

California HealthCare Foundation Reform Seminar #3

Male Voice: Let me get you a microphone so you can test this out.

Male Voice: Okay.

Male Voice: California HealthCare Foundation, the third seminar. It's the third in a series of seminars that the foundation has funded. The first one was on health information technology and electronic medical records, and the second was on technology assessment.

So I want to just, in terms of addressing the people in attendance, the packet is pretty full. We have, on the left-hand side; we have the background report that was prepared by Insure the Uninsured Project for this seminar. Lucien Wilson was our consultant on this whole project. We have, in addition to that, the two PowerPoint presentations in there, we have an evaluation that's in there, and then, on the right-hand side, we have all of the speaker recommendations with respect to articles. So we have journal articles, we have institute articles, we have articles from the New York Times and the Wall Street Journal.

So it's pretty packed, and on the, one of, the affordability article from Health Affairs by Rick Curtis and Ed Moeschler, we were provided some additional charts which are in the back there, estimates of ABX 1-1, so that that is for your reading. You also have the web addresses for all the articles, should you want to use them for later reference if you don't have these articles available.

So in terms of today, I would like to also acknowledge Terry Bowden, who is the senior program officer from the California HealthCare Foundation is here, and her colleague, Marian Mulkey, who is not able to be here, although I think we are having, this is broadcast through the Internet, and so we have, we may have several people on that.

Just to let you know the environment in Sacramento today: We have a single-payer demonstration, we have an opposition to the economic stimulus package opposition, there's a lot of activity in and around the Capitol, and so there's a lot of competition for people's attention.

Male Voice: Public demonstration outside, I was thinking a demonstration [unintelligible].

Michael: No. [Laughter] So first I'd like to welcome and introduce to you our speakers. We have, in the middle is Linda Blumberg from the Urban Institute. She's a senior fellow. To the left, to her right, is Michael Cannon from the Cato Institute. He's the director of Health Policy Studies. And to Linda's left is Rick Curtis, who is the president of the Institute for Health Policy Solutions.

Part of your agenda, or the back part of your agenda, you have their very, their bios, which are – their very distinguished bios. So rather than, since we're got started so late, I will just bypass that and note for you that that is in there, so you could take a look at what we have, what's available from their bios on there.

So first off, we would like to, we were not able to get the PowerPoint presentations being able to be broadcast from Washington out here, so we're going to do the two PowerPoint presentations and, as I understand it, is that you're going to signal us on each time you change screens so that we can follow along with you on that. Is that correct?

Female Voice: Sure, that works fine.

Michael: Okay. All right, so the first is Linda Blumberg, and so Linda, if you want to get started.

Linda Blumberg: Okay great. Well thank you very much for inviting me to be part of your meeting today. Let's start with the first line after the title. So let's start out by defining what an individual mandate is. An individual mandate is simply a requirement that all individuals in a defined population – and you can define the population however you want, for example all children, all adults, all permanent residents, whatever your target population of interest is – is a requirement that they obtain health insurance coverage, either public or private, that satisfies a minimum standard.

Now one important thing to note that an individual mandate does not mean is that it does not mean that there is necessarily a decline in employer-based coverage. It does not mean that all individuals will then buy their coverage independently, as opposed to through groups, as they mostly do now.

In fact, depending on the design details, and individual mandate can lead to an increase in employer-based coverage in much the same way that has occurred in Massachusetts

under their reforms. This happens because once everyone is required to have some type of health insurance coverage, many people will decide that the best coverage for them or the coverage that they most prefer is to get it through their employers. And that's why we often see a change, and we would expect a change in employer-sponsored insurance coverage and have seen that in situations in the past.

Let's flip to the next one, please. Now what do we have to do in order to make an individual mandate function? Well first of all, there's got to be a – the level of coverage that's required for everyone to obtain has to be available to everyone. Otherwise they can't practically satisfy the mandate.

Now currently there is no guaranteed source for purchasing health insurance coverage. There is, and California has, a non-group insurance market that is allowed to deny coverage to individuals. There is obviously some public programs there, but if you're not eligible for the public programs, you're not offered employer-based health insurance, if the high-risk pool is not available to you for whatever reason, you may be without insurance coverage.

And so, implementation of a mandate requires that everyone have access to coverage that meets the minimum standards.

Now, this is likely going to require changes to market insurance regulations and/or the creation of new purchasing options or entities, such as a purchasing pool or a health-insurance exchange. And I'll talk about the potential benefits of exchanges in a few minutes. But this is the first line of process in order to be able to put a mandate in place is to make sure that the required level of coverage is available to everyone.

Next slide, please. Now, the second line of process here is to make sure that the mandated level of coverage is affordable to everyone. It would be unfair to require individuals to purchase something that they couldn't afford. And a mandate will necessarily require some type of subsidies for the low-income population as a consequence of that.

Public insurance coverage or subsidized private insurance plans can be used to provide affordable coverage to individuals. And affordability standards are going to have to be set for individuals at different socio-economic levels.

Now of course there's going, there's no objective measure of

what's affordable and what's not for different income categories, and so we do have to realize that there's going to be some, a lot of subjective and political kinds of influences that are going to go into this. But there are a number of measures that can provide some guidance on this. And ultimately, though, it is going to be a political decision.

Now, if we're going to have a complete mandate, that requires subsidizing all individuals who are covered by the mandate up to the affordability standards. If we don't provide those kinds of subsidies to make coverage "affordable" by whatever definitions the state decides to use, available to everyone, then there's got to be an exception to the mandate. This is the way that Massachusetts decided to go about their mandate, was that if there were in fact individuals who could not obtain coverage at what was considered to be affordable rates, that they would then be exempt from the mandate. So if you want to really move towards, to achieve universal coverage, have everybody in insurance coverage of one type or another, the subsidization has to be linked to the affordability schedule.

There's clearly a trade-off here. If you go ahead and allow for some exemptions, then that protects the cost of the program to some extent. It limits what the state and/or the federal government are required to contribute towards subsidies, but the downside is that some people will be made exempt and they will not obtain coverage as a consequence.

And in Massachusetts, where they have modified community-rating but not peer community-rating, what usually happens in terms of who we think the people are that are exempt from the mandate, are usually the people who are generally in the 300-400 percent of poverty range, who are not eligible for the low-income subsidies, and they're older, so that the premiums that they face are higher than the average in the population. So, those people have some exemptions as a consequence of what the financial burden would be relative to their income.

Next slide, please. Now it's also a good idea to have coverage that would be adequate to provide effective access to necessary medical care. Minimum coverage standards sufficient for the high-income population may not provide

the low-income with adequate access to care that they need. For example, a \$2,000 deductible may not impact my access to medical care at all, but would be an enormous barrier to services for a low-income person.

And so we want to be able to take into account ideally not just what is affordable in a premium, but what's going to really give people access to the care that they need. So subsidies for difference income groups would ideally be pegged to coverage that would provide them with effective access to care at an affordable level. And that means that we need to take premium and out-of-pocket liability into account when we're thinking about adequacy. The out-of-pocket liability should include, taken into account, should include co-payments, coinsurance, deductibles, out-of-pocket limits, all of the pieces that lead us to understanding what somebody's potential financial liability would be to obtain coverage and to obtain access to care.

Next one, please. Now, I suggest that there are three central reasons why individual mandates are important in the context of comprehensive healthcare reform. I'm going to

tell you the three of them and then go through each one in a little bit more detail.

First, universal coverage can't be achieved without an individual mandate unless we go to a system that is a single-payer-type system where everybody is already automatically enrolled and the premiums, the cost of the program, is financed through the tax system or some other mechanism. So, short of a single-payer system, we can't achieve universal coverage without an individual mandate.

Second, adverse selection will occur under a voluntary system. We can make life a lot simpler, as I'll talk about in a minute, under a mandate with regard to selection issues. Also, an individual mandate is necessary to redirect current spending on the uninsured to finance reforms, and I'll talk about that a little bit more, too.

So let's go to the next slide. Okay, so as I mentioned, absent a single-payer system, an individual mandate is the only way to achieve universal coverage. This is because under a voluntary system, even one with very reasonable subsidies for the purchase of coverage, many people will remain uninsured.

We have abundant research evidence and experience to show that this is the case. Depending upon the generosity of subsidies and the types of market reforms that are implemented along with a mandate, researchers have found that the uninsured can be reduced by 30-50 percent with voluntary measures. So, far from complete coverage, although still a very significant improvement relative to where we are today. And as prices increase over time, the uninsured would grow, as healthier people begin to opt out, as the cost of coverage would increase. So, not only would we not cover everybody without the mandate, but in fact we would still continue to see declines in insurance coverage over time.

Next one. If a new insurance option is made available in a more accessible way than other insurance options are, then volunteer participants who are older and less healthier than average are going to be the ones who voluntarily decide to enroll. The more the more accessible option is subsidized, the more you'll bring in some healthier folks too, but the volunteer participants will always be more likely to be the ones who expect to use medical services. It's just worth more to them, and whatever effort they have to put in to

enroll, whatever contributions they have to make out of their pockets, is going to be more appealing to those who know that they need medical services.

Now, this adverse selection will increase average costs of a new plan. This means higher premiums for enrollees unless the government intervenes by subsidizing risk or redistributing costs in another way to those who don't enroll. And higher premiums further dissuade the healthy from participating, and in fact the fear of enrolling the higher-risk population also dissuades insurers from participating in a reform insurance pool.

So these are complexities that arise when you're trying to make a system more accessible by opening the doors to those of all health statuses, for example, but not having a mandate. And so people can still decide based upon their expected use of coverage and services – their expected use of services, excuse me – to opt in or out of the system.

Next slide, please. Spreading risk under an individual mandate is much easier. The cost of the high-need can be spread broadly at low marginal cost to the healthy. Since most people in the population are healthy, the more

individuals over which you can spread the cost of those with serious health problems, the smaller is the extra increment that each healthy person has to pay into the pool.

Also, we don't have to worry about dissuading coverage among the healthy when everybody's required to participate. And the pool wouldn't get more expensive due to insured population decreasing over time. We wouldn't have the healthier continue to peel off over time, making the pool more and more expensive.

The primary impact of the mandate is therefore to increase the financing burden on the younger and the healthier parts of the population. But their access to health insurance and medical care is more stable and secure, and the young with modest incomes can be protected via income-related subsidies. So the reform is not without benefits for them, but they are, their situation in terms of cost is going to be affected by making the system both mandatory and all-inclusive.

Next slide, please. Now, there is no, or if you have a situation where there's no risk selection in and out of the insurance market due to a mandate, this means that you

don't need to have coverage denials allowed for the private insurers, you don't need to have medically underwritten policies. These are strategies that are used by insurers to take into account the risk that they face from getting a bad selection in, that only the healthy are going to want to be insured. So once that's done away with, we don't need to have those kinds of strategies allowed. You can allow some limited age rating of policies or not, depending upon politically where the state is. Age rating will require subsidies to apply to higher incomes to keep coverage affordable for the near-elderly, as I mentioned. With regard to Massachusetts, the higher the premiums are for the near-elderly, the more that the higher income near-elderly need to subsidize in order to make it affordable; otherwise they would need to be exempt.

Peer-community rating in the near term would be more disruptive in terms of price changes that would be experienced in the marketplace, but if the state wanted to do this, they could consider phasing it in over time to kind of dampen some of that disruption. Depending upon insurance options, there may also be a need to do some risk adjustment across plans. The more variation in benefit

packages that are allowed, the more risk selection there is likely to be. And so there should be – the risk selection is likely to be between plans, where the healthy would be attracted to certain plans and the less healthy to others, and so risk adjustment could then be used to kind of even out those issues.

Next slide, please. As we think about changes to insurance markets and market rules, we're likely to think about whether insurance exchanges could provide a useful role in structuring the new marketplace. And depending upon how they're designed specifically, exchanges can potentially play a useful role at a lot of different levels.

The first is in risk spreading: Right now, competition today is focused on getting the lowest risk enrollees into insurance plans. Market regulations are required to prevent this, and an exchange can play a role there by penalizing or excluding insurance companies that violate regulations. They can establish market conduct rules to prevent evasion of the market rules. They can do a central enrollment to prevent exclusion of certain groups that might not be as attractive to the insurers.

The exchange can also potentially play a role in cost containment, particularly if they're given authority to negotiate with insurers over premiums. And insurance could potentially, through the exchange, be excluded, based on prices or growth. They could also require employers to make fixed contributions into the purchasing pool, giving incentives to the individual workers to choose more cost-effective insurance coverage options. They could require offering standardized benefit packages in the market, so that it makes it easier for individuals to choose between different plans based on price, creating more of a competitive environment than we have today.

They can also play a role in delivering subsidies; administering subsidies in the open insurance market is very costly. We've seen that with the health coverage tax credit at the federal level where 34 percent of the costs of that program are attributable administration. That can be done a lot more effectively, efficiently, if there's one central agency that's responsible for all of those roles.

The exchange can facilitate and ensure enrollment, make it easy to comply with the mandate, make it affordable and

barrier-free, and have one locale where all the processes, from determining subsidy eligibility to providing information on plans to having people make payments, is done to make it easy for individuals to participate.

They can also play a role in ensuring meaningful coverage, only allowing policies that meet particular standards, that are sufficient to meet the mandate to participate, and to make sure that prompt claims payment is being done, that services are basically being delivered in the way that they're promised.

The exchange can also promote health insurance transparency; it's very helpful to promote – we can't really have competition if individuals don't know what they're buying, to have the information that allows them to compare across plans. We can do that centrally through the exchange very much similarly to way that it's done for state employees in California.

And it can also help to promote health insurance accountability by fostering competition based on efficiency and verifying compliance with rules related to risk-spreading and claims payment, etc. So there are a lot of

roles that the insurance exchange can play. In this round I just wanted to mention a few of them.

The next slide. We went to the sources for financing for health-care reform now, and one of the things we need to keep in mind, that unless we have an individual mandate, that it is going to be very politically difficult to free up the spending that is currently being directed to the uninsured, both from Medicare and Medicaid programs that contribute dollars to safety net hospitals to support their care of the uninsured, and other spending that's going on with it in the state and the localities. If you've got a significant uninsured population remaining, then it's going to be really difficult to take that money and redirect it to help finance reform, and I think that's going to be important funding.

It's also important – remember that a voluntary reform is still expensive, because, as I noted earlier, the people who are going to be attracted to it, while it's not everybody in the population, the people who are attracted to it are going to be the people who need the most services, the most expensive people. So, while you are taking on a lot of responsibility in the voluntary system for high-need populations, you're not

going to be able to find it easy to redirect the money that is going to the uninsured today.

And so the reluctant enrollees, those that that come in only due to the mandate, are going to be less expensive, but they greatly increase the political claim to public funding that's already out there, so that it can be used to help finance the reform.

So while we're talking about financing/funding issues – we'll go to the next slide – I want to talk about briefly some of the long-run financing issues that come up.

Obviously, everybody is keenly aware of how expensive it is to do healthcare reform, and when you're talking about bringing everybody in together, then the concerns get heightened. Okay. Now, the long-run finding, the long-run cost issues under a mandate are really precisely the same ones that we face today without a mandate. It's the increased chronic illness prevalence, it's growth in health technologies and how those are used to provide services, it's prescription drug cost growth, and it's also market imperfections. We've got, we've had in recent years a lot of insurer consolidation and provider consolidation, and what

that leads to is really a lack of competition in insurance markets across the U.S.

And so these are all things that are going on now, regardless of whether there's a mandate in place, and these are all the things that are going to cause cost growth in the presence of a mandate.

So these are the long-run issues too that we observe in Massachusetts under their reforms and that they're struggling with how to deal with at the moment. So let's talk a little bit – we'll go to the next slide – and we'll talk a little bit about the options that we have to address long-run costs.

And I'm going to start off with what I consider the weaker approaches, and the ones that have more power will come afterwards. But the first option that I have listed there is a managed competition approach. This model would kind of encourage, would lay out rules that insurers would have to follow, giving a lot more information about plan benefits and their values, making sure that prices don't vary with risk, and then having people choose; those who choose more comprehensive benefits having to pay extra costs associated

with them, and giving incentives for more tightly managed types of insurers. The intent is to make individuals more cost-conscious and to increase pressure on providers to hold down costs.

But insurers have little power over providers, or at least that's what they tell us and that's what we're observing, and so even if you've got individuals who are facing higher out-of-pocket costs for insurance plans, I'm not sure that that kind of dynamic between the consolidated providers and the insurers is really going to change terribly much as a consequence. We've got a situation where the insurers don't have to compete on price very much. They're able to pass the costs, in addition to even higher profits, on to the purchasers. The providers have grouped together so that they don't need to negotiate. The insurers they know can't do without the big safety-net hospitals and the big teaching hospitals, so they kind of have the insurers over a barrel.

So I'm not sure that the managed competition approach is going to provide the insurers with any more leverage than what they have now, but it might – doing so, kind of setting up that kind of managed competition model would at least

let us know the extent to which we can get cost savings that way.

Another option, a stronger option in my view, is providing a public insurance plan, and in exchange under reform, it would operate similarly to a traditional Medicare program, with payments at least initially greater than Medicare levels, but it would use the power of a strong buyer to bring down provider payment rates and insert a competitor with a strong interest in cost-consciousness into the market to try to induce the private plans to be stronger negotiators with providers.

Another option would be to allow the exchange to be a provider rate negotiator on behalf of all the plans in that pool. Or, I think the strongest option available is to go to an all-care rate-setting approach, which is much more controversial, where the state would determine payments to all providers, and for all insurers to largely follow along with that, with some adjustments for various different circumstances like teaching hospitals, etc.

So those are some options we could discuss more if you're interested, but we're talking about options for seriously

addressing a long-run cost issue that's the case whether or not a mandate is in place, and I think that's really important to keep in mind.

Go to the next slide, and I'm now going to talk a little bit about mandate enforcement. And obviously some type of enforcement mechanism is necessary to reach universal coverage, and it's a matter of fairness. You don't want some people complying dutifully while others evade with no consequences.

But the primary focus, from my perspective, of mandate enforcement should be on making it easy to enroll in qualifying coverage. We want to make, allow people to comply voluntarily in a way that works for them; we want a lot of outreach and education investment made so that people understand what's expected of them and how to achieve it, what the benefits are for them.

And then secondly, we need a lot of easy enrollment options. We need to learn from the best public programs out there in terms of how they have gotten individuals to enroll at high rates, including [unintelligible] applications, options online, through the mail, a wide array of in-person options

where trained people can help people enroll, including outreach through the schools. We want to have provider involvement. People seeking care who have not enrolled in coverage already could get help for their enrollment that way, and providers could be guaranteed reimbursement even for uninsured individuals if they provide such assistance and get individuals enrolled.

We also want employers involved; we know the highest rate of participation in any health insurance option is for those people getting coverage through their employers. Even if employers are not required to contribute to an individual's health insurance, we could use them to help facilitate enrollment and provide information, do wage withholding to pay for premiums for individuals, to make it convenient for them, etc. So there's a lot of outreach and a lot of facilitating that we could do to make this work so that most people will comply without a struggle.

Next slide. But secondly, we're going to need to have some kind of penalties. Initially, I think they should be small, as the bugs of a new system are worked out. My preferred approach is to deem people as being covered and enroll

them in insurance coverage, using the penalties primarily to collect unpaid premiums. So, for example, if I should have enrolled six months ago, and I'm now being enrolled as a consequence of being identified through the tax system or some other mechanism, and I haven't complied, the six months of back premium would be collected. That would be paid to the insurer to keep them whole from any adverse selection concerns. A penalty add-on would go potentially to the state coffers. And that these back premiums, what you would owe would be related to whether or not you should have been a subsidized individual. So if I'm a very low-income person, I wouldn't have had to pay premiums anyway, then I'm not going to have a penalty and I'm not going to have back payments to pay. But if I am higher income and I should've been participating and I hadn't, then those back premiums would apply.

So that way, the idea is that these penalties are really more a mechanism of enrollment and getting people paid up where they belong, much more than they are punishment.

Penalties can be assessed at tax time, insurers can be required to provide a form to each individual with information on their coverage during the year, much the

same way we get 1099 forms. And the failure to report having coverage would lead to the penalties.

So, to sum up, in the last slide there, absent a single payer system, no universal coverage is going to be accomplished without a mandate. Voluntary measures will enroll the higher-cost individuals, creating higher premiums and instability in insurance pools without large additional government subsidies. We can deal with adverse selection but it's going to be more costly from a public dollar standpoint, in order to keep insurance pools stable that are open to everyone. We can't lay claim to current government dollars without full coverage, and I think we're going to need those dollars to help us finance reform on a broad-based basis. And long-run financing issues are going to be central to any comprehensive reform, regardless if there's a mandate or not. These are not easy issues to resolve, and it's going to be a struggle either way to get the political support for those really serious measures of dealing with cost.

And finally, I think enforcement can be designed to feel more like enrollment than punishment, and that that would make it a lot more palatable as an implementation.

So thank you very much.

Michael: Thank you, Linda. While we're switching over to Michael's PowerPoint, anybody have a clarifying, a couple clarifying questions? Otherwise we'll postpone all questions until after the panel discussion at the end of the session. So, as soon as – if we have any questions, we can take care of them. Otherwise, we will get right next to Michael's presentation.

Michael Cannon: Thank you, Michael. Can you hear me?

Michael: Yes.

Michael Cannon: Okay, great. I want to let everyone know that, you know, you've been sitting for a while; if you need to stand up and stretch, you're not going to offend me. I also was wondering if – because I sent Michael two PowerPoint presentations, one for handouts and one for the actual presentation – I was wondering if you could tell me what the last two lines on the first slide you're looking at say. Or just the second to last line.

Michael: Michael, at your suggestion, I gave them the second one and reserved the one for your PowerPoint to be the one that's on the screen.

Michael Cannon: Okay, well, then it should have an arrow and it should say Cato Institute Healthcare University, but that's okay, I just wanted to make sure that I was dealing with the right one, since I can't actually see what we're flipping through, and things could get hairy if there were that confusion.

So I'll just go ahead and get started. My perspective – I want to thank Michael again for having me speak to you folks – my perspective on an individual mandate is different from Linda's. I'm much more skeptical about what it's going to achieve, and the main points, if we can flip to the next slide please, the main points I'd like to make are that mandates aren't going to accomplish what supporters hope; in fact, I think they'll do a considerable amount of harm. And, in addition to the problems created by mandates that may include – that will include higher taxes – may include job loss. Health insurance mandates would give government additional sweeping powers over our healthcare sector and health insurance markets, to the point that, to my mind, I don't really think there's much of a difference between enacting a mandate and moving all Americans into a new government plan.

Now, the folks who are demonstrating in the streets outside of where you are, that'd be just fine, but I have a number of concerns with that approach, and similar concerns with the approach of mandates.

Michael Cannon: A mandate imposes taxes on individuals, enables the government to compel participation in the insurance market, allows the government to dictate the terms of insurance, but also gives the government the motive, means, and opportunity to control the delivery of medical care and even to ration access to medical care. And so I'll have more to say about each of those, why each of those effects concerns me.

Michael: Excuse me, Michael, we seem to be out of sync with you. What slide are you on, so we can--

Michael Cannon: Overview. Still on overview. What I'm going to be talking about is some of the reasons why people might mandate, might want to mandate that others purchase health insurance and then some of the reasons why not.

So if we can go to the next slide, slide number three. We can look at some of the reasons why you might want to mandate health insurance. So, let's assume that you're interested in

some combination of the following goals: improving health, saving lives, achieving universal coverage, making coverage more affordable, eliminating free-riding, where people don't pay their medical bills, and that cost gets pushed on to people who do buy health insurance, and promoting personal responsibility. I would argue that if these are your goals, then an individual mandate is not going to get you where you want to go.

If you want to improve people's health, there isn't any evidence that expanding coverage, such as through an individual mandate, would deliver greater health improvements than other strategies would. We cannot say, for example, that an individual mandate would improve people's health more than devoting the same amount of resources to community health centers or screening people and treating people for particular diseases like diabetes or hypertension, or even improving education, because health economists tend to agree that education actually has a causal effect on health.

And so, by investing in expanded health insurance coverage, we could be forgoing even greater health gains offered by

one of these strategies, if it turns out to be superior. And, moreover, if you want to save lives, I think that the large number of uninsured Americans probably shouldn't even be your first priority. The Institute of Medicine estimates that five times as many people – as many as five times as many people die from preventable medical errors in the United States as die from a lack of health insurance. So I think that there may be more lives to be saved there.

And if you want to achieve universal health insurance coverage, an individual mandate won't actually get you there. Evidence from state experiments with insurance mandates suggests that people will still forgo insurance even in the presence of a mandate.

If we can go to the next slide, you'll see a map of the U.S., where even though 47 states mandate that drivers purchase auto insurance, you'll see that some states have uninsured motorist rates that top 20percent, including your own state of California.

If we go to the next slide. In Hawaii, an employer mandate that was enacted in 1974 appears to, according to Sherry Glied and her colleagues, appears to have reduced

uninsured in Hawaii by a modest amount. The uninsured rate there is now eight percent. Still better than the rest of, than most other states, or the United States as a whole. But still shy of universal coverage.

In Massachusetts, they've gotten much closer to universal coverage. The last study showed about 2.6percent of the population remains uninsured. Now, that is pretty darn close to universal coverage, but I think that the story here in Massachusetts won't necessarily translate to the rest of the country, and here's why:

In order to help people comply with the health insurance mandate in Massachusetts, the state has had to, or the Commonwealth of Massachusetts has had to offer subsidies to a lot of people. And they have exempted a segment of the population from the mandate because they have deemed that, first of all, those people, they've deemed that health insurance is unaffordable for those people, that their health conditions are severe enough and their means are modest enough that they're not able to afford health insurance. But also, they've decided that they're not going to provide subsidies to those people.

So, Massachusetts, which is more tax-tolerant, I think, than the rest of the nation, is not willing to provide the subsidies necessary to help everyone buy insurance coverage, and that's even when they're able to pass off maybe 50 percent of the cost of those subsidies to the federal government through the Medicaid program. That's where a lot of subsidies that are helping people comply with this mandate are coming from.

And if we enact a mandate on a national level, then, if other states enact a similar mandate, then they may run into similar resistance to tax increase, to the subsidies required to help people comply with the mandate. Most other states probably won't tolerate taxes as well as Massachusetts does, and if the federal government decides on an individual mandate, well, then they're not going to have anyone that they can get half of the cost of those subsidies from except for perhaps future generations, which is probably not a viable way of funding those subsidies.

If you go to the next slide... If your goal is to make health insurance more affordable, an individual mandate would actually have the opposite effect. Special interests have a

way of lobbying legislators until the medical benefits package becomes unaffordable for more and more people.

If we go to the next slide. Before reform, Massachusetts already mandated 43 different types of coverage. To those 43 mandated benefits, Massachusetts individual mandate added new benefit mandates including prescription drug coverage, coverage for preventive care services. People are now required to purchase health insurance with deductibles no higher than \$2,000 for individuals or \$4,000 for a family.

There are maximum deductibles on prescription drug coverage, maximum out-of-pocket limits, and limits on benefit caps, such as there can be no per-illness or per-year caps on total benefits, or no fixed dollar amount per day or per stay in the hospital. Some people might prefer a \$5,000 deductible or to pay for drugs or preventive care out-of-pocket, but the individual mandate took that choice away and is making health insurance in Massachusetts less affordable, not more affordable.

Next slide. Now, if you want to eliminate free-riding, I think that not only are you focusing on the molehill of a problem, but an individual mandate won't get you there either.

Next slide. First off, uncompensated care, according to a recent Health Affairs study, accounts for at most 1.7percent, or cost-shifting the burden of uncompensated care accounts for at most 1.7percent of private health insurance premiums. Now, for a bigger perspective, every one of us gains and loses 1.7percent of our body weight every day without even noticing that. Moreover, giving people health insurance doesn't stop them from free-riding. Another study published in Health Affairs found that one-third of uncompensated care in the United States goes to patients who actually have health insurance, but don't pay their share of the bill.

Next slide. When experts estimate that upward of 30 percent of U.S. health spending is wasted, used to purchase medical care that doesn't do anything to improve the patient's health or happiness, it seems a waste of breath to be talking about free-riding as though it were a serious problem.

Now, if you want – next slide, please – if you want to promote personal responsibility, I would argue an individual mandate would do the opposite. If you're like

me, you want to live in a society where we care for people who cannot afford medical care, even if the reason that they can't afford medical care is their own stupidity, because they didn't purchase health insurance when they had the means to do so, and now they have expensive medical needs and no way to pay for them.

But you also recognize that there will also be a cost associated with our generosity, that there will always be people who take advantage of that generosity. That is part of the price of living in a compassionate society. Right now, it comes to less than three percent of health-care spending.

So by forcing others to purchase health insurance so that we don't have to pay the costs associated with our compassion, perhaps because we think our compassion should cost us nothing, well that, I would argue, does not promote personal responsibility. Indeed, that's the opposite of personal responsibility; forcing other people to pay the costs of our decisions.

Next slide. So we've looked at some of the reasons to support mandates and found them lacking. What are some

of the reasons that we might not want to create an individual mandate?

Well, first of all, mandates are taxes. And they're taxes that fall disproportionately on the young and income-constrained. They lead, as I have mentioned, to rising healthcare costs. Or, I should say, they make healthcare costs rise more rapidly. In the end, I would argue that mandates are essentially special-interest legislation. And individual mandates invariably lead or are accompanied by employer mandates, which are even more complex and do more to destroy labor markets, not just healthcare markets.

Next slide. So to be clear on what a mandate is, and health economist [Uva] Reinhardt, and Obama National Economic Committee Chairman Larry Summers can help us out on this point, a mandate is a tax. Even if the revenues never flow through the federal treasury or a state treasury, that doesn't make the mandate any less a tax.

Next slide. Now a health insurance mandate is a tax to the extent that it forces people to buy something that they don't value, and to the extent that the government subsidizes people to help them comply with the mandate, well then

those subsidies represent a tax also because that money has to come from somebody. The people hit hardest by this tax are the uninsured, who are disproportionately young.

Now this is a graph that I stole from Jonathan Gruber's public finance textbook. Jonathan Gruber is an economist at MIT; he helps to manage the Massachusetts healthcare reforms from their connector board. This graph is designed to show the distribution of health insurance coverage in the United States. 40-some million Americans have no formal coverage; those are the folks to the left of that 405.8 million. Some have coverage; it's not very comprehensive at all. And then the coverage becomes more comprehensive as you move from the left to the right of the screen.

Now, to impose a health insurance mandate, suppose the government set a minimum amount of coverage that satisfies the mandate at the least amount of coverage that anyone currently purchases.

Now I'll ask you, Michael, if that's you, to click forward because I've got some graphics here that move around, so I want to actually go to the next slide. So if that minimum standard is set there, the least comprehensive coverage that

anyone purchases, the only people affected by the mandate tax will be the uninsured. And if you can click forward, we can see that some of them will need 100percent subsidy to purchase coverage. Since that money would have to come from other taxpayers, that represents a pure tax.

If you click forward again, we can see that, to the extent that the mandate forces uninsured people to spend their own money on something they don't value, it imposes a tax on those uninsured.

If you go to the next slide and immediately click again, we see that the minimum benefits package is never set that low. If you click forward, you'll see that with a more comprehensive benefits package – and click forward again – more people will require subsidies.

Click forward again, and we'll see that the tax imposed on the uninsured will be greater, and to the extent that it forces people with health insurance to purchase additional coverage that they do not value – and I'll ask you to click forward again – a mandate would also impose a tax on people who already have insurance but whose insurance is less comprehensive than what the mandate requires.

If you click forward, we'll go to the next slide. Now, during the 2008 campaign, Barack Obama suggested mandating that employers provide workers with health insurance equivalent to what members of Congress get. When pressed, and I'll ask you to, well – when pressed, what Candidate Obama said was that that would be meaningful coverage, and the closest idea we got to exactly what he meant by meaningful coverage is what members of Congress get.

If you click forward twice, you'll get a rough approximation of how that would impact those with private health insurance in the United States. It would impose a tax not just on, or a mandate set at that level would impose a tax not just on 40 or so million uninsured Americans, but also as many as one half of all Americans with private health insurance, because the typical health plan purchased by members of Congress and other federal employees is a Blue Cross Blue Shield plan. Its premiums are about \$12,000 per year. That's roughly the average premium in the private, or the employer-based market, so it's a good ballpark estimate to guess that such a mandate would subject at least, well, about, roughly half of the market to that mandate tax.

Now this is – so we’re talking about requiring about 100 million Americans to purchase more comprehensive coverage than they currently purchase. Now, this is an awfully hefty tax to impose on people, especially in the middle of a recession, especially when the burden of the tax will rise over time, as legislatures add more benefits to the mandate, especially considering the people who will bear the brunt of this tax increase, the uninsured and those with less generous coverage, tend to be younger and have moderate incomes.

If you’ll click to the next slide, we’ll see that it’s especially onerous when you swore up and down that you would not raise taxes on the middle class.

If you click forward. And when you have a vice-president who also swore up and down that you would not raise taxes on the middle class, and if you click forward, I think that’s the end of all the funky graphics that we’ve got in my PowerPoint presentation.

Next, mandates will also lead to rising costs. Next slide.

And here, Massachusetts I think provides a pretty useful lesson in the impact that an individual mandate would have

on cost growth. There's a study released earlier this month that showed that spending, healthcare spending in Massachusetts grew 66percent faster than the overall trend.

Government spending under the Massachusetts reforms, mostly to help people comply with the mandate, is higher than projected, and revenues have been insufficient to cover the state's outlays, and lawmakers are scrambling to make up the gap. They've raised taxes on tobacco, on insurers, hospitals, firms that don't offer health benefits, but these things haven't stopped the bleeding.

So to really get a hold on spending, they're examining additional regulations that would either let the state ration care explicitly by denying coverage for services without a sufficient evidence base, or implicitly through premium caps and a unified payment system for all – or I should say, a common, as the enacting legislation says, a common payment methodology across all public and private payers in the commonwealth.

I think that one of the reasons that we have the healthcare sector that we do, where costs are higher than they should be and the quality is lower than it should be, is because we

don't have enough competition between payment systems, because the federal government, mostly through the Medicare program, but also in other ways, favors fee-for-service payment and locks most of the market into the perverse incentives that that system creates, rather than letting the market benefit from competition between different payment systems, which we see in California, mostly because of the competition that HMOs in California impose on fee-for-service payers, there's actually a spill-over effect, where the greater the HMO penetration in a market, the more cost continuant you get, not just in HMO plans, but also in fee-for-service plans.

And yet Massachusetts appears looking for a unified or a unitary or a common payment system as a way out of this, as a way to contain spending. And it's looking at payment systems that will ultimately help it ration care, moving Massachusetts that much closer to Canada by the day.

So, as an aside, actually there's a – that same report mentioned that fears, the authors concluded that fears about the Massachusetts mandate have not come to pass because employers, government and individuals are all paying the

same proportion toward healthcare spending that they were paying before the mandate was enacted.

The report called that shared responsibility. Of course, that's just a cute way of saying that people's health insurance premiums, the money they pay out-of-pocket for healthcare, including health insurance premiums, their taxes in order to finance the subsidies required to help people comply with the mandate, their premiums and their taxes have gone up by the same proportion, as their wages have gone down to help finance the part of reform that is being paid by employers, because, as we'll get to in a minute, that's where the employers get those payments, they get that money, is by reducing wages.

And that's really what mandates do: they force consumers to pay more for an already too expensive healthcare sector, but they hide that mandate tax by diffusing it, through higher out-of-pocket payments, higher explicit taxes, and lower wages.

So next slide, please. Which is really, I would argue, why mandates amount to special interest legislation more than

anything else. Mandates throw more money at a broken healthcare sector without doing anything to fix that sector.

If you go to the next slide, you'll see that candidate Obama grasped this quite well when he said, "The insurance companies are happy with the idea of a mandate, because that forces people to buy their product." I was giving a talk on Capitol Hill actually earlier today where I was making similar remarks, and someone mentioned, "Well, you know what? If free-riding isn't that great a problem, if the uninsured aren't imposing such great costs on us, why is it that we always hear that the uninsured are the problem, that the uninsured are driving healthcare spending?" And my answer was, "Well, who benefits if all of us believe that the uninsured are the problem?"

I think the people that benefit, some of the people that benefit are the insurance lobby, and others who benefit are the physicians' lobby, and that's why they both signed on, or they both signaled their support for an individual mandate, because they are the beneficiaries of that mandate tax.

Next slide. And even if you like the idea of an individual mandate in isolation, individual mandates are often coupled,

well, almost invariably coupled, with employer mandates, which create a whole host of additional problems.

Next slide. The employer mandates are probably even more problematic than individual mandates. They are no less a tax on individuals, but they also add complexity to the mandate scheme and distort labor markets through rent-seeking, efforts to avoid the mandate tax, job loss, and potentially through discrimination against older and sicker workers.

Next slide. Now, in 1993 Bill Clinton gave us one reason why the two mandates typically move in tandem: Some fear that an individual mandate would cause employers to drop coverage; therefore an employer mandate is necessary, is a necessary companion.

Next slide. I think a more plausible story is that an employer mandate appeals to politicians because it does a better job of hiding the mandate tax from workers, as I mentioned before, by diffusing that tax. If there's one thing on which health economists agree, it's that workers, not employers, bear the costs of their health benefits, and they do so in the form of reduced wages.

An employer mandate disguises that mandate tax, partly, or largely in the form of lower wages rather than higher compelled health insurance premiums.

Next slide. The additional complexity involved in an employer mandate involves decisions like which firms and which workers will be subject to the mandate? Which ones will be exempt? Will small businesses be exempt? How do we define small businesses? Will only full-time workers be subject to the mandate? How will we define part-time workers? Will it be those who work less than 20 hours per week? Less than 100 hours per month?

The government must also set minimum compliance levels for employee participation and employer contributions to health insurance premiums. It has to decide questions like what do we do about married couples who work for different employers? How much do employers have to contribute toward premiums and so forth? Every one of these parameters becomes a tool that employer lobbies can use to benefit themselves and cripple their competitors, as well as a margin that firms and individuals can exploit to dodge and defeat the mandate.

I once had a lobbyist for Wal-Mart tell me that Wal-Mart is actually kind of friendly toward the idea of an employer mandate. And when this lobbyist told me that, well, that raised an eyebrow. So the lobbyist explained that Target's health benefits costs are lower than Wal-Mart's, so any employer mandate set at any level will really impose a greater burden on Target than it will on Wal-Mart. That actually caused the other eyebrow to raise.

Next slide. A study of state health insurance regulations found that when those regulations only applied to firms of a certain size, firms would expand or contract their work force to avoid those regulatory costs, and as any economist will tell you, productivity suffers when factors other than efficiency determine firm size.

Next slide. As Larry Summers helpfully explains, when a minimum wage prevents employers from reducing wages to compensate, to pay for that employer mandate tax, a firm has to let those low-wage workers go. This is particularly perverse because a large share of the very uninsured people you're trying to help with an employer mandate are in those very low-wage jobs.

Next slide. Kate Baker and Helen Levy have estimated that 43 percent of the uninsured are in those low-wage jobs, so low that they'd be at risk of losing their jobs to an employer mandate. And they estimate that were Congress to enact an employer mandate, about 315,000 of those low-wage workers would lose their jobs. They'd be disproportionately minorities and have little education.

Next slide. So just as candidate Obama observed that some people in Massachusetts are worse off now, because not only do they have no health insurance, but they're having to pay a penalty for not getting coverage, an employer mandate would leave those workers not only with no health insurance, but with no job.

And unlike the jobs that are disappearing every month during this recession, the jobs killed by an employer mandate are not jobs that will return, because the mandate sets the minimum compensation package, effectively sets the new minimum wage higher than these workers' productivity. And as long as the mandate grows faster than the productivity of low-skilled workers, there will be more job losses.

Next slide. And if for some other reason wages for older and sicker workers cannot adjust downward to pay the employer mandate tax, then those, then employers will avoid those workers in the hope of avoiding the higher cost that those workers impose on the company health plan. Again, Larry Summers helpfully explains that employer mandates “can work against the interests of those who most require the benefit being offered.”

Next slide. In fact, Mr. Summers goes so far as to argue that health insurance mandates may do more to expand the government than if, say, President Obama just hiked everyone’s income taxes.

Next slide. So where does that leave us? It leaves us with no evidence that an individual mandate is the best strategy to improve health, and with the conclusion that a large number of lives lost to medical errors suggests that maybe we shouldn’t be focusing on individual coverage to begin with, not that an individual mandate would achieve universal coverage. An individual mandate certainly won’t make coverage more affordable. Massachusetts shows the dangers of throwing more money at our existing healthcare

sector without controlling costs first. Free riding is barely worth a mention, and an individual mandate won't stop it. And the idea that an individual mandate promotes personal responsibility, I think, turns reality on its head.

Next slide. What an individual mandate will do is tax the young and income-constrained for the sake of special interests that are already too heavily subsidized, and it would do so in the middle of a recession.

Next slide. And it would likely be accompanied by an employer mandate that would kill jobs, harming the very people we want to help and distract firms from getting the economy moving again. Much is made of the difference between an individual mandate, a new government plan, and yet an individual mandate would give government so much more control over America's healthcare decisions, compelling them to purchase insurance, dictating what they purchase, and ultimately encouraging the government to control costs by rationing medical care, as they're considering in Massachusetts, that there's scarcely much difference between the two approaches.

The main difference might be that health insurance mandates will let private insurers in on the plunder until someone got around to controlling costs. The basic approach of a mandate is this: that government can cure our healthcare problems by robbing Peter to pay Paul. The problem is that Peter always catches wise and does things to avoid being robbed, and that Paul picks up some pretty nasty habits, like not doing as much for himself or trying to get more out of Peter.

And mandates also give government more power, or governments power over you and your healthcare, will grow and grow as it's trying to keep both Peter and Paul from rationally responding to the irrational incentives that the mandate has created. I think those in search of serious healthcare reform should probably look elsewhere. Thank you.

Michael: Thank you, Michael. Okay, Rick, thank you.

Rick: These are going to be more informal remarks. A lot of you mentioned, that is Mike mentioned at the beginning, the article, the Health Affairs article on affordability, which is in

your packet, includes virtually all of the substance I'm going to cover.

But before I begin, this is a test to see if you're paying attention as much as anything else: How many of you in the audience are at least generally aware of the substance, if not the politics, of the 2007 and -8 legislation initially proposed by Governor Schwarzenegger, the shared responsibility, AB 1x1? Raise your right hand if you're generally aware. Well, we got about half, I guess. Oh. [Laughs] Michael here is noting that some changed from your left hand to your right hand, and he's wondering if that has something –

Michael: No, they're following directions.

Rick: Oh, I see, okay. And then secondly, how many of you have some familiarity with how the individual health insurance market works or doesn't, depending on your perspective, in California? Raise your right hand if you're generally aware.

Okay, that's most of you. All right. The proposal from Governor Schwarzenegger and the compromise with the speaker bill was the shared responsibility model, which had some of the ingredients Michael was talking about. It's

probably worth mentioning to begin with some of the reasons for those who supported the bills being interested in an approach that might actually be enactable, that would bring most of the uninsured into coverage.

Number one, there was real concern in California that there were a number of individuals who needed and wanted coverage and couldn't get it for anything like an affordable price.

Number two; there was a general awareness that there were an increasing number of people who were bankrupted by medical expenses.

Number three; there was concern on the part of some employers about the cost shifts to them from the uninsured, although I would agree that that number is not big. It's nevertheless part of the equation. And also, concern about basically basic fairness issues associated with such cost shifts.

Number four, and this is particularly true in California, where you'll remember, California – I don't know if this is continuing – had a number of emergency room closings two

and three years ago. As you're probably all aware, under federal law, trauma centers have to provide essential medical services to people who show up on their doorsteps, and California's very high rate of [unintelligible]-insurance meant that there were an increasing number of trauma centers having great financial difficulty. And there was real interest in stabilizing that, and there was broader interest on the part of middle-class constituencies on having a trauma system that could take care of them if they got in a car accident. So, those were some of the contextual motivations.

I might also mention, even though my role was not a political one, that it was very clear that those who would strongly support a single-payer system did not like the shared responsibility with an individual mandate approach, and I'm sure if you went outside to the people demonstrating and asked them what they think of an individual mandate, they're likely to not respond positively. That's on the one hand.

On the other hand, I would note that any approach that is going to bring virtually all of the uninsured into coverage is going to have some kind of requirement that people that can

afford to financially participate. And whether you call that a tax, in the case of the single-payer system, or a requirement to purchase coverage in the case of a mandate and structural reforms in the insurance market, it's still individual responsibility as part of the fabric of what's involved.

In California, this issue was more difficult than in Massachusetts for a variety of reasons. You all know you have many more uninsured as a percentage of your population and in absolute numbers than other states, and there's a very marked contrast with Massachusetts. In fact, California has more than double the percentage of people who are both modest- or low-income and uninsured as Massachusetts.

So there was a much much steeper hill to climb, in that sense. In addition, the individual market there in California, as most of you seem to be aware, is a different kind of an animal. Linda quickly went through the options with voluntary markets, but I'm going to compare and contrast for just one moment Massachusetts before reforms versus California.

Massachusetts was one of those states that had guaranteed access in their individual market, did not allow health rating in their individual market, but people were free to choose whether to participate or not. And as an economist would theorize, and as reality has shown in states that have done that – tried to assure affordable access in a voluntary market – the cost of premiums were breathtakingly high.

So in Massachusetts, when they were moving to this reform system, they could take their relatively small individual market, combine it with their small employer market, have only a negligible effect on small-employer prices, and when they were bringing in the healthy people who weren't participating in that expensive coverage system, it could reduce the prices. The net result was they reduced premiums by about half. In California, as most of you know, it's a very aggressively underwritten market. If you're a high-risk person at the current time and you try to get affordable individual coverage in California, good luck; it's very hard.

So that meant what was involved with designing a system that would assure relatively affordable coverage to

individuals was very different. I might also mention that the approach taken ultimately was that, except for those who are low-income and subsidized, the coverage people would be required to have was high-deductible coverage. The legislation finally didn't specify that people generally threw around the notion of \$5,000-deductible coverage, which would mean that people with higher incomes, if they had a very expensive medical episode, would in fact have adequate coverage, and their cost would not be shifted to others, which was the principal rationale for the mandate further up the income stream.

The other major difficult element were what were going to be the market reforms; that's not what this is supposed to be about, and I'm going to try to be brief given the time. But there were extensive structural reforms in California, and they were intended to make sure there was broad risk spreading.

And a couple of things that I will mention right now are there was going to be risk adjustment among players in the market, but secondly, importantly, there was going to be state-financed back-stopper insurance that would kick in if

the risk profile of the people in the individual market turned out to be significantly more expensive than a typical large employer group, a normal population. And the idea was the state shouldn't have to spend money on that if indeed low-risks did participate in the market.

And from the market's perspective, that meant the state had a strong incentive to actually bring in the low-risk to participate in the pool. The other thing I should mention is all of the participants in this understood that there is no such thing as a high-risk person or a low – well, there is a high-risk person over time – but a low-risk person over time. Anybody who's low-risk and healthy at the moment could be high-risk six months from now or one year from now. I'm sure you all have friends and relatives who would fit that description.

So the idea was to have an insurance market where people can afford coverage, and the way you make it affordable in part is make sure that people participate when they're low- as well as high-risk. The approach for the near-poor in California was not very different at all from the Massachusetts approach or what people talk about here, and

that is you'd have sliding scale subsidies for fairly comprehensive coverage for these people with very modest incomes, so that they were assured coverage.

The real tangible differences in approach were for people who had access to employer coverage, but who couldn't afford their employee share; that's one of the populations where in Massachusetts, those people were told, "No, you can't have access to subsidized coverage. You can instead qualify for an affordability waiver, and congratulations, you can stay uninsured."

That was not an acceptable solution to the speaker or the governor's people, and so in California there was going to be a way that, but because of federal constraints on state regulation and federal constraints on what you can get federal matching funds for, it wasn't clear exactly how it would be done, but the legislation called for the state to figure out a way with the federal government to be able to combine employer contributions with subsidies for those low-income people who couldn't afford employer coverage.

The next population was the one that I don't need to describe again because Linda described it in some detail, but

it's basically the population up to say 400percent of poverty who, because they're older or a very large family, would have to pay more than they could afford for coverage. And that was a major bone of contention. There were some advocacy groups that opposed any kind of an individual mandate because of that population.

There were others who proposed substantial subsidies for comprehensive coverage up to 500-600percent of poverty, which would be prohibitively expensive for government. And there were others who proposed that, for that population, California actually do have an affordability waiver like Massachusetts, and just tell people, "Congratulations, you can stay uninsured."

The compromise actually came – this is true – it came from Governor Schwarzenegger himself, who decided that there needed to be a creative solution, and in California the proposal was for an affordability tax credit that made fairly high-deductible coverage affordable for people in this income range. And that was not that expensive; it was only one-eighth of the total subsidy cost, but it made a

compromise possible that included a requirement for individual participation.

On the largest front, all of those ingredients I've just described I think have potential for designing an approach that might be workable, in terms of federal reforms. But on the biggest front, as you all realize as you look at your friends and neighbors every day, California's economy is continuing to weaken, and in times like this, state governments are not in a position to fully finance subsidies needed by lower income people.

There are some people who don't agree with this. Most economists think you do need some counter-cyclical spending at times like this, and as I think everybody in the room knows, states cannot deficit spend, and that kind of counter-cyclical spending needs to come from the federal government. So there has to be a federal role for a number of reasons here.

So, I'm just going to leave it at that. Michael, do you want me to ask these two, Michael and Linda, a question, or do want to ask for questions from the audience?

Michael: I would defer to you. Just briefly; apparently we have some problems on the internet with our PowerPoint presentation. We just want to announce across there that they will be posted on the library's website tomorrow, so that they will be available. So if you would like to lead the discussion, thank you.

Rick: Okay. Well, I think the obvious thing to do first is, since you went second and had a lot of things to say about Massachusetts, and since you've just done an article – you guys have been monitoring Massachusetts – I could pick one or two topics if you want, but there are probably a couple of things you would like to comment on.

Linda: Sure, and can mention a couple as well. But you know, I think what's really important to remember about the situation in Massachusetts is that we need to be careful to delineate between short-run cost issues and long-run cost issues. The long-run cost issues, as I said, are the issues that face all of us in terms of our healthcare spending today – what are we going to do about controlling those costs over time?

But there were some short-term cost issues that happened in Massachusetts as well, and I just want to kind of tick them off so they don't get confused, because short-run issues that happen, you have bad estimates for whatever reason when you're getting started; you can work those out relatively quickly. It's, the big issue is really what's going on over time.

And in terms of short-run issues, what they had going for them was, number one, they used to do their estimates of what the costs were going to be in the early years, they used a state survey that was done that really had tremendous amounts of problems with it. It highly underrepresented the low-income population. When you under represent the low-income population, you also under-represent the number of uninsured.

And so that really gave them a bad base of estimating what the initial costs were going to be in terms of the number of people who would be subsidized under commonwealth care. So that was a problem. They're no longer using that data, as you can imagine.

Second of all, because they didn't have an individual mandate, [unintelligible] a mandate and its penalties phased in over time, the connector would tell you, John Kingsdale has said that there has been, there was initial adverse selection into the purchasing pool. And so what they were getting in was a higher average-cost individual into the subsidized pool than they had anticipated. That also raised the average cost per individual.

That on top of the fact that they got many more in than they had anticipated, because they undercounted how many low-income there was, made a combination of a problem. So, in addition, the subsidies that were originally assumed when they were doing the estimation of the costs were less generous than what the connector board, who is slated with the responsibility of deciding what those subsidies should look like, ultimately decided in combination with various interest groups and communities.

And so all of those things ended up creating a situation where the couple of initial early years were higher cost than had been anticipated. That can be addressed relatively easily, because it's a one-time issue. What is the bigger issue

is to look at what are we going to do to control costs, and I think we have to be careful about saying, "Listen, we need to control costs, we need to do cost containment, but we're going to deny anything that's a reasonable strategy that might control those costs."

For example, we want to think about ways to make sure that we're directing people to using care that's effective care and high-value care. Does that mean that some services might not be reimbursed as a consequence of them not being, having evidence that they're effective? That may very well be, but if we continue to pay for everything at the rate we're paying for it now, we're not going to be able to both make sure that the quality is high and that we're doing anything to contain costs.

So we do need to pursue various different strategies, I think, in order to address the cost issue and to not feel like we can do anything to lower the rate of growth without changes.

Rick: I'll turn to Mike in a minute. Don't worry; I'm going to give you a chance to do rejoinders to whatever you want that I said as well. But he mentioned, and I've actually seen things written by you which confirmed, that Massachusetts cost

increases as well as the absolute cost level are higher than the national total.

Linda: That's right. But that was prior to the reform. They had a very big issue there with provider and insurer consolidation, and so they already had a situation that they were starting from that was very high-cost. So does putting a mandate in place change a high-cost state into a low-cost state? No, but we're going to have that high-cost problem whether the mandate was in place or not, and now it's time to address it.

Rick: Okay, and Michael, you get the same offer that she got; anything that I said that you'd like to comment on.

Michael Cannon: What's fresh in my mind is what Linda just mentioned. I think that there was definitely a problem with the cost projections. They definitely under-estimated how much the program was going to cost, how much the subsidies were going to cost. We really don't have a good idea of the hidden tax that the mandate imposed on people; you know, the tax that doesn't show up in government budgets.

But I don't think that the problem was the projections. The problem, I mean, the projections were a problem, but

[unintelligible] costs are there. I don't think that they're just a short-term problem, because now those costs are built into the base, and every year that the costs grow, it exceeds the national average or the regional average in whatever healthcare inflation is. Every year that the cost growth in Massachusetts exceeds that, it's going to be building on those additional start-up costs.

What I think is interesting about the under-projections in Massachusetts is it raises the question, would reform even have happened if they had better numbers on what this program would cost? So it's been interesting to me that some people have talked about the higher cost of mandates, of the Massachusetts reforms as an indication of success, because we're covering more people than we thought we would, when really this is an indication that they didn't know what they were doing as well as they should have. They didn't have a good handle on what it was that they were enacting and how much it would cost.

And I think that we definitely do need cost containment. I think the long-run problem that Massachusetts faces is now a little bit worse than what the rest of the nation faces, but

we're all sort of in the same boat. I think that we do need cost containment strategies, like evidence-based medicine. We do need value-based purchasing. We do need a lot more comparative effectiveness research. My issue with the way that the Massachusetts reforms or an individual mandate would take us is that it takes us in a very government-centered direction, where it's the government that's deciding what the payment system will be for the, say the entire state, and the government is then writing into that payment system, "Well, we're going to decide what is high-value care and what isn't high-value care, regardless of whether you're an outlier, whether the studies that we're using don't represent you as a patient because you're an outlier in terms of your preferences or your physiology."

The danger there is that this very blunt tool of one government payment system that's being used to ration care is going to end up, I think, denying care to a lot of people who could benefit from it. It will contain costs, I think it will have... Well, I should say it will contain spending, but it may actually increase costs for some people, if they are denied care that they need.

Rick: Well, let me ask a follow-up question and give Linda a chance to respond. You mentioned you had a number of [unintelligible] research on what's cost-effective, and you agree that more is needed. And so let's assume there's a substantial body of evidence that a certain procedure is not cost-effective; the outcomes are bad, and it's costly. Is that something that you think individual health plans should be able to then use and individually determine, "We're not covering that," or do you think it should be entirely up to the individual and the provider to use it?

Michael Cannon: I think that if it leads to bad outcomes, then not only is it not cost-effective; it's not effective at all.

Rick: Right.

Michael Cannon: And so the stuff that isn't effective is an easier call than the stuff that isn't cost-effective, because individuals will value another year of life differently. But certainly I think, yeah, health plans should be able to do that, and people should... The one way that I sort of sympathize with the folks who put together the Massachusetts reforms is they did try to give individuals a choice of plans, instead of having the employer decide that you're going to go into a plan. They

tried to give individual consumers a choice of plans so that they could pick the health plan that rations care, basically, according to their preferences.

So I do think that health plans should be able to do that, and I also think that those plans should compete on a level playing field with plans that have more cost-sharing that encourage patients and doctors to make those decisions themselves.

But my concern with the approach in Massachusetts is that you're not going to have different choices. All those plans are sort of going to converge into one if the state is coming up with a common payment system and attaching its own idea of how value-based purchasing should work.

Rick: Before I let Linda respond, let's take that one more step. So, plan A decides that they want to not pay for this procedure, that it's not cost-effective, and the partner's health system, without which they can't get any employer contracts, says "You do that, we won't contract with you." What then?

Michael Cannon: Well, I think that raises a lot of issues where I have a lot less competence, such as market consolidation and market

power in the hospital industry. I think then what you do is you try to address those problems by reducing barriers to entry in hospital markets and facilities markets. I think--

Female Voice: --creating more barriers to entry?

Michael Cannon: No, reducing barriers to entry. I think Massachusetts – is Massachusetts a certificate of need state?

Linda: Yeah. It's not effective. They have a certificate of need but it hasn't been [unintelligible].

Michael Cannon: One possible remedy, but there are others, and like I said, that's really beyond my competence.

Linda: The point that you're making, Rick, is a very central one in Massachusetts. I mean, there is a very big issue going on there in terms of the control that one very large provider system has over the insurers. First of all, three insurers have virtually the entire insurance market in the state, and one of those insurers has a majority of it, about 65 or so percent of it: Blue Cross of Massachusetts.

And the partner system basically holds the insurers hostage at some level, because any insurer that has tried to exclude

partners from their network has not been able to sell their plans. And so what you've got is a complete lack of competition there. The insurers will tell you they have no power to negotiate price with the providers.

What happens is they can't negotiate with partners because they'll stand out and they won't play, and anybody else just shadow prices what partners is doing, and gets mad if they're not getting the same deal that partners is getting, which none of them are, because partners is getting everything.

But, you know, so the situation is one in which – and this is not – well, it's a huge problem in Massachusetts – it's one that stretches across virtually every metropolitan area in the country. There really is no real competition in these markets anymore. The insurers consolidated and the providers then went and consolidated in response. So the insurers are at some level saying, "Listen, if you do all-payer [rate setting], we'll go along with that, because we have no power to change the prices that the providers are paying." So they're really held over a barrel.

I also want to note that the approval rating for the individual mandate in Massachusetts, even given the higher initial cost and what's going on in the state, is incredibly high. Even a majority of the people who remain uninsured are in favor of an individual mandate being in place. So, it really is a situation, you say, "Would they have done this had it not been for the misinformation about the initial year cost?" I think the answer is yes.

And our estimates were very clear that they could do further subsidization than what they ended up doing, higher up the income scale, in a reasonable way in terms of making coverage affordable, for an increment in tax revenue that was really very modest, that could be spread broadly over different mechanisms, where you might even just put marginal tax rates back to where it had been a couple of years before they implemented the reform, and you would've financed the whole thing.

So I really think that, while there have been clearly some bumps in the road, serious cost-containment where it clearly needs to be done, that there's no doubt that this thing would

have gone forward even with better cost estimates, and that people are really very satisfied to have this in place now.

Michael Cannon: If I can respond to something there, what's interesting is what you said about the people approve of the reforms – not just the mandate, but the whole package of reforms, and it's not just the people with insurance; it's even the people without health insurance, which raises the question, if it's that popular, why do you need a mandate?

Linda: Well, you know, first of all, the approval ratings are obviously much higher among the people who are insured. I mean, don't get me wrong, it's still a majority, but it is higher. But, you know, you need to have a mandate in order to avoid all of the complexities that destabilize insurance markets that we've all observed whenever you try to make the insurance system a level playing field. And if you're not going to discriminate by health status, then you're going to have a situation, and you want to make sure that you get as many people in as possible.

That if you're not going to allow denials, you're not going to allow rate variation by health status, then you're going to end up attracting a higher-cost population, it's going to

devolve the markets as a consequence of selection, and you won't be able to sustain that. The best way to subsidize and to make sure that these markets stay stable is to make sure everybody's in.

Rick: Let me – I'm sure you don't disagree with the premise there –

Michael Cannon: Actually, I do.

Rick: You do. Okay.

Michael Cannon: Well I mean –

Rick: Let me ask a specific anecdotal question. I want each of you to respond to this: Anne, you've largely answered this, and I think you have too, but just to bring it home, you've got somebody in California. They're modest income. They're uninsured. Number one, should this person have access to needed medical care, including expensive medical care?

Should this person have access to coverage at an affordable price? If the answer to either of those is yes, who pays?

They don't have enough money. They don't have the

resources. They have a modest income that, with broad risk-sharing, they might be able to afford minimum coverage.

Michael Cannon: I think you've cut right to the heart of this entire issue. And all, or a lot of what we do in healthcare reform, regulation, government programs, and other forms of subsidies, is we're trying to make sure that that person gets medical care. So my answer to your question is I want that person to get medical care. And so we enact things like price controls on health insurance premiums and on down the line, and then that creates problems like adverse selection, like Linda mentioned.

And so we try to solve that problem by forcing people to buy health insurance because we know the healthy will try to avoid that implicit tax, so we try to hit them with another tax. And we're swallowing the spider to catch the fly, and swallowing the bird to catch the spider, all to get at that one problem that you mentioned.

I think that a much better way of getting at that problem is recognizing that, look, there are going to be people in this world who don't get medical care – or, I'm sorry, who can't afford to purchase medical care, either because they have

low incomes or they were imprudent. We want them to get medical care. But however we provide medical care to them is going to induce some people to take advantage of that generosity.

So what's the best way of confronting what economists call that Samaritan's dilemma, where the more you help people, the less people are going to do to help themselves? And there is no clear answer to that, because anyway – and it doesn't matter if it's public charity, it doesn't matter if it's private charity – any effort you make to help those people, to be compassionate toward those people, is going to encourage other people to take advantage of your generosity.

So the best way I think to try to navigate that Samaritan's dilemma is to try different approaches, to let different states go different ways, bearing the cost of the approaches that they use, and each will learn from the other about what helps provide those people the care that they need without inducing dependence, without creating more need.

I think that's one of the great flaws of the Medicaid program, because states get, they can provide two dollars worth of

assistance and only bear a dollar of the cost themselves, so they err on the side of actually enrolling a lot of people in Medicaid who don't need to be there. And we end up creating a lot more need than would exist otherwise, and people take less care of themselves, they do less to help themselves.

But I think that is the heart of the whole issue, and everything from guaranteed issue regulation, benefit mandates, community rating, individual or employer health insurance mandates or single-payer plans is all just swallowing the horse to catch the goat in the end, just to solve that one problem.

Rick: Linda.

Linda: Well, health care reform at the core of it is about redistribution. I mean, that really is the bottom line, is who's going to pay and how much are they each going to pay, or are we going to leave some people out and have them get less or nothing? And so there really is a tremendous amount of value judgment that comes into any of these discussions when you can't prevent that.

So if you want to look at individuals and say, "Listen, what I really value is that everybody have access to affordable medical care that's necessary for them," then you're going to have to do something more than kind of patch in little systems, because number one, the problem is both a distributional issue in terms of the uninsured and the low-income and those who have high medical need, but it's also an issue of the cost growing over time, and so you've got a situation where everybody's affected and everybody's unhappy or unsatisfied.

You've got tons of insured people who are under-insured, and are losing their homes or going bankrupt as a consequence of high medical costs that they can't finance even though they've got coverage. So, what we've got here is a situation of saying, "Listen, if you're really sick, we want you to get care." And if you've got a system that pulls a lot of the dollars out of some kind of collectively financed system, whether it's a government-run system or if it's an insurance-based system, then the financial burden falls on people when they get sick.

Is that what we want? If we do want that, then go for it. If it's not what you want, if you want those costs to be spread more evenly, you've got to internalize a broader segment of those costs through an insurance system, or a public insurance system – public or private. So it really is all about saying “Who do I want it to pay? When do I want them to have to pay it?” And, you know, from my perspective, the easiest thing for people to make sure that they're getting the coverage that they need is to make sure that that's spread out as smoothly as possible, and we set that financing according to ability to pay, so higher income people pay more.

Rick: Michael, I'll turn it over to you to see if this prompts questions from the audience there.

Michael: Thank you. Do we have any questions for our panel? It doesn't appear so. Thank you very much. It was great having you. I really appreciate you coming and participating. Linda, Michael, and Rick, thank you very much. Do you have something to say, Michael?

Michael Cannon: I think there's a question in the back.

Michael: Oh, I'm sorry. Yeah?

Male Voice: Germany seems to get by with what is basically an individual mandate, essentially low cost with a lot of wait. They have a lot higher health outcomes than we do. Why can't we build a system based on that?

Male Voice: Could you do that again?

Male Voice: Germany has a system that's essentially based on – if you go back to its sources – an individual mandate. They have a system which has better health outcomes, some degree of waste, even some, to me, even more than we do, but generally lower costs, to both the government and the citizens. Why can't we build something on that basis?

Michael Cannon: I'm not that familiar with Germany's healthcare sector. I can say that we at the Cato Institute, if you watch our website, will be publishing over the next few months a study that actually compares health outcomes in the United States to those in other countries and finds that actually, there's really no strong evidence to show that any country really stands out in terms of better health outcomes produced by the healthcare sector than any other country does.

Rick: As you doubtless know, Germany's system is based on the Bismarck sickness fund structure, which goes way, way back to when they were really an income maintenance program for people when they got sick, and people do generally belong, as you're saying, they are required to be enrolled. For workers, it's 50percent paid for by the employer and 50percent by the worker. It's a system where basically workers and employers collectively negotiate with providers over what the prices will be, where the hospital system is budgeted. It's a system that has evolved over time.

My own view is that here, in this country, or in California, the major attributes of stability of coverage and access and so forth can be achieved in a way that people get a choice between a Kaiser-like system in California or a Blue Shield coverage with broader choice of providers, and that's an easier place to get to and probably more acceptable, at least in anything like the short run, than a complete transformation to a German model.

Linda: I'll go along with what Rick said. I'll just add too that they have a very payroll tax-financed system, as he was saying. 50percent of the cost for workers are paid for by employers.

There are certain downsides to financing coverage that way, from my perspective. There'd be a lot of pushback from employers who are not currently providing that level of contribution, and so I think it would be, while it's a very interesting system and one that has worked there for a long time, I think there's some barriers to making that politically palatable here.

Rick: And I must say, one point besides cost effectiveness research where Linda and Michael agree virtually entirely is on employer mandates.

Michael Cannon: Yeah, does anyone know what the unemployment rate in Germany is?

Male Voice: Nobody has an answer.

Male Voice: Right now it's high, but it's generally been low.

Michael: We got another question, hold on a second.

Male Voice: I just wanted to get your perspective on the talk about General Motors and their company health plan and how that makes them uncompetitive say against Toyota or Honda in

Japan, and does that enter into your thinking at the state level rather than the national level?

Rick: I'm no expert, but General Motors' biggest single health problem, anybody that's read the newspaper knows this, is they have such a high ratio of former workers for whom they still have to pay coverage relative to their active workforce. And those costs swamp – which our economists characterize as legacy costs – swamp their cost for active workers. So they have, in that sense, a very unfair competitive disadvantage compared to other manufacturers.

In addition to that, I'm not sure, I've seen stuff recently that would say it's the demographics of their remaining workforce rather than the generosity of their benefit plan compared to the production of cars by Toyota and Honda and so forth in this country. And those legacy costs do make it a very unlevel playing field for them. And it really brings home the limitations of by-employer financing of coverage that extends that far.

Michael Cannon: I think it also explains why General Motors and other manufacturers are in favor of more government involvement in healthcare, including the Medicare prescription drug

program that was enacted in 2003, it came online in 2006; there are some pretty significant subsidies in there for employers who continue to provide retiree drug coverage or... And so a lot of large employers received big checks from the government when that bill was passed, and that's why they supported that intervention, because it helped push the cost of their commitments to their retirees off onto taxpayers.

Michael: Do we have any more questions?

Female Voice: Hi. If we're not going to have individual mandates in terms of, if we want to make insurance available for everyone – you mentioned in California, you know, if you're high-risk it's difficult to get insurance – do you know of any other examples in other states where they've been able to address that problem of escalating premiums and adverse selection without an individual mandate? Are there other alternative workable models?

Rick: There are states who have tried to heavily cross-subsidize a reformed individual market by loading costs onto small insured employers, for example, or bring in revenues from anyplace else. I'm not aware that any of those has been

sustainable and workable on an ongoing basis. There have been a couple of examples like New Jersey, where it seemed to work for a year or two, a long time ago.

But I would add I don't know why it makes sense to tax others who are buying coverage, who can barely afford it themselves – small employers – in order to cross-subsidize an individual market that then makes it possible for people to stay out when they're healthy and come in when they're sick, on an affordable basis. That's just not fair, and I don't think it's economically prudent, and in fact there's no state that I know of that has been able to sustain that approach over time, again.

Michael Cannon: I think that, you know, this has come up before, that in California insurers are able to underwrite in the individual market, they're able to price insurance according to the risk that an individual is transferring to the insurer. To my mind, that's sensible, and the insurance markets, if you don't allow insurers to do that, then you're really upturning the apple cart and the entire market starts to unravel.

But I haven't – it's often decried, when you're talking about health policy, that insurers do this, but I – and I know that in

California there's a lot of dissatisfaction about risk-grading, but I have – I'm surprised I don't hear more people mention the research that's been done by Susan Marquis and her colleagues at the Rand Corporation that finds that actually people with high-cost conditions, with chronic illnesses, can purchase insurance in California at standard rates a lot of the time, a pretty surprising amount of the time.

Also, that pooling of health insurance risk, or pooling of health risk, it increases the longer the person is in the individual market, meaning that as you get sicker, as a person gets sicker over time, their premiums don't go up to reflect that, because their premiums only go up the average for the pool, and the healthier people in the pool are paying those average rates as well, so those costs get pooled. I'm surprised that I don't hear more discussion of that.

Linda: Well, that's because actually what happens is for a lot of insurers, what they do is they offer new products to those that are healthy in those pools, so that they can go into a different pool and have their rates go up at a slow rate, leaving behind those who have high-cost illnesses. The premiums then for that group go up tremendously, and they

exit the market, so there's really a lot less pooling that goes on than you might think, given the way that rating is actually done --

Michael Cannon: That is one theory that that's the way that individual markets could unravel, but research has been done by Mark Pauly of the University of Pennsylvania, Brad Herring now at Johns Hopkins University, finds that if the insurers price the insurance the right way, then there's no incentive for anyone to do that.

Linda: But there's an enormous [unintelligible] in getting them--

Michael Cannon: If they price the insurance the right way, there's no incentive for anyone to do that, and they do price insurance that way. And so there is this disconnect between the anecdotal stories that we hear about the pools unraveling and insurers closing blocks of business, and the empirical research about what actually happens in individual markets. The empirical research tends to suggest they do a lot better than the standard stories.

Rick: Well, there are other informed economists. The meeting that I happened to attend that Mark, a very informal exchange

between economists, when Mark recounted his own research, the rejoinder from Len Nichols was yeah, he had read it, and it looked to him what it proved was underwriting works, that they were very effective in screening out the higher risks and getting low-risk and keeping their prices down.

The Susan Marquis research, I believe, was that – did show that people with chronic conditions, and this is some years old now, the database in California, were able to continue to have coverage. I don't think it found that they could find affordable coverage if they applied--

Michael Cannon: That was one of the findings. Now, you can say there's a risk factor or multiple chronic... People with multiple chronic conditions probably have a harder time. I'd be surprised if they--

Linda: They [unintelligible] do. And if you look at data, the people who are in the non-group market are healthier than the people who are outside of—

Male Voice: The ones who actually get it.

Linda: They're the ones that get in, and they're the ones that stay in.

Michael Cannon: It is worth making this technical point, and that is that under the approach in California, under what they're doing in Massachusetts, the health clients who end up with sicker people do get paid more. They get a risk adjustment. The question is whether the people themselves, when they're sick, should have to pay more, not whether health plans that have a riskier population should get paid more; of course they should.

Linda: You asked about what to do about the high-cost population if you're not going to do a mandate. And as Rick said, the states have not been successful to this point. There's lots of problems, as you probably are well aware of, with the high-risk pool option as a consequence of a limited amounts of coverage in there, and there's risk-rating, and pre-existing condition exclusions, all the problems we see in the non-group markets, are also in the vast majority of the high-risk pools.

So I think if you want to do serious reform without a mandate, in order to deal with the risk selection issue, somehow the excess costs of those who voluntarily enroll need to be redistributed in some broad-based way. So you

can either use general state revenues to help subsidize the cost and the premiums in the pools that attract the high-cost, you can put assessments on those who are buying insurance elsewhere in order to help cross-subsidize, but in some way you're going to need to find external funding in order to subsidize the high risk; otherwise, those pools are naturally going to devolve.

Rick: And again, the fundamental question then is who is it that should be paying for those cross-subsidies?

Linda: Right, and from my perspective, you don't want, as Rick said, you don't want to just raise those extra revenues from other people in the non-group market, you don't want to just raise them from other people in the small-group market; it's just not a big enough base over which to spread those costs. You want to ideally spread them as broadly as you can.

Michael Cannon: I think the fundamental question is a lot more fundamental than that. I think it's the question of, are you going to do subsidies, or are you going to do cross-subsidies? Are you going to make those subsidies apparent, or are you going to try to hide them and then encourage people to gain those

subsidies with the regulatory controls that are supposed to generate those cross-subsidies?

I think that a lot of the problems that states are facing, a lot of the high-cost and low-quality care that we end up getting, comes because we are trying to do these subsidies in a too-clever way, and it turns out that actually employers and individual consumers and providers are more clever, and they find ways to produce...

They respond rationally to the incentives created by these laws and they produce a set of outcomes that we then... A set of perverse outcomes that we then have to try to solve some other way, usually with more regulation, as I said.

Michael: I'd like to step in. We've run out of time, so I'd like to thank you for your participation. We benefited greatly. So, thank you Linda, thank you, Michael, thank you, Rick very much. We really appreciate it.

Michael Cannon: Thank you, Michael. And thank you, audience for your stamina.

END OF TRANSCRIPT