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HAMILTON PROJECT POLICY SEMINAR

EVOLVING BEYOND TRADITIONAL EMPLOYER-SPONSORED HEALTH INSURANCE

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Welcome:

JASON FURMAN, The Hamilton Project

Policy Presentation:

STUART M. BUTLER**,** The Heritage Foundation

Roundtable Discussion:

JASON FURMAN, Moderator

Respondents:

JEROME GROSSMAN, Harvard University

LEN NICHOLS, New America Foundation

JOANN VOLK, AFL–CIO

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P R O C E E D I N G S

MR. FURMAN: The Hamilton Project is undertaking significant work in the area of health reform which we see as critical both for its own sake and for the economy more broadly. The first round of papers, which I think are available in the back, are concerned with improving the affordability and effectiveness of health care. And then this summer we are going to have an event on July 17, a big event that I encourage all of you to come back to, where we say that we all agree that we should have universal health insurance or be moving toward the ballpark of universal health insurance, but the really big question is what is the best way to get there? And what is the best way to get there is a question that depends part on where you want to go and which system works best, but also on which system you actually can transition to, the difficult problem of starting with the complicated system we have today and transitioning to the next one.

As a preview of that July event when we are going to bring together Jerry Anderson, John Gruber, Zeke Emanuel and bring Stuart Butler back, we are presenting one of those four papers today and it is by Stuart Butler, and it is an approach to move us in the direction of universal coverage. Stuart is the Vice President for Domestic and Economic Policy Studies at the Heritage Foundation, and we are glad he is going to be presenting this paper. He has been working on this issue, and I say there is a consensus lately, Stuart has been for the most part of this consensus for about 20 years and was recently named as one of the dozen key players in the debate over how to deal with the uninsured.

Then to comment and discuss Stuart's proposal and his approach and maybe describe a little bit what some other approaches would be or maybe we could even make a deal right here on stage and take a bit of Stuart's and a combination of everyone else's and solve this problem, we will have first Jerry Grossman, going in alphabetical order, who is a Senior Fellow and Director at the Health Care Delivery Project at the Kennedy School of Government. He is a physician who also served on the Federal Reserve Board in Boston for a decade and is leading up the Committee on Economic Development's significant work in the area of health reform.

After him, Len Nichols who is the Director of the Health Policy Program at the New America Foundation and has worked in a number of health policy jobs with the Urban Institute, the Center for Studying Health System Change, and worked on the last major health reform effort in 1993-1994, and maybe he will offer us some predictions for how Stuart can avoid a similar fate for his proposal.

Finally, JoAnn Volk who is a legislative representative for the AFL where she has been since 2001 working on health care issues, and then she also has a significant health policy background from Abt Associates, and a master's degree from Johns Hopkins in health policy.

Stuart will go first; we will then have comments on the proposal, then open it up to a discussion on stage, and then bring the audience in.

MR. BUTLER: Thank you very much indeed, Jason. I want to thank The Hamilton Project and Brookings for actually allowing me to write this

paper and to spend some more time here at Brookings. I have spent a lot of time down here at Brookings, so much so that I think back at Heritage people are beginning to get a little nervous. When I said I was coming down today, I think I got sort of the reactions where I must be evangelizing again or I am going over to the dark side, and maybe it is some combination. I am not sure.

But anyway, certainly I was pleased to offer a contribution to these series because I think the whole issue of economic security and health care is something which we all must be concerned about and are concerned about, and I hope that the many years I have been working on this which has very much affected the way I think about these things and the prospects of how to move from A to B, and that is very much have shaped the ideas in this paper. I hope that leads to a thoughtful discussion. I think we have an opportunity to really move forward on this issue if we do this carefully and as broadly as possible.

I immigrated to the United States about 30 years ago and I think like all immigrants to the United States, one of the things that surprised me, actually rather shocked me, was that your access to health care and what health care you got depended on who employed you, and it differed widely. This was a real curiosity to me as it is I think for almost everybody who comes because it is really unique certainly in major countries this system here. So I have spent a lot of time pondering that, and I think like a lot of people who have pondered it, we see a system today which I think most people would say is creaking and may be leaking. It is creaking in the sense that I think many people feel it is under enormous strain, that there are all kinds of issues associated with it that worry

people who are employed, and employers, and people who are concerned about the issue of universal coverage, and it is leaking in the sense that people are becoming uninsured particularly in certain employment sectors and that worries people, the growth of the uninsured and so on and the trend line in that area.

So I thought a lot about this and the paper is really an attempt to see how we can chart a different course for the employment-based system, that uniquely American institution, but do so recognizing that it has got to move in a somewhat different direction to reflect what is really going on in the real world.

The premise of the paper is not, and I want to emphasize this, is not that the employment-based system in the general sense of the word should be abandoned in this country. It is, however, that the sort of classical, traditional version of employer-sponsored insurance cannot deliver the goal of economic security for millions of Americans and it must be helped to adapt into a somewhat different design in order to achieve not this universal coverage but security for those who are within it. So the aim of the proposal is to revisit and somewhat change laws that in my view currently constrain the ability of the employment-based system to adapt, that these laws are obstacles, and actually the way we think about it to some extent is an obstacle to this as well. The idea by doing this is actually to strengthen the notion that your place of employment is important in how you get coverage, but to allow that system to evolve so that the objectives of universality, of assurance, of choice in coverage and so on are achieved.

Why does the current system need to evolve? Just very briefly let me share the symptoms that I think we are all aware of which undergird the

concern. We see a steady decline in the share of Americans covered by employer-sponsored insurance. It is slow but steady over time. It changes somewhat with the business cycle, but we see a general pattern. We also see particularly that there is a chronic decline in the area of people who work for small firms and in the service sector, part-time employees and so on even within the employment-based system. One can see parts of the employment-based system particularly in the small business sector where for many Americans the notion of employer-sponsored insurance is a theoretical construct; it does not apply to them in terms of their real-world situation.

We also see of course an issue of portability. People have coverage but they worry at the very least things change when they change jobs. Maybe they have to go through spells of uninsurance, maybe they have to into COBRA, and suddenly their costs shoot up. There are lots of issues which can all come under the general rubric of insecurity in the current system.

There are reasons why this is happening today and why it is likely to become more the case even in the future. One of course is that we are in a society of working Americans who are much more mobile than it used to be and that is likely to increase and continue. People's connection to the place of work than before, so issues of portability. Issues of how long do I expect to work for the same employer. These things are likely to become more problematic for an employer-sponsored system in the future than they even are today, and that trend is likely to continue.

Another related reason of course is that small employer, small groups, the gas station next to Heritage that has probably four employees, this is not a very good group for insurance purposes for spreading risk for enabling people to get the benefits of group insurance, and the more people as we are seeing in the trends who work for small firms or set up their own firms or go in and out of small firms, the more that is a problem over the long haul. We also of course see that employers, particularly small employer who do not have a lot of connection to their own employees, who have a high turnover of labor, people in restaurants and this sort of thing, are not terribly good at picking insurance for their employees and for feeling a sense of connection to that employee over time or their employees' kids over time. So employers particularly in the small-business sector are not terribly good as agents, as organizers, and as people who are going to have the connection to this person over time.

Then of course we have a tax system which is almost designed to be the worst possible way of helping people get a subsidy for their insurance. It is tied to employer-sponsored insurance only, so if you do not have that, you are in trouble, you do not get covered. It gives the biggest amount of help to the wrong people. The people in the boardroom get phenomenal tax benefits, the person who is on the shop floor or the janitor gets very little if any, and so on. It is very inequitable. So other than all these things, it's a pretty good system. So there are real reasons why these trends are occurring and why if we are sensible about it we must think about how we can help this system down a different track in order to get the objectives we want but recognizing the problems with the current system.

So broadly what would I do and does this proposal do in broad terms? Let me say the first thing in terms of strategically, I don't use this term in the paper, but to take what I would take the policymaker's Hippocratic Oath, first do no harm. So the proposal intends not to undermine the parts of the current system that work tolerably well, and I emphasize the word tolerably. I do not think it is perfect. I do not think it would have been set up this way if we had really started from scratch and thought about it, but some parts do work tolerably well particularly in the large-business sector.

Doing that I think is important for a number of reasons, keeping what works tolerably well there. People are used to it. One of the things Bill Clinton learned the hard way is that people may gripe about health care in this country, but they are not wild about big changes. So the notion of disrupting even something that they are not 100-percent keep on is not a great idea in my mind.

And also I think it is important to recognize that there are certain attributes of large, stable, employer-based plans and systems, the large corporations where are people are connected for a long time, do have certain significant advantages and one would not want to undermine those. So I think doing no harm to the bits that work I think is both politically wise and also a substantively important thing to do. Meanwhile, allow the parts that do not work so well to evolve in a more modified direction that allows a sort of parallel vision to go alongside this more traditional vision with the objective of making it better for everybody, and to do this in a gradual way.

I am a conservative. I am in favor of gradual change. I am not big on revolutions. They do not often turn out quite the way you want. It may have been all right in the United States, but the French had a different experience back at roughly the same time. So let's be a little cautious about making a big change to one-sixth of the entire economy at one fell swoop. So I like to look at ways of allowing things to kind of adapt gradually over time, and you will see that very strongly emphasized in the paper.

There are three basic elements of what I think need to happen in terms of moving forward to allow the current system to evolve in this somewhat different direction. The first is to really build on the experience we have had with the idea of what we will call insurance exchanges, the notion that there can be some entity outside the place of work that can group people together, that can offer a menu of plan choices with certain rules, certain ways of aggregating premiums and so on, roughly what, if any of you here work for the federal government, you have within the Federal Employee Health Benefits Program where you have separate literally from your place of work, the office to work in, a system, an organization, a market for plans that is available to you and can be structured in a way that allows you to move from job to job and yet keep the same plan if you so choose. And similarly, the connector mechanism in Massachusetts is another version of these insurance exchanges, the idea of setting up both a pooling mechanism and a plan exchange outside the place of work available to those for whom that is a better alternative is the first key feature. This would offer a menu in certain situations, people who work for certain firms, would be

able to via their firm to get access to that system much like if you worked for the federal government you get access to the FEHBP, I do not get access to the FEHBP, it depends on that, and the connector or the exchange would aggregate premiums, and that would be a mechanism to do that. That would require certain changes.

It would require states to set up the architecture of such an exchange, and I suggest specific things that the states would have to do which would include setting the rules and requirements for plans to offer themselves through such an exchange, decide on what requirements, either voluntary or not voluntary, that employers should be part of this exchange system. I believe that is something that should be resolved at the state level, not at the federal level, and would be in the line of the normal rules that states apply.

Workers would go through their place of employment to get access to plans available through this exchange system, and the state in the context of the exchanges would set the rules with regard to pooling arrangements, risk adjustments, high-risk pools, the sort of things they do today but in the context of an FEHBP-like system of an insurance exchange.

The federal government's role in this is critical but limited, just as it did in Massachusetts. What the federal government did in Massachusetts was essentially say if under its plan you have an exchange and somebody gets their coverage through that exchange by their employer, the tax benefits to them are the equivalent of those that would apply in the employer-sponsored coverage in the traditional system that we have today. So the key thing in my mind that the

federal government has to do is clarify either in statute or in explicit regulation that if you have an exchange system and you get coverage from that via your place of employment, then you get the same tax benefits as if the employer sponsored the whole thing themselves. That is a critical thing to get clear.

The second element would be really to envision actually, and then make some changes accordingly, employers as in many cases more a facilitator of coverage rather than a sponsor of coverage. What do I mean by that? If you think about traditional employer-sponsored insurance, the employers do two things in that. They manage health care itself or manage insurance, they pick insurance, they organize it, they select it, or in some cases if they are self-insured they literally run the whole thing with some administrator doing it in part for them. Generally, sophisticated firms are quite good at doing that and do that fairly routinely. But the second thing they do which is related to this is they handle financial transactions. They handle the money for you. If you have an employer-based plan, the employer will make a payroll deduction for you; they will allow you to change your W-2 form or your W-4 form so that you can take whatever the necessary benefits. The employer does a lot of paperwork facilitating functions much as they do in areas like some of the retirement plans where you have a 401(k) plan and the employer doe not invest your money, does not typically these days even select the mutual fund, you do that. The employer does paperwork. So I think it is very important in the health area to imagine that employment-based insurance is really two things, running insurance, and handling money and doing paperwork, and I think it is very important for us to differentiate that and to think

in the future what we may and should see is some employers continuing to do what they do today, the whole thing, but other employers basically limiting themselves and focusing on doing the second function with an insurance exchange really being the place to which people actually get their coverage and organize that way and the employer's function is limited, important but limited, and even small employers are quite good at doing that, they do that all the time already, and so understanding it in that way. That requires some changes in terms of what would be the rules associated with this, how would money flow from an employer to an exchange and so on. These are the things that states should I think take the lead in, but the critical thing for an employer to do would be to set up some kind of payroll deduction system and make any changes in the tax system, tax liability, of their employees through this system. So understanding that difference of how employers should function is a key second part of how I imagine the system to evolve in the future.

The third part is to look very firmly at the tax treatment itself. Certainly if we merely only encourage and allowed states to set up insurance exchange systems so that people who work for small firms and others could go directly there much as you do in the FEHBP, if we were to do that and if we were to have employers really facilitating that kind of coverage in the way that I mentioned, we would get a long way I think toward improving coverage, getting a lot more people covered, having the gas station next to Heritage actually doing what it can do better, and yet enabling people to get portable coverage and to get good plans.

But if you tackled the perverse problems of the tax system and the inequities of the tax system and fix that too you would in my view see a dramatic improvement in coverage and a fairer system and so on. That would be an additional beneficial and valuable component to the whole thing.

I think you can do that in various ways which I mention in the paper, but basically I think what you have to gradually do over time and everyone can do this, the various methods of doing it is to gradually taper down and put tighter and tighter limits on the current open-ended insurance tax exclusion that we currently have for employer-based coverage at the same time as you gradually put into place some form of refundable tax credit for people at the lower end of the income level. I think we've got to fundamentally change the tax treatment to make it more equitable and so on and not exclusively tied to the place of work. I think if we do that as well, we would begin to see a very significant push forward in the direction that I mentioned.

So to sort of sum up in terms of what we are trying to accomplish here in this approach in terms of thinking about the system, it is as I emphasized at the beginning to strengthen what is a uniquely American employment-based system by making it much more compatible with today's workplace realities and recognizing the inherent problems that we currently have in the existing system. Under this arrangement, this way of looking at it which I call the Health Exchange Plan. Jason and I were kicking around names earlier, everybody has to give a name to their proposal, I wanted to have the Health Security Act but I gather that was taken and has a rather dubious pedigree to it.

Under this kind of system, basically large employment-based system, the large-employer-sponsored system of today, would pretty much continue as is, large firms and unionized firms and so on pretty much as they do today. The change would begin in my view in the smaller firms because they would now have a new option to effectively offer coverage to employees not by running it themselves, but through an exchange. The firms would be the point of entry. The firms would make these decisions. So to reduce concerns about adverse selection, if you were to allow individuals to make those decisions to go into an exchange or otherwise, you could solve a lot of problems in terms of that which we well understand. The firm however would continue to be the point of entry to address that.

In terms of families directly of course you would now see an opportunity to gradually build a system with real portability where people could pick a plan, particularly if they work for small firms, where they could move from firm to firm and yet have a plan through the exchange with the same tax benefits wherever they go, no change with whatever their current firm is, with their employer simply doing the administrative paperwork and payroll deductions and transfer and aggregation functions to achieve portability and security in that regard. You would have changes in the tax system which would mean people who at the moment cannot afford coverage who are workers would have greater opportunities to do that.

You would also have the prospect of a longer-term relationship between yourself and the plan that you are in and thinking about what that would

mean. If you have a long-term contract between an insurance and an individual firm to firm, that is a very different relationship than if you are just simply covered for a very short period and it changes every year and so on.

And also it would be possible I believe that we would see all kinds of intermediaries beginning to develop around the exchanges much as we see within the FEHBP that represent interest groups or agents to act on behalf of employees. We have for example in the FEHBP a number of union-sponsored plans where the goals of the union and membership of the union, the ordinary membership of the union, is part of being in the FEHBP for many people. I would imagine that growing. I think of church-based plans and so on where people have a certain value system, an attitude and so on, that might be reflected. It would allow in my view in other words through an exchange system plans that reflect people's values, long-term objectives and so on that we do not have at all today. So I believe that with such an arrangement in place I think we would see a workplace-based system gradually evolve and change over time in such a way that it would really help us move toward the objective of universal coverage in a way which allows real choices by individuals, a reasonable balance between what we currently have in the benefits of the employer today particularly the paperwork handling functions of employers today and yet not be locked into the problems of sponsorship that we currently have.

And I think with other reforms elsewhere in the health care system, in the public problems, in Medicare and so on, I think by focusing on the employment-based system in this way these kinds of approaches are very

compatible with what other people are thinking about in these other aspects of the health care system and I think would allow us to move toward the goal that we all have of a system where we really can count on continuous affordable coverage in America which is the objective we all share. Thank you.

(Applause.)

MR. FURMAN: Jerry Grossman?

MR. GROSSMAN: Thank you, Stuart. I really enjoyed your paper. I would like to begin by being a bit contentious about a couple of your assumptions. One is that my and our assessment at CED of the large employer community is it seeks an exit just as much as anybody else. It believes that providing health benefits is not a core competence, it would indeed engage in making contributions which I will come to a little later, but it does not see itself as having that core competence.

The second part is that if you look at many Fortune 500 companies, they have outsourced their HR management so it is not that they have skill set to do that work. As a matter of fact, you will find that there are fewer than half a dozen major companies that are consolidating that skill set. Starting there, we moved on to say that we also wanted to look at a phased approach to how one might get as you suggest without revolutionary change from where we are today to where we might be a decade from now.

I think the second part is that our belief is that state exchanges are not going to have the heft and be done equally such that you could move to a federal insurance program and, rather, we call for the establishment, and you will

know where that comes from, of a health fed which if you will remember about the Federal Reserve, it was the negotiated settlement between the populists and the bankers about creating a semi-independent, self-funded, and in this case we would suggest that insurance premiums be provided to self-fund this health fed, and it would have a dozen regional exchanges. A caveat here is I have been assured you do not ever want the government building information systems, so they would put out RFPs to have someone else build them. I see Stu out there. We know that all Medicare claims are managed by outside intermediaries. So that the idea here is there would be standardization in what is offered yet recognition of the differences especially at the outset in the wage costs, the way of delivering service. It is bigger than a state, smaller than a national exchange. But importantly, the creation of an oversight agency which is independent of the normal factors of government.

Here the major thrust of those would be if you look at the two jobs of the Fed, it is inflation targets and maximum employment. I have squeezed in with a little difficulty, but if you could imagine, a critical issue to me is that Stuart's plan and many others do not face the reality that unless we can bring down the inflation of health care expenditures, anything we do now will not work 3 years from now or 5 years from now. All of the carefully balanced affordability issues will be gone. So we suggest putting together that a fed board for 14 years would be annually thinking about affordability and targets for inflation and it would use productivity numbers which is not something we do in health care, but we would develop productivity in the service industry and look at who is

performing at what level and have an agency on comparative effectiveness to clear out the issue of what new devices and drugs are better than the ones we have now. That is probably a bigger jump in the discussions that might go on politically, but I think that we want to put that out there and see whether or not that is a framework that others can buy into.

I guess the final one is to phase out employer-based insurance, and it is our belief that if you add up all of the prices that are paid by the federal government now, as Stuart talked about, the support of tax policy planning, you could begin to over time start with creating a given contribution by employers close to what they do now and as it was ready, you would create what we call a FEHBP for all like the FEHBP run by the regional fed so that their ability to both accredit and make accommodation for the institutions in their region would exist both at the outset and over time. And that over time the objective would be for that fed to set a standard benefit often like the FEHBP and one that is quite full rather than a minimized and that then it would be moved to the federal budget of general revenues and the expectation is that everyone would be able to buy a full and low-price plan and that anyone who wanted to buy up could buy up just as they can now.

So our belief is that on one side we would preserve most of the options that everyone has now, but what we would also do is create an opportunity for easy entrance for innovative products, people that use a different skill mix so that it was not all doctors that put together more convenient care and that preferences of various members of the public would be able to be met. So it

is our belief that this combination of a public oversight agency and then an opportunity for productive, innovative, private-market building of various plans would be the best mix but with the federal government becoming the eventual payer in this clear future of globalization and a dysfunction labor market that is created by this benefit now being across large as well as small business. Thank you.

(Applause.)

MR. FURMAN: Len Nichols?

MR. NICHOLS: I too want to be contentious, but I will start by pointing out that I actually wore my Heritage tie today which if you have never had one, it has a Liberty Bell on there which is the whole point, and that always makes me think of Thomas Jefferson and apropos of the remarks about how we are for evolution and not revolution. I will remind you that Mr. Jefferson said among other things, "A little revolution now and again is a pretty good thing." So I think it is entirely a good idea to think about revolution.

Let me just quibble a little bit with not anything Stuart said, but I will say an interpretation of those who end up being a little bit tax-centric, that in fact we have the employer-sponsored system not just because of the tax changes, but because of the administrative selling and risk-pooling economies of scale. In fact, that system had begun well before the tax changes that indeed turbocharged this expansion of the employer-based system. But that set of efficiencies which are obtainable are exactly the kinds of efficiencies Stuart would obtain and preserve in this exchange, and therefore I am applauding that. I just want to make

it clear that taxes did not do this alone and therefore just focusing on tax changes may not be quite enough.

The second point I was going to make is a factual quibble, one Jerry just made, and that is the last time I looked, big employers do not like this either. In fact, if you look at the Business Round Table's embrace of Divided We Fail Coalition with AARP and SEIU, Wal-Mart is reaching across the arguably Middle East-like chasm to shake hands with Andy Stern, these are very different business models that are reaching out for some kind of way forward and I think that is indicative of the fact that it is not working for big firms either and therefore I would submit that Stuart stops a little short in having his exchange focus exclusively on small firms.

But let me first praise, because indeed there is a lot to praise here, there is much to like about the creation and the support, the analytic thought that goes behind the creation of new insurance markets, and in the spirit of Jason's request that I give free advice about how to avoid the Clinton fate, I would just say do not call it a HIPC whatever else you do, and a purchasing cooperative polls very well actually in rural Wisconsin, but not anywhere else, so do not call it a purchasing cooperative, exchange works very well, thank you very much.

I like these markets and I like them because they are organized in states which allows them to reflect local market conditions. You might have heard this rumor that health care markets are local, they are not national, and therefore it actually useful to have them breed.

Having said that, I will now turn to the contentious part. I must admit to being somewhat disappointed because I have such high expectations for Stuart that there is not what I would call a ringing clarion call for universal coverage here. I say this is a disappointment in a serious way because I know actually Stuart understands the moral case which you know is as old as the Torah, and unlike most of us, Stuart can actually read it in Hebrew so he knows what is in Leviticus quite well. I would just say we all know it is real, we all know it is there, obviously he is committed to it, but in this paper he chose not to make it a central focus and I would submit that is a shortcoming that is quite serious.

I would say in the search for bipartisan solutions it has to reach to the level of covering everyone. In fact, this very day, Senator Robert Bennett of Utah agreed to co-sponsor Ron Wyden's bill which calls for universal coverage. And in building by the way state-oriented exchanges you could wrap Stuart's proposal inside the Wyden-Bennett framework, but I think the fact that Senator Bennett in this environment, just think about what happened yesterday on the polarization front, agreed to co-sponsor a bipartisan bill to reach for universal coverage around making markets work seems to me to be worthy of this is where the bar has to be set, se have to cover everyone. Therefore I was disappointed to read the kind of maybe throwaway line of oh well I think what I propose will get us very near universal coverage.

I think it is fair to say that subsidies up to the level of 200 percent of poverty would be better than what we have now where I don't know a single health economist who thinks that kind of subsidy level would be sufficient to get

us near universal coverage. Economists are bad at many things. We are real good at elasticities. We do that in our sleep, and no piece of work has been more overdone than the question of elasticity demand for health insurance and I submit the variants around those estimates is sufficiently vanishingly small it is not worth even debating. We are not, let me say it again, we are not going to get to universal coverage without mandates. You cannot get there by pushing on a strong. You've got to have mandates.

Now let me come back to Mr. Jefferson. Mandates I know worry people and they raise blood pressure and they get people excited and there is all kinds of consequences. Mr. Jefferson said, you know, sometimes we have to endure a great evil in order to avoid a greater one coming down the road. Mandates are not good, and they certainly contradict the American individualistic impulses, but they make insurance markets actually much more efficient. They make a lot of things possible that are not possible without them, and I would submit therefore you ought to really think about this. So mandates are required.

The second piece is more generous subsidies are required. There is no question that you are going to have to do that, and Stuart rightly laments the fear that if we impose the mandate without a sufficient commitment to subsidies, then you could have a situation like indeed some were determined to be in Massachusetts where Jerry just flew down from, are not going to find the markets affordable.

The solution to that is twofold. You increase the subsidy pie, this is not really hard, but the longer-run solution is exactly what Jerry said, you've got

to do something about getting the delivery system under control, you've got to do something about controlling costs. I submit to you we cannot muster the moral authority to do that unless we actually bring everyone into the system and make it possible for all of us to have access to basic efficacious care.

The third thing you need of course in the new system is a marketplace that is fair and efficient, and this of course is where Stuart's contribution is the greatest and where I give him very high marks, but I will say in my view it stops just a bit short of what would be the best, and in fact I would say maybe it's a little too passive. First of all, he would allow states total control over what the insurance regulation framework would be inside the exchange. There is nothing wrong with having states doing the regulation, there is a lot wrong I think with having a patchwork of rules about whether it's guaranteed issue here, community rating there, modified community rating here, there, and yon. I think you've got to have some kind of federal floor beyond which states can extend, and states should certainly be the entities doing the regulation.

Second, if you think about a modern economy, the whole point of a modern flexible global economy is there is going to be a heck of a lot of transition and fluctuation moving around. The average 20-year-old today is going to change jobs 15 to 20 times, whereas I have changed jobs five, and that is normal. So fundamentally we've got to have job change being possible. In order to make therefore the system fully portable, you've got to have small and large employers in the same pool. That is to say, you've got to get them all under one big tent.

And finally, Stuart would leave the nongroup market alone for reasons that I think are tactical and fitting the conservative impulse to not change any more than you have to, but I don't know very many people who actually would argue that the nongroup market works very well. And in fact, Massachusetts made what I think is a very wise decision and that is to create a connector or marketplace exchange in which the individual and the small-group markets are combined. That makes a heck of a lot more sense and makes it possible to achieve efficiency.

Finally, I would agree with Jerry, in fact I was quite intrigued to here where he said it. I've been thinking a great deal with some help from a number of my able staff to think about how do we get employers out of this. When I look at the 21st century economy I don't see how we can sustain as Jerry said us having health care costs built into the price of goods when we are competing with firms that don't. So first you got to make a market. The exchange has to be the first step. You got to have a place where people can buy efficiently and fairly.

Secondly, you got to have subsidies, no question about that. But third, you've got to have a one-time I would submit wage cash-out. You've got to fundamentally move from the existing employer contribution to health insurance, putting it in the wage base for those who had it last year, get the employer out, and from that moment on, given the commitment to covering everyone, given the subsidy structure, the affordability of health insurance is a function of the citizen and the state and the delivery system and that in my view should be where it is,

and that is essentially mustering the political will to make the delivery system far more efficient. Thank you very much.

(Applause.)

MR. FURMAN: Finally we will hear from JoAnn Volk.

MS. VOLK: Len had me counting how many employers I've had in my lifetime. I would like to thank The Hamilton Project for inviting the AFL-CIO to participate in this discussion today. In our March Executive Council statement we adopted a position in support of universal health care and outlined our principles for that reform and vowed to work with our members and employers to build the momentum to get there one happy day. So we are especially pleased to be part of this debate and welcome The Hamilton Project's contribution to the universal coverage discussion.

The central tenet of Stuart's paper that we need to build an alternative to our employer-based health care system is not only accurate, it widely recognized at this point. While that system works reasonably well for the majority of Americans, we know that the cracks in the system are growing over time. We know most uninsured are working families, small businesses struggle to afford health insurance, and firms that do right by their employees and provide decent health benefits find themselves at a competitive disadvantage both here and abroad.

In putting together this proposal, Stuart is right to be cautious about radical changes to the employer-sponsored coverage because of the central role it plays in our health insurance system, and he is right to be cautious about an

individual mandate absent guaranteed affordable coverage. But this proposal does not amount to a universal health care plan, and it does not address a central challenge to our health care system, runaway cost increases that put coverage beyond reach for a growing number of families.

Let's look at what the plan has as an option for coverage. The exchanges in and of themselves don't make coverage more affordable or available. We have learned that it is difficult if not impossible to get multiple insurers to compete in small states. Further, by allowing states to set coverage requirements and writing rules different from coverage outside the exchange, combined with the power to be selective about which firms are allowed in, this proposal suffers from the same adverse selection problems as the association health plan proposal. And by waiving nondiscrimination rules so that employers can contribute different amounts for workers to buy into age-rated coverage through the exchange, this proposal actually goes dangerously beyond association health plans and rejects one of the most successful features of the employer-based system.

Furthermore, an individual tax credit is not an efficient use of federal funds especially without limits on what insurers can charge and who can be excluded from coverage. Without a requirement that employers help finance coverage, the federally financed credit will supplant employer funds, and by making all under 200 percent of poverty eligible for the credit, coverage that may or may not be adequate and affordable will substitute for public coverage that is both. The credit is a far less efficient way to subsidize coverage for low-income families.

Finally, experience with the health coverage tax credit upon which the credit here is based has shown that trying to make a tax credit more usable has required significant administrative costs. Even with the decline from the startup costs in the early years, administrative costs run about one-third of total program costs.

And now what coverage is potentially lost or weakened under this plan? Certainly as noted, public coverage does not fare well, but employer-based coverage doesn't do much better. The cap on the tax exclusion for employment-sponsored insurance hurt those with good benefits, those who are more costly because of age of health status, and those who live in high-cost areas. It is also designed to tighten down and hit more plans over time with the growth in the threshold set at CPI rather than the much higher annual health care cost hikes. Merely asserting that health care inflation should look more like regular inflation does not make it so. The result will be a further weakened employer-based system, not a stronger one. While the proposal assumes some large firms will continue to self-insure, there are few incentives if you minimize the tax benefits for that and add a new benefit for people to buy coverage on their own elsewhere.

So while the employment-based system has its faults, it is in fact the only thing right now between the vast majority of workers and truly unaffordable coverage. A proposal to provide greater security to families must adequately address health care cost hikes and transition not leap to coverage guaranteed to be affordable and meaningful.

(Applause.)

MR. FURMAN: Thank you, JoAnn. What we would like to start with is Stuart to briefly respond to some of the comments he has gotten. Stuart, one of the things I am particularly interested in is at least two of the three comments and maybe all three seem to think you were not going nearly far enough. You said you were a conservative and said you wanted an evolutionary approach, so I wanted to know first of all whether you would be willing to be pushed further at this stage or if you see this as a first step in a process and how much longer we have to wait for the next phase.

MR. BUTLER: I think those of us who are analysts in think tanks do have multiple roles when we start thinking about these kinds of issues. I do think we do have an important role in terms of laying out what you might call blue skies kinds of models of where we might want to go which I have done on actually a number of occasions, and I allude to them in the paper itself that I have done earlier which do include mandates and a complete commitment to universality and so on. I think it is important to sketch out alternative visions of where you ultimately want to be.

But I think we also have another role which is what this paper is really intended to do which is to say in answer to your question kind of moving from A to B, and I think that this is what this intends to do, to if you like prepare the ground in such a way that we are more likely to achieve more radical approaches in the long-run than actually proposing them right now, and I think that that is a judgment call in terms of the way the political process works and so on. I can go on if you want to and just kind of touch on some of the points

because I think they all kind of fit into that in many ways in terms of how we think about the process of going from A to B.

I take Jerry's point, his first point, that there are a lot of large employers that are very frustrated with the current system and want to get out. I think then we are kind of faced with the situation about those employers, do we want to have a situation where getting out kind of means here's the money, good luck, which is overstating it, but it is kind of what is happening today? Or do we want to lay out a variant of employment-based coverage that all employers who want to get out large or small have some alternative vision short of just handing over the cash and just hoping it all works out. That is kind of what this plan is supposed to do.

I am worried about Jerry's proposal for a health fed. The notion that there should be some national entity that can decide what technologies to use and to decide what we are going to spend on health care and is kind of the font of all knowledge because it is large and federal is clearly going to be smarter than everything else I just don't buy. I think I would be very uncomfortable with that and the whole notion of standardization I think is antithetical to the idea of saying let's recognize our own limitations in terms of we should be encouraging a process of discovery, comparison, and so on. I think that is more likely to get to the right results than having the smartest people sitting in either the West Wing of the White House or in something called the health fed and kind of doing it making everybody fitting that. So I would be very concerned about that idea of nationalizing or federalizing this approach.

I think for all the problems associated with different states doing things in different ways, it is actually more likely to lead to profound insights and a consensus over time than trying to impose something through one model particularly in the context of the way the American political system works because then you have the dilemma of either you give independent power to such a body as we essentially do with the Fed in which case we don't have democratic control over that, or we put it into the Congress to essentially do that in which case we've got all the issues associated with congressional micromanagement. So that would be my concern with that.

I am glad Len Nichols wore a Heritage tie. I apologize for not wearing one myself. But if you want to make a large contribution to the Heritage Foundation, you can get one, or if you show up and give a talk which is what Len did.

I think again Len is right but he is seeing the challenge a little differently from what I am seeing. As I said, I am as committed to universal coverage as he is. I think the issue with larger firms and so on and which is one of the points I make is large firms can opt into what I'm talking about; I'm just saying they don't have to. With their ERISA coverage plans, the state cannot require them to. But in many instances I believe over time that employers will tend to think this is actually a better way of doing things and we will see a gradual movement in that way. That's what I think will happen.

On the other hand, I think when you argue that you've got to move forward now by saying let's mandate people, let's have big changes in the tax

treatments and subsidies, these are all big changes that I am not sure people are ready for yet. I am not against them, I just don't think the political system and the American public is ready. That's why I think a proposal such as I've laid out is an attempt to begin to prepare the ground and let people be comfortable with a different way of thinking about it, let's make some small steps in terms of changing the subsidy system, and so on recognizing that huge changes in the tax treatment of health care means large winners and large losers and I don't think that is going to happen in one fell swoop. I would rather see it, and I think it's more likely to happen, gradually. So that's why I favor going in a gradualist way toward a result which I do not disagree with Len on but I think has to be done in that way. And when I think of a mandate, and I have gone both ways on mandates as you know over the years, to and fro depending on how you think about it, I think the wiser way is to do as much as you can first in other ways of encouragements and incentives and so on and to the extent that you have a mandate, and there are arguments for certain kinds of mandates and levels of mandates which we don't need to go into unless you want, but there are arguments for that, I think that should be getting the final step, don't start with that before you've got a subsidy system in place that's meaningful for the reasons you've said, it would be unfair, inequitable and would require huge changes that we are not likely to see right now as a precondition to other changes.

I am glad to JoAnn jumped in to support my conservatism coming from the AFL-CIO of being cautious about mandates and cautious about moving forward. And I don't disagree with the issues that she raised in many respects. I

think questions of adverse selection beset any change in the health care system. We have to keep wrestling with that all the time. One of the reasons I argued for the states to really be the place to look at the whole picture is that I believe that one of the requirements of the states in this is to look at this issue of adverse selection and what is the best way of arranging the rules and so on. I think the state is the right place to do that, we can argue about that, I suppose, but I think it is the right way to minimize adverse section.

And I would also, and again this is probably not the place to go into great detail about the long-term argument we have always had about tax credits versus other ways and that kind of thing, but certainly I think that you've got to recognize the issues there that whatever you do that enables somebody to get health care that isn't through their place of work, whether it's public programs or tax credits and so on, always raises the question will that tend to destabilize or crowd out existing employer coverage, if it's expanding Medicaid or SCHIP, it is going to be the same issue that there is nothing unique about tax credits, the issue is when you try to do something for somebody who doesn't have employment-based coverage, there is a potential threat to employment-based coverage. We've got to wrestle with that. I think we've got to just try; we've got to step carefully with a process of experimentation and so on. That's what I really suggest here. I don't lay down a very specific issue. I didn't say there is a specific approach, and I think we've just got to try.

So this is an approach that I think attempts to move from where we are recognizing the enormous issues that are involved, tries to build on what we

have, but move us in a direction that ultimately could in fact lead to a revolutionary change when you look back at where you started and I think that's the way to think about this. I appreciate all the comments and critiques, and as you said, I think there is a lot to be said in terms of how one sees the pace of possible change as much as anything in this kind of discussion.

MR. FURMAN: Thank you, Stuart. I would like to start a discussion up here with you and then we will open it up to the audience.

The first part of is a lot of proposals out there right now have the structure of first a set of subsidies for people, maybe changing the existing tax treatment or maybe to use subsidies on top of that. Second, some sort of pooling and regulatory arrangements to ensure that plans are there. Then third, a mandate usually at the individual level and maybe a play or pay. Yours has two of the three and you have said you have gone and forth on the other one. One question for you is how much would you be willing to dial this up and have let's say more regulation in the way that JoAnn and some others called for, maybe start at the state level but promise we will do it at the federal level 5 years from now once we figure out which state is best, we will do a mandate 10 years from now to phase in a more ambitious plan?

MR. BUTLER: Let me just clarify the mandate issue. I think there is a philosophical argument for a mandate here very much in the sense of saying that if people -- we right now have a mandate in this room; we have a mandate to pay some taxes so that people have the right to go into an emergency room if they don't have coverage. In that sense we have a mandate and so that

part of the discussion of a mandate is how should we regularize the mandate that exists in a sense in a fairer way and should the recipient of the service have some requirement. I think there is a lot to be said for that.

A mandate to say you shall have a particular set of services costing a certain amount of money and the federal government will figure that out for you, I am nervous about that in terms of what it means, I am hesitant about it. And I would say also I am hesitant about saying we will do something at the national level. I don't believe one should necessarily even think in those terms. One can have objectives at the national level, one can have a subsidy system at the national level, one can have goals of universal coverage of a certain nature, but allow variants within the country both because America is a big country with different situations and even values to some extent across the country, and also we don't know what the best unified system would be in this country, and also we've got to have an ability to change that over time. Therefore I think having variations around the country in continuous competition is critical to continuously getting an improvement in the situation. That's how I see that.

I think there are all kinds of maybe middle roads that you can go, but I think a unified national system is not the way that we will get ultimately the right system in this country. I think Medicare in a sense has shown that where we are constantly revisiting Medicare and saying this program isn't modern, it doesn't meet what people -- well, there are reasons for that in terms of the way Medicare is designed, the way benefits are determined, the way the Congress is involved in it and so on that makes it very difficult for Medicare to keep on adapting and

adjusting over time and balancing costs and the quality of services. There are reasons for that which I want to try to avoid which is why I don't like a national system.

MR. FURMAN: And yet people are very satisfied with Medicare and cost growth within Medicare.

MR. BUTLER: I'm not sure a young person who is stuck with a $32 trillion unfunded obligation is a great system. A minor point.

MR. FURMAN: That's an unfunded obligation that mirrors the impact --

MR. BUTLER: If I'm prepared to pay whatever you want when you go to the doctor, I think I'd love the system too.

MR. FURMAN: You had a lot of criticisms of the plan. What I couldn't tell is if you didn't like some of Stuart's details, so we could take the same template but add in on discrimination rules, have a more robust regulatory regime, maybe take some additional subsidy, at some point we'll lose Stuart, but take some additional subsidies to go above 200 percent of poverty and maybe strengthen public programs which is a component of a lot of health insurance plans that wasn't mentioned in this paper. But if his general framework of employers as facilitators, of health exchanges, or maybe some different reform of the tax credit that addresses some of your concerns, do you think that's the right template to work with?

MS. VOLK: Yes, interestingly, I think Stuart you said that you expect the impact to be greatest in small firms, so I think that is a very real need

and the idea of exchanges as a place to go to get coverage is an important component. I think that does not necessarily require the proposal he has made. I think we are concerned that capping the exclusion of employer-sponsored coverage undermines that significant source of coverage for most Americans.

You could just add the benefit to buying coverage through the exchange, allow your employer to contribute tax free as they did in Massachusetts and you wouldn't have to necessarily weaken the employer basis of the majority of Americans to make something available for small firms. I think we still have this challenge of what the benefit is and how you make it affordable. I think we know that small businesses need significant subsidies to incent them to offer coverage for the first time because they are not going to want to start something they can't continue, so it's a pretty substantial subsidy.

But there are elements there that are going in the direction of trying to address small-business concerns especially -- an important goal and one that can be accomplished without necessarily taking it out on large firms that may want to get out of the business and under this proposal if grown could. Employers as the facilitator in helping to finance is a perfectly legitimate approach. But again the employer money needs to be there not just because, but because it is an important way to make this affordable.

MR. FURMAN: I wanted to get to the question of affordability and would like to even hear all four of your views on this. There is one approach. Clearly the expense of health insurance and the number of uninsured are flip sides of the same problem. Some people though have chosen politically to try to

address two of them. I think the Health Security Act did. Other plans are just trying to do coverage and we'll worry about affordability later. I guess Stuart I want to understand how you think of your plan, whether you think it does speak to the issue of affordability or would lead to changes in the health system. And then I would like to hear from others if we wanted to address affordability, especially again JoAnn because you made such a big point out of it, what do you think should be at the top of our list to do that.

MR. BUTLER: I see it as gradually making progress toward each of those objectives in a simultaneous way. I do think that allowing people to for example through their small business or place of work have access to a large range of competing plans with rules and disclosure information that is clear, transparent and similar is going to foster a degree of competition and choice that will help to bring costs down for the system as a whole.

I think the tax change -- and I would like to see Len and JoAnn argue this out because Len's the radical on this, and I am merely going halfway, in terms of how you change the tax system and change the subsidy system in a dramatic way. I see my proposal as making some modest steps in that direction. I think to simply just say we'll create new subsidies, large subsidies for people and some of the money will come from somewhere, Mars or somewhere like that, or Saudi Arabia or something like that, it comes from somewhere in the United States, and who? And so either you've got to tax treatment somehow or you've got to hide costs somewhere in the system and I'd like to know kind of what we do.

I am suggesting a modest limit, that's all, a limit on what the tax -- we put limits on life insurance, we put limits on all sorts of things. It is not breaking anything or denying it, it is just that it is not completely tax free without limits, there's a limit, and some of that revenue helps us to begin to see the subsidy down there. I think those who argue that as soon as you put a limit of whatever it is, it's the end of life as we know it. I think it's an absurd argument, quite frankly, and I think what's the alternative? You just have to hide taxes somewhere else in some way. So at least I think I'm being honest about it and straightforward and trying to move.

And I think also putting some limit anyway on the tax exclusion of employer-based coverage will foster a reexamination of compensation. I point out this very strongly in the paper that what we're seeing a lot today as JoAnn knows very well is people's total compensation package is skewed heavily toward health care benefits because of the tax treatment of that. I would like to see people having more cash in their pocket and so on, and I think that will be the result of changing the tax treatment as well.

And I think in terms of availability and moving toward universality, I think I am arguing for effective steps in that direction by giving new options that make a lot of senses and encourage portability and so on and it is a step in that direction too. So I see these as steps toward those goals. I don't think it's a question of saying let's pick one first and do that and then wait until that is done before we do the next, I think they should go forward in parallel and that's what I seek to do.

MR. FURMAN: Briefly on affordability.

MR. GROSSMAN: I think there is an immense underreading of the inefficiency of the present delivery system. If you look at anything that has gone on anywhere in the economy in the last 15 years, medicine has the only negative productivity of any major industry so that the whole idea of putting together an oversight that deals with productivity, comparative effectiveness, we are not suggesting for a moment -- I think one of the problems you had with our suggestion about a health fed was we were using this to set a basic benefit level and which other people have the choice from the exchanges as they do today to but up. It is really exactly what the FEHBP made national and universal.

The second part is that it is our belief that unless we get to a national structure, the ability to phase payment from the business community, Medicare, if you look at the incredible alphabet soup of health care programs, the ability to move it into the federal realm and then have it more productive, more related is to us a critical three-part agenda.

MR. NICHOLS: I would say that Stuart's judgment of all the pieces of my dream plan is a bridge too far. I think that is a legitimate political calculation and we may differ ourselves over the next 18 months on that. But my judgment is, it is not a bridge too far, it is the only way to cross the river. We can't get there unless we do it all together. Fundamentally for us to make health care affordable in the long run we have to learn to buy smarter. That means we're going to have to have a fair bit of comparative effectiveness information, we're going to have institutions that we can trust, and I don't see how we do that unless

we bring everyone in under the tent and say we are not going to perfect the system for 80, 75, 70 percent of the population and leave the rest hanging until we work it out, we've got to do it all together and that's why I think about doing these things. I think the exchange, the employer role, all that stuff are details, but I think if you set up institutions right, you can facilitate buying smarter and that really is the most important thing and that comes back to information and incentives.

MS. VOLK: I would agree with that. I think we believe that to build the biggest pool possible you can then begin to leverage shopping for health care and the comparative effectiveness piece is a big piece of it.

MR. FURMAN: I would love to open it up to the audience, and you should identify yourself and your institution, and there are microphones speeding your way.

DR. POPLIN: My name is Dr. Caroline Poplin. I have two credentials for this. Number one, I am a general internist, and number two, I am a member of the Federal Employee Health Benefits. I work at Bethesda Naval Hospital.

I don't think there is any reason to think that the federal employee plan can be scaled up to deal with everybody else. The reason it works is because the federal employees are a very large group of primarily healthy people so that actuarially you can figure out what it's going to cost. I can tell you people do not sit down and spread out those 200-page books. I'm in Blue Cross/Blue Shields, and that's how many pages it is before them when they choose plans. They do not want numbers of plans, but that is a separate point.

The most important point is that there are sick people out there and they are easy to identify. The older they get the easier they are, and no insurance company is going to want to insure those and we want to start up setting up rules for regulating benefits and determining pools, you are kind of back to the Health Security Act. What ditched that besides poor politics is that it just was too complicated and as soon as you start regulating the benefits and describing the pools and telling the people in Montgomery County they have to be in with the people in the District, they didn't want that.

Medicare takes care of all of those problems. Everybody is in, everybody pays, and if they want more health care they can get it, but in fact, people have been very satisfied and the administrative costs are very low.

MR. BUTLER: There are other people in the audience who can probably answer better who are much more familiar with the details of the FEHBP. The FEHBP has about 10 million in it as you know. It actually of course has an aging population. It does people who are retired and so on. It's a community-rated plan which really invites all kinds of adverse selection issues and yet it still works tolerably well and so on.

I am certainly not advocating microdetailing of benefits, and the FEHBP doesn't do that either. It sets broad categories and allows a lot of variation. I think that's one of the attractions of that model. Yes, there are alternative visions and Medicare for all is an alternative vision which in fact Hamilton has proposed I think in another paper.

MR. FURMAN: Will be (inaudible)

MR. BUTLER: I'm sorry, will be. What can I say? And there are big issues associated with going down that route which I alluded to in terms of the unfunded obligations.

But I think there are lots of lessons to learn from the FEHBP. As I sometimes say as a conservative, this is a program even the federal government can't screw up. Most people when they se what's available in the FEHBP, in every audience I have spoken to and the way that it's portable, say I am for that. Why can't I join? So the notion that it's somehow the worst case out there I think is the exact opposite of how people actually -- because it's voluntary. If you don't like it, you can leave it.

QUESTION: People like it.

MR. BUTLER: That's a good reason.

QUESTION: Rich people outside the government will join it in a heartbeat.

MR. BUTLER: I am not suggesting that you open up the FEHBP as it currently suggests to anybody who wants to join. That is not what I am proposing, and you will see that. I am saying that the structure of the FEHBP, the idea of an exchange, the idea of aggregation of premiums, or rules and so forth is the model to use at the state level and not to take a community-rated national program and say now anybody who wants to, particularly sick people, come first, can now join it because that of course would destabilize the system.

MR. FURMAN: Do any of you have anything?

MR. FRANCIS: I am Walt Francis. I believe (inaudible) who know more about the FEHBP than anybody else in the world. I hope that's not true. I do write about that substantially. I have a bone to pick with you, Stuart. I have appeared a number of times at Heritage events sometimes with Len and I never got the tie. So I'm a little miffed about that.

SPEAKER: I will make a note of that.

MR. FRANCIS: I have three points I will try to make. First, what you've proposed is actually better than you could make clear in your brief talk in a whole variety of ways. Let me give one example. A little-known feature of the FEHBP is that the deal is not the same for all federal employees. Agencies can decide, or some agencies can decide how generous they want to be toward what share of the insurance premiums they contribute. For example, the Postal Service, a large agency and the Federal Deposit Insurance Corporation, a small agency, operate a better deal than the 90 percent of all federal employees and agencies. This, if you think about a private-sector analog where different businesses opt into a system as you've described, that's one of the obvious areas in which individual employers could decide to be more or less generous, thereby retaining essential control, namely exposure, while as our friend from Harvard pointed out, getting rid of this function that is not to say the last one of their core competencies. That's sort of a piece of praise, and I could do more but I'll stop there.

I do have a major criticism. I think the role of states as you've described it is fundamentally wrong; it shouldn't be there and shouldn't be part of what you're proposing. I am a great believer in creative federalism, but health

insurance design and particularly design of competitive systems is not an area that is a core competency, if you will, of any state. I appreciate the desire not to have a single federal agency calling the shots which I think is what's driving you there, but we have a model already in the IRS's role in daycare which is to say negligible even though it's on your tax form in flexible spending accounts, setting the rules for how those will work. With health spending accounts in the high-deductible context you may be for or against high-deductible health plans, but the IRS is really pretty neutral and pretty capable of saying here is are sort of the rules of the game and if your plan qualifies you get to play.

But the real point I want to make about that is that health insurance is a national market employment in general as the national market. If I am IBM and I have employees in all 50 states, I don't want to have to join 50 different state health insurance pick-ups -- I'm sorry, what is the word we're going to use instead?

SPEAKER: Exchange.

MR. FRANCIS: I don't want to have to deal with or even think about 50 exchanges. There are going to be multiple private-sector exchanges. They could be national, they could be regional, they could be city only or whatever. Why should we care? So I think you are being much too constrained in your thinking about we could have broad national rules and say if you qualify, you qualify.

Frankly, one of the mysteries of the current employer-based system to me has been why don't more employers already today group together? And I'm

not thinking association plans, though that is a good example of legal impediment to something that ought to happen, but large employers, I mean IBM and 10 other companies could be setting up the equivalent of their own FEHBP. They may run afoul of antitrust laws. I have never seen any real analysis of the competitiveness of it. I think mainly it is a matter of it is so far outside their core competencies that they can't (inaudible) creative alternatives.

My third and final point, and I am sorry to take so long and it's something I'm coming out with shortly, I will argue that extending the tax subsidy to the FEHBP which is a little known fact, until about 5 years ago federal employees' health insurance premiums were not tax deferred, that is, the employees' share was not, it is now and that has essentially destroyed the competitive aspects of the program and it shows up in the cost control over the last 5 years compared to the previous 4 years. So the importance of capping the tax subsidy, the tax preference, cannot be understated, and UAW problems notwithstanding and all those issues, there are ways to do it and it is vital to both employer-sponsored health insurance over time, health care costs in general, and Medicare costs.

MR. FURMAN: Stuart, you already mounted a pretty robust defense of why you preferred to locate this at the state level rather than at the federal level, and we have heard some criticism on that. If you have more to add, you can add it briefly and then we'll move on.

MR. BUTLER: Yes, I will do it very briefly. Just to respond to these points specifically, I think in terms of bearing in mind the notion of this

proposal as moving from A to B that I think when one says that we should do this at the national level and set these rules at the national level that's where the (inaudible) what you are in fact doing is saying to every governor and every state legislature is we are now going to basically preempt your right to regulate insurance in order to get a better system in the long run. I don't think that's going to sell well right now. Ultimately I don't disagree with the idea of multiple exchanges and so on, but I think this is the right route.

And also bear in mind that with regard to firms that operate across state lines, I certainly under the basic ERISA kind of arrangement would say, yes, we would have a class of firms to continue into the future where ERISA would apply and states would not be able to preempt ERISA and so on in this situation. So I don't think that I undermined the large multistate firm situation and the theoretical ability at least of the federal government to have a very positive and effective way of regulating that arrangement, but it's an art of the possible issue here I think to moving forward.

MR. FURMAN: Yes? We only have a very short period of time, so we're going to take one more question after yours.

MR. MILLER: Tom Miller, AEI, another aggrieved tireless speaker of the past at Heritage events.

(Laughter.)

MR. FURMAN: They're mounting up.

MR. NICHOLS: I'm sorry I said it.

MR. MILLER: You opened the door.

MR. NICHOLS: I came to start a revolution. What can I say?

MR. MILLER: What happens if you have demand -- I'm even more aggrieved that I've never been invited to even speak at Heritage let alone --

SPEAKER: You're one of the tieless ones.

MR. MILLER: Two quick historical points and then a question for Stuart regarding a Federal Reserve for health care. The history is that we suffered our worst Depression while the Federal Reserve was figuring out how to do its job. It had about a 60- or 70-year learning curve before it finally got it right. I hope we could have a little faster adoption rate if we try that same type of mechanism for health care.

Second, there is a standard cliché about massive labor-market mobility increasing. If you look at the published literature in the area of labor economics, average job tenure has been pretty static for the last couple of decades. There might have been a blip in the last couple of years, but in general partly because of the aging workforce, we are not changing jobs any faster than we were before when you look at the total population.

A question for Stuart. Stuart, you have taken mostly a coverage-centric finance demand side focus at reform. Jerry has his own particular approach as to kind of turning around the affordability picture. But could you sketch out if we're coming at from that direction how we would begin to kind of complete the circle to get the type of delivery side changes which would fundamentally alter this arc of costs? Because even when everybody is covered like in Medicare, the cost picture doesn't to down, it costs more to cover more

people, so what changes the expense of care if we're coming at it primarily from the demand side?

MR. BUTLER: I will try to answer that quickly because it's a big question, and I will just say as a preface that I am not control of ties at the Heritage Foundation. I just want to make that clear.

(Laughter.)

MR. BUTLER: I was just making an observation. But as far as to try to answer your question, you're right, but of course to think as you do, if you think about the long-run impact of what I'm talking about, what we would see is more options for people, more plans out there competing in a market where you could see -- you would see longer-term relationships between individuals and the suppliers of services via a plan. You would see more transparency in terms of what the costs are in terms of that. I think those ingredients from the demand side and with the subsidy change that I've referred to which alter then people's perceptions of after-tax costs, these are the ingredients for using a consumer pressure approach if you like to begin to challenge the supply side of the equation to start operating efficiently and in line with what people's value is and in competition with each other, and I think that is the key to getting down costs. I do not believe the way to get down costs is to say we've figured out what the right technology is, we're going to let you have it, I don't think that's the right way, I don't think controlling prices is the right way. I think we have a society here where the amount of health care costs is basically a product of how much we're prepared to spend and we have a subsidy system and a lack of transparency that

causes people to demand things irrespective of costs, and that's the critical thing you've got to get under control. I think this is a step in that direction.

MR. FURMAN: The last question, and a brief question?

MR. MCMENAMIN: I'm Peter McMenamin, a health economist from Silver Spring. Ten years ago I worked for a bunch of wild-eyed radials in health policy otherwise known as the American Medical Association. Stuart was an adviser to us as was Mark Pauly, and actually the official policy of the AMA could quite clearly fit under Stuart's rubric. In fact, it goes further. They called for elimination of the exclusion, establishment of a series of exchanges, encouragement of employers to switch to defined contributions, and replacing that with a system of income-related refundable advanceable tax credits that would only be available to workers if they covered everyone in their family and which could be backed up into a mandate by applying a tax consequence if you presented to the health system without evidence of coverage.

I have actually thought a lot about the various aspects, but it seems to me that the labor ones are actually more important than the business ones because this proposal is basically business-neutral. We have a system right now where two-thirds of the tax benefits go to the wealthiest one-third of the population and most of them are not in a board room, they are high-wage employees. We have a system where low-wage workers don't get any benefit at all. It seems to me particularly if you went to a system of defined contributions you would have to change the coordination of benefits rules such that two-income families would get two defined contributions that would help an awful lot at the

low end, it might lead to changes at the high end particularly lowering average costs, but we have to recognize I think that if you really want to do that, if you eliminate the exclusion, the AMA estimated that with a change from the existing system to income-related tax credits plus $60 billion in 2000-year dollars we could cover 95-percent of the people with this kind of system. It's going to be can the AFL side agree that maybe they won't take so much in health benefits so that the CIO side will be able to afford the benefits?

MS. VOLK: I guess this is directed to me. I think it is important to remember that the tax benefit is greatest for those who have -- one factor is that it goes to those in higher tax brackets, another is that it reflects people who are higher cost because they are older and sicker, you started at the GM plant the day after high school graduation and worked there 35 years, so their costs are not just because they have generous benefits, but because 57 years old and worked in a factory their whole lives and that's an important thing to remember.

MR. FURMAN: I want to thank you all for coming. I'm glad we're seeing this increased consensus toward universal insurance. As far as I can tell, there are about 80 people here and probably 80 different ways to get there.

On July 17th we will be talking about four of those ways and Stuart will come back and we'll have a chance to really scrutinize and think about different approaches to universal. Hamilton also has an event on tax reform for those of you who are interested in that topic on June 12th, so stay tuned for all of that. Thank you.

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