



# The NEW ENGLAND JOURNAL of MEDICINE

## **Perspective Roundtable: Health Care Reform in Perspective.**

### Introduction

**DR. ARNOLD EPSTEIN:** Past, present, and future. That's the sequence, that's how it unfolds. Let's look back. When President Obama was candidate Obama, just a year ago, when we did our last forum here, he was very clear about his domestic priorities. The economy was number one, and after that was health care and energy. And he has not wavered one bit. And if you look at how health policy has unfurled from the White House, I wouldn't be the first one to comment that it looks like a redux of reverse Clintonism. For if you go back to 1993, President Clinton wrote the first textbook. He came out in January, and at the end of the month, created a task force of federal bureaucrats, advisors, and counselors to ultimately produce a 1300-page document called the Health Security Act. Enormous in its scope and complexity, and what was remarkable about it is it came totally out of the executive branch. Not a whit out of Congress. It took until September before it was even introduced to the populace, leave alone going through the committees. And the President, to demonstrate his commitment to it, said, with a typical Clintonian gesture, it will be universal coverage and not one bit less. And he appointed his wife to head the task force putting the bill forth as an additional sign of his resolve, not to mention her own formidable ability. And despite that ability, and his resolve, it did not work, and we did not get health reform last time. No legislation.

So this time, we see President Obama really following a totally different script. No executive task force, just the opposite. This is Congress's job, to propose the laws and make them. And it was the executive's job, at least until 2 weeks ago, to merely espouse eight very broad principles and to partake in a very modest public relations campaign — getting information, regional forums, things like that. And Mr. Obama made it clear that he wanted something simple, not with labyrinthine complexity. Let's stick to what we're familiar with. He made it clear that he was ready to compromise — I have eight principles, but I'm ready to give in. And, oh, yes, please get on it, time is of the essence.

And so now we've come full circle towards the endgame. It's September, and 2 weeks ago today, President Obama took eight principles and started to hone in on some of the things that he thinks are most important. And in Congress, we've seen the Congress do its job, still doing its job. Five committees of jurisdiction, three of them in the House, Ways and Means, Labor, and Energy and Commerce, have produced HR 3200, slightly different variants out of each committee, but basically the same bill. The HELP Committee — Health, Education, Labor, and Pensions in the Senate — has produced a bill on the delivery system, but they can't touch finance. And the Finance Committee is marking up as we speak.

There are some important points of agreement. First has got to be the change in the insurance markets. All the bills call for something, be it national or state-based, some sort of exchange or gateway that will make it easier for those in the small group or individual market to get insurance efficiently.

They also call for regulations of the health insurance industry — real changes, such as guaranteed issue, guaranteed renewability, exclusion of preexisting conditions, and limited risk rating. They call for expansion of the Medicaid program, not only expansion for women and children, which has been in there before, but for men and other categorical groups that we'll go through.

There are four more provisions. There are individual mandates and employer mandates. That is to say, individuals will be required to purchase insurance or pay penalties, and employers of a certain size — it'll vary by bill, 25 or 50 members or a certain size payroll — will be required to purchase insurance or contribute towards it in another way. And then there'll be subsidies for individuals to help purchase insurance, up to 400% of the poverty line, and for small employers who are willing to go out and buy insurance, there'll be tax credits.

Those are the points of agreement, and yes, in the second decimal place, they all vary. And some of those variabilities are important, about exactly how big the subsidies are and exactly how big the penalties are, but those are all places where I think the members agree, and where I think we can get to yes.

But there are some places where yes may elude us. Do we have a public plan? Is it state-based, is it national? And especially, in the details, how regulatory is it? What are the rules about competing, noncompetition? And how big are the subsidies that we're going to need? Tremendous difference from them. And where is the money going to come from to pay for those subsidies? How much of that money will come from Medicare cuts? How much of it will come from taxes on the elderly? How much of it will come from fees or taxes on health insurance firms that provide expensive policies? And what about the expansion of Medicaid? Are states ready for it, and is that expansion funded, or is it an unfunded mandate? And finally, as we try and move forward politically, it takes 60 votes, as everybody knows, for cloture. If they're not there, will we go towards reconciliation?

All those are important questions, and they're exactly the sorts of questions that I'm hoping our panel focuses on as we move forward. Their charge has been to think about what's happened to date, to feel free to talk about what they like or what they don't like, what they think the opportunities are and the challenges are, and especially how they see this thing — whatever this thing is — playing out.

**Henry J. Aaron, Ph.D., Brookings Institution**

Leading off will be Henry Aaron, a.k.a. Hank Aaron. He is the Virginia and Bruce MacLaury Senior Fellow at the Brookings. He's been a noted and well-regarded health policy analyst for many years, and brings not only that position as someone who has written, thought, and counseled others for many years, but has served himself in the past as Assistant Secretary for Planning and Evaluation. So with that wide experience, Hank, let me invite you to be first.

**DR. HENRY AARON:** I'd like to start off with something akin to the Cliff Notes for health reform, but before getting into that, observe that I think there was one sentence in President Obama's speech to the joint session of Congress which was about as clearly wrong as any President has ever said. And that was that he thought that if we succeeded with health care reform legislation, he would be the last President for whom this would be a major issue. I think the more correct observation would be that if he succeeds, he will be the first in a long line of Presidents who will be introducing legislation on health reform, probably for as long as anybody in this room is alive. The reason for that is that the industry is huge. If we got it right the first time, it would be nothing short of miraculous. We will make mistakes whatever we do. And I think by far and away the most important issue is not so much what we do, but that we do something, that we move off dead center on the issue of health reform.

So with that as background, I'm going to start also with the public option and provide a basis for what I'm sure will be disagreement within the panel, by saying that I think this has been a monumentally overhyped issue both by advocates and opponents. The reason I say it is not because a public option doesn't have within it the potential to be a game changer, but because, given Congress's fundamentally small-c conservative attitude toward preserving the interests of major constituencies, the chance that a public option would be allowed in a major way to erode the position of private insurance companies and the health insurance business is close to zero. With that constraint, if one accepts that constraint, then the fears of the opponents of the public option are grossly overblown, and the hopes of the advocates of the public option will, in my view, not be realized.

The second issue are the subsidies necessary to make an individual mandate affordable. How deep are they? That depends on the question of how complete the coverage that's mandated actually is. The major bills in both the House and the Senate, the draft bills, all contain plans of varying degrees of generosity, measured by their actuarial value, and the mandates differ depending on where a person is on the income scale.

The differences among the bills in the generosity of coverage, and in what individuals are expected to pay, is huge, and this issue is of critical, substantive importance. Just as an example, if you're just above the poverty threshold, the premiums required under the Senate Finance Committee bill are nearly five times as large as those in the first drafted Senate Health, Education, Labor, and Pension Committee bill, and more than three times larger than those of the subsequently drafted House bill, so-called HR 3200. The generosity of the insurance that would be bought for

the higher premiums in the Baucus bill is significantly lower, covering a smaller fraction of expected health care spending. As you move up the income scale, Senator Baucus's bill quits earlier, at 300% of poverty, and it does so with higher premiums and a lower level of insurance coverage than in the other two bills. That's one of the reasons why the Senate bill appears to be less expensive than the earlier Senate bill or the House committee drafted bill.

Let me turn to issue three. What do you do with employers? There are two questions here: which businesses do you exempt, how large are the companies that don't have to provide some kind of a contribution to health insurance on behalf of their employees? And if a company is large enough to be subject to a requirement, how large are the penalties imposed if they don't provide acceptable health insurance to their employees? The first issue, to put it crudely, determines how the various small business organizations will respond to this bill, and the second issue has a big effect on what the net cost in terms of required tax increases or spending cuts to pay for the bill.

Issue four are the exchanges. What are the rules they are required — are empowered to enforce, and how are they organized?

I'm going to move on because the next issue is the one that I've focused on, and I think, in the end, is going to be the critical one. It is summarized by the comment made to the two *Washington Post* reporters in the Watergate scandal by their source, Deep Throat: Follow the money. The money is of critical importance. The piece that is in your handout makes, I think, one central point, and that is that the ramp-up for spending under all the health care reform bills is slow, but then becomes steep. That means that the great bulk of the cost of the bill, whether it's 800 billion or a trillion, occurs in the latter part of the 10-year accounting period that is going to be used to measure the cost of the bill under Congressional rules. A simple rule of thumb is you're going to spend about 20% of the 10-year cost in the 10th year, and costs will be maintained at that level or higher in subsequent years.

Now, that's of critical importance, because President Obama has said throughout the year, and reiterated under terms he could not conceivably, in my view, back away from during his speech — nor should he back away from — that he will not sign any health care reform bill that is not paid for over 10 years and in the 10th year. Furthermore, members of Congress have tasked the Congressional Budget Office with providing at least a rough estimate of what the costs would be beyond that 10-year period. This requirement actually, I think, had a profound effect on the way in which Senator Baucus drafted his bill.

I told you you would get into budgetary weeds here, and here are a couple. The House bill actually rather bravely took on and addressed a legislative screw-up from some years back called the sustainable growth rate formula for paying physicians under Medicare. This was a proposal to place overall spending limits on how much is paid to Medicare physicians and stipulated that if the spending targets were exceeded, then the price, the fees of physicians would be cut enough in subsequent years to bring total payments back down to the target levels. Lo and behold, the budget was exceeded; lo and behold, Congress saw the implied fee cut, and for a number of years has done exactly

the same thing: they've said, "We're going to stick by that law, but not next year. Next year we will increase fees a modest amount, but we won't cut them as required under the formula." Well, right now, the backlog of required fee cuts is huge, in excess of 20% required for next year. Congress is not going to do that. But in order to correct it, you have to change the law, which the Congressional Budget Office will score as a spending increase relative to the baseline. The House bill said, "OK, we're going to fix this, and we're going to raise — try to raise money to pay for it." Actually, they didn't raise enough, according to the Congressional Budget Office's estimate. But when it came the Senate's turn, Senator Baucus's committee's turn, to do this, they backed away from this issue and said, "We'll fix it for next year, but not beyond that period." So they did what Congress has done in the past, and that has a very nice effect. Not only did it help the Congressional Budget Office bring in an estimate saying that the bill was paid for over 10 years by the tax increases and spending cuts contained in the bill, and in the 10th year, but in addition, although they couldn't give a hard estimate, it looked like the surpluses would widen in the period beyond the first 10 years.

So there is a bit of budgetary game playing that has been played and may well be played in any financial legislation that — any reform legislation that actually gets passed. But the challenge of raising sufficient funds to pay for a bill that members of Congress are willing to sign is something that remains to be addressed.

I don't know the answer to this. This is genuinely inside baseball. But I can see Arnie looking at his watch, and that suggests that it's time for me to stop.

**Katherine Baicker, Ph.D., Harvard School of Public Health**

**DR. EPSTEIN:** You said so many thoughtful and provocative things that I'm tempted to go for questions now, but I won't. Instead, I'm going to introduce Kate Baicker. Kate is professor of health economics here at the Harvard School of Public Health. She is one of the country's experts on the distribution and function of private and public health insurance markets. She's also spent two tours of duty in the government, most recently as one of three economists serving President Bush as part of his Council of Economic Advisors. Kate, thank you for joining.

**DR. KATE BAICKER:** So let's — what I would like to do is frame out what I think are the key problems that this raft of legislation's trying to solve and look at a couple of the features that are included in a lot of them and see how successful they might be at solving those problems.

There's clearly an overarching policy goal of making health care affordable to all Americans. Now, that means putting health care within reach of the uninsured, and keeping health insurance and health care affordable for those who are insured now. And that sounds like a relatively straightforward goal, but I think bundled in there are two goals, one that is relatively straightforward and one that is not straightforward at all. And it will come as no surprise that those two goals are related, and that trying to solve one has profound implications for the other. The relatively

straightforward goal is giving people the resources that they need to buy health care and health insurance. And if you're very low-income, or if you have very high health care expenses, the current bundle of health care that's available to most people in the country may not be available to you. It's not affordable because of your low income or because of your high health costs. And one goal would be transferring resources to people who can't currently afford the care.

So that's a relatively straightforward question, because we kind of know how to transfer resources. There are different mechanisms, different ways of raising taxes, different ways of distributing those resources. We have to decide how much we want to do of that. But once we do, we know how to do it.

The less straightforward problem, the even tougher problem, is getting high-value health care out of our system. Part of the reason that health care is unaffordable for a lot of people is that we're spending a lot of money on care that's of limited value in terms of improving health. Now, in a way that makes things seem easier than they actually are, because if we can say, "here's the health care that does a lot of good, and here's the health care that's kind of wasted — let's not do that," that would be easy. We would all be in favor of that, and we'd be done.

But of course it's not so straightforward to say which use of health care resources is really driving improvement in health and which resources aren't doing such a good job. And even if we could evenly divide them into health care that provides high value and health care that doesn't provide high value, it would be pretty hard to write down a set of public policies that pushed resources towards this while withholding resources from that, because it's not so clear to write down a set of rules that defines, here's the health care that's doing a lot of good. Even providers don't necessarily know that. There's a huge gray area of medicine. And that's where we see a lot of the growth in health care spending. It's in things that we're not exactly sure who they're doing good for and how much good they're doing. And that poses a real challenge.

Now, these two conflicting goals are obviously related, in that the more we bring health care cost growth under control, the more affordable health care is for people, and the more affordable the subsidies that we need to target those resources towards people become.

So that's the broad picture of the landscape. Let me try to then get into a few of the specifics of how different bills approach these problems and whether I think they achieve those goals or not.

I'll start with the more straightforward problem of just getting extra resources to people who can't afford health care or health insurance right now. The questions that policymakers face are how big should subsidies be, to whom should those subsidies be targeted, what's the mechanism through which they should be delivered, and one of the really contentious items in the debate is an individual mandate — should there be an individual mandate to get

health care or health insurance, and if so, how much are we going to subsidize people, and what people are we going to exempt because the health insurance we're requiring them to get is not affordable to them?

Now, I think we would all agree that getting everyone covered by insurance, especially when healthy, makes insurance markets function better. If you get covered when you're healthy, and then some people are unfortunate and fall sick, those are — you then have more people across which to pool that risk. The goal of getting everyone insured is so that we, as a community, then pool the risk of getting a bad draw and having an expensive health condition that we wish we had more resources to help cover.

The individual mandate tries to accomplish that goal by getting everyone covered when healthy. It's very different from an employer mandate, and that's another bone of contention in the debate about getting more people covered. This one, I think, is often misguided. There is an idea that if you make employers kick in some money to health insurance, that then gets additional resources to people who can't afford insurance coverage, and therefore will make insurance more affordable. The illusion there is that there is somehow some extra employer dollars to kick into the system, and that if you just got stingy employers who don't provide insurance to pay for a little bit of the insurance that their workers would then be able to get, everybody would be able to afford more care than they can right now. The reason I think that that's an illusion is that really, whatever employers kick in to any insurance policy comes out of workers' wages. It comes out of their wages because employers decide whether or not to hire people based on total compensation costs. When health care costs grow more quickly, wages grow more slowly.

Now, does that mean the employer system is bad, and that there's nothing to be gained from an employer mandate? No. Right now, employer pools are the only way that we do risk pooling for people who aren't covered by public insurance plans. Anything that eroded the employer market should be accompanied by something that promotes another way of risk pooling, either in reform of the nongroup market, risk-adjusted vouchers, there are lots of alternatives to that. But that's something to be very wary of in eroding the employer market. But it's that risk-pooling function that we want to be looking towards in the bills, not kicking in of extra resources from the employers. There's no secret pool of profits that we'll be drawing from.

The last way that a lot of these bills try to cover more people is through expansions of Medicaid up the income distribution. And that is one of the more expensive provisions of some of the bills, because right now, Medicaid is a joint federal–state program. And it would remain a joint federal–state program, but the federal government picks up somewhere between 50 and 85% of the tab, depending on which state you live in. And so most of the bills under consideration put almost all of the cost on the federal government of the expansion population for Medicaid. That raises all sorts of other issues, because the states that had already expanded don't want to be at a disadvantage compared with their stingier neighbors who hadn't expanded already, so that's a real political economy debate among the states and between the states and the federal government.

All of those provisions can be very expensive because covering the uninsured never pays for itself. It would be nice to think that reductions in emergency-department utilization, more efficient use of primary and preventive care, would actually save us money in the long run, so that these bills would pay for themselves. They don't pay for themselves, if we're honest about it, and the CBO is honest about it and says no, you need to raise about a trillion dollars.

That brings us to the second question of where you raise the money. The lesson that I take from the first issue I discussed is that it's not just about raising money. The straightforward thing is transferring money. If all we were trying to do was get low-income people some more money to buy health care, we would raise the money through general revenues. That's how we pay for transfers. We have a lot of general revenue tools at our disposal. You could do an income tax, you could do all sorts of different taxes to just raise more money. The reason we're looking to the health care system to raise the money, rather than just general revenues, is because we know the system is not efficient, and that there are ways you might be able to get some money out of the existing system that would lower the total cost in a way that promotes higher-value care. And that is the thornier problem.

I think the bills on the table don't go far enough in terms of payment reform. Medicare is the major player in this space, in a lot of this space, and if Medicare could get resources used more efficiently, then that would spill over to private plans as well. All of the cost-cutting measures that are on the table shouldn't be thought of as the same, because some will increase value and some won't.

I'll leave you with a thought on the interesting case of taxing insurers who offer really expensive plans. This is a very clever political idea, I think. Economists across the spectrum think that the way we currently subsidize employer-provided insurance is inefficient, because we subsidize people with the highest income and the most expensive policies at the expense of people who don't have access to employer-provided insurance. That seems both regressive and inefficient. This Kerry proposal to tax expensive policies is a clever workaround to political objections to taxing health insurance. It's very hard to say the solution to our expensive health care problem is to tax health benefits and make you pay more. That seems counterintuitive, even though economists think it's a great idea. Saying, well, we're going to tax the insurers who offer those plans — we're not taxing you, we're taxing those bad insurers — of course that gets passed right through to individuals, but it's a little opaque in a way that makes it more politically palatable, but it means that you can't do it based on income in the way that you could if you were to directly tax the individuals who have the more expensive policies. You could then do it in a more progressive way. So you sacrifice a little bit of progressivity, but you still go part way towards the goal of getting more value out of the system. That's an interesting case study in the balance of politics and economics. I'll stop there.

**Jacob S. Hacker, Ph.D., Yale University**

**DR. EPSTEIN:** The next speaker is Jacob Hacker is the Stanley B. Resor Professor at Yale University of Political Science. He is arguably the most prolific political scientist working in health care right now. He has written numerous articles and books, and those books have won a number of notable awards. But what really brings him to the stage today is that he is arguably the largest proponent, if not the architect, of the public plan. And so, as Hank has already foreshadowed, we might get to hear a little bit about that. Jacob?

**DR. JACOB HACKER:** So let's remember for a moment why we're having this debate. I am going to cite two sets of statistics that both emerge out of the Harvard Medical School–Harvard School of Public Health complex. One is that about three in five bankruptcies in the United States are due in part to medical costs and crises. There's another study by a Harvard scholar, but not here, that shows that about half of foreclosures are also due to medical costs and debt. And just recently, a study was done here that suggests that perhaps as many as 45,000 unnecessary deaths in the United States are due to lack of universal health insurance. So we're not just talking about a dollar and cents and financial risk issue, we're talking about a life and death issue. And that goes well beyond those who are uninsured, to the millions of Americans, like most of the three in five who declare bankruptcy — one family, one household every 15 seconds — who have insurance but who don't have adequate protection.

And with that unhappy story, I want to turn to, I think, a happy report. I just got back from Washington, and a lot is happening there. In fact, for the first time in the history of comprehensive reform debates, we have complete legislation that has been reported out of committees in the House and in one committee in the Senate, and there's markup taking place, as you know, right now, on another bill from the Senate Finance Committee.

So we are at a point, I think, a fateful moment in the debate. The architects of this effort have taken three broad lessons out of the failure of health care reform in the early 1990s. With apologies to James Carville, I've summed these up in a piece in another journal of health policy as: "it's the politics, stupid; don't forget fear; and changed politics versus more of the same."

So the first lesson, "it's the politics, stupid." The best-laid plans are no good if you cannot get majority support for them, or even 60 votes in the Senate. I think that lesson was learned pretty beautifully. The plans that have been put out are not pretty. They are meant to pass. And I think that's why we're at a point where we can actually talk realistically about their passage, though I share Hank's concerns about the financing side of the picture, and many others as well.

The second lesson that I mentioned was "don't forget about fear" — the fear of those who have coverage today, fewer than in the past, but still the substantial majority of Americans, that reform will undermine the quality or raise the cost of their coverage, the fear of government and taxes is very much a part of our discourse. I'm not so sure that

that lesson was learned quite as well as it should have been. If you have been following the discussion, it looks as if fear of government and fear of the negative effects of reform on people's care, including those who already enjoy government-sponsored health insurance in the form of Medicare, have been rampant, have been fed by misinformation, and have had, I think, a big effect on the tenor of the debate and the urgency with which President Obama is now seeking a deal, even if it is — falls well short of his original aspirations.

Now, to my mind, there are two ways in which we can respond to the fear that has been a part of this debate. One is to fight fear with fear, to talk about the risks that Americans are facing today and the risks if we don't act, and that's certainly something the advocates of reform have done. The other side of the equation is to fight fear with hope, to talk about the vision of reform and a reformed system that could actually bring us to a better, higher ground. I have to say that it's there that I think that the effort has been most anemic so far. I mean, the plans are not just complex, but they're lacking a kind of underlying articulated vision that President Obama and congressional leaders have been able to bring out and use to try to bring Americans along with them. I think it's quite remarkable in many ways how well things are going right now, given how poorly many aspects of this larger campaign of talking about and discussing the issue has been managed.

Now, let me give you one randomly chosen example, and it won't surprise you what it is — the public plan, right? The public plan was an essential element, if ignored element, of President Obama's campaign blueprint. It was actually in all of the Democratic candidates' health plans. And it was there for a couple reasons. One, the political reason is that it was a way of speaking to those on the left who believed that we need to have a substantial alternative to private health insurance, particularly for-profit insurance. And second, it was there because it was a means as well of explaining in clear and simple terms how affordable coverage could be made available to people in a system that would continue to be principally reliant on employment-based health insurance. After all, it's very hard to think about how just the creation of some exchanges that would have 20 or 30 million customers, people who don't have coverage today, or who are working for very small employers, would somehow magically transform our system to make the private insurers that have doubled premiums over the last 10 years, raising them four times faster than wages, to suddenly become cost-conscious and efficient actors helping to bring down the runaway costs of medical care.

And indeed, I think that it's worth noting that the public plan also has come to solve another problem, both political and a policy problem, for the administration as it has moved towards embracing the individual mandate, because I think there's a great deal of worry out there, not just on the left, about the idea of requiring that people get health insurance from these private insurance companies without them facing some substantial competition from a public-spirited competitor for the business of those who are now required to have coverage, the millions who will be brought into the market for the first time.

The third lesson that I mentioned in this piece was “changed politics versus more of the same.” And what did I mean by that? I mean that there has been a nostalgia, and there certainly was during the Clinton administration effort in the early 1990s, for that bipartisan politics that produced the Tax Reform Act of 1986, the Greenspan-led rescue of Social Security in the early 1980s, those smoke-filled rooms where men and men, Republican and Democrat, got together to work out their differences, in a world where all politics was local, as Tip O’Neill famously put it.

Well, that world’s dead. It’s gone. We live in a hyper-polarized political climate. Dick Arme summed up the new maxim of our age by saying “Not all politics is local, but you never offend your base.” And now Republicans, as we’ve seen, are busy trying to cater to that base. If you look at the numbers, the Republican party has gotten very conservative over the last generation. You don’t even have to look at the numbers — you can look at your TV set — and it’s moved to the right, and for different reasons than the Democratic party’s moved to the left. The Democratic party has moved to the left mostly because of the loss of its conservative Southern Democratic contingent. In fact, if you look at ideological issue scores, the Northern Democrats are basically where they were 20 or 30 years ago. But on the right, each generation of Republicans that has replaced the next has been quite a bit more conservative, according to these scores. Now, I think that’s going to change, because of shifts that are occurring in American politics today. But we’re living right now in an environment where reaching across the aisle is a way of getting your arm chopped off.

Now, this all may sound pessimistic, so I want to end, actually, I think, on a hopeful note, and on a hopeful note with regard to not just the overall effort, but the fate of the public plan. And I think that the one thing that gives me heart is that at every stage, when it looks like the public plan has been on the rocks, it’s been rescued. It’s come back, because, as I said, it is essential for two simple reasons. One, it’s an essential guarantee for Americans that they will, in a reformed insurance environment, have a real choice to the kinds of private insurance plans that have helped get us into our present mess. And second, it actually delivers substantial savings. The Congressional Budget Office has — it’s a moving target on these numbers, but — just came out with new scoring on the House bill that says that the House legislation, with a Medicare-like public plan that’s tied in part to — tied to Medicare rates, and has a provider network that builds on Medicare’s, but allows doctors to opt out, that that plan would save about \$85 billion over 10 years, which is not trivial money. Rather than trying to treat it as some kind of litmus test of a loony left, why not just treat it as something, as the President has said, that’s crucial to keeping insurance companies honest. If it can pass, it will, and if it can’t, we’ll know that soon enough.

And so it is time to step back, I think, for all of us, and decide, what is the ultimate goal in reform. It is not a public plan in itself. It is affordable, quality health care for all Americans. I don’t believe that that is something that is hard to define at a certain basic level. I think we know what that means. And so let us hope that that’s the outcome of this debate.

**Mark V. Pauly, Ph.D., University of Pennsylvania**

**DR. EPSTEIN:** Next and last speaker for this symposium today will be Mark Pauly, who's the Bendheim Professor at the Wharton School of the University of Pennsylvania. He's formerly executive director of the Leonard Davis Institute at the University of Pennsylvania. He's certainly one of the country's most distinguished health economists. Mark, thank you for joining us.

**DR. MARK PAULY:** I understand there to be four goals of health reform as currently being discussed. It is to cover the uninsured, lower cost growth, improve quality, and only tax rich people. My judgment on that is: that's impossible — that you cannot do all those four things, that you have to do something else. Something's got to go. I hate to say that, but I am following the advice of my econometrics professor in teaching forecasting who said, "When you forecast, always forecast what you don't want to have happen. Then, either you'll be right, or you'll be pleasantly surprised."

But I actually do believe in my heart of hearts that the four goals I've outlined are not going to be able to be achieved. And so what I've asked myself is, supposing that I'm right, and that that's true, there will be buyer's remorse once, if we do get something passed — and I believe we will get something passed, something that we'll call health reform — and if that's so, then what are the flash points for this buyer's remorse? They are also, of course, feeding back a bit into what should be put into the plan in the first place, perhaps, to avoid buyer's remorse.

OK, so the first thing I wanted to comment on as a flash point is the employer mandate. I might as well be outspoken here and say I think we need to lose the employer mandate. I think it's a really bad idea, for two reasons. Probably there's more, but I'll just tell you about two. One is it's terribly inequitable. If you think of the low-wage worker who's working at a small, low-wage firm that would pay, and then the person would go to the exchange and get a generous subsidy, you'd have the worker with the identical skills working for a high-wage large firm — Kate's already given you the economist party line on this. We believe workers pay for their benefits. That low-wage worker working for the high-wage firm will not be receiving anything like the subsidy available to the other low-wage worker, and I just think that's both unjust and destabilizing.

More importantly, though, despite what economists think, employers think they do pay the money for health benefits, they do think it comes out of profits, and they've been very quiet lately. I'm from the business school, so I can tell you why. Their attentions are otherwise occupied in trying to deal with the macroeconomic disturbance. But once they notice that they are probably first in line when this thing doesn't really work out to have to pay the tab, which I think is likely, then they will take notice and do something, and I think they may notice that even before passage, but certainly afterwards. And so rather than create unnecessary and inequitable opposition to what is fundamentally an important social goal — let's cover everybody in this country, or almost everybody — my view would be let's think of some other way of doing things other than an employer mandate.

I have another way, which is what I call an employer-enforced individual mandate, which essentially says — I'll get to it in a minute — start with a just and wise individual mandate, but for those people who are workers, give the employer first dibs on arranging the insurance that satisfies that mandate, and also give the employer the task of making sure — because the employer, after all, is processing the individual's payroll checks — that some money is going toward health insurance.

The second point that I wanted to make that I think is a flash point is the individual mandate. I have long been in favor of an individual mandate, since 1989. And I guess my simplistic view of this is: don't mandate if you must exempt. In a way, this is sort of the ultimate touchstone. It only is comfortable to mandate coverage if the subsidies that are being provided are regarded as adequate and enough to make care affordable.

Now, I'm here to tell you I don't know what affordable means. But I can absolutely guarantee no one else does either. It's a social value judgment. But whatever it means, the way to make sure we get there is to say that we won't offer a mandate unless we provide subsidies sufficiently generous to all the people we are mandating to feel comfortable doing that. But at this point, I think the important thing about an individual mandate is to get it right the first time, because if we get it wrong, it's just going to be another flash point for all sorts of consternation, at a minimum, and perhaps for even further corruption.

The third thing Kate had already mentioned a bit, the tax on the high-cost plans. I think this is too clever by half. I'm not in favor of clever. I went to the University of Virginia. We revere Mr. Jefferson, and we believe you ought to level with the American people, not try to pull a fast one on them. And it really does make me upset if — I know what we're trying to do here. Unions don't want to go out on a date with caps on excluded benefits, so we've dressed that date up in context of a tax on insurers, but nobody thinks the insurers will actually end up paying for it. I'd rather be straightforward on the grounds that everybody sees through this duplicity anyway, so if it actually should come to pass, it probably wouldn't be very stable. I don't think American people and voters are stupid. And we ought to do the right thing, and of course the virtue of capping the exclusion is you do get more equity out of that, in the sense that the exclusion — the value of the exclusion to low-wage people, if there might be some of them with very high-cost health plans, at least the penalty they would have to pay is quite small, whereas when you cap my high-cost health plan, I would be paying a lot more, and that seems to me to be the right thing to do.

There are a lot of issues, of course, designing either a cap or a tax, some of them having to do with other reasons for variation in insurance cost. I believe where there's will, there's a way. We can risk-adjust these things. We can geography-adjust these things if we want. But the universal health economist favorite of something to do — both to raise money, to improve equity, and to bend the health care spending growth curve — is to do something about untaxed, tax-exempt employee benefits. So if we don't do anything else, we ought to at least do that.

Fourth point, community rating. There is an issue here. What we want to avoid is what's called — the term of art is “reclassification risk.” You are at the moment a healthy, robust, magnificent physical specimen, and — but you still could get sick, so you'll want to have health insurance, so that's one thing you want to protect yourself against. And people who have insurance are protected against that. But for a lot of people there's another thing that could happen, which is not only do you get sick this year, and you'll have to pay those health care costs, but you become a high risk for the rest of your life, or at least for a long period of time, and if you're in the wrong place at the wrong time, that could result in you having to pay higher health insurance premiums for the rest of your life. So that's what we want to avoid. But using community rating to do it is the dumbest possible way to do a good thing that I can think of. And the primary reason is community rating, in effect, is not risk pooling, it's risk transfer, and it achieves its purposes by imposing an excise tax on the health insurance of low-risk people to pay for the subsidy, an appropriate subsidy, for the health insurance of high-risk people. We know excise taxes are a bad idea, and in fact, as some of my research has shown, if you do tax the low-risk people, they'll drop coverage, if they can. So you actually make the problem of the uninsured worse.

But there are much better ways. The obvious one is a high-risk pool, of course ideally funded by equitable and efficient general revenue taxes. An even better idea is what's called guaranteed renewability at class averages, which basically says, when you buy insurance while you're healthy, pay two premiums, one premium goes to cover your cost this year, the other goes to an insurance which in effect will pay the difference between the low-risk premium and the high-risk premium until you go on Medicare.

And my final point has to do with Medicare, which somehow seems more important to me than it used to. But I am somewhat ashamed of my demographic, but I'm going to say what we're supposed to say: keep your hands off my Medicare. And the main point is, as the President said, he anticipates funding most of the cost of coverage for the uninsured out of Medicare. We just don't want that to happen, but we can't be spending that money twice. We can't use it to cover today's uninsured and at the same time have it available to improve the very dire fiscal fortunes of Medicare.

So those are my five comments. I think these are all places where we need to pay some attention, where especially we need to pay attention to a scenario in which we're going to have to revisit them. I very much agree with Hank on that. Massachusetts is a state that went to universal coverage, but there were more than a dozen states that started on the way to universal coverage and never got there, even if they passed legislation. So there are a lot of slips between cup and lip here, and we want to make sure that the number of slips here is minimized.

And I guess, for a public plan, I guess my view on that is, let's say we have a public plan. Thank you.

## **Conclusion**

**DR. EPSTEIN:** I want to just pick up as we close where Henry started out, which is the notion that this is not all going to be over as we pass or don't pass legislation. And I think that's true. I head the Department of Health Policy and Management, and I will still be in business.

Having said that, we haven't been here in at least 16 years, and we have the chance of doing something, whatever that is, that may substantially change our health care system. So I really want to thank our sponsors for fostering this opportunity to learn more about it, for our panelists, to help edify us about the opportunities and challenges, and I hope you'll all join me not only at the reception, but in wishing that we'll be pleasantly surprised with what happens.