CATO INSTITUTE POLICY FORUM

THE FUTURE OF EMPLOYER-SPONSORED HEALTH CARE: DEFINED CONTRIBUTIONS VS. DEFINED BENEFITS

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Featuring:

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The Cato Institute

F.A. Hayek Auditorium

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P R O C E E D I N G S

MR. MILLER: Good afternoon. I'm Tom Miller, Director of Health Policy Studies at the Cato Institute. It's my pleasure to welcome you to our forum today: The Future of Employer-Sponsored Health Insurance.

Employer-sponsored group health insurance has remained the dominant form of health insurance in the U.S. for many decades, and that has been primarily due to the tax advantages that exempt employer-paid health benefits from workers' taxable income. The employer-based system has provided the structural foundation for maintaining a voluntary, relatively market-based, set of insurance arrangements in the private sector. But employer-organized health insurance faces growing criticism on a number of fronts, most notably that it hides the true cost of health care for many consumers and it restricts their choices. Employers also are examining many ways to reduce or shed the administrative burden of managing health benefits, as well, and to eliminate the mounting risks of expanded liability claims in the courts.

Several recent industry surveys suggest that employers may be considering combining two mechanisms, defined contributions and e-commerce, to move out of the health insurance

business and help create a more consumer-driven health care system. The new-new thing in health care might build on the recent success of the defined contribution approach to employers' pension benefits by adopting a similar model for health benefits.

Instead of guaranteeing payment for a defined set of fixed health care benefits, employers would provide a fixed dollar payment to their employees to help purchase any particular health insurance arrangements on the open market that they prefer. E-commerce information platforms and Web-based health retailers could accelerate this shift by helping consumers maneuver through a richer variety of choices.

Now, is a major shift to individual consumer-driven defined contribution health insurance going to happen soon? Or will it simply become the latest passing phase in would-be health care innovation that falls short in practice?

A defined contribution model raises a host of policy issues, new questions and possible complications, relating to tax treatment, regulation, insurance underwriting, politics and transition mechanisms. Some observers would caution that employer-based insurance is a case of "can't live with it, can't live without it."

We have three distinct voices today from the health benefits field to examine where employer-sponsored health insurance may be heading, toward a defined contribution model, or

displaced by an individual insurance model, or reinforced by some fine-tuning for the future.

Our first speaker is Gary Ahlquist. He is Senior Vice President and Managing Partner of Booz-Allen & Hamilton's Health and Insurance Group. He specializes in the strategy driven transformation of insurance companies, health plans and health providers.

Gary has authored several articles in leading journals, and he was co-author of an intriguing report earlier this year, "The Real Consumer Revolution in Health Care." It predicted a large-scale conversion of employee-sponsored health plans to defined contribution formats, and said that that transformation is inevitable.

He received a B.S. from Tufts University and an MBA from the University of Chicago. And he is currently based in Chicago, a noted sanctuary for butterfly ballots. Today Gary is going to survey the market for change in employer-sponsored health insurance and suggest who is going to make the shift, when, how and why.

Gary Ahlquist.

GARY AHLQUIST,

BOOZ-ALLEN & HAMILTON

MR. AHLQUIST: Thank you, Tom. I will have you know that I left no dangling chads, either.

We are into the realm here of predicting the future. And those of you who follow baseball like I do, remember Yogi Berra once saying, "Never make predictions, especially about the future." So that is about right in this case.

This discussion all has begun in the last few years largely over the dissatisfaction with the current managed-care system. This is roughly a $600 million commercial industry in the United States, of which none of the stakeholders in that system are particularly happy with it and their position in it. Consumers, starting with the consumers and the employees themselves -- we read a lot about this in our work with corporations -- highlights that they largely are unhappy with the restrictiveness of the system and the process they go through in interacting with the system.

They have no market signals, in their view, that tell the system what it is they actually want and allow this highly intermediated system to actually respond to their needs in some consumer-driven way. They feel very much disenfranchised by the system. Yet, while the cost numbers typically say that an

employer pays about 75 percent of health care coverage, that actually misses a huge portion of out-of-pocket costs.

The real number is that something like 47.3 percent of the total health care tab on a per capita basis is paid out of the pocket of the employee, or consumer, today, and 53 percent is funded by the employer. So, not only do we have a system which is not particularly consumer friendly but one which is pretty expensive. And that number, that 47 percent, in dollar figures, has roughly doubled between 1998 and the coming 2003.

Providers on the other end, the suppliers of the health care, also are very unhappy with the current system. They feel that their practices have been intervened upon time and again. They have built up armies of checkers to check the checkers, to see who has got the numbers right, and they are actually potentially about to cook their own goose. And that is, for the last 15 years, there has been an inexorable consolidation in the market. And many of us, me included, have been predicting, going back 10 years, that this would have an impact. And it didn't have an impact for a long time, largely due to the hyper-fragmentation of that industry.

We are now starting to see it. We see reports of providers, hospitals and doctors, passing on now 40, 50 and 60 percent unit cost increases to the insurers. And the insurers have very little to say about it because the market positions of

these folks in certain areas are so strong that they are almost cartel-like. That of course is going to fuel further double-digit cost increases, which will get onto the employers, and eventually the whole bubble is going to burst. So, while the providers are unhappy and they're consolidating, and they're passing on price increases, it remains to be seen whether or not that comes back to bite them.

The employers are not particularly happy. They were for a while on the cost side. Their employees like it. Obviously the health benefits is the key part of attracting and retaining employees. But they are now in the third year of double-digit price increases. We predict another two or three years at this rate, which means their health tab is going to double in about a six-year period. It is bound to come back.

On the benefit side, the human resource side, they have built up large departments. And they are largely in the complaint business. That is what they do. It is not particularly a value-added proposition for a corporation in a global competitive market.

And then, finally, the health plans themselves feels like everybody's scapegoat. They are the middleman. They are getting it from all sides. They are having trouble making a living, and now their profits look better and Wall Street is treating them better, but they all know that this is

unsustainable because the basis on which they are making money is merely price increases that they are passing on through, and that can't last forever.

So we have a system of managed care which grew up, which has had some benefit, delivered some one-time cost savings, has not been a particularly easy one to live within, and people are asking, what's next, and, is there a next? In this consumer-driven market, employer-based or individual is a probable answer.

What are we talking about? Let's just give a quick overview of what we mean by a consumer or defined contribution market. It has four or five key features. First, there would be an annual allowance, or voucher, or amount of money that goes on behalf of the consumer to allow them to enter the market and purchase health insurance in pre-tax dollars. This is what we would like to see it be, not necessarily what it is. We will talk about what it is as we go forward.

Second, that amount of money would somehow be risk-adjusted to take into account the medical risk of the individual. There are various forms we'll talk about later that that might take, but that is a feature that we would like to see.

Third, that this is a long tail not a short tail product. Today we think of health insurance as an annual, it is a very short-term kind of thing. We want the financial incentive

to be long-tailed, potentially, so that you could roll over, not use it or lose it. Those monies which you don't consume, not to spend on things other than health care, but to spend on your future health care. Potentially, even interest-bearing accounts which will give people an incentive, even in the medium term, to be more conservative with respect to their own health care and actually pay attention to things like lifestyle.

A feature that is wrapped around the long tail, or a part of it, it would also be, what we are seeing is, discussions around multi-year contracts. Why buy insurance for a year? We don't buy life insurance for a year. Why don't we have three-year, four-year, or five-year contracts, which may take in some inflation but would protect against medical risks in some pre-determined way?

And then, finally, this notion of reinsurance is likely to become an important feature. That is, if you incur a catastrophic event at any point in time, there is some stop-loss coverage, much the way in commercial insurance or in auto insurance we protect for the big event but we don't insure against it on a regular out-of-pocket or a premium basis. So these are some of the key features of a defined contribution approach.

There are clearly some forces that are pushing in this direction, and there are certainly those of the current system

which either would be nice to save or barriers to getting there. On the driving side clearly is the consumer interest. Some of this is actually cultural in my view. The post-Depression, post-World War II generation, generally speaking -- and I'm generalizing here to make a point -- believed in and trusted institutions. They worked for them. The baby boomers and gen-Xers generally don't. They want individual solutions, individual access, Internet, and so on. So this notion of having an institutional solution versus a personalized one is a cultural feature that we believe is driving in this direction. Certainly the managed care backlash, people being unhappy with the system, is also driving it.

On the employer side, they are beginning and will look for alternative solutions to what they currently see. Not that they necessarily want to get out of, in every case, offering this benefit, but there must be a better way they can offer the choice and access for their employees which, also has some hope of being cost effective.

There is the pension precedent. While health care is a much more complicated undertaking than 401(k)'s, the notion that we have gone from something like, in 1980, about 4 million households who own mutual funds, today it is something like 38 million to 39 million. There were 1,200 mutual funds offered in

the eighties; and there are now 6,300. Not all of this is driven by 401(k)'s, but certainly an important part of it.

The innovation that has come with that, the segmentation of the market, defining products and solutions for individuals to meet their needs, as opposed to the one-size-fits-all insurance proposition which we have today -- you take the policy that is offered or you don't, and there is no choice of really tailoring it to your individual needs -- out of the pension precedent we think will be important.

And then, finally, on the driving side, is the supply side stimulus. There is a fair amount of innovation going on now in the market. Many of these new players -- I'll talk about a few in a minute -- are actually in the open market. There is something on the order of $300 million to $400 million of venture capital which has found its way into this niche post the meltdown in the spring -- hopefully smarter money than was there before. And so we expect to see some success, at least some real experimentation on the supply side, and we will see just how this works and how it needs to be adjusted to make it work.

Surveys have shown, and Booz-Allen has done a survey of the Fortune 100 best employers to work for, that when we talk to the benefits folks in those companies, 74 percent of them said that they would be interested, likely or very likely, to look at a shift in defined contribution health benefits in the next three

to five years. KPMG surveyed employees of Fortune 1000. They reported 73 percent were interested in having defined health benefits. And so on.

On the inertia side clearly is the group model. Both from an underwriting and a tax basis, it enjoys advantages. Underwriting at the pooling level obviously is a key feature of insurance. The question for a personalized market is, can you find ways to create the pooling either through risk adjusting individuals, which substitutes for a pool, or creating affinity pools, either at the employer or at some other level? Tax laws, clearly. Actually, it is not an IRS issue, it is a HIPA issue -- and we will talk a little bit about that on the policy side -- is a barrier to this, although the current new players are not finding this to be a particularly difficult issue for them.

The infrastructure is not ready. This requires a lot more information in the hands of consumers that is easily useable and digestible. Today it is arcane. It is difficult. It is complicated. It doesn't need to be such, but it is. So, until we have a much better way of accessing information as consumers and smarter front ends and ways to approach the system to tailor it to us, it won't be widespread.

And then, finally, on the infrastructure side, a lot of this is going to be driven by the Internet, we believe. Getting people online is critical. We all know the numbers, that 30 or

40 percent of the country is online. There are a lot of folks in small companies, in factories and so on, who don't have access to the Internet on a regular basis. And so, as that grows, that will make this easier.

Just a couple of trigger factors to watch for. Because while we think this will happen, we tend to believe it is going to be more like a cresting wave than just a slowly rising tide. Clearly a recession will, we believe, drive this much more quickly from the current managed care, employer-based, to a more defined contribution world. In recessions, our clients always turn from looking at the revenue line to the cost line for the first year or so. And they examine everything in it, and they will look at health costs. It will stick out like a sore thumb. And the CEO's will start to ask CFO and the HR head: What are we going to do about this? What are our options?

Continued cost spikes on the health side could, even without a recession, cause this to happen.

And, finally, liabilities lawsuits. There is the potential now, with ERISA and so on, that employers as well as health plans could be named in lawsuits for holding back coverage, withholding coverage, rationalizing coverage, on behalf of an employee or a loved one. And we believe that will cascade through the employer networks. All the human resource people and

lawyers go to the same conferences and hear these cases. And so that could be a trigger to watch for.

The new players that Tom mentioned: There are four buckets of new entrants, largely Internet-enabled, who are making runs at this space. The first are what I would call defined contribution health plans. They are substitute or options for the traditional managed care plan. Firms like Definity Health, Vivius, Health Market, My Health Bank, there are about 10 to 12 of them who are looking to be risk-bearing insurance plans, Internet-based, individually tailored kinds of choices for consumers.

There are what we might call aggregators, who will offer other people's products through their pipe but pool the risk and the funds at the front end. And so they will be risk-bearing but not necessarily product manufacturers in this space.

There are what we would call benefit exchanges, folks who are automating and putting over the Internet the health benefits value proposition that traditionally was paper based, human driven; firms like Ebenex; Sageo, which is a spin-off from Hewitt, the big benefits consultants. These are a couple of examples.

And then, finally, there are a number of e-health players who are looking at vertical slices in the value chain,

either making a market in information, making a market in provider services and then offering those to insurers, making a market as a utility for processing transactions and outsourcing, being an outsourced option for these kinds of players.

And then, finally, on the policy front, the policy issue can largely be sized up in two words: States and HIPA. As you may know, every State has different regulations around what they define as individual and small group and large group, and they often have mandates that require certain services and certain regulations for different group sizes. And so different States are more amenable, or less at this point, to a change in the health system. And HIPA is fairly unfriendly to an individual type of approach, because basically it defines things as group and non-group. And if it is group, it is tax-advantaged, and if it is non-group, i.e., individual, it isn't. Obviously, when there is about a 40 percent, which is what it turns out to be, tax incentive, it clearly favors going into the group model.

So, in summary, we believe and have gone on record that within the next -- this was six months ago -- two years, we believe you will see Fortune 500 companies entering this new world and trying it out. We actually believe that was too long. We are now seeing some of these companies actually sign up and try this. And while they haven't gone public with it yet, we

expect that in the spring/summer of next year we will start to hear more about them. And we will see if it works.

Thank you.

(Applause.)

MR. MILLER: Thank you, Gary. That sets up our discussion very well.

Now we are going to have two slightly different perspectives. Our next speaker is Gerry Smedinghoff, who is Director of Market Awareness for UniversalCIO. That is an applications service provider, specializing in enterprise resource planning systems, in Wheaton, Illinois.

Gerry, I don't know what that is but it sounds like indoor work with no heavy lifting.

MR. SMEDINGHOFF: Yes, that about sums it up.

MR. MILLER: Gerry previously was a consulting actuary for Watson Wyatt Worldwide, here in Washington, and for Nationwide Insurance, in Columbus, Ohio. He now speaks frequently on health care and technology issues. He has appeared on the nationally syndicated PBS Television Program "Health Week," and he has written articles for the Washington Post, the "Las Vegas Review," "Skydiving" and "Contingencies."

As a recovering actuary, Gerry's 12-step program for health care reform begins with urging employers to get out of the health care business entirely.

Gerry Smedinghoff.

GERRY SMEDINGHOFF,

UNIVERSALCIO

MR. SMEDINGHOFF: Thanks, Tom.

I have been traveling across the country this year, making speeches, arguing that U.S. employers should get out of the health care business. The reason they should do so is that the health care sector is the only sector of our economy that is failing, and there is absolutely nothing employers can do about it. What I am going to show you today is why trying to provide health care, while ignoring or violating the laws of economics, is kind of like trying to run an airline while ignoring or violating the laws of gravity. Because doctors and patients, and especially employers, are no more above the laws of economics than pilots and skydivers are above the laws of gravity.

I want to touch on two themes briefly in my talk here, and I can sum them up in two words. They are: segregation and choice. Segregation, we are all familiar with this. We all can compare the city of Berlin the way it is today versus the way it was 30 years ago when it was segregated with a wall down the middle. And, of course, we can all compare the United States

today versus the way it was when it was segregated between whites and coloreds 50 years ago.

What I want to explain is why the concept of segregating your earnings through the tax code into these arbitrary categories, like health care, housing and education and retirement savings, and then hiring a police force to restrict or prohibit your ability to move your money between these categories is silly and causes a lot of waste.

The other topic I want to talk about is choice. Obviously more choice is better. We all like to decide what we want to do for a living, who we should marry, what we should wear, what we should eat, things like that. Yet, you only have to go back a couple of hundred years, when many people did not make these decisions about what to do for a living or who to marry. And, of course, if you were a slave, you didn't make any decisions.

What we do through the law called ERISA, or the Employee Retirement Income Security Act, is the employer makes these decisions for you. Technically, it's your money for your health care and your retirement savings, but your employer is telling you when, how and where you can spend it.

Now, as far as the defined contribution model that Gary has presented, I can sum up my reaction to this by quoting Tom Peters, who, in 1990, summed up the progress of the American

quality movement during 1980. He said the good news was we had made a lot of progress, but the bad news was, 10 years ago, in 1980, Americans were making lousy products that customers didn't want. And, in 1990, 10 years later, we are now making great products that customers don't want. And I think it is the same thing. That is kind of what defined contribution offers you. Instead of having no choice among a lousy HMO that you don't want, defined contribution now gives you a limited choice among several lousy HMO's that you still don't want.

I think that is the primary reason for the crisis in our health care situation, or our health care economy, today. The primary mechanism for delivery of health care, the managed care/HMO model, does not exist anywhere else in our economy. The HMO model says that we are going to take this category -- and in the HMO case it is health care -- and we are going to provide all products to all people, at all places, at all times, at the highest quality and at the best price. The HMO model has only been tried twice in the last 20 years by major U.S. companies. Both have been disastrous failures.

The first time was in the early 1980's, when United Airlines tried to do this with travel. They had this great idea. You might call it a TMO, or a Travel Maintenance Organization. They were going to cover the travelers' every need from door to door, the flight, the hotel, the rental car, the cruise, all the

way on down. Twenty years later, does anybody remember the name of the company that United Airlines formed for this travel maintenance organization?

(No response.)

MR. SMEDINGHOFF: In speaking across the country, I find roughly one in a 100 people remember that Allegis was the company that United Airlines formed to do this. The reason nobody remembers it is it lasted, I think, about 18 months. The CEO who came up with the idea was soon fired.

The other time this HMO concept was tried was when Sears did the same thing with financial services, roughly about the same time, in the early eighties. They had what was then considered to be the world-beater combination of the Discover credit card, the Dean Witter brokerage firm, Allstate Insurance, Coldwell Bankers, Home Mortgage Lenders, all the way down to the Craftsman tools and the Kenmore appliances that you would buy in the store.

The only place today where you will still a remote resemblance to any HMO model is the new car dealership. When you go buy a new car, the salesman will try and convince you to bring your car back to that same dealer for all of the service on that car. But since there is no tax code coercing you or incenting you to do this, what do we do? We get our oil changed at Jiffy Lube, we get our muffles from Midas, we get our batteries from

Sears, and we get our tires at Goodyear. And, fortunately, the good news is we don't need to get a referral from Mr. Goodwrench, our primary care mechanic, to go there.

Now, I mentioned segregation and I want to talk about the damage that it does in our economy. So I am going to refer you to the first line in the handout here, where I show you the typical dollar bill of the wage earner. And imagine that you are a business owner, a small business owner. Let's say you have 10 employees, and you are paying them each about $50,000 a year. If you have a good year and you want to reward your employees for their efforts, if you decide that you are going to give your employees an additional $5,000 in wages, what is going to happen?

Well, the first $750 of that $5,000 is going to pay Social Security taxes. The next $1,400, or 28 percent, is going to pay Federal income tax. And the next $350 dollars, or 7 percent, is going to pay State and local taxes. So the result is going to be your employees are going to be left with about half of the $5,000 that you originally intended to given them.

However, if you decide to buy health care for your employees, none of these taxes have to be paid. So, if you have a choice of $2,500 in after-tax income or $5,000 in health care, for most people this is an offer they can't refuse. So they think it is great; I can double my money by buying health care

instead of giving them cash. Well, what is the effect of doubling our spending on health care?

To illustrate this, let me explain how it would work with any other product or service. Let's assume that the IRS took over a shopping mall. Let's say the Tyson's Corner Shopping Mall here. They close down the mall tonight and they reopen the mall tomorrow morning with two new rules for shopping at Tyson's Corner. The first rule says that the IRS is going to double the amount of money of anybody who walks in the mall, and the second rule is that the IRS is going to confiscate half the amount of money of anybody who tries to leave the mall. So, if you showed up tomorrow morning with $500, the IRS would double that, giving you a $1,000.

So, you walk around Tyson's Corner and you spend, let's say, you spend $900. When you try to leave the mall, the IRS would confiscate half of the 100, or 50, of what you had left. So the net result of your shopping trip is that you would be able to get $900 worth of goods with only $450 of what you left home with. Now, if that was the case, how many people would want to shop at Tyson's Corner tomorrow?

Well, the reality is so would a lot of other people. What's going to happen once word of this arrangement gets around? As people start flooding Tyson's Corner Mall and as the IRS starts pumping mountains of cash in the mall, what do you think

is going to happen to the prices of the goods at the IRS mall? What do you think is going to happen to the cost of the retail space? Obviously, if you owned a business, you would want to set up shop there.

And, finally, what is ultimately going to happen to the value of the subsidy to the IRS mall shoppers at Tyson's Corner? And before you answer the question, I will give you a hint. What are the market similarities of health care to single-family homes and higher education?

Well, the answer is that single-family homes, higher education and health care are all subsidized by some form of tax exemption. They have all experienced inflation far in excess of the consumer price index since World War II, and they are all examples of what I call Gold's Law of Economics. And I call it Gold's Law because I named it after an actuary turned economist named Jeremey Gold, who explained the concept to me, so I am happy to give him the credit.

Essentially, what Gold's Law says is that 95 percent of a legally mandated cost advantage will end up as waste. What that means essentially is that by doubling the amount of money we have to spend on health care, or by doubling the amount of money we give to people in the shopping mall, it doesn't double the amount of resources. Resources available do not change because we segregate our money through the tax code. Essentially, all we

do by doubling the amount of money is we simply double the cost of the goods. And that is what I show here on the second slide in the handout. Since resources don't change when you move to a segregated economy, all you do is double the prices.

Well, that is if you get health care through your employer and if you get the 50 or 100 percent subsidy through the tax code. If you don't get the subsidy, when you go into the IRS mall, you are able to shop the mall but the IRS is not going to double your money when you walk in. So we have essentially created what I would call a Jim Crow health care economy. We have a privileged class of people who get the subsidy through their employer, and then we have a disenfranchised class of people who do not.

And that is what I show on the third slide here, where the people who don't get health care through their employer, they are allowed into the mall, but everywhere they look the prices seem twice as high, so they are only able to buy about half as much.

So, ultimately, what are the effects of segregating our tax code? What are the effects of segregating our monetary system through that tax code? This is what I show on the last slide here, the effects of segregation.

We have a certain amount of resources we are willing to allocate toward health care. But because we segregate our

economy, what do we have? We have this privileged class that gets about twice as much as the disenfranchised class. And the problem with health care reform is that we have been looking at not what we can have with respect to health care, but we have been looking at the difference between the privileged class and the disenfranchised class. And since most of us are in the privileged class, most of us get our health care through our employer, we are saying we don't want to be on the other side of the fence, we have got to preserve this system.

Instead, we should be looking at the entire pie of what we could have if we got rid of segregation and we got rid of the police force -- which I call the A-4 border guards -- which are the actuaries, the accountants, the attorneys and the IRS agents, who either restrict or prohibit the movement of your money among these different categories.

The other issue I want to talk about is choice. Economists broadly define the goods and services that we buy into two categories. They are either public goods or private goods. A public good is a good where everybody gets the same thing in the same way, like a public road. A private good is a good where we can all have what we want, individually tailored products and services. What differentiates the public good versus the private good is the answer to this question: Can different people

satisfy their personal preferences simultaneously without any negative consequences?

Now, obviously, with food and clothing, the answer is yes. We all wore different cloths here today, we ate different things for breakfast, and nobody suffered from somebody else's decision. With public roads and with traffic laws, the answer is obviously no. I can't drive back to the airport this afternoon and decide I am just going to ignore all the red lights.

Well, the logic of public choice theory holds that if everybody gets the same thing, like we have in our health care system, where everybody gets the same health plan that works for a company, and if your input is going to be ignored, for example, if any of you were ever in the Army, you will notice they didn't ask you what you wanted for dinner every night, you got the same something on a shingle that everybody else got, and if it doesn't pay to fight city hall, meaning that even if you are Ross Perot or Steve Forbes and spending $50 million or $100 million can't get you elected, if all these three things are true, then what you should do to maximize your wealth is choose a stance that is called rational ignorance. Now, rational ignorance simply says I don't know and I don't care. Now, ignorance may be bliss but it is not free. And with health care, it can even be deadly.

Now, take a very simple, mundane category, like motor oil. If you drive into a Jiffy Lube to get your oil changed, the

first question the person that works there is going to ask you is something like, do you want Penzoil 10W30? Well, most of us are rationally ignorant about motor oil. We don't know and we don't care. Even though we are rationally ignorant, we get a choice of motor oil.

Let's take a category that's much more important than motor oil, like the education of your children. Unfortunately the education of your children is a public good. You are stuck with the public schools in your neighborhood whether you like them or not. If you want to make a choice and go outside that system, the cost can be prohibitively expensive. Well, your health is considered your most important category. We like to say, "When you've got your health, you've got everything." Unfortunately, health care is primarily a public good in this country. It's a good where everybody gets the same thing in the same way and the choice is made for you. It is something that you don't have a choice in.

You will notice that we have our priorities upside down. The things that are the least important in our lives, like our motor oil, we have the most choice with respect to; and the things that are the most important, like the education of our children and our health, we have the least choice with respect to.

Our health care system, or our health care economy, serves best those who have the least interest and place the least value on their health. Well, what are the business consequences of rationally ignorant health care? Essentially, what you are doing if you are an employer, you are giving your employees the company credit card, you are sending them into this health care shopping mall where the credit card has no spending limit, the items they are buying have no price tags on them, and your employees are not held accountable for their purchases. Now, how many businesses operate on these principles?

And I bet most people don't operate their household based on these principles. Yet, these are the principles that we are operating the entire health care economy, or at least 90 percent of our health care economy, on. What are the public consequences of this public choice concept of health care?

Remember, a public good is where everybody gets the same thing in the same way. What we are doing, if that is the case, is wealthier older workers are subsidized at the expense of poor younger workers. Poor younger workers are not at risk for the major health care problems. They don't really use the health care system. They have much less discretionary income anyway, and they have got more pressing basic needs. By making health care a public good, we are sabotaging the best process of our economy.

When you are young, you don't have money but you need the things like an education and you need to buy a car. When you are old, you have a lot of money but you really don't need things, so you are able to lend money to younger people to get an education or to buy a car or buy a house. By making health care a public good, we're sabotaging this process and we are reversing the flow of money, from younger people back to older people.

So, what is the road to recovery? What we have to do is we have to repeal ERISA, or the Employment Retirement Income Security Act. Put these choices back on the individual level where they belong. What is more personal and private than your health care?

We also need to repeal the Internal Revenue Code and monetary and fiduciary segregation. In fact, I like to call ERISA segregation squared. Not only are we segregating our money into these categories through the Internal Revenue Code, but we segregate it a second time by making your employer responsible for making the decisions for you.

I would like to close my talk by making a plea. Mr. President, tear down this wall. Assign ERISA and the Internal Revenue Code to the dust bin of history. As Clemenceau once said, "A war is too important to be left to the generals." Well, just as war is too important to be left to the generals and just as the education of your children is too important to be left to

the government, your health and your health care are way too important to be left to your employer.

Thank you.

(Applause.)

MR. MILLER: Thank you, Gerry. I guess you moved beyond the incremental change category.

(Laughter.)

MR. MILLER: Our next speaker is Bill Custer, who is currently Associate Professor in the Department of Risk Management and Insurance at Georgia State University. And actually I confirmed this morning that coincidentally he works on the same floor and the same building where I spent some years in my misspent youth as a trial attorney in Atlanta.

He previously was the Director of Research at the Employee Benefit Research Institute here in Washington. He was an Economist at the American Medical Association and an Assistant Professor for Economics at Northern Illinois University. Bill received his Ph.D. in economics from the University of Illinois.

Among the numerous articles and studies he has written on health insurance and employee benefits there are several that emphasize the value of tax preferences for employer-based coverage, the ability of employer group plans to pool risks, and the role of employers as sophisticated purchasers of health care.

Today, Custer makes his latest, if not his last stand, in defense of employment-based health insurance.

Bill Custer.

WILLIAM CUSTER,

GEORGIA STATE UNIVERSITY

DR. CUSTER: Thank you.

My role on this panel obviously is to defend the status quo if there is such a thing as a status quo in employee benefits. The benefits that most employees receive today are much different from what they received 20 years ago and are likely to be much different 20 years from now than they are today. Some of Gary's thinking is likely to find its way into what employers do. In fact, this continual change reminds me of a story of a Bedouin tribe on the move. They are leaving one oasis and they go a ways, and there is a small boy on the back of a camel. He says, "Dad, are we there yet?" His dad turns around and says, "Son, we are nomads."

(Laughter.)

DR. CUSTER: We are continuing to see change, and that change is driven both by employee, employer and public policy needs. But there are fundamental characteristics of the employer-based system that have remained intact over the last 50

years at least, if not before, that are responses to the failures of the individual health insurance market. The employment-based system is not an accident. It is not driven by the tax code. It is a private sector response to market failures in an insurance market.

We needed to find a way to be able to give the most people coverage. We needed to find a way to pool risks. And the way to do that is through the employer. And it happens through the employer because people are not making a single choice. People are rational. People are risk averse. People are going to make a decision on whether to buy health insurance coverage based on the price of that coverage and on their own assessment of risk.

There is an information problem. Insurers cannot inexpensively look at an individual and determine their risk of needing health services. So, in an individual market, the people with the greatest demand for that coverage are likely to be the people with the highest risk. Insurers know that and have to price accordingly. So the prices are higher.

By allowing a pool that comes together for some reason other than to purchase health insurance, to purchase health insurance, you mitigate that decision. You lower the cost of coverage for both the good risks and the bad risks. And that fundamental principle has not gone away. The Internet is not

allowing it to go away. There is not that level of information that allows it to go away. The employment-based system does that.

It is not driven by the tax code. We did some estimates that I think that are out there. We showed that if we repeal the tax code, about 20 million Americans would lose employment-based coverage. That would be a catastrophic public policy event if that were to happen. But there are 160 million Americans who presently receive health insurance through their employer. So this is not the driver.

This was in fact a public policy response to one of four factors I want to use to analyze this. That first factor is that the American people view health care as a right. There is 50 years of public policy which support that proposition. There is a clear view that the individual's purchase of health services benefits the Nation as a whole. And if that is the case, then public policy dictates that you would want to expand an individual's purchase of health insurance. Because, left to their own devices, they are going to buy less than the Nation would want. And that is one of the justifications for the tax preference. And the tax preference is biased toward purchase of health insurance through an employment-based coverage because that is the most efficient way to provide coverage.

The second factor I want to mention is that information is costly. Again, the Internet has lowered the cost of disseminating information and of collecting information, but not analyzing, not developing the expertise. An employer purchasing system not only has the benefit of risk pooling, but you also create economies of scale in purchasing, which means that you create an informed consumer that individuals can't get.

In Gary's discussion of the infrastructure that needs to be built to have a defined contribution, he said we need measures that individual consumers can use to evaluate the quality of the services they are buying. And it is not there yet. And what measures we have are driven and have been driven by the employer community, developing those measures. And they are very, very raw.

Two to five years is a very short time frame to develop actual measures that you and I could use to look at a health plan even, let alone to drill down to an individual physician and come up with a measure that is fair both to the consumer and to the provider in a way they can make informed choices. While that information is costly, it also brings up the economies of scale in purchasing. Because information is costly but it is a fixed price, there are economies of scale in these purchases; which means that it is cheaper to purchase in bulk, if you like, than individually.

The other thing about this, the third factor, is that people are risk averse. And they have shown that in their choice of employer benefit plans over time. At the close of World War II and the decade following that, there were a number of different competing commercial products that individuals or employers could buy. And some of those were classic indemnity plans in which, if you had a bad event or a day in a hospital, you got a flat amount. They competed with the plans we know and use more often today, which say, if you get sick, we will pay some percentage of your bill until you no longer need services.

Well, that second type is less risk to the individual and it swept away the market. Any changes to the employment-based system that pass risks on to the individual employee are resisted. That was true in the eighties when we saw health care strikes, because employers wanted to introduce more cost sharing. It is going to be true in any type defined contribution plan. That is, clearly there is some negotiation here, there is some defined contribution or risk sharing that goes on now, but the more risk you put on an individual, the more they are going to resist it.

And the last point is simply that employers make decisions that best meet their business objectives. They did not offer employee benefits because they think it is a nice thing to do. They are offering employee benefits because it reinforces

their ability to do business. Since it is not a question of, boy, I'll just get rid of these benefits and I'll be happy and I won't have these headaches. You do that and you lose out in a competitive labor market. Clearly, in the labor market we see now, it is just impossible.

And, as Gary said, if we have a recession, some changes can happen, but employers have always been reluctant to make major changes during recessions because their benefit plan stays with them when the recession is over. And if they plan to survive in it, they are going to have a benefit plan that they need to attract and retain workers during a more competitive labor market.

So, given all that, it seems unlikely that you would have a situation in which you have public policy changes that would create a more individual market, that are likely to put people at risk of losing health insurance coverage.

One of the implications of expanding the tax preference to an individual market is that individuals who can signal that they are good risks may decide that they would no longer want to be part of an employee benefit plan and pull out. What happens in an employee benefit plan is that these are group decisions. People like to say, boy, the employer is dictating what you want to do, but the employer is dictating what you get in hopes that

you like what you get. They are trying to satisfy the group. They are group decisions.

If a part of the group decides that they want to pull out of the benefit, it becomes less likely that the employer offers the benefit at all. Who is most likely to go into the individual market? The better risks. Who is more likely not to be able to get coverage in an individual market? The worst risks.

So what happens when you expand the tax preference to the individual market is you weaken, on the margin, the employer-based system. On the margin, I mean on the smaller firms, the most vulnerable firms. Some of those people are going to begin to drop coverage. And when they drop coverage, some of their members are going to be able to get coverage, those people considered good risks; and the ones who don't are going to tend to be the people at higher risks, the people most likely to use health care services, the people who are most likely to be a burden on taxpayers through the use of public hospitals, the people most likely to motivate public policy changes.

One of the implications of what employers do is the impact it will have on public policy. And as I said, the American people think health care is a right. And when the system we have now is threatened, we get health care as a public policy issue. And you can just look back to the 1992 election.

The second most important reason people voted for President Clinton was because of health care.

And what was happening in the three years before the 1992 election is the employment-based system was eroding rapidly. Between 1989 and 1990, 2 million Americans lost employment-based coverage. What happened after he was elected? That erosion stopped. The economy recovered. We had health care being pushed. Inflation slowed.

You can make an argument, as I have several times, that had the Clinton administration moved faster in their first year they could have passed comprehensive health care reform in a program to their liking. Since they didn't, the crisis moved on and the status quo prevailed. Because there are good reasons to hang on to the status quo. Movement to weaken the employment-based system are likely to create an uncertain public policy environment and create change.

So, projecting into the future, there are flaws. Had I been asked to come up here and spend 15 minutes describing the flaws in the employment-based system, I would have had no problem. There are flaws. There are things that need to be fixed. But it seems unlikely that we can find a voluntary private market that will work better than the employment-based system. And changes that retain that private voluntary

characteristic are going to have to work around the edges and not try to erode the middle of the employment-based system.

Thank you.

(Applause.)

MR. MILLER: Thank you, Bill.

We are going to go to your questions in the audience in just a moment. We seem to have a temporary gridlock here on these issues. Bill, you have expressed quite strongly why you feel it's the employer system or not much else. But, in general, I want to ask the other members of the panel, as well, are private health care systems -- people tend to kind of always want policy to steer us in one direction, their direction, and not another. In fact, we have got all kinds of different pieces of the health care system in a distorted way with different policies.

What I would like to ask Gary and Gerry, despite your stated opinions, is there some way in the interim to move to a little bit more of a pluralistic hybrid? Can these other types of systems be accommodated within also an employer-based system? Or is this truly, as we usually kind of reach these stalemates in health care policy, it's either my way, no way, or the highway? How can this all kind of come together in a way which we might evolve toward finding out what people really do want in a choice environment?

MR. AHLQUIST: I do believe that for some period of time it is going to be pluralistic before we clear up the system and have something more unified. I think we are at a crossroads, however; that it is a very slippery slope from where we are today to either a more pluralistic environment, or in my view, a national universal government-run health system. That's very different, and I certainly don't think that would be a good solution. There are others who think it might be.

The issue of how do we get to a more individualized market has in my mind less to do with employers than it does how can we find ways to underwrite or pool risks regardless of whether the employer is the pool or somebody else is the pool. Many of the current new entrants look at ways at starting with the individual in small group markets, which are difficult to write today. But one of the reasons they are difficult to write is because they are written in a group model. All the expenses, everything that goes with writing a group is applied to an individual. Clearly you can't. If economies are scaled work, that is a hard way to go.

They are looking at doing it with much slimmer costs, through the Internet, longer-term contracts, ways which create economies and allow individuals and small groups to be underwritten that will create a more pluralistic environment.

And then we'll move to the large group market and we'll see where that goes.

MR. MILLER: Gerry, you were skeptical of the other alternatives. You didn't put on the table the idea, though, that the tax system might be leveled out and made more neutral so that it wasn't just steering us in the employer direction. If we can stimulate demand on the individual side, where they've got the same amount of dollars in the mall as the folks with employer care do, what does that open up in terms of the possibility of an evolving health insurance system which maybe moves toward an individual choice direction?

MR. SMEDINGHOFF: Actually, when I spoke I appeared opposed to the defined contribution concept. But, actually, I think it is a step in the right direction because it allows people a little bit more choice and it jolts them out of the state of rational ignorance. Now, all of a sudden, they have some information and they have a little bit of choice. I am hoping for, similar to a Berlin Wall scenario, where, a few days before the Wall fell down, the East German Government started letting a few people through, and they were stamping their passports every time they went back and forth. Once people found out about this, everybody showed up at the Wall and the government decided, well, this is stupid; why are we stamping passports? Why don't we just get rid of it?

I think as more people rush to the health care gate and they see that they might have a choice available, I think that would fill the momentum for a stronger change. Essentially, the way I look at it, it is like the public school system. The private school has to convince a parent that the education of their children is so important that it is worth spending the extra money. And there are a couple of examples. It is doing what I call an end-run around the health care system.

There is this one group in Washington called Simple Care. In fact, they have a Web site, called SimpleCare.com. It is a group of physicians who get together and say, look, we are going to cut our fees in half if you pay us in cash at the time of service. Because we think it is probably worth it to you to get the service you want right away, and it is definitely worth it to us if we don't have to deal with the hassle of the HMO and managed care or with the delay in payment. So there is the end-run concept and then, like I say, it is momentum in the right direction.

MR. MILLER: Bill, most of your discussions in the past of the employer system contrast that with an individual system without kind of an intermediate step of, as Gary was suggesting, other forms of pooling. Is private health insurance such that the only pool you are going to belong to is one you get thrown into as opposed to the one you dive in on your own? Can we find

ways to figure out what pool works for the preferences of a particular individual consumer?

DR. CUSTER: There is a decided tradeoff in costs, as you might imagine. When a pool is created for purposes other than health insurance, you are going to have a better mix of risk. And that is what the employment-based system does. When you are sitting down making that decision "I want to buy health insurance. What health insurance should I buy? How much should I spend?" now you are making the decision solely on price and your own risk. And, again, any insurer has to recognize those differences in that group and price accordingly.

There are, and Gary mentioned as one of his alternatives, some measure of risk adjustment. Somebody bears that risk. Somebody has to have that pool. And it is either the employer or it's the government, I think. I don't see how you can have an individual pool that is going to be less expensive.

MR. MILLER: If any of you in the audience have any questions, we should have a microphone for your questions. If you will wait until it appears. We are recording this, so if you could identify yourself.

MR. LISEN: Art Lisen, with the Cigna Corporation.

Mr. Ahlquist, you talked about risk adjusters, which I think is another way of doing individual underwriting. And we would have to do this presumably on very large numbers of people,

if not everybody, if we went into an individual system. Would you try to reconcile the need to do that and the types of information one need to have in order to do that with the whole issue of confidentiality and privacy and peoples' concern about the use of various sensitive private information?

MR. AHLQUIST: Yes, good question and not one that is solely restricted to this issue. The whole privacy issue in health care is getting bigger every day, especially with the Internet.

There are two approaches to the underwriting issue at an individual level that are being looked at. One is risk adjustment. Let me just cover the two, and then I will go to the privacy issue. The information that so far being looked at in pilots tends to be -- and it is done in two ways -- it tends to be readily available information that is the kind of information that we would tend to fill out. It's beyond age and sex. It would have some information about your history in there.

And the way it is being done is that there is an actual third party, who has the rater, if you will, so it is transparent or blind to the employer and the employee. In effect, they just get a dollar amount that is adjusted. Imagine a scale of 1 to 10. And if I am a 52-year-old male, who is not in great shape or whatever, I might be rated a 7. I get the dollar amount that goes with the 7. If I am a 22-year-old female and in otherwise

good health, I might be rated a 1 or a 2 and get those dollars. That information is kept confidential in that rating capability, and the employer doesn't see and the employee doesn't see it. At least that is one model that is being worked.

The other model which gets around this issue more easily is to give everybody the same amount to go to the market, $3,500, but then put in the reinsurance or a stop-loss for those who do incur a high-cost incident in any one period of time. Then you don't get into the rating question and privacy information. Both are being tried in pilots. It is a question of which way we will go, still to be seen.

MR. MILLER: Another question?

MR. VINTON: Mark Vinton, from George Washington University.

Don't you think that one of the differences in cost for the insurers, for the HMO's, is that if they have a group, essentially they are held harmless, they cannot be sued, that is ERISA? But if they take individuals, then they are under State law and they can be sued, and that greatly raises their costs. That is my first remark as far as differential in costs.

Number two, it is still amazes me to see how the American public could accept, in the nineties, the managed care system. Literally, it reminds me of Rumania 1955. If you work for the steel mill, you go to see the steel mill doctor, and he

sends you to Clinic Number 5. Now, if you belong to the party, to the nomenklatura, then you still keep a fee-for-service system, and you have the choice of party doctors, the way you want it, and he sends you to the best hospital in town, which, generally, is the secret police hospital.

Now, how can we bring the great masses of people into a system where they would keep some dignity? Because really there is a problem. For example, somebody today who has a lousy HMO, his employer chooses, indeed, his neurosurgeon, and he is going to go to P.G. Hospital. But, of course, the other person of the other category will be sent to Johns Hopkins and to the best team of surgeons. That is really the reality of the present care. So, how can we bring these employer-based people, who get really lousy insurance, into a better system?

DR. CUSTER: I would certainly argue that the fact is that the employer-based coverage is some of the best. I think certainly it is much better than what an individual in an individual market gets. And your first question, while the tort costs are significant, they certainly not the reason that the individual market is higher priced than a group market.

But your premise is that somehow people are trapped in a system that they don't want. And in fact employers have an incentive to give their employees what they want. The offer a net benefit to attract and to retain workers. And if they are

giving their employees the shaft, they might as well not have spent the money. They are not there trying to provide a benefit that is not fit for most of their employees.

Now, of course, whenever you group purchase you are trying and match the preferences of a group, you are not going to match everybody's correctly or accurately. That is an impossible task. The incentive for the employer is to provide a benefit that the employees will find attractive. If they don't, they are not going to attract employees.

The other difference is that the employer goes into the market and looks across managed care plans to do that. And those managed care plans are competing with each other. It is entirely different from the example you gave, which is there is one choice and no other. In fact, there are many choices. And the employer is acting as the individual's agent. And, again, the best employers will act as good agents and some of the lesser employers will act as less well agents. But, basically, that is the way the system works; and that is the way it should work.

Again, you have this problem that if you don't have group purchasing, everybody's costs are going to be higher, but the people who do get coverage might get exactly what they want. If you have group coverage, you are going to get lower prices, and most of the people are going to get what they want. And the

ones who don't get exactly what they want are going to get pretty darn close.

MR. MILLER: Yes?

MR. PANTOS: My name is George Pantos. I am with the Self-Insurance Institute here in Washington.

In the presentations, it would make it appear that the private voluntary employment-based system is a homogenous system, operating in a single fashion; whereas, the fact is, of the number of people covered by private coverage, half of them roughly are covered by insurance and the other half are covered by self-insurance, which is employer-provided coverage. The premise I think that has been laid down, particularly by the first two speakers, is that there is no choice and that we need to provide individual choice. And I would like to ask Dr. Custer if he could comment on that, because he has touched on it in his response to the last question.

But in the provision of coverage, the model isn't all insurance and HMO's; it is also self-insurance and PPO's. And there is a wide, wide spectrum of choice available to participants under that model, which I think it would be a disaster to just throw out in the remedies that have been prescribed. I would ask Dr. Custer if he could comment a little bit more in depth about the choice that is available today in getting at the premise that has been laid out.

DR. CUSTER: You have done a very good job. I guess just to reinforce my last response, though, one of the reasons employers can self-insure under ERISA, the assumption is that an employee benefit plan is different from a third-party purchase of insurance. Because when you go out and buy insurance as an individual in the marketplace, you have got a third party arrangement with another entity. When an employer provides you that same insurance, the employer has an incentive to do the right thing. So you needed less regulation, a much different regulatory framework, because the employers' incentives were aligned with the employees' incentives.

But I guess to further elaborate on such a choice, there is a great deal of choice both at the employee level as they look through the market and for many employees there is something close to a defined contribution, where they have choices across different styles of health plans and different types of health plans.

MR. SMEDINGHOFF: Could I combine the last two questions? The reason the individual HMO premium is so much more expensive is it is something that nobody wants. The HMO plan requires you to buy pretty much everything that is on the plate. Whereas if you are a 53-year-old woman whose mother died of breast cancer, you have very finely honed health care needs and you can very specifically state them. But the model of health

care is that everybody gets the same thing in the same way. Essentially, by law, HMO's are required to offer all these benefits, from chiropractor care to in vitro fertilization, or whatnot. So we have essentially made it illegal to exchange information between buyers and sellers to tailor the products individually.

The perfect example here is renting a car through Hertz. If you are a member of the Hertz Number One Club, you exchange information in advance with Hertz so when you fly to Chicago they know when you are coming, they have your driver's license number, so they know you can drive, they have your credit card number, so they know you can pay, and they know what car you want. When you have all this information exchanged in advance, it is much easier to rent a car. It takes about 20 seconds before you can drive out.

If we want to, we can run the car rental industry like we run the health care industry, where there is no exchange of information. We are all sort of like the blind man in the dark room looking for the black cat that isn't there. We don't exchange any information. We all just show up at the counter and we will all have to wait in line and fill out all the forms every time we want to rent a car.

MR. MILLER: Just to comment on Bill's answer to that question, there is a lot of choice for employers if they have got

the money to select among the different things in the marketplace. But the last time I saw the numbers in terms of choice of plan for employees, even with self-insurance and other variations, you can boost it up to get into the 60-percent range if you include spousal coverage, but if you screen that out for variations from HMO coverage, you still get below 50 percent of all the employees who are covered by private insurance really having any alternative beyond basically one HMO plan or one single plan. So it is not that rich a variety at the individual level.

A question here, please?

MS. BURNS: I am Mary Burns, and I am with the Department of Health and Human Services.

The comment I was going to make earlier was in fact one you picked up on. And that is there is a lot of choice in the employed market because of spousal coverage, as well, in some stuff I have been looking at lately. But that is not what I want to comment on. I want to say to you guys, if in a really tight labor market you still are covering only 68 percent, what is going to happen? And is defined contribution going to help this or is it going to hinder it? Because at the outset, or at the superficial level, it looks very elitist.

MR. SMEDINGHOFF: I can address the issue. What we think is going to happen is some form of patient's rights

legislation is going to get passed, allowing employees to sue their HMO's. Once that happens, HMO's will have to get liability coverage; the weaker HMO's go under. There will probably also be legislation allowing you to sue your employer for choosing a bad health plan. Well, that means employers now have to get liability coverage; the weaker employers go under. So that just is going to accelerate the number of uninsured. As the number of uninsured accelerates, our biggest fear is that that is going to increase the pressure for some form of national health care.

MR. AHLQUIST: The way I envision it, the defined contribution world would dramatically reduce the ranks of the uninsured. The uninsured population today, about two-thirds of the uninsured population are eligible to buy insurance but choose not to because the policies are unaffordable to them. That is elitist. If we could get 30 million people who want to buy insurance that is bare bones, they are generally healthy folks who are migrant workers, that is portable, whereby they could have access to the emergency room, which they do statutorily anyway, but some sort of coverage that is within the probability of how they think of the world, that is economic for them, I think that we might see more people go on the insured rolls and help a lot with that kind of issue, as well as within the insured ranks, many of whom, again, do the averaging.

I would disagree that most people get what they want. I think when you pool you basically serve the average. You hit the fat part of the curve but you leave about 40 percent of the people with something that isn't really what they want. And if there were more options for those folks, even within the current offering, I think it would be better.

I would also agree that the pendulum has swung back. You have to remember that 83 percent of employers offer one health plan. So, within that health plan, they may have an HMO and a PPO, but it not a whole lot of choice that you currently have even within the expanded choice that we have today.

MR. MILLER: Yes?

AL MILLIKEN: Al Milliken, Washington Independent Writers.

I was curious, when employers are paying for coverage now for those outside family members, say, for live-in lovers, or so on, how do you see that affecting this in the future? And I don't know if you want to say anything, too, about the role of the uninsured and unhealthy people. How are they going to be affected in the years ahead, do you see? Do you think their situation is going to be much worse?

MR. SMEDINGHOFF: Well, I can answer that. Ideally, if we get rid of the Internal Revenue Code, if we get rid of the segregation, one dollar bill is just as good as another, then all

these issues, like rights for homosexuals, all of those issues go away, because there is no difference in the dollar bill. The reason we have these issues about the cohabitants, whether or not they can get health care, that is all because we have this concept of segregation through the monetary system, through the tax code. If you eliminate that, all those issues evaporate.

DR. CUSTER: I disagree. All of those issues come up because we finance through insurance. You cannot ignore the principles of insurance, which is that you need to have a risk pool and you price according to that risk pool. Specifically, domestic partner employee benefits, when they have been offered, employers who offer them have strict definitions of who the domestic partner is to avoid adverse selection, to avoid people becoming a partner simply because they are sick. But once those are in place, the costs are very similar to any other family.

I would like to go back. I missed my chance to respond to your question on the uninsured. Because I think we are at a crisis point. We do have a very tight labor market. The employment-based coverage has been expanding. Any type of economic downturn, coupled with increased health care cost inflation, is going to increase the number of uninsured.

And as I said before, one of the things I think will happen if you expand the tax code to include individual coverage, is that on the margin you will also bring up the number of

uninsured. Because while some people will be able to buy individual coverage they couldn't before, they will break up groups that exist now. And the poorer risks will go on the market.

The real challenge is, how do you rationalize care to the poor risks who are uninsurable? How do you finance that care?

As I said, health care is a right. We are not going to let these people suffer without any set of health services. We need to decide what the proper set of health services is and find a way to fund them. Because there has been attempt after attempt after attempt to subsidize coverage for the uninsured, that is, to lower the price, whether it is a direct subsidy, or a bare bones policy, and it does not have a large impact. We are not going to get that core of uninsured through subsidies or price.

So you are just going to make rational decisions. If it is a dollar, and I am a 20-year-old guy, why should I spend a dollar? I can go buy a beer. And if I buy a beer and walk out and get hit by a truck, well, somebody is going to take care of me; and now we have to find a way to finance that care.

MR. MILLER: Yes?

MR. LOCKER: Adam Locker, from the National Association of Health Underwriters.

If I am at a Web site today and I have a question, and the one site has a contact phone number, I find that most operators don't have more knowledge than the bare minimum. Who do you all think these new companies with defined contributions will rely on to help consumers with questions to navigate the health care maze?

MR. AHLQUIST: I'm sorry you've had that experience. I have had it, too.

I believe that this part is going to take a while: the infrastructure we talked about, the information flows. Today, it is such a fragmented information system around health care that just getting the pieces together is one challenge. Integrating the pieces to make them mean something is a second; and third is putting them in terms that consumers can understand. That is the ultimate goal here.

The ones that are the most successful to this date, who are still early in the game, appear to be those who are starting their own information bases rather than trying to integrate somebody else's. Which means they are going to have to start small and grow out. They cannot get big very quickly. Otherwise they will just miss the mark. And it is going to take a while. There is no question about it.

MR. MILLER: We will take two more brief questions.

MR. DENNET: I am Paul Dennet, with the American Benefits Council.

I am hearing at least three different definitions of the problem that we are trying to solve. One is a choice problem and the other is an uninsured problem. I think Gerry, in particular, seems the most troubled by the tax policy problems. And I always get a little worried myself when I hear about omni-tools that can solve all problems. And it seems to me that if there is a problem of choice in the employer-based system, I am not sure defined contributions necessarily is the answer.

As was mentioned at the outset, the 401(k) plans provide more choice of pension coverage for a lot of workers. But it doesn't give me 63,000 choices; it gives me about six or eight good choices, sponsored by my employer. And I am a happy puppy with that. So there could be certainly solutions that are still within the employer context that solve the choice problem by dealing with vendors who can help to organize the market better, if employees in fact demand and really want more choice to go work for one employer versus another.

But on the uninsured problem, if that's the real problem that we are trying to solve, is defined contribution the right answer there, as well? Other people have talked about, for example, opening up the CHIP program to lower-income adults to also get coverage, for people who are near Medicare eligible, to

open up Medicare, and other people have talked about opening up the Federal employment program.

I am just wondering whether this is the right tool for each problem that we see and what the panel thinks. Of those three problems, tax policy, greater choice, and uninsured, the defined contribution tool is best matched to which of those three objectives?

MR. AHLQUIST: I believe the uninsured problem has no single solution. It is going to require multiple programs, and I don't think defined contributions is it. I look at the tax issue as a barrier or an enabler to a better solution. To me, what defined contribution does is partly around choice, but it is actually much more around making informed, incented consumers pay attention to health care for the long term. And I believe, unless we put the dollars closer to their pocket to spend, they will do what Milton Friedman says: We are all willing to consume as much as anyone else is willing to spend on us.

And we need to put more responsibility to us, hard at that is to do. Defined contribution, first of all, does that. Beyond that, it says that once you are an informed consumer you will begin to demand products and services which meet your needs. In an albeit pretty complicated and broken system, we believe unleashing 200 million consumers in this way is about the only

way we are actually going to really make a dent in that whole system and give choice and give better cost and so on.

MR. MILLER: Last question right here.

DR. MCKIRBY: I am Dr. McKirby, a retired physician.

I have a simple question for Dr. Custer. When did it become a right of the American people to have health care, and where is it written that it is a right?

DR. CUSTER: I tried to be careful as I said that to say that the American people view it as a right. And I think that if you look at public policy since the Hill-Burton Act, in 1948, on, if you look at the presidential campaign, we have skyrocketing pharmaceutical prices, we have a crisis there in pharmaceutical utilization, and the pubic policy response to that was: How can we pay for more people to get this? The public policy reflects what people think. And people think that I am entitled to some level of health care.

Again, my example is we do not let people die in the street. It would be a scandal if somebody with appendicitis, who could be treated, was not, regardless of their financial ability to pay. And that's the definition of a right.

MR. SMEDINGHOFF: Let me just add one comment. If you will read the Constitution and you read the Bill of Rights, you will notice that for all the rights that you have in the Constitution, nobody else has to lift a finger. Nobody else is

required to do anything for your right to speak or your right to vote. The right to health care, assuming there is one, means that somebody else, by law, is forced to provide it. We used to have that in this country, and we called it slavery. We abolished that in 18-whatever.

DR. CUSTER: Let me try one more way to say this, because I said a "right" to get people's attention. But health is like education in the sense that we believe, as a society, and I think I can say this, that we are better off when our citizens have access to health care services.

MR. MILLER: Well, rights or wrongs, we will end on what seems to be a perennial debate. You are all welcome to head upstairs for lunch, but let's first thank all of our speakers on the panel.

(Applause.)

(Whereupon, the Policy Forum was concluded.)