CENTER FOR STUDYING HEALTH SYSTEM CHANGE

"HOW TO MAKE TAX CREDITS FOR HEALTH INSURANCE WORK: THE ROLE OF PURCHASING POOLS"

Tuesday, April 10, 2001

9:09 a.m.

Metro Center Marriott
Salon "A"
775 - 12th Street, N.W.
Washington, D.C.

AGENDA

- - -

P R O C E E D I N G S

DR. GINSBURG: On behalf of the Center for Studying Health System Change, I want to welcome you to this conference on tax credits and purchasing pools. This conference is focused on new ideas to expand coverage to the uninsured. I've long been intrigued with policy proposals such as tax credits to expand coverage to those who do not have a strong link to employer-sponsored coverage, but I've always paused, due to the inherent weaknesses of individual insurance markets, their inability to serve those with chronic illness due to risk selection and high administrative costs.

As part of HSC site visit work, we've been examining purchasing pools for small employers, and we find that despite enthusiasm for the pools among some leaders in communities, for the most part these organizations have struggled in achieving critical mass, and were quite vulnerable with respect to risk selection. And Mark Hall, one of our panelists, has done extensive research in this area as well. This has led to thoughts about whether these mechanisms could be combined. Purchasing pools might offer superior mechanism through which those eligible for tax credits could obtain coverage, and a prominent place in tax credit policy could be just what purchasing pools might need to realize their potential.

I'm not the first person to have thought of this connection. Perhaps the first person is Rick Curtis, another member of our panel, who's developed such ideas in detail with support from the Commonwealth Funds. Indeed, Commonwealth has funded others to tackle alternative solutions to the issue of providing effective mechanisms through which eligibles can use tax credits to purchase health insurance, such as allowing buy-ins to public programs or reforming the individual insurance market.

But the focus of today's conference is whether purchasing pools can make tax credits more effective. Given HSC's research focus on private markets, this is where we think we can be contribute to the tax credit discussion. So the bottom line for this conference is will more people, including the chronically ill and older workers, obtain coverage through this combined approach than under a stand-alone tax credit? And today's panel will help us make such an assessment.

I want to proceed to a few words about tax credit proposals for those not as familiar as they'd like to be. And the focus today is on proposals to offer refundable tax credits to low-income families to purchase health insurance, and today we're seeing bipartisan support for such an approach. A proposal was recently

introduced by Senator Jeffords, S. 590, that offer tax credits to individuals and families. And there are two scales in this tax credit. For those without access to employment-sponsored insurance, tax credits are up to $1,000 for individuals and $2,500 for families. For those with access to employment-sponsored coverage, they're also eligible for tax credits, but smaller, at $400 for an individual and $1,000 for a family. And President Bush described a similar proposal yesterday in his budget.

Many see tax credits as complementary to expansions in public program such as Medicaid and SCHIP, and the latter two would continue to serve those with the lowest incomes, while tax credits would focus on those with somewhat higher incomes. Indeed, the eligibility for families in the Jeffords' proposal goes up to a family income of $55,000.

Now, let me proceed to how this conference will be organized today. We'll begin with a presentation by Sally Trude, senior researcher at the Center, to provide context for this discussion by framing the issues. And Sally is going to be drawing on HSC research and other research on purchasing pools, and she'll outline a score card for us to use in assessing the various approaches to enhancing coverage through tax credits.

At this point I want to thank Mark Hall, another one of our panelists, for his valuable comments on an early draft of the issue brief that's in your packet, that Sally drafted as the senior author, that's being released today.

After Sally's presentation, the panelists will come up, and we'll begin our panel discussion with a discussion of the experience of existing purchasing pools. And then we'll cover the key over-arching policy design issues with this combination, as they would relate to combining purchasing pools and tax credits. Then we'll assess the strengths and weaknesses of the proposal and compare it to a stand-alone tax credit. And if time, we might also hear from panelists, ideas about alternative mechanisms to provide a more effective market through which tax credits can purchase insurance.

Some other details of the conference, there will be two opportunities for questions and answers from the audience, as well as a break in the middle of the conference. We're going to start the panel discussion and break it about 10:15, and then have questions, and then a break. And when you do your questions, please state your affiliation and use the microphone.

After the conference, we'll issue a short summary, likely in the form of a press release, and we'll

be putting the full conference transcript on our website, hschange.org, probably by tomorrow.

And at this point, let me introduce my colleague, Sally Trude.

DR. TRUDE: Excuse me a moment while we get this.

[Pause.]

DR. TRUDE: Thank you for waiting. There's growing bipartisan support for expanding health insurance coverage through tax credits. Yet some are concerned that a stand-alone tax credit may not be as effective because it relies on people buying their health insurance coverage on the individual market.

Today our panelists will be discussing a policy that seeks to bypass the individual market by linking tax credits to purchasing pools. I'll be providing the groundwork for that discussion. First I'll briefly touch on problems of the individual, like I mentioned, a key issue facing a stand-alone tax credit policy. Next I'll discuss how purchasing pools use large employers as their role model in the hopes of gaining the same advantages. Then I'll discuss some of the issues for linking tax credits to purchasing pools. And finally, I'll wrap up with a score card for you to use when assessing the various approaches and their implications.

Although bipartisan support is growing for tax credits for the uninsured, some question whether this would work without reforms to the individual market. Individuals buying health insurance have little bargaining clout. Overhead costs are higher, and older and sicker people have trouble obtaining and affording individual policies. For example, in the individual market, a health plan product would cost twice as much for a 50-year old as for a 25-year-old.

On the other hand, a large employer brings together a diverse group of people, including both the sicker and healthier workers, young and old. The large employer pools these risks to workers pay the same amount regardless of their individual risk. In addition, large employers have bargaining clout. They standardize benefits, allowing comparison by price, and they gain efficiencies by coordinating enrollment and providing other administrative functions.

Purchasing pools provide a mechanism for bringing individuals together like a large employer, but there have been challenges with this approach. In general, voluntary purchasing cooperatives have had a poor track record. Many have had little success expanding coverage for the uninsured, and have not gained significant market clout. In addition, purchasing

cooperatives have struggled to gain the participation of brokers and health plans, key stakeholders in every health insurance market.

And linking purchasing pools to tax credits is going to present its own set of complex design issues. We can gain an understanding of the participation of key stakeholders from research on purchasing cooperatives from people like Mark Hall and from HSC's third visit to each of its 12 communities. As part of that third visit, we placed a special emphasis on purchasing cooperatives for small businesses and the role of brokers. Brokers help educate their clients about health insurance options and help them identify what type of insurance is available at what price. They also have an ongoing relationship, and tend to be there for handling grievances. My best example was being shown a 20-page fax of medical claims that the broker was then expected to figured out.

We found that in several of our sites, purchasing cooperatives had first hoped to bypass brokers and save the cost of the brokers' commission. They quickly had to reverse themselves and bring brokers back into the picture. One association in the Boston market had its membership triple in the last two years after bringing in outside brokers. Operational issues can also

affect whether brokers bring clients into a purchasing cooperative.

Now, for health plans, it's another story. For health plans purchasing pools can be a plan's worst nightmare. Needless to say, insurers do not necessarily want to encourage an organization to have gained purchasing clout, and they may not want to compete on price, which is a byproduct of a standardized benefit, but most important, from previous experience, purchasing cooperatives know that--I mean health plans know that purchasing cooperatives can be a magnet for high risks.

Purchasing cooperatives typically have a social mission of extending coverage to those who have difficulty obtaining insurance. Given that social mission though, when they find that they achieve it, they may be also fueling the adverse selection because they're attracting these higher risks. In the issue brief in your packet, I describe the Florida cooperative and Cleveland's Council of Small Enterprises. It's also called COSE. And they're on two ends of the spectrum.

On one end, the Miami cooperative, which is no longer in existence, had lenient membership criteria that attracted higher risks. Their typical member had one or two employees, and according to health leaders in that market, the Miami cooperative was a gateway for high-risk

individuals to come in and out of the purchasing cooperative as they needed medical care. On the other end of the spectrum, COSE has an average group size of six, and charges a membership fee of $450 per year that helps to keep single membership out.

A policy that would require those with tax credits to purchase the health credits through the purchasing pool though, would undoubtedly gain plan participation if there's enough people taking up the tax credit. It would also depend on a number of other design issues that will have to be addressed.

Today I'd like to highlight some of the issues, and the panel will be discussing some of the most salient parts, without getting into too many of the nitty-gritty details, I promise. These design issues include deciding who is eligible for the pool. As described earlier, we assume that everyone using tax credits would be in the pool. Under stand-alone tax credit policy, the 23 percent of families not taking their employers' offering would use the tax credit toward their employer's coverage, and then the rest would be in the individual market.

Under a policy that links tax credits with purchasing pools, the question is raised about who besides those using tax credits would use the purchasing pools? Would the purchasing pool only include those with

tax credits, or could sole proprietors and small businesses participate? Those are typically the members of a purchasing cooperative. Could employees of large companies use their tax credits to buy their employer's coverage?

Other key design issues include determining state versus federal authority and oversight of the purchasing pools. How would the number of pools be determined, selected and monitored? Would there be a minimum benefit requirement? How would these purchasing pools dovetail with state regulations? How might these purchasing pools interact with existing public programs? What if the children were in SCHIP and the parents were in the purchasing pool?

Fortunately, I get to leave these issues to our panelists. So I'd like to wrap up with the score card, so that as you're listening to this presentation, you can decide whether or not the tax credits to purchasing pools is going to be a better mousetrap. When all is said and done, does the new policy bring the advantages of a large employer, not just have the trappings of the large employer? In particular, does it spread the cost of sicker individuals across the group so the chronically ill can afford coverage? Does the new entity have

bargaining clout? Is it administratively efficient? Does it standardize benefits?

Next, does the new policy expand coverage or does it just change where the insured buy their insurance? And finally, what are the consequences for the rest of the people buying health insurance? In particular, how does the new policy affect the rest of the individual and the small group market?

During the panelists' discussion you can use the score card to keep your eye on the bottom line, and then you can sort of decide which is the most effective, a stand-alone tax credit relying on the individual market, linked tax credits and purchasing pools, or maybe some other approach?

DR. GINSBURG: Thanks. I think that's really presented a great framework for our panel to begin. So if the panel could come up now, and Rowan, if you could flip their name tags up so they know where to sit, and I'll start introducing them.

Let me begin the introductions with John Bertko, who's sitting on my right, and who's Vice President and Chief Actuary at Humana, Incorporated, a major national health insurer. John directly oversees the corporate actuarial group at Humana, and also he assists the Government Relations Department with actuarial input on legislative and regulatory proposals. John has had

extensive experience with risk adjustments over the last ten years in all sectors of the health care market, and this includes the Medicaid market and state employee purchasing agencies.

And on my left is Stuart Butler, who is the Vice President of the Heritage Foundation for domestic and economic policy studies. Stuart recently completed a policy brief on how health credits for families would supplement employment-based coverage, and I'm sure that's available on the Heritage website. And he's also co-authored the Heritage Consumer Choice Health Plan.

Rick Curtis, over there, is President of the Institute for Health Policy Solutions, which is a nonprofit organization that was found in 1992, and he has extensive background in health insurance strategies and issues, and he has done a lot of work on assisting purchasing pool developments to give small firms' employees meaningful choice of competing health plans, as well as to facilitate coordination of public and private funding for the uninsured. Rick previously served as Director of Policy Development and Research at the Health Insurance Association of America, and is Founding Executive Director of the National Academy for State Health Policy.

Mark Hall is Professor of Law and Public Health at Wake Forest University. He specializes in health care law and public policy, with a focus on economic, regulatory and organizational issues. And he has recently completed a major investigation of health insurance market reforms for the Robert Wood Johnson Foundation.

Someone who will be joining us a little bit later is John McManus, the Majority Staff Director of the House Ways and Means Health Subcommittee. And he previously served as the health legislative assistant for Congressman Bill Thomas, and before that was a senior associate in Government Relations at Allow Louis & Company.

And finally, Phil Vogel is Senior Vice President of CBIA Service Corporation, which is a division of the Connecticut Business and Industry Association. He runs a real purchasing pool. Prior to joining CBIA, he spent 12 years with two major health insurance companies, and he's responsible for all products and services offered to small businesses throughout--through the CBIA Service Corporation, including a health insurance program for small businesses that uses the corporation's purchasing power.

I am really pleased that you are all here. We want to tell you truth-in-packaging, I've shared in

advance the questions that I'm going to be asking the panel members, but we're expecting a lot of interaction and perhaps going a number of places that were not planned.

And I want to start the discussion talking about the experience with current purchasing cooperatives, and maybe Mark Hall would be someone I could start off with. Mark, you've done a lot of research. What's your assessment of the experience of current purchasing cooperatives in the marketplace?

MR. HALL: I'm trying to think of the right phrase. I think limited success would be about as optimistic as one could put it. I think there's also been some noted failures, you know, measured against their goals. I think clearly a failure would be the right term measured against was it worth the effort at all? Then I think you might think in terms of a limited success. Clearly, they haven't achieved the goal of making the small group market work essentially the same as the large group market in terms of administrative cost savings and purchasing power.

On the other hand, they have provided some degree of standardization and simplification, some degree of improved choice, and sort of a means to essentially police the market, particularly at the low end of the

small group market, the one and two, and up to five life groups that have faced some of the more difficult barriers in obtaining insurance.

DR. GINSBURG: I noticed that California, where we had done a site visit in Orange County, we interviewed two statewide purchasing pools that I think are considered very successful. But then we looked at the number of lives they covered, and it was something like 4 percent of the potential of people who worked for small employers or who were insured by small employers. What would you make of that?

MR. HALL: Well, several points. I think first, most people purchasing insurance in the small-group market already have--you know, are continuing to keep the insurance they had, and so there wasn't a strong reason to switch, because the pools simply didn't offer a distinctly superior price. Also, the distribution system, the agents that small employers rely on, weren't big fans of these pools, partly because of the relationship at the beginning was antagonistic between pools and agents, and small purchasers rely heavily on the advice of agents, and agents weren't inclined to send business to the pools.

DR. GINSBURG: Paul?

MR. BERTKO: Could I add a couple words?

DR. GINSBURG: Sure.

MR. BERTKO: I'm a California resident, and other than Phil, had a small company for three years. We joined what was then the California HIPC, now PAC Advantage, and in the process of which the California Health Care Foundation asked us to evaluate the prices in and out of the HIPC. It turns out that in that last part, the prices in the HIPC were actually slightly more expensive than outside of it, a couple of percent. Now, part of this was driven by Blue Cross of California, Well Point. It chose to be outside the HIPC, and I think any time you have a very large, very successful competitor outside, it probably reduces its success.

Now, putting on my old employer hat and sponsor, we went from three employees up to 20. Having the ability to offer 10 different health plans in the Bay 9dty tn th20ee employe,on massociluahisho work wialtme,ay othore

MR. CURTIS: I don't disagree with anything Mark says. I would clarify a couple of points. The failures like in Florida--and he's not going to disagree with anything I say, I don't think--were almost inevitable given the policy constructs enacted by the state. In the case of Florida--and this was replicated in North Carolina, where it was even worse because the state required of the purchasing pools that they do things that carriers in the market overall don't do, which doesn't work. I'm going to come back to that as the major lesson.

But in Florida, these organizations were set up sort of as political animals. There were--I can't remember how many, Mark, 11 of them around the state or something, originally?

MR. HALL: Right.

MR. CURTIS: They each had their own separate boards. They were not allowed to act as purchasers. They could not selectively contract with health plans. They were not the ones that contracted with health plans even, as Phil does, for example. They weren't the ones that paid the agents. They didn't even determine how much the agents were paid. Each of the health plans did that. In fact, they didn't even know how much the different health plans paid the agents. They were completely gutted as purchasers.

So of the failures I know of, there are circumstances like that or like a North Carolina or a Texas--and this is the key lesson, I think, in terms of federal policy implications--where somehow state policy makers in this case--and I hope federal policy makers don't do the same things--expected these purchasing pools to where the white hat, to accept bad risks on the same basis as good risks, to charge them the same amount, and meanwhile, the rest of the market didn't have to do that. And inevitably, that does not work, it cannot work. And the analogy here would be if--with tax credits, the expectation would be that everyone with tax credits has an option to take them to a purchasing pool, which would charge the same to sick and healthy people, but they could also take it to an individual carrier who could charge a lot less for healthy people. That is not going to work.

DR. GINSBURG: Rick, to what extent would you say that the policy makers in Florida were very naive, or to what extent did they know some of these issues, but just in the course of compromise, had to make big concessions to get this off the ground?

MR. CURTIS: I think it's a combination of the latter explanation, and of wanting to have appeared to have done great things that could be touted within the

state and nationally. In some cases it was self-delusion rather than naivete I think. But this was--there are several of us on the panel that way back, when this was enacted, said it couldn't work, and it ultimately didn't. The only reason they survived as long as they did is the former governor and one of his key appointees sort of used the bully pulpit to sort of force plans to stay in and carry the thing along. As soon as they were gone and there was not that artificial impetus, they died.

DR. GINSBURG: Sure. Phil, I wanted to ask you, as someone who runs a purchasing cooperative, which presumably is successful, that's why you're here, because of the reputation of the--

MR. VOGEL: We still think the audience knows differently.

DR. GINSBURG: What would you say are either the--both the reasons for your success, and what are the factors preventing you from being more successful?

MR. VOGEL: I think Sally did a good job of setting some of the framework. One of the things that I think we did right was, from day one we looked at the distribution system and knew that the individual agent and brokers were very important to small businesses from an explanation standpoint, enrollment, being involved totally throughout the decision-making process, and we embraced--

FLOOR: We can't hear back here.

MR. VOGEL: Is that better?

We embraced the broker and agents immediately and worked with them to train them, to get them to understand the concept because it is different. It can be construed to be more complex a sale, but we got them to really understand it and move forward, and I think that's one of the critical pieces of the success.

The second part is working with the health plans to get them to understand also that we were not trying to do what Rick was talking about and really just trying to have an adverse selected business development piece. I think, when you take a look at why we are not more successful, it would also come to--it's voluntary. It's voluntary from the standpoint of the health plans. We were very successful, had tremendous growth in the first couple of years, but I think also, when Sally said, from a health plan standpoint, they want to avoid a purchaser getting too big. They want to avoid the clout. They want to avoid really being compared apples to apples from a price-comparative standpoint, so they have reacted in the marketplace.

We have seen networks that were relatively narrow networks become--really have, you know, all providers included in the networks so that some of those

pieces became--were not as important any more. And so they are reacting outside the market, and they are shadowing us with plan designs, as well. So you have an open market outside of the purchasing pool, and they will, as I always say, our strength is we have four health plans in the marketplace with four different plan designs. So our strength is four health plans, but our weakness is four health plans in the sense of our ability to react, too.

DR. GINSBURG: You said, in a sense, that some of the plans competing that were outside of the pool were expanding their networks. So, in a sense, has that meant, I mean, this is a trend we've seen throughout the country of plans expanding their networks. Does this have implications that, at least at this moment in time, this could change, that choice isn't as important as it was when some of the purchasing pools were conceived?

MR. VOGEL: Yes. I think choice is still the number one selling piece, but it's not quite as important. We always termed it that the small business owner is the owner and the employee. So wherever the physicians were that that small business owners, for themselves, for their spouse, wherever the pediatrician was, whatever network matched them, their employees were "stuck with."

It's expanded now so that they aren't quite stuck because there is greater choice, but in our surveys, still, we do a customer satisfaction survey each year to about 400 of the companies participating in CBI Health Connections, and the satisfaction rates are very high.

DR. GINSBURG: One final question. What would you say is your, among the success you've had, how would you characterize the most important things you've delivered to the businesses that subscribe?

MR. VOGEL: Oh, I think they've never had the choice options that we offer. We actually over 18 different options to each employee. So the employees have never had that much choice before, and it shows I think in our satisfaction rates. I think we've been able to embrace the broker community so that they can explain it and simplify what can be a complex sale, and over time gotten the health plans to embrace this as something that is good, and they can work with in this structure.

DR. GINSBURG: Sure. Given the history that Sally sketched and you were talking about, the notion that brokers can be friends to purchasing cooperatives, in a sense, for someone, say, the Rick or Mark that looks at them nationally, would you say this is something that

is kind of learning that's been accepted now or is that still very controversial?

MR. CURTIS: No. Any of them that are successful small employers have, over the years, listened to Phil on this and have done everything they can do to have good relations with agents and brokers. But one thing Phil alluded to was the satisfaction rates being higher, which I'm surprised health plans haven't paid more attention to that.

The other thing, I don't know if you have recent retention rates. That's how many of the people who are in this year stay there. And with small employer markets, traditionally, there's very high churning, which results in high administrative costs, this continuity of care, and so forth. And one unique thing about the California, what was the HIPC PAC advantage, and CBIA in Colorado, is very high retention rates, much higher.

MR. VOGEL: Yes, we actually, when we take a look at retention rates, we also include companies that have moved out of Connecticut, who have gone out of business, and we still have retention rates in the 90-percent range, which in the small business market, John, you probably know the stats better than I do--

MR. BERTKO: Yes.

MR. VOGEL: But they can range anywhere from 70 to 80 to 85 percent, something that health plans are happy with, I think.

MR. BERTKO: Yes. Absolutely. Anything in the mid 80s or higher is wonderful. The 70- to 85-percent range is normal retention, meaning that you are churning that much business every year.

MR. VOGEL: Yes, and over the last year we've been running in the 90s again.

DR. GINSBURG: So this sort of thing has significant benefit for the employees who are policyholders, as far as they don't have to switch plans that often, as their company does.

MR. VOGEL: The company doesn't have to change everything. The employees have an open enrollment period so that if, for some reason, they're unhappy as an individual, they can change.

DR. GINSBURG: Sure.

MR. CURTIS: Well, and an important related thing, we were surprised by this--John's probably looked at this--small employers in many parts of the country themselves have a fair amount of turnover and who is in their workforce. And that means, as they are interviewing a potential employee, they have a health plan they're offering that's going to be attractive to

them, and it's not going to be a reason they don't come there.

So, despite this incredible stability of employers, if you actually look at the employees, there's a fair amount of turnover in who the employees are.

MR. VOGEL: And one more point just on the broker side, and Rick knows that I'm always on my high

boute

handle it for them, and that's where the agent really comes into place.

MR. HALL: I've used the analogy or the observation that, for the small employer, the insurance agent is essentially the employee benefit manager, and the large employer has an expert full-time staff to shop the market, and smaller employers use their agents in that capacity.

But just a word or two more on the agent point, if that's where you want to stay with the conversation, Paul, is that everybody knows that the purchasing pool concept was enacted at the same time that the Clinton health care reform proposal was being debated, with its health alliances, and so the whole idea was linked with large government takeover of the insurance industry or what have you. So that political climate made it extremely hostile.

I think, once we got past that in my interviews, what I detected is that there is still a degree of agent resistance because they still saw the pools as linked with government. They were state subsidized. Sometimes they were sort of sort of quasi-state entities. But other agents saw the pools more favorably, and it tended to turn on whether the agents saw the pools as a source of new business, basically. So that if an agent had a

clientele, had a set of developed small businesses and was happy dealing with carriers directly, they didn't see any reason to change, and they saw it only as a threat.

But if an agent was trying to develop new business could use the pool as a source of new business, and the pools would make referrals to favorite agents, they would actually gain business. Then the agents saw the pools very favorably, and you got these dichotomized reactions. Some agents thought they were just wonderful because of the ease of selection, the ease of shopping, the retention, and the other things that make agents' lives easier versus those who were opposed to it for a mix of economic and political reasons.

All of which I think sheds light on the issue being debated today, which is that for the tax credit population, this would overwhelmingly be brand-new business and not be taking existing business and moving it to some other type of location. So I think the prospect that agents would view it favorably is fairly high.

DR. GINSBURG: Yes, and I gathered some of the public purchasing cooperatives have really been hindered by the compromise they had to make over the opposition of agents to the legislation, and that perhaps, in this setting, given the experience of the private pools of now moving towards using agents more, that this would be less

of a stakeholder that would see themselves being highly disadvantaged.

I wanted to go into a little bit more, as some of you have mentioned, this issue of risk selection. I think what a number of you have alluded to is the fact that, under a voluntary system, any employer always has the option to compare what's available under the purchasing pool and what's available directly through an insurer. And, presumably, if something more attractive is going to be obtained through a regular insurer, that's the way they'll go.

So, in a sense, you're having, and I guess this interacts with state laws a lot, but I wanted some of you to talk more about the potential pitfalls of a voluntary purchasing cooperative with a selection phenomenon.

Rick?

MR. CURTIS: Well, it is not a coincidence that where these have been successful, relatively successful--in California, Colorado, and Connecticut, and a couple of other places--there are market rules that say marketwide insurers can age rate, but they cannot health rate. And they have been tried in some markets with loose health rating, and the reality is, if you're a purchasing pool that offers individual choice and the people that come to you have a choice of going to an outside market with

health underwriting, then you have sort of three broad options. One of them is you don't health rate anyway, and that's the kiss of death. It's just not going to work.

Second, is you let each of your participating carriers underwrite each individual in the pool that might come to them. And if you do that, you've recreated all of the administrative costs and inefficiencies, and there are people on the panel who disagree with this characterization, but the market dysfunction of a market, where people don't know what the price of competitors are until they go through a lot of work, which makes it very hard for consumers to compare.

And the third option is to try to get participating plans to agree on common underwriting standards and to use sort of a common administrative apparatus so that people only have to be looked at once, in terms of what their risks are. Now this is a lot more workable than an esteemed colleague of ours' approach, Mark Pauley, where the IRS is going to risk assess people and give a tax credit based on that which I can't imagine ever working.

I mean, this can work, but it can never work as well, from a risk selection standpoint. From an insurer's standpoint of each insurer protecting themselves with their own underwriting, it's kind of a

least-common denominator approach and won't work as well. So we don't have a case, at this point in history, of a consumer choice of competing plan purchasing pool for small employers that is highly successful in a state with loose rating rules, that allows a lot of health rating, and again it's not a coincidence. I think it can work, but it's not been successful yet.

DR. GINSBURG: Sure.

MR. BERTKO: Let me just add, being a little bit more specific about the California pool, I was one of the actuarial consultants helping to set up the California HIPC. What Rick said is absolutely true, but if the rules are tight enough, sometimes you can get by with some flexibility. In California, the rating rules were plus or minus 20 percent on the outside, at the very start, and they shrunk to plus or minus 10-percent rate bands; that is, I'm using some shorthand here to say that health risk underwriting was allowable for certain factors.

The California HIPC, at the start-up, chose to not have any health underwriting. It greatly simplified the presentation of the materials, particularly when we had 10 health plans in several reasons. And it turned out, because we got reasonable prices, to be mostly competitive. Now I will tell you that one of my

colleague consultants was actually sitting in a lunch room shortly after we had this pass, and a broker was sitting at the next table, unbeknownst to the broker. We were sitting there, and the broker said, "Well, you know, I'm just going to take all of my bad risks and send them over to the HIPC because they, of course, will have to accept everything, and they'll get lower rates."

This kind of behavior is, it's going to happen. I mean, the job of a broker, in fact, is to find the best rates for his or her clients. And as Rick said, if the bands are wider than that, the effect is going to be yet more serious.

Let me only add, within the health pool, there is yet a different type of risk selection issue that we haven't talked about too much. If you have standardized benefits with standardized delivery systems, much of the risk selection across health plans is less evident. We started out in the California HIPC with one or two PPOs, and they almost immediately disappeared because the PPOs were more desirable by people who had higher health needs, and there was no amount of risk adjustment we can do to save them. So we ended up very quickly with just HMOs in the HIPC.

DR. GINSBURG: And presumably, to clarify, those PPOs presumably would have had similar problems if they

were offered by a large employer that was having them compete with HMOs.

MR. BERTKO: Well, the answer is they would have attracted the same sort of risk, but the much, much higher subsidy of the large employer would have most likely overruled that, and the large employers make a practice to retain the PPOs by being willing to offer that greater subsidy.

DR. GINSBURG: I see.

Rick?

MR. CURTIS: And that plan, as John probably knows now, is newly offering a PPO option again, but with a leaner benefit package than the HMOs, and they're hoping that will solve the problem.

It's worth observing. I can't prove this to be true, nor could John, I'm sure, but one of the reasons I think he found a very small price difference between the HIPC in California and the outside plans is, in the outside, they can health rate, and that's probably why they have a slightly smaller price. If you had a tax

something work. Even if people in the individual market that aren't subsidized are facing health rating, it could still work inside the pools, as long as the people with tax credits have to go to entities that are subject to uniform rules across those entities.

MR. BERTKO: We'll save more debate on that for later.

[Laughter.]

DR. BUTLER: If I could just sort of weigh in a little bit on this. This whole issue, I think, of risk selection has a lot of curiosities to it and a lot of ways of potentially dealing with it. You've got a number of options or a number of situations that sort of need to be part of this equation and need to be thought about.

I mean, for example, you have within the federal employee system, you have 10 million people who are each seeking plans. The plans are community rated. They offer different benefits, and yet somehow it functions. And I think we might want to explore a little bit about why a situation like that is relatively stable and what lessons that has for any kind of tax credit approach.

I think, in addition, and I would say pretty broadly that all of the people I know, including myself, that are proponents of tax credits, recognize that there has to be some kind of underwriting restrictions and so on, combined with some way of dealing with the risk-

selection issue. Risk adjustors that look at the sort of portfolio of risk of each of the plans and look at ways of compensating over time is certainly one way of looking at this. Creating high-risk pools and taking out the highest risk group as one's separate group so that you get much less of a problem, in terms of risk selection, is another way.

So, in other words, I think there are a lot of ways to look at this and a lot of approaches that need to be explored between the federal government and the states, as you look at any kind of tax credit approach.

I think the underlying conclusion I think maybe to draw from a lot of this discussion is that there is no one solution. There may be one solution, but we don't know what it is, and therefore it's very important for us not to lock ourselves into sort of one approach. And that is why I favor, particularly with any tax credit approach, having some kind of negotiation between the federal government and the states to explore and to actually analyze how this operates and to see what the federal government can do as its part of the bargain, in terms of making this work.

And I think that is the only way forward for precisely these reasons, but there are a lot of options I think in how to deal with this.

MR. CURTIS: Just a general observation here, I think that's very sensible, but in order for that to work at the state level, a state would need to have the latitude to identify where people could take tax credits within the state.

DR. BUTLER: Oh, I agree with that, and I think that's why it has to be a negotiable situation. You have to have something like a tax credit that is available, and as a condition of having that available within a state, the state and the federal government has to come to some kind of agreement about how it's going to operate, and there will be differences in different states. And the differences are partly to adjust for differences in states, of course, but also because we don't know precisely what the best method is.

I think this is analogous to what we did for many years in the welfare area, where we said we don't quite know what the right--so let's give waivers, let's give--and even now there's diversity between the states and how they approach that, within a general rubric of what the federal government is trying to achieve, and I think that's what's got to happen in this area too.

DR. GINSBURG: Actually, we're going to return to that in the second half of the meeting.

Mark?

MR. HALL: At the risk of losing the audience on these technical questions of risk selection, I think we are trying to draw some lessons from what we observed with purchasing pools, and I thought I might just offer one more observation that I think would be relevant, as we move into the second half. And that is I guess the general question is why do purchasing pools become magnets for high risks, either actually or perceived, and does that then give us concern for how the tax credit idea might be implemented? I think that's the general line of discussion.

And Rick's point is correct, that to the extent that the purchasing pools had more generous or different rating and underwriting rules than the rest of the market, they became magnets for high risk. But even where they had the same basic underwriting and rating rules, as the rest of the market, they were still magnets for high risks in the following way, and this has to do with the very small groups.

So, in a states like North Carolina and Florida, the pools became magnets for the smallest of the small groups--the one-, two-, three-, four-, five-life groups, which is an irony because the biggest advantage that they offer is choice, but choice is more meaningful when you've got more employees. If the owner is the only

employee or the owner and his wife or children were the only employees, then, you know, the choice feature is not that meaningful. So they become most attractive for those for whom the choice feature is the less important.

Well, why did that happen? Simply because those size groups were seen as presenting the highest risk in a community-rated market because of selection concerns because those are the businesses that make their purchasing decision depend on their perceived health needs. So mom and pop decide we have an anticipated health need. We'll buy insurance for our business or we don't, so we'll drop it. And on that account, they are seen as high risk.

Now, why do they end up in the purchasing pools rather than in the rest of the community or guaranteed issue market? Well, one reason has to do with some of the more subtle rules that did differ. So, for instance, whether or not a self-employed purchaser qualifies as a legitimate business, there are various rules for testing that, and the carriers could be stricter on that in the outside market and the pools were somewhat more generous or simply agent commissions.

So, in Florida, we saw a situation where carriers dropped their commissions for the smallest groups down to 1 or 2 percent, whereas, the pools continued to pay 5 or 8 percent. Usually, the commission

are at a higher rate the smaller the group because there's more work for selling the equivalent amount of business, but it went just the opposite direction in order to actively discourage agents from sending that business to the carriers, whereas, the pools didn't.

So these kinds of fault lines inevitably develop, even if you have the basic same market rules if choice exists between purchasing in the pool or purchasing in the outside market.

DR. GINSBURG: Thanks. And before we leave this issue of risk selection, and we're going to be coming back to it time and time again, let me just reinforce one of the comments that was made about we're really talking about two different types of risk selection. We're talking about, first, the risk selections that go into a pool.

So, in a sense, the incentive for employers who have a healthy workforce to get into a pool that's healthy to keep the price down and avoid the pools that have more sick people. But then once you're in a pool, then you have the issues of risk selection among the various plans, the choices that you're offered. And in some ways they are distinct, and in some ways they are related because choice is one of the prominent advantages of purchasing pools.

Before we leave the existing thing, I want to ask are there any other thoughts?

John?

MR. BERTKO: I will only add one more that I think complements what Mark said earlier. The operation of the very toughly underwritten individual market also means that folks on that intersection of individual market and guaranteed issue small group can choose, if they are very healthy, to participate at perhaps half the cost of what the guaranteed issue product is.

And so there is a very natural dynamic there of folks who need insurance, want insurance, but are healthy, to go in one direction when they're healthy and the other direction when they are sick or in great need. So it really exacerbates everything, in terms of the risk dynamics.

MR. CURTIS: And depending on how big the tax cut is, this could be an issue even for tax-credit recipients, even if they could only take the tax credit to a given place.

MR. BERTKO: Yes.

MR. CURTIS: If the tax credit is $500 and the premium is $2,500 for a healthy young person, that $500 is a rounding error, in terms of the discount on the premium they can get if it's underwritten.

DR. GINSBURG: Okay. Good. Now let's talk about the potential of marrying tax credits with pools. And what I wanted to set out is somewhat of a basic option that we're going to be talking about. And, in a sense, this option I've assumed that individuals using tax credits would be required to purchase insurance through a limited number of authorized pools, and I think that's the key thing.

Let me also say that let's also assume that the tax credit is substantial enough to make a difference, and I recall an article by Mark Pauley in the January Health Affairs where, through simulations, was talking about a tax credit that covered about half the cost as what he thought is needed to get a significant change in behavior according to it.

So let's assume for this discussion, although with the caveat that Rick mentioned, that tax credit is going to be, say, roughly half of the cost, although realizing that when a tax credit is half the cost of someone that gets the full tax credit, that through the phaseout of tax credits, for those with incomes that are fairly high, those people are not going to be getting as large tax credits.

So, anyway, with that kind of basic thing, and we're going to be requiring people to use their tax

credits in pools that have been authorized by either the state or the federal government to do that, and that there are going to be a limited number of these authorized pools. The first design issue I would like to talk to the panel, I mean, that's as far as I could go, as far as what I thought the panel might agree on as a reasonable option, and then I want to get the panel to work out some of the other elements.

So the first question is who would be eligible to participate in these pools? Should it be just the individuals with tax credits or should other individuals be eligible to use the pool?

DR. BUTLER: I don't see a particular logic for limiting it to people with a credit. I mean, what a credit does is enhance the buying power of certain individuals to make it more comparable to the buying power of other individuals. So to say we're going to select out this curious group of people and say only they can go through this particular mechanism and somebody in an equivalent purchasing capability, if you like, and health situation is going to be barred from this, I think not only there's no logic to it, but I think sets up all kinds of perverse dynamics in terms of qualifications and so on.

MR. BERTKO: May I jump in at this point?

Actuaries are perhaps noted as having too much logic so let me say Paul didn't completely specify this. So I will take on I think that there's a separate new individual market that doesn't have the problems of the past. My worry on this is the ins and outs. So, if you have a tax credit, and, Paul, I'll add to your background that the tax credit has got to be used for the full year; that is, there is no in or out. You essentially have a tax credit with a lock-in. Then, Stuart, I would suggest that without a corresponding lock-in, no plan, in its right mind, would participate in that if other individuals could come in or out of the market.

DR. BUTLER: But if other people are locked in under the same circumstances--

MR. BERTKO: If they are.

DR. BUTLER: Well, that's a rule of the group itself--

MR. BERTKO: So that--

DR. BUTLER: --of the pool itself. I don't have any big objection to that. The only issue is whether you are saying we're going to create yet another system now, regarding traditional employment-based system, we've got individual market and so on, and now we're going to segment out another group of people and create a

completely different system, in a sense, for them, I don't think that makes a lot of sense.

MR. BERTKO: I would agree with that, but then you are saying, instantly, we have got to reform the whole existing individual market, and I am not sure that was part of today's topic.

MR. HALL: Yes. Let me just chime in as well, that I think what, Stuart, you are saying makes sense. If the other options they have are roughly comparable, which is true for small groups, down to groups as low as one, and I hope everybody knows what a one-person groups means to all of us insurance-minded people. It means a self-employed person that buys their own insurance as their own employee benefit. But, in any event, we can think about a two-person group if that makes it easier.

In any event, the market rules in that small-group market are roughly the same as what we're contemplating for these pools. But if you allow in folks who otherwise are purchasing in the nongroup market, so employees who are not self-employed, who aren't getting insurance through their employer, then coming into the pool, the market rules are so radically different that you're going to create huge selection issues at the boundary of choosing which of these options to shop in.

MR. CURTIS: Well, this is just one observation. I didn't hear Stuart say that necessarily the people

without subsidies would have to pay--get to pay the same rate as the people with--I don't know what he thinks about that, but this could only work--and I agree it's good not--we're talking about the same people. One year they make $50,000, the next year they make 80 or 30. And for them to have to be going different places to get coverage based on whether they're qualifying for a tax credit would be unfortunate, on the one hand. On the other hand, for the reasons Mark's pointing out, it would be important that in the individual market healthier people paid a lot less and sicker people paid a lot more, that for people with no tax credit or only a small tax credit on a phase-out basis, as Paul pointed out, the pool could have some health rating in that instance for those people that don't have tax credits. Otherwise, it could not work.

DR. GINSBURG: Okay. Now, if we're going to--okay, so we've talked about two options, either the pool is open to everyone, but with people without tax credits perhaps having health rating, presumably the people with tax credits wouldn't have to have health rating.

DR. BUTLER: Well, I think it depends on the design of the credit. I mean, you know, if you have a flat credit, that's one issue. If you have a credit which is related to the cost of health care, a sliding

scale credit or something like that, then I think you don't have quite the same level of issue there.

DR. GINSBURG: That's right.

DR. BUTLER: That, you know, is something Rick mentioned, you know, Mark Pauley and ourselves and others have looked at that, and I know the pros and cons and so on. But, you know, one of the purposes of having a tax credit related to the cost of your actual coverage is essentially to modify or to lessen the issue of rate setting according to health status.

MR. CURTIS: Paul, I think that kind of approach can work with respect to age rating, which is pretty standardized and it would be easy to do. With respect to health rating, to say "dubious" is an understatement. I just don't think it's practical.

MR. BERTKO: Yeah. Let me echo Rick's words. I spent a large number of years, as you noted in the bio, Paul, on this, and collecting the data necessary for it is difficult. Then, secondly, the prediction of future cost based on what you know today still has relatively low predictive power when it comes down the individual selection issues and what people know about their own health status and projected health needs. So the market rules on this have to be extremely strict and organized to allow this to happen. I agree with Rick; on average, it has something to do with age and probably gender,

given that you'd have selection for people who were--families that were going to become pregnant and can do some prediction there. I think that is much more workable.

MR. McMANUS: I'm John McManus. I'm with the Ways and Means Committee. I apologize I'm late to join the discussion.

Just a comment on having the credit be a percentage of the cost of the premium, I think that would be the wrong way to go given the current structure we're in now in which you have an open-ended employer subsidy, and the more health care you buy, the more subsidy you get, and the richer you are, the higher marginal tax rate you are, the more you get.

Part of why I think we want to go towards a tax credit is because it's a discrete amount that would force an individual to be a little more cognizant of how to spend their health care. And above that amount would be after-tax dollars. So I would not want to structure a system in which people would be rewarded by picking Cadillac plans and, therefore, get a higher tax subsidy. I just don't think--

DR. BUTLER: Well, but it's not a trade-off. It's one or the other. I mean, look at the way the FEHBP works, which is you get--what is it?--75 percent,

whatever the figure is, up to a limit. And then if you go beyond that, if you want the Cadillac as opposed to the pretty serviceable Chevy, then you are on your own. So it's not that these are mutually exclusive. I'm just merely making the point that if you're looking at the concern of risk rating and so on within plans, one of the advantages of a credit which is related to what you actually pay is that, you know, sicker individuals who are going to--not necessarily just pay more for the same plan, but want a more elaborate plan because of their actual situation, will, in fact, get a higher subsidy up to some limit. And that's the sort of argument for going in that direction. I'm not saying that that's what we should enact necessarily because of other issues, too. But I'm just saying in terms of this risk issue and how you underwrite and so forth, a variable credit does allow you to permit some greater variation of pricing without unduly hurting financially the person who has to buy it, because you're subsidizing that person in a more direct way.

MR. VOGEL: John, if you take a look at it, you've got a wide range of premiums that are charged throughout the country. You've got some very high areas and low areas. And so the higher-cost areas, if you just have one set premium amount, it becomes almost as if the

tax credit doesn't come into play because of some high premiums.

Most of the purchasing pools--and I run a purchasing pool in Connecticut--offer a wide range of benefits, and the tax credit can be pegged, if it's a varied amount, at, say, a lowest-cost plan. Then if somebody wants to opt up to the Cadillac, as we're talking about, they would pay more. But it can be targeted at some plan, some basic rough plan design that we think fits the bill.

DR. GINSBURG: Let me move us along to the next issue about who can participate in the pools. And maybe this is a detail, but I think it's pretty important.

Let's say you have a law firm, a small law firm, and they have health insurance coverage, but some of their employees, secretaries, office staff, they would be eligible for tax credits. What should those employees do under a plan where people with tax credits, and perhaps some others, went to the purchasing pool?

MR. CURTIS: I might not pick a law firm an as example. I'll start with what I think is a no-brainer, a retail store where a majority of the workers are low wage that doesn't offer coverage now. I believe it would be a win-win to allow those people to use their tax credit through the employer group to come to the purchasing pool

as an employer group. There could be no crowd-out of existing employer contributions in that instance. Very few low-wage small firms now offer coverage. Those that do are very likely to drop it within a couple of years. They simply can't afford it.

So I think that if that were an option, it would be a win-win because it's easier for people to have the payroll deduction to make their contribution. There is some conveniences of getting coverage through work, so long as there is still choice through the pool.

And just as importantly, you leverage coverage of some people who now may be uninsured who aren't quite eligible for the tax credit, but can't afford coverage on their own, but could be brought along as part of the group.

The law firm I think is no different than a big corporation in that it may have some low-wage workers or some ineligible workers that don't have coverage through the workplace. And, you know, then the question is: Do you make a tax credit workable for them to be able to get coverage through wherever their employer does get coverage, or do you not and allow them to go on their own? To have an employer sort of have a subset of employees who are eligible for the tax credit and then for those employees the employer brings them to the purchasing pool seems to me an extra layer that's

unnecessary if the employer is otherwise covering their other employees some other way.

DR. GINSBURG: Okay. But what I wanted to clarify is that, you know, the starting assumption was that you had to go to a pool in order to use a tax credit. So we're now talking about a low-wage employee of a firm that we want them to benefit from the tax credit, if it's a design like the Jeffords bill that has some tax credits for people whose employers offer coverage. How do we reconcile that?

MR. CURTIS: I personally think those people should be able to use that tax credit to buy into the employer coverage they've declined so far.

DR. BUTLER: I totally agree with that, and I think that's the argument and the logic that was used behind the legislation, both to make sure that you didn't lead to a situation where people were discriminated against because they had coverage available, particularly for dependents, which I think is the bigger, the major issue, and so on. But I think, you know, this issue about low-wage employees in these kinds of firms that don't currently provide coverage, I think it begs the question as to why you necessarily have to require the individual, the employee to go through a pool or any plan that is selected by the employer himself.

I mean, we've made the assumption up to now, I think, which we ought to challenge, as to whether you're in or out of this pool and which pool you're in, is a decision made by the employer. I don't think you have to do that. I mean, the point Rick made of a very practical nature, which is it's very convenient to, quote, get coverage through your place of employment because everything's handled by the employer, the tax is handled through withholding and so on, I don't think that requires you to necessarily then say that that employee then must select a plan or a pool that is selected by that employer. They're not connected. There's a practical issue.

MR. CURTIS: Well, I think there's a simpler or practical issue. A small employer with employees that don't want the employer to do this won't do it. The employer would only say, okay, I'm going to take you as a group to this pool where the employees want them to do that. I'm not talking about requiring people who are eligible for a tax credit who happen to work for a low-wage small firm to get their employer to offer coverage and then to go as a group to a consumer choice pool. It's where the group decides to do that. That's the practical reality with small employers.

DR. BUTLER: But if we're going to have different pools available to people, those pools may differentiate themselves in various ways.

MR. CURTIS: Yes.

DR. BUTLER: And they may--a certain pool may be much more attractive for a certain employee and another pool for another. And I think it's very important to allow people to make that choice, because I think one can envision pools specializing in certain types of individuals--I don't mean medically, necessarily--and one must allow that to be open. And I think if you delink the practical aspects of employment-based coverage in terms of payments and withholding and all that sort of thing from which pool that individual employee can join and which plan within that pool, I think that's--you want to really end up with that result so that you can give people the maximum choice and have--

MR. CURTIS: We've found a place we actually disagree about. I think that the pools should have real consumer choice so they can meet the needs of most employees. Again, where that's not true, the employer would not decide to do that and let their individual employees take the tax credit where they want. I would, in effect, let the market decide that rather than

presupposing that you couldn't have a group go together to a consumer choice pool.

DR. BUTLER: I wasn't--if there's agreement with the employer, that's fine. I don't have that--and if that's the argument, we don't have an argument. And if everybody agrees they all want to go in one pool and they're quite happy to have the employer pick it for them, that's fine by me. If you don't have that situation, I think it's just very important that the individual's selection of pool and plan is not determined by the employer in any way, even if the employer has an obligation to make payments and to adjust taxes and so on.

MR. CURTIS: Well, here's how the market would decide that, Stuart. I'm assuming in the small-employer market there would still be a participation requirement, and--

MR. BERTKO: Under ten, absolutely, without a doubt.

MR. CURTIS: And if the employee has the choice of taking the tax credit as an individual elsewhere, then the employer isn't going to meet the participation requirement if they have a couple of employees who think that and the thing isn't going to happen. You don't need a bunch of new special rules to make this a reality.

MR. BERTKO: Right. And I just would like to add here, to echo what Rick said, if there is a chance that there would be selection issues linked to whether you choose with the employer or with the pool, back or forth, it'll happen. And the market, subject to any other constraints, will say those groups of one to ten employees that are allowing their folks in or out, again, won't be offered coverage.

MR. McMANUS: I think we have to look at this from a different perspective than we have in the past. The health insurance purchasing--HIPCs have been around, talked about for over a decade now, but we see new things emerging now, for example, e-health insurance on the Internet, in which you can choose health insurance, you know, an array of options. You can immediately and in real time get rates and what your coverage options are and so forth. And 40 percent of those who have gotten insurance through this e-health insurance were uninsured previously.

So I just think we should not lock in legislatively--I know we are talking here in an academic framework, but my job is to help put legislation together. Let's not lock into ways that we've done things in the past, necessarily, and not allow for new

structures to evolve and have people available themselves of those structures.

MR. CURTIS: In that sense, I would mention that a number of these things you referenced as HIPCs had exactly that kind of data, that 40, 50, 60 percent of their enrollees were previously uninsured. It was probably correct. It's probably correct in e-mail--I mean e-insurance. But that doesn't mean that either reduced the number of uninsured. Probably in the bigger picture, they're not. These new mechanisms are more attractive to people that don't already have connections in the market. It's probably the previously uninsured who are newly coming into the market, anyway, and they're more prone to trying something that they think is new and better.

But without the tax credits or something, it's unlikely any of these things is really going to make a dent in the uninsured population. I know you know that, and that's why you guys are working on tax credits.

MR. McMANUS: What I was suggesting is, as we put the tax credit package forward into legislative language, we ought not lock into structures that we think have been effective but then prohibit us from going forward on new and emerging technology and ways of doing business. That was the point.

Obviously, you need tax credits--I mean, the biggest reason people who are uninsured cite, I think 73 percent who are uninsured cite why they can't--why they're uninsured is because of cost. What's the biggest way to address cost? Well, let's provide them the resources.

I think what's valuable in what we're talking about here is costs aren't just how much money you have but how much does the insurance product cost. And so it's marrying those two, and in a way that doesn't prohibit you from going forward in new and innovative ways in the future that's going to be difficult when you're legislating on this.

DR. GINSBURG: Okay. This is probably a good time for us to go to the audience to ask for questions or comments on what we've covered so far. And please hold off on asking questions about what we're going to get to after the break. So why don't you come to one of the microphones and identify yourself, please.

FLOOR QUESTION: Good morning. I'm Katherine Kunkel (ph) with the National Business Coalition on Health, and I've really appreciated the discussion because I've always been a firm believer that HIPCs was a very viable alternative. But I was very disappointed

from the viewpoint of our organization that it wasn't more successful.

With regard to the tax credit issue, though, I just have one burning underlying question, and that is that--it's a very practical question. For people who are low-income, the tax credit implies, at least this is my understanding, that they have to wait to get that money returned to them. Is that not correct? Am I misunderstanding? That you pay up front and then you get the refund.

DR. GINSBURG: Well, actually, it is starting out like that, but a number of the people on this panel--Stuart in particular has been dreaming up ways to avoid that problem.

DR. BUTLER: It's not dreaming up, exactly.

[Laughter.]

DR. GINSBURG: Well, in the sense that--

DR. BUTLER: Well, I mean, we don't have to wait until the end of the year to get the mortgage deduction, for example. It's factored into people's withholdings, typically. I mean, I suppose you could wait until the end of the year, but you don't have to do that. There are other ideas, including one in the Jeffords bill, which would permit lower-income people to assign a credit to an employer--to an insurer, rather. In other words, the premium is discounted in line with the total value,

and I think that's another--that's an easier mechanism if you have a fixed credit, certainly, but I don't think it's precluded by other types of credits.

So I think there are ways of doing it. I think this notion that any kind of tax measure is somehow fundamentally deficient because everybody, you know, gets no benefit from a tax break until April 15 or thereafter, I mean, it's just--that's not how tax breaks work. Everybody goes in, you know, to their employer and they make an adjustment.

Now, even if it's a refundable tax credit, in principle there's no reason why that can't be a net payment in a sense to the employer and, hence, to the employee and is just an adjustment in the total net amount that the employer remits to the treasury.

I think there are all kinds of ways of dealing with these kinds of things. So I don't think that's a fundamental problem at all.

DR. GINSBURG: Okay. Other questions?

[No response.]

DR. GINSBURG: Well, let's take a break now. We'll return at 10:40.

[Recess.]

DR. GINSBURG: As the panelists are coming up, let me reflect on where we've been as far as the tax credit option we're designing at this stage.

Beyond what I said about that tax credits would have to be used in a purchasing pool, as a result of comments from the panel, we modified that, that there would be a lock-in for a year, or something like that, and that others, those not eligible for tax credits, could use these pools, but perhaps at different payment rates than those eligible for tax credits, and perhaps even, I think as Rick had suggested, people with partial tax credits because they're in the phase-out range might also get a different rate. And this is really designed to deal with the selection issue, the fact that for those that have substantial tax credits, selection is less a concern, as long as they're locked in. And perhaps the selection is of greater concern with those who are not eligible for tax credits but see the pools as an attractive way to get insurance, that their rates would be different and perhaps would be reflecting--actually, not so much different, but they might be health rating for those people. They would not be for people on the tax credits.

So the next topic I'd like to get into is state-federal issues that, you know, given this starting model of some entity of government authorizing different

agencies to act as purchasing pools and to serve those getting tax credits, what should the federal or state governments do? And also cognizant of Stu Butler's comments that, you know, conceivably this might be the system in some states but not in others.

Mark, would you want to start us off?

MR. HALL: Well, I think that--I hate to invoke HIPAA. It's getting a bad name these days because of the privacy rules, but in its insurance regulation aspect, it has set a reasonably workable model, which is to set fairly broad federal standards and allow states then some diversity in terms of certifying or choosing options or, you know, having a default if states don't respond. So something like that I think make sense, which would allow a great deal of diversity to emerge and address the comments from John McManus before the break, so that you have a variety of different approaches that could emerge, but sort of all oriented towards achieving a general federal objective.

So that seems to be the best sort of federalism approach to take in the area of insurance regulation. Then, more specifically, what would those federal requirements be and how broad a range would states be allowed to diverge? I haven't given those details great thought, so we might turn to some other folks who have.

DR. GINSBURG: Rick, is that your sense, that you'd want to have the states do this under some broad federal guidelines requirements?

MR. CURTIS: Yes, I think Mark articulated a sensible general framework. It seems to me that the federal policymakers do have an overriding concern that people who have tax credits can get affordable coverage, and there may be some sensible policies that say if the state goes the course, it has all sorts of extra administrative costs so that the coverage would be less affordable because of those state policies, that the states make up the difference in the administrative costs so that tax credit recipients aren't hurt by them.

But I think that overall construct makes sense.

DR. GINSBURG: John, members of your committee, do you have any sense of their feelings about state roles in this area?

MR. McMANUS: This is a prescient time to have this discussion. Just last week the Health Subcommittee of Ways and Means had a hearing on the uninsured. Our jurisdiction pertains to the tax credit itself. The insurance exchanges or health insurance purchasing cooperatives would be in the Commerce Committee's jurisdiction. But we did hear testimony from Sarah Singer on combining tax credits with purchasing

cooperatives, and it's an idea that Mrs. Johnson is very interested in.

Obviously, we have to work across committees, and to the extent possible, work in a bipartisan manner. That gets tough when looking at tax policy on how Ways and Means has been doing business recently with Democrats opposing most of the provisions. But I think this is one area where you have a bipartisan consensus that the tax code can be used to help people with insurance. It's interesting that Pete Stark and Jim McDermott, members of the Ways and Means Committee who are by no terms--I wouldn't even think they'd call themselves moderates, are very interested in the tax credit idea. And I think these new ideas that we're discussing today really take the proposals on tax credits one step further. And I think it's a very productive discussion, but there has not emerged a consensus within Congress on what's the best way to approach this issue. I think we're just at the beginning stages of that, and really with the hearing last week and with this discussion today.

MR. BERTKO: Paul, I would just add that as one of many companies who cross several states, we've got operations in I think as many as 25 states. The more similarity we could have, the better. You know, there is a model using the NAIC on this, but I guess I would just

encourage it to be as similar as possible while retaining that flexibility that states have.

DR. GINSBURG: Yes. Any specific things that you think of that should be uniform?

MR. BERTKO: Well, if we go back again, I'm an actuary, so risk selection is first and foremost, you know, to get affordable premiums. And if we can have the participation rules be as similar a possible, I think that would be very useful.

DR. GINSBURG: These are participation for?

MR. BERTKO: You know, as we talked about, who can come in, how long you stay in, whether there's a lock-in. The whole debate we had about small employers being in or out, and so the employees of large firms who don't offer coverage to either their employees or to subsets of their employees. These are a lot of details, but I would suggest they're very important details that we'd want to work out to avoid these things blowing up in the future.

MR. CURTIS: I think that's very sensible. The one area where the flexibility would, I think, have to be retained is on rating for the partially or unsubsidized populations. I mean, there could be national rules that make sure that people, regardless of their age or health status, somehow can still get affordable coverage with the tax credit. That would be up to you. If you did

that, it would be important to leave states and whatever these kinds of organizations are, if they're e-commerce based pools or traditional ones, they need to be able to, for non-subsidized folks, be able to rate like the market does or they won't work.

MR. HALL: Well, I don't know if you mean to get to governance and, you know, conflict of interest and board membership issues later or not, but this is, I think, one area where there might be disagreement, certainly would be disagreement, but in terms of whether there ought to be a uniform federal rule or state variations. So one approach would be to say that the pools have to be nonprofit, they can't have any insurance industry representation on the boards, et cetera, versus an approach that says as long as they are following the rules and producing the general kind of results we want, they can have any kind of sponsorship that sees legitimate and reasonable.

DR. GINSBURG: Yeah. Actually, I think this is useful. Rather than talking about whether that should be uniform or not, it would probably be wise to have some discussion what would be characteristics of a desirable pool--in other words, like the separation from the health industry or offering products from different carriers. I

mean, should this be an element that we consider this as a key part of being a successful pool? Rick?

MR. CURTIS: From my point of view, offering competing plans so that individual consumers can choose among competing plans is elemental, with the exception that states should be able to designate if they've got an area with very sparse populations where that kind of thing just isn't sensible and can't work.

MR. BERTKO: So, Rick, let me jump in here and ask: Are you going to then prohibit COSE from becoming one of these authorized pools?

MR. CURTIS: They actually do, as you well know, offer Kaiser as well as their dominant health plan, and employers can offer choice. But, yeah, for tax credit recipients, that has--there is a very unique history there that we don't want to bore the audience with, but, in general, if a pool or a purchaser or whatever we want to call these things--hopefully we won't call them HIPCs just because of the baggage of the term. Alliances. Actually, the first alliance in the country is doing well. It's in Colorado, and Bill Coors was the genesis for it, who was on the Reagan--

DR. GINSBURG: Actually, we should say that the term HIPC did not come from the Clinton plan but came from the Jackson Hole group, which was really the intellectual spur for this.

MR. CURTIS: Yeah. It came from Alan Enthoven and Rich Kronat (ph), even predating the Jackson Hole group in a previous point in history.

But, at any rate, where were we?

[Laughter.]

MR. CURTIS: I did have another point. We just--

DR. GINSBURG: Well, you were answering a question, John's question about COSE.

MR. CURTIS: Yes. It seems to me if these pools can have just one carrier, that they are not--you know, there isn't any real distinction. It's an extra, unnecessary layer, and just don't bother with them. They would be captured by the plan. They couldn't actually be in a position of being a purchaser over time in most instances, and it would be an extra layer that had no real benefit, I think.

DR. GINSBURG: Any other thoughts about--so, in a sense, we've talked about competing health plans in the pool. Should this be a nonprofit organization, or can entrepreneurial pools be okay?

MR. BERTKO: Well, let me ask a different version of that question. My experience is, you know, with the side to Phil and other people who have been in existence for a long time, there is a fair amount of

capital necessary to start one of these things up, and I think Rick well knows that a couple of them that have failed, I think, have failed substantially because they had very low backing and weren't able to bring the necessary skills and talent to it.

If you make a requirement of nonprofit, you may prohibit some folks from coming into it that would otherwise be able to help start and run these pools. In California, I knew of a large regional brokerage firm connected to the insurance industry, because it was as brokerage firm, but otherwise I would call them upstanding guys in beating down health plans, if you call that a term. And they had a very tough time for several years trying to bring up a medium-size--medium-employer-size purchasing pool.

So I guess I'd just throw that out there as a question of start-up funds. If you're not going to provide special funding for this, then why would you prohibit other organizations and entities from helping to get these off the ground?

MR. VOGEL: Let me just say one thing here as well. In taking a look at this, it isn't--from a high level, it looks like, geez, it's very simple to administer. Then you get underneath the covers, and it gets very complex. And depending on the rules and regulations that we put in there, I would just, number

one, look at saying the private sector has been moving forward, and I would hate to eliminate the private sector from this because there has been investments in doing this. But also trying to give flexibility that, you know, on one sense that, John, I know you would like from a health plan standpoint, have it broad enough that it's pretty standardized across the country, but also the flexibility so that there is a--the efficiencies that we've gained in bringing a health purchasing cooperative together, we can actually utilize those without having to layer on on top of that more administrative rules that take away all those efficiencies, because, you know, we work day in and day out trying to bring four health plans, 18 different options, to a single employee, and you've got to try and do that as simply as possible, or very quickly any savings get eaten up. And, again, it's a voluntary marketplace out there. The health plans can simply say I'll compete outside the marketplace, as John was talking about, that Wellpoint does in California, others do as well. And we don't want that to happen.

MR. CURTIS: It seems to me a policy objective--by the way, for those of you who don't know, he's a not-for-profit private business association in the business of representing the best interests of the small employers and consumers. And that's the test here.

As John and Phil both know, most of these kinds of organizations, if they're going to go up, will retain a for-profit vendor to handle the stuff that's expensive that needs to be capitalized. Those kinds of vendors, they're sort of voluntary. There isn't any money there. This is no assurance of any volume, haven't been willing to take the risks. But in the instance of tax credits being tied to this and a very substantial population buying coverage, that would change overnight.

There would still need to be some start-up funds for the--you know, if they were to be something like not-for-profits. But I think some way of assuring they really are there to represent the best interests of the consumers, and if they're small employers, the small employers, is important. And most people who sell health plans get paid by health plans. And if they're paid by health plans, their allegiance is to them, and I think ultimately at the end of the day that can be problematic.

So I'm one who still thinks it makes sense. I think they should be private. I think they should be organizations like Phil's who are very market savvy and know how to operate, but by their very structure are representing the best interests of the consumers.

DR. BUTLER: I agree with that. I think it's very important to not sort of shut the door to innovation that could take place and new sources. And as Rick said,

once you provide a tax credit, particularly if it's substantial or if it's a combination of a federal and a state tax credit, so we're really talking about a big increase in consumer power among a certain group, it's quite possible that all kinds of different types of systems could come into being as the core of pools.

I mean, for example, you could see--I think you could see some of the large employers today which have very substantial health plans actually going into the business of covering other people. We already see that; the John Deere Company provides coverage for federal employees, for example, because federal employees come with a subsidy. And if people could come armed with a tax credit, I suspect that companies like John Deere and so on would find that potentially a very attractive market.

I think also you've got other organizations, other nonprofit organizations that we ought to make sure are not precluded, that have already a core group of people that probably would be the kind of people that would be targeted by any kind of credit, some of the service unions, for example, church-based organizations, and so on.

So, in other words, I think it's important for us to make sure that once you change the economics of

this market with the tax credit you don't sort of just continue to think, well, only what's available today might be available tomorrow, and so let's sort of get the best of today and lock that in. It's very important to be as open as possible. Even if that causes--you know, even if mistakes are made and even if there's disruption, I think it's--we've got to recognize that we're going to be dealing with a very different market and potentially all kinds of different organizations. And some of those will be organizations that are very much acting in the interests of the people who are members of those organizations, such as church-based organizations.

MR. McMANUS: That was exactly my point. In writing the legislation, we've got to be able to try to foresee or at least allow plans and those who are offering these types of purchasing pools to evolve and innovate. If we prohibit certain organizations because they're for-profit or if we say only these kinds of structures with this kind of make-up can offer the purchasing pools, I think that really limits our ability to have the synergy that's necessary and the innovation necessary to try to deal with this really monumental problem of the uninsured. And, frankly, the current system, even though who are insured, really are getting their insurance chosen by someone else, their employer, which doesn't make a whole lot of sense to me.

MR. HALL: Well, if we're going to allow for-profit, I mean, just realize it's going to require a lot more regulatory oversight. So you may have to regulate, for instance, the medical loss ratio, in effect, to avoid unconscionable profits. Or I'll remind everyone of MEWAs, another unhappy acronym in the insurance industry, which were sort of fraudulent or poorly managed or fly-by-night operations that were purchasing pools for employers that require constant sort of regulatory oversight to allow them to continue to exist.

MR. VOGEL: And it's going to come down--John, you'll like this. It comes down to risk selection.

MR. HALL: Yes.

MR. VOGEL: We've just got to make sure--I mean, Connecticut, I think one of the reasons we've been successful is because we had small case reform laws already in place. We had market rules that we were playing by, and it made it harder for people to opt in and opt out, depending on if they can go get a different price. It really kept the marketplace intact and now allowed just to really compete based on the goals of managed competition.

MR. CURTIS: I mean, that I consider to be the core point. I don't think anybody disagrees on objectives here. But if individuals with tax credit can

willy-nilly move around all sorts of different things that call themselves pools and go in and out and those pools can rate them on different bases, it's just not going to work. The individual market suffers for several fundamental reasons. One of them is, of course, that people go in and out of the market. It's sort of a market-wide aggregate, demand-side risk selection problem. People tend to go in when they're sick and go out when they're healthy. And a tax credit could potentially address that for this population, so that people go in and have health insurance.

But the other part of it is individuals, if they can move around to where the price is best on a day-to-day, week-to-week, or, I would argue, even on a year-to-year basis and they're eligible for a gazillion different kinds of pools, none of those pools can ever be in the position that a big purchaser is now like the Federal Employees Program or a big private employer. They are in that position because they have a big contribution, they represent the people who get coverage there, and they get coverage there and only there because that's where they have to take the contribution. And there is cohesion to the group. It's a stable risk group, and they can be well represented by a purchaser.

If there aren't those key elements to this, then pools won't achieve any of the goals that have been

espoused. That does not mean there can't be lots of room for lots of market innovation. It does mean, as Mark and John have alluded to, as well as Phil, there needs to be some structure around it.

DR. BUTLER: But, Rick, would you agree that probably the most important element in that is the locking-in period? I mean, we've had--we discussed this in Medicare and with the same view. And if you look at something like the FEHBP, it's true it's one large employer, but it's almost 10 million people, and they have wide selection and they have wide variations in benefits. It's on the face--and it's community rated. It's almost on the face guaranteed to fail, and yet it works pretty well. And it may be that having that year-to-year lock-in is probably the most important element of putting some stability, certainly from the insurer's point of view, in terms of assessing that market. And maybe if we focus on that, you can allow rather more variation in some of these other factors than on the face of it might be necessary.

MR. CURTIS: Well, I agree with that in general. I know John has some comments on some of the premises. But it is true that you have--it is a purchasing pool with lots of choices within it, and the way individuals choose and the way the health plans that compete for

their enrollment behave is monitored and structured. And that's different from saying in a given state you've got 50,000 people with tax credits, and you can have 1,000 different things calling themselves a pool, and any individual with a tax credit can go to any one of them in any four-month period of time. Those are fundamentally different worlds, and I don't think that a direct analogy can be drawn.

But I know John has some observations about it.

MR. BERTKO: Yeah. Just on FEHBP, we should be careful what we allude to there. Historically, as a footnote, the high-benefit plan priced itself out of existence during the mid- to late 1980s. We are participant--Humana, my employer--in several of the markets. We left a few, partly because our placement in the market--and I'll say that's partly risk selection, partly our cost efficiency--was insufficient. And I think there is a winnowing right now of health plans participating in the FEHB program.

There still is a large amount of choice. The one-year lock-in and the high subsidy, the 75 percent subsidy, is fairly successful. But on the margin, for those folks that go above the 75 percent contribution, you begin to rethink your strategy if you are a health plan on whether you can succeed in that particular market.

My prediction is that FEHBP will continue but that the amount of choice is probably going to be narrowed over the next couple of years.

DR. BUTLER: But the amount of choice right now is substantially higher than anybody in most--almost anybody in the traditional employment-based system. And, you know, we've been hearing about how FEHBP is going to kind of run aground next year for about the last 25 to 30 years, I think, and it still seems to be trundling along.

MR. BERTKO: No, no. It will not run aground, but selection--or choice may be narrowed. Those are two different things.

DR. BUTLER: That may be so. That may be so, but even if it was halved, it would still be substantially higher than most people face.

DR. GINSBURG: Why don't we move on? John, is this on something else or on FEHBP?

MR. McMANUS: Well, just on that FEHBP point, we've said plans which are highly priced moved out of the market. That's a healthy thing.

DR. GINSBURG: Sure.

MR. McMANUS: That's part of marketing and part of the private system. If you're not efficient or if you've made some bad business decisions, you should not be rewarded. So I think that is a very productive part

of that, and I think we shouldn't see that as a bad thing.

DR. GINSBURG: Okay. Let me just close off this discussion of FEHBP to say that, in a sense, the Office of Personnel Management is the manager of the purchasing pool, and one of the things that they have done over the years very quietly behind the scenes for the public, though very visible to people like John Bertko, is that they have told plans, no, you can't offer that benefit; that they have--and all this driven to reduce the risk selection in the system, because in a sense, otherwise, the thing really could blow up. But I think it's been the good work of the OPM that in a sense has prevented that from happening, but it's come with a cost of a lot of freedom lost by plans as far as what products they can offer.

MR. BERTKO: Let me only second that. We applaud the work of the OPM as an active and worthwhile manager of this purchasing co-op. But we occasionally get some bruises, as Paul has alluded to, but, in general, they're a good partner.

DR. GINSBURG: But in a sense, you know, this is my preface to, in a sense, the job that the purchasing pools are going to have to do that we're talking about, in the sense that they can't be laissez-faire. They can't let plans just do whatever they want, or else

they're not going to have a viable market. So this is actually a way of getting to the next question, which is: Will or should purchasing pools and the products they offer conform to states' existing regulations on small groups or the individual market? Or should they be permitted to develop their own rules for within the pool?

So, for example, if a state has rating bands that are 20 percent, does that mean the purchasing pool should have rating bands or 20 percent? Or can the purchasing pool do something different because it has a different clientele?

MR. CURTIS: It seems to me that with respect to full tax credit recipients, the federal government could say, if it wanted, that we're only going to allow you to vary rates by this, that, and the other thing, and those rules could be tighter than what the state allows on the voluntary unsubsidized market. But the purchasing pools would need the ability for other non-subsidized or partially subsidized people to do what the market allows or they'll suffer from risk selection.

You know, I don't care what you call these animals. Again, it could be an e-commerce-based thing that offers health plans. I would say the same thing has to be true. And as John said, for tax credit recipients,

there need to be some fairly uniform rules on that kind of thing, or it's not going to work.

MR. BERTKO: Well, I would only add here that if you have too many special rules, it could make other parts of the market blow up. So, for example, if mandated benefits were eliminated for these special purchasing pools, they would be less costly. The amount of the cost decrease is, of course, subject to great debate, but to some extent there would be a magnetic effect as people would flow towards less costly benefits. The three important things in this end of the market are cost, cost, and cost. Phil knows that. We try hard on our side and Phil and others try hard on their side to keep it down.

Any action that you take to give special treatment to these will, in fact, have some opposite and not necessarily equal reaction in other parts of the market.

MR. HALL: Well, on this, I've written in terms of there being market gradients, to some extent natural, according to the size and the identity of the purchaser and their motives, but to some extent artificial, according to the different regulatory environments that attempt to respond to these natural phenomena. So right now we have a very large market gradient between the individual market and the small-group market. And I

think we imagined these pools would sort of fit somewhere in between.

So to say that the rules should be identical to either one or the other I don't think is necessarily the case because there will be people who could potentially cross into the pools from either direction. Some attempt to minimize the gradient is good, along with John's comments that you don't want to create too many differences. But there's already a big difference, and I don't think there's an inherent logic that it has to automatically match up with this level or this level, but it could be somewhere in between.

But I think that the general sense is that it would be somewhat distinct. For instance, I think the ideas that the pools would be rated separately based on the experience from the credit holders as opposed to being rated as part of some other larger market. In other words, one idea would be to say carriers that sell to the pools must take that pool experience and include it as part of their small-group market experience for rating purposes, which is what we currently do with HIPCs. I think there's a notion that it wouldn't necessarily be required to make this a sustainable idea. Whether it's advisable I think is probably subject to debate.

Has that gotten us into the too technical area?

MR. CURTIS: We probably are there, but I would point out, that depending on what proportion of a given carrier's, what they call book of business, is tax credit or not, you could end up with some very wacky things if you require what you just suggested. So I don't think it's a good idea.

DR. GINSBURG: What about interaction between pools and public programs such as CHIP or Medicaid. Is there something that could be done to deal with, say, the family whose child is eligible for CHIP and whose--where the family is also eligible for a tax credit based on their income?

MR. CURTIS: I try to stay as subjective and even-handed as I can on all these issues, but this one is tough. This one is tough. To have a set of federal policies that in essence requires family members to go different places to get coverage so that they can afford coverage, I think would be unfortunate. I think medical homes logically start at home.

So these kinds of mechanisms, several states are talking to organizations like this or like in Kansas, and "This is not a partisan thing, I'm not a partisan guy." In fact, they tend to be very Republican states, are looking at this kind of mechanism as a way to, in this case, combine the public subsidies available for kids,

and in most cases, parents too, with employer dollars. And if there are tax credits available similarly, you should be able to pool this so a family can choose coverage, get coverage in the same place.

And this kind of structure has the real advantage of being able to rationalize things on behalf of families, and have the dollars follow the families' choice, rather than not only families running around chasing the dollars, but, you know, the 5-year-old kid one place, the 10-year-old kid another place, the mom someplace else, the dad someplace else, and, oh, by the way, all of them are going to have the change next year because somebody's status changed somehow. I think there is real potential for this kind of organization to rationalize that.

The other thing I would just mention here is, depending on how big the tax credits are, you know, most states add 200 percent for kids, a number of them have added parents, which I happen to think is a good thing. I'm very concerned that the way a number of them have done it is going to incent employers and employees to drop coverage and come over, but they're starting to change that. But that coverage, on average nationally in the employer market for families, is worth $6,000, and

usually the contribution requirement for a family, depending on the state, might be 500, $800.

So if you have basically something worth $5,400 to the family and the employer, in some combination, sitting there, and then you've got a tax credit over here worth $800 or $1,000, people aren't dumb, they'll go to the public program.

So I think having organizations of some kind able to act on behalf of consumers and rationalize this makes sense. Otherwise, you're not only going to have people flipping back and forth between individual and small group market because of tax incentives, you're going to have people flipping back and forth between public and private coverage because of level of subsidy differences over time.

DR. GINSBURG: So you would imagine someone taking basically a voucher from the CHIP program to pay the premium for their child, as they buy family coverage through the pool?

MR. CURTIS: Yes, yes.

MR. BERTKO: Let me now add the problem of affordable coverage. It's my impression--and Rick, you can certainly or anybody on the panel--that the SCHIP programs provide a fairly comprehensive benefit level.

MR. CURTIS: Yes.

MR. BERTKO: On the other side, most things in the individual market and small group market have very high deductibles. I believe that in our small group market, down at that end, the most common deductible is $1,000 deductible with 80/20 coinsurance following that. I don't think anyone would describe that as comprehensive. And so how do you mix and match these things to get some relief?

MR. CURTIS: Well, yeah. Well, I think there should be some more latitude here if parents choose something they think works better in terms of access for their kids. That's my personal belief. But even under existing standards, Phil shortly is going to be talking to the folks in Connecticut about such a thing, because he has, as most major purchasers do, have standardized benefit levels. For the kids there can be a negotiated increase that meets the benefit standards. The states would pay for the supplemental coverage in effect, and the kids would have that, and the parents would have what they would normally have through the employer plan. The non-subsidized kids would have what they would normally have through the employer plan.

DR. BUTLER: Well, I think the bottom line is, as you said, Paul, that one can envision certainly the SCHIP program as being, in certain states, converted

essentially for certain people into a form of voucher that supplements the federal tax credit, which is getting you very close then to real affordability for those people. That's sort of the--what we're talking about here, and that's why, I think, a number of the opponents of federal tax credits, you know, admit that in some cases that federal credit alone is not going to be sufficient, but they envision that as being a partnership with the state either by changing the rules, the federal legislation governing these programs, but even necessarily without that, allowing that to be mixed--the money to be mixed in so that people can join a pool or buy their own coverage through their place of work with a credit from the federal government, then on with the subsidy from the state. But that's the kind of--the pattern that I think is widely envisioned as being most likely for people, particularly very low-income people.

DR. GINSBURG: Okay. Well, let's go on then to having--to pulling it together. Frankly, I found that our discussion of these design issues went a lot better, and there was a lot more consensus than I expected. So we can proceed to talking about, well, how attractive is this idea? If there's going to be a tax credit, should tax credit eligibles be required to use their tax credit in one of the purchasing pools that is authorized and

regulated by states? Or assess this in comparison with the tax credit policy without that provision?

MR. BERTKO: Can I jump in over here? Mark and I began this debate at breakfast this morning. So given where we are that purchasing pools, today at least, don't offer all that much administrative efficiency; secondly, that one of the great advantages of purchasing pools for small suppliers is choice, on an individual basis that choice is then available through an individual company. I think that there needs to be a variety of new rules here, but it might be a hard case to make to say there is an inherent advantage to having a purchasing pool there.

I certainly am a fan of purchasing pools, as I said earlier, help set them up, but to me the case still needs to be made for mandating that they be there for this market where there is certainly a hyperactive individual market today that might need some quite substantial reforms to accept these, but I think--I look forward to having the panelists here argue the side that says purchasing pools are very worthwhile and worth imposing on the system.

DR. BUTLER: Yeah, I certainly share your view on that. I don't think you meant to sandbag us, but it sounded at the beginning that you were saying, well, let's for the sake of argument, let's assume that we're

talking about everybody having to go through a pool. And then you said that now there's consensus of what were going to do. I think we don't necessarily share that view, that that certainly may be a preferred option for even the vast majority of people, but certainly I think--I certainly feel that tax credits should be available to people to buy into their current employer-based coverage, for example, as the Jeffords' bill done.

There may be other options too. I think this is really a market test in the sense of--if this is the right way to go, it will tend to prevail over the long run, but the last thing we should do is say that a tax credit is only available if you go through this particular route. I just think that that's folly in terms of discouraging other kinds of innovative alternatives. I think it creates all kinds of perverse incentives and all kinds of distortions in the market and so on. I think we should say that if these negotiated pools are highly effective and really are the solution, then they will drive out the competitors over time, if that is the case.

DR. GINSBURG: Let me press you on that. First of all, when I was referring to the consensus, I didn't mean that everyone was in favor of this, but that we had a consensus that--

DR. BUTLER: Let's just have the record say that.

DR. GINSBURG: If there was going to be a purchasing pool proposal, that there was more consensus than I expected on what the details should be, but this is when we're assigned to take up whether we should go with this. And well, I should probably ask Mark to--

MR. HALL: Well, I was about to observe--I think the panel's going to split nicely, 3 and 3 on this, but the other 2 in favor of pools, I think they probably both have vested interests in that, so I'll speak as the sort of disinterested pool advocate. And not to impugn anybody's motives, but I mean people whose livelihood is working with pools, as opposed to those who have just gotten the grants to study them. But in any event--

[Laughter.]

MR. HALL: I think that the points that have been made are pretty strong points. If you compare pools to the option of using your credit to buy into an employer plan that you're eligible for, because the advantages of pools as compared to the small group market aren't that significant. I mean, there are some, and we can tease them out, but by and large, the advantages we're looking for are essentially already contained in the small group market. But if you compare using the

pools as against shopping with your credit in the existing individual market, I don't think there's any question that something like the pools is required.

And now I think I've split John's vote, because he's going halfway on the employer's side and the other half on the individual side. And Stuart even--his primary argument was based on shopping as an employee versus shopping in the pool. But if you look at shopping in the pool versus shopping as an individual, I mean, you just can't give people credit and say, "Go out to the unregulated, unstructured individual market and good luck."

So really the only choice then is, do we sort of regulate the entire individual market in order to solve the problem, or do we create these special shopping forums that deal with the credits?

MR. McMANUS: If I can get in, I think that the more fundamental question is not do we create these, but do you require it to be linked to the tax credit?

DR. GINSBURG: Yeah, that's really worth talking--

MR. McMANUS: And I think that's the unresolved question here. I think the burden is on those who want to require it to linked to show that you have to do that. For those of us who--and the legislative process working through these issues.

Just recently--this is the first I've heard of requiring that link to be there, and it's sort of out-of-the-box thinking, which I think is very helpful, but I think it's going to require a lot more analysis and evaluation by policy makers as we go forward on this, before we make that critical link, particularly when we don't want to, I think, box in and lock in a certain kind of product today which may not be appropriate for us 3 or 4 or 5, 10 years from now, and let's face it, Congress tends to act on these things every 5 or 10 years, and not much more than that. For example, Medi-Gap reform in 1990, locked in a product which is completely antiquated and makes absolutely no sense for the current Medicare beneficiaries' needs right now. And I would not want to repeat that mistake here.

MR. HALL: So let me just quickly make the point the Rick made at the beginning, I think, before you got here, which is, if you're going to provide the pool as an option to those who can also spend their credit in the individual market, unregulated individual market, the system will collapse because all the young, healthy people will go to the individual market and the pools will only get to old, sick people. So that's the problem. We all agree it's a nice idea to have this as an option, but if you create the choice down at the

individual end, it just collapses due to risk selection problems, and the only way to stop that is then to regulate the individual market so that it basically mimics the pools, but then you've, you know, over-extended--

DR. BUTLER: Well, let's see if you're right, rather than assume you're right, and do this. I mean, there's always proposals to have some monopolistic results. I mean, it's--how long ago is it since we said that if only everybody was in HMOs, that costs would be low and they'd all be happy? You know, it's only a few years ago. Now we're talking about this can only function if we set up this kind of structure. I mean, I just--you may be right, but I think we ought to--we ought to investigate that in the real world and make a modification if you are right. I mean, I don't think you are, but, you know, you may be.

But I think if you start by saying the only way you can have this credit is to be in the system, then you're going to set up a situation not dissimilar to what we have today, which is the only way you get a tax exclusion, a major tax break if you're an employee, is have your employer pick your plan. We have high-on insurance and we have people who are dissatisfied. We certainly don't--I think you'd agree--we don't want to

set up the potential for another rerun of that kind of a situation.

MR. CURTIS: I think we're speaking past each other. What I was hearing Mark say--and by the way, only less than 1 percent of our teeny institute's funds has anything to do with these organizations these days, and that was a small grant to develop a paper on this. Mostly what we do is work on how basically publicly subsidized programs can coordinate with the existing private market so as to expand coverage rather than crowd it out.

But I do think that, you know, a lot of people believe, and a lot of proponents like Stuart have, for a long time, said, "Gee, having purchasing pools available for people that have tax credits, so that they can have a sponsor who knows more than they do in negotiating with plans and so forth and so on, is a good thing, and let 1,000 flowers bloom."

And I think Mark's point is, "Well, again, if you're letting 1,000 flowers bloom that are supposed to be doing what the Federal Employees program does, for example, as opposed to an unregulated insurance market where they can take the credit, if 1,000 flowers pop up, they ain't going to bloom, they're going to die before they ever bloom because of risk selection problems." So

if I was hearing Mark correctly, he was saying, okay, you can do one of a couple thing. You could have market rules that are comparable for voluntary pools and for the other markets people could take these credits to, and that might work. Or you could just people go the individual market, or you could say, okay, there are a variety of a choice of pools you can go to, and that's the only place you can go to and we're not regulating the individual market.

But it is--we don't need a market test. We had a lot of them in the past, and they always failed. Where a policy maker said, "Okay, there are going to be these pool options, and they're going to be good guys and sick people don't have to pay any more, and oh, by the way, you can also go to this other place, the regular market, where there's heavy health underwriting and so forth." It violates common sense, and in fact, history shows us that won't work. There are lots of things that could work here. That won't work.

MR. VOGEL: I mean, the test is to sit down with--I mean, I was sitting with two individuals, both, you know, had small companies, but they were their own--you know, covering themselves. One had a health problem within their family, one did not. The one that did not has a high deductible plan, is in the individual marketplace. That one that has the health problem, goes

to the group marketplace, into the guarantee issue programs, because that's what they need to do to find this. So risk selection in the individual marketplace is going to take place. There's no question about it, and what we have to do is segment this out into really the individual marketplace where people are opting in and out in that individual marketplace, and then talking about the people who are uninsured, who opted out of their employer-based, and had been offered programs. And I think there are two different sets of individuals here.

MR. BERTKO: Yeah, absolutely. Let me just quantify what Phil said a little bit, because in a couple of our states we are forced to offer down to groups of one. That's not an oxymoron.

MR. VOGEL: At Connecticut, we do too.

MR. BERTKO: Yes. And the size of the one and two range, the one-life and two-life, where people can make exactly those kinds of choices, the loss experience is about 150 percent of the 339 experience.

MR. CURTIS: If you would just translate that for the audience.

[Laughter.]

MR. BERTKO: Sure. Let's just say if the cost, not including any administrative issue, where $100 per member, you know, of a blend of adults and kids in the

339 group, it is $150 per member of the ones and twos who participate in there, and we believe it is strictly risk selection. You know, these are people that are more or less actively at work, but they are choosing in or out for just the same reasons that Phil said. That policy that the healthy person chose might have only been $75 or even $60 with an individually underwritten product and the same benefit level.

DR. GINSBURG: Yeah. You know, one way of thinking of this issue is, I think everyone on the panel is agreed that the individual market today is not--does not have the characteristics that you'd want to send 10 million plus people into with tax credits, that one way or another, you would want to set up rules, and in fact, ironically, the tax credit perhaps gives you the ability to set up rules that you wouldn't have had before, because before, in a sense, the--that market seems to be so fragile because it's so small and the people are often on the margin of not going in.

But if there are going to be rule changes in the markets, one could view either states are going to be regulate these markets or, in a sense, they could delegate the regulation of the markets to purchasing pools. In a sense, it's almost like a quasi-privatization of the regulatory functions, even though it may strike you, oh, this is a mandate saying, in a sense,

it could be seen as a delegation of regulation to organizations that might resemble the Office of Personnel Management and the Federal Health Employees Benefit Program, but they would be, organizations like Phil's organization, would, in a sense, be charged with regulating the individual market. And their clout in effectively regulating it would come from the mandate that people have to use their tax credits to go in there.

MR. CURTIS: Well, but I think everybody agrees, if there were such a thing, people should have a choice of different pools.

DR. GINSBURG: Yes.

MR. CURTIS: And if there is, the state has to monitor the behavior of the pools and--

DR. BUTLER: I think maybe there is more consensus, but let's try to disentangle this a little bit. I think, speaking for myself, I believe that, as part of a tax credit mechanism, of an effective tax credit mechanism, there must be some agreement between the federal government, from which this emanates, and the state as to how should insurance within that state be reorganized to make this effective because the objective is to reduce uninsurance by making insurance more available and affordable to people, and there has to be some plan to do that.

One major element of this plan may well be the pools that we have been talking about. One of those pools might be a separated pool out of the FEHBP, for example, which is provided courtesy of the federal government, but this is a discussion and negotiation that takes place between those states. And I think these issues of the individual market and the potential for instability is precisely what is discussed at that point.

But the bottom line is that you could well have a situation, I think it's what I would favor, that the tax credit that is provided by the federal government would not have to be used exclusively through these pools. It could be used in other areas, maybe even including the individual market, but certainly the employer-based system.

But what happens is that the state and the federal government discusses this and talks about what regulations are at the state level and maybe what federal regulations are needed to make this work. But you don't say, "We've discovered, you know, the Holy Grail. It's called a purchasing pool or the ones that we've designed, and we want everybody to be in these." It seems to me you must do that. It may be that in one or two states you allow that to be the negotiated result, but it would be unwise to impose that everywhere because you then will never know if some alternative is a better arrangement.

DR. GINSBURG: So you're talking about that the federal government and each state works out how the state is going to deal with the individual--

DR. BUTLER: That's what I think because I think it does deal with these issues that if you say, well, if you do it one way, then in certain states and in certain markets it'll be unstable.

MR. CURTIS: And that's what Mark called the HIPA model, really. You have some federal objectives and make sure that people with tax credits can get affordable coverage.

DR. BUTLER: The tax credit, you know, it's designed to reduce uninsurance where it's used--

MR. CURTIS: Absolutely.

DR. BUTLER: And by making it more affordable and available. And if it doesn't do that, then there's some breakdown. Therefore, it doesn't strike me as being unreasonable to say, well, let's now have a discussion, given the peculiar situation in each state, what is the best fine-tuning of this to work in that state. But our bottom line ought to be to try to make as many options available to people and certainly not lock anybody into one alternative. Because I think history shows that that's, you know, alternatives always look attractive

before you do them, and sometimes they work, and sometimes they don't.

MR. CURTIS: Benevolent dictators don't work.

DR. BUTLER: Pardon me?

MR. CURTIS: Benevolent dictators, history shows, aren't.

DR. BUTLER: Yes.

MR. HALL: Well, let me just try to break out, and cause a little more dissension than to sort of keep the see-saw going back and forth, which is I am sympathetic to that approach and to setting general goals and letting the laboratory of those states experiment in the market. But I think there are two things that pools could achieve that it's unlikely that the market would achieve if you allowed the primary vehicle to be individuals picking among multiple different insurance companies.

One is aggregated purchasing powers of forcing insurers to bid on a large block of business that they're not going to get unless they have the best bid, which is what we get through the large employers and through the FEHBP.

The second is, frankly, just the administrative cost of selling, and the primary component of that being agents' commissions. And right now the individual market produces agent commission rates often as high as 20

percent; whereas, pools successfully deal with agents for amounts more like 5 percent. And, again, I think it's probably because of the volume of business issue as well.

And so those two advantages I think would be very hard to achieve without something resembling some kind of pool.

DR. GINSBURG: Okay. Rick, you agree with that?

MR. CURTIS: Yes, but I want to reinforce something Stuart said, that people should be able to use their tax credit towards employer coverage available to them.

DR. GINSBURG: Yes. So, in a sense, what we've done is it sounds like, to the degree that a pool is a mandatory place to take tax credits, we are not talking about directing anyone whose employer is offering coverage any change in that coverage. To the degree that the tax credit, like the Jeffords bill, is available to people with employer-sponsored coverage, we are leaving them out.

I think another point I should make is that we're talking about predominantly pools that would be serving the individuals, even though, of course, our experience with pools has been to serve small groups, and this would be a change for them. But we certainly wouldn't rule out what Stuart had brought up earlier in

the meeting, that employers, even who don't provide coverage, can still play a role through withholding and payroll deduction in the tax credit process.

So I wasn't intending to bring this group to consensus, but I really want to bring it to agree to disagree, but I think that perhaps where we are now is that the focus of this pool, you know, the greatest potential for this pool idea is in the individual markets, and there seems to be some feeling that perhaps it's okay that some states choose that this is the way they're going to implement the tax credits, not require-- I don't think there's a consensus about requiring all states to do this, although I think there is a consensus that if this approach is going to be used, that the states have a very major role under federal direction.

Let me just ask the panel if anyone has anything else to say before we go to the audience.

DR. BUTLER: I would just, I mean, it seems to me what we're trying to do here is to recognize that you've got, in the large employer market, something is working. There's large pools of people, a sophisticated buyer, a big tax break, particularly for the middle or upper income, and so on. And what we're, in a sense, trying to do is to construct something like that outside of that. So, if you don't happen to work for GM, you still somehow have this.

And that's why the credit is such a critical element, and indeed, ideally, you'd want to have the identical tax treatment, whether you're through an employer-based system, which will have market advantages, or some alternative. A credit is a step in that direction. You want to make sure that the person who is lower income preferably gets a bigger amount than they would get today, and that's what the credit tries to do.

And then you want to try to create for most people some pooling arrangement that gives the economies of scale that you mentioned, which is similar to what General Motors have or some other group. And that's sort of what we are talking about, it seems to me, trying to construct. And the arguments really have just been at the margin on all of this--what about people who don't want to be in this and so forth.

And the role of the employer in the future, as I suggested at least, would be much like as people buying houses get mortgage deductions and so on, there's a mechanical aspect of being an employer to make this easier for your employees. But they may be in pools and so on that are quite separate from anything you're interested in. I mean, their church or their union or whatever.

So it's really I think we're talking about what has to be done to create those elements of large employer-based plans in nonlarge-employer market. That's kind of what's going on here, it seems to me.

DR. GINSBURG: Yes. Actually, the thing I should probe, Stuart, is, you know, with the potential of these organizations to provide pools, do you think they have a chance of doing it without their state designating, "We're going to be a pool state, and we're going to give pools this captive population with tax credits"?

DR. BUTLER: That's an interesting question, and I don't know the answer to that exactly. I do think, however, there are certain kinds of organizations that people have a long-term affiliation with. A union is a good example. I mean, the African-American church is another example, and so on. There are things like that where you have what I call the core group of members anyway. And it may be in those kinds of situations, a credit alone might be sufficient. I tend to be skeptical. I think that either the organization itself has to impose certain rules, and we talked about private internal regulation, or the state may have to do that.

But, certainly, I think very quickly any organization would begin to start looking at annual enrollment periods or something like that or a waiting

period so you don't get people moving in and out quickly, and it destabilizes. I think that would tend to happen naturally, but it may be that you require that to be done through state or even possibly federal regulation.

DR. GINSBURG: Yes. I think the key thing is an organization can set up its rules under, say, broad outlines of state or federal regulation, but to the degree that one of those organizations is faced with insurers that don't play by those rules, who can, in a sense, market to the healthiest people, I think that's what Rick and Mark were getting at.

MR. CURTIS: And there are a number of entities out there that can characterize themselves accurately and legally as having an affiliation with people who would very quickly, and adroitly, set up the kind of rules that were just described by Stuart in order to have a risk-select enrollment, and then everybody else would suffer. There are all sorts of things you can do.

So, while it's legitimate and important to protect against adverse selection in that way, if just relying on these kinds of organizations to pop up and develop their own rules limiting membership, there will be all sorts of organizations with all sorts of rules that result in a very risk-select group and very low rates, and nobody else is going to get those--

DR. BUTLER: Yes, I agree with that. I wasn't trying to suggest--I agree with that. I think that is, you know, and fiscal situation and information they provide there's certain rules like that, as well as insurance regulatory rules, that I think you'd say have--or any organization that wants to do this has to abide by these broad cate--which, again, is not dissimilar from the way the FEHBP works, in a sense. I mean, there's some basic rules.

MR. CURTIS: The first is you are a federal employee and you have a federal contribution only.

DR. BUTLER: That's fine, but I'm talking about the plans, that they have to accept certain rules to get in. And, in a sense, what I'm saying is that you could say that to organizations. So, if you're the First Baptist Church or something like that, there are certain things you've got to do, but there may be additional rules that that organization sets for itself within some parameters that respect its particular situation.

I mean, religious organizations would be an obvious example, where, you know, maybe you've got to kind of go along with the program in the sense of what this church is for, to be a member, but even that I'm not so sure. There are many conservative Republicans in the Mail Handlers Union, for example, to get their benefits,

and I guess they are good regular union members for their $30.

DR. GINSBURG: Would this be a good time to go to the audience?

FLOOR QUESTION: I'm Conwell Smith with the American Medical Association.

And I can appreciate that we were focusing today on the role of purchasing pools, but what I'm hearing the panel say is, okay, we're not here to talk about reforming the individual market, we're not really here to talk about reforming the employer-based system, we're just going to talk about purchasing pools. And I'm finding it hard to listen to this discussion in a vacuum, if you will, because what I'm hearing is a classic case of why we do, in fact, need to reform the individual market and why we do, in fact, need to change the employer-base system.

And as far as addressing the uninsured, they seem--and I could be missing the boat on this--but they seem to be in the highest-cost market, if you will, and many of which will have trouble accessing purchasing pools, as we've seen them discussed in Congress in the past because they might not be members of those associations or an employer-based pool.

I am just wondering if you guys could speak, to some extent, to, for example, the large pool of money in the tax exclusion that goes to employers and using that for tax credits and also kind of the change to define contribution, if you will, and using that to promote the individual-based markets so that we don't run into the problems of risk selection in those types of issues if all Americans were really purchasing their insurance on their own. Because that's kind of what I hear this all coming to, in a head, to some extent.

DR. GINSBURG: Before I let people answer your question, I wouldn't want to say that this group has not been interested in reform of the individual insurance market. That's really what our discussion has been about as to whether there is a way, other than having government do it, to reform the individual market. But let me turn to the panelists to answer the rest of your question.

Rick?

MR. CURTIS: I know that the AMA has long believed in choice of health plans. I happen to strongly believe in individual choice of health plans as well. To suggest that a solution to our nation's ills is to blow up employer coverage and encourage everybody to go out into the individual market, I mean, hopefully, some of these ideas will work.

We do need individual market rules, but I've been challenged in the past, and I'm sure other panelists have, to name one state in the country where the individual market works well. Tax credits will go a long way to infusing it with healthy lives, but you still have this incredibly fragmented market, with each individual making health insurance decisions on their own. You, by definition, do not have a good risk-spreading capacity there.

Large employer groups are, I'm sure you know this, are called natural groups because people go to work there not because of their health status, but because they go to work there, and therefore the group represents a broad spectrum of risks, and it works for insurance purposes. I think doing things to take that apart is counterproductive.

That said, I've long thought moving from the exemption and deductibility, I know Paul doesn't like to take positions on anything, but he and I have known each other for a very long time, and I think I can safely say we both have long thought a progressive, responsible thing to do would be to change that to a tax credit system, and I know Stuart Butler has thought this, but I would not move it away from employment based in doing that, number one.

Number two, I, personally, if I were the benevolent dictator, would tie big tax benefits from the federal government to employment based to some requirements for some meaningful choice on the part of employees. There are a majority of employees who have benefits from their employers who don't have meaningful choice of plans. And I would have at least some choice required, as a requirement.

Number three, with respect to the individual market, if you have tax credit, that is more than adequate, and you have lots of people coming into it, you can have market rules, and I think you should have market rules that make it more functional for people that are sicker, and at least largely deal with health rating, among other things.

But there are all sorts of other things, as I think Mark pointed out before, that you can do to risk select, through benefit design, through selective marketing, through, okay, we're going to have, in effect, healthy members of the community club. It's been here for a long time. It was called something else. We just moved our headquarters to the fourth floor of a building without elevators, and people have to attend a meeting once a month to get discounted health insurance for half the price you can get any place else. That's the kind of stuff that's very easy to do in an individual

marketplace, and that's why I think it would be unfortunate to take apart natural grouping that occurs for other reasons.

DR. BUTLER: If I can answer your question a slightly different way, and I'd probably argue with Rick a little bit about what he said. But I think what we're talking about here is, in a sense, what is politically practical and possible right now, and I don't think any of us are ignoring the fundamental flaws. I totally agree with you on the tax side and have written on that extensively. But I think that, you know, we're facing a situation here where there's an opportunity to move forward in an incremental way in a certain direction, which is towards a more fundamental reform, it's consistent with a more fundamental reform, but we're not ignoring, in any way, the problem.

I think, you know, with all of these incremental steps what you want to try to do, obviously, is to take a step in the direction you want. You don't want to take a step that then causes ten other problems to suddenly materialize and so on. It's an art form trying to get this right. But there certainly is no disagreement of the, I don't think, of the fundamental problems with the individual market, and I would say with the employer-based system, too, but I'll let that go for now.

MR. McMANUS: Let me comment on this. I'm in an interesting position because the full committee chairman, Bill Thomas, wants to get rid of the employer-based system and go to the individual-based structure or the refundable tax credits, and my other boss, the subcommittee chairman, Mr. Johnson, likes the employer-based system. So it puts me in an interesting spot because I report to both of them.

DR. BUTLER: Take the Fifth.

[Laughter.]

MR. McMANUS: Let me just say this: When you're looking at the employer-based system, it was not a deliberate policy of Congress to establish that. It was sort of set up by accident because of the wage and price controls. So, to make the argument that we ought to keep what we have, you know, and saying that it works very well, I don't think that's the case. When we talk about risk selection, well, who are the people who, in the employer-based structure, who are risk-selected out? Well, those people who, by definition, can't work--the most unhealthy people of all.

So I think there's a number of faults with the current structure. I think what we're trying to talk about here is, in fact, reforming the individual-based structure because even my boss, Mr. Thomas, would say I'm not suggesting that we get rid of group marketing. I

just don't think it ought to be tied to the employer, where there's an arbitrary definition. So, having the risk pools I think really advances the discussion from where we've been in the past, where people just assume if you get rid of the employer-based tax exclusion, they all of a sudden go to the individual market.

So I think this has been a very productive discussion in that regard.

FLOOR QUESTION: If I could just clarify the AMA position because it was tied to AMA policy, and clearly that is where I get some of my thoughts, but I was more talking about it in a more comprehensive discussion of where insurance needs to go. And just to clarify, the AMA has been very supportive of purchasing pools and will continue to do so, as well as they have also been very supportive of tax credits. So, with regard to the incremental steps, I don't think we're in disagreement there, but I just thought there was a bigger picture that the discussion was moving toward. So thank you.

DR. GINSBURG: Bob?

FLOOR QUESTION: Bob Helms from AEI.

I do have a question, but in response to this last discussion, let me say that I really object to the sort of terminology of blowing up the employment system or severing the link or whatever because every

responsible academic, including Stuart Butler, that I've known about for the last several years, who have written about the effects of the exclusion, either capping it or eliminating it, have always said, Look, you had a policy in effect for over 50 years. There's an institution of employment-based insurance, and nobody predicts it's necessarily going to go away. They're talking about a little more even treatment of the thing in those tax proposals.

My question has to do with the individual market. As you all know, AEI has published, in Health Affairs, has published an article by Brad Herring and Mark Pauley, talking about the risk-pooling ability of the individual market. Now I know it's difficult for contemporaries to always predict how markets are going to happen. That's one lesson we get from economic history.

But my question to you is why can't, if you had a tax credit that really gave people an incentive go to the individual market, why wouldn't you get, as Pauley and Herring have talked about, more efficient risk sharing, even in the individual market? Why wouldn't you get economies of scale in the marketing? Why won't a combination of a larger individual market, and the Internet, and new ways, even agents using the Internet or new ways to market individual insurance reduce this agency--the cost of the agency problem in terms of those

commissions and so on? I mean, every market I know that's relied on these kinds of agents, when the market has changed, that part of the market has declined.

So my question to you is why wouldn't you expect this individual market to become more efficient, as a method of pooling risk and providing insurance to individuals?

MR. McMANUS: Well, John will say a lot more than I will on this, but you could, conceivably, if the market rules are right, and we won't talk a lot about insurance rules, other than whatever John wants to say about it, but you started with people having tax credit and moving from employment-based systems.

The employers that decide to drop coverage and the employees that decide to drop coverage are going to be, on the employer side, the incentive will be, I pay a lot, and they're not getting the tax credit, and they should go over there. So, on the employer side, it's going to be the ones with higher-cost employees who are going to save the most getting out of this.

And on the employee side, you have the reverse, in terms of what their incentives are. The ones that are sick are going to want to stay with their employer-offered plan. That dynamic alone, for starters, is a complicated one, and I don't want to pretend, you're

right, you know, none of us are real good at predicting this stuff, but I don't want to pretend that I have some unique insight, but it's complicated and needs to be worried about. Then--now, then, they go over to the individual market and--

MR. BERTKO: Okay. Two things. Let's just say that suppose that if you change the market rules substantially and required community rating and eliminated most, if not all, underwriting, then you could have a substantial reduction in cost internally to the insurance company and the brokers' jobs would be much, much simpler because the agent wouldn't have to know the exact underwriting rules of up to a thousand different companies to do this.

Now, this would be a huge change, whether it's done in a purchasing pool, whether it's done in a reformed individual market or elsewhere. If you don't make those kind of gains, I will tell you that my actuarial colleagues who do individual health insurance, and the underwriters, are very, very good at what they do. And the gains to be obtained by strict underwriting completely overwhelm any other efficiencies of scale that you get out of anywhere.

So, if you have a continuation of a current individual, toughly underwitten market, the people who do the tough underwriting win, and they always win. I mean,

it's like playing keno up in Las Vegas or Reno. The odds aren't even close to being 50-50. So you either do the job and fix it or you don't.

MR. CURTIS: Interpolating, if they are paying an agent 20 percent, and that includes effective field underwriting, for example, and the costs back at the office add another 10 or 20 percent, and it's 40 percent, they still win against something that isn't doing that.

MR. BERTKO: Absolutely.

MR. CURTIS: And may be much more efficient by your measure.

MR. VOGEL: John, I thought some of the statistics I saw, and help me out, if I took my pool, and for some reason I could eliminate 2 percent of the sickest risks and just blot them out, can't I reduce my premium something in the neighborhood of 35 to 40 percent?

MR. BERTKO: If you took off 10 percent, and let's suppose that you couldn't be perfect, you'd have to take out double the amount because you'd miss some people, so if you took out 20 percent, then you'd probably drop your cost by 35 or 40 percent.

DR. GINSBURG: Mark?

MR. HALL: Well, I was going to defer to the other questions, but just real quickly, I mean, I think

there's different concepts of efficiency operating. And when you said "efficient risk pooling," I mean, from one point of view, the most efficient risk pooling produces the greatest spread in risk because efficient markets identify separately different risk levels, to the extent that the technology is available. But from a more sort of social objective point of view, the most efficient risk pooling produces the least spread of risk.

So I think there's a difference in perhaps Pauley's view of what's efficient versus sort of social views of what's socially desirable that may be operating in the way the question was put. But, in terms of how that market will likely behave, I mean, it's clear that this is still going to produce a massive amount of risk separation or selection. Whether you could achieve transaction cost efficiencies, I think their argument is much stronger, right; that if you eliminate the underwriting component, if you introduce new technologies, if you have a much bigger, thicker market, then I think there are efficiency gains to be had in terms of the transaction costs.

DR. GINSBURG: George?

FLOOR QUESTION: Yeah, John's--your last comment got to my question about this. I thought, even when you talk about pooling small groups, that the underwriters still treated a large number of lives in a purchasing

cooperative for small groups as there may have been marketing efficiencies, and there may have been some administrative efficiencies, but they were still underwriting as a bunch of small groups.

And I'm just wondering why people seem to be talking about that somehow the individual market would not be treated as a bunch of individuals who are somehow given information, and protected, and represented by a purchasing cooperative that could provide them information, but still why would they all of a sudden-- are we talking really about their being treated as a large group like GM? They are inherently different because they are not formed for the same purpose.

So I'm a little bit confused by the discussion. It seems to me that there is a distinction between taking the tax credit to your employer, which is a group that's formed on other than purposes for obtaining insurance, and having a cooperative among individuals who have credits, have not taken them to their employers, may not be employed and are, you know, there are efficiencies to be had, but I'm not sure you can ever get to the principle. If someone can enlighten me on this, I'd appreciate it.

MR. CURTIS: Well, one objective is to try to get as close as you can, and the fact is one similarity

is individuals are getting the tax credit regardless of health status. So now you have a broad spectrum of risk. It's based on income. So now you have a broad spectrum of risk on those people.

The premise that the discussion was around was, okay, now, if those people can take it to one of, gosh, a finite number, a limited number of purchasing pools, and the purchasing pool offers choice, then the purchasing pool is in a similar position to the large employer. The person gets coverage through there because that's how they get the tax credit, just like the person gets coverage through GM because that's where they get the employer contribution or from FEHBP.

So that was how we were thinking you could end up in a somewhat similar place. You're right. It's not identical, but it's a lot closer than the individual market.

DR. GINSBURG: Carl, you're the last question.

FLOOR QUESTION: Well, it's more of just throwing a point on the table. I think there's a legal distinhey gerI tht'shrowis o butwo's deualr of purchasine dile.A antht'sn gets employeM because that's wher, yfe

In other words, I've heard two different models up here of pools; one is where the pool or the entity would be legally responsible for solvency. They'd have to pay, if there's a collective issue with the promise going bankrupt, they'd be responsible, as opposed to the carriers who are under contract with the pool. And, secondly, if an employee has a claims dispute, the entity or the pool would be responsible, as opposed to the model where the entity kind of arranges for all of these choices, but their ultimate responsibility lies with the carriers.

And those have, in terms of how you'd refashion law the way it exists now, those are very different concepts.

Does anybody have any comments on that?

MR. CURTIS: Well, at least I am assuming it's more analogous to an employer who buys an insured plan, and the plan is responsible for solvency issues. And if the carrier goes under, then you have a guarantee fund or whatever to handle that. I wasn't talking about entities that are self-insured. Now I know that there's pending legislation that creates those kinds of things, that creates all sorts of other issues. I wasn't talking about that.

With respect to the sort of what Mark called the employer benefit function, the ombudsman function, trying to intervene on behalf of the consumer if there's a problem, I assume that it would play that kind of a role.

DR. GINSBURG: Yeah. Thank you.

I'd like to close the meeting now, and close it by first thanking a number of people at the Center that worked very hard on this conference, responsible for the success, including Sally Trude, Ann Griner, Roland Edwards, and Leslie Jackson.

And then I want to thank this panel, which I think has done a phenomenal job taking a very complicated issue that they could very well have gone into real details, and they didn't. I think they kept it at a very substantive, but very broad-enough level to introduce this audience to I think one of the key issues that's going to be debated as we go, as to if a tax credit is done, and that is the--tax credit is very much the issue on the table--of how will we deal with the fact that individual insurance markets just, when they're at least unregulated, don't work as well as they need to, to deliver the goods that the tax credit proponents have in mind.

Thank you.

[Applause.]

[Whereupon, at 12:03 p.m., the proceedings were adjourned.]

- - -