

# **THE URBAN INSTITUTE**

## **TOP TEN MYTHS ABOUT THE UNINSURED**

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ROBERT REISCHAUER: I'm Bob Reischauer. I'm the president of the Urban Institute, and I want to welcome you here on behalf of the Urban Institute and the Urban Institute Press for this event which marks the publication of a new book, "Health Policy and the Uninsured."

The United States, as you all know, is unique among developed nations in the world in that a large fraction of our population lacks health insurance, something like 17 percent of the non-elderly population. The topic of the uninsured is one that is a perennial focus of policy experts and those in the healthcare world, but the interest that the American public and the political pays to this problem is one that ebbs and flows over time. It seems that this book is being published at a fortuitous juncture in that attention once again is focusing on this issue. As costs have risen and employers have shifted an increasing fraction of the burden onto their workers, the public has become increasingly concerned about the health insurance they receive and whether it's a good value and whether they will continue to be offered it.

As the public's concern has increased, so too has the attention being paid this issue by politicians. As you all know, Dick Gephardt stepped to the plate first with a very ambitious plan dealing with insurance, and he was followed by all of the other Democratic candidates in a rather unusual set of circumstances where we have, in a sense, many proposals for dealing with this issue being debated among the Democrats. The president has continued to stress tax credits as a solution to this problem and has included in his budget the proposal that he introduced last year, and the majority leader of the Senate has also weighed in and said that this is among the top concerns that he has for the coming year.

So it is, as I said, fortuitous that this book, which has a number of interesting essays in it looking at the problem of the uninsured through different lenses and new perspectives, is coming out at this time. We're here to have a discussion, which will be led by Catherine McLaughlin. Catherine is a professor in the Department of Health Management and Policy at the University of Michigan, and more importantly the director of the Economic Research Initiative on the Uninsured at Michigan. She is also senior associate editor of Health Services Research and has been a major contributor to the literature in this field.

We're also all thankful for the support that the Robert Wood Johnson Foundation has provided to this particular effort and to the larger effort of focusing attention on the uninsured and supporting the development of policy and analysis that might help address this problem.

Without further ado, let me turn this over to Catherine.

CATHERINE MCLAUGHLIN: Thank you very much, Bob. I'd like to thank all of you for joining us here today. I wish that I could say, oh, we planned this perfectly so that the timing was right, but we didn't; it was just fortuitous. Not only are economists not very good at predicting political winds and what's going to be popular, but it turns out we weren't very good at predicting how long it takes to get a book out to print. So this ended up just being lucky timing for all of us.

The Economic Research Initiative on the Uninsured, as pointed out by Bob, was developed and funded by the Robert Wood Johnson Foundation as part of a much larger coverage initiative. The original idea really came from David Colby and Linda Bilheimer, who are both here in the room, and Jack Ebeler. And they said we needed to think about the research issue surrounding the coverage initiative. It wasn't enough just to have dissemination and information provided; we really needed to have a research arm to this broader coverage initiative, and more specifically, an economic research arm. And so, a little over three years ago on a very cold, wintry day in Ann Arbor – which we like to tell recruits is unusual but is really the standard – the three of them showed up in Ann Arbor and met with a couple dozen economists from the University of Michigan, and sort of pitched the idea as a challenge. They said, we really are challenging you to think anew about the issues surrounding the uninsured.

There's been a lot of research in the last 20 years about the uninsured, a lot of information out there, but we're not sure how much evidence there is about the causes and consequences of a lack of coverage. And in part it's because some of the research has been produced in a vacuum; it hasn't been produced within a conceptual framework that predicts how individuals and firms behave. And because of the dominance of employer-sponsored health insurance in this country, labor economics is particularly relevant for providing this kind of conceptual framework. And because of the financing issues about our health insurance system, public finance economists are also very knowledgeable about the interrelationships between health insurance and labor force participation, and employees' decision-making and firm decision-making, and so we really would like you to come together and with sort of new eyes, new ideas, once again address this issue, because we really think it's going to bubble up. They were actually predicting it was going to bubble up; we were not.

And so we sat there and thought about it, and several of us are health economists who have natural interests in the uninsured. It's something that we have studied on and off for the last 10 or 20 years, so it was an easy sell to us to spend time looking at the issues of the uninsured. It was not such an easy sell to labor economists and public finance economists who have never looked at the uninsured, because they sat there and said, well, personally I understand what the issues are, and most of them had some personal experience with someone who lacked health insurance coverage, sometimes a child, sometimes a sibling. And they said, we understand the importance of insurance coverage, but what can we contribute?

And it soon became quite clear to us that we needed to do several things in order to get them willing to spend time looking at these issues, one of which was a summary of

the state of the art: what do we actually know? And we needed to have a very critical view of what we know, and not just going down study by study and say, well, this study's flawed or that study's flawed, but we needed to have a conceptual framework built so that we even knew what the relevant questions were. It's one thing to try to figure out, did this question get answered? Are we satisfied with the answer to that question? But if you do only that you may be in fact missing the fact that some important questions have never even been asked.

And so we decided to commission six papers from economists who are knowledgeable about the field and ask them, establish a conceptual framework within which you would look at, what would we predict behavior to be? What would we predict the incentives to be and how people would respond to those incentives? And then critically synthesize the literature that's out there already and say, all right, which of these questions have been answered? Which ones do we think we actually can say something about that effect, about that incentive, actually predict, how would people respond to a policy that changed these different incentives? And what is left; what are the questions that are left unanswered?

This is what we set out to do, and the result of this is this book. And one of the things we really realized was important is not only the production of knowledge. I mean, most of us are academic economists. We're not here in the D.C. arena of policy analysis and policymaking; we're not part of think tanks, we're not part of lobbying groups. We're academic economists, so we tend to be a bit dull. We're in an ivory tower; we don't always think that we have to influence policy. We feel kind of lucky, in fact, most of the time that we don't have to influence policy; that we can just talk about those beta hats and how important they are. And we're in the business of producing knowledge, so we know about the production of knowledge. We know how to go about saying, these are unanswered questions. What methods can we bring to bear? What data can we use? How can we produce some knowledge? We're less talented at, how can we translate that knowledge into something that's useful for the policymaking process?

And this is the additional challenge that David and Linda gave to us. They said, we really think you need to be able to translate this into something that's usable, something that will make a difference. And you may ask, well, why did this group of academic economists step up to the plate? Why did they say, not only am I going to learn about health insurance and learn more about the literature and what contribution I can make, but I'm actually going to try to translate that into something that's useful in the policymaking process. And the answer that I have is that all of them realize the importance of insurance coverage. All of them realize the importance of policymaking process in changing the current state.

As Bob pointed out, the United States is almost unique in the situation it has with respect to the uninsured, and everybody at the table on that very cold, wintry day – and it was brutally cold, as David and Linda keep reminding us – (chuckles) – came out at 8:00 in the morning just for, you know, a cup of coffee, warm coffee, to talk for three hours about this issue and sign on and say, yeah, we're going to do this. And a lot of us

afterward said, you know, part of this is because we remember 10 years ago in the early 1990s when they last attempted some kind of health policy reform, tried to do something about the uninsured, policymakers turned to the academy, they turned to us and said, what do you think? Can you give us estimates? Can you tell us what would happen? Can you explain what the unintended consequences might be? And a lot of us answered, well, actually no, or, you know, I don't really know. And those who did respond with answers disagreed with each other. There was no consensus.

And so, although there was a lot of finger-pointing and blaming after what many people think of as the healthcare reform debacle, no one really blamed academic economists, but a few years ago I heard a senior health economist say, you know, we do share some of the blame. We really let the ball drop. We didn't really pay attention to really good conceptual frameworks and models. We didn't really coalesce around what do we know and what don't we know, and this is our chance to do it. And I have to believe that that's what motivated a lot of us to spend a lot of time on this particular endeavor. And the result of some of that is this book. We've also funded about 40 research projects that now are trying to produce knowledge to fill in the gaps that have been identified by these authors of what do we really not know a lot about? Most of these questions he have suggestive evidence, we have studies that have in fact looked at it, data that suggest what the effects would be, but we still need more knowledge to push us into the category where we could all agree, this would be appropriate policy, this would be the expected consequences of that policy.

And so today we've set this up as sort of the 10 top myths, sort of what did these researchers find out that we know and that we don't know? And these are going to be handled by Mark Pauly and Len Nichols of saying, all right, these are things that a lot of people believe about the uninsured; what did this very careful review of over 1,500 articles that have been written about the issue of uninsurance in the last 15 years reveal about what we actually do know and what we still need a lot more research about in order to inform the process so that we all get to that endpoint that we're looking for of improving the health status of Americans?

So Mark Pauly, professor at the University of Pennsylvania and the Wharton School, someone known to many of you, is going to start off first talking about five of those myths. Mark is on the oversight committee of the Economic Research Initiative on the Uninsured. And then Len Nichols, who is here at the Center for – I always call it CTS, but I know it's Health Systems Change.

LEN NICHOLS: Close enough.

MS. MCLAUGHLIN: Did I get the formal title right? -- also a fellow economist who's been on the research committee of ERIU for the past three years.

So, Mark, if you'd like to start.

MARK PAULY: Sure. So our task here is to talk about 10 myths, and the one question you might ask yourself is why are there 10 myths? Why isn't it all crystal clear? Of course, the reason is partly the usual suspects: some people, not probably most of the people in this room, at least some of the friendly faces I see, but maybe some have a life and they think of other things other than the uninsured – (laughter) – but I need to say, with the rising consciousness of this subject being generated by the political debate, I think that'll probably go away, and this work hopes to contribute to that.

Then there are certainly also myths that get generated by people who, for various reasons, have already adopted an ideological or policy position and are desperate that what they believe to be true really be true, and so that works in that direction.

But the third reason, which I think is kind of important and in some ways is my overarching message for all of these myths, is that, to use the 85-cent word that economists love and other people don't, it's heterogeneity. It is that whether you talk about the character of the uninsured or the opportunities they have to get insurance, or the kind of insurance they get, there's enormous variation at the moment and enormous potential variation in alternative designs. And so, although some of the myths will be of the good old true-blue American type – you've said this was true and it's not, it's false – many of the myths that we'll talk about here are what I call misplaced certainty, a failure to take account of the complexity – I hate to say it but it's true – of the initial situation with regard to the uninsured and probably, therefore, of potential solution strategies.

More generally, let me just say a word about solution strategies. Of course, if there were unlimited funds to be put toward making health insurance free for everyone, and/or if the general taxpaying public were 100 percent convinced that this is all they want to spend their money on, both of which I think are not true at this moment, although who knows in the future, then in a way you wouldn't be so worried about the differences and the nuances; you would just cover everybody and be able to sleep well at night. At least I would sleep better. But the dilemma, and in a sense the challenge we face now I think, and probably for the foreseeable future, is there really isn't a ton of money to go around or a ton of political willingness, and so it's going to be incumbent on anybody designing policy to be careful and subtle and efficient – I hate to say it but it's true – and even graceful in designing policies that fit the variegated character of the uninsured population – the insured population as well which could just as well become uninsured, and actually does with fairly high frequency – and the situations in which people obtain insurance. So all of those are important.

Are we going to have a myth board?

MR. PAULY: Oh, right. So, without further ado –

MS. MCLAUGHLIN: We have our own Vanna White.

MR. PAULY: Yes, right.

(Laughter.)

MR. PAULY: Actually, myth number one is – it says here, “Hold up the product” – (laughter) – is well debunked by the cover of the book. The uninsured are all alike, is what some people may believe. And not to pick on anyone because everybody has to make a living, but the standard story about the uninsured usually consists of an interview with this person and this person and this person, if he could talk – (laughter) – and the general characterization of the uninsured is often disadvantaged, low-income, vulnerable people, and certainly that’s true, and that’s the problem, and it’s kind of hard to discuss in words statistics, and it’s easy to say, many of the – the following sentence could have almost any predicate: Many of the uninsured are . . . because there are millions of uninsured and many of them are almost anything, including short with red hair, or whatever you have in mind.

But I was pleased to see this person down here, a young male. My original suggestion was as a poster child for the uninsured it should be Fonzi because he – you know, he was young, worked part-time down at the motorcycle shop, so probably didn’t have group health insurance, was a magnificent physical specimen, as we all know – (laughter) – but this is a more up-to-date example. This person is either pondering, should I get insurance, or, where am I going to find my next latte? (Laughter.)

But the main point here is that the uninsured cover a wide range – not a perfect match for the U.S. population, to be sure. They tend to be somewhat lower-income and in somewhat poorer health, but because there are so many of them and because uninsurance actually is not something that’s all that selective in terms of how it hits the American population, there are many that are young and healthy but there are many who are not; there are many who are reasonably well off, including a sizable fraction above the median income. I don’t know who these people are or what they are thinking – maybe it’s that guy there – but they definitely do exist. And then, as is also important to note, there is a sizable fraction below the poverty line who are also sick and in a bad situation.

So the main message here is – the main myth is that the uninsured are all alike. The truth is that they are very different, and I think the message of that for policy design, at least in the current budget, and, I believe still, voter – taxpayer constrained world is that you do have to be careful and clever in making funds go as far as they can. And I think both the administration’s proposal and – not to give my own predictions here, but the Democratic frontrunner’s proposal -- Senator Kerry’s proposal both take account of the fact that the uninsured are in very different situations and sort of adopt a different-strokes approach. So that’s a myth which you can find further discussion of in both Pam Short’s paper and the Chernew and Hirth paper in this wonderful book.

Myth two: There were 44 million uninsured Americans in 2002. Well, that is the official number, of course, from the current population survey, but the problem is – again, economists complained about this all the time – we don’t know absolute truth. There are two important things to say about that count, as summarized very well in Pam Short’s

paper. First, the truth could be on either side, I guess is the main message here. The most obvious thing is what the CPS question is supposed to ask people is, did you have health insurance at any time in the 12 months ending two months ago? And then people are supposed to remember that and ask it.

So the 44 million then would be people who never had insurance in this 12-month interval, at least ideally. Obviously that leaves out a quite large number of people who lack insurance for a period shorter than 12 months or the interval in which they lacked insurance didn't quite match that window. And there is some evidence that, as you would expect, that not having health insurance, even for a period of time less than a year, is bad news, not helpful, but exactly what difference it makes still remains to be seen. On the other hand, as economists are wont to say, it is pretty clear that the 44 million kind of overstates the people who really were totally uninsured for 12 months, based on some other more direct measures that have kind of nailed people down and said, now, are you really sure that you didn't have any insurance for that time period? So it's probably a bit of an overstatement of the people who were insured for a full 12-month period.

The truth is somewhere in between. I guess I console myself with the thought that the most important thing to establish here is not the precise number as long as the number of uninsured gets into the high millions. I personally want to see something done about it. And from an analytic point of view, the thing to probably focus on more is the trend, which has recently been quite adverse, in the number of uninsured, and that's probably somewhat more reliably calculated, assuming that the measurement errors – that people do the same dumb things year in and year out when they answer these questions. So that's that myth.

The third myth is: Coverage is coverage is coverage. We think – and not just we researchers, but even a lot of people out there in the real corporate world think that the design of insurance policies really do matter. Insurance is not insurance, and our insurance is in some way better than your insurance. It may be better in terms of the kind of financial protection it offers, it may be better in terms of the kind of financial protection it offers, it may be better in terms of the potential for improvement in health it offers, it may be better in terms of the humanity of the treatment that you'll get when you contact the healthcare system, but insurance can be very different. Or to put it slightly differently, imagine a policy that gave every American as much insurance as \$100 could buy. Every American would then have insurance, we'd have zero uninsured, but we wouldn't really be in that much better of a situation than we are now.

Now, there is a more debatable proposition that if you gave people catastrophic insurance related to their income, whether that might do a lot of good, and some evidence that it actually would, compared to sort of the first dollars you spend on almost anything generally do more good than the last few dollars, so there's an important design issue there. But the punch line is that the head counts are not enough, that the actuarial value of insurance may vary, and even given actuarial value, given the same number of dollars spent on insurance, the consequences of insurance may be different, depending on the form that insurance takes and the harm of not having insurance may vary with the time



coverages lost, which is probably interacted with the nature of the people losing coverage.

Moreover, the kind of insurance that people get depends very strongly on where they get it, if they get it in a large Fortune-500 firm whose benefits department is run by an angel come down to Earth, they will get very good coverage and well designed coverage. If they get it from Gus and Otto's Garage and neither Gus nor Otto were trained as actuaries, it may not be quite such great coverage. And if they get it in the individual market, it depends on how good they are – the consumers, I mean – at searching through the wide range of possibilities available in the individual market to find at least the best buys out there compared to some Venus flytrap policies that are just waiting to consume the unaware. So all of those things are important. It's a tough world, but it does mean that insurance is not insurance.

Next.

Myth number four: Individuals without insurance choose to be so. I mean, in some general sense that has to be true. There is no law in this country prohibiting people from buying insurance, and you could go buy it, individual insurance, although if you are a very high-risk person you might find yourself paying for the insurance than you would expect to get back in benefits for sure. But, more generally, if we think of realistic choice or reasonable choice -- again, heterogeneity is the buzzword – for very low-income people or for people at very high levels of risk, if they don't have insurance now, at least obtaining insurance voluntarily is probably not an option.

We also know that – especially in some of the studies that Len and Linda did about group insurance, that matching isn't perfect and there are some people who probably want insurance who are trapped in a firm that doesn't offer insurance. Now, they don't want it so much they go out and buy it from their brother-in-law the insurance agent at an outrageous premium, but they do want insurance but they can't get it. Probably there are some other people as well who really don't want insurance but are trapped in a firm that offers it to them at such a great price they can't turn it down.

But the general message is that a lot of people don't have a realistic choice. Some of the work here – and I think Len is also going to mention this – we try to make a rough estimate of how many people in a sense are not – of what fraction of the uninsured are not either so poor or so sick that insurance is not a reasonable option. That number varies – at least according to my view of it – somewhere between one-third and one-half of the uninsured, depending on how poor is poor and how sick is sick. But then that means somewhere between half and two-thirds of uninsured probably do not have a reasonable choice, and that's the issue of targeting financial assistance to make your money go further, and that's where you need to pay attention to it.

Last myth. Now, this is absolutely a myth but it wasn't intended to be quite so mythical. Smarter people than all of us worthies who put these together may have noticed that we probably meant that to be \$400 billion, not \$400 million. (Laughter.)

But it's absolutely true – it may actually be true that they pay \$400 million, but the myth was supposed to be that they pay \$400 billion. And I'm going to try to make a score out of a busted play here by saying the way economists think about this is even if it was \$400 billion it wouldn't be true. And the way to think about that is imagine that somebody could wave a magic wand and make \$399.6 billion of employer payments for health insurance go away, so we did get down to \$400 million, well, the definition of "pay" in economics is not who writes a smaller check, but the definition would be, would employers then have \$399.6 billion more of profits that they could use to pay the widows and orphans who own their stock or to compensate their senior executives, or whatever they wanted to do with it.

And the answer that economics gives -- and it's well summarized in a couple of papers in this volume -- is no. And one way to think about why the answer is no is to think about why employers offer health insurance. Now, some of them of course do it out of the goodness of their heart, and some of them do it – at least we're trying to convince some of them to do it because offering health insurance may make your employees healthier and therefore more productive, and there may be a business case for doing that -- but most employers, at least if you locked them in a room and asked them, why are you doing this and then whining and complaining about it, why don't you just stop doing it, will say, well, we need to offer health benefits to be competitive in the market for workers; we need to offer health benefits in order to be able to attract and retain high-quality workers, which is another way of saying obtain – given quality of worker for less money.

And so the punch line would be that if somehow employers were not allowed to spend \$399.6 billion, then in order to attract the workers that they were formerly attracting with this benefit, they would have to use something else to attract them with, probably money or maybe other benefits, and that could well eat up all of the \$399.6 billion that was saved. So that's at least one way to think of why economists are out of step with the rest of the world. We don't believe that employers actually pay for health insurance or that it makes U.S. products noncompetitive. We believe that ultimately workers end up paying.

This argument also works in reverse, I would say, which is of course more germane for the current situation. Imagine that employers would be mandated to provide health insurance, as has been proposed and even approved by a majority of voters in some states in the United States. Who's going to actually end up paying for that? Well, the story is just the same as the story I told but in reverse. Initially of course employers will do most of the complaining about it, as they have, and threaten to lay off workers, but that will, at least over time, soften the labor market, cause raises to be smaller than they otherwise would have been, and sooner or later, with some exceptions that I'll mention in just a moment, the bulk of workers will end up paying for this health insurance that the politicians, or for that matter their fellow citizens, in a referendum gave them. They'll end up paying for it themselves unless they receive a subsidy. Of course, if they receive a generous subsidy – their employer does, as Mr. Gephardt proposes – proposed; I guess that's past tense now – that will go to workers.

And to even – this will be my last comment on this – even rising double-digit health insurance costs for employers may actually be – would be paid for by workers. And I guess the main message here that at least I preach to employers is, don't react to these rising costs by taking a meat ax to your benefits, because after all, for many of your workers if the reason the benefits costs are rising is because medical care costs are rising, their alternative when they don't have insurance isn't zero medical costs, isn't zero money, it's they're going to have to pay for them in an uninsured way. And we had the spectacle actually on GE stock; we had the spectacle of workers at GE going on strike for lower wages – or lower raises in order to preserve their health benefits, and I think that's some evidence in that direction.

Of course, this general theory doesn't work perfectly. If the money wage is constrained by the minimum wage – the wage can't fall below the minimum wage – and it may take while for the wage contract to be readjusted, and there may be inept benefits managers. If your benefits costs rise at your firm because the person you hired to manage benefits has totally screwed up, you can't expect your workers to take lower raises just for that; they'll say sayonara and go work somewhere else. But more generally, at least on average across labor markets, the labor economics can only be true if workers pay for health benefits, and at least a substantial portion of the empirical research that's able to structure the test in the proper way finds that that actually is what happens.

So those are my five myths.

MR. NICHOLS: Okay, let's –

MS. MCLAUGHLIN: Now we have another Vanna White. (Chuckles.)

MR. NICHOLS: Let's just move on to myth six. And we should allow the symbolism of passing from right to left to go unnoticed -- (laughter) -- because for you it's reversed, right? So that's good.

Okay, myth number six: Workers used to be reluctant to switch jobs. HIPAA fixed that. Job-lock is a shorthand term economics apply to the phenomenon of workers sticking with less productive jobs than they could have because they fear losing health insurance if they switched. This was originally investigated with some vigor in the early '90s, for during the debates over the Clinton Health Security Act, the echoes of which still reverberate in this room, some argue that if the aggregate amount of lost productivity was large enough, there could be very large, hitherto uncounted gain to universal coverage, and thus the net cost to society might be much lower than the simple budgetary cost estimates. You can see how desperate we were to prove it was a good idea.

Two things have happened since this concept was promulgated. Much research was done, and the Health Insurance Portability and Accountability Act was passed, which, among other things, was designed to make the portability of insurance more real and to reduce this phenomenon of job lock.

A job-lock can arise from any employee benefit for which there is differential valuation across workers, differential costs of provision across employers, and an inability to set worker-specific compensation packages. Now, in real life, transaction cost and tax law prohibit worker-specific compensation packages that include health insurance. And so the most severe risk of job loss is from health insurance, since valuation and cost provision vary so widely.

Now, it turns out of course the research evidence is complex, for identification strategies – or for those of you who are unwashed in graduate school economics, proofs of causation are difficult to find. But Jon Gruber and Brigitte Madrian conclude that the studies with the most defensible methods do find some job lock, though – and here’s kind of the policy point – the welfare costs in this job lock is essentially impossible to quantify. And what this means in real words is economists cannot tell you at the moment if more policy interventions are justified or not. But Gruber and Madrian do highlight three reasons to believe that many workers are still reluctant to switch jobs for health insurance related reasons, even after HIPAA, and they all stem from our myth number three, which Mark went through: coverage is really not coverage is really not coverage.

HIPAA requires preexisting conditions exclusion of no longer than 12 months – a look back, six months, and a worker could have something more generous. But more importantly, HIPAA does require credit for prior coverage; that is, you don’t have to wait again if you’ve waited at your previous employers, but it does not in any way guarantee a worker’s right to keep their current plan. This means that specific coverages of particular benefits, particular coinsurance or whatever, or perhaps more important in today’s world, specific access to preferred providers is not guaranteed and may be lost. Also, switching mid-year can lead a worker to forfeit credit toward meeting annual deductibles, which is going to hold people there.

And finally, insurance in the individual market will always cost more per dollar of coverage, so higher wages cannot make one whole. Thus, workers are often reluctant to switch to jobs with no offer that might pay higher wages but not high enough to afford their current benefits purchased in a non-group market.

Number seven: Health insurance would surely improve the health status of the uninsured. Now, this is among the more complicated and emotional disputes in health policy analysis, and probably no one, economist or not, is going to agree with all I’m about to say. It’s not entirely clear that I’m going to agree with all I’m about to say either – (laughter) – but that’s okay. Indeed, it may be most productive to merely state how the literature may be correctly interpreted on what is accepted as proven now, and to take some care to distinguish that from what we would like to know and from what we might think policy should do in the face of real-world imperfect knowledge.

Helen Levy and David Meltzer, two bright young economists at the University of Chicago, were given the hardest task I think it’s fair to say. They were asked to review the literature to assess this question: “Does health insurance really affect health status?”

They were rightly concerned that the standard of proof about causation has often been lower than it should have been in many published papers, even in many prestigious journals over the years. And they choose to use a standard of proof that is quite high, that causation may never be inferred unless a natural experiment randomly assigned a representative sample of people to have or not have insurance for the duration of the experiment.

Now, this standard of proof has rarely been met, but when it has, the bulk of the evidence suggests that health insurance does indeed have positive effects on the health of certain populations, and indeed, those most often at the center of a policy debate: the poor, the elderly, the truly sick, and children. What has not been proven by this standard is that universal coverage would improve the health of all of the uninsured, and this leads economists to the following three inferences:

We cannot say with certainty that more public subsidies for health insurance for the general population would improve health status more than would increase in the capacity of public health centers or public hospitals, better education about diet and exercise, or a more equal income distribution for that matter. This leads economists as a profession to be quite cautious about mandates to purchase health insurance, at least when other policy alternatives are politically feasible.

The second inference is understanding more about the complicated pathways that different types of people traverse from coverage to health status through health services, and indeed, health education, would help us make far better calibrated recommendations to policymakers.

And the third inference is there are many reasons to support universal coverage, but the analytic case for the short-run positive health effects is not the strongest one, at least for the higher income and basically healthy uninsured who comprise roughly 40 percent of the uninsured today.

Myth number eight: Universal coverage would eliminate health disparities. Despite considerable policy attention and focus, rather large differences, or disparities, in healthcare outcomes among different population subgroups persist in our country. At least part – and perhaps a very large part – of the reason lies in differential access to health insurance. Harold Pollack and Kronebush correspondingly focus on access to health insurance by six subgroups that are often considered vulnerable for one or more reasons. The groups are the low-income population, children, racial and ethnic minorities, people living with chronic conditions, the near-elderly, and people suffering from psychiatric and substance use disorders.

Each group raises distinct concerns for public policy, health insurance, and the healthcare delivery system. Pollack and Kronebush conclude there are four basic reasons vulnerable populations often lack health insurance: they have medical and social needs which hinder their access to good jobs and to private health insurance markets; they have general economic disadvantages, including lower incomes, which impede their ability to

pay for health insurance when it is available and less access to jobs with employer-sponsored insurance, which makes it cheaper; they sometimes face discrimination based on race, ethnicity or language; and they sometimes suffer from impaired decision-making and rather imperfect proxy decision-making. And of course, many people in vulnerable populations face multiple barriers at the same time.

As an example, taken from the HRQ's recent "Health Care Disparities" report, black women have lower rates than white women of cancer screening, and higher rates of diagnosis in late stage, and consequently higher death rates. These death rates apparently persist even after controlling for education and income. They also appear to persist after controlling for insurance. This suggests that insurance alone cannot solve the problem faced by vulnerable populations.

I conclude with two sentences from the chapter, by Pollack and Kronebush: "The data provide ample warning that one should not oversell the possibilities of improving health status and individual well being through expanded health coverage. Expanded coverage is unlikely to eliminate the high rates of death and illness that arise from multiple causes and require multifaceted interventions. In other words, health insurance alone is not enough.

Myth number nine: A worker's decision to remain uninsured has no effect on anyone else. Now, as Catherine pointed out at the beginning, one goal of the ERIU project was to bring labor economists and health economists together to study the problems of the uninsured, to enrich health economics at least with more insight about labor market choices and constraints, since employer-sponsored insurance remains so important to the American health care system.

One overarching feature of many modern labor market models, as Mark pointed out, is worker heterogeneity. We all differ in many important dimensions, including our preferences for health insurance arrangements. If we all had identical willingness to pay for health insurance, a lot of health economic analysis of the uninsured would be a heck of lot easier. But alas, this is not the case, so our lives are hard, yet interesting. One consequence of heterogeneity is that different kinds of compensation packages may exist in equilibrium, some with a broad array of health choices attached, some with only one insurance option attached, and some with only cash wages to entice workers to get out of bed in the morning.

Now, Chernew and Hirth focused their critical review essay on the connection between decisions made by different people in the nexus of this labor and health insurance markets. This particular myth was chosen to highlight the reality that some workers' willingness to work at jobs without health insurance, while this may be a minority of workers today, still has important consequences for the rest of us. First and foremost it means employers have a choice about whether to offer health insurance, and they will make this decision largely based on the preferences, expectations, and productivity of a dominant type of worker they need to produce their products and services, as well as their own perhaps unique cost of delivering health insurance through

their workforce. For example, higher-wage workers are likely to be willing to pay more for health insurance in the form of reduced wages, and so, employers of highly productive, high-wage workers are more likely to offer than are employers who can get by with lower-wage workers.

The effect is amplified, of course, by our current tax subsidy for premiums nominally paid by the employer, a subsidy that works out to be roughly proportional to the marginal income tax rate of the worker. It is also amplified for large-firm employers or high-wage workers since they have the lowest cost of providing health insurance because they can take advantage of various economies of scale.

It also means that local labor market conditions can significantly effect offer rates, and we do observe them differ by quite a lot across the United States, as much as 20 percentage points on the state basis. This variation in offer rates ultimately affects coverage rates, of course. So differential offer rates and ESI coverage rates also affect the contours of the coverage problem faced by policymakers. For example, states with higher offer rates find it cheaper and easier to be more generous with Medicaid and S-CHIP eligibility -- Minnesota and Wisconsin come to mind -- than do states with low offer rates, like Arkansas and Mississippi.

The connection public program eligibility and private offer and take-up behavior, the so-called crowd-out problem, occupied a lot of good economists' attention in the last decade. Being mindful of the connections between one set of decisions by workers, firms, insurers or governments, and others resulting incentives and constraints, is essential for good policy advice, and that is exactly what Chernew and Hirth were giving us in this paper.

Finally, myth number 10: Economists don't really know anything. (Laughter.) It's actually fairly easy to listen to economists talk among themselves or read a whole book that is largely devoted to methodological flaws in prior work and reasonably conclude that economists actually think we know exactly nothing, that nothing has been satisfactorily proved, and we need millions of dollars and years more to study and argue before we will be able to say anything at all that is useful to policymakers.

Now, when I personally start feeling this way I always remember an old joke about the difference between economists and lawyers. A lawyer can argue literally about matters of life and death in some cases, but by and large, lawyers don't feel compelled to prove their opponent is an absolute idiot. It is this aging economist's opinion that there is a bit too much of this tendency within my profession, to play methodological gotcha and to assert that all or most prior work is a pile of garbage when it comes to policy recommendations. Now, my colleague and myself, on occasion, do do this, with good intentions, of course, to raise methodological standards so that policymakers will not be fed a steady diet of self-interested junk that is often advocating a particular policy agenda.

Well, I've been in Washington now for 13 years, and I'm here to report that policymakers are going to be fed a steady diet of self-interested junk that pursues particular policy agendas regardless of what we high-minded economists do. So we may as well hold our nose and tell them what we really think, even if we're not completely sure and take care to tell them why we may be wrong. That's the hard part, of course, and I admit to imperfection on that score, along with some other categories, but I don't have time to list all that this morning. But there are three basic things I would say we economists mostly know about the lack of insurance coverage. And I think the paper by Linda Blumberg and myself make these fairly clear, even, and maybe especially, to non-economists.

Number one: The single-most important reason people are uninsured in this country is they are not willing to pay what it costs to insure themselves. This unwillingness to pay is highly correlated with low income. Thus, if you really want to increase coverage, you're going to have to subsidize people, probably quite substantially since most of the uninsured have incomes below twice-times poverty.

Two: The prices people are required to pay for health insurance vary a lot across different circumstances and insurance markets. Workers at large firms probably face the lowest prices, and they, correspondingly, have the highest offer rates and the most generous policies on average. Thus, to economists, price really, really matters.

The third thing: Even though price really, really matters, most people and firms have fairly inelastic demands for health care and health insurance. That is to say, those of us who can would pay quite a bit more than we have to now before we would go uninsured, and those of us who don't buy it now will require substantial subsidy before they will buy it voluntarily. Thus, if you really want universal coverage, you're going to probably have to learn to deal with all the excitement and downsides of some kind of mandate. Now, we economists cannot tell you when or even if the nation would rather have a mandate than not, but we can tell you roughly what the public and social cost of various kinds types of coverage expansions will be, as long as people behave roughly like they do now, as captured by our various models – improving those still imperfect; they surely are.

The insights of this volume can help those who are so inclined to tailor their coverage expansion ideas to pursue their own goals and preferred tradeoffs. We wish you good luck and God speed, and hope we have been of some modest and not entirely dismal help.

Thank you very much.

MS. MCLAUGHLIN: Thank you, Mark and Len.

(Applause.)



And finally, I'd like to introduce Chip Kahn, who is the president of the Federal of American Hospitals, previously the president of the Health Insurance Association of America, previously a staff member in the Senate, previously a staff member in the House, and currently the gracious chair of our policy advisory panel for EIRU. This is a panel of 15 D.C. insiders, many of whom are here today, who have been meeting with us regularly to give us advice on what kinds of questions they face in their effort to design better policy for the uninsured, what kind of help we can give them, what kind of knowledge we can produce, and most importantly, how to translate that knowledge into something that is useful, and, as Len pointed out, to remind us that our best efforts to produce really good estimates are just one input into the policymaking process.

So Chip's going to add a few words and then we're going to open it up for discussion from the audience.

CHIP KAHN: Thank you, Catherine. I just want to start off by saying that at least from my view – and I hope the view of the other members of the Policy Advisory Council – I think this morning demonstrates that the foundation's money was well spent, that this question of the relevance of the kind of work that's being done by those involved in this project shows very clearly – much is often lost in translation, but I think this process of translation is so critical to policymaking, and so I want to congratulate those who have taken part in the development of this book and those this morning who have helped illuminate that, and just thank them for what they have come to offer us, because clearly they are relevant.

There was mention of the political process this morning, and clearly this is an issue that's on the forefront of the politician's minds, the public's minds, and so the relevance to, not likely action this year but possibly serious action this year of the work that's been done I think is clear.

I personally am an incrementalist, and proud to be one. I've said that in other places. And one of the things about incrementalism is that you want to make as few mistakes as possible when you see policy done, or you advocate policy change. And the wonderful thing that this project provides – we all know the importance of intelligence today – is that this project will help expand our understanding so when policymakers get into the nasty business of actually having to do something to improve people's lives, hopefully, they have some knowledge from this base, and obviously others that are working in this area, and much more than we had in the early '90s. Clearly there was a concern in the early '90s, I believe, about where the policymakers were taking us, and we ended up going no place, and my hope that this project and others that the foundation and other foundations are funding will lead us in a different route and we'll end up with more people covered in the future, and that this project will contribute to that.

And I'll conclude on that note.

MS. MCLAUGHLIN: Thanks very much, Chip.

I'm happy to say that several of the authors of those chapters are here. In addition to Len, Linda Blumberg is co-author on that chapter on why people are uninsured, is here. Pam Farley-Short, who wrote about counting the uninsured and who is exactly uninsured, is here. David Meltzer and Helen Levy, who wrote the chapter about the health consequences of the uninsured are here. Rich Hirth, who co-authored the chapter on sort of what are the structural frameworks and the conceptual models that we can bring to bear to this, is here; and Harold Pollack, who co-authored the chapter on vulnerable populations.

And so, in your asking of questions, please feel free to direct questions to them. You've already heard from us. If it's a question that's appropriate for us to answer, we will answer it as well. But they're up here, ready and willing and able to address some of your questions and concerns. So we open it to the floor for questions.

Oh yes, and please give us your name and affiliation when you –

Q: Hi, I'm John Green from the National Association of Health Underwriters. And I wanted to make two points about the number of the uninsured. There's a significant number of people who are Medicaid eligible who choose not to gain coverage, and given its retroactive nature, I think that they should be considered covered. Secondly, there's a number of people who make \$50,000 or more who self-insure and pay 90 percent of their bill, yet they're not counted as insured.

So I think that the number does matter because if it's 44 million then the tilt moves towards some single-payer solutions. If it's 20 million, as the CBO asserts, thereabouts, then that's a number that, though it's still high, is more – lends itself to other policy solutions that are maybe a little more rational than knee jerk single payer.

MS. MCLAUGHLIN: Pam?

PAM FARLEY-SHORT: Yes, the Congressional Budget Office has come out with a report that pointed out that there are about 20 million people who were uninsured throughout whatever the particular calendar year was that they were looking at. In a way, that's really – you mentioned a few ways in which some numbers that are thrown around may seem high. To say that there are only 20 million uninsured is probably erring considerably on the other side because that's really picking out a group of people who were uninsured for a long – not only for a long period of time – but happened to match up with a particular calendar year. There are a lot more people who are uninsured for as long as 12 months and, you know, they maybe lost their coverage in July of one year and didn't regain it until the next. So I think 20 million is probably too low to help us formulate policy solutions.

MR. PAULY: Can I comment on that? This will be one of those Teutonic questions: you know, what do we mean by the uninsured, really? But I think one way to think about it is if we want to call a person insured, they should behave like an insured person. And at least John I think I may agree for the people who are eligible for

Medicaid. Although we don't know whether, you know, if somebody dragged them down to the Medicaid office and made them wait the whole day it takes to sign up, whether that might affect their behavior.

But I think that those \$50,000 self-insured people, we know, know beyond a shadow of a doubt that if we make them insured their behavior will change. They will use more medical care so they're not really insured in that sense. Now, what we don't know of course for sure -- which is part of one of the more celebrated chapters in this book -- is whether their health will be changed by that. But I would be reluctant to say that those people are as if they were insured because they are not as if they were insured. They may not need to be insured -- that's much more of a squishy value judgment -- but I could even worry about some of those people.

MS. FARLEY-SHORT: Even some of the Medicaid eligibles, it's probably true if they show up with a serious health problem at a hospital where they really have no choice but to go, the hospital will get them signed up. It doesn't mean that other people with chronic problems who are needing just routine kinds of care don't stay away from doctors offices because they're afraid of what it might cost them, not even knowing that they're eligible for Medicaid.

Q: Holly Rocco with Greenberg Traurig. I just have a question. You were talking about the inelastic demand for coverage and kind of expanded on that talking about an employer mandate. And sort of my attempt to scribble down as fast as you were saying what you were talking about, I was just wondering if you might be able to expand on your thoughts regarding that inelastic demand and employer mandate.

MR. NICHOLS: Well, it's not entirely clear what I was thinking, but to answer your question I would say the evidence is fairly robust that most of us respond less to the price of health insurance than we do to the price of automobiles or the price of other things that are sort of similarly expensive and important. That stems from, I think -- evidence going back at least 30 years -- that people don't respond all that greatly to different prices of medical care. Essentially, if you're really sick and they tell you, you need X, you're probably going to get it. And people who are going to buy health insurance, frankly, almost by construction, are what we call risk averse; that is, they're afraid of the consequences of not having health insurance. And so their willingness to pay to protect themselves, both from a financial point of view and, in today's world, protect themselves to guarantee access to quote, "good providers," which you know is a sort of subtle and complex and ever-changing notion -- their willingness to pay is quite high, so the responsiveness is just fairly low.

On the flip side, the people who are low-income who end up not buying -- don't have any income so you got to kind move price a lot for them to get them to change their behavior because they've kind of made their peace with living with the risk of being uninsured. And Mark's really right; on a normal day the good news is most of us are healthy so that the bet may work out for most people in a given year. But when it does not work out, we as a society end up paying the cost of that, and the literature is fairly

clear on the clinical side that people who show up and are uninsured end up getting lower outcomes.

So, you know, I think there's a lot of inelasticity out there and I think most of us believe it. A lot of work has been done about different kinds of elasticities for different kinds of firms -- maybe small firms have larger elasticities -- but none of them are really high.

Okay, so back to the mandate, what does that mean? It means if you impose a mandate, at the end of the day what's going to happen is it's going to come out of compensation to labor. (Audio break, tape change) -- would there be jobs lost. So it's going to come out of wages.

MS. MCLAUGHLIN: Kayla.

Q: I'm Kayla Leighton. I'm with the National Conference of State Legislatures, and my job in these organization meetings is to ask about state variation.

I understand that the underlying simplification the economists must do is to assume that everything else is equal, but there were some allusions in the discussion of ways in which things are not equal in different parts of the country. And I'm just curious about in these studies to what extent variables were considered that took into account some of the geographical variation and institutional factors that might have, you know, some external influence on tendencies to be insured or not insured, that all of these analyses seem to focus on the individual as the unit in which insurance decisions take place. And I wondered whether you looked at some of the other units.

MS. BLUMBERG: When studies have been done, and a lot of the studies that are discussed in this book are summarized work by other researchers -- not those sitting around the table, though some of it has been done by us -- that for instance, when you look at elasticity of demand for health insurance, we're using data that has price variation by geographic location. And we do try to take that into account, but what the majority of the results that we're talking about here are basically means of responsiveness over an entire population. But the estimation is done taking into account that there's price variation and variation in characteristics in geographic location.

But what most of what's discussed I think is fair to say in the book are results by overall means for the country. By and large it's quite difficult, as I'm sure you know, to do specific kinds of estimates for specific states or localities because the data is not as available as we would like it to be. So I think that that's -- it's definitely something to think about in terms of future research that when you've got data some surveys have, that allows you to look in depth at specific locations and specific states that it could be very valuable.

DAVID MELTZER: Can I just add to that?

MS. MCLAUGHLIN: Yeah, and then we have a question back there.

MR. MELTZER: Yeah, I just wanted to add that – I'm David Meltzer. In my chapter – and Helen Levy's chapter together -- we look at some of the studies that examine Medicaid expansions, which exploits state to state variation, and of the many, many studies in this area, those are some of the most valuable. And I think probably both of us have the sense that this is an area where a lot more really good work could be done, and I would encourage anyone who has the idea that there's a variation that's going to take place in a state to really think about whether that could be an opportunity to produce more valuable knowledge.

MS. MCLAUGHLIN: Actually, ERU has funded a whole host of studies that are looking at Medicaid expansions and the effect that they have had, and we are going to have the first research highlight from one of those studies out in about a month or two, but more are coming.

MS. FARLEY-SHORT: And there was actually an interesting study that came out of the Center for Studying Health Systems Change, which has a sample that's concentrated in a number of communities around the country that show that the – looking at differences and how – what percentage of people were uninsured in different communities, that about – I'm looking in my chapter here – about a third was due to differences in socioeconomic status, about a quarter to differences in employment characteristics, and about an eighth because of differences in state eligibility rules.

MS. MCLAUGHLIN: We have someone back here who was waiting, and then we'll move up to – yeah, back there.

Q: Thank you. I'm Tom Miller, Joint Economic Committee. I'll probably follow up with Len.

Len, you're kind of, I think, talking more about average willingness to pay rather than marginal willingness to pay, and maybe we could correlate a little bit better the interaction of the supply side of insurance with the demand side. We tend to presume that there's kind of this basic minimum of what's good insurance coverage, and therefore people should be willing to pay for it.

But we've seen over time that as we've subsidized more insurance coverage, the cost of care doesn't necessarily deliver one-to-one with the financing, which is a little bit of a drain off and a higher price. I haven't seen kind of an analysis in terms of where the take-up rate is coming from recently in terms of the people who are offered coverage. I don't think employer offer rates are down that much, but there may be a change in terms of the marginal consumer not purchasing insurance as that kind of a bit of a leakage. We've got regulatory costs and subsidy costs, which in effect impose middle-class minimums on lower-cost purchasers.

Can you talk a little bit about that area of the market in terms of whether we might be offering people more than they're willing to pay, but they should have a wider variety of things to purchase so they might find affordable coverage?

MR. NICHOLS: I'd be glad to start, and Mark might want to chime in. I think you raised a good point, and it stems from the basic point we both sort of started with, and that is worker heterogeneity and the difficulty in sort of tailoring things in real life to meet everyone's individual preferences. You know, my favorite one-liner now is "life is lumpy." And what I mean by that is transactions cost me – it's not efficient to offer a different package to every single worker imagined at General Motors. So they've got to essentially hit these – if you forgive the Aristotlean reference – the golden mean in between. By doing that, unambiguously part of what's going on is packages are arguably more generous than some would like, they're arguably less generous than others would like, and how does this get worked out.

I must say, Mark -- and I believe your co-author was Goldstein way back when even I was young -- basically laid out this hypothesis of how workers and firms work this out. And what is astounding is we still don't know much about how workers and firms work this out because we can't get DOL to collect the right data. But aside from that, we don't really understand much about the internal dynamics. What we do know, I think, is that more options would fit more preferences, but they come with the transactions cost.

As far as your larger point about overtime, everything getting more expensive -- you know, I think Mark coined the phrase, no one wants to buy – no one wants to sell 1990 technology or 1980 technology in medical care for 1980 prices; we all want the new thing. It's probably true. I would opine – I'm out here on a limb all by myself, having on economist's clothing – higher-income workers get a little bit more of their voice than lower-income workers do, and so packages probably are a bit more generous because of the nature of what our mothers told us we should have and the nature of our tax break, et cetera. And so, yes, they are being foreclosed options. Does it mean, I know a simple solution, given real transactions costs? Purchasing – (unintelligible) -- of course.

Mark, you might want to take over.

MR. PAULY: Yeah, well, let me just make a comment on that and some of these other things as well. I think that it goes back to the elasticity question. I guess I'm in the high elasticity group, Len's the low elasticity group, but we're all Episcopalians when it comes to elasticity. (Laughter.) But I think the message that does come out of the research is if you look at these people who are offered coverage and turn it down, they seem quite unresponsive to what their share is.

And so the so-called low-hanging-fruit strategies -- if only we offered them a little bit of a break wouldn't they go do it -- the answer seems to be no. The question is whether they're typical of all of the uninsured or of consumers in general, and the sort of contradictory message I think that, at least in my view of the literature, is that when – in some sense, when they are organized into firms and the decision is being made at the firm

level, then those decisions do seem to be pretty highly responsive to the price of insurance. And the Exhibit A here is that if you look at holding other things constant, you look at the difference between small firms and large firms; that makes a difference to the price of insurance all right. But the difference is probably on the order of 20 percent, maybe, if you went from a very small group to a very large group. And yet, that seems to produce almost 100 percent take-up in the large firms and a very low percent in the small firms.

So somehow -- there are two possibilities here I think. One is we behave differently as individuals, that somehow -- when we're aggregated by those benevolent benefit managers. The other, which I have some sympathy with, is that the fools who took a job at a firm that offered health insurance that didn't take the health insurance are economically inert, and who would expect them to respond to anything? (Laughter.)

But I think, to get back to Tom's point, my reading of the data, although this changes daily, is that the offering rate has not fallen or has not fallen nearly as much as the take-up rate. You could of course blame tax cuts for that. That would be one reason, because now even the employee premium share is usually shielded -- tax shielded if it's a cafeteria plan -- although I guess I'm bound to say that there are some good things that come from tax cuts. At least reducing the tax subsidy for those people who we'd want to encourage to purchase health insurance may not be one of them.

MS. MCLAUGHLIN: I see a cluster of hands here. You had your hand up a long time ago.

Q: Okay, thank you.

MS. MCLAUGHLIN: So I want to honor your question, and then we'll go back to this cluster.

Q: Very briefly, sort of the life is lumpy thing. Do you think we can and should pay attention to the gray area -- two related gray areas? One is there's healthy, there's sick, then there's people in between, who are delaying care but they're not needing hospitalization, let's say, or because of cost or poor coverage, you know, they're not seeking the care because of the out-of-pockets or lack of adequate coverage that they have.

And then the second gray area I think probably goes back to myth number three, and that was before I came here, which is the gray area of just the underinsured, and in the world of this crisis of the uninsured, are we paying enough attention to these gray areas, and, you know, should we? And do we have the data for it?

MR. NICHOLS: I think you're asking a political question, and I'm supposed to give all political questions to Catherine. (Laughter.) But of course I won't, so I'll say this: I think in fact those people who delay care because of cost -- and it does vary by population, low-income certainly much more likely and --

Q: The uninsured, by the way –

(Cross talk.)

MR. NICHOLS: Right, right, right. No, I'm with you. I'm with you. I think that's precisely where the policy conversation is about at the moment. I think all – Chip talked about incremental. That's where we are in this nation. And what we're focused on -- I believe it's fair to say both sides of the aisle – are those people who are basically below 200 percent of poverty. You can argue this or that, but that's kind of where the conversation is.

So I would submit the policy conversation is pointing in the right direction. I would submit part of the work done by the people at that table helped them get there, and so in that sense, I think we're focused in the right place. Chip's right, we're not going to do it this year, so -- you know, we're not doing it fast enough to suit some people, but I think that we are focusing in the right place.

MS. MCLAUGHLIN: Okay –

MR. PAULY: Can I comment on the underinsured? I think there is a gray area question there, and I think it's an interesting one. And the – in some ways, I guess we know what to say about the extremes. We know that if it's a very low-income person, even if they nominally had an insurance policy with a very high deductible, we'd probably be worried about their access to care that the rest of us would value.

At the other extreme, while speaking personally, I'm over-insured and I should be paying higher deductibles, but I don't because there's such a tax break. I'd be willing to give the money back.

MS. MCLAUGHLIN: (Chuckles.) I'll take it.

MR. PAULY: Yeah, but not individually. All people in my socioeconomic group have to volunteer to give up our much beloved tax loophole. But I think that's sort of the problem that sometimes underinsurance has tried – attempts to be defined relative to some standard of adequate insurance that should be uniform for everybody.

And the real way I think to think about underinsurance is to go back to the work that Helen and David were trying to tussle with. We'd like to know what impact different levels of coverage have for people with different levels of income on their health outcomes and design it based on that. And there is some research, now old but still glorious, using the randomized controlled trial version of assignment to insurance that didn't find enormous impacts of additional coverage for middle-class people above and beyond catastrophic insurance in terms of its impact on health.



So just to say what some studies do -- advocacy studies, and, golly, people's hearts are in the right place -- that if somebody doesn't have free care they're underinsured and we ought to do something about that, is probably overdoing it a bit.

MS. MCLAUGHLIN: I think that is one of the -- and David, who's not only a consummate clinician, he and I have talked that as a part of work that he and Helen did, it's not an issue of we do know what the disease is? We don't have evidence to tell us what the right dose is and who should get it, and that's part of that issue. We just -- we really don't have good evidence to help guide us to where to take -- to where to actually apply the medicine.

Jack has been patient, and then I don't know your name, and then this woman here, and we'll try to get that cluster, and then back there.

Q: I'm Jack Hadley from the Urban Institute. My comment actually has to do on that topic that was list number seven on your list about health insurance would surely improve the health status of the uninsured. And I think if I were putting this list together, I would have stated that somewhat differently. I was asked to do a similar review by the Kaiser Foundation a few years back, about three years ago, and I warned them that I didn't think you might find much here.

And the prevailing myth, in my mind at least, was kind of the opposite of this, that health insurance has no effect on health. And I think that's actually a much more pernicious myth because it's kind of the showstopper in a sense. If you believe there's no effect on health, then why were you even here talking about this? And I think the chapter by Helen and David certainly dispels that perspective. And while I agree with them entirely, the evidence is not nearly as good as we would like, and that asking the question, is health insurance the best way to improve health for everybody or exactly what's the best form of health insurance, are important questions but they're kind of subsidiary once you get past the initial question.

So I guess I would characterize the evidence as not being a slam dunk, but you know, from my perspective, when you look more broadly, I would say it's around the rim and in, and it's still two points. (Laughter.)

MS. MCLAUGHLIN: Well, as I said, Jack, I think all of us agree that we know what the medicine is, but I think the point was we're not really sure what the right dose is for whom. I think you're actually right, and you're just going to have to believe me when I tell you that we rephrased that myth at least a dozen times, because it is complicated.

This gentleman back here's been waiting, and then pass over to this woman, and then back to the corner.

Q: Karl Polzer, independent health policy analyst. I was wondering if the labor economists could help me puzzle through an analysis of a quasi-universal health care

scheme I was reading recently of a neighboring, kind of average-sized state, and they're going to try to do pay-or-play, financed partially by a payroll tax on firms.

And in line with the literature and what's been said here today, they assume more than 90 percent of the tax would get passed through to workers and it would be hard for, you know, the lower-waged workers to shoulder -- you know, the law wouldn't prevent -- would prevent it to be passed through to minimum wage workers, and there will be about 10,000 jobs lost. But the overall effect on employment would be zero, about, because they'd be able to draw down more Medicaid funds, so about 10,000 jobs would be created.

I didn't have -- you know, the job loss seems in line with the literature, but I'm not familiar with the literature on if you put 10,000 -- if you put X number of dollars from Medicaid into the macroeconomy of the health system, what about the magnitude and timing of that and how does it match up with the job loss? Of course, these are different people, and they'd be in different interest groups, losing and getting jobs. And also, if 10,000 -- if the same amount of money leaves the macroeconomy of the United States, are there jobs lost there and in what years? Does that make any sense?

MR. NICHOLS: Yeah, it does. The only answer I can give you is what I remember, increasingly vaguely, from 1993. And I cannot forget David Cutler, who was on the staff of Council of Economic Advisers, whispering in Laura Tyson's ear, "Five-hundred-thousand, no sign," by which he meant it could go up, it could go down. And because -- you're right, when you shift a dollar from one part of the economy to another part of the economy, essentially in general equilibrium you're basically asking what's the labor coefficient of those dollars? It turns out health care is fairly labor intensive. But it turns out, depending on where it came from, you could actually end up with a net gain in jobs.

However, I will point out, just like free trade where it may turn out to be serendipitous in the long run, in the short run it's going to be, shall we say, a distributional problem. And so those low-wage firms who don't offer now are more likely to lose more jobs. Some people are going to have their wages reduced over time. And then the shift -- and the question is essentially, can people working for, I don't know, say, Wal-Mart, become nurses -- in the long run?

MR. PAULY: Yeah. I guess the question is, yeah, whether the minimum wage workers could get jobs in health care, but the main punch line here is -- this is important to remind people -- it's not jobs; it's wages that is the main consequence for workers, that for the great bulk of workers, pay or play reduces money wages. Of course, if health insurance is worth it, by golly, that's a good trade. But that is a consequence that needs to be taken into account.

Q: I have a question. I'm Diane Dunston from Prudential Equity Research. And this is primarily directed at Chip. On a practical, political level, where does the most effective pressure come from for real policy that would cover the uninsured? Is it when

the hospitals get tired of having so many uninsured coming in the door, or is when the big employers are tired of having to pay higher premiums because of the uninsured that are coming into hospitals? You know, we've been listening to this debate over the uninsured forever, and is there a critical mass at which the most effective persuaders of federal policy get engaged and change really occurs?

MR. KAHN: Well, I'm convinced that the coin of the realm is not gold; it's votes. And if you go back to what generated the '93-'94 process, it was middle-class anxiety about losing insurance rather than the lack of insurance – that's an assertion but I think people would probably agree with that. So I think it comes back to that again.

And so it's not so – to get movement on the issue is not so much who doesn't have it but who does and is worried, and whether that drives policymakers to say, we better shore it up so that people won't have – the middle-class who votes won't have anxiety. I mean, I think that's where the power comes from, and I don't think the interests, whether it's business or labor or the providers, can push it over the goal line. It's got to be a perception by the politicians and the policymakers that this is not just a talking point but something that really matters deeply to voters, like drug benefits for seniors.

Q: Do you sense that in this political year?

MR. KAHN: I think the possibility – I mean the polls tell you that it's there. I guess we'll have to wait and see sort of how it plays out. I mean, yes, I think that there's the possibility of something next year because it's so relevant to the current debate. The trouble with health care, though, and particularly coverage issues, in the political debate is that it's frequently used as a proxy for other things. I mean, when the Democratic candidates talk about universal health coverage, they're really talking about, why are the Republicans giving tax cuts for the rich rather than helping people? Or they're talking about, we have a bad economy and people are going to lose their health insurance and the Republicans did that. So if we talk about health rather than using it as a proxy – I mean health coverage, then we'll get somewhere. And I think the jury's still out on that.

MS. MCLAUGHLIN: The man back here.

Q: Randy Bovbjerg at the Urban Institute. If I put on my hat as a non-expert, which in my case is not too difficult, I listen to this and I say, this is 90 percent – give or take a few percent – iconoclastic. Things that I thought as a non-expert I knew but I didn't: that life is lumpy and complicated and it does sound like we need more research. Now, that last 10 percent that Len did was really not an equivalent myth; it was an attempt to say why the first nine don't matter so much, and he really did have something positive to say.

And interestingly enough, Len, as a hardheaded liberal you seem to come out with a message that mandates was the only thing that was going to make a huge difference.

Mark, you didn't get to that. You got to be iconoclastic in the first half. Could you please address from the point of view of a bleeding heart conservative what positive message you take that policymakers should hear, other than life is lumpy and complex and we don't know much?

MR. PAULY: Well, gee, that's an invitation I'm not sure I want to accept. But I guess – well, so I'll agree with Len and also agree with myself 12 years ago, or even longer. I think if you literally want to close the gap and have universal coverage, mandates are the only answer. You can get some direct distance, maybe a long ways by pushing the strings and subsidies and so forth. But it literally – if you announce as your goal to eliminate the uninsured as a policy problem, there is this thickheaded fringe or recalcitrant minority – I mean, 85 percent of Americans are already rational, they have health insurance, so it's not as if a national trait to be quite so thickheaded. But there are, as we know in any large group, a set of people who will make wrong decisions or get themselves in situations where they don't have options, that are going to have to be dealt with. And in work with Patricia Danzon and John Hoff and Paul Feldstein – I'm not so good at arithmetic early in the morning, but 14 or 15 years ago we proposed a mandated tax credit approach, so I have no problems with that. Personally, I think the political issues about mandates are the most delicate.

I guess in terms of what would be persuasive – to some extent this is, I think, my reaction to some of the earlier discussion about the politics of it all – I think that trying to make the case on the grounds that the uninsured are raising -- healthcare costs -- is not very persuasive. The main reason is I don't believe anybody expects that if the uninsured went away, the hospitals would turn around and cut their prices. I think they'd find other uses for that money and I think that's what buyers are worried about.

Part of the argument has to be, as Chip said, that people may worry, there but for the grace of God go I. And then I guess this is kind of what a bleeding heart conservative who's a researcher would say. I would like to believe that the argument, if it could be made strongly, that the health of our fellow citizens could be substantially improved if you, Mr. or Mrs. Taxpayer, were willing to pay more taxes for this, could at least make people more willing to accept the need to pay for it. And to some extent, the absence of a lead-pipe certain case and the unwillingness to deal with what I call skeptical but well-meaning taxpayers, who aren't immediately convinced that health insurance is the greatest thing and the greatest need, is part of the problem.

MS. MCLAUGHLIN: Well, I think those of us up here and at the table are happy to stay and answer questions for people, but I wanted to thank those of you who literally voted with your feet to come and join us today that this is an important issue, and although it may not be this year, I think most of us are hoping that there is some kind of reform. And at ERIU we're hoping that the research that we do will help inform all of you and policymakers into making it the best policy possible.

So thank you very much for joining us today.

(Applause.)

(END)