Health Reform Forum: Are Individuals Mandates the Answer?
National Federation of Independent Business
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ROBERT GRABOYES, PH.D.: The National Federation of Independent Business welcomes you to today's health reform forum on individual mandates. I'm Dr. Robert Graboyes, Senior Healthcare Advisory for NFIB, the nation's leading small business association. This spring, NFIB is convening four forums to generate productive dialogue on healthcare reform. For several decades, NFIB's members have declared healthcare to be their number one concern, so we have adopted the following motto: When it's fixed for small business, it's fixed for America. And the facts give credence to our motto. Most of America's uninsured are small business owners and employees. The effects of rising costs are especially brutal on small business, and the fear of losing insurance coverage deters countless Americans from pursuing their dreams of owning their own businesses.

Today's forum focuses on the idea of an individual mandate, a legal requirement that all Americans have either private or public insurance. Now NFIB has not taken a position on the individual mandate, but given the prominence of this issue in public discourse, we want to facilitate an airing of the pros and cons of this idea.

The individual mandate is somewhat unusual in that its supporters and opponents cut across partisan and ideologic lines. Today's panel, to the best of my knowledge, contains at

least one of the following: Democrat, Republican, Independent, conservative, liberal, libertarian, individual mandate supporter, individual mandate opponent, and individual mandate agnostic.

It's difficult to guess where the arguments over healthcare reform will take us in the next few years. I am confident that in the end we'll be able to look back and paraphrase Lincoln: The prayers of all could not be answered, those of none have been answered fully. So what can we hope for? My fondest wish is that if we were to reconvene this panel, say five years from today, each panelist would say I am deeply unhappy with many recent changes, but clearly our healthcare system has improved since 2008. And this, I believe, is an attainable goal. And what should we fear? My concern is that without substantial changes in healthcare laws, policies, and markets, all four panelists would agree in 2013 that I'm delighted that we didn't do some of the things that were being discussed, but on the other hand, things are clearly worse than they were back in 2008. Of course, these four would disagree sharply over which aspects would get worse and which preventive measures would have been desirable.

That's why for us at NFIB it's so important to here divergent views. Today we're fortunate to have convened four nationally recognized healthcare policy experts. I will give

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you the briefest of introductions and let you read about their biographies in your folders.

First is Michael Cannon, Director of Health Policy Studies, Cato Institute. Second is Peter Harbage, Senior Fellow, Center for American Progress. Third is Bob Moffit, Director, Center for Health Policy Studies at the Heritage Foundation. And finally, Sherry Glied, Professor and Chair, Department of Health Policy and Management at Columbia University.

We're going to begin, I'm going to invite each of the panelists to make a few remarks, and afterwards we'll have Q&A from the audience, and I'll have a few other questions myself. Today what we are hoping to cover, first of all, is a few questions that we'll begin with. First is universal coverage, much talked about in the press, attainable without individual mandate.

Secondly, if you have an individual mandate, can you enforce it? If so, how? And third, if you have an individual mandate you, by definition, must define health insurance, requiring you to find a minimal benefits plan. So the question is how do we devise a mechanism, can we devise a mechanism to prevent the cost of this plan from swelling uncontrollably? And four, since this is NFIB, we're especially interested in hearing how might an individual mandate impact small business.

And let me turn it over at this point to Michael. You can do it here, you can do it there.

MICHAEL CANNON, M.A., J.M.: I'll go ahead and come up here. Thank you very much, Bob. I want to thank Bob and NFIB for inviting me to participate and inviting me to be a part of this really impressive panel. When you think about an individual mandate, I think it's important to ask what it is you're trying to achieve when you're weighing whether or not to support such a mandate. For example, if you want to improve people's health, I don't think there's any evidence at all that an individual mandate is really a good approach or much less the best approach. If it's saving lives you're after, according to the Institute of Medicine, from two to five times as many Americans die from medical errors in the United States as from a lack of health insurance.

So if you're interested in saving lives, maybe you might want to focus on something other than expanding health insurance. If you want to correct the serious quality problems in the US healthcare sector, an individual mandate will do nothing for you. If you want to achieve universal coverage, an individual mandate won't get you there and a lot of reasons why that's the case.

If you want to make health insurance more affordable, an individual mandate would have the opposite effect. If you want to eliminate free riding in healthcare, and eliminate

uncompensated care. Well, first you focus on a very small problem. Uncompensated care for the uninsured accounts for less than 3-percent of healthcare spending, and an individual mandate wouldn't even eliminate free riding. But it would increase wasteful spending, which has already been clocked at 30-percent of the nation's healthcare tap.

If its personal responsibility you're concerned about, you should oppose an individual mandate, I would argue, even if it comes with an escrow account option. And there are reasons for that that I hope we can get into later, but since this is an NFIB forum, let's look at how an individual mandate would affect small businesses.

If you want to make coverage more affordable for small businesses, as I noted before, an individual mandate would have the opposite effect. When government mandates that people purchase insurance, it has to define what insurance is, it has to tell people whether or not they're fulfilling, or satisfying, that mandate. So as soon as you pass an individual mandate, a line forms outside the door to find the minimum benefits package, and that's exactly what happened in Massachusetts, the one state that has an enacted individual mandate.

The Christian Scientists demanded that coverage for faith healers be included, and while they were unsuccessful, so far, the Commonwealth added prescription drug coverage at a

minimum deductible to the minimum benefits package, thereby eliminating affordable insurance options for everyone. Small business owners who provide health benefits should take note.

If you want to avoid taxes on small businesses, their owners, or their workers, an individual mandate, again, would have the opposite effect. Every individual mandate proposal includes new government subsidies to help people to comply with the mandate. Now someone has to pay for those subsidies, and who do we think that's going to be?

Well, small businesses should also take note that every time an individual mandate is proposed, be it in Massachusetts, California, by Senator Obama or Senator Clinton; Senator Obama does have an individual mandate when it comes to children. It is tied to a mandate on employers; now why is that? Well, here's one reason. "If you impose an individual mandate, what is to stop every other employer in America from just dumping his employees, or her employees, to have a sweeping and extremely dislocating chain of events start?" That question was asked by William Jefferson Clinton in August of 1993. individual mandates lead to employer mandates because people will want to forestall that possibility.

Another reason that individual mandates are almost always coupled with employer mandates, I haven't found yet a proposal that doesn't, is that when the discussion turns to mandates, the most powerful players are large employers who

benefit when mandates impose relatively large burdens on their smaller competitors. Now it may be appealing to think that an individual mandate could be dealings from an employer mandate, but experience shows that that happens rarely, if ever. So any discussion of mandates, even an individual mandate, I would argue is a threat to small businesses.

Moreover, support for an individual mandate is philosophically incompatible with opposition to an employer mandate. If the government has no right to tell employers how to run the businesses, what right does it have to tell individuals how to run their lives? Whether out of principle or out of self preservation, I would argue that small businesses should oppose all mandates, whether employer or individual, which is why for one, I'm concerned that the NFIB, which bills itself as the voice for small business, has joined a coalition that promotes ideas such as "businesses, individual, and communities have a shared responsibility" when it comes to providing needed healthcare, and "companies that do the right thing by providing health coverage for their employees face enormous costs", suggesting that small businesses who cannot afford coverage for their employees are somehow doing the wrong thing by not providing it.

In my view, the fact that NFIB is flirting with the idea of universal coverage presents an enormous threat to small businesses. One way or another, that sort of policy, a policy

of universal coverage, is a bomb that will blow up in the face of small business owners.

So what would make life easier for small businesses? Well, I think it would be to deregulate health insurance and to stop penalizing individually purchased health insurance through the tax code. Give individually purchased health coverage the same tax treatment as employer sponsored health insurance so that employers who do not offer coverage are no longer at a disadvantage in the labor market. Give workers ownership of their healthcare dollars so that their cost consciousness will eliminate ways to make insurance more affordable for everyone. And let individuals and employers purchase insurance from out of state so that they can avoid the unnecessary regulatory costs to which so many small group plans are subject.

Tax reform and deregulation, or how to relieve the burden of health benefits for small businesses, and they have the added benefit of being the right thing to do. Thank you.

ROBERT GRABOYES, PH.D.: Thanks, Michael. Next up will be Peter Harbage.

PETER HARBAGE: Great, thank you. Just want to thank Bob to start and NFIB for inviting me and having this forum, I think its outstanding that NFIB wants to play a leadership role in healthcare and aggressively address the concerns of its members about the high cost of healthcare and how best to get a

hold of the healthcare system. So I think it's a great and it's an important work, and I congratulate NFIB on that.

Health insurance is so important, everyone should have it. It should be universal for the simple reason that health insurance is how we access healthcare in the United States, for better, for worse, by any measure, those who are insured are receiving more care, more timely access to care, and live longer. So from my perspective, there's a basic moral question and a basic economic question about what are we trying to accomplish in terms of health insurance.

Now how you get to universal coverage is by making it accessible, affordable, and mandatory. There is no such thing as universal, voluntary anything. And so what you hear from a number of leaders from both the right and the left is the discussion of this concept of shared responsibility. It's what Massachusetts has worked on, it's what California has been working on, and other states. If you look at the presidential candidates on the Democratic side, you see support there. You see support for shared responsibility from the Center for American Progress. You can also find in support of the individual mandate and shared responsibility; you can find statements from former treasury secretary Paul O'Neill. You can find statements from Tommy Thompson and, of course, former Republican presidential candidate Mitt Romney. So there is an ideological divide on shared responsibility and individual

mandate. I think you can also find ideological bridges, as well, that bring people together on the issue.

Now as we've seen in the presidential debate, as soon as you start talking about an individual mandate, the first question is, well, when do you start to send the uninsured to jail? And I have been asked this question. Or when do the penalties kick in? And those are fundamentally just the wrong questions. The question that needs to be asked is how do we make coverage the norm? How do we make insurance coverage the norm? How can we make insurance coverage universal the same way we have public education, which I haven't read all of my colleague's work here on the panel, but I don't think anyone here necessarily, and I would appreciate being corrected, would talk about dismantling the public education system that we have in the United States, because we have a basic, fundamental agreement as a society that public education is good for both individuals and the economy.

The other question, and I appreciate the comments earlier on this, is what are we trying to accomplish with universal coverage? Well, I think there are a lot of different ways of looking at what we're trying to accomplish. When Linden Johnson signed Medicare into law, which is of course basically universal coverage for those over 65, he quoted Deuteronomy, "Open thy hand wide unto thy brother unto the needy in thy land". There is certainly a moral question here.

There is certainly an economic question here in terms of our competitors in other countries who simply don't have double digit cost increases every year in their healthcare spending. There's the waste, just the waste in the economic system that goes into failing to have universal coverage. The Institute of Medicine, of course one of the smarty pants think tanks here in Washington DC has looked at the cost of universal coverage and found that the benefits, the economic benefits, exceed the cost. The real question is sort of who are the winners and who are the losers and who make those payments?

There is, in fact, hidden tax that exists in our healthcare system, the cost shifting that occurs from those who are paying for insurance and those who are not. If you cannot pay your healthcare bill, healthcare provider, like any good business person, will find a way to try to shift those lost revenues to those who can pay. And it was said that the one estimate for that is less than 3-percent, there are estimates that are as high as 12-percent. And, in fact, the median estimate for a range of studies that have looked at this question find the hidden tax to be somewhere between 5 and 7-percent, meaning that premiums for those who are insured are 5 to 7-percent higher than they would be otherwise if everyone was insured, and you can decide for yourself if that's a lot of money or not.

Again, I think health insurance is absolutely how we access care, it's how people will be able to have better access to wellness, and better access to preventative care. So you also, aside from everything else, do have a component that would increase healthcare quality. And really, for me, I guess there are a couple of other things since it was discussed earlier, I just want to mention in terms of the benefits of universal coverage, this really comes back to President Roosevelt's freedom from fear. It's parents whose kids, they are afraid to have them play sports, they are afraid of when they're going to get sick, they're afraid of them getting in the hospital, and that has a toll on society in terms of the lack of insurance.

And it's also people who want to start their own business. Anyone who has tried to purchase coverage on the individual market finds it to be very difficult. And in California, where I'm based, there is a major ongoing issue with what's technically called the rescission, where people purchase insurance, that individual starts to use that insurance and uses a lot of insurance, the insurance company goes back and finds some technical reason to cancel the policy, leaving the person high and dry, and two years of back premiums.

So there are any number of reasons to try to fix the healthcare system and the importance of universal coverage.

Then the question is how can you make it work? It's, again, not a question of when do the penalties apply. The question is how do you support individuals who want to purchase insurance? How do you support small business owners who would love to purchase insurance, not only for themselves and their families, because that's difficult enough, but who also do want to purchase it for their employees. And, again, the trick is making it affordable as a start, and there is an investment there that has to be made in terms of public program expansion, and also subsidies for people at higher income levels. It would be wrong to mandate that somebody purchase insurance that they could not afford, so all individual mandate programs, policies I've seen, do include an increase in government spending.

Then the trick is to also make insurance seamless and easy to obtain, making it accessible. So it means guarantee issue. It used to be that if you were an individual and you had some kind of preexisting condition, whether it was cancer last year, whether it was quite literally acne when you were 13, insurance companies could use this as a reason to try to charge you higher premiums. They have since discovered that it's just easier to deny people coverage, and so the first step really is to look at guarantee issue and make sure everyone can purchase it. You need to simplify, not only expand, but simplify enrollment in the public programs.

There is also a need to create a pooling mechanism. Again, a major challenge that small businesses face when they try to purchase insurance, is they're doing so as two or three people, or four people. They're not doing so as a large corporation, and so their risk pool is skewed and so they end up being charged more. But if there were pooling mechanisms that were available for both individuals and small businesses to go into, you would find a more efficient approach, a more efficient way to do that.

You also have to have a way to help track and monitor people's insurance, and I'm looking forward to Sherry's comments on what happens in auto insurance in certain states, where a very common example for a reason why a mandate won't work is because auto insurance doesn't work. Well, there are certain things about how auto insurance is enforced that make it inefficient that you could easily correct, and some states are correcting it have moved their coverage rates up as high as 98-percent in terms of their coverage rates.

And then the last question is that's always asked is do you have a penalty system, and how big is your penalty, is how the question goes. The penalty could be as simple as making sure people just pay the premium for insurance and having the government assume enrollment into an insurance program, whether it's big or small, and someone would have to decide that. But it's really not necessarily the case that you have to penalize

someone. It's about making sure they're paying into the system in a way they aren't today, and it's about making sure that they're enrolled.

Again, the individual mandate isn't that the philosophy isn't one of a burden, it's one of a promise. It's the same promise that we have in other social insurance programs, it's about making sure that people have a shared responsibility to pay into a system, and they also share in the benefits of that system so that everyone has equal access to healthcare and the economic benefits that come with that.

ROBERT GRABOYES, PH.D.: Thanks Peter.

BOB MOFFIT, PH.D.: First of all, thank you very much, Bob, and the NFIB for inviting me to join my colleagues on this panel. When Bob called me up and invited me, he said to me, look, I'd like you to show up at this panel because I know you're confused on this to some extent, but ambivalent about the issue of an individual mandate. We just celebrated St. Patrick's day, I'm an Irish Catholic, I want to get through this world obeying a few rules and regulations as I possibly can. So my general instinctive view on this is we ought not have one.

For purposes of full disclosure, I should conceded at the outside a scandalous inconsistency. When I was in the Reagan administration, I opposed every mandate that I could possibly oppose from sunup to sundown, whether it was employer

mandates, individual mandates, benefit mandates, which characterize health insurance in the states. In 1989 while I wasn't looking, before I set foot in the Heritage Foundation, the Heritage Foundation endorsed an individual mandate to purchase health insurance as part of a comprehensive overhaul of the healthcare system, and that was an original position of the Heritage Foundation.

The central policy debate on healthcare should not be, in any case, whether or not we ought to impose an individual mandate for health insurance, which is not a goal, but it's rather a tool of public policy. The central debate should be what kind of a healthcare system do we want? I want a new system, which is patient centered and consumer based, operating within the economic environment of the normally functioning market for health insurance, that maximizes value for individuals and families. In other words, I want something that does not, in fact, exist today. The question, short of adopting an individual mandate for the purchase of health insurance, the question is what are we trying to accomplish, and as Mr. Harbage points out. We can accomplish a great deal, including dramatic expansions of health insurance coverage, approaching your universal coverage short of an individual mandate.

There has been a shifting in intellectual alliances among liberals and conservatives on this issue, libertarians as

well, who have at one time or another supported individual mandates in particular areas of public policy. The list is impressive, and the context outside of health insurance, even on those specific points where the issues are strikingly similar, social security reform comes to mind. Everyone on this panel, every single one on this panel, has supported an individual mandate to achieve what they believe to be on balance some overwhelmingly desirable social good. We accept this in many areas of public policy without even thinking about it. We have a mandate today that children be educated. We have a mandate that automobiles be insured. We have a mandate that individuals perform work as a condition of getting welfare benefits. We have a mandate that young men register for military service, particularly in times of international crises. I'm sure we all have rejected individual mandates in other occasions because of a healthy bias of hope toward individual freedom, or potential considerations of which I think weigh heavily here. The public is deeply conflicted on this issue.

Before outlining my own prescriptions, let me make some preliminary observations. In discussing whether or not we should impose a healthcare mandate, we can't overlook one basic point. Conservative audiences are often bewildered on this, but liberals often overlook it, but the fact is that the truth is we already do have a healthcare mandate. Its tax payers

mandate, it is rooted in two federal laws, the Hill Burton Act of 1946, and the Emergency Medical Training and Labor Act of 1986, which in effect grants every American in every state of the union the legal right to emergency care to secure healthcare, at least to the point that their condition is stabilized. So on a very basic level, the question of whether or not we're going to impose a mandate on our fellow citizens is to indulge a metaphysical abstraction.

We all pay for the healthcare of those who do not have or pay for health insurance, and we do it in a couple of ways. We do it with private health insurance, absorbing the cost of uncompensated care; it is not a simple matter to measure, the studies vary. In my experience of serving as former Governor Erlich's appointee to the Maryland Healthcare Commission, our staff calculated that the cost of the uninsured added $948 annually to family insurance premiums, not an inconsiderable amount for middle class families. Secondly, of course, we pay for those without coverage through taxation. The Taxpayers Mandate is neither efficient nor complete, but neither are other forms of the mandate.

And so I think the first question, then, is do we tolerate the status quo, which is, in fact, a taxpayer's mandate. Is it tolerable? It is growing, it's interfering with the efficient and effective delivery of appropriate care in America's hospitals, it reinforces the cultural conditioning

that one doesn't really have to buy health insurance, knowing that care is ultimately free, and it imposes intangible costs and a quality of care for those who are insured.

In my view, the status quo is not tolerable. I know of no administrator of any hospital, nor member of the medical profession, who works in emergency rooms, who thinks that the status quo is tolerable. Some have argued for a mandate on the basis of market efficiency, it will make the insurance markets work well. Paradoxically, there are no significant consumer driven health insurance markets in the private sector that are significant. Oddly enough, paradoxically, in the public sector we have two health insurance markets that are characterized by consumer choice and competition, Medicare part D, which covers the prescription drug program, it is risk adjusted. We also have the Federal Employee Health Benefits program that has been working since 1960, neither of which is there a mandate for either one. Both are driven by consumer choice and competition, healthcare costs are contained, adverse selection is minimal, and both are models of economic efficiency, at least compared to what is going on in many cases in the private sector.

The question of universality of coverage, I suppose by universality of coverage, we mean literally universal, that that is somehow desirable. I think it is unlikely that universal coverage would be achieved through an individual

mandate to purchase health insurance. In fact, universal coverage, meaning payment and compliance and care is not even achieved in single payer systems in Great Britain. There are people who do not pay their national health insurance contributions, and yet nobody arrests them and brings them to jail. In Canada, there are likewise individuals and families who fall through the cracks. And, as Michael knows, in Massachusetts, the first year of implementation of the law, which is a mandate law, the political authorities there made a prudential decision to exclude 60,000 residents of that state from the individual mandate requirement. So we have to take a step back and ask what it is that we want to accomplish.

I think we can accomplish a lot by just simply changing the way we approach the issue. I will just mention three options. One is to reform the system through universal tax treatment of the health insurance, in other words, basically create universal access to coverage. Give every American access to coverage, and if they decide either that they do not want coverage or that they do not want the tax break, they impose upon themselves a tax penalty, in effect, which in fact is what many of the proponents of individual mandates want.

Another options is to have automatic enrollment for people, either at the place of work, or through a state agency, which would enable people to sign up for insurance and have automatic enrollment. And if people did not want to enroll,

they could affirmatively deny it, they could deny enrollment. But at the same time they would be told and they would be able to make the determination in writing that they would, in fact, be directly responsible for the healthcare bills, possibly through a garnishment of their wages, just like we collect child support, if they decided that they didn't want to pick insurance.

Michael mentioned the escrow account, I think the Romney proposal was the best, the original Romney proposal that was never debated in Massachusetts, which was that everybody should have health insurance, but those who don't, if they want to self insure they can, but if they're going to self insure, they're going to make sure that they pay their bills by posting a bond of $10,000. That's a free choice, you either do it or you don't. It's hard to see how that's objectionable even on very strict libertarian grounds, but I will leave that for further discussion. Thank you.

SHERRY GLIED, PH.D.: Thank you. Let me just take up on the points that some of my colleagues made and try not to repeat ideas they may have already mentioned.

So I think it is important to think about what is our goal here, and I think it is important and consistent with what several of the panelists said, to say that there has always been a strong community interest in providing healthcare to people in need in this country. And we've always responded to

that goal by providing tax money in one way or another, to hospitals for uncompensated care, for physicians, and so on. That has generated a system that operates very inefficiently, and the question I think that we have, in my view probably the number one question in health policy right now, is what can public policy do to address this inefficient way of providing care to people today.

Now that is not to say that there are no other serious problems in the healthcare system, medical errors are a serious problem. The fact that healthcare costs in the United States are so much higher than in other countries without very much that is obvious to show for it is, I think, a serious problem. So is the fact that we all eat too much and are getting fat, as a nation. But on the whole, we have no idea how to use public policy to fix those other problems. We don't know what to do about them. And we actually do know we have an entire menu of public policy options with respect to expanding coverage. So that's why I think these other problems are problems, but they're not my problem because I can't do anything about them. I don't know what to say about the obesity epidemic, or even medical errors.

So the question is if we're thinking about expanding and rationalizing coverage, where does the individual mandate fit in? And I think, as several of the panelists have said, there are many other aspects of healthcare reform that we might

think about, universal FEHB, or a connector, or many other, changing the tax treatment. But let me talk for the moment, really just to focus my remarks on individual mandates.

So I think that there are really three arguments in favor of individual mandates, and a fourth that I'm going to come to at the end. And the first is that they make everyone pay for their fair share of services that one way or the other they're already getting, this free rider problem. And I think it's a legitimate problem, I think that there are definitely costs to it. I think it's also important to realize that if we imposed a mandate with subsidies, the taxpayer cost would probably be higher than the free rider problem in recognition of the fact that we would be giving people more care than they're getting now. So I think there is a free rider problem, and it is an important problem. The mandate doesn't solve the fiscal issue introduced by the free rider problem, but I think it's still important.

A more significant issue for me, a more significant role of the individual mandate, is that it is likely to improve the functioning of the non-group and small group markets. And I think that is where the individual mandate actually has a potential impact on small business. And why would this be the case, why do I think this would be the case? I think the mandate can address two problems that currently confront these markets.

The first one, and I think the classic one is the problem of selection. Which you can think about in many different ways, but I think the basic fact is that people know a great deal about their own health. Much more than insurance companies do, and that is just a very well recognized fact in health economics, health policy. And that means that people can use that information to make insurance purchasing decisions. And the consequence of that is that insurance companies are going to be very zealous in trying to keep people out. They are going to do a lot of underwriting. You are going to have a lot of problems in operating the market, because everyone is worried that the only people who want to play are the ones who have inside information that they are sicker than average. The people who enter the individual market are playing with loaded dice.

So insurance companies respond to that in very aggressive ways that we find repugnant, but it is a very natural consequence of the way that market works. Forcing more people to enter that market, particularly more healthy people to enter that market ought to reduce the extent to which individual insurance sellers and small group insurance sellers need to worry so much about this problem. And we see this because when we look at markets in which almost everyone participates, like FEHB, and even Medicare D, we do not have to

see this kind of behavior, because it is just not as much of a worry if almost everyone is in the market.

The second related point with respect to the non-group market is another thing that individual insurers have to do is get after people to actually buy insurance, keep making the payments. They actually have to sell the product pretty aggressively and the consequence of that is that the costs of actually marketing individual insurance are just much, much higher than the costs of providing insurance on groups. Those marketing and underwriting costs are the real difference between individual insurance and small group insurance and large group insurance costs.

So one hope I think is that a mandate by pushing more people into those markets would reduce the cost of operating the markets. And to give you a sense of how important that might be, if you look in the OECD statistics, if you look across other developed countries that run fragmented insurance systems, countries that run systems in which there are multiple private insurance companies, we still have much higher insurance administration costs than those countries do, and I would argue that is primarily because we have much less participation in that market. We have a lot of people who are able to stay out. And so perhaps we could bring our administrative costs down by just compelling more people to be in the market.

I think the third important factor about individual mandates, and I think a very important one actually, is that they reduce the public cost that is necessary to get coverage nearer to universality, and I think I agree completely with Bob Moffit, we are not going to get to universality. No one else is at universality. And it is a chimera. But we could get closer to it. And it will cost a lot less with a mandate than without it. And to understand why, here is what we have learned in the last 15 years of public program expansion and efforts at looking at tax credits and changes in the tax treatment and so on.

What we have learned is that it takes a lot of money to get uninsured people to voluntarily take up coverage. You have to provide very large subsidies to get voluntary take up of coverage. Now why? It is not I think because people are strategic free riders or because they do not want coverage. It is because you are basically trying to get healthy people to plunk down money now against something that may happen in the future. And those are healthy people with lots of other things on their mind. Lots of other costs on their mind. Lots of other activities on their mind. If you think about small business owners, trying to get a business going, this is just not your number one priority. Right? So what we see is that take up rates for individual insurance and even for Medicaid and SCHIP and any of these programs are relatively low.

Now, over half of the people, even in the income group just over 100 percent of poverty, over half of those people already have private insurance. If you try to subsidize coverage enough that everyone will voluntarily take up coverage, you have the make the subsidies worth virtually the entire cost of insurance. If you really want to get close to universal coverage voluntarily, the subsidies have to be as big as the price of insurance. You basically have to give it away free, if you really want a lot of people to take it up.

Now if you give it away free, you are going to take all of those low-income people who are now paying for their own coverage, and say to them, listen, if you just drop your private coverage, you can have free coverage from the government. That is going to make the cost of expanding coverage very expensive. The mandate lets you turn around and say look, it is not free. You have to buy it. It creates a wedge. It says if you have to buy this coverage, because we are going to make it more expensive, more difficult for you, to remain uninsured. And it allows you to keep the level of the subsidies lower. So from a sort of efficient use of public funds perspective, I think again, the mandate makes some sense.

All this said, a mandate is by no means a panacea. There are a lot of problems with it. First of all, look at Massachusetts. You may view this as a fail-safe mechanism, or a booby trap, but it is very easy to pass a mandate and then

exempt a whole lot of people from it. And if you pass a mandate and then exempt a whole lot of people from it, you have not accomplished a whole lot. So I think that there is a sort of fragility to a mandate that is not there with a lot of other kinds of insurance changes.

Second, if the subsidies are too small, or you make people buy something inappropriate, this turns into a very regressive tax. And I do not see why that is a particularly desirable public policy goal.

Third, we worry and I think Bob alluded to this earlier, that the benefit package could be wrong. It could be too fat. We could be loading it up with all kinds of things. Or it could be too skinny and we could be forcing people to pay out money for something that they do not value. So either way, it could be difficult to design that.

And fourth, gaining compliance with the mandate will be a challenge. And the problem is this. The problem is that if you really want compliance with insurance, people have to buy the coverage before they get sick. Going after them afterwards is not really getting universal insurance or getting expanded insurance.

So you really have to act quickly and then the penalties do not have to be very big as someone said earlier. If you move quickly and you reconcile a list of insured people against a list of residents, that is kind of what we do with

car insurance in the places where you really work it out. You build a system that actually works. You can catch people before they get sick, and you can say listen, buy the insurance now or you are going to face some limited penalty right now. The problem is we do not have a list of residents, and we do not have a list of insured people. Putting this thing together will not be trivial.

That said, I do not think that when you think about the mandate, you want to think of it as all a public policy around expanding coverage, and I do not think it has to be perfect to start off with. There are ways that you could do compliance. I think, and get somewhere pretty quickly. You have to recognize that this is going to take a lot of work and it is going to be a process that takes some time just like any of these other problems do.

But I want to finish with one last point. And that is to not underestimate the significance of using the mandate to get people to reprioritize. That is, using the mandate as a mechanism for saying to people, buy your health insurance today. You know there is a long to do list and you do not weight which one of those things is most important. Move health insurance to the top of your to-do list. And if we look at some of the mandates that actually work in policy, I think about seatbelt laws, which is a really interesting case.

So who benefits from seatbelt laws? In my view, parents benefit from seatbelt laws. Why do parents benefit? Because you can say to your kid, buckle your seatbelt. It is the law. Not because anyone is every going to pull you over, but because you can turn to your kids and say, this is the norm in our society. Buy health insurance. It is the norm. And I think that that change in the norm could really make a difference. If you look at the countries that have mandates. I am just going to close in one second. Which are Switzerland and the Netherlands, they have very high take up of their health insurance even before they put the mandate in, right? They basically have a social consensus that buying health insurance is something that you ought to do. And I think moving us toward that social consensus is really the potentially most significant role of a mandate.

ROBERT GRABOYES, PH.D.: Thanks, Sherry. Thanks to all of you. Great openings. So we have really covered three big areas individually. Now I would like you to start shouting at each other and arguing about these things. So, the first one is, well, the three would be enforceability, can you enforce such a thing? And the second one is controllability. Can you keep the benefits package from getting fat? And the third one is to focus; this is NFIB, on the effects on small business, because we heard some very, very different views here. Let us

start with the enforceability. Any one of you want to start by adding something to the enforceability argument?

MICHAEL CANNON, M.A., J.M.: I think that it is an important aspect of the administrative cost question, the cherry race, which is on the one hand if you can, I am not sure, there may be some savings in administrative costs of getting more people to purchase health insurance. But there are administrative costs that might not show up in the insurer's balance sheet to implementing that mandate. One of them is tracking down people and making sure they are complying. It has been suggested that, actually I think in Massachusetts they do it through the tax system. It has also been suggested by Senator Clinton that employers would have to garnish workers' wages if they do not comply. That is another administrative cost. That is an administrative cost that would be imposed not on the taxpayers, but on employers themselves. And the administrative costs grow the closer you try to get to universal coverage. I think the 98th percentile is going to be less costly in terms of, the administrative costs of getting the 98th percentile to sign up are going to be lower than the administrative costs of getting the 99th percentile to sign up for coverage.

SHERRY GLIED, PH.D.: There will surely be administrative costs of the mandate. There would be administrative costs of virtually anything we might do with the

health care system at this point. I was actually trying to figure how much the administrative cost of withdrawing the tax exclusion would be, and I think they are just enormous. Much bigger than the mandate. But, so I think administrative costs cannot be sort of the be all or end all of this although they do matter. I would be perfectly happy if we got to 95 percent. I mean forget the 98th percent. You can have the 98th percent. I think we can get pretty far without having a lot of administrative costs. If we had to add an extra line on people's IRS forms, that would not be, having just filed my taxes yesterday, that would not be that onerous. There will be some administrative costs, but I think it is not enormous.

BOB MOFFIT, PH.D.: Well, I am not for a universal mandate. So my view is that yes, you can probably enforce it. If you want to get really, you can really ratchet up the penalties and you can do it. The question is this, is that are you prepared to accept the kinds of social costs that are required to enforce that kind of mandate? What are we going to do? If people do not, all right, if they decide that they do not want to send in proof of insurance to the IRS, what are we going to do with them? Are we going add a surcharge, a surtax? How are we going to handle this? I do not think that at the end of the day you will ever get 100 percent.

And my point is as I said earlier, rather than going through all this, why not just take the steps that will get you

close to near universal coverage with a dramatic reduction in uninsurance by taking other steps, and I mentioned some of them. But I mean, yes, it is a question of what you really want to do. We could set up a police state and we could enforce a mandate. But the question is, is that what we want to do?

PETER HARBAGE: I think you could probably get it done efficiently without setting up a police state. Again, we have a number of a mandates that are in place today and they vary in their effectiveness, and Sherry has an excellent paper that talks about how to make it more effective. One is tracking and monitoring to make sure that again, using auto insurance as an example. Making sure when people do not have insurance you reach out and contact them. And in the context of health insurance, what you could have is the government reach out and say, we noticed you came off your health insurance. Did you income change? Because maybe you are eligible for a public program. It does not have to be aggressive. Most people at the end of the day want to have health insurance. That is why in part we are having this debate. Whether it be some people at the end of the day who do not want to participate, yes. And that is going to be true of any system. But right now it is about an 80 percent insurance rate.

So how do you get, depending on the state, in California where I am from it is closer to 90 percent

nationally. I just assume California is exactly like the rest of the country. So how do you get to 95, 98 percent? Start with auto-enrollment. I think that is fantastic. Start with making it easier and then move toward, but at the end of the day you are going to find if you want universal coverage, you are going to have to have a mandate of some type.

ROBERT GRABOYES, PH.D.: Let me continue on this-

MICHAEL CANNON, M.A., J.M.: Could I just jump in?

ROBERT GRABOYES, PH.D.: Sure.

MICHAEL CANNON, M.A., J.M.: I wanted to respond to one thing that Peter said. I do not think it is clear that everybody does want health insurance. Which makes enforceability difficult. Mark Pauley and Kate Bundorf of UPenn and Stanford respectively published a study in the *Journal of Health Economics* last year that estimated that if you look at the uninsured, and you compare them to the insured with similar characteristics, similar incomes and other characteristics, that as many of three quarters of the uninsured it turns out, they estimate, could afford health insurance if they wanted it. And they give a range. It is from a quarter to three quarters of the uninsured. But these are people who, a lot of people have the assets, could purchase health insurance, and have chosen not to.

So it is not that we just need to give them a reason and all of the sudden they are going to sign up. There are

going to be ornery folks out there who are going to resist because they place a very low value on health insurance. And I think part of the reason is because of one of the proposals that usually comes along with an individual mandate, which is community rating or in essence telling healthy 18 year olds that they have to pay the same amount for their insurance as 50 year olds with a heart condition.

The problem with those law is they make health insurance a lot more expensive for these young invincibles as we patronizingly call them without; they make it more expensive for those folks who know they are not going to need health insurance.

So yes, they are rolling the dice by not buying it. But most of the time, that gamble pays off. And it is because, they resist because they sense that they are being targeted with a huge hidden tax increase.

ROBERT GRABOYES, PH.D.: Sherry?

SHERRY GLIED, PH.D.: I think that you cannot read the Pauley and Bundorf work to suggest that people do not want health insurance. Because if we look at the same people and they take a job the next year, they all sign up for health insurance. I think it is better to read that work as saying there are a lot of people for whom this is just not a priority. It does not mean that they do not want it. It does not mean that they are ornery. [Interposing.] It does not even mean

that. Look, all of us have many, many things that we ought to be doing with our money and our time, and we have to decide which of them to do first. If you are 25 years old and you are healthy and young, this is not high on the list of things to do first. I do not think that there is anything objectionable to the idea of the government saying look, you may have your own list of priorities. We want to you to reorder it a little bit. That is not, and I think a lot of people are going to sign up just by being told to reorder their priorities. So I do not read that literature to say that people do not want health insurance and they are ornery. Of course there are some people who are ornery. But there are not very many.

MICHAEL CANNON, M.A., J.M.: What share of those who have signed up in Massachusetts did so without subsidies?

SHERRY GLIED, PH.D.: We do not know yet.

MICHAEL CANNON, M.A., J.M.: I think there have been data that-

SHERRY GLIED, PH.D.: I have a paper under review in my bag. I do not think we have anything out yet.

ROBERT GRABOYES, PH.D.: Let me get to Bob.

BOB MOFFIT, PH.D.: Let me first of all, the answer to that question, Michael, based on some of the information I got from my colleagues up there is it is going to be when the numbers come out, well over 100,000 in the-

MICHAEL CANNON, M.A., J.M.: What share of those who have purchased insurance since the mandate was enacted did so-?

BOB MOFFIT, PH.D.: We did not do it through the subsidies. That is right. The people above 300 percent.

MICHAEL CANNON, M.A., J.M.: But what share? Not what is the raw number. What is the share?

SHERRY GLIED, PH.D.: Of, among those who were uninsured. If that is the number, it is well over a third.

BOB MOFFIT, PH.D.: Yes, I think the total-

SHERRY GLIED, PH.D.: And that is before the mandate has been enforced at all. Nothing has really happened yet.

BOB MOFFIT, PH.D.: We cannot judge Massachusetts yet based on-

SHERRY GLIED, PH.D.: It is too early.

BOB MOFFIT, PH.D.: It is too early. I mean, the numbers so far look good, and they are getting better. And I think later on this month we will probably see. But let me get back to this question of what people want and what they do not want.

In my view, Sherry, the best paper that has ever been written on this whole question of the uninsured and where they are was written by two of your colleagues at Penn State University. There is a wonderful, I suggest everybody get a chance to read this, a paper by Pamela Short and Deborah Graefe was published in 2003 in *Health Affairs*. It is called “Battery

Powered Insurance." And what Professors Graefe and Short did is they look at the Census Bureau data over a period of four years. And they had about something like 80 million people who were uninsured during this period. What they did is they looked at the data to find out how many times were people uninsured and what did they find? Well what they found was, is that roughly 12 percent of the entire uninsured population was chronically uninsured.

The other 88 percent were people who were mostly in and out of coverage. They were covered by employers. The employer dropped coverage. They went into the individual market. They were there for a while. The premiums went through the roof for some reason. They dropped the individual coverage and they were uninsured for a while. Then they ended up on Medicaid. Then they come out of Medicaid. Medicaid by the way is very unstable as well. The point is, is that people, we know if you have 88 percent of people who had coverage, it is not that people do not want coverage. There is no evidence to support the idea, this idea that overwhelmingly the people who are uninsured somehow or other, they really do not care about coverage or they do not want it. They had it. We know they had it. That is what the data says. They get it through the employers, but the problem is, is that our problem in the insurance markets which are profoundly dysfunctional, is that the insurance markets are broken.

People do not have an ability to keep the coverage once they get it. So what we have to do is to reform the insurance market so people can buy their own coverage and keep it and bring the coverage from job to job without these god-awful tax and regulatory penalties that we have today. I mean what we are doing now is not just a bad idea. It is just stupid. I mean it is insane. So we have got to change that and we will have a better idea about the issue of who wants coverage and who does not.

Now I want to make clear my view on this, and it has to do with the ornery question. Yes, there are people who do not want to buy health insurance because they are ornery. They think that health insurance is some kind of violation of their audiological or philosophical conditions. There is something wrong with it and they do not want to buy it. Now, my view on this is that we ought to respect that. We ought to respect, if people want to self-insure, we ought to say, okay. You are a wild, rugged individualist. You want to kind of go on your own. You want to self-insure. You are going to pay your own way. I agree with that. But that is why I liked the Romney proposal. Which was we will trust you, but we are going to verify that you are going to do it. If you are really going to take care and pay your own bills, post a $10,000.00 bond. At least that will pay the first night at Massachusetts General. It might not do anything else, but it will pay the first night.

But when you do that, you establish something I think that Sherry is trying, a very important point that Sherry makes. Because what you will establish is this idea that we have a social contract in this country. That is to say you have an obligation to protect yourself and your family from the cost of devastating illness. Which in most cases people who end up in the emergency room really sick, they cannot pay it. And they are not going to pay it. We are going to pay it. So when we are talking about the individual mandate, let us get clear. There is an individual mandate. The individual mandate is a taxpayers' mandate. It exists today. It is getting more burdensome. And it is compromising the quality of care, particularly in American hospitals.

ROBERT GRABOYES, PH.D.: Is there anything-? Okay.

PETER HARBAGE: Well just-

ROBERT GRABOYES, PH.D.: Real quick, because I want to on to a couple-

PETER HARBAGE: Yes, no. Since the original comment back to me came from Mike, I just want to address it real quick.

ROBERT GRABOYES, PH.D.: Sure. Absolutely.

PETER HARBAGE: I think I just want to say what Sherry said, is I think is my comeback. I think it was pretty good, and [laughter]. And then we will just go from there.

ROBERT GRABOYES, PH.D.: Okay I have one other, I want to get to controllability, but there is one other question about enforceability. Okay, let us say that somehow we get there to a relatively enforceable system that gets you not to 100 percent, but to 95 or 98, whatever. Is there any evidence on how stable that is, or once you get there, does the system start to unravel? Just a couple of anecdotal pieces. I had a graduate student last year from Switzerland where they have this nearly 100 percent system. And as the semester wore on she was telling me that she was getting more and more letters from people in Switzerland who were dropping their payments, essentially dropping their coverage. You hear anecdotes from the Massachusetts story similarly, and so if you manage to get enforceability how long can it last? Sherry?

SHERRY GLIED, PH.D.: I think we are under this delusion in the United States that health care reform is something we just do and then it is done. The Germans passed their health insurance system in 1883 and every two or three years the German Parliament revisits health care and does a massive reform of their system. We are not going to just solve this thing once. And if we think that the individual mandate, if we pass it, is going to solve this forever, we have another thing coming. We can pass this and then three or four years down the road we will look at the data and if it looks like a lot of people are not complying, we are going to have to do

something about it. But I do not think that we should, if we make our task to build a system that will last for 100 years, I think not only will that not happen, but we will build a really bad system. Because we will do what we did with Medicare. We will build a system that is so entrenched and so highly structured that we cannot change it for 100 years even if we want to. So I think it is better to just take a very, an approach that says this is a work in progress and we are going to keep working on it.

ROBERT GRABOYES, PH.D.: Anyone else? Mike?

MICHAEL CANNON, M.A., J.M.: I think the question of whether it is enforceable over time is really a question of whether it is a stable system. And if you do not have a stable health care sector, then it is going to change. It is going to move and it is going to push in one direction. The system we have right now is not stable. That is why we are so unsatisfied with it. That is why we are trying to change it. So you have to look at what are the incentives that we have right now and the change that we are considering is going to create. Will those incentives that are created make the system more or less stable? I would argue that an individual mandate makes the system less stable. Because it creates, and here we are getting into the issue of controllability.

One of the biggest incentives that it creates is it makes lobbying, it sets out an even better deal for special

interest lobbies who want to get their services covered by this minimum benefits package that everyone now has to purchase. We are seeing it happen in Massachusetts. That drives up the cost of insurance and makes us even less happy because the system is even less stable than it is right now. I would think that if; I do not think that it is realistic to think that we could possibly come up with a set of health care reforms that would make the health care sector stable for 100 years. But I think we can come up with a set of incentives that is more stable than other sets of incentives. I just do not think that an individual mandate adds stability. I think it adds instability.

ROBERT GRABOYES, PH.D.: Anyone else, or shall we segue into controllability? Okay, so there is this issue. If you have an individual mandate you have to define what insurance is. And that means you have to define the minimal benefits package. What treatments are covered, they come in a variety of forms. And what Michael has been talking about is a tendency for political interest groups, disease groups, provider groups, consumer groups, to want to come in and add additional pieces to it. My Swiss student mentioned a successful drive to include spa visits in the Swiss system. I do not know if that is good or bad, but the question is, is there any institutional mechanism that can control this

tendency to throw more and more into the package until once again you have got a completely unaffordable minimal package?

Bob, start?

BOB MOFFIT, PH.D.: Yes, first of all I think frankly this problem is distinct from the whole question of the individual mandate. In every state in the union right now you have state insurance officials and state legislators defining what insurance is. So the fact that, and no state except Massachusetts has anything that looks like an individual mandate. But state legislators impose mandate benefits all the time. In the State of Maryland where I live we have, depending upon who is counting, we have as many as 62 or 63 provider and benefit mandates. The Maryland state legislature is constitutionally incapable of spelling the word no. They cannot do it. And everybody has got a shot at adding their particular thing to the individual market.

The reason why this happens with impunity is because most of us do not actually own insurance. We do not actually have anything to do with it. Insurance is bought by our employer or it is defined by the government, which of course defines what the benefits are. But in the case of the individual market and the case of the small group market, regular insurance, the state legislature defines the benefits, absent an individual mandate.

However, the way in which the third party arrangements are today, too many Americans, too many people think well the employer is buying the health care package so what is that to me? Of course it is everything, as you all know. Households pay 100 percent of the cost. Employers actually pay nothing as economists will tell you. But the point is that if people own their own insurance, right, that is to say they had the policy, the policy belonged to them, and they were taking it from job to job, well then when a bunch of guys get together with the state legislature and they want to drive up your premiums 12 or 13 percent because they have this new thing that they want to, some innovation that they want to impose on your benefits package, well then now for you this becomes an issue as a citizen. And you would get citizen involvement that you do not have today.

So an awful lot of this does not depend upon the individual mandate, it depends on the structure of the insurance market. That is the real driver here. Now I mentioned earlier the Federal Employee Health Benefits program. During the Clinton years, the Clintons loaded it up with a relatively high number of mandates.

Historically however, the interesting thing about that program, I know a lot about it. I was in OPM during the Reagan administration and I have been in the system myself about 11 years. The thing that is interesting about that historically

is the degree to which mandates are not characteristic of that system, historically. And the reason for that is, is that when you start adding benefits, members of Congress who pay the premiums start to think well wait a minute, how does this affect me and my constituents? And anywhere you have a large concentration of federal workers and retirees like Alaska, you know who the senator is, that becomes a personal issue. And the answer is to the well-meaning mandate add-er from some other state, the answer is no, you are not going to do that. And it does not happen.

So you have to have a countervailing political force when it comes to this issue of loading up the benefits package. Right now for the most part in most states of the union, you do not have a countervailing force to people adding benefits. You only have one word. And the answer is from the state legislators, a giant yes.

SHERRY GLIED, PH.D.: Just a couple of points on this. First of all, just to go on from exactly where you left off, if the question is whether people are going to be able to comply with the mandate, if there is going to be a subsidy structure and you are going to basically say that unless the subsidies are reasonable, we are going to let people out of the mandate. We are going to have this fail safe provision; you have suddenly tied the government's money in with the mandate. And I think you have changed the politics of it.

The politics are key here, because if you look at the large group market, there are virtually no mandates on that market. I think there are actually two at this moment. There is a 48-hour maternity mandate and a pregnancy coverage mandate, and that is it. And that is because there is strong countervailing forces on the federal side.

So this is a political question in terms of how you set it up. But I really like Bob's idea and I think for the NFIB it is one to think about, which is the escrow account notion. Basically to say the option is you either buy whatever the government decides is an insurance policy, or you put aside five days of the hospital, figure out what is five days in the hospital. That is the amount that goes in the escrow account. And that way you basically have a fail-safe. If the insurance gets out of hand, people are just going to say the heck with this, I am putting the money in an escrow account and you can actually monitor that and figure out whether you are getting out of hand.

PETER HARBAGE: Just real quick, the way I think about the question is really not controllability, it is really the sustainability of whatever you set up and how that is offset by the affordability of the program. And I do not think the question really is so much about the benefits, because I think when a lot of people think about their policies, whether it is California or the democratic presidential candidates, what you

see is them tie to FEHB. They will tie into the most common privately sold insurance product in their state or something else. But the question is how affordable does that policy have to be? Do you cap the premium at five percent of somebody's income? Is it seven percent? And once you answer the premium question, then you get to the cost-sharing question. And this is where we spend a lot of time in California talking about whether or not the individual should have any protection on their share of cost side, on the co-payments.

One way to look at it is to say the uninsured have no protections today, so anything, even if it's only on premiums, is a step forward. Another way to look at it is to say this is a government mandate and you should have clear rules dictating what someone's buying so they know what they're buying and they know exactly what protections they're getting. So I think the real question isn't so much in benefits, but when you have the mandate, one of the key questions is really what defines affordability and what's really a fair percentage of income for people to pay in. And I think you'll find that that's really the key question.

The benefits question, I think, when I think of mandated benefits I think of mandated preventative care for children under 16, because again, insurance companies don't have a whole lot of an incentive to offer that. I think of mandates that are held in most states that psychologists be a

covered provider class. I think of mandates for that all cancer tests be offered as part of an individual policy because again, the insurance company could think to itself as a perverse incentive here, “Well, if we find out they have cancer, then we have to help pay to fix it, but if we sort of just let it go, then maybe it’s cheaper from an actuarial point of view.”

So I think a lot of the benefit mandates exist for very good reasons and it’s to protect the individual in a marketplace where they have no other protections.

ROBERT GRABOYES, PH.D.: Very patient, Mr. Cannon.

MICHAEL CANNON, M.A., J.M.: The question of controllability is, I think we all agree that there’s already been this dynamic where providers have been going to the legislatures and saying, “We want our services covered so that our markets expand.” And the legislatures are saying, “Okay.” The question is with an individual mandate, you’re forcing more people to buy insurance. You’re making that an even more attractive strategy for providers.

Is there any way to control that? Bob and Sherry offered a couple of ways of checking that. I don't think, as much as I support Bob’s notion of letting individuals control their own health insurance plans, control the money that purchases it, rather than having the government or an employer control that, and being able to have portable insurance and

making them price conscious about the premiums; as much as I support that, I don't think that's going to be an effective check in this rent-seeking behavior by providers, and the reason is that providers are concentrated interest, and so they lobby very effectively, and the costs of the laws that they get enacted are spread out over a very broad group of people who individually have little incentive to even educate themselves about these lobbying efforts, much less oppose them.

I think one of the reasons why we've seen fewer benefit mandates at the federal level than at the state level is because you get some very powerful concentrated interest on the other side, the large employers who have a ERISA regulated plans. And, by the way, I think it's not necessarily going to stay that way. We almost got a lot more regulation on ERISA plans in the patient's bill of rights debate, and the only reason we didn't, in my view, is because the democrats got too greedy and they wanted to be able to sue employers as well. If they had just given that up we would have had even more regulation.

But I also don't think that the idea of an escrow account is going to provide much of a check on this tendency to load up the minimum benefits package with more and more services making insurance more expensive, and the reason is you got a person, yes, it's better than an individual mandate without an escrow option, but think about a person who's

concerned about the high cost of health insurance, you know, “My premiums are really, really going up. I could forego health insurance and still comply with the mandate by just putting 10,000 dollars aside in an escrow account, but what if I got cancer. You know? What if I had to stay two nights in a hospital in Massachusetts?” Then that person is in a much worse situation than they were before, and the very reason the people buy insurance is so that they won’t be put in that sort of situation. Maybe some healthy people will take that option. I don't think very many of them would.

SHERRY GLIED, PH.D.: Why are they worse off?

MICHAEL CANNON, M.A., J.M.: If they put 10,000 dollars in an escrow, forego health insurance, and then get cancer.

SHERRY GLIED, PH.D.: Why don't they just buy health insurance and put 10,000 dollars in an escrow account too?

MICHAEL CANNON, M.A., J.M.: But it’s not that much of a check on the rent-seeking behavior of providers because I don't think many people are going to take that option. I mean, you’re saying why don't they just keep buying health insurance; exactly. I think what would be a check on that sort of lobbying behavior is giving consumers or employers the ability to avoid these laws that the legislature has passed. Right now most of this lobbying is going on at the states. They’ve passed 1900 or so of these benefits mandates. If employers and individuals had the ability to say, “I do business in Virginia,

but Virginia's regulatory environment for health insurance is just much too costly and poses way too many unneeded, unnecessary regulatory costs." Maryland – and I've actually got the states backwards – Maryland has a much friendlier regulatory environment. I'd like to buy a health insurance plan regulated by Maryland. Giving individuals and employers the ability to exit a regulatory regime would put a check on this sort of behavior by providers, but if it's the federal government imposing an individual mandate, that's going to be the locus of all the lobbying. So it's very difficult to make that happen, to give employers and individuals that power because how can they exit, you know, buy insurance from abroad.

ROBERT GRABOYES, PH.D.: I'd like to get to audience questions, and I'm going to forego my small business specific question because we're getting it in bits and pieces. I would like to get to– anything else here, or can we get to the audience?

BOB MOFFIT, PH.D.: Just one thing is that if people own and control their own health insurance, they own the policy, instead of the insurance industry becoming an enemy for the policy holder, there's a good chance that the insurance industry will actually be a friend. [Laughs] So that's a different relationship between insurance companies and consumers, and exists today.

ROBERT GRABOYES, PH.D.: Alright. Questions. Yes?

DANE VONBREICHENRUCHARDT: Hi, I'm Dane vonBreichenruchardt [misspelled?] with the US Bill of Rights Foundation, and I'm real ornery. [Laughter] Real, real ornery.

ROBERT GRABOYES, PH.D.: Good. So are the people who wrote the bill of rights.

DANE VONBREICHENRUCHARDT: The two questions that I have, the two things that I ask if you would address is that I fight daily with other places like Epic and others on electronic privacy and medical records privacy. It's a huge issue with us. And now you're talking about another system of records, okay, dealing with the medical. You know, so it's a sort of electronic jack boot coming through the door, as I see it. I told you I was ornery. The second one is that I don't trust the government to take anymore money from me. We already have a social security system that is broke. It has no money. In fact, not only doesn't have any money, we all know that at the office of the national debt, there's a five cabinet drawer thing that has holes, nothing but—

MICHAEL CANNON, M.A., J.M.: The social security trust fund is a myth.

DANE VONBREICHENRUCHARDT: Yes, and so I just want to drive that point home. So for the ornery one like me, I don't want my name in another database, and I don't trust giving this government any more money because I'm afraid it's going to go

spend it someplace else and we'll have another cabinet full of IOUs. That's it.

BOB MOFFIT, PH.D.: Well, I believe that ornery people should be protected. In fact, I'm very much in favor of that idea. I don't think you should be forced to buy health insurance. I think you have a right to self insure, and I think you have a responsibility to pay your own medical bills, and I'll make sure that you do that if you decide to go without health insurance. That's my view.

DANE VONBREICHENRUCHARDT: Well I want the insurance, don't—

BOB MOFFIT, PH.D.: Oh, it's fine, and I think you should have any insurance you want.

DANE VONBREICHENRUCHARDT: I just don't want to have to go through my name being in another database to be abused and hand over money that I've worked for to a government that's already demonstrated it doesn't have the ability to spend my money—

MICHAEL CANNON, M.A., J.M.: So what you're emphasizing are the privacy costs and the administrative costs imposed on people who are already purchasing health insurance, never mind the people who it's going to be tough to get after.

BOB HALL: Hi, I'm Bob Hall with the American Academy of Pediatrics. Maybe we're one of those rent-seeking provider

types. I'm not sure. One of the things that I'm really interested in finding out— [Interposing]

PETER HARBAGE: Probably. If the consensus from the panel, probably.

MICHAEL CANNON, M.A., J.M.: I think so. Yes. Doesn't mean you're not a good person. [Laughter]

BOB HALL: One of the things that I'm really interested in is the apparent assumption that increasing the benefit package automatically leads to skyrocketing costs. One of the things that unusual about children and what they get in the United States under the Medicaid package is early and periodic screening diagnostic and treatment, which is essentially the most open-ended assurance of care in the United States that anybody gets. Now I think there can be a strong argument made that they're limited to actually receiving those services based on provider payments or making it harder for kids to get into the program, but I'm wondering if that really has, if that's the full explanation, if there really is an automatic jetting to just ballooning amounts of services as people get more access to coverage. It seems to be just a basic assumption that most of you all have.

PETER HARBAGE: Well, I'll go ahead and jump in because I think I was trying to touch on this point a little bit. In terms of when people talk about wanting to eliminate benefits, you know, what is it exactly? I mean, is it vaccinations; is

it again preventative benefits for children. I've never heard of the spa benefit before, and I would bet money that doesn't exist in the U.S. So it's like what do you eliminate, and the flip side of the question I think is what you're asking. What is the investment that can be made in order to make the system more efficient? Three-quarters of health care costs are related to chronic disease care because we don't do a very good job at helping people to understand their disease and to take responsibility for it. Others simply don't have access to the care that they need, to deal with the asthma, except when they're in the ER. And there is economic costs and there is extra costs to the health care system for that. So I think the point that you're raising is an excellent one, that there are benefits that should be added, that do have an upfront cost, and in fact will result in lower costs in the long term and will recoup. There will be a definite ROI for some of that. I think the medical home concept in primary care, and I know you all work on medical home a lot, is another one, just making sure that people have the coordinated care in our system, in our fragmented system, that simply doesn't exist today. Again, it will increase quality of care, quality of life, and help reduce costs in the long run.

MICHAEL CANNON, M.A., J.M.: Couple things about that: I think that some states – and Bob, correct me if I'm wrong – do mandate coverage for massage therapists.

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

BOB MOFFIT, PH.D.: I'm not sure—

MICHAEL CANNON, M.A., J.M.: I think that's on the list, and if it's not, I will e-mail you all and apologize for misleading you. Other benefits that people might like to cut: There are a lot of devout Roman Catholics in this country who might not like to have to pay for services they find morally repugnant, like in vitro fertilization and contraceptive coverage, which a lot of state mandate. And should abortion be a mandated service? That's a fun discussion. Let's have that. Because a lot of people consider that a medical service and believe that it should be covered under insurance. We're going to have that debate if we get an individual mandate.

On the question of whether mandates increase the cost of health insurance, there are very few health care services that are cost— not cost saving, that results in lower health care spending down the line. Most of them do not reduce health care spending because you caught something early. The question of whether coverage for those services reduces health care spending down the line is a different one, and probably, I think, is less likely, once you're talking about coverage, that coverage would reduce spending down the line.

So what you have to look at is the mix of services that are mandated, how many of them would reduce spending down the line, how much of them increase spending, and when you do, I

believe most of the literature on benefit mandates has found that they do increase health insurance premiums.

PAUL DENNETT: Hi, I'm Paul Dennett with American Benefits Council. I wanted to see if Bob could talk a little bit further about the auto enroll process, whether that's done, in your mind, absent an individual mandate, or but would it also require some other system reform, because I'm not quite sure what you'd be auto enrolling people into in the current market, given the problems you pointed out with the—

BOB MOFFIT, PH.D.: Absolutely, no. As I said, we're under a time constraint, I didn't actually develop the full-blown argument, but the point is that I think we have to have a fundamental change in health insurance markets. We have to make them friendly to individuals and families. We have to ease their access to it. My argument is that we're never really going to have a normally functioning market unless people can pick and choose plans that give them value, alright? To maximize their value, not somebody else's value, not the value of the Commonwealth fund or the Heritage Foundation, or the Kaiser Family Foundation, but, you know, them, you know, that's the key thing. We don't have anything like that, but my point was that with regard to expanding coverage, I think two big things have got to take place. One is we have to change this dramatically regressive and inequitable tax treatment of health insurance and create a health insurance tax treatment

and a subsidy system that would enable people basically to have universal access to available coverage, basically, and be able to get it.

Now the question is if you're really going to try to get as many people insured as possible, short of a mandate, you can do what we do, in many cases through employers with pension programs and retirement programs. You can have auto enrollment in effect. That's what we do, for example, with 401Ks in many companies. But you don't have to take it. You're not forced to take it. You can say, "I don't want it." And you're out of it.

Now, that was what I was talking about. My view of automatic enrollment is it's really an alternative to this idea of having the federal government impose some kind of an individual mandate. Auto enrollment is not a mandate, and it's a different approach.

PAUL DENNETT: And I agree with you that in the employer context it could take care of a lot of people who are free writers who decline coverage for themselves or their dependents, who could afford it, but I think I understand you correctly to say if you went beyond that, you'd' also have to accompany that with some market reforms and insurance—

BOB MOFFIT, PH.D.: Oh yes, absolutely, because the market will pull. You know better than I do, the markets do not function very well in many different states. I also agree

with Mike on this argument about the dysfunctional markets in different states. I mean, if you really look at our health insurance markets, especially at the state level, they're like dinosaurs. We should have a national market for health insurance, just like we have a national market for just about every other good and service in the economy. This is a really strange set of circumstances in health care.

PETER HARBAGE: I guess I would just add that one of the phrases you used when you were talking about auto enrollment was universal access to coverage, and I think the challenge with that is the challenge that was raised before when you get into risk selection. You're going to have a situation where people who need insurance the most – of course in many cases those are the ones who aren't getting into the market today because they're blocked out – but if you have universal access, say if you have guarantee issue, the technical term, that everyone has to be able to buy insurance, you could actually see, and there are cases where it has happened, a spike in premiums. And that's why by having an individual mandate you smooth out the risk, you bring in both those who are healthy and say to them regardless of their orneriness level, that someday you are going to use the health care system, and someday you're going to use that system, and you need to pay into it today for the system that you're going to use so it's going to be there tomorrow. But if you have just, you know–

MICHAEL CANNON, M.A., J.M.: But an individual mandate doesn’t spread risk.

PETER HARBAGE: You’re bringing the healthy and unhealthy into the system.

MICHAEL CANNON, M.A., J.M.: It’s only going to spread risk if you’re charging the health the same that you’re charging the sick. What you’re talking about are price controls on health insurance. An individual mandate could be accompanied with risk-base pricing, so the healthy are just paying for the cost they generate and not spreading risk to help the sick. What you’re talking about is a price control.

SHERRY GLIED, PH.D.: Actually, I don't think that’s right, but let me just, on the auto enrollment point, I mean, we do have an example of auto enrollment that has its problems, but exists, and that’s Medicare B, which actually operates in the way that says, you know, you’re in unless you say you want to be out. If you’re out and you decide to come in later, you’re going to pay a penalty for not having agreed to do it when it was first offered to you.

In fact, the German health care system, which has a private health insurance option if you don't want to be in the public insurance system and you make enough money, is the same deal. You can pick to be in private insurance, but if you don't, if you select to be in private insurance, you can’t switch back in order to deal with exactly the same kind of

selection problem. So I think there are ways to deal with auto enrollment and selection at the same time. Mandates are one, penalties or others are different ways of coping with it.

On the question of risk-based pricing in the individual mandate, I think it's important to realize that even if you went to risk-based pricing, there'd still be a fair amount of selection in the individual insurance market. Risk-based pricing is not going to eliminate adverse selection in insurance markets.

PETER HARBAGE: Well, I think—

MICHAEL CANNON, M.A., J.M.: But it contains it.

SHERRY GLIED, PH.D.: It just makes it, it's not as bad as under community rating, but that doesn't mean it's gone.

PETER HARBAGE: Doesn't it also help if you have some kind of purchasing pull where if you're not in the group market all the individuals and perhaps even small businesses are coming into that—

SHERRY GLIED, PH.D.: There are many ways to deal with selection in insurance markets I think, you know, but I think that to believe that getting rid of community rating and rating restrictions would be enough is naïve.

ROBERT GRABOYES, PH.D.: Maybe one more. Yes, please.

FEMALE SPEAKER: Just, I wanted to ask you more about the European countries that you mentioned. Which of those, would Germany be a reasonable model since they have a private

option? Have they managed this issue of paying for itself over time? I guess do all of you as a counter, do all of you agree with Mr. Cannon that it's really going to cost more, we should just say that up front that more coverage is going to cost more, or can we save money by preventing or getting people with diabetes earlier, etcetera?

SHERRY GLIED, PH.D.: Several different questions all wrapped up in one there. On the whole, I think the literature suggests that many preventative activities are cost effective, which means that they are relatively cheap ways of achieving a health outcome, but very few preventative activities are cost saving. So prevention is a good strategy in terms of improving the health of the population in many cases, but it is not a fiscal strategy. It is a health strategy. This success to the extent that they have been successful of European countries in restraining the cost of health care has not come through prevention. It has come through essentially containing the prices that are paid to people in the health care system. That is the main way the European countries are much cheaper than us. They just pay everybody less money than we do.

BOB MOFFIT, PH.D.: In other words, prevention drives up your long-term care costs. [Laughs]

SHERRY GLIED, PH.D.: Another way of thinking of this is if we really, you know, treating people is generally costly.

So if we really wanted to contain health care costs, we would just let people die.

MICHAEL CANNON, M.A., J.M.: Like smokers and D.O.B.'s who have the decency to die before they start costing Medicare a lot of money.

SHERRY GLIED, PH.D.: Really elderly people with pneumonia. Right? I'm not recommending this. I'm just saying that if all you cared about was cost, there are ways to do it, and prevention would not be the way.

PETER HARBAGE: And I think you'll find a lot of those studies ignore the economic impact of somebody not being able to work, somebody who's disabled, the total cost to society. And I think that the Institute of Medicine has done a good job looking at that in a report they issued, *Hidden Cost, Lost Value.*

MICHAEL CANNON, M.A., J.M.: Well, I'm interested in the total cost to society of everyone on this panel not being as economically productive as they could be if they had different jobs in the private sector or something like that. But I think that we raised – myself included, myself included – I think that yes, universal coverage or expanding coverage, it's just going to cost money. Now, there may be benefits to spending that money and they're probably will be benefits, but it's going to cost money, and that money has got to come from somewhere, and that's important to keep in mind. But I'm glad

that Sherry raised the issue of cost effectiveness because that is something that's not part of these discussions about health insurance and expanding coverage. I mean, the whole idea of an individual mandate is premised on the idea that by God, what we need to do is expand health insurance coverage, because we have too many uninsured Americans.

Now I think we do have too many people without health insurance. But this is why I began with a why, you know, what is our goal here. This, I think, is by the way the most important point I'm going to make today. If your goal is to improve health outcomes, there is absolutely no evidence that health insurance is the best way to do that, that that is a cost effective way of doing that. The economists who have looked at this have found yes, you will get benefits; you'll get health benefits, but if you compare the health benefits of expanding coverage to other strategies like uncompensated care subsidies, subsidies for free clinics, nutrition education campaigns, discrete programs for screening hypertension, even things that seem completely unrelated to health care, like education. There is no evidence that spending money expanding health insurance coverage is a cost effective way of improving health, relative to those other things. There's no evidence that expanding coverage will buy you more health than spending the same money on those other things.

So what does that mean? If your goal is to improve the health of Americans, then it is game over for expanding coverage. It is game over for universal coverage and an individual mandate. And the reason is because you don't have any evidence that an individual mandate or expanding coverage is the best way to get you what you want. If that is what you want to maximize, then what you want is not universal coverage. You want experiments with expanded health insurance coverage, more money for free clinics, more money for other things, and see what delivers the best health outcomes. Doesn’t meant that there’s no arguments for universal coverage, but you can’t argue that we’re doing this because we care about people’s health. And you have to then ask, okay, what are the arguments? Why do we want universal coverage? And we should have a debate about those, but we can’t argue that we’re doing this for people’s health.

PETER HARBAGE: There’s a whole literature that people how are insured versus those who are not insured receive more care, more timely access to care, live longer – pick your measure – have greater access to prescription drugs, have greater–

FEMALE SPEAKER: –being diagnosed earlier with cancer–

MICHAEL CANNON, M.A., J.M.: Absolutely, and you can find health benefits to health insurance, but that’s not the question I raise. The question is we have a lot of people

without health insurance. We have a given set of people with an without coverage. We have a given set of health outcomes. If what we want to do is improve health outcomes, there's no evidence that insurance is going to get us the biggest improvement in health outcomes. None.

ROBERT GRABOYES, PH.D.: Why don't we begin to close up. Sherry and Bob, I don't know if you have any last—

SHERRY GLIED, PH.D.: You know, I think we can take this argument. The absence of evidence is not the same thing as the evidence of absence. There is always something that we could test against health insurance and say there must be some program that would be more efficient than health insurance. But we've had 40 years of free clinics and public subsidies and nutrition counseling and lots of other things, and I think at a certain point you have to buy the idea that you're going to get something out of health insurance. And here's the other way I would say it: We all spend a lot of money on health insurance ourselves. If you actually think health insurance ain't worth much, then we are all, most Americans are remarkably stupid for spending three or 4,000 dollars a year on something that just really isn't a very cost effective way of maintaining our own health. I don't buy it, and I think we would have to be doing experiments forever to rule out every other possibility.

MICHAEL CANNON, M.A., J.M.: Well, I want to respond to that, Bob. Two interesting things: One is that health care

researchers and health economists like to get on providers' case because providers provide a lot of medicine that isn't evidence based. They say, you know, "We really should be testing these things to make sure they work." Well, you know what, I would think that health policy types should be subject to the same standard. And now, darn, I've lost my second point.

PETER HARBAGE: That's okay—

MICHAEL CANNON, M.A., J.M.: You escaped, Sherry.

PETER HARBAGE: No, I had a quick questions. I just can't resist asking. You have no insurance whatsoever. You don't have health insurance.

MICHAEL CANNON, M.A., J.M.: Oh, that was my second point. Okay, we might get value from health insurance. We do get value from health insurance. It's unrelated to health. But you can't argue that expanding coverage, you're doing that because you want to improve health. You've got to argue about some of those other benefits.

PETER HARBAGE: So health insurance is good for you—

MICHAEL CANNON, M.A., J.M.: I have health insurance BE I value it.

PETER HARBAGE: —but not everybody.

MICHAEL CANNON, M.A., J.M.: Some people—

PETER HARBAGE: Health insurance is good for you, but not everybody.

MICHAEL CANNON, M.A., J.M.: I don’t think that’s what I said at all. Although, it’s probably true, but I don't see how you’d draw that conclusion from what I said.

PETER HARBAGE: Okay, I just want to understand. Well, you just made the point by saying it’s probably true.

MICHAEL CANNON, M.A., J.M.: Well, but—

ROBERT GRABOYES, PH.D.: Bob, you’ve been quiet in the last few minutes.

BOB MOFFIT, PH.D.: Well, I’ve been quiet because I didn't have an opportunity to say anything, but what I’d suggest is that in the whole question about the individual mandate I think you have to look at what we’re really trying to do. If the argument is you want to dramatically expand health insurance coverage and all of the good things that come with that, which in fact is better access to better health care, in fact, if you want to do that, you don't have to go to an individual mandate. You really don't. What you can do is you can make very, very specific changes in the tax treatment of health insurance, which would universalize that tax treatment, to give everybody direct and immediate assistance to buy the health insurance that they want. The same thing I would say is also true with regard to the way in which we decide that we want to cover people. We can institute policies of automatic enrollment with the right of people to reject the coverage. That’s fine.

My whole approach here this afternoon was to say, in effect, that there is a difference between proposing an individual mandate and making the transparency of real choices available to me. Transparency of choice. A mandate is a legal command, and economically it's a tax. There's a world of difference between a legal command to do X and a transparency of choices to do A, B, or C, or any other option that you want to pursue. With the knowledge beforehand, however, whatever those options are, are going to have predictable consequences. Ultimately at the end of the day, we're responsible for our health care, and ultimately at the end of the day, we're responsible for paying for it, not somebody else. Thank you.

ROBERT GRABOYES, PH.D.: Thanks all of you. Let me clarify one thing: I do want my health insurance to pay for visits to spas in Switzerland, but [laughter] so far NFIB has not granted this. [Interposing]

That's about all the time we have, so I'd like to extend a thank you to our panelists and to the attendees. This has been a really valuable, insightful discussion. I've had fun.

In closing I'd like to mention that last week NFIB unveiled a national, multi-phased health care campaign entitled Solutions Start Here. This campaign will engage the small business community, policy makers, and key stake holders in a robust dialogue about the unique health care needs of small

business owners and their employees. As part of the solution Start Here campaign, NFIB has created a petition calling for policy makers to specifically consider small businesses when addressing health care reform. The petition was sent to each of the presidential candidates last week and it's here with us today. I encourage each of you to sign it before you leave.

Thank you again for you time. I look forward to seeing each of you at our April forum, Cost Versus Coverage: What's the Priority. And a hand for the panelists please. [Applause] Thanks you all of you.

[END RECORDING]