

NEW YORK'S UNINSURED:
Looking Back
and Moving Forward

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NEW YORK'S UNINSURED: LOOKING BACK AND MOVING FORWARD

INTRODUCTION

MR. PAUL HOWARD: The Manhattan Institute's Center for Medical Progress encourages the development of market-based public policies that promote medical innovation and improve public health. In addition to hosting conferences like this one, the Center for Medical Progress publishes original and periodical reports, books, and op-eds that remind policymakers of the connection between healthy, well-functioning markets and high-quality, affordable health care. Our published material can be found at the Manhattan Institute's website: www.manhattan-institute.org.

Our title today, "Looking Back and Moving Forward," was meant to convey that current New York policymakers have to look backward before they move forward with comprehensive or universal health-care reform. Today's health-care

markets have been constrained in many ways, for better and for worse, by the decisions of previous regulators, governors, and legislators. Gridlock in Washington over health-care reform has thrust states back into their time-honored role as laboratories for new social policies. This is, in many ways, a welcome development. Just as Wisconsin led the way in welfare reform, states like Massachusetts and perhaps even New York can help guide the nation toward a workable consensus on issues such as covering the uninsured.

Our intention today is twofold. Our first panel will explore the history of insurance reform in New York, discuss the demographics of New York's uninsured, explore why insurance remains so expensive in the individual and small-group markets, and consider how various reform proposals can create more affordable access to health care. Our second panel will discuss reform experiments in other states and explore the lessons that those efforts hold for New York policymakers.

Douglas Holtz-Eakin, our luncheon keynote speaker, is a former Congressional Budget Office director. He will discuss whether health-care reform should include an individual mandate to obtain health insurance. Democratic presidential candidates have proposed it, Republican governors have imposed it, and health analysts have debated it. I'll let Doug decide where he stands.

It is now my honor to introduce Dr. James R. Knickman, the first president and CEO of the New York State Health Foundation. Dr. Knickman comes to New York State Health with tremendous experience and expertise in health-care analysis and policy development. Prior to joining the foundation, Dr. Knickman was vice president of research and evaluation at the Robert Wood Johnson Foundation, where he was responsible for external evaluation of national initiatives. Throughout his fourteen-year tenure there, he led grant-making teams in the areas of clinical care for the chronically ill, long-term care services, and population health.

From 1976 to 1992, Dr. Knickman served on the faculty of New York University's Robert F. Wagner Graduate School of Public Service, where he was active in community service directed at improving health-care delivery to vulnerable populations. He also served on a wide range of advisory boards and published extensive research

on issues related to improving health services for homeless families, frail elders, and individuals with HIV. Today he serves as chairman of the Robert Wood Johnson Health System and is a member of the editorial boards of the *Milbank Quarterly* and *Inquiry*.

DR. JAMES KNICKMAN: We are pleased today to formally announce and kick off the New York State Health Insurance Consortium. An important element of our foundation's mission is to assist efforts to expand insurance coverage in New York State. Another element of our mission is to increase public awareness among New Yorkers about pressing health-care issues. Our support for this six-institution consortium is motivated by our interest in expanding insurance coverage and in improving public awareness about health issues. The consortium will focus on options for insurance-coverage expansion.

In the book *Good to Great*, Jim Collins says that the first step to being an effective organization or bringing about positive change is to get the right people on the bus. We have engaged five excellent institutions to help us in this task: the Manhattan Institute, the United Hospital Fund, the Rockefeller Institute in Albany, Cornell University, and Columbia University. We are pleased to build on what has happened in Massachusetts, Maine, California, and Colorado, and we hope that these organizations can make a difference in our state.

Much misunderstanding exists about what will happen if one approach to coverage is taken rather than another. There are also many disagreements. A reporter who called me yesterday asked if our consortium was for universal coverage. I almost didn't want to answer because the question of whether you are for universal coverage is politically charged. I said that what we're interested in is expanding coverage; we're interested in universal coverage. We also want to look at the downsides if every last person is covered. We have to begin to build a consensus that will take us from ideas to policy that actually helps people get coverage.

We also hope that this group will do a fair amount of convening, as we are doing today. Our consortium will work closely with state decision makers: analysis that is not tied to the policy debates in Albany is probably worthless.

What types of work will we do? First, the group needs to model the implications of alternative options. We need to consider what makes New York different from other states. Many models are based on national data sets that you massage to look a bit like your home state. In fact, New York doesn't have an average health-care system. But it's important to learn from other states. We're not the first state to think about all this.

We also need to develop market incentives to ensure that people use health care efficiently and that providers deliver health care efficiently. We need to work on understanding the market for individual and small-group coverage. A fundamental part of the problem is making that market work.

We will be launching a website that will present many of our findings to a broad audience.

PANEL I: NEW YORK'S UNINSURED: A HISTORY OF GOOD INTENTIONS AND UNINTENDED CONSEQUENCES

MR. HOWARD HUSOCK: I'm vice president for policy research at the Manhattan Institute. We are pleased to be part of this new consortium with the New York State Health Foundation. We are glad that the foundation has gotten the consortium under way.

The current presidential campaign has, more than any other in recent years, highlighted the federal government's approach to health-insurance policy. But as Dr. Knickman pointed out, for years to come many key health-insurance policy decisions and innovations will probably occur at the state level. We've already seen Massachusetts implement a very ambitious reform program based on a mandate for all citizens to purchase state-negotiated insurance plans. We hear that California may be considering a similar plan, and we know that Governor Spitzer is interested in this option as he ponders how to address the challenging combination of very high Medicaid costs and a significant pool of the uninsured, each of which is pulling in a different direction.

How should we think about the role that states play in health insurance? More specifically, what are the choices that New York faces? What are the key factors that will influence those choices? We're very fortunate to have for our first panel a group that can provide just this sort of informed analysis. We see Jim Tallon, Tarren Bragdon, and Mark Scherzer as a team complementing one another.

Jim is going to provide historical context. Tarren will offer some creative solutions focused in part on the individual small-group plans that Jim will discuss. Mark will critique both of them and address the question of how their proposals affect the most vulnerable, the group that we always have to keep in mind when we go forward with any health policy.

We'll begin with Jim Tallon, president of the United Hospital Fund in New York. Jim is the former majority leader of the New York State Assembly and former chair of the Assembly's Standing Committee on Health. He also headed Governor Spitzer's transition team, Healthcare Policy Advisory Committee. He chairs the board of the Commonwealth Fund as well as the Kaiser Commission on Medicaid and the Uninsured.

MR. JAMES TALLON: I served for nineteen years as an elected official in New York and for the last fifteen years at the United Hospital Fund, an independent organization focused in New York City. It is a small analytic organization that looks at health-policy questions. We are not the trade association representing the hospital community. A very active and effective trade association—the great New York Hospital Association—represents hospitals in New York City; Pat Wang, its senior vice president, is here today.

Many people in our discussion today would like to see the balance between government and markets shift more in the direction of markets. Philosophically, I don't necessarily start there, but I always enjoy a conversation with people who have a different point of view. I'm representing a mixed market and government system in this conversation. I've just done six public hearings around the state. Mark Scherzer has been with me, at the request of the governor. On health-insurance questions, there is a strongly held point of view that government should take on this responsibility. This point of view is rooted in the experience of sitting through hearings and listening to testimony from patients who get caught up in the complexities of our current payment system.

Also testifying are health-care providers, hospitals, and particularly physicians, who say that the bargaining relationship between insurance and health care is balanced in favor of the insurance industry. Some physicians argue that the insurance industry varies administrative procedures and practice standards not to achieve efficiency but to systematically be able to deny claims. We're not going to spend a lot of time on that subject today.

Upstate New York—outside New York City—has a fairly traditionally organized health-care system of community-based physicians, community-oriented hospitals, and referral centers. It has a traditional pyramid structure, which serves 9–10 million New Yorkers who are outside the New York City metropolitan area.

Downstate New York is very different. The downstate system did not emerge from 1965 with Medicare and Medicaid. There has been a societal presence and sense of obligation for the provision of health-care services in the New York metropolitan area, whether manifested by a tradition of public hospitals—which in 1970 became the Health and Hospitals Corporation, still operating the largest public

hospital system in the country—or the voluntary, not-for-profit hospital system, which has its roots in the ethnic and religious communities of the nineteenth and early twentieth century. This not-for-profit system developed an academic orientation and significant teaching focus. Upstate, I may be looking at community-based physicians and providers of care; downstate, I'm looking at access points largely in hospital clinics and community health centers with staff physicians, faculty practice physicians, and a residual community physician structure.

In the principal orientation of health care, the insurance side in New York developed from the 1930s. The United Hospital Fund actually incorporated Associated Health Services of New York, which became Empire Blue Cross Blue Shield in 1934. From the 1930s through the mid-1980s, we had a dominant not-for-profit insurance structure. State law includes a prohibition on ownership of health-care facilities by publicly traded corporations. Interestingly, that prohibition did not extend to the financial side. While there was a tradition of not-for-profit provision of health-insurance services, the commercial insurance industry developed as an adjunct to the life-insurance industry in the 1950s through the 1970s. Therefore we've had a mixed for-profit and not-for-profit orientation in health insurance.

Another trend line is state oversight growing from this social welfare tradition of responsibility for community services. We see increasing activism by state government. In 1965, New York adopted health planning and the nation's first certificate of need law. In 1969, it required Medicaid rates and Blue Cross payment rates to be set off a common pool to guarantee Medicaid beneficiaries access to city hospitals. In the early 1980s, when I was in a leadership role in the State Assembly, we adopted a rate-setting system in which government sets the overall payments for all insurers from Medicare to city hospitals.

The final trend line is based on Nelson Rockefeller's guidance on the state of New York's responsibility to take an active role in health care. If one wants to go back to Rockefeller and Reagan as the governors representing the left and the right coast, moving forward from the 1960s, they develop different visions. Medicaid came along, and Nelson Rockefeller said to a former governor of New York—and this is a gross oversimplification—"We have a tradition of doing all these things in New York. Do you mean that the federal government is going to pay for half of them?" We took that opportunity and that

vision from Nelson Rockefeller and carried it through on a bipartisan basis to this very day.

We have a significantly developed Medicaid program. Forty-three percent of the state's expenditures go for long-term care services, while 7 percent are direct subsidies into the health-care system to enable it to care for large numbers of uninsured patients. In the long-term care side of about \$20 billion in expenditures, about \$10 billion is what might be called "traditional long-term care," for the elderly and the younger disabled. The other \$10 billion is for the severely mentally ill, the mentally retarded, the developmentally disabled, and former substance abusers, who, in an earlier time, were the direct responsibility of the state.

The state's decisions on insurance laws in the early 1990s were well intended, but an unintended consequence occurred in 1987, on my watch. We had an all-payer rate-setting system. Medicare had withdrawn after some initial years, but the state was responsible for setting Medicaid, Blue Cross, and HMO rates. The system that made Blue Cross the dominant carrier was about to expire. Blue Cross was writing 77 percent of hospital insurance in New York City in 1987. The HMOs came to us and argued that managed care is more efficient, using services paid on a diagnosis-related group (DRG) per episode admission rate. They noted that they were actively reducing the length of stays and needed the ability to gain that value back in the market for themselves. They wanted to negotiate rates with the hospitals, and we decided to allow them to do so. To build protection, we put into law a provision stating that those rates as negotiated had to represent the totality of costs for caring for the population for which they were responsible.

The unintended outcome was that the state government never enforced that provision. The state essentially said that if two consenting adults—that is, the hospital and the insurance company—agree that it is a fair deal, who are we to second guess them? In the following four to five years, two aggressive HMOs—one focusing on a good doctors' market, the other on a tight cost-control strategy—in effect ate Empire's lunch and significantly diminished the number of Empire's enrollees.

In the early 1990s, a large number of the state's residual enrollees in Empire Blue Cross Blue Shield were almost trapped, because as they looked for other opportunities they met the commercial health-

insurance industry. Our state legislature also met the industry. But as we looked at this challenge, the practices that we found surprised members of the legislature, who had been living in this New York pooled environment.

Women pay more; even in current assigned high-risk pools, women pay double what men pay. Occupations were blacklisted. I'll never forget the combination of construction work and interior design that was on the list. We found the exclusion of body parts. We also found that insurance companies used lengthy questionnaires where an applicant's mistakes became the basis for denial of subsequent claims. Part of the question in today's debate is whether a private health-insurance industry that doesn't serve sick people is still relevant.

The first rule of "health-insurance school" is to cover healthy people. Those who are chronically ill and at higher risk should go somewhere else. In 1995, the legislature did its first round of community rating, a guaranteed-issue open enrollment, and a subsequent round of insurance reform leading to the current law. The legislature wrote the law in response to the large number of enrollees facing huge rate increases under their residual Empire plan, while the health-insurance industry was not welcoming those who fell into any of the disadvantaged categories.

Based on testimony from the carriers and brokers, my sense is that, even if the small-group market in New York tends to be more costly than it is in other places, it is an open and competitive market. People have said: Don't touch the small-group market in New York; you have a competitive environment now. The direct-pay market is clearly broken. Whether that is because we have not executed on our own subsidy strategy, or whether that market ought to be pooled into larger markets, will be debated in the remainder of this conversation.

MR. HUSOCK: Our next speaker, Tarren Bragdon, is a health-policy analyst at the Manhattan Institute's Empire Center for New York State Policy in Albany. He is the author of a publication being released this very day: *Rx New York: A Prescription for More Accessible Health Care*. He is also a former member of the House of Representatives of the state of Maine—the youngest person ever elected to that body, where he served on the Joint Standing Committee on Health and

Human Services and subsequently played a role in the development and enactment of the Maine Consumer Choice Health Plan, a state-administered consumer-choice exchange. In addition to his ongoing role at the Empire Center, Tarren will become the chief executive of the Maine Heritage Policy Center.

MR. TAREN BRAGDON: I want to talk about the uninsured in New York and discuss some characteristics that are too often overlooked. What are some characteristics of states that are doing a better job of covering the uninsured, and how can we expand private insurance options for individuals in New York?

There are two approaches to reaching the uninsured. One is to expand public programs to higher income levels. The second approach is to maximize private coverage, reserving scarce public dollars for very select populations who most need subsidy or assistance. These two approaches are not always mutually exclusive, although they appear to be in New York, particularly as of late. I had the opportunity to attend some of New York State's Partnership for Coverage hearings and testified at the Rochester hearing. I was surprised at how much emphasis was placed on public program expansion, with very little discussion on how to make private insurance options more affordable and accessible.

When we look at the reality of public program expansions, we need to remind ourselves of how large New York's Medicaid program already is: it costs \$48 billion—as much as the Medicaid program in Texas, Florida, and Pennsylvania combined. I'm not sure how much larger you can go, in theory and in practice, in an attempt to cover the uninsured. In fact, many states have a lower portion of their population uninsured compared with New York. Those states have more people with private coverage, not more individuals on public coverage. If you look at top-performing states at covering their populations, they are top-performing because they maximize private opportunities, not because they have larger public programs than New York has.

If you look at just one population—children—you can see this even more dramatically. Eleven states have a lower rate of uninsured kids than New York has. Nine of these states had SCHIP or Child Health Plus eligibility levels below New York's before the expansions.

Nine states with a lower rate of uninsured have SCHIP income-eligibility levels below 250 percent of poverty. The strategy to maximize coverage of individuals is to maximize private coverage opportunities so that you can target scarce public dollars to populations that particularly need assistance.

It's important to understand that the uninsured are a diverse population. There is a notion that all the uninsured work for one particular small business and that if we could only find that small business and cover them, we could pat ourselves on the back and go home. But in reality, it is a diverse and dynamic population.

What we've seen in New York over the last seven years is not an erosion of employer-based coverage. We've seen the uninsured rate hold fairly steady: about 17 percent of New Yorkers under 65 were uninsured in 1999, and today it's about 16 percent. That's different from what other states are experiencing. As we've shrunk options for people who don't get coverage through their employer, and made it more difficult for people to find private coverage opportunities, we've had to expand public programs but have really just shifted people from private to public without getting a significant portion of that uninsured population.

I want to go through the statistics that pertain to the uninsured population, because they're often overlooked when we try to simplify solutions to covering the uninsured. About half of the uninsured are young adults, aged 18 to 34. About one-third are aged 35 to 49, and only one in six is near retirement—aged 50 to 64. The average age of the uninsured adult is 36 in New York—that's five years younger than the average person with private coverage.

Almost a third of all the uninsured in New York are noncitizens—legal as well as illegal immigrants. If you look at public program expansions, many of the federal Medicaid rules and regulations do not allow you to capture this population, and this is a significant uninsured population at all income levels. Almost one in three noncitizens earning over \$75,000 a year in New York State is uninsured. These are individuals who, for whatever reason, don't have access to employer-based coverage and have no place else to go.

Some 90 percent of the uninsured are in good health. Jim talked about how past legislative efforts have focused on protecting the sick and those most in need of health insurance to pay claims.

That's critical. You need to have a functioning safety net that takes care of those populations, but you don't want to penalize everyone else with a nonfunctioning private-sector safety net so that these healthy, young individuals have no place to go but their employer to get coverage.

Two-thirds of the uninsured have no dependent children. About two-thirds of the uninsured are single. If you have no dependent children, the consequences of not having health-insurance

We need to recognize that this one-size-fits-all approach may be very simple and equitable, but it's not effective or realistic for what people actually need and what they can afford.

coverage are less significant. We need to understand that because the coverage options that are attractive to single individuals who are not parents may be very different from the coverage options that are attractive to individuals who are older, have dependent children, and are in different life circumstances. We also need to recognize that health-coverage options change over time. The health insurance that you are interested in at age 25 might be very different at age 35, 45, or 55. We need to recognize that this one-size-fits-all approach

may be very simple and equitable, but it's not effective or realistic for what people actually need and what they can afford.

Sixty-one percent of the uninsured have incomes of over \$25,000 a year. One-third earn over \$50,000 a year, and this is household income. Again, the vast majority of the uninsured are single and are not parents.

The majority of the uninsured lack coverage for a very short period of time; seven out of ten adults who become uninsured will become reinsured within a year. This is a temporary situation for a large number of people who find themselves uninsured on any given day or month. What people need temporarily, when they are between jobs or when they are working through a waiting period before they can get health insurance through an employer, is very different from what they might be interested in having as their permanent health-insurance plan.

Jim highlighted the death spiral of New York's individual market. The individual direct-pay market is where those who don't have access to insurance through their employer can go to buy coverage. Indeed, it is the only place where one can go to buy private, non-subsidized coverage.

In 1993, there were 750,000 people in this market in New York. Today there are 57,000: that's a [92.4] percent drop. If you look nationally, the individual direct-pay insurance market is the only growing private insurance market. A functioning, affordable, private-sector safety net is critical if you're going to give people affordable unsubsidized insurance options so that states can direct scarce public dollars to those individuals most in need.

About 2.2 million New Yorkers don't have access to health insurance through their employer. They are working, but either their employer does not offer coverage, they're in a waiting period so they cannot sign up for coverage, or they choose not to sign up for coverage.

Sometimes I think that as policymakers, we too often try to be innovative when we need to be effective by learning what other people are doing well and replicating it.

My Rx New York report provides seven policy recommendations.

One, we need to have more flexibility and allow more competition and innovation in New York's small-group and direct-pay markets. Large companies in New York pay premiums at the same rate as large companies in the other 49 states. However, the small-group and direct-pay markets are paying a much higher premium.

Two, we need to provide people with temporary insurance opportunities. Seven out of ten uninsured adults are uninsured for less than a year. New York is one of five states that does not allow temporary health-insurance plans.

Three, we need to ensure that people have access to tax-free health insurance through a Section 125 plan through their employer and encourage as many employers as possible to offer health insurance. If you look at employers who simply offer and pay a very small share of the premium, the vast majority of employees do enroll. It's a very efficient way for them to get health insurance.

Four, we need to ensure that we have incentives that encourage employers, particularly small employers, to offer health insurance.

Five, we need specific strategies to reach out to noncitizens with targeted private insurance plans that respond to their unique needs, which may be very different from those of other uninsured populations.

Six, we need to look at Medicaid eligibility. For example, we have an odd formula driven by the federal government offering a fertility bonus. The more kids you have, the more you can make and still qualify for the program, which is ridiculous. It doesn't reflect cost-of-living differences or account for who is truly poor versus who is middle-income but has a lot of kids.

Finally, we need to take a new approach when we look at Medicaid eligibility and move to fixed-income levels that may even vary by region.

MR. HUSOCK: Our final speaker is Mark Scherzer, an attorney in New York and the legislative counsel for New Yorkers for Accessible Health Coverage, which is a coalition that has advocated for health-insurance reform at the state level for the past fifteen years. He serves as cochair of the Consumer and Patient Rights Committee of the New York State Bar Association's Health Law section. Mark has been awarded Lambda's Liberty Award for his work on insurance cases involving HIV/AIDS patients.

MR. MARK SCHERZER: New Yorkers for Accessible Health Coverage is a coalition of voluntary health organizations serving the seriously and chronically ill and disabled in the insurance system. It was organized in 1991, when we faced a crisis in New York with Empire Blue Cross. It was formed because we had many high-cost consumers—our constituents—who are a small minority of the overall population but spend a very large majority of our health-care dollars. They are the bane of any insurance system, of public policy, and the Medicaid system. While many of these constituents are covered through public programs such as Medicaid or Medicare, many of them also rely on private insurance. They are people who worked for 20, 30, and 40 years and suddenly found themselves ill but were able to enter the marketplace through their employers or on their own.

Our concern has been very closely tied to the individual market that Tarren spoke about. Tarren, to some extent, was comparing

apples with oranges when he talked about shrinkage in the individual market. I don't think we had 750,000 people in that market at any given time. That's based on census figures, and if you looked at the same census figures today, you would find that they still think that we have several hundred thousand people in that market. We know how many people are in the market based on assessments from insurance companies in our insurance pools. There has been significant shrinkage, and it's a very broken market, which is a great concern; but it hasn't been of quite that dimension.

The individual market—for people who don't get coverage through their employers—is a residual market. It tends to go down in size, for example, when the economy is better and more people are getting jobs. It increases when people lose their jobs and have to get coverage on their own. It's a market in which people have to buy coverage without getting it through an employer at those favorable group rates and usually without any subsidy.

If you have a voluntary market and you have one with easy access—as New York does, which we think is a good thing—it's clear that the people who are going to buy insurance under those circumstances tend to think they're going to need it; and the young, “invincible” people who may think they're never going to get sick are not going to purchase it. It's what the insurance industry calls a situation of adverse selection. You're going to attract sick people to that market.

I agree that we had good intentions and unintended consequences, but this framework connotes a certain narrative. It says that we thought we were going to solve the problem through regulation, but we didn't, so we need to go back to market-based approaches. There are a lot of nuances in this situation, and I want to go into the particulars of the evolution of the market because there are important questions. Is it a problem with the basic architecture? Did the architect screw up the design? Is it a problem of how the builder built the design and whether the builder followed the architect's plans? Is it a problem with maintenance? There are different ways a system can go awry, and all those elements have some role to play, but I would probably differ with Tarren on the source of the problem.

I'm not sure that there were good intentions underlying every decision. Just after 2000, there was an ideologically driven devotion to

the idea that an insurance market with very generous benefits open to sick people, instead of one where people took personal responsibility for their own health-care costs, was not a good thing.

Let's pick up the chain where Jim left off in 1991. At the time, the state had an underwritten health-insurance market. Many other states now have a system in which insurance companies can turn down people based on their health, can exclude body parts, or insure the family but exclude a kid with asthma. We had a variation in premiums based on health. Empire Blue Cross proposed as a remedy for that situation that it was going to act more like a commercial insurer. This is where my constituents really became activated. Empire Blue Cross decided to resolve the problem by accounting for the population of insured people at the time—people who may have been paying premiums for the last 30 years but had recently become sick—and telling them that if they were now unhealthy, their premiums would increase dramatically, and if they were healthy, their premiums would be reduced. That way, Empire Blue Cross could continue to compete for business with commercial insurers without taking the financial hit it had been taking.

Our people—driven largely by AIDS activists in coalition with people with multiple sclerosis, cancer, and other serious and chronic illnesses—said that that was not fair. The whole idea in the insurance system is that you pay in when you're healthy, and then, when you need the benefit, it's there for you. You don't get punished down the road by an increase in your premiums because you happened to have become sick. Why not make the commercial companies look more like Empire? That's where we came up with the idea that in New York, everyone would pay in the small-group and individual markets and pay the same rate, regardless of age or sex. Everyone would have an opportunity to enroll, and that's how we'd resolve the problem.

The policy seemed to work fairly well in the small-group market. Admittedly, New York has problems in the small-group market, and we can discuss some of the ways that those problems can be addressed. In the individual market, the solution was very market-based—everyone plays by the same rules in the same market. Every insurance company other than Empire left the individual market so that they wouldn't have to take on all this adverse risk.

By 1995, Empire was losing \$10 million a month on its individual consumers and felt in financial jeopardy. We debated whether we could take care of sick people through high-risk pools, which many other states have, and which Tarren recommends we think about again for New York. Consumer groups like ours looked at the high-risk pools in other states. We found that states like Florida had basically closed their pools—if you were a sick individual, you could not purchase a policy. States like Illinois had very long waiting lists, while South Carolina excluded coverage of HIV/AIDS in its high-risk pool. Other states made people in those high-risk pools pay premiums of up to five times the standard average premium.

We found that, based on what we saw in these states, high-risk pools would be at the mercy of political decisions, instead of being a market where the welfare of a much larger group would be at play. We rejected that notion strongly and advocated trying something else. We suggested distributing that social function of covering the sick across the whole marketplace, and asking every HMO to give everyone a standardized policy and deal with the problems of adverse risk through risk adjustment. We are still largely trusting in the marketplace. There was a trade-off for industry, which was that we deregulated rate-setting. We allowed the industry to bypass rate hearings if it wanted to increase rates. But even that was not enough to control costs in the individual market, which still had about twice the incidence of very high-cost diseases as in group markets, and twice the expense to be covered.

By 2000, when we were seeing rate increases of 60 and 70 percent a year in the individual market, we decided to do something else in New York, which was to subsidize through a broadly based scheme a stop-loss system. The idea of the stop-loss was to remove the financial effect of the sick people from the market by covering the high-cost claims. When you got to a certain point of expenditure, the system would cover a good portion of high-cost claims using publicly financed pools generated by assessments on insurers. The Healthcare Reform Act of 2000 ratcheted up the subsidy for the high-cost pool over a period of three years. Then we stopped with the Healthcare Reform Act of 2003.

The market remained relatively stable in size from 2000 to 2003. The dramatic drop-off, from more than 110,000 people in the

individual market down to the 57,000 in that market today, took place in the last four years.

In the last four years, though health-care costs increased at the rate of 14–15 percent a year or more, we stopped increasing the subsidy for the stop-loss pools. Insurance markets are fairly precarious, and that market then fell apart. I think that Tarren and I both assume that the voluntary market cannot sustain the presence of a whole lot of sick people on its own and requires a subsidy from a very broad source of financing. In other words, you can't ask a market of sick people to subsidize one another's costs effectively and continue to operate as a market.

Tarren and I would differ on where a stop-loss system should be used to fund the high-cost claims. In New York, we're funding only about 40 percent of the claims that are eligible for subsidies now. How can we think we have an effective system if we're only financing 40 percent of the costs that might be eligible?

You can't ask a market of sick people to subsidize one another's costs effectively and continue to operate as a market.

And there are questions about whether the design is sufficient in what we consider eligible costs. Do you remove the people, or do you remove the financial effect of those people? Do you want to reintroduce to New York something that we've eliminated, which is the administrative cost of underwriting people? After all, we hear about administrative costs being a big part of the problem of the cost of insurance. Are we going to provide enough to finance it? The assessment that Tarren reported of \$54 million is barely more than we're providing now, which is an ineffective subsidy for the high-cost claims. Would you do it through an adequate benefit structure, or are you going to do it through a comprehensive one?

If you want an effective insurance system, you're going to need to deal with the problems of the sick people who drive the cost in that system. Sick populations are not going away, and we need to have a solution that provides them with adequate care in a way that allows them to continue to contribute to the cost through

their premiums and not rely entirely on the public system. You can't have it both ways. You can't attack a public system and then force people into it by removing the possibility of continuing to participate in the private one.

MR. HUSOCK: With regard to how we deal with the high costs of the present system: in last week's *Washington Post*, Robert Samuelson, in a provocative column titled "Rx for Health Care: Pain," said that we have no incentives in the present system for containing cost. Jim referred to this wink-and-nod relationship between insurers and providers, with government not taking an active role. Mark is saying that we have to find a broad-based way of supporting these costs. Tarren is implicitly saying, "No, we have to find a way to give people incentives to control costs." But Samuelson makes the very broad point that the absolute level of cost is so high that, as he put it, "it's crowding out a tremendous number of very important other public needs that government should be investing in." How can we think about controlling costs in a humane way?

MR. TALLON: Obviously, whether we are at 16 percent GDP, or move to 17 or 18 percent, there are trade-offs. But in an aging society, with the technological promise that health care offers us, it is not wholly clear that spending less money on health care is an absolute value to be sought. I understand the dilemma. All our mechanisms—whether they're government taxation or market mechanisms—are strained by that growth.

America works on the cost-controlling model, which is based on a belief that the physician asks himself each day how he can reduce health-care costs. Maybe some doctors do decide to go into primary care and not one of the specialties that attract them. Along comes the patient, who is forced to spend a lot of money on health care. Going forward, the tough issue is whether in this environment market competition can control cost growth, or whether we need the aggregate power of society exercised through government to take out those excesses that, at least when you compare us with the other OECD countries, seem to stand out.

My sense is that the debate going forward is about throwing more risk at the patients. Doing so essentially discriminates against

sick and lower-income people, and we as a society choose not to confront that systematically, sector by sector, in health care.

MR. HUSOCK: To paraphrase Jefferson, we're getting the health care we deserve or that we're implicitly asking for. Mark, should we care about controlling costs?

MR. SCHERZER: There are ways to do so, although some involve spending money on public health preventive-care and primary-care initiatives that could bring down the incidence of chronic and serious illness or avoid their complications, recognizing that preventive care and primary care are important elements in the system. But those are very difficult decisions to influence and control in a system that relies solely on individual decisions in the marketplace and that is hesitant to use governmental mechanisms. There are ways to reduce costs. Other countries reduce costs much better; their ways don't involve shifting a lot of cost to the sick people, although they may avoid creating the sick people to begin with through prevention.

MR. HUSOCK: Can we reduce costs, Tarren, without shifting costs to very sick people?

MR. BRAGDON: Absolutely, but what you need is, on both the provider and the insurance side, a functioning market. We have the same dilemma in every other aspect of the economy, where there is a push-pull between what consumers are willing to pay and the cost of providing a particular service. Other services are just as life-sustaining—whether it's food, shelter, clothing, or having a job—and for some reason, we trust the free market and the economy to function in a way that creates balance between the two and allows innovation. But in the health-care world, we lose our basic understanding of economics and say that only government can wring out these savings under a command-and-control structure. We've tried that here in New York.

Jim has articulated a multi-decade strategy. Maybe we need to try a more rational approach and at the same time recognize that we need to give people more options. Sometimes, whether it comes

down to health-care providers or to health insurance, people will make choices that are different from the choices you and I might make. That's what happens in a free society.

MS. ELIZABETH BENJAMIN: I'm from the Community Service Society of New York. I thought you began your statement by saying that the states with lower rates of uninsured tend to have large privately insured populations and very small Medicaid populations. But it seems to me that Maine has the largest Medicaid population, according to your chart. Rhode Island, also on your list of low uninsured states, also has a large Medicaid population. Is there a disconnect in your analysis?

More important, I want to know more about Maine's Dirigo health plan. Maine is often talked about as one of the three New England states that first moved forward on universal coverage, and I thought you might have insights on that, since you're from the state.

MR. BRAGDON: The consequence for Maine of not having a functioning private market is that it has had to expand Medicaid, because people don't have any kind of affordable private-sector safety net.

The best-selling plan in Maine's individual market is a \$5,000-deductible plan available for \$260 a month for an individual in any state of health who is under age 30. The odds of their using that plan are less than 5 percent, so only very sick people are in that market. Medicaid has been expanded to provide them with coverage. Maine, like New York, is dysfunctional. It's one of five states with guarantee issue and community rating in this private-sector safety-net market.

We need to become more functional in both New York and Maine. Dirigo tried to correct this by subsidizing the current insurance regulations. It has a tiered subsidy formula, up to 300 percent of poverty. Some 60 percent of people are in the highest subsidy category, and 80 percent of people are in the highest two subsidy categories. Maine has spent \$45 million a year and reduced the uninsured population in Maine by less than 10 percent.

MR. STEVE ELKIN: I'd like to know why I cannot get a high-deductible health-insurance policy or a medical savings plan in New York State.

MR. TALLON: You can buy one if you are in any of the group markets in New York. You cannot buy it in the direct-pay market in New York. We fully concede that the direct-pay market needs to be broadened. One proposal is to blend the small-group and direct-pay market into a broader pool—put 60 thousand people into 2.2 million. You'd have to have some subsidies.

Another proposal is to pool the direct-pay market and run it as a separate, adjunct pool administered on a statewide basis. There are several other proposals. But clearly, in New York you cannot get a high-deductible health-insurance policy or a medical savings plan now.

If I sell you that high-deductible product directly in New York, then by definition my public policy is going to be that those who are older or have a higher health risk and don't benefit from that policy are going to end up paying more. The arithmetic from a public-policy point of view leads me to question that solution.

MR. SCHERZER: The idea behind New York's requiring uniformity of policies in that market was to avoid segmentation, in which healthier people would peel off. We've allowed segmentation in other ways. We've allowed sole proprietors of businesses to peel off into their own separate pool so that they're no longer supporting individuals who are not sole proprietors of business.

I don't think that the population of seriously and chronically ill people particularly cares whether people are allowed to have these high-deductible plans. Our concern is that every time more people are allowed to peel off into some other product—and it's the healthier people who are going to do so—the sicker people are going to be left without other cross-subsidies that they need. It's perfectly fine and justifiable if that subsidy is coming from a much broader financing base—for example, the tax system—but it should be coming from somewhere. It is our inability to state that this will be a private market system because it involves individual insurance—versus stating that this is where government has a role—that has inhibited us in allowing more variation in the marketplace. We're insisting that the marketplace solve the problem and not saying that it is a broad governmental responsibility to solve the problem of how to pay the cost of sick people.

PANEL 2: PUBLIC SECTOR EXPERIMENTS: MANDATES, MEDICAID, AND MARKETS

MR. PAUL HOWARD: States have taken the lead on health-care reform, and none in a more prominent or interesting way than Massachusetts. We have with us today as our first speaker Jon Kingsdale, the executive director of the Commonwealth Health Insurance Connector Authority. Jon will be discussing the Connector Authority. He will be followed by Ed Haislmaier of the Heritage Foundation, who will discuss what aspects of the Massachusetts experiment may be applicable to other states. Len Nichols of the New America Foundation will follow on the politics of health-care reform initiatives in other states, particularly California, Utah and Colorado. David Gratzer, a senior fellow at the Manhattan Institute's Center for Medical Progress, will conclude the panel by talking about market-oriented reforms and private-sector initiatives. Please join me in welcoming Jon Kingsdale.

MR. JON KINGSDALE: Thank you, it's a pleasure to be here. About three years before the Massachusetts legislature passed its second health insurance reform proposal, in 2006, the Massachusetts Blue Cross Foundation sponsored a similar set of conversations and initiatives [to today's]. Maybe that's a propitious sign for you.

I'm the executive director of a new, independent authority which we refer to as the Health Connector. I'll briefly describe its several functions and focus on the more innovative ones, particularly our function as a commercial exchange or marketplace.

People often ask me how reform is going in Massachusetts. I usually say about as well as can be expected. We're doing fantastically well, yet we have huge bumps in the immediate road ahead. Number one, we have reached a lot of people. We thought there were somewhere between 372,000 to more than 600,000 uninsured people in the state when reform started. We've now revised the lower estimate to about 400,000 people. We believe that, as of January 1, we will have newly enrolled over 300,000 of them. That's a big dent over the last eighteen months. And of that group we estimate about 100,000 are in private commercial insurance—net new enrollment—and a substantial amount in partially subsidized insurance.

The program has been successful in terms of reforming the non-group [insurance] market. The prior panel on the uninsured in New York (See *New York's Uninsured: A History of Good Intentions and Unintended Consequences*) addressed the issues of shifting dollars around between insurance companies with reinsurance pools and all the dysfunctions of the non-group market. I'm going to make a bold claim, which is that we have the only functioning non-group market in the country now, as a consequence of reform; that it is an absolute necessity for making an individual mandate work. What I

Pre-reform, the non-group market in Massachusetts had guaranteed issue, guaranteed renewal, and offered very few products. It was hard to shop and a terrible value; you had to call and hope you could find somebody at an insurance company willing to answer your phone call.

mean by "functioning" is you can get a choice of products, ease of purchase, and the value of benefits comparable to what you can get in the group insurance market. Let me give you a couple of numbers on this. Pre-reform, the group market in Massachusetts had guaranteed issue, guaranteed renewal, and offered very few products. It was hard to shop and a terrible value; you had to call and hope you could find somebody at an insurance company willing to answer your phone call.

The typical uninsured individual in Massachusetts on April 1, 2007, before reform of the non-group market, was a 37-year-old male Bostonian. We don't rate on gender, but uninsurance is definitely gender-linked. We've done a lot of focus groups, and clearly there is a bunch of guys who think chronic illness only happens to women. And they don't want to be spending \$4,000 a year for a high-deductible health plan with no drug coverage. They get that something could fall on them, but they don't really believe in chronic illness.

After July 1, 2007, that same 37-year-old could buy a policy for \$184 a month. It's still a lot of money, but just over 50 percent of \$335, with a \$2,000 deductible, full drug coverage, and coverage

of ER and office visits before the deductible kicks in. So people pay literally half the price and receive twice the benefits—a very concrete demonstration of the success of reform.

Third, and this is very important, public and political support for reform was high when we passed it. Every representative but two and every senator voted for it. They're virtually all Democrats. A Republican governor championed it, and it's being funded by a Republican administration in Washington. I maintain you do not want to reform the financing of 16 percent of our GNP on a 51 to 49 vote. Since then, support has grown: a September 2006 Kaiser poll found a three 3 to 1 margin of support among likely voters—61 percent for, 20 percent against, with the remaining undecided. Redone in June 2007, 67 percent were for, 16 percent against—four 4 to 1. Over 90 percent of the public is aware of reform, and even a majority of employers, according to a poll released in November, support it.

I would also point to the fact that we have a very diverse board at the Connector, to which the legislature passed the buck, addressing questions like what's minimum credible coverage, and what's affordable insurance, and things that they just didn't want to be torn asunder over. And we span the entire political spectrum in Massachusetts, from center to far left, and have had unanimous votes of that board on all those contentious issues, which I take as real political capital. We're dealing with things that you know cost huge amounts of money and are very personal.

We have a bunch of different roles at the Connector. We're a policymaker and a regulator. If you're going to mandate coverage, what's the minimum credible coverage somebody has to have? If you have to have it, as long as you can afford it, what does affordability mean? If we're going to make employers offer this tax dodge through pretax, payroll-deduction contributions to fund premiums, what are the rules and regulations? We're a big insurance purchaser, so we decide on behalf of hundreds of thousands of people what the benefits are and what their contributions are, and we negotiate that with MCOs [managed care organizations] and do the enrollment rules.

We're a cheerleader. We have grants to do outreach with community-based organizations. We partner with the Red Sox, Bank of America, CVS, Comcast, the MBTA and the Greater Boston Interfaith Organization, and anybody we can find to go out and find the un-

insured because, frankly, they're not always easy to find. You don't find a lot of them on the train reading the *New York Times*. They might have multiple jobs, and health care is number seventeen on their list of priorities.

We also serve as the Travelocity of health insurance. We're a commercial exchange for the subsidized insurance program that we run, but also, for the non-subsidized commercial insurance. So we have specific target markets: non-group and a subset—somebody called it direct pay here—of that non-group market, which is lower-priced, somewhat lower-benefit plans for young adults who we're trying to lure. This is largely about getting them to help support the rest of us.

Another target market is voluntary benefits. It's one thing to make employers offer a Section 125 pretax payroll deduction plan. These part-time workers, and others who have been left out of the contributory scheme, aren't necessarily highest on employers' priority list. They're not necessarily plugged into the media. It's a retail battle to find them and get them to take advantage of what is actually an over 40 percent government subsidy. With an average, marginal federal tax rate of 28 percent, the tax subsidy for employee provided insurance, as the Manhattan Institute people know, is huge in Massachusetts. The total tax subsidy on average for the individual who shifts a dollar from wages to premium is 41 percent, plus the employer makes 7.65 percent on that deal as well. So that's another target. The small-group market is the third target.

We make shopping easy, and I have lots of grandiose visions of fancy things we can do. We have a very pedestrian website, yet it is virtually universally applauded as a breakthrough. It's really a commentary on how badly the market functions in health care, where people don't have information on the products and the prices available to them. You put in three pieces of information—age, size of household, and zip code—and we have forty-two options for you, approved by a competitive bidding process. We make it easier for you as a shopper. You may want no cost sharing and the highest premiums, or more cost sharing and a lower premium. People can see the three lowest-priced options side by side and a comparison of network benefits.

We have an estimated commercial enrollment for January 1 of 100,000. Twenty thousand are coming through us, but we're also mov-

ing the rest of the market. The health plans themselves are now trying to imitate us by offering more options. The biggest health plan virtually copies our website, which I just said was pretty pedestrian.

I think we've had some impact, and we're doing about as well as you could expect. There are tough problems coming our way, so wish me well. Thank you.

MR. EDMUND HAISLMAIER: Thank you very much. This conference applies the typical formula for addressing the topic of health reform. It is focused on the problem of the uninsured and the subsidiary issues of cost and access. However, those are really symptoms of the larger problem we must address if we are to significantly improve the health system.

I would argue that the better starting point, not only for developing an effective set of policies and reforms, but also for reaching broad agreement on both goals and methods, is to ask the question, "How do we improve the value proposition in health care?" "Value" is the expression of the relation between cost and benefit. I think we can all agree that at both the societal and the individual level we don't seem to be getting good value in our health system.

When we consider not only the number of the uninsured but also the wide variations in treatment costs and outcomes and the resulting escalation in health-care spending, we get the sense that we are either spending too much for what we are getting out of the system or we're not getting what we should be for all the money we're spending. Viewed from this perspective, we can quickly see that seeking and providing better value—that is, more and better for less—seems to be well down on the list of factors motivating decisions in our current health-care system. Rather, both current market competition, as was discussed in the previous panel, and government regulation, as was also discussed, seem focused on doing more at higher cost, and simultaneously constraining costs by doing less. The single most effective way to control health-care cost is to not treat people. We've mastered that not only in the public but also in the private sector, as has everyone else. And if you must treat them, don't pay the provider. That too we seem to have mastered.

Where all this leads us then is to what is now a growing debate about how to ration or allocate the benefits of new medical tech-

nologies to keep the total cost under control. Now if this strikes you as similar to the dynamics of government-administered single-payer systems, you're right. The reason is that both our system and their systems are payer-centered. We just have more payers than they do. The result is to produce what Michael Porter and Regina Herzlinger of Harvard Business School talk about as zero-sum competition. That is competition centered on finding ways to shift cost onto somebody else—government, insurers, providers, consumers, employers.

In short, the health-care system is a trillion-dollar game of hot potato. In a recent visit to Anchorage, I encountered a slogan of a local business that summarizes a common practice in our health-care system. The slogan was, "We cheat the other guy and pass the savings on to you." In contrast, what would we think of as a slogan for a value-maximizing system? Let me suggest, "We do the best job, at the best price, of keeping you healthy, and, if you are sick, of getting you the best treatment." A value-maximizing system creates competition at the individual patient and disease level. This is Michael Porter's point. Who does the best job of treating this condition? Who will do the best job for me, given who I am and my preferences, not just my illnesses?

The key to getting that result is to shift from a payer-centered system to a consumer-centered system. The key characteristic of a consumer-centered system is that it is the consumer, not the employer or the government, who controls the dollars and picks the plan that best suits him. Consumers also have a regular opportunity to choose a plan without medical underwriting, and thus transform what is a seller's market into a buyer's market. In this kind of system, the role of the government and employers becomes assisting the consumer with financing that arrangement. The government has a role in setting the basic rules and organization for the system, but the plans and providers must compete on value in order to get the consumer's dollars.

Do we have experience with this? The answer is yes. Professor Herzlinger points to the Swiss system, which works very much like this. We often point to the Federal Employee Health Benefits Program, covering 9 million Americans, including 300,000 retirees who have no Medicare because they're in the old federal civil service system. Every year they get a chance to pick the plan, and the

employer doesn't. In this case the federal government doesn't even go so far as the Massachusetts Connector in determining which plans are allowed in. It's pretty much any willing plan that meets basic standards. As the president of the National Association of Retired Federal Employees says, "There are no bad plans. There are just plans for different people."

What are the results? Despite a much older workforce, it turns in a consistently better record in cost control and patient satisfaction than private coverage in the employer market. When you adjust for differences in benefits, it does a better job than Medicare in controlling costs. They had drug coverage for decades at FEHBP, because you wouldn't be able to sell a plan without it, but nobody told them to put it in there. It took an act of Congress and three attempts over twenty years to get it in Medicare. Two years ago, the average premium increase was 1.8 percent; it was just about 2 percent this past fall. So we have some successful models.

Can a state engineer such a transformation in its markets? Here are four ways a state could do it:

One, the state, using its powers to regulate insurance, creates a consumer-choice insurance market for as much of the state's population as possible, with a level playing field for insurers and as much latitude as possible for insurers to vary the design of benefits.

Two, the state transforms as much of its existing spending on health-care services as possible from a provider-centered system, where the relationship is between Medicaid and the doctor or hospital, to a consumer-centered or patient-centered premium-support system, where public dollars are used to buy the disadvantaged into the system.

Third, the state needs to create and apply a market-wide risk-adjustment mechanism to address some of the issues that were mentioned on the previous panel, such as the disparities between sick and healthy. In this case, New York is a little closer, because it's an inclusive mechanism; you don't put the sick people off in a corner and say, "That's all you get." [Insurers] would have to compete for the sick people as well, and the sick people would have choices leading to more specialized coverage and the best treatment for diabetics or for cancer patients. Right now, if you're good at that, you don't want to tell anybody, because [the sick people would] all come to you.

But for all of this to work, you have to have a backdoor mechanism that transfers money from people who are healthy and are buying cheaper premiums, based on some other factor like age. Where New York goes wrong is expecting that the money should come from the taxpayer, rather than a pool throughout the whole state—a back-end risk-transfer reinsurance pool.

Once you've done these first three things, remove any remaining regulations or subsidies that protect providers or plans that fail to deliver better value to patients. Congress solved the problem of the uninsured in this country by mandating that hospitals treat them. But the hospital goes broke doing it, so we subsidize them, and we then prevent competition. We [get in the way of], as Regina Herzlinger says, the people who focus on doing the best job at the best price. In other words, we take the only people who are focusing on value and we cut them out of the market to prop up the other people. Isn't that kind of backward? First you have to fix the market. Once you've done it, there ought to be some hospitals and doctors that go out of business.

The significance of Massachusetts is that it was the first state to do the first two of these four things, and they did so in a limited fashion. Any other state can apply these basic concepts and principles, but they will have to tailor them to their own unique circumstances. States can also learn from some of the details in Massachusetts because it was a prototype, and with any prototype, you learn to do things better in the second or third version.

One thing we discovered in moving away from a payer-centered system to a consumer-centered system is that when you look at the data on the uninsured and coverage patterns, the vast majority of people who experience uninsurance are in and out of coverage. Let me leave you with the thought that the data suggests that nationally—and this will vary by state—about 40 percent of the people who experience uninsurance are most of the time insured and above 200 percent of poverty. If we move to a system with the insurance attached to the person, instead of the job, about 40 percent of your problem might simply go away with no new spending. That is a message that attracts a great deal of interest in bipartisan state legislators around the country. Thank you very much for your time.

MR. LEN NICHOLS: I'm going to discuss markets, mandates, and Medicaid. I'll start with markets because I might be the token member of the center left on the panel. I'll just say I've come not to bury markets, but to praise them. In fact I'm a big fan of markets. I spend most of my day job actually trying to make markets work better.

And I will point out a couple of optimistic things. One, if you look at all the presidential candidates' proposals, only one is actually anti-market, and that is Kucinich's. I don't know if this will pass as news in this group, but Kucinich is not going to win the nomination. And so, from the point of view of those of us with scar tissue from various state and federal struggles, it is heartening to see how many Democratic candidates have embraced some form of market competition as the centerpiece of their proposal.

The key here is: How do you make markets work for everybody? How do you make markets for all? And I would certainly bow to Massachusetts as a catalyst. There's no question in my mind that we wouldn't be having the conversations we're having in Colorado, California, Utah, and even Washington D.C. without Massachusetts, where you had two very interesting factors come together. You had a Republican presidential aspirant willing to use the word "all" —it hasn't been since Richard Nixon that this was true—and a Democratic legislature, with the exception of California, willing to accept the word "limit." That was an appropriations bill, not an entitlement. With this we can work out a bipartisan compromise, and that's what everybody else on this stage thinks. But I couldn't agree with Jon more that this cannot be done, and should not be done, on a 51 to 49 [basis].

In making markets work for everybody there are always going to be tradeoffs and winners and losers. But what's interesting to me, as I look in California, Colorado, and Utah, is that they've all come to basically the same conclusion: You've got to make the individual market and the small-group market function far better, and you have

You've got to make the individual market and the small-group market function far better, and you have to have mandates. Yes, mandates are going to be what make markets work better.

to have mandates. Yes, mandates are going to be what make markets work better.

Let me just say a little about the differences in these states and then we'll get into why I think the mandate case makes sense. California is the bluest legislature on the planet. It's actually not correct to call their legislature rank and file Democrats; they're more like Trotskyites—they take the unions' talking points and go off and make their speeches. There is leadership there, thank God, and it is at the top. They do have power and wisdom and a few sticks and carrots of their own. I think there will be a deal. California has also elected Republicans to the legislature, and anything Grover Norquist puts forward they will sign. You could have a million Al-Qaeda lined up on the Oregon border and they would not raise their own taxes to defend themselves. They would send public school teachers out to do the battle. They will not raise taxes.

It turns out that in California the only elected moderate in the whole state sleeps in Arnold's bedroom, and this turns out to be useful because Arnold is a big guy and he's hard to ignore. In fact, he is smart and, believe it or not, he gets it. It was hard for him to get to the philosophical place of crossing the Rubicon and saying, "You mean a mandate is necessary?" But he got there, and in a way that makes a lot of sense.

What's going on in Colorado? There you have an almost perfect purple state—very slight [Republican] R majorities before, very slight [Democratic] D majorities now. It has the full human family in the legislature—they are all represented—and they have an awareness that to do something serious about health-care reform they're going to have to go to the people and ask permission to raise taxes. I'm not sure what's wrong with their constitution, but the legislature doesn't have the authority to do that. In my simple, scar-tissue ridden view it's useful because it means their entire process of talking about what they might do has been done in the public eye, with the intention of making sure all major stakeholders are at the table and both parties are indeed deeply involved. What they have right now is a commission made up of folks across the spectrum who say you've got to have mandates to make these markets work.

And finally, on Utah, I got a call from them in mid-May, and they said we're coming to Washington and would you meet with us.

I said sure. I told them that when I do these sorts of conversations I usually insist on its being bipartisan. They said they had some Democrats in Utah, but they tend not to bring them to Washington; there's no real reason to because they don't really have any power. And so I met with them. Utah has now been working for four or five months. Utah won't have a public process. It'll all be behind closed doors. Jon joked about Massachusetts being center-left. Utah is right of center to far right, but those guys get that the business community is paying for the uninsured right now. You may not know it, but Utah has exactly the same uninsured rate as the nation as a whole. And to be blunt, the chairman of the United Way board, who happens to be the owner of the biggest bank in Utah, is not happy about paying for the insured right now. He wants to figure out how to buy smarter. To make those markets work in Utah, as in California, Colorado, and the nation, you've got to have mandates.

I submit to you—and this is extremely important politically—mandates are required to make everyone pay their fair share. The panel this morning made clear the uninsured are quite a diverse population, but the poster child tends to be the low-income population. Actually, at least 10 to 20 percent, maybe 30 percent, of the uninsured are fairly high income and could afford to buy insurance now and choose not to. Those are the free riders that Governor Romney started talking about early on, and they're not paying their share, and their costs are also being shifted to the rest of us, and it's an absolutely pure public finance principle to make them pay their fair share.

Second, and this is maybe the most important technical point, requiring people to buy enables your insurance market to work far more efficiently and fairly. Ed talked about the adverse selection problem. The Blue Cross meltdown in New York is a perfect example of how trying to impose excessive regulations in the absence of a mandate is a stupid idea because when you do that, you raise the premium for the healthy and they play roulette and don't buy. But when you have a mandate, you make the healthy buy. You reduce the fear of adverse selection sufficiently, and you can get insurance consumers to accept rules like age-rating.

At the Utah discussion, probably the single most conservative human being I've ever sat next to for six consecutive hours blurted out, about four hours in, "Okay, I get it. We have got to do this.

But man, do we have an education task in selling the mandate to our people!”

But I would submit it is a venerable philosophical position to oppose a mandate. It can lead you to an analytically defensible health policy. Doug Holtz-Eakin is going to be anti-mandate and explain why. In fact, McCain’s plan may be the best Republican plan. However, if you oppose mandates, what you’re basically saying is you are against market-based solutions to solve the health-care problem. It doesn’t say you’re not going to make improvements, but you’re not going to solve it.

Everything we’ve talked about in this panel on solving the health-care problem means buying smarter across the board. We’re going to need to turbocharge incentives for the consumer and provider to make this work. Markets are essential, but you can’t get an insurance market to work unless you have rules to purchase and requirements to buy. It doesn’t have to be one-size-fits-all. I totally oppose that. What I recommend is you pick an actuarial value target and allow the market to vary products based on that. The target probably has to be a scaled down package—maybe even more scaled down than the Massachusetts package. In Utah it will be even more scaled down, as it should be. People have different views of affordability. But you’ve got to have a target and force people to buy.

The third plank is Medicaid. Watching governors, state legislators, and policy people in the various states and Washington, talk about financing, as Ed knows, is the least fun day in all these discussions. It takes about fourteen milliseconds for the governors to figure out they have to increase this Medicaid batch, they have to use this Medicaid lever.

As Jim Tallon said, in New York they discovered the federal government would pay for half of this. If a governor wants to expand coverage without hitting the taxpayers too hard, he has to maximize that federal leverage. That’s why every state’s thinking about this proposes taking kids to 300 percent of poverty under SCHIP, taking adults up as well. Medicaid is the financing lever. I agree with Jon completely: The best thing is to reform it by using the tax system. We’re spending \$180 billion now. That’s enough. Give me \$180 billion and I’ll solve the problem and take Ed to lunch.

But to do that, you've got to have federal government involvement, and that makes my last point. States cannot do this on their own. If Massachusetts, California, Colorado, and Utah work it out, there will be a huge federal role in making all these financial packages possible. I submit to you that the SCHIP battle we just had is instructive, depressing, and, at another level, hopeful. What you had was a bill that engendered 18 eighteen Republican senators voting "yes," enough to override the veto, by the way. That is the most bipartisan piece of legislation since World War II. Forty-four Republicans voted "yes" in the House. The White House chose to veto it, but look at Republican support for that scaled down bill.

This is not a partisan struggle between Democrats and Republicans on how to use public and private markets together to cover children. This is a civil war within the Republican Party over what federal policy should be on health care in general. That's the rhetoric the White House is throwing out. [Charles] Grassley, ranking member of finance from Iowa—a good, earnest, Midwestern Republican—is unhappy with the White House for pulling the rug out from under him, when what he thought he was doing was solving a problem. My simple point is that the Republican civil war will play itself out, and we will come back and have a bipartisan conversation going forward. Those eighteen who voted for SCHIP will vote for comprehensive reform in 2010 if we're lucky. Thank you very much.

DR. DAVID GRATZER: Sir William Osler was one of the most important Canadian physicians in the nineteenth Century. He crossed the 49th Parallel and became arguably one of the most important American physicians of the twentieth Century. Sir William Osler has many achievements to note. Perhaps foremost is his medical textbook, used for sixty years after its first publication. He was also the founding dean of the Johns Hopkins School of Medicine.

Osler, besides being a tremendous writer and a keen intellect, was an extraordinary clinician. Most of the patients he treated actually were elderly. He was a geriatrician before medicine really sub-specialized. Osler's writing is as lucid as it was a century ago, when he wrote it. Osler observed, with the best of intentions, that doctors prescribe medicines and treatments that make their conditions worse.

Osler would see patient after patient and take people off medicine, and his patients tended to do better as a result.

I had my own Osler moment when I saw a patient who had bipolar affective disorder and had been prescribed lithium and then had seen a couple of internists and a couple of family doctors who prescribed a battery of other medicines that, among other things, undermined kidney function. I simply took the patient off a slew of meds.

We're talking today about New York and the uninsured. To take a step back, I can't help but feel that, after decades of reform, what New York needs is less intervention—an Osler moment in public policy. Before I talk specifically about New York, and solutions one might be able to find in other states, I want to mention two major ideas I'm not going to discuss.

I'm not going to talk in a very substantive way about moving away from an employer-based health insurance model. We have a system that no one in the Western World has. I don't think anyone on our panel, left, right or center, would design an employer-based system today. [It is a benefit that] arose in response to wage and price controls in the Second World War.

It worked relatively well in the day when you were born [in Hershey, Pennsylvania]—you went to work for the Hershey company, your kids swam in the Hershey swimming pool, you stayed in the Hershey house, and eventually you retired on the Hershey pension plan. That doesn't work in a labor force that is constantly changing jobs.

The second important idea that I'm not going to talk about is what we're really doing about uncompensated care in the United States. Ed talked about money that gets spent on hospitals rather than on patients. Not unlike the old welfare system, we've created a bureaucracy to help people, instead of helping people directly.

I am not talking about those two central points because they would require a Washington-based system. If you favor moving away from an employer-based system to a single-payer system, you might like the Heritage model of tax credits or President Bush's idea of a standardized tax deduction, which is my position.

In New York, unfortunately, rather than taking a careful look at other states for new ideas, we're going to look at three or

four decades of reform and simply push in the same direction. We now spend more in New York on Medicaid per capita than any other state—about double the national average spending more than Texas, Pennsylvania, and Florida combined. And yet one finds that the percentage of uninsured, and it's very complex and difficult to make such a comparison, is only slightly lower than the national average.

The big initiative of Governor Spitzer's was simply to expand children's health insurance, which makes for great photo ops. I like children. I think giving children health insurance is splendid. But expanding it into a middle-class entitlement is problematic. The only reason it works is that children are cheap to insure. But doing that doesn't really get at fundamental problems. I do applaud reforms the governor has made in other areas.

What are the fundamental problems, and what are the ways we can address them? Let me speak in non-ideological terms. I think we can agree that if we want to help the uninsured, we're going to have to do four things:

First, we're going to have to have a good market for individual insurance. We've spoken before about the young and invincible, and one shouldn't forget how many uninsured Americans are like that, despite their depiction on the show "ER" or in Robin Cook novels. You find about 50 percent of the uninsured are between the ages of 18 and 35. And they've decided not only do they not need to wear a seatbelt because they're never going to get into a car accident, they don't need to buy health insurance because it's costly and they're never going to get sick.

Second, we need a robust market for small employers. Millions of Americans are employed by mom-and-pop grocery stores and restaurants. We want to make it attractive for those small businessmen, the engine of creativity and innovation of the American economy, to offer health insurance.

Third, we need a smart Medicaid program that does more than spend a lot of money or cover a lot of people. We need to spend the money intelligently on health rather than health care. We should do it in such a way that it's easy for people to get on the Medicaid rolls, but also get off the Medicaid rolls, so that there isn't a Medicaid trap the way, for instance, there was a welfare trap not long ago.

And the fourth thing I think we can all agree on is that we need an open and competitive market for health services. You should have some knowledge of your doctor, not simply about the pricing that the doctor offers, but also some knowledge of how good a physician he is and so on.

Some of you have bigger ideas in mind like single-payer. But I think we can agree that right now, those are the four things we ought to pursue in New York State. And despite the fact that I think we can all agree on these four worthy goals, we're gunning zero for four in New York State. The reality is that the individual market is extraordinarily dysfunctional, expensive, and regulated, pricing many people out of the market.

eHealthInsurance did a study a couple years ago, which I wrote about in the *New York Post*. If you were a family in Kansas City in relatively good health and sought a policy for your family of four—two adults, two children—you'd pay about \$171 a month. In Long Beach, California it's about \$180 a month. In New York City, it's \$1,730 a month. Obviously there are differences among markets and so on. Still, you're looking at costs in New York that are multiples of costs in other states.

Part of the reason for that is the mandates. In New York State, you just can't buy a bare-bones policy. You have to buy a policy that covers off-label drugs, surgical second opinions, and midwives. All those mandates drive up costs. Guaranteed issue and community rating were added with the best of intentions, but they simply don't work well within a health insurance model because they don't work well with any insurance model. If we had guaranteed issue and community rating, slightly modified, for homeownership insurance or tenant insurance, you could buy a policy after your apartment had caught fire.

Second, the small-employer market is dysfunctional. Its costs are at least 15 percent higher than the national average. The number of carriers involved in New York State is small compared to what it is in, say, Illinois or other states, and this limits people's options and limits competition.

Third, Medicaid is now approaching \$48 billion, a vast sum of money without as much to show for it as we would hope. Because the individual insurance market is so problematic, and Medicaid isn't

particularly well thought through, it has become a trap. Many people stay on Medicaid because they couldn't afford health insurance if they left its rolls. Exactly the opposite of what you would want.

And finally, we want a competitive and open market for health services. New York is just as bad as every other state. There is little price transparency, never mind the lack of attempts to look at value.

What are some ideas one can find in other states? Here are some ideas I like:

South Carolina has suggested that the cost of any future mandate would have to be studied before the legislature would approve it. There are a couple of states now, none I can name off the top of my head, that have suggested that if you want to add a mandate to health insurance, you need approval not in one but two sessions of the legislature. I would suggest that the better approach is to look at what states like Colorado and Florida have done. They allow people to buy a bare-bones policy. For the most part, if you want a high-deductible plan, you can simply buy a high-deductible plan. In other words, we ought to deregulate the individual insurance market. There are people who are chronically ill who would have difficulty affording an insurance policy, but other states, like Massachusetts, focus aid specifically on those individuals, rather than distort the entire individual insurance market to address their needs.

What to do about the small-group market? I don't have much to add to the discussion about the Commonwealth Connector. I think that's a worthwhile project. As you probably gathered from the earlier presentations by Jon and Ed, there are also some tax fairness provisions that I think New York would be well advised to plagiarize.

Medicaid is a huge issue deserving a conference of its own. We're focused on the uninsured today, so I'm going to focus on plans that are relevant to that issue.

What do I mean by getting away from the Medicaid trap? Florida and South Carolina have exciting initiatives. Medicaid has a menu of private competing health insurance options in two counties in Florida. In South Carolina, there is a health-savings account type of plan. In both states, younger, healthier people who might be on Medicaid rolls just transiently, are able to save some money so that when they leave those rolls they are able to better afford health insurance, getting around that Medicaid trap.

What should one do about transparency and pricing? Some experimentation is worthwhile. In Florida, I'm excited by the disclosure of prices that's now required. I'm interested in what's going on in Wisconsin with regard to hospital pricing as it's being discussed right now within the legislature.

Ultimately, whether or not you believe in what's going on in Massachusetts or in other states, you're going to have to accept that more of the financial burden is going to fall to the individual. And providing them with basic information is the key. New York does a nice job, incidentally, with its report cards on cardiac surgery. It is not enough simply to expand Medicaid; you have to arm people with information and reform other sectors of the economy.

I'm a psychiatrist. I know that often you don't come up with a perfect solution, but sometimes you come up with a functional solution for a patient, and that ought to be your goal. We can do far more for the money we're spending. That's not simply the good dollars-and-cents analysis; it's the compassionate thing to do. Thank you.

MR. HOWARD: I'd like to thank the panelists for those tremendous presentations. I think people might be surprised by how much agreement there is on the panel, at least on some key issues relating particularly to insurance exchanges.

I wanted to pose one or maybe two questions to the panel. An article in the *Wall Street Journal* back in July touched on the problem—which is certainly not unique to Massachusetts—of a shortage of primary-care providers in the state. One of the trends we've seen as health-care costs have risen is public and private insurers squeezing reimbursements, particularly for primary-care providers. At the same time, states want to expand access to insurance and primary care. Another issue the panel didn't dwell on is the problem of costs and cost shifting. My impression is that covering the uninsured with a couple of mechanisms might not be all that hard, but lingering in the background is this problem of cost, which is creating other headaches. Perhaps, starting with Ed, you could address those two issues.

MR. HAISLMAIER: I attempted to lay out my view that we have a system that's all about cost shifting at every level, with every player.

The result of that system is it costs more and delivers less. And that's fundamentally what needs to be reversed.

With respect to the specifics of the primary-care providers, this is actually a much bigger problem in a number of states. Yes, it's partly driven by reimbursement. It's also partly driven by the way we skewed the system of medical education.

Let me comment on the first one, and this is where I think Len and I would agree on the elements but disagree on the sequencing. My standard for evaluating state reforms is that if you're talking about mandates and money first, you're missing the point. If you're talking about mandates and money after everything else, then you're doing what I would recommend. There are enormous amounts of money sloshing around in this system, but we haven't got a clue how we're spending it.

According to a national study, for every 100 Medicare patients, there are collectively about forty-seven visits to the ER on average in a year. The comparable figures for the uninsured are about 44 per 100, for the privately insured 20 per 100, and for the Medicaid population it's 80 per 100. When the data suggests that your Medicaid population is using the ER at twice the rates of the uninsured, and four times the rates of the privately insured, you need to rethink what you're doing before you go to Washington to ask for more money.

When every legislator has to deal with the inevitable Medicaid crisis, they'll face three ugly options: throw people off the rolls, cut the benefits, or pay the providers less. When you pay the providers less, you [end up with] fewer providers, so patients go and use the ER. You're shunting these people off to the single most expensive place on the planet to get medical care. Until you tackle that, you really won't get a handle on it.

MR. HOWARD: Jon, do you have any thoughts?

MR. KINGSDALE: Yes, it's an interesting conjunction of issues that you pose, Paul—the shortage of primary care and the cost issue, which I don't often hear conjoined, but I'm glad you did. Let's start with cost. The dirty secret of our health-care system is we use fewer drugs, we see the doctor less often, we spend fewer days in the hospital, [but] we're actually not that much sicker than a lot of

other countries that have much better smoking rates and alcohol consumption rates. But it costs us two to three times as much for a unit of service here because we're slopping around in money like none of the other OECD Countries. A day in an acute-care hospital in the U.S. costs four times as much as it would in the other ten OECD countries, not counting Japan, because it's not apples to apples.

So how does that apply to physicians and primary care? The primary-care shortage is a conjunction of our mushrooming demand for care and the imbalance in the way we pay specialists and chronic-care doctors.

We clearly ought to have a system that pays specialists maybe one-and-a-half times what they make in Canada, Britain, France, Israel, or Germany, rather than three times what they make in any other civilized country, because they do have extra medical school costs. We should pay primary-care physicians maybe twice what they make in other countries because in America we want to reward people. So I believe the way to contain costs and increase primary care is some kind of a rational pricing system so that when folks go into residency programs, they don't feel they have to choose dermatology, cosmetic surgery, orthopedics or some other very remunerative specialty.

To deal with increasing demand, non-physicians need to provide primary care. It can be done more efficiently and effectively by clinicians who are not trained for seven to ten years, so that those who are that highly trained can concentrate on something more interesting than otitis media and rashes.

MR. NICHOLS: I agree with my friend Ed that you have to do cost and coverage at the same time. The good news is these governors get it. In Schwarzenegger's proposal, one of the big planks is to increase Medicaid payment rates, because California is notorious for having very generous income-limited eligibility but it pays providers roughly thirty-three cents on the dollar. For OB-GYN it is lower than twenty cents, and so patients go to the ER to find somebody that will treat them when they're pregnant.

So you have to raise Medicaid payment rates to rationalize the system. I'm for making sure we get coverage along with cost because it concentrates the mind. If you make a social commitment to cover

everybody, you have to worry about cost. And I've watched enough in Washington and the states to know that if you don't force them, they will avoid it, and so I'm in favor of turning up the heat on the moral case and getting the commitment. Then we'll get serious about how to deal with costs.

The way to move toward [more available primary care] is to do it in a market-based way. A number of different little experiments are popping up: pay primary-care providers for a consultation or help patients navigate the system; spend time with patients to learn what their problem is or take longer histories; pay primary-care providers more for evaluation and management; give patients a premium reduction if they sign up for a medical home; and get people into a primary-care setting where they can get well-managed preventive and chronic care. That kind of incentive is part of one of the big proposals in Congress. Senators Ron Wyden from Oregon and Bob Bennett from Utah, who are not typically ideological soul mates, have come together on this. You've got to pay primary-care doctors more, and you've got to pay them for what they do.

DR. GRATZER: On Medicaid, historically speaking, the policy, as Ed pointed out, is to control price. The people who are the easiest to squeeze at the provider end are those who do primary care. Is that what you want? A young asthma patient who grows up in certain parts of Manhattan would [usually] have access to a respirologist. Unfortunately, if he's on Medicaid, I'm not sure he would because of price and wage controls. Wouldn't it make more sense if we had a primary-care doctor seeing these patients, rather than the emergency room.

LUNCHEON ADDRESS

HOWARD HUSOCK: Douglas Holtz-Eakin is currently a senior fellow at the Peterson Institute for International Economics. From 2003 through 2005, he served as director of the Congressional Budget Office. Prior to that, he served as chief economist of the president's Council of Economic Advisers. In both positions, he was widely recognized for his thoughtful views on fiscal policy generally, and specifically on health care and entitlement programs, which are certainly our meat here today.

He is the former Trustee Professor of Economics at the Maxwell School of Citizenship and Public Affairs at Syracuse University, where he chaired the economics department, and was also associate director of the Center for Policy Research. He currently serves as the policy director of John McCain's presidential campaign. Please join me in welcoming Douglas Holtz-Eakin.

MR. DOUGLAS HOLTZ-EAKIN: Thank you very much for the chance to be here. This is obviously a very interesting moment for the issues of health care and health-insurance reform. I confess I am not one of those people who came out of the womb deeply interested in health care. But a couple of things happened to me along the way. On December 31, 1990, I had a right renal autotransplant. They take your right kidney out, you donate it to yourself, and then they put it on your left side. And I was lying in my hospital bed after [the procedure] and reading the *New York Times*, and it said that 50 percent of the population couldn't change jobs because of their health insurance [situation]. And I thought, wow, am I ever going to go to another job, or is this it?

So I started doing a little work on health insurance, and then I made the mistake of accepting a job at the Congressional Budget Office, where all you do is health care. There are some side issues, like the military and taxes, but all I did was health care. So I started thinking about it a little more.

Then John McCain asked me to work on his campaign, and so I resigned from my nice little think-tank job with the Council on Foreign Relations and went to work for the campaign. In July, money got tight, and for the first time in my life I got fired, and I was un-

employed and uninsured. It was shocking. My son had finally gotten out of school and had a job, so I thought maybe I could go on his health insurance. But I didn't.

So I started thinking about different issues associated with [coverage]. Individual mandates for health insurance are a big part of that debate. There are many Democrats who have proposed it. Senator Clinton's proposal has it, Senator Edwards has a proposal for an individual mandate, Barack Obama has a partial individual mandate. It's not an exclusively Democratic issue. Governor Romney imposed an individual mandate during his tenure in Massachusetts. There are senators of stature on the Republican side who have health-reform plans that include individual mandates.

I've talked to a lot of people who are very interested in pursuing reform in the United States, and they come down on different sides of this issue. I thought I would think out loud today about individual mandates because we rarely hear much public discussion about how you decide whether to have them. In the interest of full disclosure I should mention that Senator McCain's health reform plan does not include an individual mandate, but the following remarks are my own.

I'll give away the punch line, which is that I don't think there should be an individual mandate. And I want to walk you through how I came to this conclusion.

Why not a mandate? General principles started to leave me unable to sleep when I thought about proposing an individual mandate. Principle number one was freedom. It's literally that simple. The core of what I believe to be the uniqueness of America is that it is a place that offers an opportunity for the ceaseless pursuit of personal, political, and economic freedom. And that has carried this country for over two centuries, and it is something that we should be proud of and embellish and not diminish. Any intrusion on that as a matter of public policy should be done not casually but with a great deal of thought.

There's a corollary to that, which is that a federal mandate steps on the state's toes. There are cases, obviously, where federal preemption of state authorities has proven to be a sensible way to go. But going to a federal mandate for individual health insurance is one of those policies I'd want to be really convinced of first.

The second general principle that I appeal to, and it's still a vague notion, is [a wariness toward] interfering with market flexibility. There isn't yet a rock-solid, ironclad case, but there is a lot of suggestive evidence that the United States has entered into a period of great moderation in its overall economic fluctuations. Regardless of whether we are now entering into a slowdown that ends up with the dreaded "r" word attached to it, we've had, since 1985, only two mild recessions. We've been in recession much less over that period than in comparable periods prior to it. I think that can be attributed, to a great extent, to the kinds of deregulatory efforts that were undertaken in the '80s, the globalization efforts that followed on that, and the broad use in public policy of flexible market mechanisms such as the auctioning of permits under the Clean Air Act [to control emissions causing] acid rain.

Those flexible mechanisms should be interfered with as little as possible. This is a slippery-slope argument. I don't think an individual mandate is going to cause a recession. But you should always be careful before you pull the trigger on something that reaches in and reduces that kind of flexibility, because if you do it too often, too casually, you undo something very special we've benefited from.

Those two general principles stack the deck against a mandate. But in the end I'm not a philosopher; I'm an economist. Principles get me only so far. I have to do benefit-cost analysis. So I took out my spreadsheet and started thinking of other reasons we might not want an individual mandate.

The first thing is that it's a distraction. It focuses on the wrong problem, in my view, which is coverage, instead of focusing on health-care spending. In my CBO days we discovered the Hubble's constant of health care, which is that over a variety of periods, no matter how you measured it, health-care spending per capita outstripped income per capita by 2.5 percentage points every year for decade after decade. The number isn't exactly 2.5 all the time, but there is this big mismatch. That's the premier problem in American health care, because it's the reason so many people lose their insurance.

Many employers, who are basically self-insured, have one problem, which is that their bill keeps going up. They can pass some costs to their employees, but they may or may not be able to pass all

of them, so they start dropping their coverage. Individuals stop taking up coverage that's offered, and it makes it harder for people to get alternative insurance, whether it be individual market or small-group.

This causes great government programs to come under tremendous stress. Look at what's going on with Medicaid in some states. The outlook for Medicare at the federal level is the premier problem. It's important to focus on that problem, particularly given the evidence accumulated by people like this group that we're not getting quality commensurate with that kind of spending. If we were spending all that money and were thrilled with the outcomes, that would be one thing, but we're not, and I think a focus on an individual mandate really misses the point. It focuses the public on the wrong problem.

There's also a dangerous follow-on to that, which is, Suppose you just go do the mandate. This is an unfair caricature of what went on in Massachusetts, but to make the point, let's say you impose the mandate but don't do anything about the cost side. You have a mandate for people to buy a product that they can't afford or didn't want to buy to begin with. You've imposed this tax on them that will go up every year. You might try to shift it around with subsidies, but you've got a big tax on people that comes from the mandate, because you haven't dealt with the primary problem. So deal with the problem; don't lead with the mandate.

Then I started wondering what problem is actually solved by an individual mandate. What I started to ask was, What do people want to get out of this? Number one, it is the quickest way to solve the political problem of the uninsured. This has become the report card for success in many settings. And the quickest way to get it is to assert you'll have 100 percent of the people.

But that, of course, is entirely illusory. You're never going to get to 100 percent of the people. So the real question is, Would the individual mandate provide more effective coverage than an alternative proposal?

It offends my instincts as an economist to think the uninsured are remarkably heterogeneous. The duration of their spells of uninsurance, their health status, their income, and their employment status are remarkably heterogeneous, yet we have this one-size-fits-all solution. That almost never works. People assert that mandates will control costs. They'll say you need to cover everybody to control costs

because it would stop this cost shifting—you're going to be able to spread costs across more people.

Suppose we have about 50 million people, round numbers, who are uninsured. Suppose we have a mandate that means all those people have to have insurance. And suppose you can get \$3,000 out of each of them, about a quarter of a \$12,000 policy. I think that's an upper-bound estimate, given what we know about these people, but suppose we can do that. You've just received \$150 billion. That's what you have to solve "the cost problem." One hundred fifty billion in a two-trillion-dollar health spending bill is about a year-and-a-half's worth of cost growth.

And then you're back to reality. [Another way of looking at it] is it is going to cost you about \$150 billion to solve the uninsurance problem. Remarkably, all the national proposals end up with a \$150 billion price tag at the start.

There's also the problem that all the people you cover might spend more, not less. The third-party payer problem raises its ugly head, and we don't know where that will end up. On the list of things universal coverage is supposed to do, which is cover everybody and control costs, I'm unconvinced.

The geek community—I'm a lifetime member—says you have to get adequate pooling. We need all these people in [because of] adverse selection and moral hazard. But on the ground right now, I'm unconvinced.

In the United States we don't have textbook insurance markets where this mandate might actually put everybody in the pool. We have the majority of people in employer-sponsored insurance, where most are self-insured, and that's the pooling. And that really isn't going to change dramatically.

It would be stunning if the purpose of the individual mandate, particularly to some of its strongest proponents, was to push people into the individual market, or the small-group market. There aren't robust insurance markets in the United States. We need serious insurance-market reforms that generate better competition.

Fourth on my list of problems that mandates are supposed to solve is the fairness issue. You've got young and healthy people and they're not buying insurance, and then they wait till they get sick and impose costs on everyone else. It's just not right.

I thought, Is this really what's driving our problems? I don't think so, because I don't think people want to make that assertion about the sick. I don't think they want to make that assertion about low-income folks who can't afford [insurance]. I don't think it's a problem with the elderly. The question is how many high-income young people, only about 20 percent of whom don't have insurance, have an acute-care episode and then free-ride? The problem just doesn't look big enough [to require] a big blunt instrument like the individual mandate as the solution.

There's another solution to this problem that just proves I'm an economist and have literally no regard for human feeling and shouldn't be allowed to give lunch speeches. It's the solution that the market would deliver. Let's let those [uninsured] people who free-ride go to the hospital, get health care, and go broke. Insurance is a financial product, and it's a financial product meant to insulate you from the financial consequences of a health episode. If these folks are trying to take advantage of the financial product, they [may not] have to buy it, but they don't have to walk out of the hospital solvent either. Bankruptcy can solve this, and if the word gets out that if you play this game, then you're going to be bereft and owing everybody for years and years and years, people will buy insurance and the problem will be solved. But that's the heartless economist solution. I've not really pushed that with any political superiors. I don't think it's a campaign proposal.

What problems are you going to cause if you do the mandate? That's the flip side. You should always worry about what could come out of doing it. I think there is a very real set of problems that could arise.

The mandate is a demand-side regulation. That's what it is, period. The proponents like to think of it as a demand-side regulation in isolation, but it doesn't stop there. Because if you start regulating the demand side, and you have a vision of the outcome, you're going to have to start interfering on the supply side to get things to line up where you want.

First and foremost, if you say you have to have it, someone has to provide it. You're going to get play-or-pay provisions. Employers have to offer this to you, or else. Or you have to tell the insurers [to comply with] guaranteed issue, and you go into the supply side on

that front. You start to go after the two pools we have in the employer and non-employer areas and tell them how to do their business.

Once you put it in the political arena, there is no question that health insurance becomes a political animal. What constitutes adequate coverage, what benefits will be in the policy—all of those questions will now be determined by a political market, not an economic market. And we'll see an array of additional kinds of potential mandates. And the last point is, once you've made it a political football, the price is going to be politically determined. Since most of our health-care problems are reflected in the inadequate pricing of things, I don't think that's a good place to go. You're going to create worse pricing in a lot of ways.

I think back to what I believe was my most depressing moment as CBO director. I was testifying in front of the Senate, and someone asked me, "What is the right price for inhalation therapy in Alabama?" And I said, "The fact that you're asking that question reveals just what kind of trouble we're in." If you make that kind of price-setting part of the political agenda, you will have outcomes, I assure you, that you really don't want.

Moving into demand-side regulation leads you to supply-side regulation. It doesn't mean these markets will work better—that's the idea in the textbook. We pool the risks, we stop the free-riding, we do all this stuff. I don't think the dynamics work that way in a political setting.

Finally, I've never really seen anyone, with the exception of Massachusetts, lay out how they're going to enforce this. Enforcement costs are real. We have other mandates. We have the U.S. individual income tax, and enforcement costs are a real part of that. The last time anyone checked, the compliance cost, broadly defined, for the U.S. income tax was \$140 billion a year. That's a serious cost for the economy. To somehow perceive the mandate as a costless intervention understates its impact. We ought to be serious about asking people who want to impose the individual mandate how exactly they're going to enforce it: What will be the penalty structure; who will do it; and what are the associated costs. If there are young people free-riding today, some of these same people who aren't buying insurance probably won't comply with the mandated costs. And enforcement isn't going to be automatic by any means.

One of the striking moments in my political activities recently was looking at some polling data on Republican voters in early-primary states. In that sample, health-care reform was the number-one issue. Does the next president have to change the health-care system? Yes, absolutely. The individual mandate will be perceived as a quick fix to the problem. The question I have is, Is it durable as a fix? If you believe it's the right fix, will you take care of cost so that it's not just a mandate to buy something you can't afford or don't like? For those who are less enthusiastic about it, as I am, what are the costs from the point of view of our principles? What are the costs from the point of view of the functioning of health markets and the potential to make them function better? What will be the cost of adopting a policy that, in the end, won't meet what we promised and disappoints the American public?

I'll stop there and take any questions you might have.

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MR. HUSOCK: Doug has done a masterly job of anticipating objections that might be raised. I was wondering whether Jon Kingsdale or Mark Scherzer are still in the audience, since they were both somewhat mandate-oriented in a panel discussion this morning.

MS. BETSY MCCOY: Is your emphasis on cost control misplaced? Perhaps many people would rather have, instead of a third car or a third television set, an extra year of life.

MR. HOLTZ-EAKIN: I tried to focus on one little piece of the health-reform landscape. There's a completely different set of issues involving the cost of care and whether it's too much relative to what you get. The U.S. system is characterized by fabulous medical science, but in many

cases extremely low-cost, high-value opportunities are underused, because we don't have a system that channels dollars effectively.

The analogy is Medicare. Part A is for hospitals, Part B is for docs, Part C is for insurers, and Part D is for drug companies. We're making sure everyone gets their money, but patients are nowhere in there. We need a system that is coordinated around the patient. And one that doesn't guarantee a fee for every service or device but rather pays for the delivery of high-quality care.

EDMUND HAISLMAIER: I don't necessarily disagree with you about mandates, but the fact is I can't drive my car unless I have insurance. I don't see enforcement as the problem. What I do see are some real problems at the federal level, so I hope you can advocate some fixes there. One possible fix is to give employees a portable health-insurance voucher that is worth a certain number of dollars and let them choose whom they want to buy their coverage from and how comprehensive it should be. Also, instead of giving deductions worth different amounts to people in different tax brackets, why not give everybody the same tax credit, so that poor people get the same benefits as rich people?

MR. HOLTZ-EAKIN: I want to endorse consumer choice but not belabor the point. I think on tax policy you are exactly right. One of my jobs at the Peterson Institute was to answer questions about how we get from here to the year 2030 without going bankrupt. And a key part of that is a tax formula of exactly the type that you described.

The key to making U.S. health care work better in general is to put the money in the hands of families. The way I would do that would be to repeal the exclusion of employer-sponsored insurance and provide a tax credit that is \$2,500 for an individual, \$5,000 for a family, and available for purchases in both the employer and non-employer markets.

On enforcing the mandate: I didn't say it couldn't be enforced. I hope there was a little more nuance than that. I would like to know how you will do it. We know that it will be costly to get every last person. States that have mandates on auto insurance don't get 100 percent compliance. It's not a black-white issue. The issue is how costly it can get. We can get pretty far with vouchers, tax credits, and

lots of other things that will reduce the number of uninsured. The question is which of them is more effective, and at what cost.

MR. HAISLMAIER: There were actually two variants in Massachusetts. There was what then Governor Romney proposed and then what the Massachusetts legislature passed. What the governor proposed was not a requirement that people buy insurance. He said that if you don't buy insurance, then the alternative is that you set aside money so that we can be assured that you will in fact pay your bills and that the providers will have at least some initial money to go after.

MR. HOLTZ-EAKIN: So market-insure, or self-insure.

MR. HAISLMAIER: Essentially, yes. What prompted this question were your comments about bankruptcy, because the governor said you could buy a bond or set aside the money in an escrow account paying interest. If you failed to do either of those, the state would withhold any money it owed you, like a tax refund, and set it up in your personal account. The other thing he did is propose to change the law relating to judgments so that in the event you knew this wasn't enough and you wound up in court, and there was a judgment against you, there would be an automatic order of wage garnishment against you, as happens in child-support cases. So the creditor, the hospital, or the doctor wouldn't have to go to court a second time to go after you.

The legislature didn't buy that and put in what John Goodman calls a "play or pay" mandate, which is, You buy insurance or we fine you. I would add that this was in the context of other changes. For example, some of the pooling arrangements that we rely on today, such as that an employer won't get to participate if it doesn't make eight out of ten of its employees buy insurance, were being taken away. I'd like you to address the question of personal responsibility versus [such requirements].

MR. HOLTZ-EAKIN: I haven't thought about this at all. But it seems to me that if someone says you should buy insurance or self-insure, and if you don't you'll face financial consequences, that's letting the market work. Why do you need the governor proposing it?

MR. ALEX LUBARSKY: I went to a meeting about two months ago where a New York senator was present who said that health care in America right now costs \$1.6 trillion. A month later, five U.S. senators said it was \$2.3 trillion. Today I hear that it's \$2.4 trillion, so it seems to be growing by the week. If we take a more market-driven approach, will it impact the actual health and well-being of the nation?

MR. HOLTZ-EAKIN: A different set of health-care and insurance markets should reward low-cost prevention in ways that this one just doesn't. Medicare is a prime example. Medicare does not pay for prevention or diagnosis of diabetes. It does pay for amputations, which is crazy.

We could have a system in which we did the low-cost preventive thing and used technological innovations we hear so much about—you know, a cell phone that measures blood sugar level and sends it in automatically so that you can monitor it—but there's no financial incentive. There's a lot of talk about coordination of care, preventive care, health IT for low-cost collaboration. But there's no business model to make it happen.

MR. HOWARD: In conclusion, please join me in thanking Mr. Holtz-Eakin for sharing his reflections on the advisability of individual insurance mandates. I would also like to thank our panelists, our audience, and our co-sponsor, the New York State Health Foundation, for helping to make today's conference lively and thoughtful.



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