Sherry Glied

(interviewé)

Background :

Reforme Clinton, même goupe de travail que Nancy Min Ann De Parle

Nominated July 9, 2009 by President Barack Obama (D). Confirmed by the Senate June 22, 2010.

Education:

- Yale University, New Haven, CT, 1982, B.A. in economics;

- University of Toronto, Canada, 1985, M.A. in economics;

- Harvard University, Cambridge, MA, 1990, Ph.D in economics.

Career Record:

- 1992-93, Senior Economist for health care and labor market policy, President's Council of Economic Advisers;
- Professor and Chair, Department of Health Policy and Management, Columbia University's Mailman School of Public Health;
- 2010- 2013 : Assistant Secretary for Planning and Evaluation
2009 - Present (3 years)

Awards: Eugene Garfield Economic Impact of Health Research Award, Research! America, 2004; Robert Wood Johnson Health Policy Investigator Award, 1996.

Memberships: Member, Institute of Medicine; National Academy of Social Insurance; MacArthur Foundation's Network on Mental Health Policy; Board member, AcademyHealth; Research Associate, National Bureau of Economic Research.

other Better But Not Well: Mental Health Policy in the United States Since 1950, with Richard G. Frank, Johns Hopkins University Press, 2006; "Trends and Issues in Child and Adolescent Mental Health," with A.E. Cuellar, Health Affairs, (2003); *"Health Care Costs: On the Rise Again," Journal of Economic Perspectives, (2003);* "The Uninsured and the Benefits of Medical Progress," with S. Little, Health Affairs, (2003); *"Is Something Better than Nothing? Health Insurance Expansions and the Content of Coverage," Frontiers in Health Policy Research, MIT Press (2003),* D. Cutler and A. Garber, editors; "Is Smoking Delayed Smoking Averted?" American Journal of Public Health, (2003); "What Can the Take-Up of other Programs Teach Us about How to Improve Take-Up of Health Insurance Programs?" with D. Remler, American Journal of Public Health, (2003); "Inside the Sausage Factory: Improving Estimates of the Effects of Health Insurance Expansion Proposals," with D. Remler and J. Graff Zivin, Milbank Quarterly, (2002); "How Do Doctors Behave When Some (But Not All) of Their Patients Are in Managed Care?" with J. Graff Zivin, Journal of Health Economics, (2002); Chronic Condition: Why Health Reform Fails, Harvard University Press, 1998.

http://wagner.nyu.edu/glied

In 2013, Sherry Glied was named Dean of New York University's Robert F. Wagner Graduate School of Public Service.

From 1989-2012, *she was Professor of Health Policy and Management at Columbia University's Mailman School of Public Health*. She was Chair of the Department of Health Policy and Management from 1998-2009.

On June 22, 2010, ***Glied was confirmed by the U.S. Senate as Assistant Secretary for Planning and Evaluation at the Department of Health and Human Services, and served in that capacity from July 2010 through August 2012***.

She had ***previously served as Senior Economist for health care and labor market policy on the President's Council of Economic Advisers in 1992-1993***, ***under Presidents Bush and Clinton, and participated in the Clinton Health Care Task Force***.

She has been elected to the Institute of Medicine of the National Academy of Sciences, the National Academy of Social Insurance, and the Board of AcademyHealth, and ***has been a member of the Congressional Budget Office's Panel of Health Advisers***.

Glied's principal areas of research are in health policy reform and mental health care policy. Her book on health care reform, *Chronic Condition*, was published by Harvard University Press in January 1998. Her book with Richard Frank, *Better But Not Well: Mental Health Policy in the U.S. since 1950*, was published by The Johns Hopkins University Press in 2006. She is co-editor, with Peter C. Smith, of *The Oxford Handbook of Health Economics*, which was published by the Oxford University Press in 2011.

Glied holds a B.A. in economics from Yale University, an M.A. in economics from the University of Toronto, and a Ph.D. in economics from Harvard University.

http://www.nyu.edu/about/news-publications/news/2013/05/28/sherry-glied-economist-and-health-care-policy-expert-named-dean-of-nyu-wagner.html

Sherry A. Glied, a Harvard-trained economist from Columbia's Mailman School of Public Health whose expertise in health care reform has led to important governmental posts, was today named by NYU President John Sexton and Provost David McLaughlin to be the dean of NYU's Robert F. Wagner Graduate School of Public Service. She will take up the new post on August 1, 2013.

John Sexton, NYU's President said, "In the last 10 years, Wagner has been on a remarkable upward trajectory: it has soared from 19 to 6 in the US News and World Report Rankings for schools of public affairs – a great feat. So, in selecting a new dean, we were keenly aware of the need to find someone outstanding who could sustain that trajectory – a highly regarded scholar, a talented administrator, and a person of vision and drive.

"In Sherry we have found such a person. The quality of her scholarship has led not only to success within the academy, but to important policy-making and advisory positions as well. At heart, universities are judged by the quality of the people they attract, and it says a great deal about NYU and about Wagner, its successes, and its momentum that we are able to attract someone as talented as Sherry Glied as dean."

An extensively published scholar in the area of health care policy reform and mental health policy, Sherry Glied was first appointed to Columbia's Mailman School of Public Health in 1989. From 1998 to 2010, she was chair of the Department of Health Policy and Management.

Professor Glied has also served in important policy-making and advisory positions in government, most recently as the Assistant Secretary for Planning and Evaluation in the US Department of Health & Human Services. She had previously served as a senior economist for health care and labor market policy on the President's Council of Economic Advisors, had participated in the Clinton Health Care Task Force, and had been a member of the Congressional Budget Office's Panel of Health Advisers.

Ingrid Gould Ellen, a professor of public policy and urban planning and chair of the Search Committee, said, "The Search Committee has utmost confidence that Sherry is up to the task of sustaining the momentum of the past few years. She is a leading health economist with high-level government experience and boundless energy and enthusiasm for the mission of NYU Wagner –from research to teaching to public service."

She received her B.A. from Yale, her M.A. from the University of Toronto, and her Ph.D. from Harvard in economics. She was elected to the National Academy of Sciences' Institute of Medicine, is a member of the National Academy of Social Insurance, was a member of the Board of Directors of AcademyHealth, and was the recipient of the Research!America Eugene Garfield Economic Impact of Medical and Health Research Award. She is a fellow at the New York Academy of Medicine, and a faculty research fellow in health economics at the National

Bureau of Economic Research.

"Provost David McLaughlin and I would like to thank the Dean Search Committee, led by Professor Ingrid Gould Ellen, for their hard work and their judgment, for their hard work and discernment," said John Sexton. We would also like to thank Ellen Schall, Sherry Glied's predecessor, for her superb leadership over the past 10 years and for doing so much to improve the school. And we'd like to thank Tyra Liebmann and Scott Fritzen for so capably taking on the role of Interim Co-Deans these past few months.

"First and foremost, however, we would like to congratulate Sherry Glied on her appointment as Dean of NYU's Wagner School, and welcome her to the University."

http://www.pbs.org/healthcarecrisis/Exprts_intrvw/s_glied.htm

PBS. Health Care crisis. Who's at Risk ?

Sherry Glied, Ph. D, (Columbia) (PAS de Date)

Are We in health care crise ?

In some sense we've always been in a health care crisis and we always will be in a health care crisis. The nature of health care, because it's always changing and it's getting better all the time, means that we can never completely resolve the problems that we're facing today and that we never have resolved them in the past. ***We have a real conflict between how much money we're willing to spend on health care and how much we want for that money, and that's a perpetual conflict.***

Who is at risk in this?

The people who are most at risk today are those who have no health insurance at all. They're at risk of not getting regular care when they need it. They're at risk of not catching real problems before they get serious enough to not be treatable. They're at risk of not getting the best treatment when they actually do get sick. And they're at tremendous financial risk. They could lose everything that they've saved in their lives because of some even fairly minor health problem.

What's happened to the doctor-patient relationship?

We've always had a set of multi-level relationships in health care between the doctor and the patient, but then once insurance came into the picture there was also this third level. The doctor and the patient made some arrangement about what appropriate treatment was and then the insurance company, they came in from the outside and paid for it. But in the new contracts, in managed care contracts, the insurance company has more of a say in what is covered by that contract and what is not covered. So they can say, "You can't go to Dr. X. That's not in your contract." And the employer has some negotiation with the insurance company to arrive at that. It isn't entirely clear how that affects the doctor-patient relationship. It need not, but it does affect the payment relationship to the doctor and the patient. And that leaves both of them at a different kind of risk than they used to face.

Talk about problems regarding individual versus group insurance.

There's actually no period in American history when we've had an individually based health insurance system, which I think is striking. The reason for that is that people vary tremendously in their anticipatable health care risks. So some people know that they're going to be sicker than others do at a moment in time. And that means that the people who know that they will be sicker are going to want insurance a lot more than the people who know that they're going to be healthy. And that creates a problem that economists refer to as adverse selection. It means that the sickest buy the insurance and the healthy people stay out, and that drives premiums up very high. Now in order to try and avoid that problem, insurance companies try and target premiums to reflect people's expected health risk. So if they know that you're going to be sick, they charge

you a high premium. And the reason that they do that is really the converse, which is that way, if they know you're going to be healthy, they can charge you a low premium which will allow you to continue buying insurance. Otherwise, they'll charge a high premium to everybody and the healthy people will just drop out of the market. So they try and use that information to charge premiums to people that reflect their risk. That's a lot like the car insurance market, where if you've had a lot of accidents you'll pay a lot higher car insurance premiums than if you've had very few accidents. The difference, though, is the range in health insurance is so huge. I mean how much damage can you do to your car? It's pretty limited, but your health -- the amount of money that could be spent on your health is almost infinite. So the differences between the healthy and the high risk people are very, very large in this market, and that really leads to a lot of sorting. In order to avoid that sorting, what we do is try and sell insurance to groups that exists for reasons other than buying insurance. That is, if you get a bunch of people together for some reason that has nothing to do with insurance at all, it's a fair bet that some of them will be very sick, but a lot of them will be really healthy. And the people buying insurance won't just be the sick ones. So this is a way of basically compelling the healthy people to share with the sick in buying insurance together.

Is the employer the best place to be forming the group at all?

It is increasingly the case that employers may not be a stable source of coverage for lots of people, because they may not naturally form these groups. People may be moving in and out of employment or moving from employer to employer. The problem is, I think, from a policy perspective that there's nothing else. If you look around and say, "Where else in the market are we forming groups for reasons other than buying insurance," I think you'd have a very hard identifying such places. So we're in a situation where we don't have alternative group besides employment, even though, increasingly, employment may not be the way to go. I think that's a real policy quandary for us.

Will it ever be possible to go back to fee-for-service?

I think it's almost impossible. It's really hard to imagine going back to that system. In any system of health insurance what you need to do is come up some way to ration care. We don't like to use that term, but you have to limit how much care people will get, otherwise, they will just -- people who are sick particularly will just use enormous amounts of care that they can't afford to buy for themselves. ***So we need a system to make people make trade-offs about how much care they buy. In the old system the way we did those trade-offs is by making people pay out of pocket for a large share of their health expenses***. The standard contract used to be 20 percent out-of-pocket with a big deductible up front. That was the standard old fee-for-service contract, although many of us forget. Unfortunately, health care costs have gone up so much that in order to make that contract limit people's expenditures enough, you'd have to make them pay an awful lot of out of pocket, or you'd have to stick them with a very high premium. And what we observe is, when people are faced with the choice of a contract with a very high out-of-pocket medical savings account type contract, which is really an old style fee-for-service contract, they never choose it. They always prefer managed care. Very tiny fractions of the population choose those big deductible contracts.

Another possibility is to offer an old fee-for-service contract and people still do, but it usually comes with a very high premium. When people are faced with the choice of a very high premium and absolute free choice or a much lower premium and managed care, they all flock to managed care. So when you are actually asked to make that choice and face the true cost of it, people don't want that fee-for-service contract anymore.

How did we get to this point in terms of insurance?

When you look at the history of employer-sponsored insurance in this country, what you see is that over time, employers and insurers are always trying to come up with ways to make this coverage more affordable. ***Remember that health care costs in this country, until very recently, were growing at an astronomical rate over a very long period of time***. And nobody liked that. So everyone was trying to come up with ways to save some money. We used to have second

surgical opinion programs, utilization review, which we think of as a new thing, actually started in the '50s and '60s. People have been trying to come up ways of controlling the cost of these programs. ***Now, what happened is, in the '80s especially, health care costs really skyrocketed.*** They went up very quickly and employers began to ask employees to pay a larger and larger share of the premiums of their health plans. That made people very dissatisfied. Employers were dissatisfied because they were paying higher and higher premiums. Employees were dissatisfied because they had to pay a larger and larger share, and it really caused a search for cheaper alternatives. One of those alternatives was managed care contracts with many more restrictions on them. And what happened is that as employers began to introduce these contracts into their mix, employees began to select them.

Would it be better to toss out our system and start over?

Tossing it out and starting over again is an attractive idea. *The Clinton Health Care Reform of 1993-'94 is a classic example of what happens when you take that idea and really think it through. And the problem is that there isn't a solution out there.* There's not a single system in the entire world anywhere that does what we need to do perfectly. And so when we think about redesigning the system, you have to understand that we're not going to come up with a perfect system even if we spend the rest of our lives doing it. Now some of the things that are wrong with our system I think that we can fix. ***And one of them is, we need to get everybody insured. And I think everyone who thinks about health care policy will agree that getting everybody into some kind of insurance is an absolutely key element to making this work.*** For one thing, it will make sure that the healthy people don't stay out and it will keep the premiums down for the rest of us. It will also mean that everyone has insurance when something goes wrong that they don't expect, and that's really critical.

What about having a single payer solution?

There are a lot of health care systems out there, and I think one of the things that strikes me is that no two systems in the world are the same. ***If there were one perfect system, we'd see everybody doing it except us. But we don't see that. Germany doesn't have a single payer system***. They have a lot of competing health insurance plans called sickness funds. ***England has a very different system than Canada. France has a different system than Canada, England, or Germany.*** So there isn't one perfect model out there. I think that's the first thing that we should be clearly aware of. The second thing you should be aware of is that every one of those countries reforms their health care system every three years, and if their systems were perfect, they wouldn't have to do that. There are always going to be compromises and weighing one thing against another and we're always going to have to do that whichever way we go. ***Now Canada has a single payer system, which is very attractive in many ways.*** *It really reduces administrative costs, but right now they've gone through a period of extreme cut-backs in their health care system. When you look at consumer satisfaction in Canada, it's as low as consumer satisfaction in the United States, which is extraordinary, given how high it was in Canada ten years ago. It does cost a lot of money to buy people health care.* How are you going to do that within a context of the government budget? How are you going to deal with the fact that some people would really like to spend a lot more money on health care than the government does while others are too poor to spend any more? So every one of these systems faces problems and they're all sort of variants of the same problem that we face.

What are the impediments to reform in the system?

There are a lot of impediments to reforming the system. One of them I think is that Americans have very different sort of schizophrenic views about what health care is all about. On the one hand, I think we think everyone ought to have a right to health care. It ought to be the same for everybody. And it's very striking to me that when you ask Americans, "Do you think everyone should have access to the same health care a millionaire gets," people answer almost uniformly, "Yes, everyone should be entitled to the same health care." But, on the other hand, if you ask people, you know, "Do you think people should be able to buy more expensive plans if they want them? Do you think the government should restrict how much money high income people spend

on health care in order to keep everybody in the same plan," they're uniformly against that, too. So there's a tendency to both think of health care as something that's really special, that everyone should be entitled to same thing and to think of health care as just like everything else that we deal with where rich people should be able to buy more and poor people are stuck with less. *When we get these ideas together and we try and make policy, we're really torn between this notion that we have to restrict how much money we all spend on health care, that we have to make sure that everything is perfectly egalitarian*.

I think it's really hard to steer a course between those two very different sort of polarized ideas, about which way to go. And politics falls out that way, too. (à reprendre)

(i) You know, some people say, "If we go with a national health care system, it's government run and that's a terrible thing. It's going to be Pennsylvania Avenue all the way."

(ii) (ii) ***Other people say, "If we don't go with a government system, it's the market and the market is evil and we're going to have these for-profit investors on Wall Street making all the money out of the health care system."***

What is your proposal?

There ought to be some limit to the difference between how much really rich people and really poor people can spend on care. That is, while I don't think people feel that they ought to spend the same amount, people do feel that everyone ought to go the same way. That is, if a new treatment comes along, everyone should have some access to it. It shouldn't be limited to just the people who can afford to pay for it. ***I think we need a system of health care financing that takes that into account, that allows people to take advantage of new forms of technology as they come along***. And what I've suggested is that what we might want to do is put a tax on health care that funds health care. I know that sounds sort of contradictory, but if you think about the old country doctor in the small town in America the way we always think of it, how did that country doctor operate? Well, in those days they were all men, so I can fairly say "he", he used to go out and visit the big house and take care of the family of the rich person and charge the rich an arm and a leg for that care. Then, in exchange for that, he'd use that money basically to keep himself in business so that when the poor person down the street came, well, he might have to wait longer in the doctor's waiting room, but the doctor would treat him, too, and not charge him very much. So we had a system that essentially redistributed from health care of the rich to the health care of the poor. And for a long time we implicitly had this system in our hospitals. It was called "cost shifting". Hospitals used to charge a lot to people with private insurance and they'd use that money to pay for the care for of people who couldn't afford it. That meant the more people who had private insurance spent, that is, when technology got good, got better and they spent more and more money on health care, they was more and more money to pay for health care for the poor. All boats rose together, even though some boats were bigger than others. *What I'd suggest is that we re-institute that system. We'd have to do it explicitly now because with managed care and provider choice and so on, we can't really have the same kind of inputs and subsidies we used to have*. But we could do it explicitly, we could put a tax on health care spending and use it to fund uncompensated care.

Should we go above 15 percent GDP expenditures on health care?

It's funny when you look at historical documents, people were complaining about the share of health care in the GDP when it was five percent. ***They said it would be unsustainable if it hit ten percent. And, you know, we're chugging along very strongly at 15 percent and the economy doesn't seem to be suffering for it. It doesn't really matter what share of the GDP we spend on health care. Just like it doesn't matter how much we spend on movies. We could spend 80 percent of the GDP on movies and that would just mean we were a wealthy society and we liked to watch movies and there's nothing ethically, morally, or economically wrong with that. The GDP is going to be spent somewhere and if we choose to spend it on health care, that's fine.*** There's nothing wrong with that. The issue is how we can finance the health care that we provide to low income people. It's a distributive issue, not a size of the pie issue.

Doesn't matter how big the pie is. We can make it as big as we feel, as a nation, we want. What matters is how we're going the make sure that everyone gets a slice.

What about the health care demands of the Baby Boomers that will be coming?

Well, when you get older, health care becomes more valuable to you than the things that you spend money on when you're young. When you're young and you have some extra money, you might want to spend it on a new motorcycle or a new car. When you're older, you might want to spend it on the new knee. There's nothing fundamentally worse about spending in on a new knee than on a new motorcycle. Our tastes for what we want to buy are going to change as we get older, and as we get older, it's almost certain that we'll want to spend more money on health. So what does that mean? It means that rather than a lot of jobs being in the motorcycle-building business, they'll be in the knee-building business. I don't think that there's anything fundamentally wrong with that.

Is there an ethical or moral obligation to make sure people have coverage?

I think when you think about the moral obligations associated with health care, it's a very complicated moral question. One issue is: should people have access to coverage? But what does that mean? For example, I could provide everyone in this country access to the kind of health insurance coverage that existed in 1965, all the treatments that existed in 1965. It would be very cheap. We could offer that instantly. No one would want it. Think about all the things that have happened since 1965 that you would have no access to then. So when we say, is there a moral right to health care, I always want to know what health care? Is there a moral right to exactly what? Does it mean that you have a moral right to have your knee replaced if you can't walk up four flights of stairs, or do you have a moral right to have your knee replaced if you can't walk up one flight of stairs? I think it's hard to talk in moral imperatives when you're really talking about a continuum.

One of the things that strikes me when I look at the data is that uninsured people in this country actually get a phenomenal amount of care. The average uninsured person in the United States gets as much care as the average Canadian in dollars. We spend a huge amount of money on these people. That doesn't mean that we're doing the morally right thing. How do we think about that? It's not just an amount of money. It actually has to do with something substantive. And I think we need to define that before we start tossing around the idea of moral rights.

Can we maintain the status quo?

It's dangerous in health care to say that we can't remain in the status quo, because if you had looked at this situation 20 years ago, you would have said, "This is untenable. We can't remain here for another year," and here we are. So, while I'm an optimist and hope that everyone will get coverage soon because we'll be so disgusted with the horrible situation we're in, I think there's nothing to say that we can't remain in the status quo. Our system is not a rational system, but is it a system that will fall apart instantly? No. It will probably continue to be cobbled together in this patchwork way unless we actually do something about it.

http://www.investigatorawards.org/investigators/sherry-glied
Investigator Award : Sherry Glied Ph. D.

Robert Wood Johnson Foundation

The Employer-Based Health Insurance System

Award Year: *1995*

Within the framework of health policy and U.S. labor market changes, Dr. Glied takes a close look at employer-based health insurance, its strengths and weaknesses. She examines: how employer-based insurance systems operate and perform in response to changes in the

health care market; increasing differentiation among health plans; an apparent reduction in the number of long-term jobs; and the shifting demographic composition of the U.S. labor force. She studies the ability of employer-based insurance to pool risk, reduce administrative costs, and encourage innovation as well as the impact of the employer-based system on job lock, labor market performance, and industry competitiveness. In addition to developing theoretical models, the project integrates the findings of existing studies in economics and health services research, conducts new analyses using a variety of secondary datasets, and studies noteworthy examples of employer-based systems. Piecing these elements together, findings identify the linkages among health policy, the economy, and the future of employer-based coverage.

http://www.nejm.org/doi/full/10.1056/NEJMp0802027#t=article

Universal Coverage One Head at a Time — The Risks and Benefits of Individual Health Insurance Mandates

Sherry A. Glied, Ph.D.

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The health insurance reform enacted in Massachusetts in 2006 and the proposals of the leading Democratic presidential candidates seek to achieve universal health insurance coverage while relying primarily on private insurance. Achieving universality is a challenge in any system that assigns insurance coverage, whether private or public, to identifiable individuals. The difficulties of finding, enrolling, and accounting for all eligible participants escalate when most of the financing for coverage is expected to come from premiums paid directly to multiple insurers rather than from funds collected centrally by the government through taxation. *To address this problem, some reform models incorporate an individual mandate, a legal requirement that every person obtain insurance coverage. The Massachusetts health plan mandates coverage for both adults and children, as Senator Hillary Clinton's proposed plan would do nationally; Senator Barack Obama's plan would require parents to obtain coverage for their children.*

Universal coverage that relies on private health plans is hardly unprecedented; several other countries, including Germany, whose health system dates back to 1883, as well as Israel, the Netherlands, and Switzerland, use this model. Neither is the individual mandate unique to the United States. *The Dutch and Swiss systems, which, like the U.S. models, rely relatively heavily on premium payments rather than payroll taxes, incorporate such mandates*. ***The individual mandate in the U.S. plans, however, has become a flash point for controversy.***

The idea of an individual mandate as a means of achieving universal coverage dates back to the 1993 Clinton health plan. At that time, conservative proponents of expanded coverage argued that the availability of free or subsidized care for the uninsured would generate what they called free riders — people who were aware that inexpensive care would be available in the case of an emergency or a health catastrophe and who would therefore choose to forego the purchase of private insurance. Though such conservatives rejected a substantial role for government in providing health insurance, they asserted that the free-rider problem legitimated a requirement that everyone hold basic insurance coverage.

The free-rider problem remains a central element in the argument for an individual mandate. Research verifies the existence of such a problem but suggests that its magnitude is quite small. Funds diverted from uncompensated care would not be sufficient to pay for the subsidies needed to cover most uninsured people. Eliminating the free-rider problem through universal insurance might make the health care system more fair, but it wouldn't make it less costly.

Achieving universal coverage is more important as a means of improving the functioning of the insurance market. A fundamental problem in health insurance is that people know much more

about their own health than insurers do. Prospective purchasers can — and do — use this information when making decisions to obtain or retain coverage. Insurers respond to this behavior by aggressively seeking out healthier purchasers and discouraging the enrollment of those who seem likely to require costly medical care. This inevitable response drives up the costs of marketing and underwriting coverage, which are substantial components of the very high administrative costs of insurance purchased in the nongroup market. Compelling everyone — whether healthy or sick — to participate in the insurance market may diminish the use of these wasteful insurer tactics. Mandated participation may also make it easier for insurance regulators to limit the extent to which sicker people pay higher premiums by reducing the risk that healthy people will be driven out of the market. Proponents of an individual mandate hope that such a policy would help to reduce the administrative costs of health insurance in the United States to the considerably lower levels found in other private-insurance–based universal systems.

Although the desire to curtail free riding and strategic behavior by insurers provides the philosophical underpinnings of the individual mandate, policymakers' interest in the mandate option owes as much to its fiscal implications. Universal coverage achieved through an individual mandate could cost much less than achieving the same result by giving people subsidies for buying coverage voluntarily.

The individual mandate responds to two lessons learned from previous efforts to expand coverage. ***First,*** although most uninsured people would like to have health insurance, the protection it offers against a potential adverse event is not an urgent priority for all of them. Many in this group are healthy. Most have relatively low incomes and many other demands on their pocketbooks. *A decade and a half of incremental expansion efforts have demonstrated that inducing all uninsured people to take up coverage will require very substantial subsidies — subsidies that might well exceed the cost of the coverage itself*.

Compounding this "take-up" problem is a second characteristic of insurance coverage. As the graph shows, even in the group with incomes between 100 and 199% of the federal poverty level, more people currently hold private insurance than are uninsured. *Almost all of those who hold private insurance now pay at least a portion of the premium for that coverage. If substantial subsidies were made available for the purchase of new coverage, many who now pay for their own coverage would (eventually) make use of these subsidies instead.* Subsidized coverage would crowd out existing private spending, greatly increasing the public cost of an expansion program. ***The individual mandate gives policymakers a new tool with which to respond to the take-up and crowd-out problems.*** Increasing the cost of remaining uninsured by imposing penalties in association with a mandate can promote coverage while keeping subsidy levels in check so that they do not lure the privately insured into the subsidized program.

The individual mandate offers new options, but it also introduces risks. The mandate is in many respects analogous to a tax. It requires people to make payments for something whether they want it or not. One important concern is that the government will provide insufficient funds for the subsidies intended to accompany the mandate. In that case, the mandate will act as a very regressive tax, penalizing uninsured people who genuinely cannot afford to buy coverage. *This concern has led Massachusetts to create a hardship exemption for its mandate — an escape clause that effectively undoes the mandate if subsidies are insufficient.* The ease with which it is possible to lift the mandate if the legislature fails to appropriate funds may make the individual mandate a rather rickety form of universal coverage.

The tax analogy explains another concern about mandates. Conservative proponents of small government fear that special-interest groups will urge legislatures to broaden the minimum mandated benefit package. The relative invisibility of the mandate "tax" may make it easier for special interests to achieve their goals. The mandate, then, would become a means through which special interests use government to force transfers of funds from consumers to the health care sector.

A final concern about mandates relates to their administration. Like taxes, a mandate requires

enforcement if it is to be effective. Compliance with taxes, as well as with other mandates in current operation, is never perfect. It varies with the rules and procedures governing enforcement. The nature of insurance makes a health insurance mandate particularly tough to enforce. Taxes can be collected retroactively, but to be effective, an insurance mandate should be in place at the beginning of an insurance term, ensuring that people have coverage when an adverse event occurs. Developing a system to promptly identify and penalize scofflaws will take effort and ingenuity, particularly in our diverse and mobile country. It may require a degree of intrusiveness and bureaucracy that some will find unpalatable. If subsidies are generous and benefits valued, voluntary participation will be high and enforcement problems will be manageable. If subsidies are insufficient or benefits inappropriate, the mandate will be very difficult to enforce and draconian in effect. ***The risks associated with individual mandates suggest that they are no panacea.***

Perhaps the most important benefit of mandates is symbolic. *By mandating the purchase of health insurance, governments signal to their citizens that coverage is critical.* For many uninsured people as well as their families, communities, and elected representatives, this public commitment to coverage may lead to a reassessment of priorities. Although making mandates functional will be demanding, just passing a mandate may serve an important purpose by moving health insurance higher on the agendas of all these constituencies