

**Employment-Based Health Insurance:
A Prominent Past, But Does It Have a Future?
Panel I & II
Brookings Institution and the New America Foundation
June 16, 2006**

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HENRY AARON: ...confronting American workers and businesses. Health care is the largest industry in this nation, two trillion dollars. Economists have estimated that the welfare gains from improved health equal those from all other economic growth combined, and a lot of that improvement is traceable to advances in health care. So there's a vitally important question which is whether the 175 million Americans and their families, workers and their families, are going to continue to receive health insurance as a fringe benefit of employment. Will American businesses be willing to write the necessary checks and grapple with the headaches of sponsoring health care for their workers?

Today's session is the first in what we anticipate will be a series of programs co-sponsored by Brookings and the New America Foundation on this question. Now before we begin, I would like to explain today's format. First of all you're listening to me, Henry Aaron, I'm a Senior Fellow here at the Brookings Institution. You will shortly be listening to Andy Stern, head of the Service Employees International Union, and then there will be a second session that I'll describe presently. The second session is going to present the perspectives of two business leaders; John Matthews, a Senior Vice President at Costco, and Todd McCracken, President of the

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National Small Business Association. As I say, Len will moderate that second session. and since it's just barely possible that there may be some disagreement among the various people who are going to speak today, Len and I are going to try and bat clean up and wrap things up in a final session. In each session you're going to have a chance to ask questions. We will have microphones for you. Please wait until you have a microphone in your hand to ask your question; otherwise, most people won't hear you. Tell us who you are and ask your question. And from past experience I know that it is probably worth explaining that a question is a sentence that ends with a question mark [laughter] not an exclamation point. We will have no formal breaks, coffee is available outside, so are the other facilities that enable us to comply with Washington building codes. Please use both as necessary, but not I beg you, all at once.

We're fortunate today to open this session with remarks from one person who I think has done more to shake up the American labor movement than anybody else has done since the 1930s and to energize that movement as well. The share of American workers in unions now is barely a quarter of what it is in 1950. To help reverse that tide Andy Stern has been trying to change the way unions approach the task of organizing workers and how unions relate to employers. As President of

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the Service Employees International Union, he has gone about organization by tackling whole industries rather than individual companies. He's recognized that even as workers seek a larger share of the pie, they have a shared interest with employers in making the pie as large as possible. And with respect to today's topic he has called upon all of us to take a close and critical look at the way most of us receive our health insurance; mainly through plans sponsored by employers who write the checks to pay most of the premiums. Last year he led his own union, the Service Employees International Union and four others to form an independent organization with a total of about six million members names Change to Win. Andy has agreed to share his thoughts on the future of employer sponsored health insurance with us today. And after he is finished he has agreed to take your questions. And I think he can handle that job quite nicely. Andy Stern [applause].

ANDREW STERN: Good morning. As this is Brookings I guess we don't good morning. First of all let me thank Henry, Brookings, New American Foundation, Len and others for this opportunity. I always appreciate that people keep the light shining on probably the most talked about, the most needed, and the least acted upon issue in America today, which is our health care system. I love this country. I think America's a

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gift, for generation after generation people have come to its shores, they've expected to work hard and expected and hoped that that work would be valued and rewarded. It's always been a big part of the American dream. But nothing is more fundamental in our lives than any of us who have ever been sick or had a family member that's been sick, nothing is more fundamental to that dream than your health. Without it everything; your finances, your family, your friends, your future, is all disrupted or at stake. At SIU we look at this health care situation in America from a number of different vantage points. We're the largest union in the United States, we're the largest union of doctors in the United States, the largest union of nurses, home care, hospital, nursing home workers in the United States, nearly one million health care workers strong. So we see health care from the bedside but we also see it at the bargaining table and the dining room table as well. And for most people right now who are fortunate to be able to take up employer sponsored health care they still find themselves facing massive economic insecurity about affordability and more importantly about its sustainability over the long run. And obviously for all of us who are trying to represent low wage workers in America; security officers, janitors, child care workers the obstacles to getting health care for the first time are just enormous.

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So first let me say I don't think we have a problem about health care, I think we do have a crisis. Now you say crisis in Washington and that's kind of word that's thrown around so much it can be a little bit mind numbing, because again I've probably been to more conferences than almost anybody but Henry and Len, you know, where this subject has been discussed, analyzed, refined, revamped, and nothing gets done in America. And Americans sick of it. They are incredibly sick of it. Politicians find words and firm promises don't mean anything to most Americans any more. Employers stated about their concerns about the health care system are heartfelt but haven't brought about any change. Last year more women in America went bankrupt than graduated college and the majority of them because of health care bills. Americans now say the number one New Year's Resolution, it used be, you know, I want to lose weight and now it's I want to get out of debt. And the 5 and \$10,000.00 bills that now employers are finding themselves having to pay when they have even a minor illness and go to the hospital, if you talk to many of the health care providers is their largest concern. Because after adjusting to the whole issue of the uninsured, now they're trying to adjust the inability to collect the bills from the insured, which used to be the way that balanced the float in the health care system. Americans now, as we all

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know, had negative savings for the first time in history last year. The average workers has a 121% of debt from their income, so 5 or 10 or \$15,000.00, \$20,000.00 is really the tipping point in too many people's lives. And there will be more children in America in the very near future who live in households where the parents have gone bankrupt rather than the parents being divorced.

So we have a crisis in America. The health care crisis is a huge part of it and people pay the price. I was in Minnesota last months and I met with a housekeeper, of all places at a hospital. He has worked at the hospital for ten years, has a wife and four children. The employer pays a significant amount of his health care and between he and his wife they figured out a way to buy the family health care but the problem the family health care only covers two of their four children. The other two children require additional premiums. He sat there with me and talked about he and his wife's discussion about which of their kids were the least likely to get sick, which kids were they going to play Russian roulette with in terms of their economic future. Because after paying for his own health care share and then his family's share, he couldn't afford the other two children's share. And you know what in America that's a disgrace. He works in a hospital that made \$34 million last year, a non-profit, and yet

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he and his family aren't covered by health care. That was bad enough.

Then I went and I was down at a campaign that we were doing at the University of Miami for housekeepers, gardeners, janitors, there and I met a guy named Hyro Gracis [misspelled?]. He happened to be at a church at a community meeting and he was sitting next to me, he was scheduled to speak. In the middle of the uh the service, he started crying. I'd never really met the guy and I turned to him, I said, "Hyro are you okay?" And he said, "I'm really sorry, I just had a tragedy in my life." I said, "Well Hyro what happened?" He said, "Well my sister has been in America with me for the last 20 years. She's worked at a nursing home every single day of her life. And she was probably using chemicals that really weren't good for her and she got a respiratory problem and she went to the hospital, she got treatment and surgery, and she has a \$5,000.00 bill. And she went back to the nursing home and she's getting sick again and we didn't know what to do." So she went to the hospital and they said, "Well the truth is until you pay your \$5,000.00 bill since you're situation is not an emergency under the terms, you know, we're going to provide treatment." So they went home, like all families did and they had a family conference and they had a family conference of what they were going to do and they decided to send his sister

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back to South America to a country where there is health insurance to get treatment. So the family all pooled their money and by the time they were able to do it they flew the sister home. She was weak. And two days later she died.

She died simply because she was poor. And in the richest country on earth, God forbid, that people who live here, who work every day are dying because they're poor. I don't want to drone on about the problems forever. I've been to too many conferences where people do. I think we all know the basic state of play here. We have the perfect storm. We have unacceptable quality, we all know about the Institute of Medicine Report, we all talk about evidence based medicine but we certainly are not yet practicing in America. We all talk about disease management and although there's some great experimentation this is just not our health care system in a universal fashion. It's anecdotal and episodic and not the kind of quality I think America can afford to do without.

We all know about the costs. You have more information on your seats. I don't know how employers are going to be able to afford and I don't know how workers are going to be able to bargain a health care system that costs \$17,522.00 for a family. I can't even imagine those negotiations in 2010 if they're as bad as they are today. And I can't figure out how an employer's going to compete in the global economy paying

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those kinds of costs on the price of a product. And then of course we have the information that you see on the seats about what's happening to employer based health care, 45million workers with no insurance. And here's the real issue that I don't think we've yet confronted. We're morphing from a comprehensive to a catastrophic health, we're not having a debate about in America.

In 1987 when Ronald Regan proposed catastrophic insurance for Medicare, they talked about \$2,000.00 in out of pocket expenses was catastrophic care. Now I haven't calculated, Len probably could what real dollars from 1987 to today, but people are paying way more for that for what they're calling comprehensive more or less catastrophic health care. So we are just watching a steady march between higher deductibles, higher co-pays, higher premium sharings, to a catastrophic health care system because what people are now beginning to see. And then we move into HSAs and high deductible plans, we are moving to a catastrophic health care system which I think is unsustainable. And obviously we have a huge problem for American business because it's pretty hard to compete in the global economy when your price of your health care is put on the cost of goods, where in other countries it's shared amongst society. And clearly we have a problem when some employers provide health care and others don't.

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So that's kind of the state of play. But more importantly there's a bigger state of play than just the health care state of play. We live in a new century and we need a new health care paradigm because we have a new economy. Today America, now joined by the rest of the world, is experiencing the most profound, the most transformative economic revolution in the history of the world. If you think about economic revolutions there's been three major ones; agricultural, it took 3,000 years, industrial took 300 years, this revolution is probably going to take 30 years. No single generation in the history of the world has ever seen an entire economic revolution in their lifetime. And for all of us, we understand what it means. The world is digitized, googlized, globalized, in your face, on your screens, 24/7, and the changes in America are far from over. Alvin and Heidi Toffler say, "We're building a new civilization in front of our eyes." And no generation, I think, has ever experienced so much change and it has to affect our health care system and here's why.

One let's understand the scope of the change. The world is flat, Thomas Friedman's [misspelled?] right. How flat? What that means we all can decide. The world is flat. It's a very different economy. I look it at in this way, when I was born the amount of manufacturing that was done in a year when I was born in America, is now done in a day. The amount

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of phone calls when I came to Washington D.C. in 1983 that were done in a year are done in a day. And the Furby, for any of you who have kids ever seen the Furby, this nice little toy has four times the technology than the Apollo Space Craft that landed on the moon. That's how far, so we can't drive into the future in America looking in the review mirror. We are as far today from the New Deal as the New Deal was from Abraham Lincoln. And I don't think Franklin Roosevelt turned to Abraham Lincoln for the answers to the economies of the 30s. I don't think we can just simply look back for the answers in 1935 and imagine them working today.

And then there's a series of other things that affect our health care system. One is the shift to contingent workforce, 25% of all Americans will be contingent if you count part time as contingent, in America. Some of that is just economic distortion caused by people trying to avoid some of the costs we talked about before. Some is just the reality of a very different economy. Two, we obviously know that we are in the midst of a major shift from defined benefits to defined contributions, both in health care and in pensions.

And most importantly we're in a shift from employer managed work life to self managed work life. You know it used to be one job, you know there was a myth, it was more of a myth than a reality but you got a job at GM or down the street at a

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factory or a diner and one job lasted a lifetime. And the employer provided health care, the employer provided pensions, and the employer provided you know your job security, your job promotions, it was a one job and a lifetime economy, at least in our minds. And now we know that kids by the time they're 35 will have to 8-12 jobs with 25% of the workforce contingent. We really are moved to a self managed work life. You know where people are going to move from job to job and if we don't want to move from job to job we're not going to have much choice, because according to analysts, creative destruction in our economy means that in the next 25 years three-quarters of all the corporations that exist today won't exist in their present form. So even if you want to stay with your employer, you're employer is not going to be there so we're living in a world which is what all of these shifts are doing to where people are self managing their work life.

And fourth there's a growing desire on the employers who I think, to their credit, held on the line on employer sponsored health care for a long time. But they're not fighting they're fleeing the system. They're not solving the problem, they're shifting the cost. People don't want to manage risk anymore, the world's too fast, and so employers are going to any way that they can either shift the cost or define their contribution because they're not anymore going to listen

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to the HR director who comes up and tells them he has this year's schemes about how they're going to solve their premium problems in America because people are sick of it. CEOs are sick of it. There's no answer to it. They don't see an answer to it and so they have to adjust for that reality.

So what's a stake? Well we have the best health care system in America. And it seems to me we have to make a series of very fundamental changes. And this is not a matter of policy. If we could solve this health care system by policy it would have been solved every single year. There's more good policy about health care in America than I can imagine. It is the most studied, researched, you know, we have commissions and committees publicly and privately all throughout Washington and the United States. It's really about politics and leadership.

So the first question is, the first point I would make is let's just stop studying the problems and think about what are the politics and the leadership we need to solve them. Because there are plenty of smart people who, given the opportunity, could solve the health crisis in America. And if you don't believe just take a trip around the world, everybody else has been smart enough to figure out, I'm sure we could learn something.

Our choice is we could keep making incremental changes in the health care system. I love the discussions about let's

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solve the problem disease by disease, you know pick your favorite disease and let's have the government solve that problem. I totally appreciate the desire this to solve this interest group or constituency by constituency. Let's do the 55 pluses this year and the children next year. You know and I appreciate every provider would like us to solve the nursing home or the hospital or the rehab crisis. That's all fair. And I certainly appreciate that everyone would like to build a better funding stream for the health care system but the truth is we're way past incremental change. It's not going to work. As the Institute of Medicine says, and I think it applies here, "Trying harder will not work, it's changing systems of care will." I think the same thing's true about our health care system. It's not just trying harder, it's not making incremental changes, it's actually changing the system of health care.

That's designed to deal with all the other economic realities. You can't apply a 20th Century health care system to a 21st Century economy. And so the fundamental change for me means one, you have to recognize that employer based health care is ending, it's dying in front our very eyes. The charts say it there. It will not rebound, I believe, in the next economic upturn in America. It was a good friend. It served America well in the 20th Century. We love it dearly.

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Employers, to their credit, lived with it for a long time despite all of the distortions that it created. But it's collapsing in front of our eyes. It may still be breathing but anybody who can look into the future says, "This employer based health care system is over in America." If we don't say that we're just going to keep building on a very unstable foundation that's not really appropriate. It's sort of like I used to like 8 tracks, for people that are a little older than me. Then my moved from 78s to 33s to 8-tracks to CDs, now they have downloadable music. I like all the things, this downloadable music is confusing. I can't figure out how to get there quite yet. You know it's like the health care system. I understand all the old systems and it really was nice and I enjoyed it but we're not there anymore. That's not the world we're going to so we have to solve this health care system. As someone I talk to a lot from the Boston Consulting Group says that a successful organizations are ones that leap into the future and hope the world catches up with where they are. And we kind of keep trying to catch up to this health care system and we really get to make it get farther into the future and then have the system catch up with us.

So we've got to get rid of the employer based health care system, it's not going work. And for employers, there's a good reason why it won't work, by 2008 according to MacKenzie

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[misspelled?] employers will spend more on health care than they will make in profit. That's just not sustainable. You can't pay more for your health care than you're going to make in profit any more than GM can be a health care company masquerading as a car company. This is just an unsustainable economic situation. It's killing our economy. It's hurting families and it's pretty crazy.

Now my biggest concern is this: we've tried to change this health care system by a lot of moral preaching. You know, this is bad for America. It's a privilege instead of a right. We did actually organize this health care system entirely wrong if you think about the choices we made in education. Education we made a decision everybody's in but we're going to tinker with how much you get, whether you get the music teacher or you get the computer lab. That we don't insure. But we insure everybody's in. With health care we should have started with that premise, that everybody's in and we're going to tinker with how much you get. We have a problem that we started with the wrong premise, that only some people are in and others are out which makes working the system totally impossible because some people can get, make different choices in terms of whether they cover their employees, don't cover, they ask the government to do it. So we have a system that was constructed in the wrong way. And we're simply not going to just talk our

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way out of it, we have to fundamentally make that change. So here's my concern, my concern is I can't figure out where are the employers in America. The only way this health care system's going to change is when it becomes a job and economic problem, not a moral and spiritual problem. Because boy is it a moral and spiritual problem because problem right now. Everybody in America knows who to blame, you know, we just finished a poll and people like ripped out President's and congress people's eyes in the whole not individually because they're just so sick of nothing happening about the problem. We all know nothing's going to start here in Washington D.C. and my question for some of the employers that are here and certainly for the ones that aren't is where are you? I mean you should be the ones sitting in the middle of the street screaming, "This employer based health care system is dead. We can't afford to compete in the global economy with this employer based health care system." Are people so busy making money in America as CEOs that they can't like look up and say there's a real crisis we have in our country, can we do something about it. Are CEOs too busy to think that they love America anymore enough to try to create probably the most fundamental thing that this country needs?

And so I'm here today to say I think the employer based health care system is dead. I think we need to find a system

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that's not built on the back of the government. I'm here to also say I don't think we need to import Canada or any other system. We're going to build an American system because we're Americans and we don't like anybody else's system. And so we're going to build our own and we'll import what we like from anywhere else and we'll create what we like from the best that we have. We can travel all of this country from FEPHP to Tricare [misspelled?] and the Defense Department to Vermont or Massachusetts. There's all kinds of ideas about what to do in America to build a new American health care system. At the moment there's just now much political will. But since we're in Brookings maybe we can have the Brookings Compact with the New American Foundation Compact where today in America a group of people come together and say let's kill the American based, employer based health care system and let's build a new American system. And most importantly may the employers, may unions, may good people of policy just come together and do something about it. We've waited way too long to make this decision but this decision will not arrive until American business leaders make that call for change. I'm not sure what they're scared of, they may not trust Washington, neither do I, to solve this problem. But really it is time for the American business community to say that the economic development of our future, more or less, the health and welfare of our citizens is

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dependent upon changing this health care system. It is an economic driver that's unsustainable and needs to change.

Let me end by saying this: we had a convention at SIU in 2004. We marched 20,000 people across the Golden Gate Bridge for health care. And I marched next to this woman named Lisa Scott [misspelled?], I'll never forget it. Lisa is a 33 year old single mom, worked every single day of her life, lived in Iowa, North Dakota. A nice little small town, did everything everybody would expect for her to do. And she had a daughter named Janelle [misspelled?]. And Janelle got sick. And Janelle went to the doctor. Janelle got x-rays. Janelle got cured. A year later Janelle got sick again with a respiratory infection, Janelle went to the doctor. Now she had an \$800.00 health care bill and she wanted an x-ray and they told her they wouldn't do the x-ray until she paid the bill. So she went back to her doctor, and her doctor said, "Well let's just take some antibiotics, see if it goes away on its own." And three days later this 18 year old girl died because her mom couldn't pay \$800 worth of health care. I walked across the Golden Gate, her life is a tragedy. And too many lives are tragedy, too many countries, economic systems like ours are becoming a tragedy all because of our health care system. This is now simply a question of leadership and political will. It is not a question of policy. No more

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policy conferences. What we need is more leadership and that means American business, American unions, American government, American policy makers have to step forward and say, "End this employer based health care system now and build a new 21st Century that's affordable, has quality, and everyone's covered." And if not us, if not the business leaders in America and the policy leaders in Washington solving this problem, then I'm not sure who is. And God if not now, after all these years, after all these trends, after everything you see going on in front of our eyes, then when? Thanks.

[Applause].

HENRY AARON: She has the microphone. I know the only rule I was told was wait for the microphone.

KAREN TITLAR: Now that I have the microphone. My name is Karen Titlar [misspelled?] and I'm with the Leapfrog Group [misspelled?] which is an organization of large health care purchasers who are actually trying to change the system by taking responsibility for what you pointed out is a toxic health care system. Apparently we have a lower profile than I thought we did. But what I would like ask is, we are trying to work collaboratively with all the different stakeholders in the health care system and we are having a difficult time working with providers to some extent. There are a lot of very progressive providers, but there are a lot of providers who

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don't want to adhere to evidence-based medicine, who don't want to work towards a health care system that reinforces quality rather than reinforces the quantity of care that you give. I'm wondering how you think your union could help to encourage your providers, and I'm assuming you're already doing that, to take the leap forward to working with a system that is based on quality and reinforcing quality through an appropriate incentive system?

ANDREW STERN: I'll say two things; one is clearly a lot of people now, there's a lot of focus on what you're doing and Leapfrog is probably as far in front of this as anybody is in terms of you know how do we provide quality and actually we'll have a discussion in our union about stopping bargaining for some of the things we sometimes bargain for in unions and start bargaining about why can't people be seen in an emergency room in 15 minutes? And what we can do to work as a team to help and how do we provide quality care. But the truth is until the people that buy health care demand it, we're going to have uneven distribution of the results because volunteerism doesn't work. It just doesn't work. You know profit works, incentives work, tax credit worked, volunteerism doesn't work and we have a voluntary system. The biggest purchasers of health care in America, which are government related entities don't demand it and until they do nothing is fundamentally

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going to change. And so people who have good will who actually have answers to the problem, if this was a business and someone had an answer to a problem of how to do something with higher quality everybody would adopt it overnight as a competitive responsibility. It's unbelievable in America we actually have better ways to do things and people don't have to adopt them and we keep paying them. It's like your kids, you keep giving your kid the allowance who doesn't mow the lawn, he learns the lesson. In America we keep paying providers for not doing the right thing and they keep not doing the right thing. If someone decides we're not paying them anymore to do it, life will change almost instantaneously. That's why we need system reform as well as people sort of incubating the next generation of ideas. But once we have those ideas, somehow we have to enforce discipline about disease management and evidence-based management and all kinds of other things we actually know the answers to right now.

RON BROWN: Ron Brown [misspelled?] *LA Times*. I guess the obvious question if you want to replace the employer-based system, talk a little bit about what you think are the options and sort of your sense of which are more attractive.

ANDREW STERN: The easiest thing to imagine, for me, is taking the FEPHP and expanding it outward. Some people like to say if it's good enough for congress it should be good enough

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for all Americans nine million federal workers, I believe, have the FEPHP. I don't mean to say it's the perfect system, I'm just saying it's a platform that meets a lot of the desires that people have in America. You know people make an individual choice, providers in the public and private sector being able to compete, employers sort of shedding their responsibility on the defined contribution. You can add all kinds of quality ingredients to the system that it currently doesn't have. And it's such a big platform, it's easier to imagine to expanding that up, then you know creating something new. You have Tricare and the federal government, you have a bunch of other, I say examples of broad-based national health care that have worked. Or you can do what you're doing now, not doing now, but could do differently which is to set some national standards and allow states to somehow construct the system. Former Governor Kitzhaber of Oregon started what he calls the Archimedes Project. And he says if you just give me all the money that's being spent in health care in Oregon, I'll have universal coverage. And he did a pretty good job with the Oregon health plan almost ten years ago. He simply says there's enough money in the system, just give me enough flexibility. That means there's no more Medicaid as we know it necessarily or no more Medicare so there are choices we are making by all of those changes. I have been criticized a lot

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about saying I don't think the Medicaid program was sustainable ten years ago. Because I think we need to use that money as a basis to expand health care to everyone. We need to obviously take care of people who are poor and sick and have you know unique diseases. But we can't have everything done in silos in America. We need one universal system and that means to do what Governor Kitzhaber says we're going to have to think about money and programmatic things differently. But we could set a series of standards like they do in Canada in some ways, you know, forgetting how it's financed and let provinces or states decide how to best deliver the system. Because the truth is people in states seem to learn to work better together than the people in Washington D.C. I don't know if it's the water here or something, but people go to state capitals, they work out all kinds of difficult issues and they seem to have to get something done. In Washington they don't seem to have to get anything done so no one works at the difficult issues. So I think that's certainly a possibility. There are people who would say let's just go Medicare for all. For me this is a situation where I think there are a set of principles, we've adopted ten. One is getting rid of this employer based system, two is it has to have affordable coverage for everyone, it has to have a choice of doctors and plans, it has to have core benefits, preventative care, controlled costs, electronic

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records, full transparency of results and other information we need to figure out for long term care and there's going to be multiple payers. There's not going to be single payers, I think, in America. The question is what's the mix? It's a mix a question not an if question. You know, how much are government? How much are individuals? How much are employers going to pay into the system? Or are we just going to do something like the Center for American Progress talks about a flat tax, and just take it off everybody and just put it into social insurance at a larger base. I think the single payer issue is kind of a stocking horse for I'm not sure what, because we're going to have a multi-payer system or some kind of system, you know, that it's built into the cost of goods in America. Oh, I'm supposed to call on you. You choose, besides have the microphone just pick whoever you want. I'm going to empower you.

EZRA KLEIN: Ezra Klein [misspelled?] from the *American Prospect*. I'd like you to talk a bit more about what the leadership will entail. It's been my read of the past couple of health care reform that there is in fact a lot of leadership on it, but you always crash about the shoals of your specifics. Clinton had a lot of leadership, polls were very good, everybody knew we were about to solve it, and then when the actual plan came out the very stakeholders in the health care

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system and the 85% of people who do have care were scared they would lose what they already had. And that was what they were able to demonize but not the actual less determined belief that we needed a sort of universal system. So how do you move beyond that? How do you have the leadership that allows these specifics to emerge unscathed?

ANDREW STERN: I'd say a couple things. One this isn't 1993, it's 13 years later and many of the Veterans of Foreign Wars from the 1993 battles who now meet, Democrats and Republicans, insurance executives and others in their salons around here all admit it was a huge mistake to not do something back then. You can talk to people at HIAA, everybody thinks - we thought we were going to get something to done and we thought we were going to have another chance so we all had a big fight and I think everybody admits they're wrong. And even a lot of the discussions that some people are involved amongst different bedfellows, there's just a lot of sense we just can't do this again. You know if we get a shot at it, we've got to do something, the question is what. So one is I think there's a much more sober reality facing us because the numbers are so appalling and the trajectory is so bad that we're fighting about what we're going to do. We're not going to have much left to fight. Because I worry not only are we are morphing into catastrophic insurance but employers are pulling their

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money out of the system. You know once the system loses money, in any system, it's harder to get it back. And so we've got to make these changes. Two we did not have one American business leader get out in the middle of the 1993 debate and call, you know, we were looking for them. The President of the United States was looking for them and everybody was scared. I don't know they were going to go back to the country club and people were going to say, "You were out there talking about that universal health care you must be some kind of socialist, communist, Clintonist or something." I'm not sure what it was. This will not change until the employers demand it. That's my personal opinion. I've watched everybody else in America demand it, nothing's happened. And the politicians, in all due respect, they're not responding, they're responding to business constituencies. And this a business crisis now. The only question is that business get out of it so its not their crisis anymore by either going to defined contribution or just dumping, you know, insurance or outsourcing or restructuring the way work is done which many people do now between contingent, part time, and other people that therefore don't qualify. Everybody in the college I understand is not a tenured professor anymore, they're all lecturers or something. It's all structured in an a way that we distort our job market and labor markets by our health care costs. I just think until

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the business community gets up and does something and I don't mean like in little private rooms, I mean something dramatic. It's like where's Lee Scott [misspelled?] and Howard Schultz [misspelled?], I can imagine a line up in this room that would probably - you wouldn't have one little camera you'd have the entire world, when they said the employer based health care system's dead and we want American politicians to fix it. Oh I ruined you. I took your job. In unions we don't take people jobs [laughter].

WILL AMATRUDER: Will Amatruder [misspelled?] Catholic Law School [misspelled?]. I've been in the federal employer health benefit program for over 20 years so I have some knowledge personally of how it works. There's a very large government subsidy, I mean in the neighborhood of [inaudible]. My question is how do you politically get around of the issue of the allergy so many people have to that five letter word, taxes.

ANDREW STERN: You know, I say three things; one is I think people have an allergy to the five letter word when it's generic, when it's just given to the government. I don't think people have the same feeling when it's the six letter word called health—is that six, h-e-a-l-t-h—six letter word called health. There's a lot of polling data that says people would pay more for something. Two is I don't think we're talking

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about, you know there is a government subsidy. There's government subsidies everywhere. There's government subsidies in the tax code, there's government subsidies in Medicare, Medicaid, VA, Tricare, the government, you would think as a purchaser. I mean we are the only government in the world as a purchaser who doesn't believe in market principals so we don't bargain for prescription drugs costs. So I mean you'd like the market to work except it doesn't work right for the people who are on the other end of it. So to me people are ready to do something; there's a lot of money in the system, there's a lot of government money in the system. I think if necessary people would pay more to get something that is guaranteed and secure because people are scared to death now that they are one illness away from losing their house and losing everything they have at 30, 40, 50 and they are. So they're right and they want some security.

BRUCE SMITH: Bruce Smith [misspelled?] of George Mason University. This is a very fascinating debate.

ANDREW STERN: Usually when people start that they have like a real hard question. You know, that was a really interesting point you made, then there's an and or a but.

BRUCE SMITH: I'm serious a great talk but aren't you still stuck somehow with some role for the employers. You don't like single payer, I don't know how you collectively, if

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you did something like mandating everyone have a policy elected, evidently the Massachusetts plan, how do they collect there? And won't the employers have to play some role in deducting from the pay check and giving it to the government? I mean you can't put the whole thing on the IRS sort of doing it as part of tax collection, that's beyond.

ANDREW STERN: No my issue is basically the system that's built on employers is not sustainable. They shouldn't all be out looking and talking to their favorite insurance company and their favorite HR director about this year's new design of their health care plan, but they should contribute, I think you know unless we're going to go to some value added or other kinds of national taxation basis. They obviously have and should have roles and try to help people who have issues find decent care, make sure, you know, all the things employers, I think, believe in, that they don't want their employees to be sick and uncared for and untreated. So to me it's just a question of what is their role? But it's not providing health care.

BRUCE SMITH: Could I just add a footnote to that that whatever kind of scheme you have you're going to have to have, if not a single payer, you've got to have some government that is either defining what is the minimum set of services and coverage that's that out there or administering somehow

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deciding what plans are eligible or determining what drugs are going to be reimbursed like that British centralized thing. So who is going to?

ANDREW STERN: I'm not a Libertarian or an Anarchist I'm just trying to get the right role for government which is I think is setting standards, it is dealing with the financing, it is helping organize the system. I'm just saying how it's been provided once the political process organized it. I'm just saying, for the sake of argument FEPHP, the government is very involved in organizing the system but then private company's provide the services.

SCOTT DALWISH: Scott Dalwish [misspelled?] from [inaudible]. You say that the major problem is with business leaders not coming forward although the problem affects them the most. Why are they not if the major affect is on them and how do we get that message to them that they really do need to stand up and lead?

ANDREW STERN: The good news I can leave that to my next panelist to answer that question, and you know, these are employers Costco, that have done a very responsible job in terms of their own employees. I don't know I think they're scared. It's like why are unions scared to talk about the way we do our business is nuts because it's not very well received in your community and I think it's not very well received in

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the business community. I'd say another problem, there's a bigger problem and health care is only a part of it, as we change into a global economy you know people all of the sudden don't think of themselves as American business leaders. I'm not saying they're being disloyal to their company, but I bet you Jeff Himhold [misspelled?] when he gets up every morning isn't just checking on the American results of GE, he's looking at the global results. People tell me who run companies now tell me that they spend an enormous amount of time traveling around the world. Running a global economy has all kinds of issues about national loyalty. So we live in a world where companies, not countries are making the rules and business leaders are becoming global leaders and I'm concerned we're going to lose their leadership in America. So much of America's greatness came from our business community and entrepreneurial spirit and it was applied to our country. When it's applied to our world it makes you nervous that we're just going to be another market. America, they were doing pretty good for a long time anyway they just didn't make the change so I'm moving on to worry about what's happening in Poland or developing a market in Indonesia. I think the country is suffering right now from a lack of business courage and leadership and I'm worried that it won't get better but worse.

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BARBARA SMITH: Hi I'm Barbara Smith [misspelled?]. I wanted to ask you a question about the role of price in the context of a larger system. I think that ultimately what one of the things that killed the plan in 1992 aside from delay, lack of even getting it to the Hill, is the fact that business leaders in an ideological way took the point of the view that so if they start regulating prices for health insurance than the next thing you know they're going to be regulating prices for software. Or they're going to be regulating prices for cars, or they're going to be regulating prices for [inaudible] and on and on. So on a real ideological level they really viewed it as the camel's nose under the tent. So the question is how do you get the business community to accept the notion that with a more integrated system inevitably will come more bargaining power and more constraint on pricing of health insurance?

ANDREW STERN: I'm not a [inaudible], there's smarter people here than me. Some people would say if do this and everybody's covered the market we'll drive things in the right direction. The problem with the market is we have so much public money in the system but if the main purchaser doesn't act responsibly, forget as government regulation, just as a purchaser. If we just treated government as a purchaser with God knows what percentage of the total health care dollar that

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it controls directly or indirectly and said we're just going to name three people to purchase health care for the federal employers we'd probably do really well in the market because we'd have huge purchasing power. So one is to try to think about the government not as a regulator but a purchaser, which should give them more opportunities with a lot political pressure and then you have base closings and lots of ways we try to deal with complicated situations where people don't have the political will to make hard decisions so we give it to a group of other people and tell them, "You're the Medicare purchasers. You're the government purchasers. You get hired. You're immune. You get one report we vote it up or down or we don't even get involved because you're just the purchasers, so that's your job, just purchase health care for all of America." So to me I just think we need or, you know, some people would say if you give everybody a certain amount of money and they can buy things the market again will work. And some people would say we should make people do the things that work like Leapfrog that's proven because that will bring down cost. If we do manage diseases if we do, do evidence-based medicine it certainly both get better outcomes and better quality and we've got to get out of nursing homes and into home care because the world is - institutional care is just too expensive. And we don't have a system right now that rebalances the role of

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nursing homes and home care because more people can spend more time at home. Technology has improved, capability has improved but we give more money to be in an institution than we do to stay in your home. So just a lot of adjustments that need to be made.

JOHN GABLE: John Gable [misspelled?] Center for Studying Health System Change.

ANDREW STERN: Uh-oh somebody who really knows something, now I'm really in trouble.

JOHN GABLE: For decades organized labor supported the highly regressive employer exclusion as part of the [inaudible] which is the fundamental basis of the employer based system. So my question for you is how representative is your opinion on employer based systems of the rest of the labor movement. And my second question is do you think union members who right now enjoy some of the best union membership will be willing to give up - to have less rich policies in order to obtain universal coverage?

ANDREW STERN: Well I'm probably not - some of the people would say I'm not in the mainstream of the labor movement, but I find that unusual. I think people are all getting to the appropriate conclusion, that the system is unsustainable. I think all of our tax breaks and our ability to bargain, we'd all like to be rid of it. Just like employers

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want to be rid of it, we want to be rid of it because it's just too hard. To sort of have your relationship be with your employer about health care right now is not a very productive moment in life. Because you are trying to protect the interest of one group of people. They're trying to protect the interest of those people and other people, shareholders and Wall Street and from the sides of the table you sit the world has different adjustments to it and it's a difficult moment in history. So I'd say people are ready to move it's just, you know what everybody's scared about is you don't want to get dumped out in the process. So moving is different than ending, so we're transitioning out in the employer based health care system, we just have to say it's ending but it doesn't mean we're ending it tomorrow. It means we have to know from where you go to where you're going and I think that's the first process in change. And two is, in every country in the world, that even has universal systems, you know not every country, in many countries in the world that have universal system people bargain above the minimums. It doesn't mean a union couldn't bargain with the employer to wrap around the basic benefits, just like people wrap around Medicare or anything else. To me it doesn't necessarily mean giving up, it's just we're ending certain tax breaks for employers in return for getting employers out of the system and how much they're going to pay

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is obviously an interesting issue that I don't think they solved well in Massachusetts. And then the question is what's the basic benefit and what do employers do for themselves or union employees or their non union employees to wrap around you know the basic core benefit. We need a basic core benefit in America, that's the next step we need. And we're all going to fight about what it is, is it mental health and chiropractors. Let's have an American lottery like we did with the draft, we only can afford five diseases we'll pull them out of a hat and be done with and go on because you've got to move on here. While we're all debating we're dying lousy in terms of the current system.

MALE SPEAKER: You've emphasized that there needs to be a change of will in the private sector by business and by labor but in the end the world will not change unless public policy changes. My question to you is a simple one. What advice would you give to a candidate in 2008 about how to address this question?

ANDREW STERN: Probably not much different than him, to say to people, the system is dying we all know it. We're not asking you - we want to create a new American health care system that works for everybody. When we look at education we made the right decision that everybody should be covered and then we just adjusted how much coverage they got. We made the

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wrong decision about health care where some people are in and some people out. We have to readjust back to the education model and we need something that you're guaranteed for the rest of your life. You know the problem we have in America with self managed work lives if that's where you believe it's going, and I do, is we don't have the entities, intermediate organizations. In Massachusetts we created connectors to make up for a lack of ways to make connections. You do look at America and say how do I have TIA-CREFF for health care? Or how do I have TIA-CREFF for pensions for all Americans so I can move from job to job and not have to have a preexisting condition, re-sign up, put my 401Ks all back together again when I'm trying to retire? Who's going to advise me? Where's my personal economic self managed work life trainer? Or the entity, or union, or organization, or AARP or someone that's going to help me manage my work life? Because people are going to manage their work life, both because employers are changing so fast and because young workers see ways to promotion by changing jobs not waiting until their foreman of 40 years dies and they get the shot of it. People are moving their way through life by changing jobs a lot more and employers are changing a lot more. You know these are extreme, like don't talk in [inaudible] but these are extremes but we're moving to a self managed work life and we don't have institutions to

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really help manage your way through and that's a challenge for unions and everyone else about where are the institutions in the 21st Century that are putting a drag on employer's competitiveness and where are employer's responsibilities to they country as well? I think that's the balance we're trying to find here but we need to do it as team USA. I'll just end by saying this, you know when Ireland was in trouble, when Ireland's largest export product was people, business, labor, government came together and they made some really hard choices about that economy. But they made one big plan, not lots of little incremental plans and now it's the second most successful economy in Europe. We are not going to have a five year Soviet plan in the United States but having a plan should not be seen as a bad idea. That's what candidates should run on because this is a very complicated moment of history. We're in a huge economic transformation, no one really knows. Bill Clinton at least had the framing of it right, "We're building a bridge to the 21st Century." He just built a bridge on high tech jobs which went over the wrong river, not that he would have known it though. I mean how would he have ever known? Who would have ever known that the world was going to go flat and all the reasons that the Berlin wall was going to fall and all the things Thomas Friedman [misspelled?] talks about. No one could have known. The world is changing. So you make bets

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and you don't criticize people who make a good bet to try to solve a problem. You make the next bet and the next bet. You know we like to like kill the person who made the last bet, rather than thinking about what's the future. We need an American plan about our future because this is not our father's and grandfather's economy. It is not the New Deal. It is a brand-new civilization that we're creating in front of our eyes, and America needs to get ready and have a plan and needs leadership to get us to that point. Thanks [applause].

LEN NICHOLS: You know I've spent enough time in this town to know when a hard act to follow has been before me, so I'll cut straight to the chase here. My name is Len Nichols. I direct the Health Policy Program at New America, and I'm quite honored to be cosponsoring this set of events with Henry and I look forward to even more interesting discussion as we go forward, but Andy thank you so much for inspiring us and making us think about building a bridge over the right river. I think that is where we want to go, no question about that.

What we have now is for something not entirely, completely different but something somewhat different in that we're going to hear from business and two quite distinguished representatives of different corners of that world. First we'll hear from John Matthews who is the Senior Vice President of Human Resources and Risk Management for Costco Wholesale,

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the Seattle based retailer that pioneered the membership club concept. John's responsibilities include the full array of human resource functions including personal policies, employee development, benefits and retirement plans and labor relations. He also oversees risk management functions of insurance program, safety loss control, general liability, and worker's compensation. And note here in the bio, you have it in your packet probably, that John also spent 20 years in the Navy and it's pretty clear that only a Navy guy could actually handle all of those responsibilities because he's used to going on three hours sleep one week at a time. I'm very impressed with all that. He'll tell you about Costco but you should note it's a \$52 trillion company going at the rate of 25 to 35 units a year.

I'll go ahead and introduce Todd and we'll go in order in that way. Todd McCracken, I'm quite a pleased to have before us today, is the President of National Small Business Association and he's been that since 1977. He directs all the activities of this advocacy oriented association. Todd is a registered lobbyist, represents the organization in myriad settings, and is the director of the government arm, plays a key role in develop NSBA's policies on issues and strategies and implementing them. I had the privilege of testifying with Todd, now I think a couple of times, on association health

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plans. Most recently about the Enzi bill and I must say that last hearing we had was quite intriguing in the sense that we were talking about all the fine arcana [misspelled?] of the Enzi Bill and I think it's fair to say we kind of ended that in more or less a draw. There were other people involved but Todd and I were by far the more entertaining. I will say that at the end, it was like a three and a half hour marathon that went on. They kept coming up and asking more and more questions and finally because the senators wanted to do something positive for small business they said to Todd, we've got two minutes left Todd, what else can we do for you? And Todd whipped out of his pocket 45 seconds each on taxes, pensions, and regulation. And I must say they all wanted to cosponsor that bill that afternoon. I was very impressed with how he managed to pull that bipartisan compromise off. I also note Todd actually has a degree in economics, so I'm glad to be joined on the podium with the help of an economist. Let's start with John, thank you very much.

JOHN MATTHEWS: Thank you very much. Does this sound okay back there? Good morning everyone. As I try to measure the audience before I get started, how many of you are Costco members? Do we have show of hands, thank you very much. We appreciate that.

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Costco's a very unique organization. A lot of you who may have been members might not appreciate some of the things that happen on a day-to-day basis to make it work. It is a growing organization, we have about 90,000 employees in the US, about 120,000 world wide. Our motto is pretty simple we try to bring goods to our members at the lowest possible cost and so we use our leverage and purchasing power to try and bring those economies to members. We do the same thing for executive members and we offer health care to small business in the same fashion. We can use our purchasing power to go on out and buy products that small businesses can use to offer to their employees.

The company has been build from the very beginning on a desire to try to grow from within. So we typically bring college kids in early on and work them in part time hours while they're going to school and classes and many of them stay with us. We have very low turnover rates in the company. Overall it's about 20% which is unheard of in retail. For people who have been with us a year or more, turnover is about 7% and I don't know of any organization in retail that's coming even close to that. It's very much an issue from an HR standpoint. Once we get people plugged in and understand what the career opportunities are with Costco, more than likely we'll keep them.

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We've taken a very broad view of compensation from the very beginning. We've always wanted to pay wages that were demonstrably better than competition. So we've always stepped up and had a good, what we felt is a good wage package. And in fact a cashier working for us on a full time basis at the end of four years is making about \$40,000.00. So it's fairly competitive. We also try to do the same thing with health care and today about 86-87% of the employees are covered. Those who are not covered are simply in the waiting elimination period as new hires coming through.

More significantly, within that model, 97% of the people who are eligible for health care accept health care and take it within the organization. We for sometime had not made any changes to our health care model. We'd cover, at one point it got as high as 94% the premium burden for employees they were picking up 6%. And we realized that was a mistake because we were taking the employees right out of the consumer model. They didn't know what the costs really were, we needed to bring them back into it. A few years ago we made some changes and we did some cost shifting, not dramatic, we shifted to 90-10. It's still much better than a lot of plans in the marketplace today. But just to give you a sense of the environment, I'm on the hook to our CEO Jim Senigal [misspelled?] that if I go over that 90% or take 89% and the employee slips from 10 to 11. He

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has me in his office and his question is very direct, he says, "How are we going to give it back?" It's not like I'm going to drop it to the bottom line and I'm going to drop it to the bottom line and we're going to then take advantage of this thing but rather how are you going to give it back. We work really hard to keep that relationship with our employees and I think as a result we've established a loyalty with the workforce and that's paid dividends to the organization over time.

Five years ago, if you were reading the *Wall Street Journal* or reading the annual reports and seeing what analysts were saying about Costco, they would always say that it's a great company, strong, well run, but way too generous. And you're giving way too much to your employees in terms of pay and benefits and you really need to tune that up. We're in the business for the long term not the short term. While we don't disregard the quarterly episodes what we try to do is keep our eye on the long term. We want to be around 25-30-40 years from now. We want to be a viable business enterprise. We believe we can do that if we take care of our people, give them good jobs, meaningful work, compensate them well and fairly that they can raise family, own homes and be just what we'd all want to be and that's contributing Americans and work within the system. Costco took a lot of heat for taking that stance and

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they held our price down for quite some time in the market place. We held our position. And if you look at what's happened in the press over the last five years of all the pressure that's been brought to bear on organizations like Wal-Mart who do something different than they're doing now I think what you can see is a role of companies, that Andy was talking about earlier, not by words necessarily but by our own actions, day to day every single day taking care of our people. And that created a model that others can follow. We're very proud of the model we have. We think it's successful. We think it's sustainable. And we think it can be a force to cause others to do similar things.

We haven't seen radical changes in other employer health care plans but we have seen some and you noted probably in the press the changes that are happening in some of the locations at Wal-Mart. I think probably one of the most significant things and I'll tie this back into what I think is one of the key things we what we ought to be focusing in is their effort to move towards clinics in their location. I usually don't tout their successes very often but I give credit where credit is due. I think that's a smart move. I think providing primary care access at the local level in our communities is something that's very much needed in our country. America fails at primary care. And Todd and I were

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talking earlier about some of things, what you would you do differently and what is it that really needs to be looked at. We talk about health care and health care's a big apple. But if you parse it a little bit differently instead of thinking of health care in its entirety think of it in terms of primary, secondary, and tertiary care. The least expensive portion is primary care. It's the one that we do the poorest job of in the United States. Kids can't get physicals, and can't get inoculations, and eyes checked and teeth checked. When parents can't get physical and routine checks and all the preventive things that were necessary in order to get ahead of the health curve down the road America fails in that area.

So one of the things that I think that we can do today, if we're going to go in direction of a mandate, if we're going to set a model in place, mandate primary care coverage. Mandate that every employer provide primary care for every employer for every employee and all their kids. That a very doable piece. We're already doing it. We take care of our health care for part time workers, for full time workers, and we take care of all the dependents. And we're already doing in that model in our health care plan to take care of the primary care issues. If we could solve that, get ahead of that, and we continue to work in the country on personal responsibility of their own health care and taking amore responsible position

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individually about health care choices, I think that over a long period of time will put us on a more solid track. Clearly there's thing that need to be done in the health care model that exists today. I think in government, although I've heard reasons, not to bite on this, I think Shadig's [misspelled?] proposal to get rid of fences around state criteria has some merit. I think we need to open the doors as to how people are allowed to by health care. I think there's too many rules around it. There are too many barriers and restrictions held within states. I think if you can open it up as a product as are most other insurance products available in the country today, life, auto, home, all you can buy it wherever you want to buy it, but if it's health care I've got to buy it in a certain locale. I think we need to get away from that, get rid of some of those barriers, I think that will open up some of the economics associated with it.

I don't agree that employers are out of this business I think we have a very significant role to play. I think probably one of the most significant things we can do in a for-profit system is continue to foster the research and development that goes on. I think there's a lot of very good programs like Leapfrog that we talked about earlier that are making strides, albeit slow, but we are making strides in this area. I think that employers do a far better job of delivery

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of health care services, customer service of bills and response to that and I don't know of the government systems that do it as well. To take that piece out of the equation I think would be a detriment to the system.

Lastly I think we're just coming into an era of putting data together in a way that we can make sense out of it. We're starting now, and Costco's been working for probably seven or eight years, because I wear both the risk management and the HR hat we've been working to put worker's comp, short term, long term disability, all the return to work programs, all the ADA together with HR so that the employ is served from one piece rather than from several pieces. Our idea is we could provide a better service to employees who are out on, for whatever reason, and help them more effectively in a return to work format. We're just now getting to a point where we can merge that data and put that together. I'd hate to ever see that component of data for health care taken out of that model. That would reduce our ability to handle that part of the problem. I that's probably about it for me.

LEN NICHOLS: Okay John, great. So we'll go to Todd and then we'll take questions as a group.

TODD McCRACKEN: Thank you very much. It's a pleasure to be here today. When Len asked me to participate in this panel one of the things that I was supposed to do, among other

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things, was to respond to what Andy Stern had to say this morning. I've got to tell you I guess I could pick a few nits, but I don't think there's a very wide chasm of disagreement certainly among the small businesses that we represent. We think that the employer based system is fundamentally broken, especially broken for small businesses and the employees that they employ. And while we don't favor doing anything to jettison it in the near term as we build for solutions in the future we really have to look to a different model, we think, for a whole host of reasons.

And you've also heard, I think a great deal today, about the overall cost pressures and why the system is leading to this breakdown. And all of that true. But even there I think it's mostly been presented thus far from the larger business perspective. The reality is it's even worse in the small community because they not only have to deal with all those costs, they also have to live within the health insurance market place currently regulated by the states. They have to function within it. And that system, in addition to the overall cost structures on employees is, I think it's fair to say is coming apart at the seams.

There are many reasons for that. I happen to believe that the beginnings of the problem were Arissa [misspelled?]. I mean while Arissa has done some very good things for the

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large business community being able to control their cost and manage health care plans and self insure. For small businesses that means they were the ones left behind with actually buying insurance from insurers much more risk adverse than they had been before. They began to sharpen their pencils a little bit more and find reasons to exclude coverage and not cover this company and have preexisting conditions exclusions and all the rest. We saw that getting worse during the '80s and early '90s until most all of the states acted on some kind of insurance reform and put into place waiting bans and various other mechanisms. Some went as far as community rating, others didn't. But the whole idea behind what the states did was to create something like a pool and tell insurance companies, "You can't exclude people for that reason. You have to have people together in some kind of a grouping sharing costs not just paying what you think their real cost of care is going to be."

That had some moderate success but the reality is that has a downside too. Because when you community rate in a voluntary market place the people who feel like maybe they really don't need coverage that much because you raise the average price a little bit by doing that. And that's kind of what we see happening steadily, I think, over the last 30 years in the small group market place. And it's gotten to the point now where for the first time , certainly in the last 30 years,

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most small businesses do not offer health insurance. And there is no reason that I can see to expect that that's going to change.

And it leads to whole range of problems. The insurance market place as its currently structured for small businesses leads to an enormous volatility for small companies that large companies simply don't face. That is to say if you employ seven people and two of them leave and your average age goes up or down by seven or eight years in addition to what you see in health care cost inflation, your premium's going to go up another 20 or 30% on top of the. You haven't done anything differently. You can literally see your health insurance bills going about 40 and 50% a year. Small business owners know that. They realize that so it injects a level of unwillingness I suppose to start health insurance in the first place if you're not currently offering it. Employers are very reluctant especially, I think, for small business. I think it's true across the board but they're very reluctant once they have the benefit in place to take it away. That creates a very bad feeling for your employees and that's not you want. So they don't want to start offering if they don't feel like they can keep on offering it. And the market place as volatile as it is today, it really creates a feeling that I don't know what next year's going to bring. I want to offer this benefit but I

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can't pay 50% more than what it's costing me right now. Guess what this thing that's a big benefit so it really creates all kinds of incentives, I guess is how I would say it, for small businesses not to begin to offer it.

So what do a lot of folks called for an employer mandate, we'll just tell them they have to offer it then. But the economic dislocation that comes with an employer mandate is enormous. Not only does it hurt our global competitiveness it also squelches the start ups of many of those small firms in the first place and they employ almost half of the private workforce now. The economic dislocation that's caused by an employer mandate is huge.

Not only that but it's extremely inefficient for me to just look at it from a tax law perspective. Whether it's because of politics or policy, almost every responsible proposal to employer mandate on employers comes with some way somebody, some of those employers for health coverage. And we frankly just don't think there's a good, effective, efficient way to subsidize employers for the provision of health insurance. I mean do you subsidize low wage employers? Well any economist will say that will encourage low wages. I'm not sure that's what we want to do. Do you subsidize low profit businesses? Well profits are highly variable from year to year and you give incentives for companies that try to hide profits,

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you don't want to do that either. Do you subsidize small companies? Well those of who represent small companies like that but the reality is some small companies might really need that subsidy, others frankly don't. Many small businesses are highly profitable. So there's not an efficient way really to target those subsidies in way that makes sense. Probably the one that gets at where most people think the money needs to go is to subsidize low wage employers. But the inefficiency there of course is there a plenty of low wage workers who don't live in low income households. There is not an insignificant number of people who you will be subsidizing for coverage who also don't need the subsidy.

We believe the only way to get around all of these problems we've been talking about is to require individuals to have a coverage. Then you can require the insurance companies to sell insurance at something like a community rate. You can target your subsidies by household income, you can actually subsidize people for coverage who actually need the help. And you've also done something that I think is too often overlooked, you've given employers an incentive to stay in the health care system. The reality is, in the small business community, the business owner knows all of their employees intimately. You have seven people you work with every day you know their stations in life, you know their wants, needs, and

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desires and the reality is in some companies, I don't want this to be construed as most people, but in some companies that have a relative lower wage those workers would really have the money that health insurance so that employer buys in the money, not the health insurance.

But if they're required to have health insurance suddenly the provision of that insurance through the employer is a benefit that they see and that is visible to them. If I can help you get the coverages that the government says you have to have that's something I think most employers would jump up to do. Right now they can't in many cases just offer premium only coverage, that is to say, offering it to their employees in a way that they really don't pay the premium because a lot of insurance companies for [inaudible] luxuries and say well we sell it to you small business, unless you pay at least X percent. And that's a real roadblock for many companies to even get the coverage available to their employees. But if we had the requirement on those individuals to have the coverage, then suddenly there is that incentive for companies to make it available, select the coverage, and all the rest. Obviously in addition to the subsidies we have to figure out a way to equalize access to treatment. There's a whole bunch of things that we need to do to make a system like that work.

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But for us we think the path forward is pretty clear. And I think it really is time, as Mr. Stern said, for people to step up and take some political risk and call for that kind of change. I guess one quibble I would have with his remarks is I think at some point unique, but I think has pretty much had it with the health care system and has really rallied for change. Unfortunately I feel like too much of that energy has been devoted into proposals that really aren't going to do a whole lot to include the situation. But if we could much more prominently in this country focus those attentions on real reform that will change this in the long term we think we can actually solve this thing.

LEN NICHOLS: Wonderful. Great way to start it off. Let me turn to the audience, we'll do the same rule that Andy had but I'll help you along if I need to from time to time.

DAVID HELMS: Good morning David Helms [misspelled?] with Academy Healthnet, over my life in this field I've actually gotten to administer programs that offered subsidized insurance to small employers and I commend you for how you're looking at this issue. I think it's very hard to target those subsidies efficiently. And I heard a commentary a minute ago about why big business doesn't get around this issue. I just want to repeat a story, a very senior member of a major US corporation, General Electric, was presenting to his boss the

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analysis of the Clinton plan and talking about how much money that was actually going to save General Electric. And Jack Welsh, it's reported, pounded his fist on the desk and said, "I don't care if we save money that's just too much government." So the question I want for you both, I think we ought to be moving towards some kind of individual mandate and I don't care whether it's selectors or FEPHP or some other mechanism is going to require government being in this game to structure the rules and give us incentives to do things right and I really would like the two of you to talk about just how much government this time are you willing to take so we can get to universality and start getting on with improving the system, other things that are needed.

JOHN MATTHEWS: I'll start and go back to the point I commented on earlier that we'll take government in a small bite. But let's start small and let's start with something we can do and be successful at that. Let's solve primary care. We can do that in the United States. If Cuba could do it, we can do it.

TODD McCRACKEN: I think our view on the proper role of government is really to set up the framework. Obviously if you're going to mandate people to have coverage, you have to define what that coverage is, you have to tell them what it is your mandating so somebody has to do that. Our view is that

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that mandate should start off at least as minimal as possible and not be a huge comprehensive package of every benefit that's currently offered. And I think that would be more affordable to the outset of folks. We think the issue is buying private coverage. So we really see government's role, you can't do this without a government role, it's very clear, but we think they should be sort of a traffic cop not the actual hands on in the health care system itself.

LEN NICHOLS: Just to push a little bit on that, Todd would you go for the FEPHP type of framework or some kind of purchasing connector or whatever?

TODD McCRACKEN: Something like that might work for folks who don't have otherwise a connection through their employer for health insurance. It's also our sense that things like that may arise in the private sector. If you've got the requirement for all individuals to have coverage you shouldn't assume that the health insurance market place will look tomorrow like it does today. There will be some pretty dramatic changes in the way health insurance is sold and marketed I think if we have that requirement. So it may very well be that those kinds of exchanges and pooling mechanisms for choosing different health providers will arise on their own. And we shouldn't overlook the power of something like and

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sometimes the market place can do things more efficiently than they FEPHP model will.

JOE MINERICK: Joe Minerick [misspelled?] The Committee for Economic Development. For John Matthews, two questions. Number one you mentioned [inaudible] employer share [inaudible]. What did you do at that margin to make your employees more cost conscious? And if you believe that you had to take your share down further to get real costs consciousness do you think you could do that in a bargain with your employees in a way that would keep your cohesion and how do you think you would go about doing that? The second question, would you please bring back the frozen eggplant patties [laughter]?

JOHN MATTHEWS: When you start talking about products to the HR guy. That's a non-starter. I'll buy you lunch Joe.

To your first question we work real hard at tying together an education and communication program to our employees that help them understand what's going on in the market place just to be aware of things that number one, what are other companies paying? What's the value, the benefit that you're receiving here? What is the cost when you go do certain normal, routine things on a day to day basis? And almost all of them could tell you what the price of milk is or the price of gas but none of them could tell you what it costs to go visit a doctor. If that's the case and that's what we're

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dealing with, they can't be really effective consumers in that. So we failed as an organization by being too paternalistic in this process and I shudder at some of the plans that are still in existence today where organizations are hanging on to 100% employer paid health care and there are still a few around there. I think it's crazy. But I also think the very radical shift, we've got some retailers in Seattle, that have simply said, "Hey we're not in the health care business. We're in the department store business." And so cost sharing there is 50%. I think that's too onerous and I don't know if families can handle that kind of a share. I think there needs to be something and we've picked 90% and I don't know that that's right. But what we're trying to do is to help our employees become more sensitive, more aware and we're going to do that by talking them not whipping them with steep prices on the cost of health care. And we're hoping that's going to work.

DAVID MITSAR: Hi, for John Matthews, I'm David Mitsar [misspelled?] with Wal-Mart Watch here in town. My question is that Costco's plan covers about 80% [inaudible]. Wal-Mart's plan covers less than half. And Costco clearly gets that happy, healthy are more productive and [inaudible] quite accurately said [inaudible] longer. What do you think it's going to take for other companies to come to that same conclusion.

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JOHN MATTHEWS: I think the continued open discussion in our country about what that responsibility looks like, about sharing responsible leadership examples, and what that looks like. I think the communication that's happened in the last five years about this subject, about business ethics, has had dramatic change in the board rooms. I think a lot of the American people may not be seeing it just yet and there are still examples of what not to do that are happening. And there will still be examples of what not to do happening ten years from now. I think that there's a very gradual shift around. When you look at the younger generations of people coming into the work force they're interested in ethics. They want to talk ethics. They want to know fairness whether it's environmental or whether it's healthcare but they're talking about issues that I certainly didn't have on my agenda when I was coming into the workforce. I see this as a change and I see that change coming because of things that are happening in the press. Things that are happening in open conversation in the dialogue that's going on in America today about what social responsibility is and what it looks like and what we can do about it as Americans, individually collectively.

BRUCE SMITH: Bruce Smith again. I wonder if we could go back to this issue of the individual mandate which seems to me to be an attractive notion. If you do that presumably

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you're not going to touch Medicare. You're not going to tangle with that one. Presumably you're not going to touch the federal system, you're not going to touch veterans, so you've got a bunch of kind of exceptions there. Then we come to Medicaid, maybe this would sort of blend and merge with Medicaid. If you don't touch Medicaid then what have you got? You haven't got too much but let's say you're going to try to work Medicaid into this system. If the employer kind of administers or collects or something the individual mandates that a part of it, what about those that aren't employed then. How does that mandate work? How do you sort of enroll the people? Who does the enrolling? How do you collect and pay for it? How would these kind of practicalities work and in particular how might you sort of use, or reconcile, or absorb Medicaid in the process.

TODD McCRACKEN: I'll take a stab at that I suppose. First off I'm not sure that I 100% buy into the premise that all of the government programs would be exempt. That may be a more politically expedient thing to do to leave those alone. But the other, I think, attractive thing about an individual mandate is that it does at least allow you the option of taking the money you're spending on those people there and folding them into a private system if you want to do that, that's above my pay grade so I'm not going to offer an opinion on whether

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you should do that or not. But at least with that kind of a model unlike other employer type mandates it creates the framework for a system where you actually could privatize some of those systems that you have now. Whether you want to do that or not, of course, still is an open question. I think probably with Medicaid though you probably have an even more likely chance. Because with Medicaid you have people who were moving in and out of private workforce. So it probably would make even more sense to fold them into the larger more privatized individual mandated system. Obviously if people at lower incomes, I mean in our vision at least, people at lower incomes would be completely covered. I mean insurance for them would be essentially free. So they wouldn't have a real incentive not to enroll, nevertheless there are people who have free coverage now so it clearly does happen. Right now today there are many providers, hospitals for instance, who actually employee companies that sign up patients who are eligible for Medicaid or some other government program so they can get paid. And I would certainly see something like that, providers, if people don't have insurance, let's sign you up for insurance. I have the form right here, you're enrolled when you walk in the door. I don't think there would be big obstacles to actually physically signing people up the bigger question I think once people who are of higher income and who aren't

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getting all of their insurance paid for by the government.

What if they choose not to be covered? Our suggestion, we're open to other ones, but it's probably along the lines of what Massachusetts [inaudible] you have to some kind of a - the IRS is the logical enforcer. You've got to have some kind of not insignificant tax penalty for people who don't show coverage. It has to be enough that it's meaningful.

MARK GRUEN: Mark Gruen [misspelled?] Bedford Press Associates. Question for Mr. McCracken I guess the best way of putting it is if you have an employee mandate for lack of a better word, let's call it that how do you get from here to there? What's to prevent an insurance company from offering in order to meet the employee's mandate so to speak, a bare bones policy such as that offered by Wal-Mart or by Golden Rule or somebody like that, that's high cost, low coverage, and they don't pay for your doctor bills.

TODD McCRACKEN: Well as I said before if you're going to have an individual mandate somebody has to define what that mandate means, what the package is you have to have. To us one of the main reasons to have individual mandate is so that you can impose some rules on the insurance companies that they can't exclude people for various kinds of coverage and to insure the coverage they offer is real. Right now that's a hard thing to do especially in the individual and very small

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group market because you can create a system where people just wait until they're sick and wait until they're about to go to the hospital. And we all say you can't sell fire insurance when your house is on fire. It's a similar thing but if you're required to have the coverage then you can begin to tell the insurance companies that you better do it this way. And you can begin to place a little more parameters than you can in sort of the wild west individual market we have today.

LEN NICHOLS: Well should we move to the would-be policy wonks. Why don't you just come up and join us and please join me in thanking our business representatives [applause].

HENRY AARON: We've heard a number of different points of view, now you'll hear perhaps yet another. It was a long time ago that Winston Churchill quipped about democracy that it was the worst form of government, except for all the others. That's not quite true of employment based health insurance. If we had the powers of God and could remake the world I don't think many of us would choose to link health insurance to the work place. No one would want to make people stay in a job they wanted to quit out of fear that they would lose health insurance and unfortunately, or fortunately, that is the system we have and it is has been shrinking. So the question is, is employment based health insurance really dying? Another quote

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that I'm fond of is Mark Twain's remark that, "rumors of his death have been greatly exaggerated."

The simple harsh fact is that most Americans still get health insurance where they work. Employment based health insurance covers 175 million workers and their families, that's 60% of the population. To be sure that fraction is down from the year 2000. In that year 64% of the population got their insurance through somebody's employment but such fluctuations aren't new. The fact is that employment based health insurance today, even after the decline since 2000, covers 26 million more people than it did in 1993 which was when President Clinton initiated his health reform effort.

So why the roller coaster? Well the answer is simple. If labor markets are tighter employers expand coverage to attract workers. When labor markets are slack they cut labor costs all around and dropping coverage or paying a smaller share of premiums is a handy way to cut labor costs. I want to be clear I'm not here, and I don't think anybody you've heard from today is here to give unstinting praise to employment based health insurance, but neither should one, in my view casually pronounce it dead. It works for most of us. It works because it does rather well something that any viable health insurance system has to do; that is it pools risks. Good risks

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and bad risks are insured as part of a single group and that's the only way that a fair insurance system can work.

Think about it, suppose each of us had to go every year or two to buy our own individual health insurance. Insurers would look at our age and our health and they would set premiums based on how much they expect our health care are going to be over the next year. They'd add some extra charges for selling costs, maybe a lot for selling costs, because they'd be trying very hard to attract us as customers. They'd add something for administration and profit.

And we would discover that lo and behold 55 year old workers who had chronic emphysema would be charged more than health 30 year olds were charged. That is, in fact, more or less how the market for individual and small group insurance works today. When selling individual insurance every responsible insurance vendor has to estimate the risks its taking on and charge premiums high enough to cover the anticipated costs. People with chronic illnesses and the old pay more than do the young and the healthy. I want to emphasize that charging such premiums isn't necessarily a callous act by rapacious capitalists even if it turns out to be the case that some people can't afford the premiums they're charged.

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Yes it's sure some insurers do behave outrageously but I think on the average I think insurance company managers are just as moral as the rest of us. They work for shareholders who expect a fair return on their investments and those managers cannot knowingly sell a product for less than it costs to produce. And make no mistake, insurance for the old and chronically ill is costly. Setting high individual premiums for the sick may be a business necessity but it's the case that such premiums are at war with minimum standards of decency. The only way to resolve this conflict within a private insurance system is to set premiums based on average costs over large groups. That way everyone pays a group wide average premium for similar coverage, it's called pooling, you've heard that word repeatedly today.

It's an historical accident that we in the United States pool through the work place. Other nations do it other ways. Many European nations pool over the entire nation. Canada pools by provinces, Germany pools by broad occupational categories. But fairness requires that one way or another you have to pool somehow. That's why I believe, and this is subject that hasn't come yet today, but it's one reason why I believe that that proposals now being advanced by the Bush Administration are a step in the wrong direction.

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Those proposals would narrow or reverse the tax advantages to make it attractive for most of us to have our employers buy health insurance for us rather than buying it on our own. The administration's proposals would thereby encourage employers to drop sponsorship of health insurance. The goal, they say, is to encourage each person to become a cost conscious soldier in the war to hold down health care spending but those proposals don't offer a whole lot of help to make insurance affordable for the chronically ill or for older workers who will face brutally high premiums. And they don't do enough to make insurance affordable for the poor. The result, were we to adopt those proposals it's quite likely that a great many Americans would find health insurance unaffordable.

Talk of consumer choice makes terrific sound bytes. Invoking visions of savings awaiting to be grasped by cost conscious health care consumers goes over smashingly in some of venues and the idea or the call to have skin in the game, you've hear that expression, is really now quite chic. But the most careful estimates indicate that implementing the administration's proposals will actually decrease the number of insured Americans. And the analyses that claim sizable savings from moving to individually purchased insurance do not withstand close scrutiny.

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It's a historical accident that we pool through single employers. That system has some really serious side effects. We know that workers lose health insurance when they change jobs and that doesn't make any sense at all. The highly fragmented system we have is virtually impervious to cost control. And that helps explain why the United States spends about twice as much, on the average, as do other developed nations. None of whom, I have to inject, depend on cost conscious consumers to control health care spending.

Then there's the issue of international competitiveness which Andy Stern raised in his remarks. There are, in truth, not many economists that believe that health insurance actually does undermine competitiveness but there's also no doubt that business executives and labor leaders do believe it and that fear is a genuine problem.

Right now we have a deadlock in Washington about what to do about health insurance. Come to think of it we've had a deadlock for about seven decades in Washington about what to do on health insurance ever since Franklin D. Roosevelt pulled national health insurance from the Social Security Act of 1935 because he believed that including it would cause the whole bill to fail.

Today I think the best hopes for progress are state efforts to extend coverage by various means. You've heard

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about Massachusetts and Oregon, well there's also Vermont, and Maine, and Illinois, and a number of other states that have introduced reforms that promise to extend coverage. I think we would do well if the national government gave financial carrots to encourage such efforts but pay that financial support only if the states make measurable progress in reducing the ranks of the uninsured. That happens to be a principal that's embodied in legislation that recently introduced by Senators Voinovich [misspelled?] and Dewine [misspelled?], two Republicans, and Senators Bingaman [misspelled?] and Accata [misspelled?], two Democrats. A solidly bipartisan team that is cosponsoring what they're calling the Health Partnership Act to give states seeking to extend coverage financial support. At the same time there's a bipartisan group in the House working on drafting a similar bill.

States could, I believe, actually break the deadlock that has ossified health care policy in this nation for one more year than I have been alive. And today happens to be my 70th birthday [applause]. I didn't say it for that reason, I said it to underscore that the things have been on hold here. And I said it in order to urge us all to work to try find a better system to ensure coverage for the mass of American workers, than the one we have. I hope we succeed and I hope we do it soon. I'd like to see a new and better way of providing

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health insurance for all Americans. But until we do, I would really urge in a rush to scrap the employment-based system to remember the old saying, "Be careful what you wish for you might just get it." [applause]

LEN NICHOLS: Well I would agree with just about everything Henry said and add a little bit more. I would say while the employer system is certainly the second best alternative to everybody's ideal and it does do an incredibly important job of pooling risk and allowing economies of scale to be reached in the purchase of health insurance, I think it's fair to say that while we've had this paradigm that America basically depends on the employer system, it never worked well for small firms, as Todd McCracken said. And it never worked really well for low-wage workers. It's just when health insurance was cheap low-wage workers who did work for large firms basically got it through an implicit cross subsidy with their existing coworkers who made more money. And that was indeed the model we used to kind of hold more or less labor peace, the proverbial janitor at General Motors. I submit to you, Brookings used to have janitors, New America's too young we never had janitors, but Urban where I worked before did have janitors, but now none of us have janitors. Why? They work for janitorial services which do not offer health insurance. So fundamentally those low-wage workers got a good deal if they

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happened to get a job in a large, relatively high-wage company and that's fundamentally one of the dynamics that's going on.

Let me give you just a couple of facts that make it sort of I think compelling as to why I think the sense of urgency about doing something about this problem is indeed building. I must say that as a person from a think tank that is trying to promulgate a solution around the individual mandate, I am nearly orgasmic with how many times that's been endorsed today. So thank you very much for all that. I think it's important to remember that small low-wage firms are the ones least likely to offer it for very good reasons. The problem with health care cost growth outstripping wage growth in general so much, as you all know it has and we won't belabor those facts much, the problem with that is that more of us are becoming low wage relative to health insurance every single day.

Let me give you just a few facts, some of them are in the handouts and I don't think we have them loaded so we'll just give you the basics here. Just think about the relation between family premiums and median family income. In 1987 - I'm not sure why, maybe Henry knows, we know a lot about 1987 it's really interesting, it must have been quite a boring year, we studied the health care system to death. In 1987 we know that a family premium was basically equal to 7.7% of median

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family income. That is the income exactly in the middle of the distribution, half the families make more, half make less; 7.7% in 1987. The most recent data would suggest it's 18% of median family income today and obviously rising. That means, let's think about this for a second, and by the way this premium includes both employer/employee share because I, like most economists believe fundamentally the employer share comes out of wages because it comes out of productivity and compensation and I'll let my businessmen confirm or deny that. I would just say, think about it this way, today half of our population either has to or would have to spend more than 18% in order to achieve a family policy. I submit to you, it's not sustainable. You know a very famous Harvard economist made quite a reputation saying some years ago, after Social Security, but not too far after, John Dunlop [misspelled?], "If something is not sustainable, it won't be." [inaudible] at Harvard [laughter] but I think it's fair to say he's right.

But to put it even more bluntly just go from income to wages, because at the end of the day health insurance comes out of individual job's productivity. And think about this, in 1996 a family premium was one-third of the 25 percentile worker's wage. That is a worker who makes less than 75% of all workers so for them they would have to pay a third. Well you think that's the person on the bottom of the distribution, you

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know. Today the median worker it would cost one-third of the family premium to buy. So what I'm trying to tell you all, simply, what Andy says we now know, and I think it's bubbling up around the country, the unaffordability of health insurance is coming to a job near you. It's coming more quickly than you may think.

So let's think about these facts and you look at the statistics, there are lots of them some of my favorite come out of the Agency for Health Care Research and Quality. John Gable [misspelled?] does a great employer survey which tells us premiums in real time AHRQ takes a little longer but drill down a little deeper in some ways. And they present statistics among other things organized around percentages of firms that are made up of low wage workers. So for example what fraction of firms is mostly low wage, by low I mean \$7.00 an hour or less in real terms and what fraction of workers work in firms that are mostly low wage? And basically we're now up to a third of firms and roughly 30% of workers now work for firms that have more than half of the workers with them being low wage. Those are the firms that can't offer. They're never going to offer. And what I'm trying to say is by moving those janitors out of Brookings and Urban and putting them into the janitorial firms which don't offer we are fundamentally

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segmenting our market in ways that are just going to exacerbate the trend.

So we state the obvious. We have to figure out how to control health care cost. We have to keep pooling risk in some dimension of the employer system, it's surely going to be with us for quite some time despite Andy's beautiful of the future. I do think we will move away from it at the bottom end but the large firms are probably going to stay there for awhile and firms like Costco seem to be doing quite fine, I'm going to just leave them and hope they keep appearing in public and inspiring people.

But I will say it is interesting how when you get down to the question from the gentleman from Georgia Mason, which is in my view the question for the next three years, how do we integrate an individual mandate type framework? How do we integrate a growing social consensus around these issues with the existing programs for a low income population, i.e. Medicaid. To do that it seems like we have to sort of finally maybe be honest about our making these subsidies more seamless. Consider the following, for SCHIP right now in virtually every state if you make less than twice poverty the society has decided you shouldn't pay for children's coverage for everyone making less than twice poverty. But you're only eligible for SCHIP if your employer doesn't offer. So let's think about

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what that's about, we're saying we really want to subsidize people who make that income. We know they need help unless they have an employer to pick up the tab. Again go back to the segmentation of the work force. That assumes high wage workers are both able and willing to absorb the cross subsidy required. I'm looking at these guys and I'm suggesting in real life that's less and less true, in many small businesses it never was true and that's why don't offer. So we have to think hard about our willingness to subsidize people based on income regardless of what their employer situation is.

You go back to Todd's statement about how it's much more efficient to subsidize individuals then it ever will be to subsidize firms for all of the reasons lobbyists understand. I would just say at the end of the day let's do that and let's move forward.

Let me just end with this question, I think we all see kind of where we might end up, that is to say with the requirement for everyone to buy, the requirement locus on individuals with subsidies. What we have a hard time seeing is the transition. How do we move from here to there? And transitions are notoriously difficult and can stymie change. So let me pose the question how do you guys think the business community, and I realize it's quite diverse and that's why we wanted both of you here to give us some knows in that

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distribution, how do you think the business community would respond to the following concept; once we have the purchasing entity and that can be a connector like Massachusetts, it can be privately run I totally support the proposition that this can be organized outside of the government. The government might want to start it and get it going. Once it's there what if you said to businesses, "Year one you contribute what you did last year. Year two you give your workers a wage increase at least equal to what you gave last year." So you hold the worker harmless in that sense and after that health cost risk is between government and individuals where I would submit it's going to ultimately always be. Thank you very much [applause].

TODD McCRACKEN: Well something like that probably would work. We're going to wind up dislocating somebody no matter what you do because it always, well you contributed this year you've got to contribute X next year you don't know what the economic situation of that company it's going to be next year, whether it's going to exist. You've got a whole host of issues. We also look at it as an opportunity, if you tell people to have coverage I'm not sure the transition is quite so traumatic as I think some people think it might be because having employer base coverage would satisfy the requirement. You don't have to go out and buy it on your own. I think the transition conceptually could happen naturally and for people

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who don't have the employer base you might want to subsidize them a bit more for a short period of time than you would other people. But at the end of the day we think you should subsidize people based on household income. I would be reluctant and I think our members would be reluctant to see a stand of if your paying now you've got to keep paying it for the next five years but if you're not paying at all now you're good to go. Because I think that's always been at the heart of some of the equity issues of employer health care too.

MALE SPEAKER: I was just wondering if in your model if an employer is already providing health care for those employees what does it that look like then?

LEN NICHOLS: My model would be to leave the employers alone if they're happy so you get a permanent from any kind of requirement as long as you're doing. I think that's the spirit of Todd's point, as long as you can cut a better deal on your own we leave you alone. That, to me, was the mistake of the Clinton plan, we didn't leave enough people alone. We made some other mistakes but that was the biggest thing. We didn't leave enough people alone, so I would leave you alone as long as you want to be but what I'm trying to do is create a home and a haven, a place to go for those who are having a hard time out there and or are finding costs.

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MALE SPEAKER: I wouldn't see that transition as being very difficult in that sense.

MALE SPEAKER: [inaudible]

LEN NICHOLS: Well I wouldn't I would go back to [inaudible] and I think there's a lot of very useful coincidence of thinking here today that there's got be some kind of core definition of what we require. And I think John's point, start with primary care. That's a no-brainer. We start there and maybe you add this or that around the edges and then you build up to what, I would submit to what you can afford and are willing to pay for. Yeah, in my view you've got to have some kind of core defined, that will be where the rubber meets the road in Massachusetts.

HENRY AARON: In the spirit of Bruce Smith's question from before I think there are a few other issues that need to be resolved in implementing this. The first is how do you provide sufficient subsidies and finance them for the tens of millions of Americans who will find the requirement that they have coverage themselves extremely burdensome or simply impossible to meet? This would involve very large transfers and probably to a significant degree we now finance from wealthy employees to poor employees in the work place. But we would have to find a way of doing independently. That would imply let's the word, that five letter word, taxes big time

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which is not a small barrier to overcome. A second obstacle to be overcome is how you would make sure that insurance companies did not engage in vigorous efforts to select good risks by advertising selectively. You would have to provide a venue through which individuals who are going to receive a lot of information from a lot of would be vendors about the kind of insurance that they really ought to have, yet unbiased information and helped to wade through what would be a mountain of very complex material. This was something that the Clinton Administration plan actually took on, they were called health insurance purchasing cooperatives and they were one aspect of the bill that drew most intense fire from opponents who were suspicious of a large government in a previously private government activity. You have two big mountains to climb, subsidies for those who can't afford it and regulation of the market for insurance and without those two elements both of which have to be regarded as rather difficult gambles I would submit an individual mandate is not a good idea but a bad one. One has to make sure if one is mandating for individuals that those of modest means can afford to buy it. And one needs to make sure that all of us who are going to be bewildered by the choices we will confront are able to make informed choices.

That was not meant to be a conversation killer by the way [laughter].

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TODD McCracken: Can I jump in on that? I guess we're still back to the same issue of we're trying to bite the whole apple and we're looking at this and our mindset is that we're going to go after this and to your point for those who are below a certain level, we've got to cover them and for certain groups we've got to be able to solve these things. But what you're saying we need to solve is the whole thing and right now they don't have it and we're somehow solving health care, probably through emergency rooms. But why can't we start smaller?

HENRY AARON: I agree with you completely. I was responding to Len who was sweeping the room on behalf of the individual mandate and warn that here that have to be overcome to make it real. I share your view which incidentally is not consistent entirely with the message that Andy Stern was presenting at the beginning, that we may have to make progress by modest steps rather than solving thing. I think it's very difficult if you look at the political history of any democracy certainly one of diffused and decentralized powers of the kind we have in the United States to locate a situation in which you have remade a two trillion dollar industry with one piece of legislation. I don't think you can find it. We evolved and change in response to pressures. I actually found your emphasis on primary care to be quite intriguing in an area

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where I think a lot of progress could be made. It seems to me, entirely plausible that certain parts of primary care out to be taken out of the standard insurance package. Why we finance vaccinations for children through individual doctors and charges to insurance when we want 100% of the population covered strikes me as kind of bizarre. I think there are a lot of areas where we could small steps that would be –

MALE SPEAKER: Have some success. Find a model.

HENRY AARON: Build some confidence that this is something that this is something where we know what we're doing.

LEN NICHOLS: If I could just jump in because I do think I gave you a little bit of the floor there. I would say go back to Andy's characterization, which I think, most of us who do this for a living would share. And that is this system is creaking, if you look at the objective barometers of the system as a whole compared to '91-'92 as the time when we really talked about this as a nation last except premiums are three times higher and as a fraction of income, much higher. That's the strain I think. I agree with Henry states can be great laboratories, great examples, great catalysts. Massachusetts, there's no question Massachusetts conversation has transformed the way people perceive it. The American Medical Association this week proposed universal coverage with

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an individual mandate. They've never been willing to go that far toward government because government's inevitably involved in this little thing. All I'm trying to say is I'm all for incremental but I don't want to wait until I'm 70 and I'm closer than I'd like to be. And I'd also like to say there is this moment where more and more people recognize there is a compelling mutual self interest in trying to wrestle. And let me say one last thing, who would have thought a year before the Medicare Drug Bill that a Republican, conservative president and a Republican dominated congress would spend, let's be frank, 700 billion at least, on drugs basically for poor people. Middle income Medicare beneficiaries had drugs what really is going out the door is money for people who didn't have them on the substitution for what Medicaid was doing. So my point is how did that occur? People didn't suddenly demand drugs in a way they weren't demanding it before. It was perceived to be in all those politician's interest. And I submit to you what people are hearing out there on the [inaudible] is telling those politicians, "You better solve this problem or we're going to pick one who does." That's what going to do it.

MALE SPEAKER: Emboldened by my colleagues referring to me earlier I probably should just shut up at this point [laughter]. To pick up on what Len and Henry both have just

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said, I'm kind of amazed and struck by this whole drug prescription under Medicare, for a number of reasons. But I don't know whether the Democrats were playing some kind of game here or the Republicans concocted it on their own and didn't even consult with the others. The other guys maybe liked it coming forward but then jumped all over them like crazy. It just suggest to me, it maybe reinforces Henry's point that if you can get the thing down at the states maybe you could do more because that whole prescription thing was just unbelievable pile on and melee it seems to have simmered down now, but when we look at was that a success? I mean or was it a debacle? I mean the rhetoric and the political nonsense that went on are just way out of proportion to what was done, how do we - how do we replicate the kind of civil expert kind of dialogue that we've had here and still get the politicians in the act?

HENRY AARON: Campaign finance reform, next question.

FELICITY MARTINEZ: Hi my name is Felicity Martinez [misspelled?] I'm with the Reform Institute. We work primarily on campaign finance reform but this is one of the issues we're looking to work on as well. My question is about physicians and how the current system, given in the debacle in the '80s and the '90s how specialized physicians are just not coming through the system anymore. Medical schools are seeing a

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shortage in doctors wanting to go into specializations because of all the issues that we've talked about today. I wonder how the individual mandate could help encourage and reinvigorate the young people that are in med school right now to go back into specialization. Because we may be dealing with the primary care through the system but I worry, then, about the tertiary care which is where most of these issues get dealt with the specializations.

MALE SPEAKER: Well let's start with the AMA because they just supported out they must think something good is going to come out of it, I'll just defer to their overall judgement. But let me, if I could quibble a little bit. Two thirds of all doctors in the United States are specialists as opposed to primary care if you define primary care including internal medicine. I see Greg nodding [inaudible]. Certainly it is true individual specialities are having trouble recruiting faculty in certain parts of the country for certain specialities, recruiting physicians. At the same time I think it's fair to say that the problem of recruiting docs in general and getting people to go to medical school has to do with the perception of the relative gain versus the pain that you've got to go through to become one. And I think it's fair to say, the malpractice cloud, if you will, is real. Now I think and I've looked at all the studies that have been done, the data would

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suggest the malpractice problem, as a percentage of cost is actually far, far less significant than the malpractice problem in the minds of physicians. But as Henry said about business people and labor leaders it doesn't matter what the hell economists think if it's in the doctor's head it matters a lot. So I submit to you malpractice reform is one key element to the grand bargain that we will eventually cut, whether it be state by state, and I say don't hold my breath for Mississippi. We'll do it state by state or we'll do it as a nation and malpractice reform will be part of it. That's the way you solve that.

BARBARA SMITH: Hi I'm Barbara Smith. With respect to some of the financing issues that were raised, I have to questions so this will be the first one. I wonder if you don't perceive or believe that there will be some continued role for employers in the form of payroll taxes or some other of business tax to contribute to the subsidy or some form of play or pay in the sense the employers who are providing substantial benefits then don't have to contribute to that so that they're not hit twice. I wondered what the future role of business and the context of an individual mandate. And secondly with respect to the primary care benefit package, given the fact that roughly 85% of medical expenditures are driven by roughly 15% of the population that have very serious health care

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problems, does a primary care benefit package or a package that's built pretty much exclusively around that at least in the first stages really get to the major cost drivers in the system? And what does that do for your ability to effectively manage chronic illness which has been shown to really require a lot of speciality care [inaudible]?

MALE SPEAKER: I'll bite on that one. Why do you brush your teeth? So you're not part of that population that has major restorative work done on things and it's that idea. We need to go after, and I know our focus has been trying to get these things down now, let's get a solution going forward. I really think a goal ought to be the next generation and trying to find those kids. You look at the kids in America today, they're overweight, their tendency towards diabetes is higher than it's ever been. They're going to have very serious problems with bones and joints and medical issues that are going to be on the table and are just waiting to happen. If we can get ahead of that curve, if we can work with them in a constructive, positive way about good, healthy habits, brushing their teeth then you're going to find a way that you can get past that curve. Until that time we're going to continue to have our generation screw up and be part of that mass at the end, which is going to be very expensive, but that is what it is. We can at least target and make a goal to go after a part

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of our population and be successful with it and change the way we think about it.

HENRY AARON: Could I just add one point before we go? Let's grant the skepticism in your question, which in fact I largely share, the reason being that unlike our teeth that don't have to fail, we're all going to die and we're going to fight hard not to. And that's going to be expensive. So like the old gas commercial, you pay me now or you pay me later, that's true of health care. But we have millions of kids who don't get adequate screening. Even if it doesn't save money, and it might, but even if it doesn't, isn't it a real gain to make sure that kids get these screening tests, are all vaccinated, their eyes are corrected at an early stage so they can learn to read. Their parents can go to work because they're not at home with illnesses that could be taken care of and all the rest. That's a real plus even if at the end of the of the day, it doesn't save anything.

BARBARA SMITH: The purpose of the question was not to denigrate the importance of primary care but rather to say that can we do it -

HENRY AARON: It doesn't solve the cost problem.

BARBARA SMITH: It may not solve the health problem.

HENRY AARON: It does a lot for a part of the health problem. I think the gist, the force of what Mr. Matthews was

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saying, and I think it's really right, is we establish confidence that enables us to move forward by demonstrating our capacity to do something that works. What he was describing, it seems to me, was something that could work. And therefore it's intrinsically valuable, and it does something for our ability to take the next step later on.

MALE SPEAKER: I'll try to address your finance question. Our view was that the government is paying a lot of money right now to subsidize health care primarily through the tax exclusion on health insurance. And our view was that that exclusion needs to be extended to more people, that is to say people who would be buying on their own in an individual market, but it needs to be less generous than it is. There needs to be some kind of a cap on it. That would pay for part of it and to the extent we need to raise taxes beyond that to pay for the balance of the benefit, we think, we don't think a payroll tax or anything like that really makes sense because that's relatively aggressive and a tax on jobs. We think it should be as broad based as possible kind of tax.

FRANK CLEMENTE: Frank Clemente [misspelled?] at Change To Win. All the support for the individual mandate is troubling for me and I just wanted to, my question is that one of political expedience because you don't think anything essentially more, I guess, democratic could be achieved or is

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it really what you believe? In other words, we've got Medicare for 40 odd million people. Say we moved the entire country under a Medicare like system. It feels right to me. It feels like it's something the population would understand. They have a lot of experience with it, more equitable. Don't have all excessive costs of the insurance industry, jumping to the individual mandate is that purely one of it's the way to achieve comprehensive coverage?

LEN NICHOLS: Great questions, others should chime in. I'll answer personally, I will say when I think about what I want to achieve I want both every resident of the United States to have access to quality care and I want costs to be contained over time so that the system becomes sustainable. Those two things are what I mean by health reform. Individual mandate is one of I think three ways to get there. One is, single payer Medicare for all. The other is employer plus individual which is after all what the Clinton deal was. Everybody talks about the employer but the individual was there too. And the third is individual alone. I think as a technical matter, as a policy matter, Medicare for all could work you're right. People are comfortable with it. You could make that happen. I think you heard Andy say he had a hard time envisioning a single payer framework being acceptable politically. That's really where I come out there. I just think it's not feasible.

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I also would submit if you've ever really watched the senate and finance mark up closely, single payer wouldn't be quite the cost containment vehicle that you might dream because it turns out Medicare is both an insurance program for the elderly and an income support for providers so let's not forget that.

Employer in many ways is appealing and simple, we understand it, seems fair to make those who don't pay now pay something. My problem is what Todd just said and the way I look at it as an economist. The employers who offer now, like John's firm, are doing it they've made a business model that works. Those who don't offer now are not immoral or mean, they're low wage employers. And to put a requirement on them is essence a tax on low wage workers. I have a hard time thinking of the justice of taxing low wage workers to finance universal health care. Fundamentally an employer mandate is a question about financing. Given it's about financing I'd rather design, as Todd just said a more broad based tax that did not penalize employment and did not penalize low wage workers - and to me the way you do that I mean I would do it with progressive consumption tax, you could do it through income tax rates whatever, what's interesting is the amount of new money we really need to make the individual mandate work, realistic estimates would be between 100-200 billion a year. That sounds like a lot of money in today's political environment but we

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spend two trillion on health care now. We're talking about a relatively small injection of funds and I submit to you those could be achieved [inaudible]. So I look at individual mandate as the practical alternative that preserves American preference for choice and gets us universal.

HENRY AARON: We'll just take a couple more questions, the gentlemen here.

MALE SPEAKER: My name is [inaudible] I came from Europe and I'm not affiliated here but I plan to engage. As you know in Europe there are a lot of sustainable plans which do work and there are huge funds allocated for this probably which you don't cover here which is disability prevention and rehabilitation funds. I have a question if during the health reforms in the future in the states are there any plans to go about it?

HENRY AARON: Are there plans to - could you repeat?

MALE SPEAKER: The rehabilitation and disability prevention because that's a part of European health care systems. For example in the case of Poland was very successful there were huge funds allocated for this particular issue.

HENRY AARON: If the debate on acute care is in a primitive state in this nation the debate on long term care and rehabilitation is really unborn. I was looking for an appropriate adjective. There is at the present time I think no

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serious national discussion on the issue of how we would handle long term care which really encompasses what you're describing. It is something that is handled through private insurance for the elderly, to some degree through income tested government programs for those without assets or income. But in general how we would move away from that system I think is a debate that really has not yet even begun. We're hypnotized, focused, and immobile on the issue of what to do about acute care.

MALE SPEAKER: Thank you very much. My point was that it saves really a lot of money and maybe it's good to start thinking about it beforehand. You pay for health problems to pay for the prevention.

HENRY AARON: The one thing that I think there is attention now developing about are the early stage health habits that produce long-term disease and the obvious one, the one that is now the subject of a lot of conversation, and I suspect a concern to Costco, is obesity, which produces all kinds of bad consequences and I promise you by the time I'm 71 I will have lost 20 pounds [laughter].

JOHN MATTHEWS: There's another part of that too and that's again going back to education of the American population. And what we found with our employee base, we talked to them in terms of most of them own homes all had homeowners insurance, but the risk of a fire in a home is about

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1/500. All that drove automobiles had automobile insurance, but the risk of damage to your vehicle is about in 1/240. The risk of needing long-term care and having some form of coverage is about one in four over the age 55. Sometime between that age and the age of 75, one in four that you'll need long-term care coverage. People don't know that and they don't understand the impact of it so they haven't addressed it. For years we purchased life insurance because people died. Now that we're able to keep them alive longer and there's not a means to provide coverage for that type of condition. So I think that's a part of the obligation too is where we need to become more aware of what these conditions are and address them early on. But they can't do it if they don't know. We set a program in place within Costco and we offer long-term care insurance for all our employees and their families, their moms and dads if they want to buy it can come on in through our purchasing power and buy it. Any employee that's been with us for ten years or more, we buy it for them and put it in place and you can use purchasing power like that to make good deals and very affordable deals. And obviously the earlier in life that you buy these things, the cheaper it is and the most sense it makes. I bought a policy I think when I was 50 years old and we got going on this thing, and I can contribute to that for 25 years and if my wife or myself ever need it, my pay

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back's about four months. When you look at that it's kind of a no-brainer. Why wouldn't you do it? And yet most Americans are not even beginning to think in those modes.

HENRY AARON: Are there any other questions? Well then on behalf of all of us, the New America Foundation, Brookings, we want to thank our two speakers in this panel and although he has left, our speaker in our first panel as well, Andy Stern, and all of you for coming. Len is there anything you would like to add?

LEN NICHOLS: Thanks for coming and keep singing the song of the individual mandate.

[END RECORDING]