It anticipates our discussion about political feasibility later on. When I think back to when we did the analysis of options of what turned out to be the tax caps in the Reagan Administration, I think one of the things that influenced us against a tax credit proposal instead of just a simple tax cap was what we perceived to be quite strong opposition from some people in the White House and particularly the Treasury Department. They were against using any sort of tax credits for social engineering. There was instead a strong movement to simplify the tax system.

My question to you is: What has happened to those arguments either at the Treasury Department or in this administration? Do you anticipate that there will be strong opposition to tax credits, even if officials do perceive that they might achieve some social goal?

Ms. Wilensky: I am sure the issue is going to come up. There is no question about the fact that this is the use of the tax code to accomplish something, a social purpose, and that the movement behind the 1986 tax reform legislation sought to eradicate as many uses as possible of the tax code for accomplishing social objectives, no matter how desirable.

The key issue – and this is an issue we economists have battled with tax lawyers for at least twenty years – is that it is not as though the tax system is indifferent to what is going on now. The tax exclusion currently is estimated to cost $58 billion, counting federal, state, and local revenues. This is not an indifferent system that we have put together. That is a very serious tax expenditure and an implicit use of the tax system to do things that some of us have expressed great concerns about over the years.

This does raise the issue of whether or not a tax credit will open a door because it is making a change from an implicit tax expenditure. Most economists do not even understand why it is an issue. Some political discussions I have had suggest that other people do not regard it as quite so obvious. So, I think that it will raise fundamental concern about using the tax code in such an explicit way, and it will, I am sure, need some very hard discussions before it could possibly pass Treasury.

This is one of the reasons I think the coordination between HHS's activities and the Domestic Policy Council will be so critical and probably not so short-lived. There are some very legitimate differences in how you view credits among Labor, Treasury, OMB, HHS, and on how to continue the elements of the health care system you want and also avoid destroying too many other scared cows at the same time. I am sure we will have the same battles.

Dr. Butler: I might just add a footnote on the Bush Administration's position on credits for social purposes. The Bush Administration did propose an expansion of refundable tax credits as a strategy for day care. And as far as I know, it has not been strongly in opposition to the Bentsen health credit for uninsured children. So, I think we have a different climate today.

I also want to thank you again, Gail, for your tremendous contribution to the conference, both in discussing the technical aspects and in raising exactly the issues we have got to deal with. Thank you.

What Would Health Tax Credits Mean for Medicine and Insurance

Mr. Haislmaier: I would like to start by telling you that what we have assembled here is a very fine panel of villains. If you ever ask anybody who is to blame for the problems in health care, they will tell you it is the doctors, the insurers, and the drug companies.

But I am very pleased with the group of villains that we have to talk to you today. As has been brought out earlier in this session, I think possibly the weakest point in what Stuart and I have written is our attempt to convey a vision of how we would see the system functioning down the road. I think it is fairly easy for people to understand that by putting dollars into the hands of consumers, they start to have interests in the choices that they make.

The second half of the equation is, of course, the providers. The question then becomes, how will they behave. If we had the papers and the monograph to write all over again, now a year later, I think Stuart and I would have devoted a lot more attention to that. But that is the purpose of this conference. We do not claim to have all the answers.

I want to make one other comment. I was speaking the other day at the National Education Association's Retirement Benefits Conference. One of the people who followed me was Walter McClure of the Center for Policy Studies. He was promoting his "buy right" plan, showing how local employers can band together and exert pressure on providers to get the best quality for the best price.

He made the observation that what we are trying to do is create a sound market out of something that is an unsound market right now. He noted that, while it is true that technology will change markets and will change people's behavior, very often it is the structure and the framework of the market, as well as people's thinking, that shapes how the technology is used. He gave a classic example. When the Spanish introduced the horse to the new world, he said, the Indians of the plains area of North America, who were a fairly sophisticated civilization at

the time, turned horses into the greatest device they had ever had for hunting buffalo. Whereas, a much more primitive culture of Indians in the southwest simply ate them.

So, the question is, what is going to happen if we change this macroenvironment, as we are proposing to do? How are providers going to respond?

To answer that or to maybe shed some light on that and to also offer their critiques of what we are saying, we have three very distinguished gentlemen. Let me briefly give you an introduction of all three. Then we will take them in the order that they appear in the program.

Let me start with Dr. Charles Aswad, who is the president of the New York Medical Society. In addition to being a prestigious organization, it is also within a state now involved in a very intense debate over whether the state should move toward a state-run comprehensive system. Dr. Aswad and his association have been very involved in that.

He also has a number of other accomplishments in his distinguished career. He has held various positions with the New York State Academy of Family Physicians – including president of that organization – with the American Academy of Family Physicians, and with the American Medical Association, serving as delegates to those organizations in the past.

The next speaker will be Mr. Ben Lytle, who is the president and chief executive officer of the Associated Insurance Companies, Incorporated, otherwise known as the Associated Group. I am particularly pleased that he is here with us because I think he represents a very comprehensive view from the insurance industry and, in our discussions, has struck me as somebody who has been very thoughtful about the whole area of health care.

His companies include Blue Cross and Blue Shield of Indiana and also commercial insurers, including managed care companies. It is the tenth largest health insurer in the U.S. It is also the only health insurer in the top ten that serves as administrator for all of the major national and state health care programs: Medicare, Medicaid, CHAMPUS, and state high risk pools. I think you will agree that he brings a very broad perspective to our discussion, with twenty years of management experience in the areas of insurance, finance, and computers.

Finally, Mr. Richard Teske. He is currently the director of federal government relations and public policy for Burroughs Wellcome. He

also has had a long and distinguished career in public service. With the Reagan Administration, he held several positions in the Department of Health and Human Services, most notably the associate administrator of the Health Care Financing Administration, and a deputy assistant secretary of HHS. Previously he served as a special assistant to Senator David Durenberger and held a number of other positions, including director of government affairs for the Minnesota Chamber of Commerce and director of legislative research for the Minnesota State Senate. With that, let me begin with Dr. Aswad.

Dr. Aswad: Thank you very much. Let me explain how I became one of the villains honored here today. In 1987, the Medical Society of the State of New York undertook a task force to consider some of the solutions to the problems of the uninsured and underinsured in New York State, approximately two-and-a-half million people. Between 1987 and the present, we developed a proposal which is strikingly similar to The Heritage Foundation's. As we were approaching the conclusion of our proposal, we learned of the Heritage proposal and invited Dr. Butler to come to New York and discuss it with us.

In many ways, this is another classic example of what happens in many areas of policy. When an idea's time is ripe, it will surface in many places. I think that the time is ripe in the United States for this type of discussion and, perhaps, for the development of solutions to this vexing problem of what we are going to do in this country about health care.

I am studiously going to avoid getting into our own proposal because it does differ in some ways. Maybe later we can get into it, because we think we have some proposals that might address many of the questions that were raised earlier.

Basically, I think that in the medical community there is a growing concern that something seriously must be done in this country to address the number of the uninsured, that started out at 42 million and now has drifted to between 30 and 37 million. Whatever the number is, it is certainly an unconscionable number, and it is just not acceptable in a country such as this to have that many people outside of a health system.

Physicians and other providers of health care around the country are as concerned about this issue, because in many ways we deal with those prospective patients every day in many, many ways. They may be thought of as a group, but in private practice they become individuals.

You begin to see how people's lives are impacted by their lack of access to adequate health care and to payment mechanisms for health care.

In New York State, which is probably one of the two or three most regulated states in the union, we have been impressed at the Medical Society level that more and more regulation does not seem to create better and better solutions. In fact, we find that access some twenty years after Medicaid is not much better – and, perhaps, in some ways is worse – than it was at the inception of the program. So our perception when we went into this study was that there has to be something other than sheer regulation. There has to be something more innate than regulation because it is clearly not solving the problem. If it were, we would not all be here today talking about it.

What further concerned us in New York was that when you talk about the most logical solution to the problem, which was extending employer-based mechanisms, many were saying that since the health care system in this country developed through the employer provision of insurance, and since 90 percent of population were covered, let us just impose the additional ten percent on employers and we will solve the problem. In our study, however, we found that 500,000 small business employers in New York State raise the issue that they do not have the capacity to provide those benefits without serious jeopardy to their survival as single-person enterprises or very, very small businesses of under 25 employees. If that requirement were to be imposed, they said, some other type of tax relief to those who could not afford it would have to be engineered. So there would be yet another basic cost that would be incurred by society in subsidizing employers to do what they could not, perhaps, do independently because of the nature of their business. So, that did not seem to be a very viable solution at first pass in New York.

We then came up with a proposal which is strikingly similar to The Heritage Foundation plan. We were impressed that if a mechanism were available through tax credits and if all people were covered, access problems in a sense would be eliminated. We tie ours to a sliding scale based on tax liability, so that higher income groups would get less relief than those at the very end of the scale who, perhaps, could be vouchered into a purchasing system.

That raises the very serious question of what we are talking about in terms of health care. The problem that we identified in New York was

that we have a perception, when we discuss national alternatives, that national health care mechanisms will provide the same type of health care that we provide at the present time. That is clearly not doable. In other words, there must first be a definition of what health care is. There must be a definition of a basic package of benefits. There is no way we can talk about funding this rather broad menu of services that we provide in this country and assume that somebody else is going to pay for it.

But the definition of a basic health package is really not as complex as it appears. There are two studies already that have developed such a package. Many of you, I am sure, are familiar with the Health Policy Agenda for the American People exercise, which concluded about five years ago. It is a very substantial volume of proposals, and contains a basic benefit package that should be provided to all Americans that was agreed to by over 120 constituencies in this country.

This June, another basic package proposal was passed by the House of Delegates of the AMA. This eliminated many of the services that many people predicted medicine could never agree to eliminate. So, there are two really very effective basic benefit packages that have had wide support.

Assuming that you pick one or the other of those, the thing that is inherent in those packages is a rationing system. They are not the benefits that presently are provided by many of the plans that industry has agreed to over the bargaining and negotiating table. So, the first thing that would impact on the health profession would be that a whole group of people who now have coverage for many services would not conceivably be covered for those same services under a basic benefit plan, because it would be just too rich a package to fund across the whole society.

Our feeling is that you include in the basic package the tax treatment for how you pay for it, and then you leave to the individual the option of how much they want to purchase beyond that. If they want to purchase more, in a free society they should have the right to do that, but there would be no tax credit for it. That would be their own financial responsibility. We believe that would allow market forces to contain some of the escalating costs that now occur at the negotiating table when every good negotiator tries to get the best, richest possible package from the industry they are negotiating with. That system also

would be an inherent deterrent, and would also in a sense enable all to obtain a basic package. It would not be leveled only on the very, very poor or on the present Medicaid population – like the exercise that is going on in Oregon right now. Many of us in New York were offended by the fact that talking about a basic benefit package and rationing only for the Medicaid sector is really not a very honest way to do it. If we are talking basic benefit packages, it should be for all Americans and not just for the least represented sector of our society.

So if the universal basic package concept occurs in this country, there will be a fundamental difference in how care is delivered, because the constraint would be that the menu of services in the basic package is the only thing that is covered. Everything else beyond that would either have to be paid for by non-tax supported supplemental coverage, or out of one's pocket, or not delivered at all if that person decided not to seek that additional service coverage. That would be a basic change in the system of delivery of care.

The other aspect that is of great concern is, what would be the limitations of services at various levels in the life expectancy of individuals? I think the Heritage proposal and others are forcing a basic ethical discussion in this country which has to be held. We must as a public policy issue come to some closure on what is expected to be covered at what point in life.

The quality of life issue has to be confronted. Most health dollars are spent in the last year of life, possibly depriving what are very critical services to people at the front end of life because there is not enough money in the economy to provide that care. Those ethical issues of what care should be covered and what should not be covered will be triggered by this type of debate.

Unless we do that, we are doomed to failure because the technology is exceeding our capacity to pay for it. There is no question that what is on the horizon in the next five or six years, as potential new services – just because they are there – could consume all the savings we could effect by more judicious use of services and by cost containment measures. If they are there and people expect to utilize these technologies, costs will continue to gallop away from us. So we really have to discuss, as many of the national health systems around the world have discussed, what at a certain time in life is covered under a basic plan and what is not. You are all familiar with those restrictions in

England. No renal dialysis after the age of 55. The incredible thing is, when you poll Englishmen, most of them do not realize the limitation exists. They are not aware of that as being a limitation in their program.

Those are just some of the basic issues that will alter the way health care is delivered once this debate is concluded. We simply will not be able to have a federally-funded or subsidized program that gives us the same extent of services that presently are included in most of the packages negotiated by industry and labor, because many of them are far richer than any plan in any nationalized system in the world.

So, if we compare national health-type delivery systems to what is delivered under private plans in this country, it is clearly not a comparison that stands up to any logical scrutiny. The waiting lists in the United Kingdom, in France, or in Canada for basic surgery are far in excess of anything that would be tolerated in the United States by a public which expects that if you come into an emergency room with chest pain, you are ready for your bypass surgery the following day. In Canada, you may wait three to four months and may not survive your illness long enough to obtain the conclusive service necessary for you. Those are issues that the public absolutely has to be confronted with when they discuss the issue of how much is affordable and how it is going to be paid for.

Mr. Lytle: First of all, let me say that I definitely support reform and, in fact, chair Indiana's commission that is looking at health care reform. One of my commissioners is in the audience today. But having struggled with the health care system for twenty years, I want to make sure that we do not make things worse, because this system does not always act predictably. It is with that in mind that I approach the problem.

I certainly do not represent the insurance industry. I have not been elected to such a post and do not think I have the capacity. But I am one player, and my experience has already been outlined.

I would like to divide my comments to concentrate first on those things I support and am enthusiastic about in the Heritage proposal, as well as those things that give me some concern, and second, irrespective of my thoughts, how I think the insurance industry would react if the Heritage plan were adopted today.

I will tell you that when you add all those comments up, where I am going to end up is that while I am not ready to fully endorse the Heritage proposal, I find it very creative, and I think it seems to address some

of the fundamental problems in the system, not just the symptoms. I think it needs to be expanded, studied, and become part of the mainstream of debate.

What do I like about the proposal?

First of all, there is a lot I like about it. One aspect is that it definitely does not seem to serve or disserve any particular interest group. All the other proposals seem to be tightly aligned with some specific political philosophy or interest group.

Second, it can be phased in. I do not think any reform proposal is going to work unless we can phase it in. As a matter of fact, it will be a prescription for disaster if it can't be phased in.

Third, it seems to get at two of the fundamental problems in the health care system. One is the need for greater equity, particularly in the tax system. The current tax law creates two classes of citizens: those who work for large companies and those who work for small companies or are self-employed. I am the father of two grown sons. I have watched my sons and their wives decide that one of them is going to have to work for a big company – so that the family will have the benefits they need.

The other fundamental problem the Heritage plan attempts to address is the lack of consumer involvement. Greater consumer involvement is absolutely necessary to reform the health care system. I have heard a lot of discussion here today about consumers that contrasts with what we in the Midwest believe. I am not part of the Washington establishment or the normal circles of debate on issues. It has been refreshing to hear the speakers today. They are all knowledgeable. Each has a real grasp of the issues. But the one place that I disagree with several speakers is their lack of confidence that the consumer can make effective decisions on health care issues. We have 300,000 individual policy holders – people that buy individual policies. These folks are sharp. Do not kid yourself here in Washington that people out there cannot make tough choices about using the health care system or choosing the health care coverage. They can.

In fact, remember that adverse selection is the insurance industry's term for "the consumer outsmarted us." He figured out that he could buy a policy and get more in benefits than we charged him in premiums. It happens all the time. It is very healthy. So, there is nothing wrong with a little adverse selection. That is what makes the market work.

What concerns me about the proposal or what needs more work?

First of all, I think it is being presented as a total solution, and it is not. I think it is a part of the solution. It gets at some of the fundamental things wrong with the system. But it needs to be presented in a way that recognizes that there are other parts of the health care system that need to be addressed. It should be presented as the first phase of a multi-phased plan or it should be presented as part of a total reform proposal that still needs additional work. I will address some parts that I think are missing. This will be a short list. There are other reforms that I won't have time to mention today.

Second, beyond the pieces that I believe are still missing in the proposal, there are six design or implementation issues in the Heritage plan that still seem fuzzy to me. I am not really clear how they would work. I do not think they are show stoppers; I think they can be fixed. I simply do not understand how at this point.

Third, I think we should remember that the Heritage proposal is really a part of what has been discussed here a number of times today. Dr. Aswad described them as ethical issues. It is important to heighten the level of public consciousness that as a society we cannot have it both ways. We cannot extend every life and maintain a marginal quality of life for every person in the United States, without diverting resources from the education system, our infrastructure, the problems of drug abuse, and other places. The public does not understand that yet, because we still somehow believe we can find some sucker to pay for everything we would like to have. We are going to have to raise the level of consciousness and get these tough issues into the center of the debate. We are going to need the media's help to do that because it simply cannot be done by policy makers.

Let me now list a few elements I think are missing from the Heritage proposal as well as what I think is fully satisfied, and what needs additional work.

First of all, I think the Heritage proposal fully addresses tax equity and employee benefits reform. I think it is excellent in that regard and long overdue.

Second, I think it fully addresses the need for properly motivated consumers. I think it partially begins to address the problem of expectations and of the ethics by getting people involved in the health care system more personally. But I think more is going to have to be done

to heighten that level of debate and make it clear to society that we cannot have it both ways.

Third, I think it partially addresses the critically, chronically, and terminally ill. The Heritage proposal states that high risk pools would be fostered. About three to five percent of the population consumes 40 to 50 percent of all health care resources. About ten percent of the population consumes about 65 to 75 percent.

The problem is how to deal with this severely ill population, which may not have much choice about where and how they get their health care services. Society has not demonstrated much appetite to deal with the problems of this population. I am not sure that high risk pools, at least as they are currently constructed at the state level, are going to solve the problem.

Next, let's consider what is not addressed by the Heritage plan. I would propose that Heritage invite other people to help them flesh out the proposal.

First of all, it seems to me that the relationship to Medicare and Medicare and state high risk pools is not clearly defined.

Second, I think we have look closely at how physicians are paid and the incentives fostered in the payment system if reform is to be meaningful. Physicians need to be allowed to make a good living, and to be able to repay the cost of their education and be protected from reasonable malpractice risk without those needs affecting how they practice medicine.

Third, we need to remove barriers to inefficiency in the system, especially in hospitals. How many hospitals do you think would exist in the United States next year if we converted all the not-for-profits and tax-supported hospitals to stock companies, and the executives and the board of directors could make money by merging with other hospitals? Half the hospitals would be gone by next year.

Within the hospitals, there are tremendous opportunities to make hospitals more efficient – perhaps by as much as 30 to 40 percent. The hospital today is the same basic design as it was at the turn of the century. By restructuring hospitals you can achieve significant efficiencies, but there are barriers against those efficiencies. It is a nightmare to achieve a major management restructure of a hospital.

Fourth, we need incentives to save for old age and disability. In Indiana, at least, two-thirds of Medicaid goes to the blind, the disabled,

and the elderly. It is no wonder there is nothing left for the poor. So, we are going to have to create incentives for people to save for old age and disability. I think that has to be a fundamental part of reform.

Finally, the tort system has to be reformed. It is a fundamental difference between our health care system and any other system the world.

There are a lot of ideas about how these concerns can be solved, and all that needs to be done is to bring some of these ideas to the forefront, much like Heritage has done here.

Regarding the implementation of the Heritage plan, I have some concerns. But again, I do not think any of these are show stoppers.

First of all, I am fuzzy about the requirement for all persons to carry catastrophic coverage and exactly how it is going to work. I am not sure whether Heritage proposes following the precedent of auto insurance in most states, or whether we are creating a new federal mandate. The whole idea of an employer withholding the premium but then paying it to the employee's insurance company seems clumsy. There may be a better way to manage the mandate. There are people who simply will not pay $1 for health insurance if they can get it free. And some of these people are not poor; they are just cheap. We are going to have to figure out how to deal with those people. What responsibility does society have for these folks?

Second, the whole issue of submitting the definition of a basic health care package to a political system seems to run the risk of the same problems we have had at the state level with mandated benefits. But I think there are, again, ways to protect against that. Politicians will be under constant pressure from interest groups to expand benefits.

Another potential problem is that some employee benefits are less expensive at the work site because they are packaged with health insurance. For example, group life and disability is inexpensive today because it is usually packaged with health insurance. When that health insurance is taken out of the employee work site, you are going to have to have some other way for people to buy group life and disability without escalating the cost.

The fourth issue is that the whole idea of groups forming for the purpose of buying insurance as the Heritage plan suggests runs counter to good underwriting principles. The whole idea of group formation

deserves some further work. I also believe that employers may still choose to play a major role under the Heritage plan.

The percentage level of tax credits already has been raised today. Perhaps they should be higher or lower. I cannot really say. It is just that at the outset I am not sure that I am comfortable with a 20 percent credit.

What would happen to the insurance industry under the Heritage proposal? Let me assume here for a minute that the Heritage plan is implemented just as it is. Let me reemphasize, I am not speaking for the insurance industry; these are just my own opinions and I could be wrong.

This proposal has been presented as budget neutral. Personally, I think it is insurance industry neutral as well. I think the insurance industry would neither ride a boom or suffer a bust as a result of the Heritage proposal. I would like to address four different areas that I think will be impacted, however: competition, products, consumer education and information, and marketing and administrative costs.

Overall I think the Heritage proposal would create an increase in competition. Some small group underwriters will leave the market, companies that have specialized in selling to groups and don't have the capital or expertise to convert to marketing individual policies. On the other hand, there will be some huge new competitors entering the market.

Any company with strong name recognition, direct marketing skills, or a strong agent system can enter the system. Some insurance companies do not offer the health insurance today because they are not in the group insurance business. Others stay out of health insurance because they see it as having an unstable future. Many individual insurance companies, whether individual life, or individual property and casualty, will reconsider health insurance. Many might find it an attractive market. There will be some fallout after a few years. But overall, I think competition will increase, and I think that it will be good for the consumer.

As far as products go, I think managed care products will increase. Individual policy holders are more willing to accept managed care products and make trade-offs against their choice of provider than their employers are. For all the talk of being tough and implementing tough cost management, employers generally are very cautious. They

adopt managed care slowly and carefully. Some employers have done a terrific job with their benefit plans. But consumers are much more aggressive in terms of accepting trade-offs than the employers are. I think there will be a choice of prepaid options or catastrophic coverage. In other words, people over time will begin to ask: Do I want to finance my basic health care needs through prepaid care? And that will mean they turn to a certain type of insurance policy. Or they may say: Am I willing to pay higher out of pocket costs and just buy catastrophic care?

Over time, I believe consumers will choose catastrophic plans as a better deal, and conclude that they really do not need the insurance company to serve as a savings account for them. They are quite willing to just buy the catastrophic care. But I think that it will be a slow movement.

In the area of consumer education and information, I think we underestimate the consumers. About 50 percent of the consumers in any given year have almost no interaction with the health care system at all. Another 40 or 45 percent have interaction up to about $2,000. In a given year, 90-95 percent of all people are not making complex life and death choices. They are capable of making these choices. Consumer education will become a competitive advantage under the Heritage plan. One of the things insurers and providers will do in competing for consumers under the Heritage proposal is to educate the consumer on their products. In the process, consumers are going to become better informed, and they are going to learn to use the system better.

There will also be intermediaries who emerge to help consumers who do have difficulty in making choices. Independent insurance agents, in the traditional role that they play, and many physicians will to advise their patients on comparisons of different products.

Consumers will learn the value of healthy behavior. Today, we are appropriately reluctant to delegate to government the right to mandate or dictate behavior. We have difficulty making scientific linkages between behavior and given diseases. Yet we would like to create incentives for consumers to live healthier lives. Under the Heritage plan, individual health policies would encourage healthy lifestyles with premium differentials. So, the value of healthy behavior would become very real to consumers when they started paying for it.

Last, I would like to discuss marketing and administrative costs. I think these costs will be highly variable based on competition. That is why even though there may be an increase in administrative costs, I do not think you will see them skyrocket. Remember, administrative costs in the health insurance business today are lower than in the property and casualty business or life insurance. They could be depressed even further by heavy competition. The elimination of small claims, which will happen as a result of more people buying catastrophic coverage, and the piggybacking of other products, will all tend to reduce administrative costs over time. While group insurance generally has lower costs than individual insurance, large blocks of individual insurance can be fairly efficient. Group formation under the Heritage plan is still possible also.

In summary, I think neither a boom or bust for the insurance industry will result from the Heritage proposal. I think consumers are a lot smarter than we are giving them credit for, and I think they will create a lot of economies in the system. There are some significant areas that are not dealt with in the Heritage plan that should be. The Heritage proposal deserves to be mainstreamed and be given consideration. Heritage may also want to consider giving it a new name and co-authoring it with other experts so that opposition to the plan is not created just because it is Heritage's plan.

Mr. Haislmaier: Thank you very much. Mr. Teske?

Mr. Teske: Thank you, Ed. As the cliche goes, what goes around comes around. When I was in ninth grade, the debate topic was, "Should the United States adopt a system of national health insurance?" It seems I have made a career out of this question ever since.

I also remember that, in that same year, I attended the Republican convention as a Goldwater page. For that heresy, I was sent to live with my 80-year old grandfather, who was so conservative that he believed Roosevelt ruined the country – but he meant Teddy.

Then, for eight years, I worked at HCFA and Health and Human Services, and I have been privileged – or disadvantaged, if you may wish to put it that way – to have actual hands-on experience with most of the health care reforms of the last decade. The one basic truth I learned through all of this is that how you pay for health care literally

determines the form of the entire health care system. This simple truth is recognized by The Heritage Foundation proposal.

But I have been asked to respond not as a conservative, not as a Republican, not as a health policy analyst, but as a representative of business and a pharmaceutical manufacturer. It is in this narrowed role that I hope you will listen to my comments.

There are three basic elements to any health care system: cost, quality, and access. These form the so-called "iron triangle" of health care reform. If you affect one, you will affect the other two. The goal of public policy is to seek the proper mechanism that best balances cost, quality, and access. But of course there is no utopian alternative that does this perfectly.

In the Soviet-style systems, to retain the Marxist ideal of equal access and to control costs you must endure 1960s-style quality. In socialist systems like Canada, they have American level quality, but to control costs they restrict access through rationing.

In the U.S. until recently, we wanted the highest quality and unrestricted access. Thus, costs skyrocketed. Now, in lieu of successful new American reform models to balance cost, quality, and access, health care policy has degenerated into a Faustian alliance between fiscal conservatives worried about costs and national health liberals worried about fairness.

The mechanisms that best avoid Marxist, socialist, or employer-mandated approaches have been variously called competition, capitation, or consumer choice models, such as the Heritage proposal. The essence of this type of plan is the empowerment of the consumer to choose, rather than adopting a single monolithic national health system. Consumer choice would enable more cost efficient use of scarce health resources. Generally, this entails the consumer to be an active participant in the choice of his health coverage, with significant financial or tax incentives to choose the "most reasonable plan."

This generally entails any or all of the following: raising deductibles, ending first dollar coverage, restricting present benefit programs, increasing taxation over a certain level of benefits, ending tax deductibility, or making benefits a part of income.

The major problem with these consumer choice plans, however, is that they have been vigorously fought by consumers at every turn,

mainly because they are viewed as taking something away that the consumers already have.

Three recent examples. Number 1. Catastrophic health insurance was repealed not because of the new benefits but because beneficiaries rebelled against the new taxes needed to pay for the benefits they believed they were entitled to free of charge.

Number 2. The budget summit agreement floundered in major part on the proposal to increase Medicare Part B premiums from 25 percent to 30 percent of program costs. This same plan was proposed by the Administration and defeated by Congress repeatedly throughout the 1980s.

Number 3. In the private sector, the chief cause of industrial unrest has been management proposals to reform health care benefits. In 1989 alone, almost 80 percent of all strikes had to do with health benefit reform. We thus have sufficient evidence that these reforms are not attractive to a broad range of elderly, poor, or labor families.

We – and that means me and you – simply have not been able to convince Americans of the value of these reforms. We must prove they are in their own self-interest, not in some vague health care interest. To put it another way, since the Great Society we have been told we were entitled to these benefits free of charge. Policy makers thus need to explain to people why they should now pay for them.

Why do employers offer health benefits? It is not something the company gives away; it is something employees earn. Why do companies and their employees choose to offer and accept these benefits rather than increased income? Well, Heritage answers, because of the favorable tax treatment. That may be part of the answer but not the entire answer. It is because it is in the interest of employers to have a healthy worker and to discourage absenteeism.

Employers have learned that employees won't use the extra income to get health insurance if left to their own devices. Therefore, from an employer's standpoint, it is cost-effective to offer health benefits rather than to offer increased income. The Heritage proposal states, however, "if employers reduced or eliminated benefits, they will be required to add to the employee's paycheck." This returns us to where we were before employee benefit plans. There is no assurance employees would use their increased paycheck to purchase health insurance or the

correct package of insurance. Therefore, these reforms may risk having a less healthy and thus a less productive work force.

Heritage would respond that it would require a minimum package of benefits. But as we have seen in the public arena, given the incentives, the minimum package would soon become the maximum package. Heritage would state as one advantage that "good health care would not be dependent upon employers." But as an employer, I am not so sure this is best to assure a healthy and productive work force.

Finally, by replacing health packages with tax credits, there is an incentive – or could be an incentive – for employees to not avail themselves of health services so they can maximize their income. This means there is an incentive to delay treatment. This argues against recent proposals to support prevention or early intervention activities. It is well known that if a person waits for treatment, that treatment will be higher in cost than if he had availed himself of that treatment earlier. As I say, this may be a possible outcome of the plan.

Now I wish to react as a pharmaceutical manufacturer whose business will be directly affected by this proposal. Generally, drug benefits continually have been shown to be one of the most popular of optional benefits, along with dental and eye care. And where drug coverage may be optional or even unnecessary for the 20-year old, it may be mortally mandatory for an 80-year old. Therefore, because drug coverage is not considered as important as hospitals or doctors are currently, coverage for drugs would be affected by adverse selection.

How it would that affect the system of health care or drug coverage? If the patient base is too narrow, with drugs as an optional benefit, controls might be reintroduced to control drug utilization or cost. We could return to the present system that uses restrictive formularies, prior approval systems, maximum allowable cost programs, price controls, certificates of need, or other drug utilization review programs to control access to the drugs themselves. All of these restrict access to the newest or highest quality drugs in order to restrict overall costs.

My concern is that with drugs probably being somewhat optional in these plans, and no obstacles to reintroducing these types of restrictive processes, you may wish to consider some type of prohibition in this plan. Therefore, in my industry, we could still possibly restrict access and deny quality therapeutics as a result of this plan. This seems to be the opposite result we seek to obtain with the plan.

We believe drugs are a cost effective alternative to other therapies such as expensive hospital care or surgery. I am concerned that this natural marketplace advantage is not employed nor recognized in this proposal. But how would pharmaceutical manufacturers overcome this problem? Today, prescription drugs are detailed to physicians, HMOs, hospitals, and other providers – not consumers. There are strict FDA regulations and laws prohibiting direct-to-consumer advertising of prescription drugs. Although some may not agree with the scientific or medical rationale for these restrictions, we must at least acknowledge that consumer choice plans would dictate changing these laws so we could reach those making the decision, the consumer. It is important that we at least are cognizant of this potential outcome.

Now, it may sound as though I oppose the Heritage plan. Perhaps the analogy is democracy: it is the worst plan, except for all the others.

But before you judge my comments as too harsh, let us go to my statements at the beginning. There is no utopia. This comes as close to a market plan as any proposed. It has the best potential as the mechanism that best balances cost, quality, and access.

There will be trade-offs with any proposal, and some no doubt will not benefit larger employers or pharmaceutical manufacturers like myself. But undoubtedly, the nation and the greatest number of Americans would benefit immeasurably if the Heritage proposals were to become law. Heritage is to be congratulated for this truly important and viable plan. Thank you.

Mr. Haislmaier: Thank you, gentlemen, very much. Before opening it up to some questions from the floor, I am going to exercise the moderator's prerogative and ask one myself.

The question of equity has been raised with regard to those working for small employers versus large employers, and regarding differences on the income scale. In designing this package, we sought to introduce a level playing field, not only among individuals but also within the health industry. Mr. Lytle referred to the fact that insurers will come out neither as winners nor losers. The idea was that tax relief should apply to all kinds of insurance equally, and furthermore that it should apply equally to out-of-pocket as well as insurance products, so that the consumer's and provider's decisions would not be biased.

So, it then becomes a question of the consumer: well, do I want a prepay plan, pay extra and get a prepaid medical plan, or just get

catastrophic? If I get a prepaid plan, am I willing to get a discount and accept the restrictions of an HMO? In the doctor-patient relationship, the doctor says what is the best therapy and in some cases might recommend a drug therapy because it is a lower cost. But in other cases he might recommend that instead of taking the low-cost test, which gives us about 60 percent of what we want to know, you pay the extra to take a better test that gives you 90 percent of what we want to know, as opposed to doing both tests, which is what we do now and contributes to driving up the cost.

Dr. Aswad, could you react as to how doctors in this sort of scheme would feel about being in competition with each other, about having to look at technology and saying: Well, can I use it to lower my costs and attract more patients?

Dr. Aswad: I think central to the answer is the point that several have raised today. That is, the absolute necessity to clarify the issue of liability, because the problem right now is that, unless that issue is solved, physicians are not in a position even to make that kind of rational judgment. The reason for that is they have the specter out there that if they do not use all the technology currently available for a particular problem, and if an adverse event occurs, they are liable for negligence. Thus liability reform is absolutely essential to any market reform.

Secondly, I part company slightly with the idea that you can opt whether you get a basic benefit package or a catastrophic package. One thing I think is essential to the whole solution is that all Americans are covered with a basic package to start with. Otherwise, you never address the issue of the underinsured or uninsured. If people ignore the option of a basic plan, you are right in the same problem again.

Someone earlier used the great expression, "the young invincibles." There are many identified in New York studies who are in the $70,000, $80,000, $100,000, or $200,000 income brackets who have said they can make better use of $4,000 worth of insurance premiums in the investment area than they would insuring against something they do not really conceived of as a risk for them. They may be a relatively small percentage of the underinsured or uninsured, but they are a significant percentage.

Therefore, as much as I am opposed instinctively to mandating, I think there would have to be a mandated basic benefit package so that

you then would have everyone covered for that package, and you would not have that issue of whether they want it or do not want it.

Now, if they opted not to buy it under law we could use a mechanism like the example of automobile insurance as a mandated requirement in many states. I think that mechanism could be utilized. If you entered the health system and you had not complied with that requirement, you then would have your personal assets attached for the incurred expense. You would not go into a bad risk pool or uncompensated pool, which is killing many hospitals in this country today.

Mr. Krebs: Fred Krebs, U.S. Chamber of Commerce. Ben, you seem to imply in your remarks that all employers would move out of the insurance benefits area. I am not so sure. I can see it for some, but it seems to me that if you look at the question of the work force and the nature of competition for employees, you may very well have many employers continuing to provide benefits because it would be something that they could use to bring people in.

Mr. Lytle: I agree. I thought I said, in talking about the formation of groups, in fact just the opposite would be the case. I think a large number of employers would stay in it. One of the critiques I have of the Heritage proposal is that it is unwise to assume that everybody is going to move away from employer groups. We should assume that there is some efficiency there in the payroll deduction device at a minimum, and try to work out some way that employers could stay in under their proposal if they chose to.

You are right. I think a lot of employers would place a high value on it and stay in the system.

Mr. Satinover: Jeff Satinover, The Sterling Institute. A couple of comments, mostly addressed to Mr. Teske. I want to disagree with a couple of things you said. But I gather from the tenor of your remarks that you're playing the devil's advocate.

With respect to the iron triangle, it really isn't a linear relationship. If you make an iron triangle, it is basically an equation that says quality times access equals cost. But any incremental increase of quality, at the margins of quality, is associated not with the linear increase in cost but an exponential increase in cost. So that the decision about where you

are going to make the cutoff point really is one that is easier to make than it appears if it were an absolutely linear relationship.

We see this, for example, in epidemiological data, where the majority of the advances in prolonging the human life span occurred years and years ago with conceptually simple methods. Then a small increase was made at the inception of antibiotics. As we move closer and closer to the theoretically attainable maximum, even marginal increases in life span cost dramatically more. So that will, in effect, set a practical limit to what we can achieve as to quality.

That leads to a second point I want to make, having to do with your comment that creating a financial barrier to care possibly will delay treatment and therefore increase morbidity and mortality. I am aware of studies that have looked at that problem, one that was carried out by Blue Cross/Blue Shield of North Carolina with respect to different levels of co-payments, and another one on fees charged to indigent patients in Boston area emergency rooms. These showed that the introduction of such a barrier was not associated with any increase in morbidity and mortality.

Mr. Teske: Let me respond to this very quickly. If I were to detail my pithy cliche about the iron triangle, I would need to have taken 20 minutes just on that. So I am sure you can make a simple version of it look foolish.

With regard to the studies about the incentives to individuals, my point actually was that there is a financial incentive not to have health care, so that at the end of the year you might get more money on your tax return. First of all, I would quarrel with your claim since the studies you mentioned were about co-payments. So, I do not know that it is an exact analogy.

Let us just assume, however, you take the broadest analogy in terms of financial incentives. I think that would run counter to the experience I have had in government programs. Take Medicaid and in other places where there is no stake or any kind of incentive or barrier put up, like co-payments. If you were to talk to Medicaid directors across the states, they would argue that regardless of a study, they see it every day in their Medicaid populations. If there is a barrier to treatment, then people will delay that treatment, and the cost of the treatment will be higher than if they would have availed themselves earlier.

This is something I changed my mind about after working for the government. You can find a study to damn near prove anything in health care. I remember saying to somebody: "Well, let us get another study to prove X, Y and Z." I remember saying: "When was the last time you read a study to find out the answer?" You usually read studies to reaffirm your answer. What you usually have to do is look at the hands-on experience of the people operating the programs on a daily basis. I would say their testimony would contradict what you suggest.

Mr. Haislmaier: Let me interject here. This gets back to my original question. That is, we were trying to even out the situation right now where people might want to go with a co-payment. That decision is significantly disadvantaged relative to buying more company-based insurance because the insurance is subsidized. What they are paying out-of-pocket is not subsidized. So, our thinking was that if you even that out, by giving people an equal subsidy for a more comprehensive insurance policy or a less comprehensive with more out-of-pocket, their decision will not be based on what is tax-free. What will matter is their needs. In fact, it might work the reverse, namely that they would have an incentive to buy cheap preventive care now to avoid incurring a large deductible or co-payment on their catastrophic policy later.

Mr. Teske: I grant you that point. All I am saying is that, practically speaking, health care to most people is a huge black box when it comes to insurance, coverage, and all this. They just want to know one thing: If I get sick, will I have some kind of coverage? But if you introduce a tax credit, they might say: If I do not avail myself of health care throughout the year, at the end of the year I am going to get a little package of money, some kind of kickback from the government because I did not use all the health resources that I might have availed myself. I would say that the issue is not so much in terms of health care as much as in terms of the behavior people would have toward any kind of tax loophole.

Dr. Aswad: Let me just take a pass at that. The way we approached it in the New York State Medical Society plan was this. We said that once you identified the basic package, and you had insurance companies competing to provide it and to sell the package, the way you would get the tax credit would be based on your tax liability according to your

IRS determination. In other words, if you are in the highest income bracket, you would get virtually no credit for the premium toward that policy because you could well afford to pay for your own insurance. That would correct the problem, where in Medicare many people who really do not require Medicare assistance are getting it as an entitlement rather than as something they truly need.

As you go down the scale, if you have a large family and are in the low income bracket, you would get proportionately more of the premium deducted. So, the credit would not be based on your out-of-pocket expense; it would be based on what percentage of the premium you can afford to pay, and the credit would be against the premium, not against out-of-pocket expenses.

We took it a step further and said that, using the experience of many HMOs and IPAs, where there is a prepayment required of $1 or $2 or $3 and there's a marked reduction in access based on just that deterrent, you could even include for the lowest income group in this plan a voucher system whereby they would be given a fixed number of vouchers that would be their prepayment.

Each voucher would be worth $3. That would solve the problem of the poor not having $3 in cash to enter the system. They would present the voucher as their entry fee, while someone else in a higher bracket would actually present cash. At the end of the year, you would say to those same people, if you have not used all of those vouchers, you will be refunded in cash for the unused vouchers. So that even in the lowest income brackets, you would have some disincentive to utilize the system too liberally. That has seemed to generate some interest.

Mr. Haislmaier: We did mention the same sort of refundable deductible, or "no claims bonus," in our proposal. Let me also correct a misconception evident in Mr. Teske's remarks. The basic core of our proposal would be that your tax relief at the end of the year is for what you used. So, if you did not use services, you would have more income in cash but you would pay more in taxes. Whereas, if you did use it, it would not matter whether you went to the doctor and said: Here's my credit card, please bill me for treating my ear infection, or you went and got insurance to pay for such things. Your tax credit would be there. So, it is not a question of giving tax credits for not using health care.

One thing for Mr. Lytle. Maybe you could address a question regarding that small percentage of people who use the greatest volume

of resources. The argument I have used – and I would like you to respond with how valid you think this is – is that in those cases where you have very high users of very expensive services, it makes the greatest sense economically for a third party to step in and evaluate the situation and manage the situation to make it economical.

Mr. Lytle: The problem with that population today is that it is something that nobody wants to come to grips with. There is literally a bottomless pit. It is my reinsurance pools that are paying for it, but insurers won't necessarily get the job done. In fact, even if you had government as another layer serving as a reinsurer or a stop loss insurer, you still would have an additional problem because the media and the sheer emotionality of those cases creates difficulty when you actually try to manage the case.

There is a recent case that I am familiar with where a child was terminally ill for a couple of years. His life span was probably going to be less than two years. The parents of the child wanted to keep the child at home, naturally. The problem was that the nurse and the physician involved were saying that he needed 12-hour nursing, but after the 12 hours the parents really are capable of dealing with the other 12 hours.

But the parents refused to do so. They say they have a life to live and wanted to have a life outside of taking care of this child for the next two years. They wanted 24-hour coverage. They went to court and they got it. You can see it from the parents' standpoint, and you can see it from the court's standpoint. But the fact of the matter is, medically, the 24-hour coverage was not necessary. When you start getting into managing those chronic cases, it can become highly emotional and they almost always end up in the court.

Ms. Behren: Ruth Behren, Norwich Eaton Pharmeceuticals. The one question I have concerns mandates. I can see half the lawyers and the American Civil Liberties Union rubbing their hands together over the constitutionality issue. Do you see any problems with that at all?

Dr. Aswad: I think that is really what I was trying to point out as one of the fundamental issues that has to be decided when we talk about a national health policy. That is not going to be something that can be contested indefinitely, because if we went to, say, a national system, à la Canada, there would have to be a firm decision as to what is the law.

Everyone would have to be bound by the law – period. It could not be discussable, negotiable, nor suable. You would be a citizen of the country, the plan is such, and you would be in the plan. That is the public debate that is going to have to occur in this country. People are going to argue that that is not the way we do it in this country. If so, then I think we are going to have to be talking about the uninsured and the underinsured for the next 25 years, because you cannot have it both ways. You just cannot have it both ways.

Mr. Haislmaier: I would like to thank our panel very much.

The Political Prognosis

Ms. O'Beirne: There is not going to be very much about the politics of health care reform that this panel does not know, and we are thrilled that each of them was able to come and lend their enormous expertise. They have been watching the debate for years, and their thoughts this afternoon are going to be very important for all of us.

I was the one who assured Stuart in July that October 23rd was not a problem. "Congress will be long since gone," I said, "and we won't have any problem whatsoever attracting Capitol Hill staff – or more explicitly Marina Weiss." Well, Marina is very sorry she cannot be with us. She had always told us she expected she would be free from her Senate Finance Committee work with Senator Lloyd Bentsen, but always with the proviso that if by some fluke Congress happened to still be in session, she of course could not join us. She extends her apologies. I am sorry she is not with us not just because of her immense experience on Capitol Hill, but also because her boss, Senator Bentsen, has championed a tax credit proposal to help low income families buy health insurance for their children. I would have valued her comments on our more comprehensive tax credit proposal.

Let me now introduce our panel, beginning with Deborah Steelman. Debbie currently is in private practice in downtown Washington, practicing labor, health, and employee benefits law. During 1988 she served as director of domestic policy for the Bush Campaign and has been chairing the Social Security Advisory Council, which many call the Steelman Commission.

Debbie served as an associate director at OMB from 1986 to 1987, and as staff director of intergovernmental affairs. She has also served at the EPA and with the U.S. Senate.

Next to Debbie, we are so pleased to have Karen Ignagni, who is director of the AFL-CIO Employee Benefits Department. Currently, she heads the Federation's activities on health care, pensions, Social Security, and child care.

Prior to joining the AFL-CIO, Karen also spent time as a staff member in the U.S. Senate, on the Labor and Human Resources Committee, and so brings that enormous expertise and experience to

us. She has been involved in health issues for over 15 years and serves as a member of the Social Security Advisory Committee.

Ron Docksai is Vice President for Government Relations at Marion, Merrell, Dow. He is chiefly responsible for their federal relations. Before joining the pharmaceutical industry in that role, Ron was Assistant Secretary for Legislation at HHS for over two years. Prior to that, he was staff director for the Senate Committee on Labor and Human Resources, which is the Senate's principal authorizing committee on health care legislation. Again, Ron's insights were gained over many years of experience on Capitol Hill and the executive branch and will be brought to bear this afternoon on the proposal we have designed.

Most important, Ron's insights really stem from his roots in Queens, New York! This has given him enormous insights into the plight of the common man and I am pleased to say that Ron and I knew each other back then. Ron holds a Ph.D. from Georgetown and master's degrees from NYU in both international relations and public policy and health policy.

I am going to ask Debbie to begin. We have had a fascinating day. The issues this panel is going to address about the tax credit approach include: What is the prognosis? What will the pitfalls be? What will the political pressures be? What will Congress be hearing when health care next comes to a head? What are the drawbacks of the tax credit approach when Congress does decide to take up the issue? Is there anything Congress might do in the interim to respond to runaway health costs, which most recognize as a problem?

The consensus that has emerged today is that nobody is satisfied with the status quo, and everybody is concerned with cost. Yet none of the widely-talked about alternatives has the requisite political support, which is why it appears none of them are going anywhere for the moment.

Is there anything Congress might do that would make it more difficult eventually to move toward the tax credit approach? And what sort of incremental changes might be made that will eventually move us in the direction that many of us would like to see us go in?

Debbie, of course, has been exploring many of these issues in her work as chairman of the Social Security Advisory Council. The Council is holding hearings all over the country, they are getting public response

both to the status quo and the most widely talked-about reforms. Thank you, Debbie.

Ms. Steelman: Thanks very much for asking me here. Usually, I like to engage in what I term creative thinking about new ideas. But I was asked to give a political prognosis, so if it sounds more negative today, please forgive me.

There are five basic political obstacles that this proposal faces. One is, it is new. And the rule in Washington is, if it is less than ten years old, it is going to have a hard time. The committees with jurisdiction on the tax code, health policy, and Medicare have a very structured way of thinking about tax credit proposals. You can say: No, Debbie, it is not new. People wrote about this ten years ago, and there is nothing new about it. Then why is it still considered new? That is a complicated question.

Earlier proponents, like Alain Enthoven, have come full circle. They have changed their minds, and now are going around talking about having seen the light and that this, in fact, cannot work. So, it is having a second phase of newness.

Change just in and of itself is threatening to the ordinary people involved. Yes, if you ask them is our health care system a mess, they would say "yes." Would you prefer Canada? They would say "yes." But if you ask them individually, have you been unable to get to care that you felt you needed due to financial circumstances this year? They say "no." Has anybody in your family been unable to get health care they wanted due their financial circumstances? They say "no." If you ask them: Are you satisfied with the quality of care that your doctor is providing you? Yes. Do you trust the people at your hospital? Yes. How much is the maximum you should be forced to pay out-of-pocket, for health insurance? They say $5,000. How much did you pay last year? $184.

So, yes, people think the system is a mess. Do they think it is enough of a mess to change what they have? I think the answer to that is still "no." That affects not only this proposal but any proposal that we are talking about, whether it is mandated health benefits or anything else. It also affects this proposal monumentally because it represents a significant change in the way people get benefits, or at least they perceive it to be a significant change.

This proposal represents the biggest change of any proposal currently under discussion today for a number of different institutions: insurance, employers, unions, and government. This proposal would represent a monumental change in the business people are in or at least the business they think they're in.

Second – and this is definitely an inside-the-Beltway one – congressional jurisdiction. The people who have primary concern about the uninsured, and who stand to gain the most politically to any answer to the uninsured problem, are Democrats on the Senate Human Resources Committee and on the House Energy Committee; Waxman and Kennedy, to name but two.

Tax credits would be taken up by the tax writing committees. So tax credits as the answer to the uninsured is not the answer that the Waxmans and the Kennedys are likely to have a great deal of enthusiasm for unless it somehow involves some matter under their jurisdiction. In the House, there is even an additional problem, which is, that you have Medicaid split between Energy and Ways and Means. So that by virtue having a proposal that addresses the same population under two committee jurisdictions means that many more people you have to get on board.

Third, this is a proposal that I think is very easy to characterize depending on where you sit. Where you stand depends on where you sit. If you are in the middle class, it is very easy to characterize. It gives you the freedom to negotiate your own benefits. But if you sit someplace else, for example, if you now believe that employers already have no buying clout and that is why there is such a cost containment problem, and you view the individual insurance market as having even less clout, then this proposal offers no solution.

It is very easy, in fact, to say this proposal does not empower anybody. People can say: "They are taking away a system that has worked very well – with the slight exception of the cost problem – for 50 years. They are going to take it away from you, when you have got perfectly good employer-sponsored insurance, which you yourself were polled and admitted that you liked very much, even though it may cost you very much." It is very easy to say to the middle class that we are taking away your benefits, making it a partisan debate. That is the most difficult of any of the problems I have mentioned so far. It is so very easy to characterize this as taking away something. It is very easy

to scare people who get their information from the TV ads, not even from the newspaper. It is very easy to mischaracterize.

Fourth, what is the political coalition that will be brought together to support this proposal? Think of insurance, unions, employers, employers of all sizes – small, large or whatever. Given the choice of accepting mandated health benefits, or a tax credit and losing their own tax advantages. Many employers still consider employee benefits a good recruitment and workforce stabilizer.

If given a choice, where are they going to fall out? I think that is a very predictable answer. Because tax credits suggest the biggest change, they offer proponents of other proposals the opportunity of mischaracterization. Because they are scary politically, you could force people who are now on the fence or simply stalling regarding the mandate proposal, to jump into a mandate proposal.

What is the alternative political coalition you are going to bring to bear? If the middle class, if you are depending on the guy out there who really is not getting as good a deal from the current system as he could be, and/or who is a healthy individual and doesn't want insurance at all, or one who is self-employed and gets few tax advantages, how can you get that person to write in? How can you organize that person? How did seniors repeal catastrophic? What is the coalition you are going to bring to bear to get this thing to pass?

Lastly, just like in all proposals, the trouble is in the details. It is a catch-22. Either you put forth the details so soon that you make every everybody's eyes glaze over, or you put forth the rhetoric and deal with the details later, at which point they come around left flank and kill you that way.

I think The Heritage Foundation has done a very good job of putting forward the concept, the rhetoric, and the idea. I think that is the main reason that the proposal has as much following as it does. But I do worry about the left flank in terms of the details. Pun intended, I guess you could say.

The first detail is adverse selection. I do not think you have adequately answered how this proposal gets around adverse selection? And how is it, in fact, going to affect personal behavior?

Second, What are we going to do about the fact that provider costs increase have exceeded the CPI year after year for decades? If

employers do not have the clout to get the cost down, how does the individual have that kind of clout?

Third – and this is one where I think you will run into the greatest danger of dividing your own base – is the regulatory structure that would be put forward to make this proposal work. When this proposal goes to Congress, it is not going to go to a state legislature; it is going to go to the United States Congress.

You have to deal with certain realities, like Pete Stark and how he feels about the insurance industry. If you look at what he has done very recently regarding Medicare, it is an open door for him to say: Okay, if we are going to have individuals do this, then we have to have a regulatory structure around both the insurance and provider industry. Once you create such a regulatory structure, either through rate regulation, product regulation, all payer systems, or whatever you do to make it acceptable to certain congressional committees, these necessary compromises scare many of your own supporters.

That is a real brief run-through of kind of the political obstacles I was asked to lay out. I hope that stirs up a lot of conversation, and my colleagues can agree or disagree with me.

Ms. O'Beirne: Debbie's insights keep us from becoming Ivory tower types. We don't spend too much time designing utopian policies that don't have any relevance to reality because we check with Debbie.

I would next like Karen to address, in general, the kind of response we could expect from employees. Earlier this morning, Karen, we heard one opinion expressed that the tax credit proposal might not strike some employees as a plus because they are perfectly happy with their existing plans. Would you address the concerns of employees in the service industries who do not have any such plans. Thank you.

Ms. Ignagni: I am delighted to be here. I guess the first thing I want to say is that what my chair from the Social Security Advisory Council says goes for me to. I think Debbie did an excellent job of assessing the political realities and pitfalls. I thought long and hard about what I'd say coming here, talking about what you folks have put forth and how the AFL-CIO and labor in general would react to it.

The first thing I would say, stepping back for a moment, is that the more you are in this business the less you know about what to do. That

is the only thing I am sure about these days. That is the one general truth I wish to leave you with this afternoon.

In that capacity, Debbie is right: where you stand depends on where you sit. I think it is really remarkable, and it is probably a sign of where the debate has moved, that The Heritage Foundation, NAM, the business Round Table, the Chamber of Commerce, the AFL-CIO, are all in many ways talking about the same big three issues.

Expanding access. There is less and less debate about the fact that that has to be done. The question is how.

Containing costs. It is clear, as Debbie says, that the slope of the curve cannot be dealt with from the standpoint of basic economics for much longer.

Quality. It is really quite disturbing when you think about the whole value-for-money issue. When we look at data out of the Rand Corporation and elsewhere, about how providers are practicing medicine and what is going on, and what consumers are getting, and how much we are paying for health relative to the other industrialized countries, I think there is a great deal of common assessment about the problems. That is really a sign of the times.

A lot of this centers on cost containment and dealing with that affirmatively. The quality issue was hardly ever mentioned until several years ago. There is some debate as to whether or not that has sufficiently hit the consciousness of people in Congress. But I think it is getting there.

On the access issue, I think we have come a long way. So, another question is: What do we do about it? Undoubtedly, we at the AFL-CIO are likely have a different view about how you approach this kind of question.

I think one of the major burdens of proof, if you will, with respect to any proposal surfacing on Capitol Hill – whether it be from you, from us, or elsewhere – is will it contain costs? I think cost is the thing that is driving the engine here for a number of important groups.

I am going to leave access for a moment and come back to that. But from the standpoint of balance sheets, from the standpoint of economics, from the standpoint of the United States as a competitive country relative to other countries, and from the domestic side of the competitive equation, that is something we really have to deal with.

We, of course, have not developed a formal position on this proposal yet. But I think a number of folks in the labor community would question whether we could get there from here with respect to The Heritage Foundation proposal. I think there are a number of good reasons for that skepticism.

I would point to Medicare as probably the closest case in point. Medicare is a system, as everyone in this room knows, where individuals pretty much go out on their own and obtain services through the complex delivery system. I think the unanimous consensus throughout the health care policy community, no matter where you sit, is that we have got to do more to affirmatively manage care to deal with utilization, channeling people into more efficient providers, and really doing a better job of managing cases.

The question is, if you move to a totally tax credit based system, and the individual essentially is to go out and advocate through the system themselves, like under the Medicare program, will we get there from here? Can we achieve the objective, as Debbie said, of containing costs? I think that there is legitimate question as to whether or not that will work.

Having said that, I do think that since we are talking about the political realities in Congress, the issue of informed consumers resonates very, very well. It is a very appealing notion, as it should be, because the one thing we have learned, thinking back to the debates when we were on Capitol Hill during the cost containment days, was the attractiveness of letting us see if the competitive economy can really take hold, can work and improve things. That was the era of deregulation.

We moved in the Eighties, at least in the labor community and management community and everywhere else, to try to do our best, using the best and brightest folks, to try to get costs under control. We learned a lot. I think the things that you are seeing surfacing now in the political debate are as a result of that experience out there in trying to affirmatively manage care.

The first thing we learned during that period is that we need an information base. We just simply have to have better data to figure out what is going on both with respect to cost and quality. I think that is implicit. You folks have talked about it. Stuart, I've heard a number of your presentations, and you have done an excellent job of outlining

that. You need informed consumers, and we agree with that. No matter what we propose in terms of our policy proposals to Capitol Hill, that will certainly be part of the equation. A medical information management system – call it what you will – we simply have to have it. We cannot just have it for Medicare. We cannot just have it for Medicaid in certain states. We have to have it for all payers.

The question is, what is to be the repository? And how do you analyze the information? I will leave those details. But information is important. I think the acceptance of that has substantially contributed to the debate. But I think where the debate will turn is on whether or not individuals can on their own change provider behavior.

I would submit, given the evidence of Medicare, and given the evidence of some very good, smartly designed health plans that have been organized by labor and management, consumer power really leaves a lot to be desired. One does come out of the Eighties with the question, can one company or one union really have the kind of economic clout to solve these problems? That problem simply multiplies when you talk about the individual as being the key decision-maker in the health care system, and so we have got to do some talking about that.

My own view is that we need purchasing agents in the system, to sort through the very complex delivery system that has evolved, to move toward managed care, to move toward the right kind of providers with adequate data and consumer choice. Consumers do have an important role in this equation.

When you look at the aggregate, the various pairs in the system – state and local, individuals versus companies, and so on – there has been a tremendous growth in the share that individuals have paid out-of-pocket. This is not just for co-insurance. It is also for premium sharing and for uncovered services. That begins to get back to your question, Kate, because of the complex numbers of people that we represent. We represent physicians, we represent nurses, we represent teachers, police, fire, we represent hospital orderlies, nursing homeworkers, et cetera.

How you approach this, as Debbie said, really depends on where you sit. So what we at the AFL-CIO have been doing is a process probably much like the process you folks at Heritage started and finished as you were proposing this particular plan. Our principals have

been looking at all sorts of remedies to deal with the cost issue and the access issue, and they'll be making some recommendations toward the beginning of next year.

The process is still going on. But I think there is one thing I can say. As we look at the access side of the equation, there is a tremendous amount of movement in and out of the work force. So, to the extent that you deal with that through strictly a tax-based approach, there is an advantage. I think many people in Congress will pick up on that. Dealing with it does not have to involve high administrative costs, but some proposals have not given full thought to that. We need to look at that whole question of administrative costs. But I think you folks have given us a lot to think about.

On the quality side, it does appear necessary to have some kind of superstructure. That is a bad word in Washington these days, and I use it advisedly. There needs to be some kind of organization to encourage protocol development, and to disseminate protocols. We have a new agency, but they clearly need to really beef up the effort to learn more about what physicians should do and to get that information out to physicians, and to figure out a way to make sure physicians are, in fact, functioning and using that information in a positive way. This is not a negative comment. I think they are doing a great job with fairly few resources.

I would submit there are also opportunities to deal with malpractice with respect to protocols, and to consider whether adherence to protocols becomes a defense in malpractice suits. Other kinds of things have been proposed, too, and I think we ought to look at them.

I think you could achieve all of those kinds of objectives with respect to quality in the context of this kind of plan or in the context of a plan that went to the other side and was totally government operated. I do not think solutions are necessarily dependent on one or the other.

You at Heritage has given us a lot of think about. If the question is whether labor thinks that we can get the quality advances that we need to get to as a society totally based on consumer driven choices, I think the answer and the evidence would suggest "no." But that approach, coupled with some major government strategic planning, is something we have never had in the health care system. No business operates the way we have tried to operate the system in the United States. No country operates that way. We really need to begin to give more serious

concern to how to organize consumer-driven choices in a better and more efficient way. So, it is not necessarily a question of more health care; it is a question of allocation of resources. We, perhaps, come at this question a little differently.

Although I was not able to be here, people during the day also probably have raised the issue of catastrophic health care legislation. I do not want to be glib in raising it again, but obviously it has got to be part of the political equation. I think what you saw in catastrophic was a situation where people just were very frightened about making a change. People who had relatively low income and would pay relatively little for the plan were completely confused and concerned about what would happen to them. We could talk all day about what it means. But I do think that experience should give all of us pause in thinking about this or other plans.

So, in sum, I want to applaud you for coming forward. I think this is an excellent addition to the debate. It will probably not be the kind of proposal that we will be recommending. But I think it is a sign of the times that two very unlikely constituency groups have really come to the same conclusion about what the problems are. That gives me real confidence about coming forth with the solutions. But I think we have to take account of the past.

A number of people in the labor community and people in the liberal community, if you will, probably will be asking the same questions of many proposals: How can you guarantee that this will work? We have tried a number of things. Where is the evidence? In a sense, I approach this the way I approach managed care, although in my heart I do believe we need to re-orientate the delivery system.

I understand how we can achieve more efficiency and so on. But there is still a very, very difficult question to answer: How can you assure society that things will really change in a positive way based on the past? That is the burden of proof for managed care; that is the burden of proof for this plan; and that will be the burden of proof for whatever plan we come up with, too, to be quite honest. Thank you.

Ms. O'Beirne: Thank you, Karen. I am going to ask Ron to tell us something in his remarks about what he is seeing going on in the states, with respect to proposals that look like this, as well as other sorts of reforms. Because he was working for Dr. Bowen when catastrophic health insurance passed, I wonder if he might also share his impressions

about what lessons he thinks Congress may have learned. The congressional reaction was largely driven by consumer perception of what happened. Therefore, consumers' perceptions about what the tax credits proposal means are very critical.

Mr. Docksai: I could not resist, when talking with Bob Helms during the break, reminding him of the time four years ago, when he and I were appointed by the President to a task force to come up with a proposal for catastrophic health insurance. I remember getting a present at that time, a Webster's Dictionary epigram calendar. Every day had a new maxim such as "Make hay while the sun shines," or "A stitch in time saves nine." You get the idea. I do not remember the exact day when we had our first meeting of the catastrophic health insurance task force. But I remember, and I will remember to my grave, that day's epigram being: "The road to hell is paved with good intentions."

We were asked to give a political prognosis. That is a most difficult thing to do, particularly on this subject. It is probably the least scientific of today's whole wonderful program.

I have learned so much today, as I know all of us have. But the specific thing we were asked to do here is more descriptive than prescriptive. We were asked to say whether or not the idea is politically doable now or ever. In that regard, I would make three quick observations.

First, the Senate Finance Committee and the House Ways and Means Committee historically, have habitually not been interested in tax credit ideas. Before 1986, there was a tendency to not favor a tax credit approach, for a range of reasons. Yet after the Tax Reform Act of 1986, one would find members particularly gun shy. I know Senator Bradley and a number of House Ways and Means and Senate Finance Committee members are particularly vigilant when it comes to changes in the tax code which they feel might lead to a return to what they see as loopholes and unfairness.

I am not making a case for or against that view. I am just saying that it is a political problem to deal with in discussing any tax credit idea at this point. I happen to like the Heritage tax credit idea very much, but that is a whole separate subject. The question of whether it is doable federally is a question of getting it past the gauntlet of tax committees.

Second, having said that, it is interesting to note that a number of dramatic things are occurring in the budget deal and are occurring

totally absent from the headlines one reads. Usually, in the wake of revolution, you have the Thermidor. I think the Thermidor will come following the pending budget deal, if it ever is consummated.

There are in these discussions a number of things concerning the possibility for opening up whole new areas of federal policy. One is the earned income tax credit. The *New York Times* last Sunday, the October 21st issue, had a very interesting article on the thousand dollar cash payment, the earned income tax credit, which the House passed a version of. This measure increases tax benefits by $22 billion, with $11 billion intended for child care.

Those of you who followed the earned income tax credit debate, and the whole genealogy of it over time, will find that since Russell Long's days the tax credit has been characterized in different ways and used for different purposes – used at times for what John Kenneth Galbraith described as social externalities. It was meant to solve particular problems for the elderly or for health problems, for child care related problems, for child health care problems. The point here is that the income tax credit grows each year. With its growth, and with the increase of support for it is a parallel growth-constituency there is a growing constituency of legislators – not just constituencies, but legislators – who are interested in this kind of approach.

If you look at the members supporting this idea, they are not on the tax writing committees, but they do make the majority or plurality on the floor, which usually leads to this type of debate when it comes to appropriations. This is something to look at politically when you are talking about federal implementation.

Third, the current tax law favors employees of large firms and higher income employees at the expense of small firms and lower income employees. That was very effectively said in the earlier panel, the point being that the issue of fairness – whether or not all Americans become entitled to the same limited federal tax subsidy – was an issue before 1986, and it has been an issue since 1986.

But with all that aside, it becomes a question again as to whether people will be energized enough politically to move their members of Congress, to move their respective associations, to get on the backs of people in Congress to do something about the idea.

The comment was rightly made, I think by Mr. Lytle, that in economics, you cannot have it both ways. But, in politics, you *can* have

it both ways. We are dealing here with a political question, not an economic question. Because it is a political question, it is not a question of black and white but of various and alternating shades of gray.

Professional pollsters measuring public attitudes toward health care – and believe me, people in my industry spend a lot of time and money on market surveys of public attitudes about health care – have found that to the extent that most folks think at all about the issue of health care, and that is a debatable subject in itself, most of us share a fashionable dislike of the current system and an ambivalence about what should be done about it. And perhaps as a tribute to American democracy, public ambivalence is reflected in Congress. We want more services, better drugs, we want increased forms of therapy, we want more access, and we do not want to pay for it. You have a consensus for wanting more out of the system but less of a willingness to pay for it, and, at the same time, various degrees of urgency about it.

We all have heard the trite expression, "there is a health care crisis." Frankly, when you take market-type surveys, people change their attitudes when it comes to voting people into office and energizing their particular civic association. One of my favorite questions asked in the Gallup poll last year was, "If you had 100 services offered to you, of these 100 services, pick the top ten that you think should be offered for free, and start with the item you believe should most be free." Health care came in sixth of the ten. The first was burial plots, and second was lawyers.

The final point I want to make is this. I know we have talked in the past few years about Canada's health care system, but very little attention has been paid to how Canada's health insurance system emerged in the first place. It did not emanate from the head of Zeus and come out of Parliament. It came into being as an experiment. It was patterned after the universal Saskatchewan system in the 1940s, making it analogous to the U.S. Social Security system, which was based on a number of very successful experiments held in states.

I am not here to make a case for or against Social Security. What I am saying is that the Social Security debate, which took about 23 years in the U.S. Congress, was very often associated with the fringe. Through Norman Thomas and a small group of people, it became popularized in time after it was demonstrated in a low key way in a locale or a state.

In the case of a federal tax credit, these cases are something one might consider. We look at what is happening in Congress from the debates on health care and other areas. Friends of mine who have been involved in the product liability issue for the last 20 years about three years ago finally switched the whole coalition toward pushing product liability in the states. Now you have 17 states over the last two years which have passed the same product liability type legislation they wanted passed in Congress. States were doing it, so they switched their coalitions to the states. It is a very good example of applied American federalism.

We are seeing action on health care reform at the state level for a range of reasons. The main reason is that the idea was not moving anywhere at the federal level. It was heavily discussed among a lot of people, including me, and we spent a lot of time on it, but it was not moving anywhere. Today, in Oregon, Connecticut, and a range of states, you have various health care systems being implemented, for better or worse.

The point here is that one might consider this when it comes to the consideration of a tax credit idea. G.K. Chesterton made the observation that if a thing is worth doing, it is worth doing badly. Whether or not a tax credit idea can work in a particular state, that kind of demonstration experience takes the wind out of anyone's sails at the federal level who points to an idea and says there is no empirical reference and this has not been tried before. Once it has been tried, politically it is a whole different matter, as we found out in the product liability example.

The final comment – as my Hungarian grandfather said and as Richard Teske knows: The recipe for Hungarian Chicken Soup is; "First, Steal a Chicken." There is a lot of wisdom implied in that. Wisdom in politics says the shortest distance between two points is not always a straight line.

So, regardless of the dangers and notwithstanding our prognosis, as President Reagan found out in 1988 with tax credits, what was considered a year before as impossible became much more possible with exertion of political will and the right circumstances. It could very well be the case here. Thank you.

Ms. O'Beirne: Thank you so much, Ron. If I might ask the first question. To build on Ron's very last point, the go-for-it point, we mentioned

early in the day that given the current budget climate, having a budget neutral proposal, versus an enormously expensive government program, means it takes on a whole new appeal. So, fully recognizing Debbie's point about the fact that it appears new, which is a problem in Washington, might the budget realities engender a different response from Congress today than would have been the case some time ago? The response to the Pepper Commission report, which was looked forward to and got an awful lot of attention in advance, was that it was unrealistic and now has very little credibility. Would you respond to those two points?

Ms. Steelman: On your first point, the way I interpret your question is: Does the budget reality mean something important for a big idea? My view is, if there is political support for an idea, there is money. S&Ls, the San Francisco earthquake. There are lots of examples you can point to. I do not view money as the biggest obstacle that this or any other health care proposal faces.

I agree with what Ron said. The biggest obstacle is ambivalence. That is one key attribute that The Heritage Foundation proposal has that some others do not – simplicity and ability to communicate directly.

As to the Pepper Commission proposal. Again, I would have to say that goes back to the fundamental ambivalence we have inside and outside the Beltway. When the Advisory Council comes out with its recommendations, it is going to be hard to get anyone to slap us on the back and say these guys have the right answer, and we support them 100 percent. This just does not happen on the health issue.

Ms. Ignagni: It is a very interesting question. I think there is a macro level to this question and a micro level. Taking the micro level first, it is clear that the biggest hurdle facing health care reform on the reimbursement side is that government is not paying its fair share for Medicaid. Sixty cents to the dollar on average. You go to certain states, and it is 30 cents.

Now the same concern is being raised with respect to Medicare. Whether or not a proposal like this could actually result in a change of that dynamic, I am just not sure. But I do think that is one major budget hurdle that any proponent of a health care reform plan is going to have to deal with squarely if he is going to achieve the objective of equity.

On the macro level, it is clear that there has been enough work done with respect to complete reorganization of the system. And then there are some less ambitious proposals. There is a great deal to be saved in doing things very differently with respect to containing costs, standardizing claims forms, changing administrative structures, unifying administrative structures, straightening out the plethora of often conflicting regulation that we have, and anti-competitive regulation at the state level.

So, I think that there is a compelling case to be made that it is not totally a question of more funds. It is a question of reallocating resources in a smarter, more efficient way. I am not sure that the case is getting that hard to make any more, but people in Congress and government cannot have it both ways. You cannot talk about health care reform and then not expect to step up to the challenge of what is a fair wage for providers or adequate reimbursement for hospitals, et cetera. I think that for too long we pushed those issues under a rug. We simply cannot do that any more.

Mr. Docksai: Congressman Gradison talked about the Congress as a great ship, a great ocean liner. He said that in the wake of the catastrophic legislation, regardless of the circumstances of the wind, it will be a long time before the ship is turned back in that direction. Regardless of the economics of it, it will be a long time before Congress, at least the part of it I follow, would feel in a position to consider something like that. It is for reasons totally separate from the economy or the economics of a health care proposal.

I go back to my point again that if it is going to happen, I see it first happening in the states. Not automatically, of course. It would have to be pushed in the states. My idea is, once it happens in the states, people on the federal level no longer have the moral authority to say it has not been tried in a particular state and found successful.

Dr. Butler: Stuart Butler. I would like to direct a question to Debbie Steelman. Your initial comments were very illuminating in terms of the way ideas do become reality or not, as the case may be. I broadly agree with you on that. Let me just ask you to consider another dimension of this process of political change. I on the conservative side have spent many years learning from my colleagues on the left of the political spectrum. They taught me that big changes and big ideas do not happen

all at once politically; they move forward incrementally. Something is done, which may be modest, but it begins to set in motion a dynamic that makes it more likely you can take the next step. We have seen, of course, many major federal programs starting in small ways and then growing even larger. There is a long literature of political science analysis as to how this happens.

I would like to get your reaction, and maybe that of others on the panel, about how such a process might apply in the case of our proposal. I think what you have said is quite correct in terms of how people view the overall package we propose. But it seems to me that it is also an approach that can be moved forward in an incremental way. I would like to lay out this and see what you think.

Consider the discussion that is taking place in Congress, at the same time we are meeting here, about children and the idea of tax credits, to deal with various problems faced by children in low income families, such as day care. It is a shame we do not have Marina Weiss from Senator Bentsen's office here, since there still is a major provision in the child care package to give a tax credit for health care for purchase of insurance for children not covered under company plans. So, we are, in fact, already seeing an example of an incremental first step in the direction that we have proposed.

If this measure does become law, a number of things will have happened and certain dynamics will then flow from this. You have the principle of a refundable tax credit for the purchase of health insurance. You will see the insurance industry and medical profession reacting to that and beginning to design packages for that new market. After a number of years you will have established a track record. The clamor will then be: Why should it only be children? What about wives who are not covered under a such a proposal? Pressure will begin to develop to expand this credit.

Then people will say there is a snag, of course. How do we pay for this? These days, one looks for some way of paying for such a thing which is internally consistent for what you are doing. The idea of some modest cap on the exclusion seems likely. It will be portrayed as: Why should the rich get unlimited health benefits at our expense? You might begin, in other words, to see a dynamic moving remorselessly in that direction of what we suggest.

I just want to see if you think that is a realistic scenario, and would it tend to lead to a set of coalitions developing that might tend to accelerate the broad proposal after taking the next step? Or is this a fantasy world? It seems to me a rather similar scenario to some other pretty major programs and reforms that have occurred before in this country. Not withstanding what you said initially, it seems a plausible way in which a radical idea such as we are proposing could be implemented in an incremental manner.

Ms. Steelman: There is an awful lot of wisdom in what you say. There are several ways to do it. One is children. One is states, as Ron suggested. One would be for the poor. If we are not satisfied with Medicaid as a program, particularly for working poor, would this tax credit notion be an acceptable supplement to enable them to buy mainstream health insurance? There are a number of different ways you can do it. Children is clearly one. We have the good fortune of having Senator Bentsen as a proponent.

The one fundamental point, however, is that the child care tax credit is an additive. It is not changing the system; it's an additive. Any time you are dealing with additives, it is one chemistry that is entirely different from change. So, it really has not met any of the key tests I have talked about. But there is no question that achieving a first step is fundamentally important, whatever that step is, whether it is a state, or whether it is a children's deal, or whatever.

When running into the money problem of how to pay for a credit, the tax cap is the place where health junkies have always gone. You can point out all the inequities with the current unlimited exclusion. You can point out all the health policy reasons why it is bad from overutilization to inequity and to others. But there is no question that one of the most rock-solid coalitions currently supports it, one in which I see very little dynamic for change, particularly in light of the coming recession, and all the chaos surrounding this budget. There is a heightened sensitivity on the tax cap.

My view is that when there is political support for an idea, there is money. As one who has labored long and hard in terms of deficit reduction and balanced budgets, my overall desire is perhaps very much like the American public. Overall, I believe deficit reduction is a very important thing. But I am tired of the issues I care about bearing the battle alone. I am not willing to sacrifice all the needs that I care

about so that others can see the budget go their way. I think you have to get in there and fight for the dollars and get rid of the public ambivalence. Make a total political attack. Then, wherever the money comes from, let the chips fall where they may.

Karen, maybe you might have something on it.

Ms. Ignagni: Yes. Just to be a real naysayer – although you never say "never" in Washington. Anything could happen, and certainly it is happening in Congress as we speak. But I do think there is a lot in what you say in terms of the intellectual underpinnings, Stuart. We like very much what we heard at the beginning of the Eighties. We as much as any employee group, or indeed any group in this room, went out to try to do what we could to really make the competitive notion work in health care.

I think that approach is a very tough sell now. Folks who are trying to market this new generation of managed care products that are really supposed to work – not simply moderate costs for a short period of time – face a very tough sell. People say: How can you be sure? What if we lose five, six, years? – believing that will be the case and things will get worse.

There is no really good answer to that. I suppose you could make that point with any proposal. But I know it will be made with this one with respect to putting the burden on consumers to make efficient choices and to have that solve the cost problems.

But Debbie is right and you are right that there are lots of variations of this. Unquestionably, there is going to be discussion about limiting the deduction to whatever package people agree to as a basic package. There has also been some discussion to of tying the deduction to managed care. All of this is a variant of the kind of thing that you guys have put on the table. Who is to say in the context of a large policy decision discussion where people will ultimately be on lots of these questions?

So, I think that your spirit is right. You should keep pushing it, and others should keep pushing their plans. And hopefully, we will begin to catch the attention of people in Congress.

Although I agree with Ron in spirit – and the evidence is exactly as Ron has suggested – that states really have led the way in some major policy initiatives, such as Social Security and welfare reform, it really gives me pause as a policy person when I look at what is going on in the

Medicaid program. When people in New York have access to a certain kind of package, yet people in southern states do not have access to anything near that, I do not know. Maybe anything is better than nothing. But at some point, we have to think about this.

I guess we are talking about policy, not having to make pragmatic choices but talking about what is right and what is wrong. I am worried about fairness. I am worried about equity. And I am worried about just having a standard that would be a decent standard for everybody in the country, however we get there.

Ms. O'Beirne: Ron mentioned earlier that the Senate Finance Committee and the Ways and Means Committee sometimes can be hostile to the idea of a tax credit. That has been the case over the years. But Stuart did raise the example of the tax credit that Senator Bentsen put on the Senate child care bill. There are already some in the Senate saying: Why not spouses?

In talking to Marina about that tax credit she explains that they are already seeing markets respond. She has told us about school districts that have gotten together to market insurance policies to parents, sending information home through the school because that is the market. So, I think people – at least in that example, – are seeing the possibilities of the tax credit approach and the sort of things that might flow from it. And Senator Bentsen would be key in that regard. Let me throw it open to questions from the audience.

Mr. Whaley: David Whaley, Senator Symms. What I have to ask Karen is: What are you considering as far as cost containment measures in your approach?

Ms. Ignagni: If I were a king, what would I be considering? I am very worried about playing off one group against the other. As I look at the track record over the last few years, what I have seen is that providers, managed care organizations, and others have been competing for the best risks. And the cost pie is not getting any smaller; it is getting bigger. I am not sure we are doing anybody any good.

I can tell you that we work vigorously at bargaining tables with employers every step of the way and try to cut deals with providers, managed care entities, and so on. We have done that but, I think it has been at the risk of increasing costs for some other group that was not

as well positioned economically. I think the problem is coming home to roost now.

I am not sure what the best answer is to that question. I think that there is a compelling case to be made for extending DRGs to all payers, to locate and add an RVS system for all payers, and to really establishing some equity here so that providers do not play consumers off against one another.

But I do think that there is also a real need to start looking at capital budgeting in the system. It is very disturbing when you look at our reliance on capital relative to other industrialized countries. Some friends of mine have just returned from Germany, and I asked them some questions, about how the Germans talk about how little, relatively speaking, they have in terms of technology? One friend, who is a physician, retorted quickly that the Germans were quick to point out that perhaps we have too much. I am not sure what the right answer is, but we have got to start talking about that as a society.

But the important point for us is that when we look at cost containment, we do not think basically it should be done by government fiat. We are looking at models that would involve some negotiation with providers and consumers and with government as a player. That is one of the reasons I talked about government paying its fair share, because no system will work unless government is prepared to pay the costs that need to be borne.

I am very disturbed as we have talked over the last few years about expanding Medicaid and so on. Very good people have very good objectives in that regard, namely trying to get more people covered. But there has been very little consideration to the reverse side of that equation. When you look at the percentage of providers that participate in Medicaid and you look at what is coming down the pike, then we have to really begin asking some basic questions. But I would not presume to tell you that I have the answer about how to contain costs. But certainly there are some proposals that we would like to see debated.

Mr. Whaley: If what I hear from you is correct, it is that price fixing and price controls over the past have not worked and, in fact, they have done just exactly what many people have said they would, which is squeeze out services. Because Medicare pays a lower reimbursement

rate than the market might command, you have fewer and fewer providers willing to provide. Is that –

Ms. Ignagni: No; they provide. They just shift the costs onto everyone else. That is the problem. What we would like to see is some leveling of the playing field across all payers to try to eliminate the gaming that is going on in the system.

If people can think of a better way to do it, we are open. God knows, we really have a crisis out there. It has become *the* issue at bargaining tables. In fact 78 percent of the strikes last year were over health care, and I think things are going to get worse. This is in an era when labor and management are working together to try to solve the problem. We would look at any and all proposals. But we want to try to level that playing field.

Mr. Whaley: Do you have any comments on cost containment measures that are possible?

Ms. Steelman: Nothing that everybody in the room has not already heard 100 times.

Mr. Docksai: At the risk of repetition, let me just make one general comment. In industry, there is a big emphasis right now on quality performance. The whole emphasis is on quality performance, what the Japanese have done in the car industry, et cetera. Translating that into health care, there are many of us who believe in putting the patient first, or the idea of looking at what is or is not good for the patient. One of the great political things about the Heritage proposal is the whole notion of empowerment – giving the consumer a choice. Looking at the current system, at the analyses of the system from left or right, at the American health care system as one great money laundering operation where you cannot trace the course of a dollar, the great thing about the Heritage proposal is its openness, the ability to find the dollar. It goes to and from the customer, the patient. To me, that is the great political strength of it. Whatever form of it is chosen to pursue, it speaks well not only of the political future of the proposal but to the whole notion of cost containment by lowering institutional barriers which help to increase costs without being seen. Secondly, to support the point about "Outcomes" made by Dr. Paul Goodman of the

University of Minnesota, the argument being made is that 10 to 20 percent of health care expenditures are wasted. Dealing with these would not mean cuts in access to coverage, but it would mean creating a better system. There is something to be said there politically for the notion of quality, as well as economically.

Mr. Alexander: Alec Alexander, Congressman McCrery. Do you all share the view that the fundamental driving factors for health care inflation, as Heritage identified, is the perverse tax incentive and the insurance structure, as they have laid out? Do you share that? You talk about cost containment. But what do you each of you see as the fundamental problem, the cause of the inflation that makes price increases in health care so much higher than the CPI?

Mr. Docksai: It is accountability. Many instances can be given in the present system where the question of who pays is hidden. Much has been written about the third-party payment system, and I do not want to repeat it all here. But to me, it is a fundamental problem in the system. Whatever system is finally adopted, it would seem to me at least that getting away from the notion of hiding the dollar, and using an institutional apparatus to make the dollar accountable to the consumer, would be a way toward changing basic behavior economically.

Ms. Ignagni: I have always had a problem with my good friend Ron and others in the conservative community about the framework of the analysis. I think I would raise two issues. One is, in any particular benefit program or plan, 70 percent of the costs are really borne by five percent of beneficiaries, two to five, and 70 to 75. You know that the parameters bend depending upon the group. That is the first question: Whether or not people would, when they are critically ill and falling into those situations where there are high cost cases, change their behavior based on what insurance they have. I suppose they would. Maybe they would ask providers a few more questions.

But I also think you have to couple this with the realization that these folks are often critically ill and unable to ask questions, and we must consider what happens to people when they are critically ill. We have to think about there are ethics involved, and it is a matter of sociology, as well.

Then I think you have to couple all this with the Rand data about inappropriate utilization, unnecessary tests and unnecessary procedures. Frankly, we have to begin to ask questions about who is driving that. I won't give you the answer that, perhaps, you might expect. I do not pretend to come here and say that is totally provider-driven. But it is certainly not totally consumer-driven. Somewhere in the middle is the right answer.

So, that is why I have a problem with any explicit and fundamental reduction of the problem to one particular factor because I think it is a tad too complex for that. I think there are a lot of things going on. If there is one thing we have realized over the last few years, nobody now talks about solving this just through government action, or solving this just through consumer purchasing.

Where I really agree with Ron and Debbie is that informed consumers making informed choices will play a big part in any solution. It has to. The working of the delivery system has to change. But clearly, providers have to change the way they practice medicine. The question is how to bring that about in a reasonable way. Reasonable people are going to disagree, I suppose.

Ms. Steelman: There is no question that the isolation of cost consciousness in the context of the decision plays a big part. But I guess I have to agree with a lot of where Karen is headed. I think physician education right now is a tremendous area of potential savings. It is very procedure oriented. Some ideas about changing personal behavior won't do a thing for costs. Clearly technology is a big problem. Personal responsibility outside cost-conscious behavior, such as smoking, alcohol, and violence, is a big part of our problem. There is nothing that we are going to give to the violent inner city in terms of a tax credit for insurance policies that is ever going to change that.

There are bigger issues at stake, such as cost shifting. Clearly the government's responsibility is to live up to its own obligation. I would agree with Karen's opening statement: The more you know, the less you know.

Mr. Krystynak: Chris Krystynak, Senate Budget Committee. I would just like to respond a little bit to the question of cost containment. I think, to some degree, cost containment is a red herring. We ought to have a better look-see at cost containment because most of the cost

increases that we see are introduced by increased coverage and increased utilization. Certainly a good portion of it is due to input inflation.

For example, in the Medicare, Part B, we see a 10 percent rise per capita. Half of that roughly is due to input inflation, but about three-and-a-half percent of that is due to an increased share inflation that is due to the fact that the $75 deductible is not keeping pace with what the people are using. They are pushing more people into the program, and then more money is coming out of the program. Another 2 percent is due to increased consumption on the part of the elderly, due in general to the rapid rise in real income that the elderly have incurred over the last few years. Of course, that translates into increased utilization and increased demand for extensive technology.

I think we have to differentiate very carefully. I think we are doing a very good job on cost containment. Certainly PPS has kept parts of the costs on Part A down very well. Your proposal is to extend some sort of approach like that to other systems, not necessarily an all-payer basis.

RB/RVS will make some dent in the issue of appropriateness of care. That will be helped by the protocols that you are looking for. But I do not see that we have this gigantic problem of cost containment outside of the issue of expanding coverage. So, when you talk about cost containment, you have a great deal to talk about if you want to talk about managing people's demands, and stopping them from demanding things. But I think the Heritage approach gives people the opportunity to manage it for themselves rather than have the government manage it for them and tell them what to use and what not to use.

Ms. Ignagni: Again, it all depends on what you think is driving the demand. Is it consumer-generated? Is it provider-generated? Is it a little bit of both? I do not disagree in principle with what you say, but I do think that reasonable people disagree about what is, in fact, the problem, and therefore what are remedies.

Mr. Docksai: There is obviously some level of disagreement here, but there is also more agreement than perhaps meets the eye in terms of definitions. Some people confuse the term "cost" with "value." A mathematician would look at this and say value equals benefit over cost.

Looking at health care, what I was talking about earlier concerning Paul Goodman is a point very often made by our friend, Dr. Jack Meyer. He talks about the amount being spent federally on health care. He is not shocked at all to see that 11.6 percent of our GNP is spent on health care. He says: "I am not shocked at all by the increase. I am shocked by the question of efficiency and economy, how it is spent, what value we get from it" – the very point you are making.

When it comes to the value to the patient, the value of that money being spent, a man like Goodman and others who do cost-benefit analyses would come in not to make the point that we should be spending less on health care, but that for what we spend, we are not getting enough value for it. Here, it is a question of individuation, of allowing more of an increase in competition for these services by the consumer. Increasing competition, a number of us believe, would increase that value. I think that is a basic tenet.

Mr. Haislmaier: Can I make a comment? I think that is very important, and it is part of what we were trying to get at. Maybe we did not express it as well in the monograph as we should have. The point is that a system like PPS, the DRG system, or the relative value scale, is meaningless if it is just controlling cost, since you do not know what you are getting in return.

Frankly, it becomes even more meaningless to talk about it when it is shifting costs to somebody else. Those systems will fail. And it can be argued that PPS is failing now. They are having serious troubles trying to even get RB/RVS off the ground because it does not address the question of what we are actually buying. It does not matter whether it is $5 or $2 if you do not know what it is relative to the benefit you are getting. That is why the command and control systems will always fail. Price controls will always fail because they cannot measure the other side of the equation. That is what we are trying to get away from.

Our position on who is driving demand is indeed heavily dependent on saying that consumers are driving demand. But the other point that we are making is that we can see that providers do create a lot of this. That, we concede. But we point out that consumers have no incentive to resist it.

The other point I would simply make is that when I talk about consumers and providers, I would put the insurers in the provider category of offering a service. So that, yes, the consumer maybe is not

price sensitive when he is having a heart attack or a major operation, but his insurer is acting as a surrogate. And the patient can be price sensitive in what he is getting in his purchase from the insurer.

Ms. O'Beirne: We are just about to end. People have been so patient and so interested all day long. We do not want to keep you longer than we promised. I just want to end with one general question, if I might, asking each of our panelists to respond quickly.

Ron mentioned the idea that the notion of empowerment is so powerful politically – the idea of having a system that allows families to decide where to purchase health coverage. Anybody who favors this proposal has got to identify who the constituency will be and somehow get them motivated to do something about it. Coupled with that, let's go back to comments made earlier this morning by Gene Steuerle from the Urban Institute, regarding people similarly situated not being treated very well by the current system.

Would you all be good enough to just comment quickly on the political dynamics of a system that empowers families to make their own decisions on their own behalf and provides them with the wherewithal to do it. And on the fairness issue, a system that demands that people similarly situated be treated similarly, and that provides the sort of mobility you want in the job market to move from place to place and not have your family's health insurance coverage interrupted. Might not those powerful ideas – ideas that in the child care debate wound up after two years reversing what originally began as a very different system based on government management of day care. Because of the potency of those arguments, might not those backing this plan be optimistic?

Mr. Docksai: What you are really asking is: What do you have to tell the crowd in order to get them to storm the Bastille?

I think those who are in the Bastille are often big companies. I say that tongue in cheek. But those who are in big companies look at their actuarial base of what they would lose under this kind of system. But the benefits to small employers, to independent businessmen, and to consumers generally – that great political benefit would be so carryable that it would overwhelm the political forces of the large employers looking at their unfriendly liability situation.

So, if I understand your question correctly in terms of where the political forces are in giving our prognosis, the great political forces are with those various associations, with small employers, with the consumer generally. Working for a very large employer, I would make the case that in the long run, it would be benefited. In the short term, there might be a political dichotomy there.

Ms. Ignagni: I think that your proposal could meet that test, Kate, as you have outlined it. I also think that a Social Security insurance kind of model could, as well. Probably the Congress, when they are ready to decide, will decide somewhere in the middle.

I think that it is important for people to keep the dynamics you have talked about in mind – particularly that access to health care should not depend on whether an individual is employed, for whom he or she works, how many hours, and so on. In that sense, Social Security is an interesting model in that there is employer-employee involvement, no matter what employer you work for, where you go, et cetera.

Finally, I think that the answer is probably somewhere in between. In everything we have talked about today, clearly the empowerment of the consumer is very, very important, because if we have learned one thing, it is that we need to know more about what is going on. But also, in terms of fairness and equity, we simply cannot have a system where providers are allowed with impunity to play one payer off against another. Even though a payer gets a short-term discount, the overall payment pie continues to get larger. That is a cause for economic concern.

So, I always end up with the thought, as Winston Churchill said, that you can always trust Americans to do the right thing once they have tried everything else.

I think we are probably in that mode in our society. I guess if all of us move away from our ideology a tad and are willing to talk about various proposals, then we might get somewhere.

Ms. Steelman: I am going to take a page out of Ron's book and quote a source. One of the books that was very instrumental in my thinking is Dick Neustadt's *Thinking in Time.* He puts forward the thesis that inappropriate analogies from history will get you in trouble every time.

Child care as a precedent for empowerment on this issue is an inappropriate analogy from history on at least two grounds, if not more.

Number one, it is additive. Totally. The child care proposal is asking for a lot more money in lot of people's pocket. Number two, that group of people, namely, parents, is not accustomed to a regulatory structure in raising their children.

So, it was a very novel and powerful idea that we were able to articulate. We could say: You do not need regulations; you raise your own kids. It is a very different thing going into a system where everybody is accustomed to regulations out the wazoo. Now, they may hate it. Or they may say they hate it. But they get it from their insurance company, they get it from Medicare. They get it – it is part of the system. So, to get people to think in terms of empowerment is a very different notion in health care than it is in child care, at least to my way of thinking.

It seems to me that one of the most powerful precedents for the empowerment idea is that people are, in fact, disenfranchised in some way – so you are going to franchise them somehow. One of the problems in doing anything in health care is that 85 percent of the population is franchised through Medicaid, Medicare, or private insurance. So, you have only got 15 percent of the population that you would be trying to sell the empowerment rhetoric in the same way that we did with child care.

So, while I do consider empowerment a very powerful tool in terms to putting forth political ideas, I do not think it works quite as smoothly on this issue.

Rep. McCrery: Jim McCrery. A big part of your 85 percent of the universe that is already franchised, as you put it, would see this as an additive. They would see it as a benefit that they are going to get, as a tax credit they are going to get that they do not now have.

Ms. Steelman: Where you stand depends on where you sit!

Rep. McCrery: That is what I am saying. But you cannot just say 85 percent of the people do not see this as anything good and juicy.

Ms. Steelman: Not in the simple way that child care was. I was just trying to say I think it is a little different.

Rep. McCrery: I am just saying, though, that there is another group of people, and a pretty powerful group, that you can rally around the