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**Getting to Universal Health Insurance Coverage Conference –
Day 2
Session IV: Can an Individual Mandate Promote Individual
Responsibility?
National Academy of Social Insurance
Washington, D.C.
February 2, 2008**

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[START RECORDING - PART 1]

GAIL CHRISTOPHER: Thank you. Good morning, again.

I'm Gail Christopher, and I'm very happy to be able to moderate what I consider to be an extremely important panel. I'm also happy to have left Battle Creek before the 15 inches of snow fell last night. [Laughter] As I know many of you are, I'm with the W.K. Kellogg Foundation and it's an honor to represent them here in this important meeting.

Our topic, "Can an Individual Mandate Promote Individual or Personal Responsibility," has a great deal of relevance in this time when we might even actualize in our lifetimes the possibility of universal healthcare. The concepts of the mandate and/or personal responsibility seem to be finding their way into the centerpiece of public policy at many levels, at the state level and at the federal level.

So I think it's important to analyze the issues, to explore them, to debate them, and that's what our very skilled panelists are going to do this morning. You have their complete bios. Now, each panelist will speak for the appointed time, and then we will engage in what I hope is a very lively, interactive dialogue. I understand that that is probably the case with this group.

I would ask you to ask questions and not make speeches, and I'll remind you of that if the need arises. Our panelists are distinguished panelists this morning and include Mark

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Pauly, Jon Gruber, Kieke Okma, Gene Steuerle and Paul Van de Water.

Mark Paulie is the Bendhelm Professor and Chair of the Health Systems Department for Wharton School at the University of Pennsylvania. Jon Gruber is Professor of Economics at MIT. Keike Okma is Adjunct Associate Professor of Public Policy at New York University. Eugene Steuerle is a Senior Fellow at the Urban Institute. Paul Van der Water is Vice President of Health Policy at the National Academy of Social Insurance. Join me in welcoming them. [Applause] Mark?

MARK PAULY, PH.D.: Well, good morning. I was asked to make some general remarks about individual mandates. I need to say at the beginning, although some may know, I personally am in favor of individual mandates as one of the tools that might help us get to – I'm never sure what I'm supposed to say here, but what I'm in favor of is universal health insurance, whether or not that means universal healthcare – I think universal healthcare is a more narrow definition. I'm a strong devotee of the "for Pete's sake, let's do something" school of political science here when it comes to trying to reduce the number of people without health insurance, and hopefully reducing that number to something very small.

I thought I'd first just give a kind of general discussion of what might be possible rationales for individual

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mandates, why isn't it - especially to a market-oriented economist who's heard about the invisible hand - efficient to just let people tell them what their preferences tell them and not push them around? I think there are a number of different explanations.

The most obvious one, at least to me - and this is actually what I wrote my doctoral thesis on and I'm still revising it - [laughter] is the concept of altruistic externalities, or, if you really want a mouthful, good specific altruistic externalities. The general idea there is that at least most members of our species feel discomfort and pain and sadness if we observe another member of our species suffering from an illness, especially one that medical care could do something about.

So this is really concern about the welfare of others. It is limited in the sense that we're not so interested in making people happy as we are in making them healthy, but it certainly is a possible rationale. Within the set of altruistic externalities, actually, I distinguish and think you can see in the data two kinds of folks. One kind is what I call rational free-riders. These must be people who majored in econ, but they figured out if they have a relatively low income at the moment and if they were to either go on eHealthInsurance.com and buy individual coverage or take that lousy job at Starbucks, where they at least offer you health

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insurance, but then you have to push various CDs and stuff, that they would be paying for health insurance.

Whereas, they can get what's not very good health insurance - it's actually pretty terrible, but it sure is cheap - by entering the hospital through the emergency room and presenting as a charity care patient. The observation here is that the rest of us in the community suffer from that behavior in one of two ways. If the person who is uninsured does use the hospital or other provider as a charity care patient, at least some of that cost may be shifted to us.

I'm not guaranteeing that that must be true in the short run, but it must be true in the long run. The other strategy, of course, would be to not use care you can't pay for, and then that makes your fellow human beings sad to see you suffering where the suffering could be alleviated.

So there are some people, I think, who are rational free-riders. Brad Herring wrote his doctoral thesis on this issue and he got a statistically significant coefficient, so he got his PhD. What he found was that in states that had a more generous provision of charity care, sure enough, more people were uninsured.

But it turned out that even if you abolished all charity care, you deported the good Samaritans as illegal aliens, you would only reduce the number of uninsured by a

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little more than 10-percent. It's statistically significant, but it's not enormous.

The other group, which I am becoming more and more convinced are important here, are what I call irrational buyers. It's hard to believe, but some people get up in the morning and they don't think about health insurance. In fact, they don't think about insurance much at all. They're just not into insurance and so they're not into health insurance.

A fair number, especially if you get above the poverty line, of people who are without health insurance - of course, they're young and foolish and all of that, but they don't carry other kinds of insurance either. These I call irrational buyers. Sometimes I've called them the lunatic fringe. They are people who hardly will step up to go to the effort of signing up for insurance even it was free, and they're certainly not going to pay anything for it. But you get the same kind of altruistic externalities there.

A third argument is more for specific kinds of coverage than coverage in general, although coverage in general wouldn't hurt. There may be kinds of preventive care which have cost offsets, but because there's high turnover in the population insured, people irrationally don't choose as much coverage or preventive care as would be efficient to do so, because they don't see the cost saving later on once they've moved to another insurance plan.

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Then the contagious disease, of course, is the classic economics care. "I want you to have health insurance so I don't catch something from you." You need to be a little careful there if the treatment is like the polio vaccine where you confer complete immunity. Obviously, the only people who will benefit from a child being vaccinated against polio are unvaccinated children. Vaccinated children will already be okay. There will still be an altruistic dimension there.

I used to say that's not likely to be very important, although with AIDS and with other methicillin-resistant diseases in the wings, maybe that would become a more important context. And then the final one is what is known as behavior and spillover. This relates to work I've been doing with Jose Pagon at University of Texas-Pan American.

The metaphor is the only way to get good opera in a small city is to have a lot of other opera lovers live in that city. The observation here is that if a sizable fraction of your town are uninsured and either unwilling to pay for high-quality or easily accessible care or when they do it creates spillover, you may as an insured person suffer.

At least we found some hints in the data that suggest that insured people in towns with larger uninsured populations say that they have a greater difficulty getting a doctor's appointment, and a whole set of quality measures are reduced for the insured as well as the uninsured. Now, obviously, if

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the town is big enough or the market can be segregated enough, the well-off insured can avoid having to share even the high-cost, large-scale facilities with the uninsured, but there is some spillover there we think.

The question to be asked about individual insurance is – my sister who’s a communist asked me this – why are you mandating that poor, middle-class individuals pay for their health insurance? Why don’t you make employers pay for it? To economists in the room, this will come as no surprise. To non-economists in the room, this will sound totally implausible.

But economists believe that – and we have some empirical evidence to show it – the great bulk of a mandate’s cost will fall on workers with wages above the minimum wage. Not all of it, I guess, because when Wal-Mart wasn’t providing health benefits for some of its workers in Maryland, it must have felt that that yielded higher profits than if it were to have provided those benefits. But still, in this case maybe, a deeper and more thoughtful common sense would tell anyone that the great bulk of that cost, if they were required to provide coverage and make a “employer contribution” will come out of wages, probably in the form of no raises for the next 10 years or something like that.

For workers whose wages are close to the minimum wage, so you can’t reduce the wage below the minimum, that may cause unemployment. But I think the primary argument for an

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individual mandate over an employer mandate – there are two I'm going to give here – is political transparency. I think it's important that citizens know who's paying for what, and it can be terribly confusing to think that the boss is paying for it. And then the other reason is that capitalists don't understand economics.

They think it's their money and they will fight tooth and nail to avoid an option which actually isn't going to hurt them very much, but would rather diffuse that incentive than leave it present. So for my mind, employer mandates are poison. Individual mandates are a better idea. Having said that, there is a way to engage employers in enforcing individual mandates – I have a strong opinion that in many cases where the benefits manager of the firm is skilled and not the owner's brother-in-law, but actually somebody who knows that they're doing, the most efficient way for people to get their health insurance arranged may be through the job.

To achieve all of the economies of group purchase, an employer may need to say to prospective workers, "If you work for our company, you take our insurance. Work for somebody else if you don't want to do that." So going to the extreme of giving the employees the right to opt out of a group seems to me to be both inefficient and not consistent with decentralized markets.

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What I think is generally debated about mandates is not so much the fact of mandates, but what the content of the mandates are. Should it be universal and comprehensive for all? I think the things to worry about there are two. One is for upper and middle-income people - do they really need comprehensive coverage? We buy it when we can, although we have a big tax subsidy pushing us in that direction, but certainly permitting people to purchase policies with high deductibles if they have income levels that allow them to be able to afford the deductible seems like a door we'd want to keep open.

The other downside with universal and comprehensive coverage for all is that every provider or sub-group will be lobbying for their coverage to be attached to the general plan. I think Jon Gruber may say a little bit about that in Massachusetts.

There's a kind of Christmas tree effect that goes on here. One specific insurance model for all of this is actually a kind of empirical question behind this that hasn't really been investigated. Do people have the same preferences when it comes to the kind of health insurance they want, or do they have different preferences? My perception is they have different preferences. Look at Medicare after all, I mean big Medicare, which is uniform for everybody, but 90-percent of the people who buy it buy a supplemental policy. They take this

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one-size fits all and then pay for custom tailoring. It does suggest that people have variations in their preferences.

So my preference would be, at least at the start, to go with a rather light hand on what the coverage has to cover, maybe specifying a minimum actuarial value and minimal acceptable coverage. Mandates and subsidy - well, technically, once you have a mandate you don't need subsidies, right? If you can make people do things, you don't need to pay them to do it. They only affect distribution.

It does give you a lot more freedom of movement for policy makers and policy design, which is what some market-oriented people fear most. But here I think this is as close to the current presidential campaign as I'll get. I'm trying to avoid it, both commenting on it and being part of it. But there is, at least to me, a logic that says if you have put in place a subsidy program that is adequate in the sense that it makes coverage affordable for everybody, then there's not really a strong argument against mandating that people take that coverage.

If, on the other hand, you are afraid that the mandate will cause people who can't afford coverage to be forced to buy it, it must mean your subsidy isn't as big as it ought to be, so there is a connection between the two. Another way to say it, I guess, is that to some extent the mandate can be sort of the canary in the coal mine. If it's too hard and undesirable

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to mandate a given subsidy plan, it probably means the subsidy plan is not adequate in terms of making coverage affordable.

Having said all that, nobody really knows what affordable means, although Kate Bundorf and I can give you a million definitions if you want them.

What about enforcing a mandate? Well, first of all, a universal mandate does not have to be perfectly enforceable to do a lot of good. If we couldn't make Bill Gates buy health insurance, it wouldn't bother me. Some undocumented people or barter traders will escape, but we don't need perfection here, at least compared to where we are today. Almost perfect is better than status quo or everything else.

I think that it will be easier to enforce a mandate if your subsidies and policy specifications - what you're requiring people to do - yield policies that are pretty close to what they really might be willing to buy. I guess that's what the last line says. The ideal arrangement, I think, would be to have a mandate that only is needed to deliver a small push to those people, again, who get up in the morning and don't worry about health insurance, toward a desired policy rather than a total arm twisting.

Is there a way to enforce a mandate? Well, this is a benchmark idea. I'll be listening with great attention to what Gene and Paul have to say. This is what a group of us proposed in 1991. We specified that the mandated coverage be means-

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tested subsidies and means-tested minimum coverage, and that would yield an individual obligation which was supposed to be affordable. The way to enforce that is when you take a job, you have to fill out a W-4 form.

In the new regime, if you have a certificate of insurance coverage, you attach that to your W-4 form and less money is withheld from your wage than if you can't attach that certificate.

In fact, if you don't attach that certificate, an amount is withheld from the wage as a tax or penalty for not having insurance, which is just enough to raise the money that you would have had to pay anyway to buy the qualified policy at your income level. That solves everything probably too neatly.

How about rugged individualists? Only right-wing law professors argue about this, at least that's been my experience. But they do argue about it. Why should people be forced to have health insurance if they don't want it? I thought of two ways to deal with this, one flippant and one maybe a little serious.

You could have a no-insurance card that people would have to carry that says, "Do not help me in case of accident or emergency. I made my choice." [Laughter] Or, somewhat more seriously, I think you could require uninsured people to post a bond, to have a health savings account or some kind of

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earmarked account that would be there to cover at least a lot of the costs of charity and bad debt care.

Actually, I think if you started there, you'd end up with them ending up with insurance, so that might be a solution. I guess I have a third solution here, which is tell people to grow up. [Laughter]

So, my conclusion is that mandates should not be the centerpiece of health reform. Health improvements in the capability of additional insurance coverage to produce them, consumer behavior and distribution should, the mandates that nudge with the deft hand can help a fair amount, especially in dealing with the problem of people viewing virtually any scheme, no matter how carefully designed, as problematic. I once wrote an article talking about regulations to prevent things happening that probably won't happen.

There is a tendency to want to have every string tied up. Modesty and realism compels me to say I don't think anybody can come up with a plan that's perfect from the beginning, and we ought to actually design plans that can be modified when we learn more. "I was wrong" should not be something that a politician never wants to say. And if we build some experimentation in at the beginning, you may be able to work towards something that has real permanence. Thank you.
[Applause]

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JONATHAN GRUBER, PH.D: Thanks, Mark. That was a really fantastic introduction. I think Mark has perfectly introduced this because he was on this before most of us were. We're all sort of newcomers. It's the hot topic. Mark is the guy who's been talking about this for years, so I hope he gets the credit he deserves if this eventually becomes part of our national law.

I want to talk about the one experience we do have with mandates, which is in Massachusetts. As you all know, in April 2006, governor Romney signed the Massachusetts Health Reform Law, which includes an individual mandate, the first such mandate for health insurance in our country. What I want to do is talk about what the mandate is in Massachusetts, how it functions, and then along each step talking about the set of issues that have arisen so we can both look at the specific case and the set of issues that have arisen.

So, what we have is a situation where all individuals, by December 31, 2007, were mandated to have health insurance, with some exemptions that I'll come to, or they would lose their individual tax deduction, which is worth about \$219, so not a very big penalty. The law stated that starting in 2008 the penalty would rise to half the cost of health insurance and that it would actually be assessed monthly, so, for every month that you go without health insurance, you would have to pay half your monthly premium for health insurance.

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Immediately, this raises a number of important questions which we on the Connector Board have tried to resolve and are still not quite there. The first issue is one that Mark raised - what are you mandating? What is the minimum? I talked about this yesterday and the trade off with affordability. I'd just remind you the issue is obviously the more comprehensive package you mandate, the more you have to subsidize to make it affordable.

Moreover, the more comprehensive package you mandate, the more you're telling people who are now insured, "You know what? You're not really insured. We're telling you what's insured." So I think that's led me to think that you want a fairly low minimum. We've decided in Massachusetts on a plan with a \$2,000 deductible and a \$5,000 out-of-pocket maximum, but with preventive care or generic drugs covered before the deductible. I think most economists who are familiar with the Rand Health Insurance Study would say that's pretty close to what economists think is optimal health insurance, so I don't view that as a skinny or insubstantial benefit package, but many would.

I think if you want to go beyond that - in Massachusetts, since it's such a generous state, that was low enough that we ended up with maybe, out of the few million insured in the state, maybe 35,000 who have insurance that generous. In California, if you went with that, you'd be

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talking about millions of people who have insurance less generous than that, and that's a real issue you'd have to face. So in California we're talking about more like a \$5,000 deductible minimum policy.

Many people view that as offensive, unaffordable, but you've got to ask yourself, if you're going to make a \$2,000 deductible in California, you're going to be telling 3 to 5 million people, "Sorry, this reform, which is supposed to cover the uninsured is also going to affect you as well." That raises some political problems that we talked about yesterday, so that's the first issue.

The second issue is, well, how big should the penalty be? As I said, the Massachusetts law, which was an amazingly vague piece of legislation, really astoundingly vague, just said up to half the cost of insurance. Well, in fact, we have a cost of insurance that varies along the income distribution, by age because it is age rated about three times poverty, and by region. So potentially there are about 80 different penalties that could have been levied in the state. The Department of Revenue said, "We just can't do this. You need to simplify this."

And we therefore had a bit of a debate about simplification and basically what was decided was to have a penalty which is half of the premium cost for a 27-year-old. For young people, we have a separate low premium, so they have

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a separate penalty, which is half of that. For people above 26, we are setting the half of the premium for a 27-year-old in Boston, which is basically where the bulk of the uninsured reside. Now, I raised a bit of a stink about this and got nowhere because I felt that it was wrong to not have an age grading to this penalty. In particular, while this penalty amounted to 50-percent of the premium for the 27-year-old, it amounted to about 25-percent of the premium for a 64-year-old. It wasn't clear to me why we should have a penalty that was smaller effectively on a senior than on a younger person.

Now, the counter argument is, well, it's not smaller. It's the same dollar amount. It's the dollar amount that matters. One of my board members said, "Well, this is ridiculous. You wouldn't have a higher speeding ticket on an old person than a young person. Why would you want to have a higher penalty?" My answer back was, "You would want to have a higher speeding ticket if the old person is more likely to kill people when they speed."

And the answer is that the 64-year-old, if they avoid the mandate, exerts a potentially larger externality by using more medical care outside of the system. That's why their premiums are higher. So I felt that it was wrong to not have an age-rated penalty. I was sort of booed down on political ground. One of my poor members even said, "Gee, now I know why I dropped my economics PHD program." [Laughter] Which I

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thought was kind of a cheap shot. [Laughter] But, in any case, actually if you think about it, you really do want at least some age rate in the penalty. The level is a harder issue. I don't know what the right answer is there. I think half is probably decent, but that's a harder issue.

So, we have the level issue, we have the structure issue, which is to have higher with age. We have what are you mandating. The next issue is exemptions. As I said yesterday, we talked about the three tools we can deal with affordability. We have subsidies, we have what the minimum level of coverage is, and then we have exemptions.

In Massachusetts, we have both systematic and case-specific exemptions. What we did is we mandated that everyone who's subsidized has to have health insurance. This comes to Mark's point. The view was, look, if we feel the subsidies are sufficient, than we feel they should buy the health insurance. In particular, our actuaries told us if you did not mandate, then you could be talking about premiums in our subsidy pool which are 25-percent higher because of the adverse selection.

So we felt it was a pretty strong argument for mandating everyone below three times poverty who's in the subsidized pool. We also felt that it was appropriate to mandate everyone above median income. Our feeling was that if you feel that health insurance is not affordable at the median income, than we really can't have a mandate at all, so that was

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another cut off. That left us with between 3 and 5 times poverty.

The median income is about 5 times poverty in our wealthy state. There we put in what's called the affordability schedule. We had a certain percent of income, which essentially ramped up from the subsidized level to fully phased in at five times poverty. We've exempted - the numbers are hard to come by precisely - perhaps about 15-percent of the adult population. They got exempted because they were in that 3 to 5 times poverty range.

Another issue, however, was what about case-specific exemptions? We also have in the law that individuals can appeal on a case-specific basis. If your house burned down, if you're the victim of domestic violence, if you have a significant death in your family that has affected your ability to earn a living, et cetera. There is actually an individual appeals process. I think a very interesting question is how we trade off the more systematic approach versus the individual approach.

At one level, many people felt, look, let's just mandate everyone and let's let them make individual appeals if they can't meet it. The feeling was that that would be sort of administratively overwhelming. On the other hand, you can say, "Look, we have the systematic mandate. Why have any individual appeals? We decide on affordability and we're done." So think

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the interesting question will be how much these individual appeals get used and what the right trade off is between the more systematic, income-based approach and the more case-specific individual approach.

Another issue is how generous should the alternative be? This comes to the work Mark talked about that Brad Herring did. We had in Massachusetts what was called an uncompensated care pool. After all, the whole idea of our reform was to see-saw. We were already spending \$600 million a year caring for uninsured. Let's draw that down and instead deliver it in upfront subsidies. That was sort of the miracle math of this plan - we won't have to spend any more.

We'll just take the money we're already spending in the back end and move it to the front end, in terms of subsidies. However, to make that work, you have to get people to stop using uncompensated care pool. This issue is how tough you are going to be on people who say, "Look, even though health insurance is subsidized or even if I'm rich, I don't want to pay the \$35 or \$70 a month.

I'd still rather get it for free at the hospital." That's something we're struggling with. So far the uncompensated care pool has not gone down much. We are, quite frankly, probably not being tough enough at telling people, "I'm sorry. You are mandated a private health insurance. You can get it for \$70 or \$100 a month if you're in the subsidized

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range. What are you doing coming in here and trying to get it for free and screwing up our financing?" So basically that is a real issue, but how do you do that?

You can't lock the doors to the emergency room. Once they're in, you have to treat them. I think the real issue is that what we've done so far is we essentially have a one strike and you're out rule. You can come in and then we tell you, "Hey, you'd better sign up. Don't come back." We'll see how well that works, but that is another issue they have to struggle with.

Two more issues - one is what do we do if this doesn't work? What do we do when the 30-year-old superman person earning \$25,000 a year says, "Look, I don't want to pay \$100 a month for health insurance. I just don't think I need them at that subsidized rate. I just don't want to do it." What's going to happen with the political backlash there? We just haven't hit that yet. That's potentially the biggest barrier to the success of this law.

Then finally, let me end with a story that talks about the role of employer mandates. Mark mentioned employer mandates. Employer mandates played a wonderful political role in Massachusetts. Romney proposed his law to the legislature with no employer role, no employer financing role. The legislature immediately said, "Fine, we're going to take your law and we're going to add a pay or play component, maybe 5 or

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6-percent of payroll, a pay or play component." That was all that was in the press.

If you look at the *Boston Globe* from fall 2005 through early 2006, the articles were things like "New Law to Impose Big Taxes on Business." And then the last paragraph would say, "Oh, yeah, there's like an individual mandate or something in this law, too." So what happened was that was all the debate. At the last minute, they killed that and passed the law. It was delightfully Machiavellian. It wasn't on purpose, I don't think, but in the end we end up with this trivial \$295 per year per employer charge on firms that don't offer health insurance and a law that no one knew what they were getting into.

So in some sense, if you ask how this could have happened in Massachusetts, it may have been that the cover of the employer mandate was exactly what we needed to get the individual mandate through. I think it's sort of an interesting story of other states who actually need employer mandates to finance things, like in California. I haven't had time to talk about California. I was pretty involved there. I'm happy, if there's time afterwards, to talk about what could have happened there as well. Thanks. [Applause]

KIEKE G.H. OKMA: Thank you very much to NASY and NPA, the older, sort of non-wine agency 00:31:07 that helped to sponsor my study for this conference. I first, before I start,

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want to raise an issue of re-distributional justice. This county has about 300 million inhabitants. My county in the Netherlands has about 16 million, so we are about 20-percent of your population. Out of the 660 minutes of speaking time at this conference, I only get 12. [Laughter] Now, that's not fair is it?

And I'm not even talking about the rest of the world, because I'm the only one speaking from another country and even though we are small, we are somehow representing the of the world. And then I speak slower. I think Jonathan speaks twice as fast as I do, so what's the justice here? [Laughter]

Let me start with a brief story about a Canadian Premier [inaudible]. A couple of years ago he went to Sweden. He visited Sweden for two or three days and had an interview with one of the leading papers in Canada. He noticed in Sweden that the Swedes are pretty healthy. They pay far less than we do in healthcare, plus most of them were blonde. So his solution was easy - let's dye our hair. [Laughter] I did my editorial in English and then a French-speaking paper. The French-speaking paper left it out.

But anyway, it's a warning. It's a warning not to scout around quickly and draw inferences too quickly. I also have two remedies. One is get out your passport, travel more and spend more time looking at other countries. The second one is read my extensive paper if you really want to know about the

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Netherlands. If you haven't read that, you really can't talk to me about the Netherlands. Well, perhaps you can try a little bit.

Let me raise 10 points. My new technology, my ten-point technology is only using 10 fingers for the sake of simplicity. One is can we learn from the Dutch experience? Well, we've had a lot of recent attention in the media, *Wall Street Journal*, *Washington Post*, *New England Journal* - sadly, most of the things you have read are not true, are inaccurate and are misleading.

For example, the *Wall Street Journal* claimed that the new system in Holland is reducing that wait list. False - the wait list went down already, just before this scheme went in power. Professor Antolfen [misspelled?] claims that this new model of Holland is well suited for US cultural preference, well suited for your cultural preference. Keep that in mind and we'll see how that works.

Sherry Kleats [misspelled?] and her colleagues take it as proof that individual mandates actually work. The *Wall Street Journal* characterizes the system as competition with a small dose of government regulation. In my letter to the *Wall Street Journal*, I said, "Well, actually, it's a little bit of competition with an enormous dose of government regulation." But we'll see that later.

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So my first point is to watch out. Don't believe stuff you read easily. Before you seek to draw lessons from other countries, make sure you know enough about the experience there.

Second, how is the Dutch experience labeled? What do we call it? That's an important one because labels mostly obfuscate reality. They may express ambitions or claims. They may not be clear. They may have implicit assumptions about behavioral change, they claim results without substantiation, or they may be unknown to your audience. This year in three different classes - one at Columbia University, one at NYU and one at Stony Brook College for 200 medical students - I raise the issue to the students. I ask them, "What is social insurance?" Not one single student knew the answer, not one. So that [inaudible] still has a field to work on, I would say. [Laughter]

Other labels that pop up in the discussion about Holland are the notions of managed care, private insurance, consumer-driven healthcare, mandates, even socialized medicine, so there is a whole world of ideology, preferences, truths and half-truths and non-truths behind that. Be careful you recognize those labels.

Third, what is it - what is the Dutch experience actually? Two years ago we, with remarkably little political opposition, did away with the system of socialized health

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insurance system that we have had in place for over 100 years. So all of a sudden we did away with that. We replaced it with a system, sort of a universal mandate it seemed.

The rules, however, very closely resembled the rules of the formal social insurance. Everyone has to sign. No one can be turned down. All employed people pay part of the contributions, which is still the same as in the previous system, as earmarked taxation via their employer. The other half of premiums are flat-rate premiums paid directly to the insurance agency. It's about \$100 or \$140 a month per person. The coverage is identical for everyone in the country and it's almost identical to the previous coverage. No one pays his way into preferential treatment.

Like in other countries, you can talk your way into preferential treatment, but you can't buy your way into preferential treatment. There is a lot of regulation. Here I think I have come across what I have described in a little commentary in *Health Affairs* in 2000 as Professor Alan Antolfen's duck [misspelled?] problem. I claimed when Antolfen started these consumer-driven healthcare ideas in the '70s, he was talking about private markets.

And 20 or 30 years later, over time, he's been adding all sorts of restrictions. If you want to have mandates, you have to define what these people are covering themselves for. If you do that, you need some sort of cross subsidization. If

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you want to make it work, you have to make sure that as many people as can get into the pool. You have to make the pool watertight, because otherwise you get these sort of self-selecting ligatures. There was a very confused discussion yesterday because it wasn't clear whether we were talking about the pools of social insurance or private insurance. It makes a huge difference.

So if I added up all the things Antolfen had added, I concluded, well, it walks like a duck, it quacks like a duck, it swims like a duck - to me, very much, this new plan sounded like a duck to me. Well, he didn't really appreciate that, but it's an important one, the duck problem.

Four, is it a shift from socialized medicine to private markets, as some people have claimed? Well, socialized medicine - I think there about two places in the world where socialized medicine still exists. It's Cuba to some extent, although there it's all a lot of legal chartered system. Maybe some parts of China, but that's almost falling apart. Socialized medicine doesn't exist anymore.

It means that both health insurance provisions and the provision of care have been nationalized. That never happened in the Netherlands. The provision of care, since the Middle Ages, always has been private, mostly charitable and not for profit. Like in England, the physicians, family doctors and a lot of other health professionals are self-employed, actually

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for-profit entrepreneurs, although they would label themselves differently. So it was never socialized medicine. It has remained a system sort of mixed with a mostly independent, non-governmental provision of care.

But we have sort of nationalized or collectivized defending side and we have now entered a bit of a fuzzy system that has never been tested really. It's hardly private. Moreover, what's very interesting, no one in the Netherlands really knows whether we can talk about a private or a public scheme. The only authority who can determine that is the European Court of Justice, and they only will do that if someone will take a case to the court. No one has done that.

For ideological reasons, the government started out as presenting the scheme as a private scheme, then realized it would go against some of the international obligations and the international trade, so we relabeled it as social insurance, but we really don't know exactly whether it's a duck or a swan. It's more - and I think Antolfen is correct in saying it's more sort of a work in progress. Professor Pauly did suggest, it does allow for experimentation because we are zig-zagging around with some of the things because we're messing up a lot of things. We have to repair that. I'll give you a couple of examples.

Point five - does the private market, or whatever it is, increase consumer choice? I think Professor Pauly is right

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in saying there's not enough evidence. We do know what consumers want. They want maximum choice of providers. In Europe, they couldn't care less about the choice of insurance. They don't really care about it.

It's the providers people want. Our aging parents or aunts or whatever, they want to have free access to their own dentist, family physician or hospital. Free choice of provider is number one. Insurance is something that people take for granted and they don't really pay much attention to it.

And the pharmacists, it's very interesting - in the social insurance, actually, de facto citizens had more choice than under the private system that had more selective contracting. Under the European rules, every citizen in Europe with social insurance can shop around and can go to other countries and the home country's social insurance will pick up the bill. Your private coverage may or may not include a thing like that, but not necessarily so. So the extension of consumer choice, ironically, is because some of the basic rules and the wider coverage of the social insurance has extended to the new scheme.

Now, is it - if we know what "it" is - an individual mandate or employer-based scheme? On paper, we call it an individual mandate so the rest of the world, in particular the American rest of the world, is very happy with that. We are a living laboratory of that. However, perhaps these two labels

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are misleading, this dichotomy. Consumer choice is associated with individual choice. We all individually are choosing. What we saw in the last two years is that the majority of Dutch are part of employment-based schemes. They sign up with their scheme chosen and negotiated by their employer.

All schemes are mostly identical across the system. In 2007, 20-percent of the population shifted schemes from one plan to the other. Over half of those were part of an employment-based package. At first, people thought, oh, wonderful. The market works - 20-percent is a huge shift in insurance coverage. However, one year later only 5-percent of population changed again and out of those, 80-percent as part of their employment-based coverage, which means that 1-percent of the Dutch population made a real general, individual consumer choice. That's hardly an individual mandate.

But does it improve healthcare? Does it help to contain costs in situations where individual consumers shop around, drive insurers and providers to offer better, cheaper care? Well, the thing that happened first was an acceleration of market concentration. Most of the insurance are now about five different conglomerates covering over over 80-percent of the markets entity and sort of anticipation of all those new schemes.

And the second one in the provider markets, there was actually a huge, rapid process of market concentration. In

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some regions of the concentration, there are virtually provider monopolies, so cost control has not been very successfully because predictively a sort of a bilateral oligopoly, as we've seen in some markets, has been driving the prices. Last year the premiums went up by about 10-percent on average and this year they went up again. So cost control has not really been very successful yet.

But, point eight, this should improve compliance. That is an interesting study of Sherry's and her colleagues. Generally, they claim, compliance is better by automatic withholding. Yeah, sure, of course. That's what social insurance does. You're in a boat you can't escape. You are in a boat with no escape, which is why compliance is 100-percent almost by definition.

What is more important, not only that in our previous system 60-percent of the population, under social insurance, were automatically insured and automatically complied, but 40-percent of the population in Holland that had not any mandate or obligation to take out insurance actually so. The insurance rate of the population, even without mandatory insurance, was less than 2.0-percent or 1.2-percent uninsured. That's a staggeringly low rate in any private market, so that's very important. That's a cultural and historical given that's a tradition. People cover themselves.

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One very interesting thing that happened last year was the number of uninsured almost doubled. Now, that was very embarrassing for our government, of course, so we tried to figure out a way to reason our way out of that. At first, we looked at penalties. We're going to go after the bastards. If you're going to be hospitalized and you're not insured, you're going to pay the hospital bill out of your own pocket, and then you have to take insurance retroactively. The fees and penalties were flying around.

Then the Health Insurance Association announced they would kick off those delinquents from their roles. Government was sort of thinking, well, it doesn't look good, certainly not in Holland. We won't like that. Politically it would really cause a stir, so they first had a study - who are those guys, the 1-percent who are about to be kicked out of the insurance roles? Well, who are they?

Well, guess - they were young immigrants, welfare recipients and single moms with families. There's a Dutch saying, "You can't pluck feathers from a frog." [Laughter] Whatever penalties you would impose, just think for two seconds and you'll know it's not a good idea. And already the local welfare offices of the cities of Amsterdam sort of had warned the government, "Don't do it. You'll be creating a mess." So, of course, government now [inaudible] on two things and interesting, very pragmatic, very Dutch, we talked - times up?

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Can I claim back a minute or two from Jonathan because this is my last argument? [Laughter]

So what government did is very interesting. I have to talk about the penalty for realizing it's not going to work. The government went and talked to the health insurance and said, "Please keep these guys on. We will take over the cost and administration to go after them. Meanwhile, we will give back the whole prepayment of monthly fees to the welfare offices." So we've been worming our way around and set up secretly a little bit of a separate risk pool. Anyway, don't think that that's something that's easy to do. The Massachusetts example shows the same thing. So what?

The points that are important - and I want to go back to one point that Uwe Reinhardt made yesterday. It's not just ideology we're talking about. It's more than that. It's a mix of ideological components, plus historical notions, plus cultural notions, plus a lot of pragmatism. It's not market or government. That's a bit of a dichotomy that isn't helpful to understand what's going on.

My last part is this - don't believe everything you read. Read more carefully. Go and travel. Be aware of the misleading labels. The new model of Holland is a hybrid, it's new, it's untested and the Dutch are very pragmatic in repairing things that are messing up our system. Private markets have not proven to be increasing consumer choice,

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they've not driven down costs, they have encouraged the market to merge and concentrate much more than before. Now, as a total counterpoint of all of that - so what? The Dutch are the happy guys.

The Dutch children are the happiest in the world. We're healthy. We don't really care so much because whatever we label it, we know our social contract between government and society means that everyone has access to healthcare. Even if people wouldn't be insured, they still have access. That's such a solid underpinning of the whole thing that messing around with individual mandates is not going to affect our society very much. Whether it's helpful is a different matter, and perhaps that's a matter of belief. Thank you. [Applause]

PAUL VAN DE WATER: I'll start while he's working on his slides. Gene Steurle and I are sharing this presentation, but the good news is we each only get to speak for half of the full amount, so equity is preserved.

Like Mark Pauly, Gene and I believe that mandates to purchase health insurance do have a firm grounding in social insurance principles of risk sharing and sound financing. But while well-grounded in principle, mandates must confront important administrative challenges, as listed on this slide. Most important, a mandate to purchase health insurance, as we've heard many times over the past day and more, require that

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subsidies be made available to make sure that health insurance is affordable to all or nearly all. Given the long history of less than full participation in means-tested benefit programs, administration of mandates and subsidies, therefore, need to be carefully coordinated.

More generally, I think our conclusion is that it's important to emphasize compliance over enforcement. That is, it's better to get people signed up for insurance to begin with, rather than to have to check up on them and enforce penalties if they've in fact failed to get insurance.

I do disagree with Mark Pauly in one respect, namely his contention that a mandate does not have to be perfectly enforced. Now, of course, no human endeavor can be performed with perfection, but my view as a long-time civil servant is that government should only undertake activities that they can do well. Undertaking a task that cannot be done well will further encourage and undercut confidence in the capabilities of government and, in fact, in the effort to expand health coverage.

As Christy Ferguson said yesterday, the system must be seen to be fair. Therefore, unlike Mark, I do care about Bill Gates. But I guess the good news is that I think Bill Gates will be fairly easy to check up on. [Chuckles]

Although this session focuses on individual mandates, as we've heard from Mark and Kieke and Jon, this is not to

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suggest that employers don't have an important role.

Significantly, of course, an individual mandate can increase the attractiveness of employer-sponsored insurance. That's certainly the goal and hope in Massachusetts. We've heard Kieke talk about the experience in the Netherlands.

Indeed, the Netherlands and Switzerland, the other country with an individual mandate, do provide, I think, some limited guidance for us. Both countries have achieved coverage rates of 98 to 99-percent, but in both cases, as Kieke said, coverage was almost as high under the mixed public/private arrangements that had existed before the imposition of an individual mandate. In addition, the cultural and institutional features of these two countries differ significantly from ours.

In Switzerland, for example, every resident must register his or her presence with the local population control office shortly after taking up a new place of residence. The enforcement of the health individual mandate in the Swiss Cantons builds upon this preexisting registration requirement, which, of course, we don't have. If you're Swiss and if you don't sign up for insurance or pay your premium, an employee of your Canton or commune is likely to come knocking on your door to enforce compliance.

In the Netherlands three important features hold down the level of premiums, which, of course, facilitate compliance

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with the mandate. First and not to be forgotten, of course, is that the Dutch, like virtually everyone else, spend a whole lot less on healthcare costs than we do, so the cost of insurance is naturally less. But second, half of the cost of insurance is paid for by an income-related tax, so the premium covers at most the remaining half. Finally, fully 40-percent or so of the population is eligible for a premium subsidy.

Now, even despite all of these good features about 1.5-percent of the population – by the estimates of the Dutch statistics in the Netherlands – are still uncovered and a similar amount, in addition, as Kieke said, are delinquent in their payment of the their premiums. As Kieke also said, the Dutch overly optimistically assumed that non-compliance wasn't going to be a problem, and they therefore had to play catchup ball to figure out what to do, since there was a bit more of a problem than was expected.

Both the proponents and opponents of individual mandates in this country cite our experience with automobile insurance to bolster their cause. Opponents, of course, argue that the mandate is ineffective because in some places, using the best consistent estimates, the non-compliance rate can reach 25 or 26-percent. Proponents of mandates look at recent activities in some states to show how data matching and information technology can be used successfully to crack down on uninsured motorists.

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The government's experience in collecting debts Gene and I think also carries some lessons for the enforcement of individual mandates. I think basically it says; that it's, as I said at the beginning, that it's hard to - if not pluck feathers from a goose, it's hard to collect big penalties from people after the fact if you don't have any ongoing stream of income against which the penalty can be offset.

[END RECORDING - PART 1]

[START RECORDING - PART 2]

PAUL VAN DE WATER: In the case of social security, people have gotten excess benefits. If you can withhold the excess from their stream of ongoing Social Security or SSI benefits, you have some hope of collecting it. If there isn't that ongoing stream, hope is much less.

The same thing on the tax side, the tax authorities, as in Massachusetts, are often turned to as the enforcement mechanism, but, again, the tax authorities rely primarily on getting payments continually during the course of the year. The greatest enforcement, 99-percent or so on the tax side, is when there is continual withholding, as in the case of wages. If you have informational reporting as banks report interest, compliance is still pretty good, about 95-percent. But if you don't have any information reporting and, of course, no

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withholding, compliance can be as little as 50-percent. And Gene will continue the theme.

EUGENE STEUERLE, PH.D.: If I can get to my slides, I only have a very few, I promise. I'd like to ask you to try to remember three things from my talk, whether you remember any of the details of the slide. The first one is that when I often deal with health reformers, they often want to come in to design their tax system, their own welfare system. One has to be a little careful about that. We do have lessons from tax systems we developed elsewhere and welfare systems developed elsewhere. So if somebody comes in and says, I'm going to create a subsidy or a mandate, I'm going to phase it in this way and phase it out that way, those are tax and welfare systems. They all have all sorts of tax and welfare implications up and down the income scale. There are a lot of lessons from existing tax and welfare systems of things we do well and things we do very badly.

We have to be careful about how much we want people to imitate us. I'm reminded of Chicago Cubs outfielder, Lenny Dawson, who once said, "I want all of them kids to look up to me. I want all of them kids to copy like me." [Laughter] So my second lesson is, if you're a health reformer, there's a test I want you to apply to any reform package. I want you to think about that \$30,000 to \$40,000 a year worker out there and

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what you're going to do for that worker. In the case of Jonathan, the \$20,000 a year single person, a young person who's in the market. These are people who are median or a little below median. The question is what are you going to do about them when two-thirds of them are buying insurance and they're paying - if they're a family buying a policy, they're buying these \$8,000 and \$10,000 policies.

And then you have another perhaps one-third, or whatever the number is, who aren't buying insurance. And now you have a government coming and saying, "Gee, I can't make these people pay \$4,000 or \$5,000," when a lot of them are paying and a number of them aren't paying. I'm not going to solve that dilemma for you. You'll see that a little bit in my slides, but what are you going to do about this worker? That's where I think the original Hillary healthcare reform falls apart. I think it's where some of the Massachusetts healthcare reform falls apart. People try to think they're going to do too much with this particular set of workers, as opposed to trying to figure out what a reasonable compromise is.

My last lesson, and it's the main one with respect to the mandate part of this, is don't try to ask too much of mandates. If you start out with asking whether we can use mandates as a vehicle to try to increase the number of people who buy insurance, you can go a long way. If you say we're

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going to get mandates to get ourselves to universal health insurance, you're probably making a mistake.

Taking those three comments, let me give a couple of applications. What is one of the things we know from the existing tax or, if you want to, expenditure system? Well, we got a lot of lessons from the Earned Income Credit. One thing we know from the Earned Income Credit is we can't get it in regular paychecks. The reason we can't get it in regular paychecks, the main reason is because the Earned Income Credit phases in and phases out on the basis of income, and most people's incomes are highly fluctuating.

A tremendous number of the population actually faces unemployment every year. They get in and get out of the workforce. Family structures change for 15 to 20-percent of the population, depending on how you define the changing family structure from children to divorce to remarriage and everything else. It's very hard to know in April what your annual income is going to be, so - I'm going to give this amount of money to somebody with \$30,000.

I'm going to phase it out at \$35,000. Well, if you want to do everything at the end of the year, maybe you can give a subsidy then. One thing you can't do, by the way, at the end of the year is collect a lot of money from somebody at the end of the year. So the Earned Income Credit experience tells us it's very hard if you want to have a lot of

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fluctuations, according to income and other variables, to then apply that during the year.

Now, what are some of the lessons generally from compliance? With a mandate, we're talking about collecting, right? Well, what we know from the IRS is that we really can't collect very well at the end of the years, which is why the IRS tries to do withholding during the year. That's the reason why Mark Pauly says he wants to have a withholding system to work. But withholding is only going to work right for some people because a lot of people aren't in the tax system, right?

By the way, Social Security has a flat rate. That's how they solve a lot of their fluctuating income and withholding problems. They try to have a flat rate, so, for 95-percent of the people, we have it right as soon as we collect the money. That may not be the mandate you want, but that is something that is administrable.

One of the other lessons, of course, is that employer is going to be engaged. The employer is our administrator for almost all of our tax systems, whether we like it or not. It doesn't mean that the employer has to have a mandate, but the employer is often the collector for penalties or for taxes.

One thing we do know, by the way, is something we really can do with a mandate. I think it's actually something where we can go a long way. If we think about a mandate and the penalty of a mandate is we're just going to take away

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something we otherwise give you, then it's a little bit easier to enforce. So if we think about it, at least for middle and upper-income people, if you don't comply and buy health insurance for yourself or your children, you can't itemize your deductions. Or if you want another one that I think we could have had - we could have had children's health insurance here. We could have had it.

I think there was a very easy compromise. Or we could have had it a few years ago when we bumped up the child credit. If we bumped up the child credit a little more and said here's a child credit and we made it universal, but we said you don't get the child credit unless you buy insurance. That is enforceable because what we're doing is just simply not giving something to somebody unless they perform certain actions. So that's a type of mandate that we really can make work.

I commented earlier that we can often ask too much of mandates. Think about our problem again with this \$30,000 a year worker, and think about why things like the original Clinton health reform failed. The problem was that the argument was we can't make that \$30,000 or \$40,000 a year worker pay too much. But, in fact, a great many of them already are. They're already paying \$6,000 or \$8,000 or \$10,000 a year for health insurance out of their wages. We say, "Well, we can't make them pay that amount," so we have this group of people who are already paying it, but then we

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can't give that huge mass of people subsidies because we don't think we can afford it, so we don't do it.

Well, think about an alternative. Think about an attempt with this group to give them moderate subsidies that are affordable, \$2,000 or \$3,000, whatever you think is reasonable, and we have moderate penalties that we take away from them if they don't buy insurance. Then the wedge between buying and not buying health insurance - because I'm separating the two - might be \$4,000 or \$5,000 and maybe between the two, a moderate mandate and a moderate penalty, we can actually create a big enough wedge that we can actually get something done.

But again, if you ask too much of a mandate - if you think you're going to collect \$4,000 or \$8,000 from somebody at the end of the year or even try to mandate that size from somebody making \$30,000, you will never get to municipal and you won't get it through the political system. My next slide is a very simple comment on when you're thinking about administrative agencies, the IRS is good for people who pay taxes. Welfare system is good for people who don't pay taxes. The simple fact is that we don't have a universal system anywhere for the most part, so you've got some people falling between the cracks, you've got some in one and some in the other and you're going to have to coordinate these agencies if these are your administrative agencies.

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So what's the summary? Mandates are easier if you have the following elements. I'm not saying you have to have all of them, but you need to have some combination. They're easier if they only apply above people with low incomes, so you just don't worry about applying a mandate to people with low incomes. Then it is easier. It is easier if you can somehow or another have it reflected in withholding. It's easier if it's based on existing government programs. A mandate is easier if the mandate is that we're going to deny you some government benefit if you don't comply with the law.

A mandate is easier if it operates as a simply play-or-pay system, nothing more elaborate. The reason the employer mandate, whether or not you like it - I'm not arguing for an employer mandates, but the reason that sort of works in Massachusetts is that it's sort of simple. If you don't have health insurance, you pay a little bit of money on the side. We don't get into elaborate schemes.

A mandate is easier if it involves collectable and moderate penalties. They have to be collectable and they have to be moderate. By the way, the mandate has to be moderate both in terms of the size of the insurance policy and the size of the mandate. Those aren't the same thing because you could have a penalty that is not the cost of the insurance policy.

And finally, a mandate is easier if it's coordinated across programs. It has to be coordinated across other subsidy

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programs for a whole variety of reasons, for administrative reasons, for dealing with people, for combined tax rate reasons. For a whole variety of reasons you've got to coordinate the mandate with the subsidy. You have to coordinate it with other welfare programs. Thank you.

[Applause]

GAIL CHRISTOPHER: Oh, good. I see people standing at the mics already. I didn't have to invite you. If you can't get to a mic, we can bring a microphone to you. I'm going to let the floor start. Please identify yourself and ask your questions.

DWIGHT BARTLETT: Dwight Bartlett, I'm a consulting actuary and former Chief Actuary of the Social Security Administration. I've been very skeptical of individual mandates or tax policies which would shove many millions of Americans into the individual insurance market, given the low ratio of expected benefits to premiums on individual policies. I wonder if the panel would comment about that.

JONATHAN GRUBER, PH.D: I think that's a very good point. I think it sort of relates to - this panel is just about mandates - where they fit in the broader context. I guess I've been viewing it as that any [inaudible] reform is

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like a stool with three legs. You have to have subsidies to make it affordable. You have to have a place for people to go, which is a pooling mechanism so they escape the sort of harsh and unfair non-group market, and then you have to have the mandate. I think the stool falls down without all three. I agree. I think just mandating people to just go out and buy an existing market without market reforms at least, or even better a pooling mechanism, isn't a good idea. But Mark may disagree.

KIEKE G.H. OKMA: Can I add one thing? I think we're now talking about Alan Antolfen's half-duck.

MARK PAULY, PH.D.: Well, one observation is that today's individual insurance market is almost surely not what it would look like if you had a mandate, since the largest share of the administrative expense on individual insurance goes for persuading people to buy this terribly un-economic product [chuckles]. But if people had to buy a product somewhere, then it would sell itself. The other observation, at least the way I've thought about this, is that the mandate is individual. The takeup of the insurance can be group, as I said, and there's no reason to think that, for those groups that are large enough or well-managed enough, people wouldn't discharge their obligation in that fashion. There will always be writers and poets and artists, I guess, who will fall

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outside the group system, but I think they could do reasonably well in an improved individual market, which, as I said, is almost surely going to happen if the necessity to persuade people to take the insurance is no longer present.

GAIL CHRISTOPHER: I'm going to have to ask the panelists to keep their answers as brief as possible, so that we can get as many questions in as possible. I'm going to go to this side.

MERTON BERNSTEIN: Thank you. Merton Bernstein. I live in Massachusetts. I've been following the debate there as closely as I can, trying to find out as much information on what the miracle plan is supposed to do. One thing I have not heard is what it costs to administer. What does it cost to administer a program which conditions a subsidy on income, which is, as Gene just pointed out, fluctuates all the time? What does it cost to administer, to determine the size of the subsidy, which depends upon income? What does it cost to enforce the mandate as, say, compared with a social insurance system withholding, which is surely the most economical?

GAIL CHRISTOPHER: Okay, thank you.

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JONATHAN GRUBER, PH.D: I think the one clever thing the law did was spread those responsibilities across different parties so nobody could calculate the answer to your question. [Laughter] But actually it's surprisingly cheap. To do the income determination, we're piggybacking on the Medicaid system of income determination that we're already using in the state, so that was just sort of the extra marginal cost on Medicaid, which was low. The mandate collection determination and collection comes to the Department of Revenue. The actual Connector, the entire new entity that runs this entire new law, is \$25 million on a billion-dollar law, so that's not too bad. The administrative costs have actually been very low.

For the first three months the entire Connector was Jon Kingsdale, the director, and a half-time intern, so that was really cheap. But even now, fully staffed, it's about 50 to 60 people. The total budget is about \$25 million, so it's actually been pretty cheap so far to run the thing.

GAIL CHRISTOPHER: Okay, thank you. Over here?

KEN APFALL: Ken Apfall [misspelled?], University of Maryland. Jonathan, you had talked about wanting to spend some time talking about California. My question is a little bit different. What is the applicability of Massachusetts to

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California and the applicability of Massachusetts to, say, Texas?

JONATHAN GRUBER, PH.D: I think that, first of all, the Massachusetts model could work anywhere, but for the financing, which is a bit like saying, "Other than that, Mrs. Lincoln, how was the play?" People ask me, "Can you use this plan elsewhere?" There's not reason this plan couldn't work anywhere. It's not that fancy a plan, actually. There's no reason that basic three-legged structure couldn't work anywhere.

But California had two major disadvantages relative to Massachusetts. First of all, it had about twice the percentage uninsured, which means 10 times the number, about twice the percentage uninsured. Second of all, it didn't have this preexisting source of financing. California was like Massachusetts plus a tax increase in the teeth of an incredibly bad fiscal situation. So actually, the truth is - and maybe this is ex-post rationalization of the failure - if you'd rated states 1 through 50, California wouldn't have been in the top 10 or 15 that should have gone next after Massachusetts.

There are many states which are in much better shape and are much more natural to go next. So I think the fact California failed is very unfortunate, but I don't think it means that state reform is dead. I think it was sort of that

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California maybe leapfrogged above where it should have been on the list. Texas would be even lower on the list, so Texas is not happening.

But there are a number of other states which have low uninsurance rates and which are not in such dire fiscal situation that I think could very readily do what Massachusetts did. None of them are going to be as easy because we had \$600 million sitting there that we were already taxing. It's a lot easier to rededicate a tax than to levy a new one.

JOE WHITE: Joe White, Case Western Reserve University. I've been puzzling as to why in 2007 we were talking about individual responsibility and individual mandates and in 1991 we were talking about play or pay. In particular, what is the difference? That's basically my question, but I have a quick comment on it. All the democratic plans include an employer mandate, right? They include a pay or play for employers.

In any system, individuals are compelled to contribute and required to have insurance, or at least in most other country's systems, so why isn't that in individual mandate? What's the difference between what normally happens and what we're calling an individual mandate here? To me, there seem to be two things, but you may have other answers. One is that enrollment isn't automatic, which means that an individual mandate is a situation which is, in fact, less mandatory than

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most of the social insurance systems where the enrollment is mandated, but it's automatic, so you don't get a choice about it. It's really a penalized choice as opposed to an automatic enrollment.

The second and huge thing is that it's an individual subsidy. That's the big difference here to me. Individuals are supposed to buy insurance at a flat rate and then get an individual subsidy. Jon Gruber has now given two talks which have convinced me that this really absurd. This is really very, very hard to do.

It makes it very, very difficult, as opposed to the norm, which is that there is a pool and the government or whoever subsidizes the pool. And then, as Gene Steurele referred to, individuals basically pay a percentage of income, but they are mandated to participate and they are mandated to contribute. What is the difference here? Aren't we really talking about individual subsidies, rather than individual mandates?

JONATHAN GRUBER, PH.D: I'm going to let others address this, but just a quick clarification. Massachusetts works just like you said. The subsidies don't go to the people. You are billed a certain amount and then the state pays the difference to the insurance companies. Go ahead, Gene.

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EUGENE STEUERLE, PH.D.: I think this goes a little bit back to Mark's notion on transparency. I think the social insurance notion behind - social insurance is not the progressive. We can redistribute the people a lot of different ways, so we can distribute also the money we want to the poor. What a mandate and the social insurance gets into is even after you go through that redistribution, are we requiring people to spend some of that redistribution on health insurance?

We're saying that, yes, we are, which makes it for me really more of a horizontal issue than a progressive one. That maybe sounds strange. I get all the progressive I want without dealing with health insurance. So once we talk about equal treatment of equals, it's you buy insurance and I don't and the reason we get into social insurance and a mandate is saying, no, that's not fair because you're going to fall back into a free care system.

The problem, it seems to me, with the '91 proposals is mainly because they sort of centered on the employer. They hid that notion that we had obligations. They hid who was going to pay. They often hid what the progressive of either system was because, in fact, the employer mandate we think is paid by individuals, so we just got some very strange results.

On top of which, by the way, we left out all the people that were in the employer system. So you're right that there is a close correlation between what you could achieve, in

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theory, between employer and individual mandates, but I think in practice the employer mandates ends up hiding a lot of what's going on and dodges that fundamental, horizontal-equity, equal-justice system that if I buy insurance and you don't and we're equals, that's not a fair system.

MARK PAULY, PH.D.: I guess I have two points. One is if you want employers to pay for health insurance for people, an employer mandate won't get you there. You need to impose a tax on profits and use that money to pay. That would be fine with me, even though I teach at the Wharton School. [Laughter] But that's how you'd have to do it. If you impose it on the employer, either the cost goes back to the workers or workers are laid off if their wages aren't high enough that they can absorb the cost. That's a reason not to do it.

The other reason is a political reason. I actually wrote a book on this and the amateur political science there pointed out that one of the most vociferous and I think one of the most effective opponents to Hillary care was the National Federation of Independent Businesses. When I would talk with them - because we were supposed to be on their side as being against Hillary care - they would say, "We can't afford this." And I would say, "You don't understand economics." So I think copies of my books are available in the remainder pile at various local bookstores, [laughter] but the basic punch line

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is employers seem so terminally confused about whether it's their money or whose money it is. That doesn't seem like a good model for political decision making and it doesn't seem like a good model for political equilibrium.

GAIL CHRISTOPHER: Gene, you wanted to respond?

EUGENE STEUERLE, PH.D.: No, I wanted to just say one thing. Clearly, an individual mandate could be viewed as a tax by another name, but sometimes names do make a difference.

GAIL CHRISTOPHER: Okay, we have a question from this side.

DOUG ANDREWS: Doug Andrews, University of Waterloo. This discussion has taken on a bit of an international flavor, so I'll speak at this point. I'm a Canadian and I'm a member of NASI. I did come here to understand why you do not have everyone covered for certain medically necessary physicians and hospital services. I do congratulate NASI on organizing this conference.

Ruth Faden declared her perspective that it's a matter of social justice that everyone has coverage for medically necessary services, and I share that perspective. There's a tremendous amount of rhetoric in this area, and it's easy to

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get distracted and to debate at cross purposes. The critical point should be to ensure that everyone is covered for certain medically necessary physicians and hospital services.

Having 47 million or 15 million or 1 million uncovered for basic care services should not be acceptable. But when we speak of universal coverage we should mean coverage for everyone for certain services. We do not mean coverage for all services. All the political candidates appear to agree that people should have access to insurance, but disagree on how to provide that access. The ensure coverage for everyone will require more than mandating coverage and expecting people to have private coverage with or without subsidies.

Does that mean that government provides all services? No. For example, in Canada, most hospitals are private and most physicians are in private practice. Does it mean that government is a single payer? No. For example, in Canada, government pays for approximately 70-percent of healthcare. The other 30-percent is paid by insurers, employers and individuals. The comparable percentage paid by government in the US is approximately 50 to 60-percent, depending on how you count certain items like tax expenditures.

Does it mean higher taxes? It does not have to mean higher taxes. The US spends about 16-percent of GDP on healthcare, of which taxes for healthcare represent 8 to 10-percent of GDP. In Canada, we spend 10-percent of GDP or

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healthcare, so taxes represent about 7-percent of GDP. You're already spending more for government-funded healthcare than any other country in the world. How much do you want to spend? That is a separate question. There is no perfect system.

The biggest complaint of Canadians is that waiting lists are queues. No one with a medical condition wants to wait, but the waiting is based on assessments of medical necessity. When I take my son to emergency with a broken arm, we have to wait four or five hours. When I take my daughter to emergency because she's overdosed on pills, the doctors start work immediately. I think that's the right way to determine queues. The key is that my son and daughter both have coverage, regardless of their income, whether their parents have insurance or how much has been spent on them already, et cetera.

GAIL CHRISTOPHER: I'm going to have to ask you -

DOUG ANDREWS: I've done comparisons of international healthcare systems trying to measure costs and quality. I do not think the US is getting good value for its expenditures, but that is a different issue. You can address it later on or not. You do not have to pay more taxes, but there will be tradeoffs. The critical point now is to focus on ensuring that everyone has access to certain basic services.

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Do not accept partial solutions like the Massachusetts plan where thousands of people do not have coverage because they do not qualify for subsidies or don't qualify for employer coverage and can't or won't pay for coverage. Commit to having everyone covered for medically necessary physicians and hospital services. Other nations and countries have done it. Americans have great willpower. You can do it. My question is [laughter] when? [Applause]

GAIL CHRISTOPHER: Okay, does any panelist want to respond? [Laughter] Thank you very much for that input. Next question.

LARRY SEIDEN: I'm Larry Seiden [misspelled?], I'm professor of economics at the University of Delaware. I've been very influenced by reading the articles of Mark Pauly and Gene Steuerle in the '90s and Jon Gruber's in the last decade. Jon's a little younger than they are. All of them have emphasized that if you have an individual mandate - and I personally favor it - to make it affordable, we've got to change the tax treatment, in particular to replace the inefficient and regressive tax exclusion.

It would be a big source of money. Replace it with a refundable, progressive tax credit. So what I'd like to ask any of the three of them is to explain why in your articles

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you've emphasized that this would be such an important component of a package.

EUGENE STEUERLE, PH.D.: I think they're going to me because I'm maybe the oldest of the group writing on this. I think it's one component and it's an important component. Just as my discussion with the mandate, my problem with health reform is I think we keep demanding too much. We start off with the claim we have to do everything before we can do anything. The existing tax exclusion is broken because it's regressive and it creates very bad incentives.

Because of the margin, it provides incentives to buy more and more insurance. Everything we do to increase cost of the system is, by the way, in Jonathan's number I understand is basically driving up the number of uninsured. So it is an important component. Our discussion here is mainly on mandates, so that's why we didn't discuss it too much in this session.

But you'll see that almost every speaker here talked about mandates and said, now how do we coordinate the mandates with the subsidies? And one source of the subsidy would be, of course, converting the exclusion for employee-provided benefits.

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MARK PAULY, PH.D.: Well, when I was young and foolish I thought and actually calculated that you could pay for a system of subsidies that would be equitable and would allow everybody to have health insurance using the money that's currently being used as a subsidy through the exclusion. More people would have gained than lost with that kind of conversion, so I was very excited and came to Washington and showed that 60-percent of people would gain. And then I was told it's not right 60-percent. [Laughter]

I think it's the politics of an ingrained middle-class tax break that make it hard to mount a frontal attack on it. I do want to endorse what the administration proposed this year, which was to give everybody a capped deduction if they health insurance meeting very minimum qualifications. I thought that was a pretty clever way to sail through the political shoals. That part of it, though, as critics quickly noted, is not going to help low-income people very much.

You need a subsidy to help low-income people. But what could, of course, come out of capping the tax exclusion is a lower rate of spending on healthcare, which is sort of the other problem. But we might as well continue to talk about the problem we can solve and not about the problem that nobody has a clue as to how to solve.

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JONATHAN GRUBER, PH.D: Well, I am young and foolish and I just did a paper for the Hamilton Project which showed that Mark was right. We could have a very generous plan, more generous than the Massachusetts plan nationally, and have \$40 to \$50 billion a year left over if we paid for the employer exclusion. The employer exclusion is the third largest government health program in America after Medicare and Medicaid. It's a political third rail. It makes Social Security look like a walk in the park.

But it is the purpose of everybody who cares about this topic to continue to push this battle. No health economist that I know of - we started behind the veil of ignorance and said, "How should we spend \$225 billion a year?" We do it through the employer tax exclusion. Basically, we need to take this issue on and keep battling. We've made some headway in the Bush proposal.

Hillary Clinton has put her toe in the water by capping it for some people. So it was in the presidential panel, Presidential Tax Panel Report to cap it, so we are making some progress. Gene and Mark led the fight. I think we need to keep this fighting going on to say, "Here's a pot of money we could use so much better. Let's keep railing for it even if the politics is against it."

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GAIL CHRISTOPHER: We have one more question from over here.

FEMALE SPEAKER 1: Hi, I just wanted to challenge one of the assumptions that seems to keep coming up in these presentations, which is that somehow if you don't have insurance, you can just go get free care. That is just not true. Certain hospitals provide a certain amount of charity care. Public hospitals will provide charity care.

MARK PAULY, PH.D.: Who assumed that?

FEMALE SPEAKER 1: Excuse me?

MARK PAULY, PH.D.: Who assumed that if you don't have insurance -

FEMALE SPEAKER 1: I've heard almost every speaker say "or you can choose to go get free care."

MARK PAULY, PH.D.: It'll be free, but it won't be as much.

FEMALE SPEAKER 1: It won't be free. Hospitals, in fact, subsidize the insured population by charging uninsured

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patients much higher rates than they're billing insurance companies, and I think this whole discussion assuming that people can just easily go get free care - if you look at the way the uninsured behave, that is not how they behave. In fact, they avoid getting care until they have no choice about getting it, and then they're faced with huge hospital bills that they can't pay.

The other point I wanted to make is that I think there's always going to be a certain percentage of the population - if nothing else, the undocumented workers - that no one is talking about covering. We do need a safety net for those people. San Francisco's model is very interesting, in that it allows the medically indigent to go to any public clinic or hospital and actually get free care. I think that we need to maybe understand that an insurance system will not necessarily work for 100-percent of Americans. The bottom line is access to care, not access to insurance.

GAIL CHRISTOPHER: Thank you. Does anyone want to respond? We have two people responding, I think. Yes, Gene?

PAUL VAN DER WATER: I agree with Mark. Certainly none of us here on this panel, I'm quite sure, believe that people without insurance have access to the same kind, quality and amount of care as those who do have insurance. That is exactly

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why we're here and discussing these issues. We're all searching for the best way to deal with this problem. As far as the undocumented workers are concerned, that's a big problem. Again, Gene and Mark at least have pointed out that we shouldn't expect an individual mandate to solve every problem. The problem of undocumented workers is certain amongst the ones that will not be solved by an individual mandate.

GAIL CHRISTOPHER: Mark, did you want to respond?

MARK PAULY, PH.D.: No.

GAIL CHRISTOPHER: Well, believe it or not, we've kept within our time frame. I would just like to say that our conversation focused on the issue of mandates and did not really delve deeply into the context of personal responsibility as it relates to healthcare costs, which I think is driving the discussion. So I would encourage us at some point to really unpack this conversation of individual or personal responsibility and the relationship between health insurance and access to it and personal responsibility.

I wish we had had a little more of a conversation about that, which would have driven us more to the population that we're really talking about. Who are they and what are the

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issues contextually that influence behaviors and manifestations of personal responsibility.

I want to thank our panelists for a wonderful, intriguing dialogue. [Applause] We are going to take a half-hour break while there is a set up for lunch. Thank you.

[END RECORDING - PART 2]