source videos used:

- Original U of RI video, posted 11/5/2012: http://www.youtube.com/watch?v=AqHz2XcUGok
- Replacement posted 11/17/2014 by American Commitment after U of RI deleted original (hooray!) :http://www.youtube.com/watch?v=2fTHqARiV_Q&feature=youtu.be

Prof. Jonathan Gruber at The University of Rhode Island's 2012 Honors Colloquium

Nov. 2012

transcript 11/18/2014 by the ObamacareTruthSquad,
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Prologue—The Obamacare Conversation We Never Had

So unaccountable has been this Administration, so intent on ramming Obamacare through—and with such little consideration for the intelligence (or securing the consent) of the governed—that four years into the contagion, Grubergate is the first chance ordinary Americans have had to hear an adult-level explanation of Obamacare.

In the newly-discovered videos, we finally have one of Obamacare's key designers laying out its design, workings, and intentions, in non-technical language.

These videos finally provide an opportunity to respond to Obamacare talking points at their source and rebut the plan itself on its dismal merits. This is a chance not just to rail against the process, not just to expose the calculation—even arrogance and deception—of its central-planners and their callously careless, chilling vision for American health care, but a chance to debunk Obamacare's design. It's hopelessly defective.

At the ObamacareTruthSquad we think the substance of the presentation is even more damaging to Obamacare than its designers' obvious disdain. We've transcribed one of Professor Gruber's video appearances herein for posterity. Not only does the video reveal the deliberate deception, but when its promoter's glib pitch is frozen on paper for scrutiny, Obamacare falls apart on the merits. And, ultimately, that's what people care about—does it work? No, it doesn't.

We've flagged some of Obamacare's glaring errors, falsehoods, and mistakes in context with commentary interjected into the transcript. The comments and references are meant to equip concerned citizens with the intellectual ammunition they need to begin critically examining the entire plan.

Last, we offer a simple solution to the whole mess, one that doesn't take anyone's privacy, choice, or freedom.

Executive Summary

Professor Gruber professes that U.S.' medical care is the best—but too expensive—therefore we all need to buy more insurance so that everyone will be able to afford... more insurance. He proposes a mandate to make sure everyone's on-board, willing or not.

The professor confesses repeatedly they don't know what to do, so the only choice is wild experimentation with the American health care system under innumerable "panels of unelected bureaucrats['s]" thumbs. Not to worry, Prof. Gruber reassures us that he was on several such panels and enjoyed it very much.

The good professor further explains that cost of America's existing government-run care threatens the nation's very economic survival, but we can worry about that later after everyone's over-insured. (If all that seems incoherent, that's because it is.)

Paradoxically, in the middle of a plan that compels over-insurance, the professor advocates his Cadillac tax to ensure that Americans *aren't* over-insured, explaining that isolating people from the cost of their consumption induces greater demand and consumption, increasing cost. In short, the Affordable Care Act increases cost (thanks Professor!), which was the biggest problem to start with. But we have to try it a few decades to find out what's in it.

SELECTED HIGHLIGHTS

The Plan

- The three-legged stool [1] [2] [3]

Obamacare Doesn't Control Cost

- Cost control is "the only issue," "single most important issue," "total issue for the future of the U.S. economy," but not addressed; "we don't know how to control"[2][3][4]
- Obamacare's cost control—the "spaghetti" approach; never solved, still the biggest problem
- Uncompensated hospital care was $56 billion a year; 'fixed' with Obamacare subsidies "about a trillion dollars' worth"

A government takeover

- "We need to really de-skill the delivery of healthcare in America."
- "trickle-down" health care

The Process

- Constitutionality questioned by the drafters
- Gruber describes helping write the law
- Gruber cites CBO as independent source [1] [2] [3] [4], despite supplying with CBO data and models
- John Kerry is a hero for the innovation of blaming insurance companies; a "clever exploitation of the lack of economic understanding of the American voter"

The Cadillac Tax

- Cadillac tax; "in principle we'd like to get rid of this" [employer plan deduction]; expands to cover all employer plans over time

Romneycare

- Romneycare v. ACA: RomneyCare has no employer mandate,
- RomneyCare: didn't increase premiums; doesn't, and wasn't meant to control cost
- Massachusetts' "little dirty secret" "rippin' off Medicaid"
- Medicare: horrible manager, payments politicized, cost threatens to collapse the nation, ergo "is the natural form of single-payer"

TRANSCRIPT

Transcriptionist's note: Prof. Gruber speaks at approximately 220 words per minute, drops words and syllables, and is otherwise extraordinarily difficult to transcribe. Every effort has been made at accuracy, and the text has been proof-read multiple times, but errors are inevitable. *Caveat emptor, caveat regis.*

RICK MCINTYRE: […] (2:12) But it's also true that without insurance too many of our citizens are left without access to both preventive care and palliative care. With the Massachusetts health care insurance law and the national Affordable Care Act, we're beginning to address the insurance side of our national health problems. These laws actually look a lot the same in many ways, even though we didn't hear very much about them in the recent presidential debates. One of them of course associated with Gov. Romney and the other with Pres. Obama. Another similarity between the two laws is that tonight's guest Jonathan Gruber has done research that influenced both laws in decisive ways. Called "Mr. Mandate" by the New York Times. Jonathan Gruber is "Professor of Economics" at MIT and director of the health care program at the National Bureau of Economic Research, one of the oldest and most prestigious economic research organizations in the country. In addition to many many academic articles, a public finance textbook, he's also the author of this marvelous book which you can buy afterward on the table just outside, called "Health Care Reform, What it is, why it's necessary and how it works" (3:30) I never thought I'd see an MIT economist with a comic book, but there you go. The world is changing. He is also a Van Halen fan, he owns eight parrots, and he doesn't like to travel too far from his family in Lexington Massachusetts. So I want to thank John for adjusting his schedule to be with us tonight, and to speak about the political and economic impact of the health care reform debate, and the Supreme Court decision on the Affordable Care Act, I give you Professor John Gruber. (4:06)

GRUBER: (4:13) Thank you, thanks to Rick for that kind introduction. I am indeed a heavy metal fan, but given the recent events [Superstorm Sandy] I will not sing "Rock Me Like a Hurricane" tonight.

Tonight I'm going to talk about healthcare. Now healthcare is the single largest sector of our economy, so it's hard to really talk about healthcare in 35 minutes or so. And so in thinking about what I want to talk about I always try to keep in mind a story that's told in my family about the time my sister came running into the house and said "Dad, Dad,"— saw my father and said — "Dad, Dad where's Mom?, I need her," and my father said "I don't know. Can I help you?" My sister said "No you can't help me" and started to walk away. And my father said "Well what do you need help with?" and my sister said "Well I need help with my math homework." Now my father's a PhD in finance, so he was a bit taken aback that my sister did not want help with her math homework. He said "Well can *I* help you?" and she said "No, I don't want to know that much about it."

(5:05) So I want to try to not tell you more than you want to know about healthcare reform tonight. I'd rather keep it short and leave time for questions. I'll probably go on longer than I want, but I hope we'll have time for questions to hear what you want to know rather than what I want tell you.

The History of Health Care Reform in the U.S.

(5:20) What I want to do today is talk about the basis of past, present, and future of health care reform in the U.S. I want to start a little bit with the past because it's impossible to understand and appreciate healthcare reform without some understanding of the past. We've been trying to reform healthcare in the U.S. for about a century. It first began with Teddy Roosevelt's efforts in 1912. If you want to read about this there's an excellent book about the history of healthcare reform by Paul Starr called "Remedy and Reaction."

Clashing Visions—the Left Wants Single-Payer

(5:45) Over the last hundred years healthcare reform has really crashed on the shoals of two different shores. On the left, we have people who think, "Look healthcare reform? We should have a single-payer system, one government insurer like they have in Canada." They say "Look, what are the two big problems with healthcare in the U.S.?"

(6:02) The first is the high and rising number of uninsured citizens. We have about 50 million Americans without health insurance. It's gone up steadily for about the past 30 years. These individuals do not have access to insurance, and their health suffers as a result.

Unsustainable Growth of Health Care Costs

(6:15) The second problem is the unsustainably growing healthcare costs in our country. (6:20) In 1950 healthcare was 4% of our economy, today healthcare is 18% of our economy, by 2080 it's projected to be 38% of our economy, by a century after that it's projected to be 100% of our economy.

That's not tenable. Even if you want to be a doctor someone's got to buy your services. Okay. So basically we've got an unsustainable rise.

Canadian Single-Payer

(6:40) The Canadian system potentially solves those. The insurance problem's obviously solved─you're insured from birth in Canada. The cost problem's also potentially solved─you just set a national cap, you say "We won't spend more than X on healthcare," and you're done. So, single-payer advocates have said there's a clear answer.

Single-Payer is Politically Infeasible

(6:51) The problem with that is that it's politically infeasible. It's politically infeasible for two reasons. One reason which is discussed well in Paul Starr's book (7:01) is that we've built a system in America─ every time health care reform fails we put another piece in (7:06)─and we've built a system in America that basically works for most people.

That is, most Americans are actually pretty satisfied with the US health system. They wish it was cheaper, but by and large they like it. Most Americans have insurance from their employer or the government, it's quality insurance─if it's from their employer they often have many choices-and they're pretty happy with it. And in America you don't get too far in politics making 200 million people unhappy to make 50 million people happy. That calculus doesn't work. (7:34) So that's the first problem.

Insurance Industry – too powerful to kill

(7:36) The second problem is that we have an $850 billion private health insurance industry in America, and it's not going quietly into the night, right? There's no way private health insurance is going to let us nationalize that industry, that's not happening. So for that reason single-payer is simply not happening.

The Vision of the Political Right

(7:53) Then on the right, you have the other extreme which [says?] "Look we have a well functioning private market, let's just let it be. Maybe we just give people some tax credits so they can buy healthcare in that market, but let's just leave people alone with what's working."

Insurance 'Carnival of Evils'—the non-group market

(8:04) What's wrong with that solution is that it's not working. Okay? The private health insurance system is broken for the large minority of people that do not have access to either employer insurance or government insurance. They face something called the non-group insurance market. Which in my comic book I portray as this horrible, you know, Carnival of Evil. Okay? Basically this is the market where if you've been sick you can be denied coverage, or your coverage for any of that illness if it reoccurs can be excluded (8:30), where prices are multiples of what they are in the group market, and where when prices get high and you want to switch policies, once you leave one policy you can never get insurance again. (8:37)

Perfectly legal in every state. In most states, I'm sorry. And in most states it's perfectly legal to charge the sick multiples of the healthy. (8:45) The problem with that market is that if you give someone a $2,000 tax credit and they've had cancer, that's not going to get them cancer coverage because no insurer will give it to them. So, while the Republicans- while the right is correct, that the system largely works for most (8:58) Americans, it doesn't work for substantial minority of Americans. So that's where we've been stuck. And we've been stuck there for about 100 years. And basically about every 20 years someone's tried to fix that. (9:08) You know we had─ Roosevelt made a big effort, and then Truman, and then Kennedy─ then Truman, then Nixon, then Clinton.

Mitt Romney's Massachusetts Vision

(9:14) And now- that led us to the early 2000's, and we introduce the hero of our story. Let's call him Mitt Romney, Mach One. Okay? Mitt Romney Mach One had a vision. His vision was something that I call "incremental universalism." It sounds like a new religion, but it's really an idea for healthcare reform.

"Incremental" borrowed from the left─ borrowed from the right, I'm sorry─meaning "Let's build on what works. Most people are happy with what they have (9:36), let's build on that incrementally." "Universal" borrowed from the left meaning "let's get to universal coverage."

The Three-Legged "Stool"

(9:46) And Romney's plan to do so was to build what I like to think of as a three-legged stool (I have a lot of─ having written this book I have a lot of visual images I like to use to sort of portray these things). So I think of it as a three-legged stool, to try to get to this goal of universal coverage incrementally.

First Leg of the "Stool" – 'Guaranteed issue' plus 'community rating'

(10:03) The first leg of the stool is to end the ability of insurance companies to discriminate against the sick.(10:07) Okay? Let's be clear, this is a fundamental failure of American democracy. We're the only nation in this world where because you're sick, you can be denied insurance. We're the only nation in the world—developed nation, I'm sorry—in the world where basically you can go bankrupt because you get hit by a car. Okay? It's a fundamental failure of a nation of our level of wealth that people who are not offered insurance by their employer or the government do not have access to fair insurance.(10:31) *[Obamacare is bankrupting people now. If they're unlucky enough to get sick, many will be bankrupted by their deductibles. If they stay healthy, Obamacare bleeds them in premiums for services they don't need.]*

So the first leg of the stool, to fix that, to say to insurers "You cannot discriminate against the sick—you have to give insurance to everyone, and you have to do it at a fair price. (10:39) You can't charge the sick more than the healthy."

Now in fact this leg of the stool was not put in by Mitt Romney. In fact Massachusetts was one of seven well-meaning states in the mid-1990s that put in these insurance regulations. We called them 'community rating.' Which enforced that insurers do not charge the sick anymore than the healthy. And offers insurance to everyone— and anyone who wants insurance can get it.

Markets collapsed where tried...

Now, what happened was exactly what economists said would happen (11:01) when they did that, in all seven states. Which is, it destroyed the insurance market. Because if *insurers* had to charge everyone the same price, but *people* could wait 'til they were sick to get insurance, then insurers lost money. I think (11:14) the analogy that I've finally come up with that works best—since I'm a sports guy—is it's sort of like saying to a bookie "You have to take bets at halftime." (11:20) Okay? Well, at halftime you[?] know who's winning. The bookie's gonna lose money if he has to take bets at halftime. (11:26) Okay? It's sorta the same thing with insurers. If you tell them "You have to take anybody for insurance at the same price but people can wait 'til they're sick to buy," insurers lose money. (11:33)

And that's what happened. Two of the states got rid of their laws; the other five states, the insurance market collapsed.[sic]

Second Leg of the Stool - The Individual Mandate

(11:39) That's why you need the second leg of the stool. The second leg of the stool Mitt Romney introduced was the individual mandate, (11:45) a requirement that everyone buy health insurance. Because once everyone's in the pool, then you can price fairly to everyone. You can make the first leg of the stool work once you've got that second leg.

Third Leg of the Stool - Subsidies

(11:54) But a stool still can't stand with just two legs. You need the third leg, and you need the third leg because if you're gonna mandate people buy health insurance, you have to make it affordable.

[Note that Jonathan Gruber, mastermind, has no power to make insurance affordable, any more than a mandatory Ferrari is made any cheaper or affordable by any mandate, subsidy, or totalitarian decree. All the government can do is take one person's health care money, and give it to someone else. That doesn't make care or insurance cheaper, only shifts the shells around.]

Need for Subsidies Explained

(12:04) When we were writing this law in Massachusetts in 2005, a family health insurance cost about $12,000. The poverty line was $22,000 for a family. You couldn't tell a family they had to spend 60% of their income on insurance. That was both impolitic and inhumane. So the third was subsidies to make health insurance affordable. We put in a program called "CommonwealthCare" which offers very (12:26) heavily subsidized insurance up to three times the poverty line—or up to about $65,000 for a family.

So the three legs of the stool: fix insurance market so insurers can't discriminate, have a mandate so that insurers can survive with those first regulations, and have subsidies so the mandate is feasible. That's the three-legged stool we put in place.

Experience with RomneyCare in Massachusetts

(12:43) [We] put that in place in April 2006. How's it doing? Well, I'm biased, okay? I wrote the law, and I implemented the law. So I'm very biased. Okay? I was on the board—um, **I'm actually one of those 'unelected bureaucrats' you may have heard about from a certain presidential candidate, who actually appointed me to be an unelected bureaucrat to make healthcare decisions.** So I'm an unelected bureaucrat appointed by Gov. Mitt

Romney to make healthcare decisions for the citizens of Massachusetts, so I'm very biased. (13:09)

Nonetheless, what's very nice— and the reason I wrote this book—the comic book—and the reason I'm excited about this is: the objective facts are very clear. Which is, the law has been incredibly successful at what it tried to do.

RomneyCare's Goals – cover uninsured, and fix insurance market broken by earlier experiment

What'd the law try to do? Two things. Cover the uninsured? We've covered two thirds of our uninsured citizens in Massachusetts. Our uninsurance rate is now down to about 3% compared to about 18% nationally, okay? Success.

The second goal? Fix a broken insurance market. **Remember** we put that first leg of the stool in by itself, **we destroyed our non-group insurance market**. (13:40) We fixed it. In fact over the first couple years this law was in place, premiums in that market fell by 50%, (13:47) literally in half, relative to national trends.

We've done this all with broad public support. So the law was successful in accomplishing what it was designed to do. Which was **to cover people and fix a broken insurance market.**

RomneyCare was the model for the unAffordable Care Act (see differences, here)

(13:57) In fact it was so successful that—despite what Mitt Romney Mach 2 might tell you—it became the model for the Affordable Care Act.

Now how do I know this? I know this in two ways. First of all, **when Pres. Obama** said—**talked about Mitt Romney's advisers helping him to help write the law, he's talking about me** and a couple other people from Massachusetts who literally shuttled back and forth to the White House and helped them write the law. (14:19) And was asked every time "How did you do it in Massachusetts? How did it work in Massachusetts?" They based it on what we did, okay?

Second of all just read the laws. (14:27) And they're really the same basic thing. Okay? I've said it in more colorful language in other contexts.

But basically, it's the same three-legged stool. You've got— you fix insurance markets— And once again—this is not emphasized by politicians, so I can't emphasize it enough tonight—no more will America be a country where one bad gene or one bad traffic accident makes you bankrupt. Okay? That will no longer happen. *[tell that to this 29-year-old woman, bankrupted by her Obamacare policy]* People will be insured and priced fairly [sic]. Okay so fix insurance markets, it has the individual mandate—unless you can't afford insurance. (14:58) If insurance costs more than eight percent of your income you're (14:58) exempt from the mandate. But as long as you can afford insurance you are mandated to buy it, and **there's [sic] enormous tax credits—about a trillion dollar's worth, of expanded public insurance and tax credits—to make insurance affordable.** *[that is, in addition to raising people's premiums, Obamacare spends a tremendous amount of taxpayer money. These figures make the $56 billion in uncompensated hospital care Gruber complains about later seem like a bargain.]*

CBO Enrollment Projections – 32 million Americans will gain insurance

(15:10) Same three-legged stool. And as a result, the Congressional Budget Office projects [*Misleading. CBO relied on Gruber, yet Gruber cites CBO as if an independent source. (See American Commitment video of Sen. Max Baucus stating that the CBO used Gruber's testimony and model in its projections)*] that it will have a similar effect. They project that about 32 million Americans will gain health insurance–that's a little bit less than 60% of the population.

In Massachusetts we covered about two-thirds of the uninsured. The reason for the difference is, um, that, ah, the national— it doesn't cover illegal immigrants and we don't have many of those in Massachusetts. They have a lot of 'em in California and Texas. So as a result, ah, it's going to cover somewhat less of the uninsured than we did in Massachusetts, but still, much— very heavy majority of the uninsured will be covered. Ah, and, um, and, and— so the law was seen by the CBO as accomplishing the same goals we accomplished in Massachusetts. (15:49)

Massachusetts' "little dirty secret" – Federal money

(15:53) Now, um, however, the story does not end there, because the federal law is much more ambitious than the Massachusetts law.

Federal Medicaid money used as slush fund

And it's more ambitious in two ways. (16:00) Okay? The first way it's more ambitious is **that there's a little dirty secret we have in Massachusetts we don't like people to know. Which is, the whole reason we have universal health coverage is not 'cause we're such nice guys, it's 'cause the feds pay for it.** So what happened was, we had

a pretty powerful senator you may have heard of named Ted Kennedy? **Ted Kennedy was delivering about four hundred million dollars a year in slush funds to our safety-net hospitals, basically rippin' off the Medicaid program** – the federal Medicaid program – for about four hundred million dollars a year.

President Bush, I think quite frankly appropriately said "Look, I'm not gonna let this Democratic senator rip me off any more. I want that money back." (16:33) Governor Romney, to his credit, went to President Bush and said "Can we keep the money if we use it for universal coverage instead of as a slush-fund for hospitals?" And President Bush, to his credit, said "Yes." (16:42)

So, the reason we could make that happen was 'cause the federal government paid somewhat more than half the bill of doing it.

Feds don't have the same luxury

Now at the federal level we don't have that luxury. It's not like China's gonna pay half the cost of our doing universal coverage. Okay? We had to raise the money. And that's a much— that's a difficult aspect we didn't have to deal with in Massachusetts.

Funding Obamacare

(17:01) How's the money raised to finance— and let me step back and say President Obama made it very, very clear — **President Obama** largely left the writing of this law to Congress. But he **had a few principles he was very clear about, and one principle was the law would not increase the deficit.** And in fact if you look at the non-partisan (17:16) Congressional Budget Office score [*The third time Gruber has referenced the CBO score as if an independent source*], **this law reduces the deficit by about a hundred billion dollars over the next decade.** Okay?

How does it do it? It does it by— somewhat by cutting spending, and some of it by raising taxes. So cutting spending— and in both cases I would say that there's a piece that's not-so-controversial and a piece that's maybe more controversial.

Cutting Medicare Advantage – "not controversial"

(17:34) Cutting spending, **the piece that's not controversial is reducing over-payments** to private insurers *[i.e. Medicare Advantage]*, who insure the individuals on the Medicare program. Medicare is our universal coverage for seniors.

About a sixth of seniors get their insurance from private HMO plans. The idea of those plans is that, um, if you get insurance from a private plan maybe it could deliver it a bit more efficiently than the government. So the idea of Medicare HMOs was to save the government money. (18:00) Despite that, President Bush passed a law in 2003 which said that these plans would be paid a hundred and eighteen percent of what Medicare's paid.

Now you might say to yourself "How can you save money if you pay them eighteen percent more than Medicare," and the answer is (18:07) 'you can't.' Okay? It was a stupid law, and a lot of how the Affordable Care Act is paid for is just repealing that over-payment to insurers. Now that does not harm patient health, that does not harm anything except insurer profits. That's a no-brainer. And that's one piece of financing of the law.

Cost Control – lowers Medicare hospital payments' growth rate

(18:26) The second piece is a little more controversial, which is it lowers the growth rate of Medicare payments to hospitals by about half a percent a year. It doesn't lower actual payments to hospitals, but the rate at which Medicare payments to hospitals grow is slowed by about half percent a year. (18:39) That is a little more controversial. I think it's mixed information about whether that's really gonna matter for patient health. Ah, but when you hear discussion about the elusive $716 billion dollars in Medicare cuts, okay?, and when Romney says they're cuts and Obama says 'no they're just reductions in over-payments,' Romney's wrong and Obama is half right.

Obama is half right in the sense the insurers' over-payments—that's an obvious cut in insurer over-payments. The hospitals? We'll see. We'll see how that plays out, it's not entirely clear.

Raising Taxes – The Medical Device Tax

(19:06) Um, the other half of the financing came from raising taxes. And once again here we have I think an uncontroversial piece and a more controversial piece. The uncontroversial piece is it's an increase in taxes on the sectors that benefit from having 32 million insured customers: medical technology, pharma, the insurance industry.

[*Presumably the federal government would've gotten more income tax revenue from these industries as a result, in their usual proportion. Instead Gruber feels entitled to a larger-than-usual share, because he, Gruber, has given*

these industries a gift. Unfortunately the ingrates don't see it that way, annoying our mastermind.]

Now one of the few things that pisses me off the most about critics of this law is when the medical device industry says "This is an unfair law because it's financed with a small tax on our sector – well they don't say "small," but it's a small tax on their sector – (19:34) "that's unfair, it's gonna cost jobs, and whatever." These guys are getting 32 million new customers, and in return they're asked to kick back a little bit in a higher tax.

[a) *2.3% of gross receipts can easily amount to 20% of profits, on top of income tax. That isn't small. b) It doesn't apply just to a company's possible increase from the ACA—it applies to their other business too, everything. c) Gruber is implicitly saying the ACA raises total American health spending (for the industry to make more income, there has to be more spending.). d) If the tax is so small, why is our mastermind so upset?*]

Okay, it's kinda like saying, "We're gonna put $100 bill on the sidewalk for you, when you pick it up we're going to take $10 of it back," and you complain about that. Well you have every right to complain about the $10 we're taking back, but you ignore the fact that we put the freakin' hundred dollar bill on the sidewalk in the first place.

[The mastermind is annoyed at the serfs. They aren't grateful enough.]

Okay? So basically it is *crazy* to think that these sectors are complaining about a tax, which is gonna be swamped by the money they'll make off of having 32 million new customers. [*A basic error: 32 million projected prospects is not the same as having"32 million 'customers.' " It's not even close.*]

Funding the unAffordable Act – The Medicare Payroll Tax .. "one of largest tax increases"

(20:03) The more controversial piece is there's a major new tax on the wealthy in this law. **Perhaps one of the largest tax increases on the wealthy we've seen since World War II.** (20:10) There's an increase in the Medicare payroll tax for families making above $250,000 a year. Okay? And that's about a quarter of the financing of the bill. So that's where the money comes from. And once again, by the *non*-partisan Congressional Budget Office [*fourth reference to CBO without disclosing he advised CBO*], this lowers the deficit by about $100 billion in the first decade and by even more beyond that. So this is a rare piece of fiscally responsible legislation in Washington.

Okay? So that's the first place [sic] that was harder than Massachusetts.

Cost Control – Not Massachusetts' law's goal.."haven't increased" costs

(20:36) The second piece that was harder than Massachusetts was we had to deal with cost control. Okay? Look, fundamentally this is a coverage bill. In Massachusetts we didn't pretend it wasn't. In fact in Massachusetts the cost of health care in Massachusetts has risen at exactly the national trend since we've passed our law. And that's just fine—our law wasn't about cost control. I like to say that criticizing the Massachusetts law for not controlling health care costs is like criticizing the Patriots for not winning the World Series. Okay? It's a different sport! It wasn't what they were trying to do. Okay? **We weren't trying to control health care costs. That wasn't the goal of our law, and we haven't.** (21:08) **We haven't increased them**[1]**—**they've gone up at exactly the same rate as the national costs—but we haven't lowered them.

"You Have to Make It About Cost-Control to Get It Passed"

(21:13) The federal government did not have that luxury. The dirty secret is the American voter doesn't actually care about the uninsured. (21:19) **The dirty secret is you can't really get a law passed by saying "We're helping the uninsured." (21:22) You *have* to make it about cost-control to get it passed, because that's what the American public cares about.** So they *had* to make this law not just about the uninsured, [but about???] cost control. That was a challenge. (21:32) And here's why that's a challenge. The reason it's a challenge – and I want you to see [a???] graphic image (21:36) Think about controlling health care costs in America as having to climb up two hills. (21:42) The first hill is scientific, which is 'we don't actually know how.' In particular **we don't know how to control health care costs without potentially risking the health of Americans.**

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1 Trudy Lieberman, CJR, January 28, 2010, "[T]he media relies way too much on the same sources, who utter the same thing again and again to different news outlets. The problem with this, of course, is that a particular view of the world spreads widely, perhaps reinforcing that view as the correct one—which it may or may not be, depending on the facts and on which side of the river you call home. (Jonathan) Gruber has been the cheerleader-in-chief for the Massachusetts health care plan, which is the model for federal reform. He sits on the board of the Connector, the state's policy brokerage service, and thus has something of a vested interest in positively spinning the reform efforts there. Last year on the PBS NewsHour, he told how premiums for individuals buying their own coverage in Massachusetts had dropped dramatically. **But he didn't mention how premiums for workers in small businesses had risen to sky-high levels in order to make that possible.**"

So let me give you two facts about health care costs which will seem really contradictory but you'll see in a minute I'm pulling a trick on you.

Health spending growth "has been worth it"...

(21:56) The first fact is that from 1950 'til today, health care spending has gone up from four percent of our economy to eighteen percent of our economy. (22:05) And it's been worth it. Health care *sucked* in 1950. Okay? An infant born in 1950 had four times as large a chance of dying the first year after they were born. So with a heart attack? Five times as much a chance of dying [in] the year after (22:16) the heart attack. (22:18) You hurt your knee skiing in 1950? You're in the hospital for two weeks, you're on crutches for eight weeks, you've got arthritis for the rest of your life.

Now you hurt your knee skiing, you get arthroscopic surgery , you're on the slopes the next weekend (22:29) or maybe two weekends (22:30) after. Okay? Healthcare is just much much better, and **by any reasonable calculus the increase in health care spending has been worth it.** (22:36) If you're really interested in delving deeper into this there's an excellent book by David Cutler called "Your Money or Your Life", which goes through the argument of why the increase in healthcare spending has actually been worth it. (22:46) Okay? That's fact one.

...even though possibly one-third is wasted.

Fact two is we waste a huge amount of what we spend on health care, by some estimates up to a third. Now how are these two facts consistent with each other? How could the growth in cost be worth it, and yet we waste a third of what we pay? Well the reason is – the secret is – the other two-thirds is awesome. Basically the other two-thirds has been so great that it's carried the one-third we waste.

Capping health care spending is bad, because we don't know which efforts will pay off in the future.

(23:08) **The trick is we don't know what's in the two-thirds and what's in the one-third in the future.** We can look back and say it's back-surgery or Viagra, okay, but looking forward we don't know what it's going to be. We don't know what's gonna be in the fat, and what's gonna to be in the muscle.(23:20) So the problem is, **if we just say "We'll just do what single-payer advocates might say and just cap healthcare spending at 18% of GDP" that would be a disaster.** If we'd done that in 1950 and capped spending at 5% of GDP, millions of Americans' health would've suffered enormously. **Millions of Americans I think would not be alive today if we'd made that decision in 1950**. [*Twelve minutes hence Gruber praises this same measure—tying health spending to GDP—as cost-control "leadership" (see 37:25).*] Okay **that's a terrible decision to make and we can't do it, even at 18% of GDP.**

"We really don't know how to control health care costs"

(23:43) **So there's this scientific problem—we don't really know how to control health care costs. We have a lot of good ideas and I'll get into it— but we don't really know how.** (23:50) Let's say we figured that out— and I think we are, we are climbing that hill. We are much further up that hill than we were five years ago, I think in five, ten years we'll be near the top of that hill. I think then we'll *know* what to do.(23:59) The problem is once we get there and we're out of breath, and we're panting and we look up, and there's a bigger hill in front of us and it's called "politics."

Political barriers – mammograms and death panels

(24:06) Okay? And you all know the story of death panels? The death panels? Just to review, the story was that a Republican congressman, suggested the Affordable Care Act include a provision where Medicare reimbursed doctors— for discussing end-of-life care options with their patients. Sarah Palin heard about this, called it a "death panel" where doctors would decide whether or not you lived, (24:23) um, it got politicized and actually had to be removed from the bill. (24:27) Okay?

But I think there's a story which is actually maybe even a little more instructive, um, which is mammograms

So November 2009, ah, the, um, Preventive Services Task Force, which is an outside expert body who recommends when you get preventive care like— when you get your vaccines, when you get your flu (24:44) shots, stuff like that – they issued a recommendation that women in their 40s no longer get mammograms. They said that, "look, we're detecting so many false positives, leading to so much excess surgery, and we're so good at treating cancer once we catch it (24:57) – breast cancer, once we catch it – that it's really not worth mammograms in the 40s. Women should start mammograms in their 50s."

I heard this decision and I was just like "whatever." I went home. My wife who is a cancer survivor said to me "You know what, Jon this is a big problem for you," (25:06) because we're in the heat of negotiations over the law. So, "This is going to be a big problem for you. People are going to be really upset about this." I said "whatever." Went to

bed.

The next morning—as always—she was right. And, the headline was "The Government's Gonna Take Away Your Mammograms." Okay? Now forget the fact this wasn't the government—[it] was an outside body [*a distinction without a difference, especially where Obamacare adopts their recommendations*]—*forget* the fact that no one was taking away anything, it was just recommending preventive services.(25:26) Nonetheless, the outcry was enough that **if you read the Affordable Care Act—and I recommend you do *not*, okay?— (25:31)** (*laughter*)

[The mastermind makes another joke at our expense: his law's too complicated for us.]

—but if you read the Affordable Care Act (25:35), if you look at the definition of "preventive services," it says "as defined by the Preventive Services Task Force before November 2009." They literally [unintelligible] in the law. They wrote in the law "We didn't like this decision so we're gonna sort of outlaw— we're gonna, we're gonna rule it out." (25:50).

On cutting mammograms for women under fifty

(25:51) **Now if you can't let scientific expertise work in that way, how can you possibly do the much more serious things we have to do to control healthcare costs?** And the answer is "You can't" in today's political environment.

The spaghetti approach to health care costs

(26:01) So what do you do? You're President Obama—and Democrats in Congress—**you promised you're gonna make this bill about cost control but you don't know how**, and even if you knew how the politicians wouldn't let you do it. (25:44) Kind of a tough spot to be in. [*Suggestion: since you don't know how, and it's politically difficult, maybe you're not supposed to be "solving" this problem. Maybe it's none of your business.*] **So what you do is you take what I call a 'spaghetti approach' to health care cost reform. (26:12) You throw a bunch of stuff against the wall and hope some of it sticks. Okay?** (26:15) What I mean by that is that what the Affordable Care Act does is in five different areas, try[sic] to do the best that we think we can do in healthcare, subject to what was politically allowable.

[*comment: that is, Gruber was in intimate consultation with drafters telling him what was politically allowable.*]

Okay? Now, the *number one* thing that upsets me about health care reform is when people say to me "Well, the Affordable Care Act wasn't a good idea because it didn't do enough to control health care costs." (26:37) And my favorite image – and my graphic novel's image – is [a] baby crawling, saying that "Look on health care costs, you have to crawl before you can walk and run." The notion that we shouldn't pass this bill because it doesn't do enough to control health care costs (26:46) is kinda like saying we should keep a baby penned up until it can run. That doesn't work. The baby's gotta crawl. Okay? And that's what the law does. It's the crawling before we can walk and run. (26:56) And how does it crawl? It crawls in five different areas. Let me try to go through them relatively briefly and then we'll be close to done. Okay?

The Cadillac Tax

(27:03) The first area I can't be brief 'cause as an economist it's my favorite, okay?, which is, uh, the Cadillac tax. Let's talk about this for a minute.

In America we have a pernicious feature of our— of our tax code, which says that if MIT pays me in wages I get taxed—if your employer pays you [in wages?] you get taxed—but if your employer pays you in health insurance you do not.

So if MIT comes to me and says "John would you like a thousand dollar raise or wouldya like a thousand dollars of orthodontia benefits for your kid?" I say "well if I get the thousand dollar raise I take home about 600 bucks, but the thousand dollars in orthodontia benefits [sic] I get a thousand dollars in orthodontia benefits." So I get that and my kid gets the braces that spin and change colors, and every month the new braces [sic], okay?

So basically, this system, where – this *tax distortion*—where some forms of compensation are taxed and others are not – causes three fundamental problems.

(27:51) First of all it's expensive. If we taxed health insurance like we tax wages in America, we would raise $250 billion per year more.

[Mr Gruber seems indifferent that by "rais[ing] $250 billion per year," he's talking about an enormous increase in

the tax on ordinary people's wages—union workers, shopkeepers. Washington regards this as a lost opportunity, more of your money they'd like to spend, if they could just get their hands on it.]

(27:59) To fix the idea, that is twice what it would cost to cover every uninsured American with health insurance today. Twice. Okay?

Second of all, it's regressive— it's a bigger tax break the richer you are. *[Incorrect, it's a tax on income. Gruber's confusing wealth with income.]* Because the richer you are, the bigger this tax— your tax rate is. (28:14). So one way I like to describe this tax break is "the government offers a bribe to employers [who/to?] offer health insurance, and the richer you are the bigger bribe they give. [*a) Ironically, Gruber is using a class-warfare appeal to rationalize his stiff tax on low and middle-income workers' health benefits. b) It's false. Someone who makes millions a year doesn't escape taxes, because they're not paying millions in deductible employer premiums.*]

(28:20) How can that make sense?

Third it's inefficient. **As my braces example illustrates, people buy excessive amounts of insurance, and get excessive amounts of healthcare *because* they are over-insured, because this tax subsidy sort of induces them to do so.**

[That's an interesting argument coming from the architect of a law forcing Americans to over-insure, and which mandates many services be offered without charge. Secondly, the mastermind doesn't seem to notice the serfs are 'over-insuring' themselves with their own money , which was formerly none of his (or the government's) business.]

So in principle we'd like to get rid of this. (28:36). So for instance we can get rid of it or we could even cap it. We could say "once you're above a certain level you're not gonna get this tax break anymore." So I give speeches (28:42)— you know I've been giving speeches for a dozen years making this point, and I'll make the point, someone'll raise their hand and say "Well wait—you're gonna to *tax* our health insurance?" I'd say "No no no, I'm gonna end a tax *subsidy* to your health insurance." They look me and they go <*makes befuddled face*> "you're gonna tax my health insurance?" <*Gruber gesticulates, exasperated*> And you just can't get through, and it's politically impossible.

a) Gruber's annoyed by the ingrate, but the ingrate's right and Gruber's wrong. Gruber wants to tax these poor rubes' health insurance.In Gruberland the real problem isn't that he wants to take people's health care money, the problem is they're too ignorant to appreciate his Gruberisms. b) Elsewhere, Gruber argues the opposite, that calling the mandate a 'tax' or 'penalty' makes no difference.

John Kerry's Deception
(28:59) **And so despite the fact we thought we might get it as part of this law, it turned out I thought it was gonna be dead, until a second Massachusetts hero arose, John Kerry. And John Kerry said "No no no, we're not gonna tax your health insurance, we're gonna tax those evil insurance companies."** (29:11) "We're gonna impose a tax that if they sell health insurance that's too expensive, we're gonna tax them. And *conveniently* the tax rate will *happen* to be the marginal tax rate under the income tax code."

"A very clever ... exploitation of the ... American voter"
(29:17) **So basically it's the same thing. We just tax the insurance companies, they pass on higher prices, that offsets the tax break we get. It ends up being the same thing.** (29:27) **So it's a very clever, you know, basic exploitation of the, of the, of the lack of economic understanding of the American voter.**

(29:32) Okay, and basically the Cadillac tax is put in— and basically that's gonna help control health care costs because it's gonna end this excessive subsidy for the most expensive health insurance plans. (29:42) **And over time it's going to apply to more and more health insurance plans.**

So that is gonna be a— That has two functions.

First of all, it raises a lot of money of time. Not much initially, but over time it raises a lot of money [*a tax increase*], which is why this bill gets more fiscally responsible over time. Second of all **it will increase efficiency of delivery of healthcare in America by making people actually face the real cost of their health decisions**. [*Meanwhile, Obamacare and its subsidies do the exact opposite, insulating and hiding the real cost of healthcare decisions.*] That's one piece cost control. (30:02)

[Comments: 1.He's canceling the tax deduction for employer health insurance. 2. He repeatedly recites a rate of 40%,

however, many if not most people affected (e.g. union workers) don't pay anything close to a 40% marginal rate. The Cadillac tax taxes a large part of middle-income and low-income people's pay at a higher rate than movie stars pay. 3. He's counting on large and increasing revenues, that is, this tax hits more and more plans over time. 4. On the one hand he says it'll discourage these plans, on the other he depends on more and more revenue from them over time. Bluntly stated, Gruber intends to end employer-based insurance, by stealth.]

Insurance Exchanges

(30:01) More briefly, what are the others?

Second: insurance exchanges. If you're at all interested in health reform, I *urge* you to go on MAHealthConnector.org, to see the future of healthcare. This is Massachusetts' health care exchange. And it is an incredibly wonderful shopping experience, where you can compare apples to apples, different insurance plans. [*interestingly, Obamacare destroyed Massachusetts' successful website and replaced it with one that never worked. The fallout continues as of this writing, 11/15/2014*] And economists will tell you that promotes good competition. An open and transparent marketplace is the best promoter for competition. [*Agreed, but that's not what Obamacare is. Speaking of "open and transparent" versus "government takeover," the Obama administration forbade insurers from making their new rates public, only just releasing an announcement yesterday, Friday, after the mid-term elections and the day before Obamacare's second Open Enslavement period.*] And indeed we've had very low increases in our rates in Massachusetts, and we've had new entrants into our insurance markets. This will spread nationally. **Every state will have an exchange. That will [ensure?] competition in insurance markets[2] and lower insurance prices.** [*but not competition or lower prices for supplies, tests, and services, a* sine qua non.]

IPAB

(30:41) Third, the unelected bureaucrats that we call the "IPAB," the Independent Payment Advisory Board. Let's just be honest about what this is, okay? The way Medicare– Medicare is the largest single insurer in America. It insures about 40 million elderly and disabled people.

Blaming Medicare's payment inefficiency on Congress

(30:56) **The way they set their rates that they pay doctors is by Congressional fiat. Okay? As a result of that politicized process we've got a system that's way out of whack.** For example specialists are massively over-compensated relative to primary care doctors.

The idea of the IPAB, is to set up an independent panel of experts who would actually try to bring a more rational reimbursement system to Medicare to try to lower costs. So, <*patronizing*> it's not "unelected bureaucrats making your healthcare decisions." (31:21) It's experts who'd recommend a new reimbursement system that Congress could vote up or down on. [*a distinction without a difference*] Okay? But hopefully, they'll have a good enough idea—and hopefully by then politicians will be brave enough— that they could vote "up" and we could actually get a more rational reimbursement system in Medicare. (31:35) Okay, that's the third.

Comparative Effectiveness Board

(31:37) The fourth is research in what we call "comparative effectiveness." Look, we have 18% of our economy devoted to a sector we've got no frickin' idea what works. I mean we kinda know what works—we have an FDA and they don't approve drugs unless they work—but we've no idea of what works better than what. (31:50) So if there's a new drug to treat a disease, and it costs six times another drug and does no better, as long as it works the FDA approves it. (31:57) The FDA doesn't say "this isn't cost-effective," the FDA just says "it works."

We have no one saying "this is a stupid thing to do because it cost six times as much and it does no good, does no better than the existing drug." [*in other words, the person who told us we can't know what will be tomorrow's fat and muscle (and ought not cut them lest we sacrifice tomorrow's innovations) proposes doing it*] (32:06) We need that out there. So what the law does is set up $3 billion of funding into something called the "Patient-Centered Outcome Research Institute," which will do research into comparative effectiveness to understand what works and what doesn't.

(32:20) Now once again politics intrudes. If you want to read the law, you will see that the [coreff?-garbled] —this is funny—that it says, "by the way, none of this can ever be used." (32:29) Actually what it says is insurers are not allowed to base their decisions on the research done by this institute. Now that's sort of stupid, right? Why are they doing it if insurers can't base their decisions on it? Well the notion is hopefully some generation of politicians will be brave enough to strike that, and this research will really matter. In the meantime we do it, we build the case for what works and what doesn't a**nd hopefully eventually politicians will be brave enough to use that.** [*e.g., health*

2 False. See Obama's Promise of "Competition" in Obamacare: Also False .

rationing by unaccountable bureaucrats, a.k.a. 'death panels.']

Obamacare's Pilots and Experiments—We're all Gruber's lab rats now

(32:46) Finally, pilots and experiments. Dozens and dozens of pilots and experiments of alternative ways of organizing healthcare in the U.S. *[a) "dozens" is hundreds of thousands fewer than letting a free people try things.We call it "competition." b) Gruber seeks to re-organize health care in the U.S. How is that* not *a government takeover?*] We have this crazy health care system in the U.S., where doctors are paid based on what they do to you. *[We also have a "crazy" auto-repair system of paying mechanics for what they do to your car, babysitters for how many hours they spend, and landscapers for what they do to your yard. Some people prefer that, others sign up for service contracts. We call this "freedom," and it produces "innovation." Government masterminds don't.*] Okay*?*

Doctors should be paid based on how healthy they make you, not what they— not what they do to you. (33:06) And so it's trying to move the U.S. away from our fee-for-service system towards a system where doctors are paid based on how healthy they make you [*a) Good luck measuring "how healthy they make you." b) Creates a huge financial incentive for doctors to ditch the sick and cherry-pick healthy patients.*] (33:13) through using things like Accountable Care Organizations, which are units of doctors and hospitals working together under one reimbursement scheme to try to improve your health. (33:22) **We don't know if these are going to work. We don't know.** So what you do? You try it, you experiment. [*In other words they don't know what they're doing, and they're experimenting with our health. We're their lab animals.*]

(33:26) The law— so far we have about one hundred and forty-one of these Accountable Care Organizations that have set up nationally, funded with money from the Affordable Care Act. The Affordable Care Act includes money to evaluate them to see if it works. So we'll learn. So the hope is when all this is in place— if the Affordable Care Act gets implemented (33:42)—and it's all in place, that we'll— we're gonna move way up that first learning curve. And that— we hope that second curve— that second hill will shrink a little bit so we can actually do something about it.

(33:51) So that's the Affordable Care Act in a nutshell. Let me end by talking about where we go from here.

ACA's Future—the four threats

(33:57) So what's the future? What do things look like?

First threat: had to get passed

Well the Affordable Care Act faced four threats. First it had get passed. We were— you know I went out with my— After it got through the Senate, I went out to dinner with my family said "well it's passed. It's finally through the Senate." And my family said "Is there [any more?] risk?" and I said "the only risk would be if some <*disdainfully*> Republican won Ted Kennedy's seat. That's never gonna happen." (34:16) Well, it happened. And Scott Brown won Ted Kennedy's seat and the bill barely squeaked through.

Second threat—SCOTUS

(34:21) Next was the Supreme Court. Now, **when we were writing this law**, **occasionally people would say "well do we have a constitutionality issue here?"** [*For the Congress and any congressional panel taking Gruber's testimony:* ***Which people thought there might be a constitutionality issue, and what was their concern?***]

And we'd say, "Phttt, that's stupid. No objective expert we've ever talked to said there's a constitutionality issue here." Unfortunately, the Supreme Court does not consist of objective experts. [*Hubris.*] Okay? In fact, the day before the Supreme Court's decision, they polled 21 constitutional scholars, 19 of which said the mandate was clearly constitutional. And yet the Supreme Court, on its merits, found the mandate *un*constitutional. It only passed muster because John Roberts pulled the trick of calling it a 'tax.' (34:53). So that barely squeaked by.

Third threat—Obama's re-election

(34:55) The third barrier is Pres. Obama has to get reelected. Now, despite what candidate Romney will tell you he *cannot* repeal the Affordable Care Act on day one. **He *cannot* issue waivers to states.** It simply cannot happen, even if he had 57 votes[sic], he couldn't do it. [*Yet Obama did and does, despite—and defying—the unACA.*]

But, he *can* slowly kill the bill from the inside. Which is basically this– Implementing this law is going to be [an] incredibly complicated and treacherous process. (35:16) And it's gonna require enormous federal leadership and financing to make it happen. A president that's not dedicated to this law succeeding *will* cause it to fail.
So he can't kill it on day one, but he can kill it on— within the first year or two—by not supporting it. So the third thing that has to happen is that Pres. Obama has to win. We'll see about that next Tuesday. Once again it's gonna be close no matter what.

Fourth threat—needs states' enthusiastic support

(35:34) Finally, the fourth barrier is: states have to implement the law. Now despite– I have– I have in my book these monsters representing different myths about healthcare. One of the monsters represents a federal takeover of our healthcare system. (35:47) **There's huge power for the states in this law.** The states basically set up their whole new insurance market, their exchanges. **But the states have to have to want to**, and many states for political reasons don't. So the fourth step is states have to actually implement this law and implement it successfully, and that will be rougher. (36:01) That's gonna take a while, we'll have to see where that goes.

(36:03) So, presuming Obama wins, then we are gonna have to have a law that's gonna be in place that's gonna go very smoothly in some states, mildly smoothly in some states, very badly in others. But eventually, (36:15) if it phases in and works as it should, it should deliver enormous benefits to U.S. So we'll have to see─ basically we're gonna have to see where that goes, um, and it's sort of hard to predict what's going to happen without, you know, we'll know a lot─ we'll know a lot more after Tuesday. (36:28) So, I've gone on long enough, why don't I stop there and leave the rest of the time for, for questions. (36:35). <*Applause*>

Q: "I've read news reports indicating that Massachusetts' universal health care costs are growing at or near the rate of the state's economy. Is that accurate, and if so how should that be addressed for the long term?"

GRUBER: (36:53) At or near the rate of the state's economy would be a huge victory. I mean, I mean, uh, basically, um, health care costs in Massachusetts—as in the U.S.—are growing well above the rate of the economy. Like I said, it's gone from four percent of the economy to eighteen percent of the economy in ahh─ over the last sixty years. Um, two comments. First of all once again, remember that's nothin' to do with our healthcare law. (37:15) Our health care law wasn't about health care costs and basically **health care costs have grown at the same rate before and after the health care law**, which is at the national rate. [*see footnote #1*]

Second of all is 'what should we do?' Well, as I said, **we don't know.** (37:25) And even if we did know politicians wouldn't let us. Massachusetts has gone farther than the other states. **Just as we led on coverage, we're now leading on cost-control. We've passed a law that's more ambitious than the Affordable Care Act, which actually sets a target saying "health care costs have to grow at the level of the state─ of the state economy.**"

[*Notice that this measure which Gruber approvingly describes as "ambitious" and "leading on cost-control" is exactly the same approach Gruber said would've resulted in millions of Americans not being alive today, and eliminating vital medical innovation, discovery, and progress.*]

(37:44) Now that— that requirement actually has very few teeth, so it's not clear what it means to say that. It's sort of more of **an aspirational law.** [*Memo to all: add "aspirational law" to your lexicons.*] Nonetheless, it sets up another panel of unelected bureaucrats to try to make this work. Now I'd be skeptical except [that] I was on one of the first panels of unelected bureaucrats [*question: how many panels of unelected bureaucrats has Gruber referenced in this talk, how many times has he offered this as a solution, and how is this not a complete government takeover, root and branch?*] and ours worked great. So I'm more confident that we can actually accomplish some solutions in Massachusetts to help control health care costs, but I think— the point of my talk is it's gonna be hard. (38:06)

Q: You've probably already described this but, <*reading audience question*> "Please describe and comment on the recent changes on the MA health care law passed in July."

GRUBER: (38:11) Well, there weren't really changes to the coverage piece, what passed in July was this new cost-control piece. And what passed was a law which said that, um, " there's a new commission, set up to try to manage health care in the state, and (38:23) **it's goal is to have health care grow at the rate of the state economy**." [*In other words, a government takeover run by a commission.*] Which would be a huge victory, just to grow at the rate of the state economy. Um, and, ah, it has a number of tools, the most important tool is we've mandated that our public insurance systems move to the kind of alternative reimbursement scheme I described at the end of my talk, ["*We control the delivery, we the control billing, but it's not a takeover." The mastermind, uprooting society to experiment on it.*] move to kind of a managed-care type system where providers are paid based on how healthy they make you rather than on what they do to you. [*He has no idea what those terms even mean, his goal—or how to accomplish it — yet presents this as if credible.*] (38:45) I think that's really gonna help, um, but I think, you know, it's really as I said more of an aspirational law. We're gonna have to see how it plays out.

Q: "Can you elaborate on how the ACA will affect the income—future income—of health professionals? (i.e. doctors, nurses, pharmacists, physical therapists)"

GRUBER: (38:57) Yeah, so let's talk short-run and long-run. Short-run, ah, everyone's income's gonna go up. Short-run you got 32 million new customers who are paying their bills rather than having uncompensated care, (39:11) um,

so incomes are gonna go up. [*Unless they don't pay, due to their higher Obamacare deductibles. In fact net uncompensated care costs could rise if millions of previously insured people are now routinely not able to pay their newly-hiked Obamacare deductibles.*] (39:14) Long-run, it's harder to say, but I think we're going to see a bit of a 'torquing' <*demonstrates a twisting motion with his hands*> in the distribution, where right now I think we're gonna see a— we're gonna see pressure on specialists for their fees to come down, and hopefully primary care to be paid a bit better. [*In other words, Gruber presumes to price and value physician's services.*]

(39:26) **The other thing I think we'll see is, hopefully, moving to a system where people are not delivered medical care by people who are overqualified to do so.** Move to a system where a doctor in America never again takes a temperature, takes a blood pressure, ah, you know, does many of the things doctors do. Now mostly nurses do that, but basically, we need nurses to be doing many many more things—and people even below nurses do many more things. (39:45) Okay? **We need to really de-skill the delivery of healthcare in the US.** So that people are delivering healthcare at the level at which their skills are appropriate. And that's gonna mean a big growth in sort of the lower-paid end of the spectrum, um, and I think perhaps a shrinking at the upper-paid end of the spectrum. (40:03).

Q: "We have heard tonight about politicians and economists being involved in the creation of the ACA. Were medical doctors involved? If not and—or if so—why?"

GRUBER: (40:13) Um, yeah, I mean basically everyone was involved. Uh, you know, ah, there was a huge amount─ they drew on so many─ Think about a national piece of legislation. [*an example of exactly why this should not be nationally legislated*] It's, it's impossible to pinpoint, like one key person or even a group of key people. (40:27) There were [sic] huge involvement of stakeholders of all types: <*counting off on fingers*> doctors, nurses, hospitals, pharma, the insurance industry. This was really an incredibly collaborative effort, and that's why it's so frustrating, to me to see this bill painted as being partisan. [*sometimes it's hard, to be a mastermind, givin' all yer love, to just one plan...*] Someone described it to me as being "the most bi-partisan partisan bill in history." Okay? This is a bill which brought in the best thinking from the right [*says Gruber*], the left, and all the provider groups. [*but not the People*] (40:46) Okay? I mean, this─ So basically there was huge consultation of all these groups.

Now to be fair, this is a bill which is more about coverage and insurance reform, and less about the actual delivery of medical care. (40:59) [*Oh joy—delivery of care is next. The ACA's meddling is just the beginning...*] So, doctors were involved, but **it really isn't a bill which is tryin' to change the delivery of medical care. That was not—that was politically impossible** (41:05) quite frankly. It's more a bill that tries to change the insurance infrastructure **hoping that has trickle-down effects** [*trickle-down healthcare*] to improve the delivery of health care. (41:12) [*Central planning at its worst—the mastermind simply up-ends society, and hopes something trickles out.*]

Q: Healthcare will always be reformed, but when will the U.S.'s healthcare coverage be on par with other First World countries? Is single-payer in the distance?

GRUBER: (41:19) Okay, so let's [garbled]─ The U.S. versus other countries. So you often hear the U.S.─ Two facts about the US. You know, we pay more than anyone else, and that's absolutely true. The share of our GDP we spend for healthcare is about twice the average developed country's. And you also hear, "And yet we get worse healthcare." That's wrong. Okay? For the people in this room, by and large, we have the best healthcare in the world. (41:41) Okay?

Look— look at this the simple way an economist would look at it. Okay, how would [an economist?] look at it? They'd say "Well people have a choice, some people have a choice about where get their healthcare. Every year about 650,000 people come to America to get their healthcare. No one leaves. They go to Canada to buy drugs, but no one's goin' to France to get surgery. (42:01) Okay? People come here because our healthcare's the best, if you're *in* the system.

(42:05) On the other hand if you're out of the system it's horrible. So a black child born today, has a less of a chance of seeing their first birthday than one born in Barbados. They have the same chance– the black infant mortality in the U.S. is twice the rate in Malaysia. Okay? It's crazy. So the differences we have─ it's really─ the problem isn't that healthcare isn't working for people that are in the system, it's the access problem, the 'tails.' [*now Americans aren't people, they're 'tails.'*] So what you want to do is first you bring the tails up and that's what the Affordable Care Act does─ equalizes things. You bring the tails up. (42:36) **But we still have the fact that we spend twice as what [sic] as everybody else does. That's a lot harder problem.**

Now once again, single-payer in theory could help with this, but there's a lot of issues about it, to, say, capping healthcare. [*Inconsistent. He praised Massachusetts' peg to state GDP, earlier. (37:25)*] **You know, um, we don't really know the answer.** (42:49). I think there has to be a robust debate about this. Vermont─I helped work with the state of Vermont—to sort of propose a single-payer system. They're very far from it, but they're thinking about it. Um, I think it would be great if a state like Vermont tried it─we could learn from it.

(43:00) I think— the thing about healthcare costs is, we have to remember, **for as long as we exist as a nation, we will always struggle with controlling health care costs.** (43:10) [*Nice plan.*] It's never ever ever going away. I like to say there's only two real problems that matter in the world okay? healthcare costs and global warming – either way we're underwater. Okay?

Basically, it's never ever ever going away. Given that, we don't have to be panicked about solving it tomorrow. Okay? If it takes 10 years to solve our healthcare cost problem, – first of all **we're never going to "solve" it.** Let's get away from the word "solve." **We're never going to solve our healthcare cost problem.** If it— But we have to start to bend that cost curve. If that takes 10 years – or even 20 years – it's not the end of the world. Okay? We have to do it at some point, but we can't be panicked that you gotta have the answer today. (43:45) What would be a terrible thing to do, would be to dive in with the wrong answer and finally have that fail, and then have— people feel burned out and never try anything. We have to move incrementally and learn, and then once we know the right answer then we can do it. Single-payer may be that right answer I don't know. We're gonna have to learn. (44:00)

Q: "For clarification, was Romney involved in Mass[achusetts] when the act was passed in Massachusetts? If so, why doesn't he support the ACA?"

GRUBER: (44:08) Romney? It's Romney's baby. I mean, basically I got called up by the Romney administration. My job was to be the numbers guy – I mean how does a nerd get in a room like that? By being the numbers guy – so basically I was asked to sort of model, um, the effect of the healthcare law for Massachusetts, to understand the implications.

(44:24) And, it was a Romney administration plan. Um, This was, to be clear, not popular in Massachusetts initially because this was a right-wing bill. Okay? What was the core of the Massachusetts law? An individual mandate—which was an idea of the conservative American Enterprise Institute— and health insurance exchanges, which is a market-based solution to healthcare problems. The left didn't like that. In Massachusetts we'd always been a strong employer-mandate state, okay? And in fact when this law was signed, up in the podium was Mitt Romney, Ted Kennedy, and a speaker from the Heritage Foundation – a right-wing think tank – [tanking what are [sic]?] wonderful right-wing principles that were embodied in this law. (44:56). Okay? So Romney – so this was a sort of Nixon-goes-to-China moment—Romney had to really champion this, okay? And he did. And I've gotta say honestly he was enormously impressive. Okay? And he was really the leader.

(45:07) Why doesn't he support the ACA? You know I'd love to get him drunk and ask him but I can't, right? Um, I, um, ah, you know, ah, basically, um, the ah, it's just politics. Look, it's it's indisputable it's politics. Look at it this way, in 2006 someone from the Heritage Foundation stood up and supported this bill. Right before the bill passed you had many Republicans supporting the ideas behind this. The minute Obama endorsed it it's the devil's work. How can that be anything but politics? There's just *no* other explanation. Okay? It's just politics, and if he wanted to be the Republican presidential nominee, he had to take that position. He was in a tough spot. He had three choices, he could disown the bill, like Newt Gingrich disowned the fact that he supported the individual mandate—in spite of the fact it was Newt Gingrich's– one of his main ideas – he could've done that he didn't want to do that, because then he'd have nothing to run on. (45:55) He could endorse it and say "I'm a centrist candidate and this is the right thing to do." He wouldn't have gotten the nomination. So then he tried the third thing which was to say "it was the right thing in Massachusetts, it doesn't work nationally." Well that was a stupid position—it was an intellectually incoherent position—but, he got the nomination. [*Saying RomneyCare wouldn't work nationally isn't incoherent at all. Gruber, earlier, said the Massachusetts plan* depended *on ripping off the federal Medicaid program, a luxury he said the fed's didn't have.*] Now let's see [if it gets him?] the election. (46:11).

Q: Is the individual mandate a tax or the penalty and is the right approach to ensuring some type of universal healthcare coverage?

GRUBER: (46:21) Um, the individual mandate is a penalty. Okay? It's basically– The way it works is, if you don't have health insurance, you pay– you pay a penalty through the tax system. Now– **But who really cares what it's called**?

[*Earlier Gruber insisted a peasant at a townhall was impenetrable, for not understanding the difference between "ending a tax preference" and taxing her health insurance. Now, suddenly, words don't matter.*]

The idea– **It doesn't really matter what it's called.** What it is is it says that– It's, it's, what– The way to think about it— it is a charge for free-riding on the healthcare system. It says is that if you could afford health care insurance, and you're not buying it, then you're imposing costs on the rest of us.

[*a) False choice—some people pay cash, some don't use the system at all. b) It's bogus. The vast majority of*

Obamacare is devoted to making free-riding the new national sport: tax credits, cost-sharing reductions, and Medicaid expansion.]

Hospital uncompensated care amounts to $56 billion a year. We spend $56 billion every year, delivering care to people who are uninsured, who can't afford their care, and who don't pay their bills. *[a) a bargain compared to Obamacare's trillion in subsidies. b) Simply paying for that with federal tax money—like Obamacare does—doesn't change that, it makes it worse.*] Now for some people they can't afford insurance and they shouldn't have to be forced to buy it. (47:00) But someone who can get insurance for less than 8% of their income should be forced to buy it, in my view, and that's the view of the individual mandate.

(47:07) Now, um, the other question is "Is it the right approach?" Once again, ah, you know, ah, one quarter of the Affordable Care Act which, I like— is, basically if you believe we should have a non-single-payer paid system, this is the best you're gonna to do. (47:22) This is the best private-based system– private-based approach–you could have. [*Says the mastermind. He didn't build that.*] Now is [it] the right thing to do relative to single-payer? I don't know. But if you– if we're gonna rule single-payer out–which we had to do politically, this is the– in terms of covering the uninsured in a cost-effective way, this was the best we were gonna do.

Q: "Is it true that ACA has provisions will increase paperwork for health providers?"

GRUBER: (47:46). Um, probably. Ahh, probably. I think it basically– it's really– that's really a big unknown because it depends on these pilots and how they work out. I mean basically the fundamental parts of the ACA, the coverage parts don't really. I mean, they have more paper[work] because they have more patients I guess. If an uninsured guy gets insured, the doctors fill out paperwork. (48:03) I think that's a small price to pay for someone getting lifesaving healthcare. [*False choice. What about added paperwork for all other healthcare, wasting everyone's scarce time on earth, making healthcare more expensive? You're a jerk, Gruber.*]But, um, but in terms of fundamental level of paperwork in the system, I I think, I guess I'd say maybe a bit in the short run, but hopefully down the long run– that's part of the idea of these pilots is to move to using–integrating health IT—and using it more effectively. Because the idea in the long run is to reduce the paperwork. Once again, if you say "you shouldn't do the ACA because it might increase paperwork," that's saying "we're just gonna leave this problem alone." [*Lame excuse—false choice.*] We have a huge paperwork problem in the U.S., and we have to deal with it. [*By making it worse.*] This tries a bunch of approaches that'll hopefully make that better, we don't know. (48:33)

Q: "What inspired you to explain the ACA using a graphic novel as opposed to another form of media?"

GRUBER: (48:40). So basically the publisher did. So the publisher called me and said, "you know, we know you're sort of –" I mean basically, I was frustrated about the level of misunderstanding about this law. I obviously believed in it, and I felt like it was a rare opportunity where you could actually convince people of your point of view without spinning. I don't like to spin, not just the exercise but the activity. I don't like to do that. Um, and, ah, but the thing about the ACA is that if you can just tell people about the facts, then most people come around to liking it. (49:10). I realize the poll numbers – **if you just told people what was in the law they liked it, but they didn't like the words "the ACA."** They didn't like the words "Obama Care", but they liked everything that was in it.

So I've been looking for some way to explain it. The guy called me up he said, "You wanna do a comic book?" I said "no thank you" and hung up. They called back and he said "look this is really a very important medium, it's a great way to explain things." He said, "look when you're on an airplane, they want you to know what to do in the case of an emergency they hand you a comic. It's a great way to learn." I said "that's really interesting," and hung up. (49:34) And then my family basically said "No, you're being an idiot. You should do this. This will be– you're always complaining about people don't understand this law [sic], this is a great avenue," and and they convinced me to do it and I'm glad I did it. It was a really– it was a fun exercise, and ah, and um, (49:47) you know, ahh, I uh, I think it's been hopefully a little bit useful.

Q: "Of the 18% of GDP the US spends on health care, what is the breakdown for: insurance profit; hospital profit; drug company; physicians; and health care workers?"

GRUBER: (50:06) Uh, I can't do it precisely but roughly about 30% of our healthcare spending is hospitals, about 20% is docs, about 10% is drugs – so that gets you up to 60 – then you get into sort of a mish-mash. You know, and that includes insurance profit, insurers, ah, the typical load on insurance – that is, the difference between what insurers pay out in claims and what they get in premiums – is about 15%. So **insurers on average charge about 15% more than the cost of medical care delivered.** (50:35)

Now it could never be zero. Even for Medicare – a government-run insurance plan – it's one and a half percent. But it's a lot bigger. And that's one of the big arguments for single-payer, is we have a lot of administrative costs. Now to be fair – let's be fair to the insurance companies for a minute, because I think they've been a bit maligned actually. Some of that money is profit, that – you know they probably make more profit than they should. Some of

that is wasteful paperwork and that's a shame. But a lot of the money is actually managing care.

So you take Medicare, they have a one-and-a-half percent administrative cost, that's great. (51:01) But you know what? **Medicare lets doctors do whatever they want and just pay[s] for it.** If you haven't you should read Atul Gawande's June 9th 2009 New Yorker article about McAllen, Texas versus El Paso, Texas comparing Medicare spending in the two communities. The two communities, very near each other, very similar populations, very similar healthcare outcomes. **Yet spending is twice as high** in McAllen as in El Paso. Because they do massive amounts of extra testing [*rather like indiscriminate "preventive care" in Obamacare, yes?*], unnecessary work. Okay? And that's a very popular article, Pres. Obama used to like to cite it.

What a lot of people don't know is that there was a follow-up article that did the same comparison not for Medicare, but for private insurance. And that comparison found no difference between McAllen and El Paso.

(51:38) Why? Because **Medicare just pays bills. They don't care. You submit the bill, they pay it.** Private insurance looks over your bills and (51:44) [notices??] if they shouldn't pay 'em. That's part of the 15%. (51:48) And that's a *good* part of the 15%.

So in some sense, managed care requires management, (51:53) and management costs administrative dollars. So the notion that the whole 15% is a waste is just wrong. We just don't know what portion of it's a waste and what's not. But we certainly don't want to say all of it's waste; some of it is actually doing the management we need to do in order to make healthcare better.

Q: "As private institutions, many hospitals seem to be able to skirt consequences for negligent care through sealed, out-of-court settlements. With an individual mandate, will taxpayers gain as much (or more) oversight of hospitals as we currently have about our government.?"

GRUBER: (52:23) Oh that's a hard question. I think – I'd separate – I think the mandate's got little to do with it. The question is will this law lead to more oversight of hospitals. And I think that raises – I think there's [sic] really two issues that are raised by this question.

One is the issue of transparency. Ah, we have incredible transparency about what health care costs, and we need to increase that. That's part of the ACA, that's part of our new Massachusetts law, is increase the transparency when shopping for healthcare. [*that's not shopping for health care, that's shopping for insurance, a moral-hazard-inducing third-party payer.*] And make people understand more of what health care costs than what hospitals do.

(52:51) But let's be honest, that's far from the only answer. I mean look, when you're unconscious in the back of an ambulance, you're not price shopping. It doesn't matter how transparent hospitals are, you just go into the nearest hospital. [*a) False choice. Most care is not provided (or sold) to someone riding unconscious in an ambulance. People shopping on value controls the price of non-emergency care, and also causes people to prefer advance arrangements with less-expensive higher-value providers of emergency care. b) Obamacare-style narrow networks in a fully-insured 29-year-old woman's policy just bankrupted her as she was ferried unconscious in an ambulance to the nearest hospital.*] Okay? (53:01) Um, the second issue this raises is malpractice. Ah, what about malpractice? Malpractice is really really hard. Because we know very little about it. Um, and once again, the key thing we have to avoid in healthcare– there's really–.

We have to be humble in our thinking...

Maybe more than any other take-away from the talk I'd leave you with, is **we have to be humble** in our thinking about healthcare reform. We have to avoid sort of black and white thinking, saying there's a right answer and a wrong answer. (53:23) 'Cause there's so many things we just don't know. So take malpractice, what do we know? We know that the costs of the malpractice system – all in – are 0.3% of healthcare spending. Okay? "Well why is malpractice such a big deal," you say? Well that's 'cause there's **"defensive medicine."** There's– How much healthcare do doctors deliver because they're afraid of getting sued? (53:41) And that we have no idea. The best estimates from experts that I respect and know is about 3% of healthcare spending, the best estimates from doctors' groups is a hundred and twenty percent [sic] of healthcare spending. (53:51) Okay? **We have no idea.**

Okay? Once again, what do you do? You're humble, and you experiment. [*translation: Gruber, rudderless, performing experiments on us*] And what the Affordable Care Act does is have pilots – give states the power to pilot with alternative ways of remediating disputes. So for example in Massachusetts, part of our recent law – this time, a neat feature – it's got a great name, I forget what it is. It's something like, you know, like, you know, "Apology Without Harm" or something. (54:14) which is basically – If a doctor can come to you the next day and say "you know what I screwed up, I did the following thing wrong in your surgery and I'm really sorry," and you cannot sue the doctor based on that admission. They piloted this system, they find that with that system malpractice claims go

down 60%. (54:29) People just want [garbled] feel hurt. They just want to know– No, it's not gonna help with wrongful death, but it's gonna help with a lot of malpractice issues. So I think there's [sic] things we can do that'll help. But we just have to move forward and try them out. [*Who's "we?" Does Gruber have a mouse in his pocket?*] (54:42)

Q: "Most people believe a certain amount of healthcare is a right. I can't think of any other right where we allow the private marketplace to provide[sic], why should healthcare be different?"

GRUBER: (54:50) Well I– actually, uhh, there's an issue as to if it's a right or not, I would say it is. People can differ. But actually virtually every right the private market does deliver. And what are our rights? The right to have food, enough to survive? We have a private food marketplace. The right to have– have shelter, against the elements? We have private housing marketplace. Um, in fact healthcare is probably more public than just about any other market which serves our basic human needs.

Ah, the healthcare market today in America is 50% public, 50% private. (55:21) So the notion we have a "private system" is just wrong. We have a purely mixed public-private system, it's literally almost exactly 50-50. Now you could say it should be 100 or 70, others say it should be 30 or 40, but the notion we have a private system is wrong. Actually of all the basic needs in our lives, probably healthcare is met more by the government than virtually any other.(55:38)

Q: "Even with the individual mandate and subsequent penalty, why would some people still not be covered (beyond illegal immigrants)?"

GRUBER: That's a great question. So there's – there's three – Well – There's three reasons. The first is the last parenthetical, which is illegal immigrants are not covered by this bill. Politically it was impossible to address that problem. That is about, ah, illegal immigrants are currently about, ahh, I forget the number, they're maybe like about 15% of the uninsured? (56:02) Ah, but in a place like California or Texas they're more like a quarter or a third of the uninsured. That's reason one.

Reason two is not everyone's subject to the individual mandate. As I said there's an affordability exemption. If you can't afford health insurance – if it costs more than 8% of your income – you are not subject to the mandate. Moreover if you're very very low income, if your income's below the tax filing threshold – which is about three quarters of the poverty line for an individual – you're also not subject to the mandate. So some people are exempted, and they won't buy when they are exempted. In fact in Massachusetts, it's funny if you –it's not funny it's sort of sad – if you look at who remains uninsured in Massachusetts – we have about 150,000 people still uninsured – they're virtually all very very poor. (56:38) There are people who are so poor they're not subject to our mandate. They can get free insurance – **in fact they could've got free insurance before – they just won't *take* it.** (56:45) <*Gruber gestures bewilderment*> That's frustrating. So that's the second group.
(56:47) The third group is people who will just– be subject to the mandate and who will choose to pay the penalty, or just evade the law. (56:52) And that's going to be a sizable group. Look, the penalty is large but– It's large enough to encourage people to do the right thing by and large, but for some people they won't. And that's the third group. So that's— those are the people who remain uninsured.

Q: "Nationally, 34% of families raising children and youth with special health care needs who have health insurance say it does not meet their children's needs. Are there provisions in the ACA to help bridge this particular gap in care?"

Gruber helped write the law

GRUBER: (57:10) That's a great question, and it really raises one of the very hardest things **we had to struggle with in writing this law**, and I had to struggle with in Massachusetts. (57:23) Which is, if you're gonna mandate insurance, you have to define insurance. And that's ugly, because we've never done that in America. We've never defined what insurance is. That's had some very awful consequences. For example, many Americans have today what are called "indemnity" insurance policies. They say, "We'll pay the first $500 for your hospital stay." Well, the typical hospital stay costs like $12,000. That's meaningless. Okay? But people don't know that. They buy their insurance, they go "Oh $500 sounds like a lot of money, that sounds like a good idea. I'll do that, it's cheap." Okay, those should not be allowed. (57:53) <*sternly*> Under the ACA they will not be allowed. [*Not a government takeover?*] But more generally the question is, "what do you set as the minimum level of insurance coverage?" There's a tension here. On the one hand you want to provide "real" insurance. [*Gruber isn't* providing *anyone anything. He's giving away what isn't his.*] On the other hand you don't want to make insurance so expensive that people can't afford it. And you don't want to tell a lot of people who like their insurance they have to give it up. So that was the tension. (58:11) That tension was resolved with

[Original UofRI video was deleted 14:36 17-Nov-2014, at this stage of transcription.][Transcription continues from re-posted version which, to this point, matches exactly.]

mandating what is a fairly basic insurance package, (58:14) but one that has to cover maternity, has to cover substance abuse and mental health, has to cover a lot of things that are raised in the— in in this question. But not all.

So I think there will be more coverage of special health needs than there are today, but it will not be complete. And that's a tension. That's just a political tension we had to face. [*To Gruber, the inherent inhumanity of a central health-control system—and any collateral human suffering—is a "political tension,"; academic.*] So I think the direction is we'll go— that 34 percent number will go down a lot, but it's not goin' to zero. (58:36)

Q: "How can we reduce end of life costs, considering in particular the excision of the end of life conversation coverage in the ACA (i.e. death panels)?"

GRUBER: (58:46) Yeah, so, um, this is one of my favorite things in health care. So people say "Well we know we have waste in American health care because we spend a third of Medicare's dollars on the last six months of life. Well actually that doesn't prove anything, because no one knows it's the last six months of life 'til you're dead. (59:01) Okay? The fact you wanna know is how much we spend on people who we *know* are gonna die. That's a tiny amount. In fact we *want* to spend money on people in the last six months of life. We want to keep people alive with medical care, that's sort of what it's *for*. People who might live, we wanna spend money on. So basically we don't know how much we waste [on] the end-of-life. We know those end-of-life costs are high. (59:20) We know we have to address them.

Ah, one way to address them is obviously to improve palliative care, to improve our palliative options, use of hospice and other palliative options. Um, and then basically I think fundamentally it's about changing the way providers are reimbursed, and the way they think about care. [*but Obamacare's not a government takeover*]

There's enormous difference across the U.S. [*which is why we need a uniform, government-controlled system. Not.*] If you look at people in the last six months of life in, um—the numbers are roughly right, I don't have them exactly right—in Minnesota (59:45)—in Minneapolis, the typical person, the last six months of life will have fifteen doctor visits. In Miami it's forty-five. Okay? And they still die, right? They've got six months of life, both places.

So clearly we'll have to figure out how to get the end-of-life care to be more sensible and more rational. (1:00:03) And convince patients that it should be about palliative care and improving their care, not about just having a doctor hold their hand at two hundred dollars an hour.

Q: "What are the main differences you see in [sic] the Affordable Care Act and health care system in Massachusetts?"

GRUBER: (1:00:16) Um, so, what are the major differences? Well, um, first of all the major difference as I said— The Affordable Care Act is the Massachusetts law plus two extra pieces, the financing and the cost-control, so those are the major differences.

Within the part that's like the Massachusetts bill, I would say the main differences are it's much less generous. Ah in Massachusetts the way it works is you pay, um, insurance is free 'til you're a hundred fifty percent of the poverty line, and then it only costs about five percent of your income at three times the poverty line. The federal bill costs ten percent of your income by three times the poverty line. So it's much less generous.

Umm, the mandate is weaker initially, eventually about the same. But, you know, ahh, **the other big difference is the federal law includes an important employer mandate, which the Massachusetts law really doesn't.** (1:01:01) [*A huge difference, since many or most Americans have employer plans*.] So— But by and large they're pretty much the same thing. (1:01:04)

Q: "When you began health care reform, where did you and your colleagues start, and why did you start there?"

GRUBER: (1:01:11) Well, it's actually really interesting. Um, ahhh, the Robert Wood Johnson Foundation sponsored a project, maybe in a bout 2000, where they asked about twelve different teams of experts—I was one team—to help with— sort of "Your plans for health care reform." What was amazing was how similar the plans were. They all basically looked a bit like the Affordable Care Act. Basically the notion of an individual mandate, a private insurance market supplemented by government regulation and subsidies—it was kind of the economist's vision of where we should go with health care reform. (1:01:40) And it had been sort of floating around. As I said it had been sort of an idea on the right, the economists sort of – Look, economics is kind of a right-wing science. We kind of agreed with that. It was—it was pretty much the sort of consensus I see among economics' experts view of how we should do things. (1:01:54)

And so when I walked into, you know, the executive offices, and it was about 2003, and was told by Mitt Romney's,

you know, health secretary "Here's what we're thinking of" it was like "Oh my god this is awesome. This is what economists say you should do."

So, really it was just a wonderful confluence of someone who wanted to do the right thing. And ah, you know, it was very exciting for me.

Q: "Which pilot projects funded by the ACA do you think may show actual cost savings applicable nationally?"

GRUBER: (1:02:22) Oh, this is sooo hard. So here's what's really hard, which is, we've done a lot of pilots already. And they haven't gone well or they have gone well, depending whether you're an optimist or a pessimist. So the typical pilot we've done in the past will be something we'll have to do in fifteen sites, in four sites it'll be very successful, in eleven sites it'll fail.

Now, the typical reading of that is "the pilot failed." The other way to read that is "Gee if we just figure out what they did in the four sites, we're good to go." The problem is, can you— how do you apply that nationally?

Kaiser Permanente

So, for example, we have a system that *should* work, that should be the way health care is delivered in America. It should take over health care, it's called "Kaiser Permanente." Okay? Kaiser Permanente is a plan out of California where the doctors are paid on salary not based on how much they do to you, the doctors and hospitals are integrated —they deliver their care together—it's sort of the [*mastermind's*] dream model of how health care should be delivered. (1:03:10)

Okay it's a very effective—cost effective—health plan in California. *[Kaiser's exchange plans were California's most expensive. LA Times, Kaiser's Obamacare rates surprise analysts, June 12, 2013]*

Kaiser can *not* expand. They've tried, and every time, they get shut down. And when you ask the executives "Why?" they say "The doctors just don't buy into our culture." [*suggestion for the mastermind: why not just force them?*] (1:03:21) Okay? And that's part of the problem, is things that work in one place might not work elsewhere. [*Ergo the need for national, one-size fits-all Obamacare. Gruber, you're an $%^# jerk.*] That's why we need so much studying and so much piloting.

Accountable Care Organizations

What do I think is most promising? I think there's [sic] two directions that are most promising. One is Accountable Care Organizations. We have about a hundred and forty experiments of those[sic]. Which is where doctors and hospitals get together, get reimbursed one lump sum, and coordinate their care.

The other's a model which is less popular now but I think growing. I'm working with an insurer in Maryland on this —which is a model where you massively empower primary care physicians (1:03:51) and give them huge financial incentives to manage care. [*I.e., turn doctors into federal supervisors and managers. Why not a federal salary too, while we're at it?*] You basically say to a primary-care physician—this is at CareFirst in Maryland—you say to the primary care physician "If you sign up for this plan we'll boost all your rates twelve percent. And, we will let you keep half of what you save on all medical spending, downstream of you." [*Arbitrary and capricious, the basis of tyranny.*] (1:04:05) So all the specialist savings, all the hospital savings, we'll let you keep half.

Now this works out to be a great deal for the insurer because primary care spending's a tiny fraction of health care spending. It's five percent of their bill, so a twelve percent increase is less than a percent of their bill. And they get to keep half the savings—they're mighty happy to give half the savings back to the doc.

That's another model. We're gonna have to try these models and see what works. [*He's not a mastermind, he's a model-maker.*] (1:04:29)

Q: "Why not Medicare for all?"

GRUBER: (1:04:35) Medicare for all is single-payer; it's just another form of single-payer. Um, you know **that would be the natural form of single-payer** in fact. It's a successful popular program. [*that only works because it's supported by working people who are not in it*] Probably my favorite moment in U.S. democracy was when in the summer of 2009, when things were sort of getting dicey for health care reform, and a woman stands up at this townhall and says "Keep the government's hands off my Medicare!" (1:04:56) <laughter> And that to me symbolizes all that's wrong with our democracy. And um— Medicare would be a natural option. It's popular, it'd work, and **if we're gonna do single-payer that would be the way to do it.** [*And yet Gruber says Medicare pays as much as twice as much for the same outcomes. Great solution, Professor.*]

But once again politically, it's just impossible right now. Our private insurers are too strong, and too many people are happy with their private insurance to give it up for a Medicare plan. [*suggestion: why not wreck their plans with Obamacare? Then they'll jump gladly.*]

Q: "Since you talked about a mandate for employers, what percent of businesses will cancel health insurance for their employees after its full implementation?"

GRUBER: (1:05:23) Um, well you know there's lots of estimates of this. Um I believe the best estimate, um, is that about, ahh— that total employer-sponsored insurance will drop by about two to three percent. About two [point?] three percent reduction.

Now that's the 'net' of two things: that's probably about— there's probably gonna be about five percent of sm— maybe more than— probably be more than ten percent of *small* businesses that drop health insurance. On the other hand there's a bunch of people who are now offered employer-health insurance who will take it up. [*Until the 40% Cadillac tax makes it unaffordable]* In fact a quarter of the uninsured in America today are actually offered insurance by their employers and turn it down. Those people— 'cause [of] the mandate—will start to take it up, and that will offset the drop in those small businesses.

So on net there'll be a very small drop in employer-sponsored insurance. (1:06:06)

[*The remaining text was transcribed from the original UofRI video*]

Q: "Assuming an ideal outcome for the ACA, what do you see as the next big issue for health care?"

GRUBER: (1:06:13) Well it's clearly cost control. I mean basically, if the ACA's implemented as written–. I, I have a dream. My dream is that in— by the year 2020, someone stands up at a town hall and says "keep the government's hands off my ACA." Okay? Um, coverage is taken care of. The ACA passes, we've solved coverage. (1:06:32) **So clearly the next—the only issue—is cost control.** It's the **single most important issue.**

(1:06:35) Lemme be clear for the youngsters in this crowd, okay? If you look over the entire infinite future of the U.S., if you do your best calculation and project it out as far as you can, and you calculate how much we've promised **in the Medicare program** versus how much we'll collect in taxes, **we are short by $75 trillion dollars**. That's trillion with "tr." Okay?

(1:06:56) **If we wanted to bring the Medicare system into balance today, the current 1½ percent Medicare payroll tax would have to be raised to 12 percent.** Okay? That *is* the issue. **That's the *total* issue – for the future of the U.S. economy – is healthcare costs.** Okay that's the single biggest issue beyond anything else. [*Hence—in Obamacareland—the thing that's dooming the national economy sounds like the perfect model for single-payer, doesn't it?*] (1:07:14) And **that's clearly what we'll have to spend, you know, the next – the rest of our future as a nation fighting about,** and hopefully working toward solutions.

Q: "Can you develop a plan to save the Red Sox?"

GRUBER: (1:07:27) You know, here's what's fascinating. So I'm always asked— I'm always asked "why didn't Pres. Obama do a better job selling the Affordable Care Act? What's wrong with him, why couldn't he convince people?"And, the parallel here is to the Red Sox, which is I spent countless hours constructing and reconstructing the optimal batting order for the Red Sox and the optimal [roster ???] for the Red Sox. But you know, at the end of the day I'm still worse at it than Ben Cherington – well I'm probably better than Bobby Valentine – but I'm worse than John Farrell and worse than Ben Cherington. That is, that basically, we– in America we've lost the respect for expertise. We go on sports websites and we say "I know better than this guy" – we *don't* know better than that guy. Okay that guy's paid to do it and he's an expert, we're not. (1:08:06) Okay?

And it's the same with President Obama. You know health— selling healthcare's really hard, it's really complicated. He's surrounded by people waayyy smarter than any of us, about how to do it. The fact it hasn't been done isn't a failure, it just means it's incredibly hard to do. (1:08:09)

So my plan to save the Red Sox is basically, get a better manager, they need a first baseman, they need a pitcher, um, and they need some patience.

<*applause*>

RICK MCINTYRE: I want to thank our co-sponsor for tonight, I want to thank the College of Arts and Sciences, Dean Brownell(ph) and the […]

———————— END OF TRANSCRIPT————————

Grubergate links and videos

Sources used for the transcription

- Original video, University of Rhode Island, posted 11/5/2012
http://www.youtube.com/watch?v=AqHz2XcUGok
- American Commitment, 11/17/2014, after U of RI deleted theirs (hooray!)
http://www.youtube.com/watch?v=2fTHqARiV_Q&feature=youtu.be

Notable Audio Clips on the Web

Gruber tied to the process, the President

- "Full disclaimer, I was involved in the writing of the legislation." http://youtu.be/zhavicDc0Ts?t=35s
- http://dailysignal.com/2014/11/17/obama-2006-stolen-ideas-jonathan-gruber/
- States not expanding Medicaid "are killing about 6,000 people a year."
"Most Americans are simply not affected. About one and a half percent of people will actually end up paying more for their health insurance under this law." https://www.youtube.com/watch?v=dRj8OsgfqEk
- Gruber videos, list of http://nicedeb.wordpress.com/2014/11/14/the-gruber-tapes-1-6/

Best of the Best

- All of #GruberGate in Two Minutes - (includes Max Baucus clip saying Gruber helped CBO)
https://www.youtube.com/watch?v=kDomkBtJC7Q
- Megyn Kelly: Gruber's ARROGANCE http://www.youtube.com/watch?v=CPdClw_Ir6Q
- Jake Tapper, CNN: http://www.cnn.com/2014/11/14/politics/gruber-update-friday-white-house-obamacare/index.html
- http://freebeacon.com/issues/obama-encouraged-us-to-pull-every-clip-on-obamacare-so-we-did/

Related

- Obama: We Didn't Mislead on Health Care
http://www.politico.com/story/2014/11/barack-obama-health-care-112930.html#comment-1697417754

The ObamacareTruthSquad

The Antidote—A Simple Fix for the Whole Mess

INTRODUCTION

Professor Gruber just explained America's health care problem as cost, and insurance coverage (for a few). He admits not knowing how to handle cost, then prescribes universal insurance, plus spaghetti roulette for cost-control.

With all respect, that's backwards. Universal subsidized insurance equals universal moral hazard squared.

We submit that cost *is* the problem. Not insurance, not anything else, *cost*. Cost *is* the coverage problem. Cost is the *access* problem. Solving cost solves coverage, mostly, and eases all that remains. Mitigate cost, and worries wither. So, let's address cost.

Let People Shop, and Let Them Choose

When it comes to Obamacare, Republicans and Democrats both are chasing the wrong rabbit. The solution isn't more government (Democrats), or a different, 'smarter' sort of big government program (Republicans), it's 'choice.'

Consider: Obamacare sends almost all care through the insurance process—through all those middlemen—and now adds bureaucrats, fees, taxes, and electronic paperwork. Now your premiums go through all those nit-pickers, who then make your doctor jump through loads of hoops and—after all that hassle—(maybe) pay your doctor.

That's the basic problem, isn't it? All of that is wasted effort for everyone. It wastes your time, the doctor's time, your office visit—and your premium—on busywork. Yet, everyone is trying to solve the problems of middlemen (e.g., insurance), with more middlemen (government busybodies). That's a bogus direction.

The solution is simple: just pay your doctor (for ordinary care). That's faster, cheaper, and then your doctor works for you, not some bureaucratic machine. If we made prices public, people could (and would) shop for value, quickly driving prices down.

In other words, make prices public, let people shop, and let them choose. Medical care could cost half of what it costs today. Real insurance—for disasters, not everyday care—would then be much cheaper, easier to afford, and affordable to more people. Fewer people would need help, and helping those people would cost less per person, a virtuous circle.

Those simple steps go an enormous way toward solving the biggest problem—cost—and make the remaining problems considerably smaller and easier to handle.

Best of all, it can be done without any giant federal programs, without takeovers or mandates, no acts of Congress required—and all without taking anyone's liberty, privacy, or choices.

This is a nation of the People. We can fix it. Just let us shop, and let us choose.