

THE BROOKINGS INSTITUTION

EMPLOYMENT-BASED HEALTH INSURANCE:

A PROMINENT PAST, BUT DOES IT HAVE A FUTURE?

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PANEL ONE

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WRAP-UP SESSION

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P R O C E E D I N G S

MR. AARON: There is 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 business 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.

Before we begin, I would like to explain today's format. First of all, you are listening to me, Henry Aaron. I am 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 will describe presently. That 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 National Small Business Association. As I say, Len will moderate that second session. Since it is 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 are 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 a question. Otherwise, most people won't hear you. Tell us who you are and ask your question. From past experience, I know that it is probably worth explaining that a question is a sentence that ends with a question mark, 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 are 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 fairly a quarter of what it was 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 the Service Employees International Union, he has gone about organization by tackling whole industries, rather than individual companies. He has 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.

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, namely 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, named Change to Win.

Andy has agreed to share his thoughts on the future of employer-sponsored health insurance with us today and after he has finished, he has agreed to take your questions, and I think he can handle that job quite nicely. Andy Stern...

MR. STERN: Good morning. First of all, let me thank Henry, Brookings, the New America 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 is a gift. For generation after generation, people have come to its shores. They have expected to work hard and expected and hoped that work would be valued and rewarded. It has always been a big part of the American dream. But nothing is more fundamental in our lives, and any of us who have ever been sick or had a family member who has 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 SEIU, we look at this health care situation in America from a number of different vantage points. We are the largest union in the United States. We are the largest union of doctors in the United States and the largest union of homecare, hospital, and nursing home workers in the United States, nearly a 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.

For most people right now who are fortunate to take up, be able to take up employer-sponsored health care, they still find themselves facing massive economic insecurity about affordability and more importantly about sustainability over the long run. 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.

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 is kind of a word that is thrown around so much, it can be a little bit mind-numbing. Again, I have probably been to more conferences than almost anybody but Henry and Len, where this subject has been discussed, analyzed, refined, and

revamped, and nothing gets done in America, and Americans are sick of it. They are incredibly sick of it. Politicians find words and firm promises don't mean anything to most Americans anymore. Employers' statements 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 a majority of them because of health care bills. Americans now say the number one New Year's resolution — it used to be I want to lose weight — is I want to get out to debt.

The \$5,000 and \$10,000 bills that now employees 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. After adjusting to the whole issue of the uninsured, now they are trying to adjust to the inability to collect bills from the insured which used to be the way that balanced the float in the health care system. Americans now, as we all know, have negative savings for the first time in history last year. The average worker has 121 percent of debt from their income. So, \$5,000 or \$10,000 or \$15,000 or \$20,000 is really the tipping point in too many people's lives. There will be more children in America in the every near future who live in households where the parents have gone bankrupt rather than the parents going divorced.

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 month, and I met with a housekeeper, of all places, at a hospital. He has worked at the hospital for 10 years and 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 is the family health care only covers two of their four

children. The other two children require additional premiums. He sat there and talked with me about his 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? After paying for his own health care share and then his family's share, he couldn't afford the other two children's share. You know what, in America, that is a disgrace. He works at a hospital that made \$34 million last year, a non-profit, and yet, he and his family aren't covered by health care.

That was bad enough. Then I went and was down on a campaign that we were doing at the University of Miami for housekeepers, gardeners, janitors there, and I met a guy named Hiro Grossis(?). We happened to be in a church at a community meeting, and he was sitting next to me. He was scheduled to speak. In the middle of the service, he started crying. I had never really met the guy. I turned to him, and I said, "Hiro, are you okay?"

He said, "I am really sorry. I just had a tragedy in my life."

I said, "Hiro, what happened?"

He said, "Well, my sister has been in America with me for the last 20 years. She has worked at a nursing home every single day of her life. She was probably using chemicals that really weren't good for her, and she got a respiratory problem. She went to the hospital and got treatment and surgery, and she had a \$5,000 bill. She went back to the nursing home, and she was getting sick again. 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 bill, since your situation is not an emergency under the terms, we are not going to provide treatment."

So they went home, like all families do, and they had a family conference of what they were going to do, and they decided to send his sister back to South America to a country where there is

health insurance to get treatment. The family all pooled their money. 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. In the richest country on Earth, God forbid, people who live here and who work everyday are dying because they are poor.

I don't want to drone on about the problems forever. I have 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 it in America. We all talk about disease management, and although there is some great experimentation, this is just not our health care in a universal fashion. It is anecdotal and episodic and not the kind of quality I think America can afford to do without.

We all know about the cost. 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 in a health care system that costs \$17,522 for a family. I can't even imagine those negotiations in 2010 if they are as bad as they are, and I can't figure out how employers are going to compete in a global economy, paying those kinds of costs on the price of a product. Then, of course, we have the information that you see on the seats about what is happening to employer-based health care — 45 million workers with no insurance.

Here is the real issue that I don't think we have yet confronted. We are morphing from comprehensive to catastrophic health care, and we are not having a debate about it in America. In 1987, when Ronald Reagan proposed catastrophic insurance for Medicare, they talked about \$2,000 in out of pocket expenses was catastrophic care. Now, I haven't calculated what real

dollars are from 1987 to today, but people are paying way more than that for what they are calling comprehensive health care, more or less catastrophic health care. We are just watching a steady march between higher deductibles, higher co-pays, higher premium sharing to a catastrophic health care system which is what people are now beginning to see, and then we move into HSAs and high deductible plan. We are moving to a catastrophic health care system which I think is unsustainable.

Obviously, we have a huge problem for American business because it is pretty hard to compete in a global economy when the price of your health care is put on the cost of goods, while in other countries, it is shared amongst society. Clearly, we have a problem when some employers provide health care and others don't. So that is kind of the state of play.

More importantly is the 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. 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 have been three major ones: Agricultural 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.

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 are building a civilization in front of our eyes. No generation, I think, has ever experienced so much change. It has to affect our health care system, and here is why.

Let's understand the scope of the change. The world is flat. Thomas Friedman is right.

How flat, what that means, we all can decide. The world is flat. It is a very different economy. I look at it in this way. When I was born, the amount of manufacturing that was done in a year in America is now done in a day. The amount of phone calls when I came to Washington, D.C. in 1983 that were done in a year are now done in a day. The Furby, for any of you who have kids and have ever seen the Furby, this nice little toy, has four times the technology than the Apollo spacecraft that landed on the moon. That is how far.

We can't drive into the future in America, looking in the rearview mirror. We are as far today from the New Deal as the New Deal was from Abraham Lincoln. I don't think Franklin Roosevelt turned to Abraham Lincoln for the answers to the economy of the thirties. I don't think we can simply look back to the answers in 1935 and imagine them working today.

Then there is a series of other things that affect our health care system. One is the shift to contingent work force in which 25 percent of all Americans will be contingent if you count part time as contingent. Some of that is just economic distortion caused by people trying to avoid some of the costs we have talked about before. Some of it is just the reality of a very different economy. Two, we obviously know we are in the midst of a major shift from defined benefits to defined contributions, both in health care and in pensions. Most importantly, we are in the shift from employer-managed work life to self-managed work life.

It used to be one job. There was a myth. It was more myth than reality, but you got a job at GM or down the street at a factory or a diner, and one job lasted a lifetime. The employer provided health care. The employer provided pensions. The employer provided your job security, your job promotions. It was a one job in a lifetime economy, at least in our minds. Now, we know that kids, by the time they are 35, will have 8 to 12 jobs with 25 percent of the workforce

contingent. We really are moving to a self-managed work life where people are going to move from job to job, and if we don't want to move from job to job, we are 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, your employer is not going to be there. We are living in a world in which all these shifts are moving to where people are self-managing their work life.

And fourth, there is a growing desire on the employers, who I think to their credit held the line on employer-sponsored health care for a long time, but they are not fighting; they are fleeing the system. They are not solving the problem; they are shifting the costs. People don't want to manage risk anymore. The world is too fast. So employers are going to, any way that they can, either shift the costs or define their contribution because they are not anymore going to listen to the HR director who comes and tells them he has this year's scheme about how they are going to solve their premium problems in America because people are sick of it. CEOs are sick of it. There is no answer to it. They don't see an answer to it. And so, they have to adjust to that reality.

What is at stake? Well, we have the best health care system in America. It seems to me we have to make a series of very fundamental changes. 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 is more good policy about health care in America than I can imagine. It is the most studied and researched. We have commissions and committees, publicly and privately, all through Washington and the United States.

It is really about politics and leadership. The first question and 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, can solve the health care crisis in America. If you don't believe it, just take a trip around the world.

Everybody else has been smart enough to figure it out. I am sure we could learn something.

Our choice is we can keep making incremental changes in the health care system. I love the discussions about let's solve the problem, disease by disease. Pick your favorite disease, and let's have the government solve that problem. I totally appreciate the desire to solve this interest group or constituency by constituency. Let's do the 55 pluses this year and the children next year. I appreciate every provider would like us to solve the nursing home or the hospital or the rehab crisis. That is all fair. I certainly appreciate that everybody would like to build a better funding stream for the health care system.

But the truth is, we are way past incremental change. It is not going to work. As the Institute of Medicine says and I think it applies here, your trying harder will not work; it is changing systems of care. Well, I think the same thing is true about our health care system. It is not just trying harder. It is not just making incremental changes. It is actually changing the system of health care, so that is designed to deal with all the other economic realities. You can't apply a 20th Century health care system to a 21st Century economy.

The fundamental change for me means, one, we have to recognize that employer-based health care is ending. It is dying in front of 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. Employers, to their credit, lived with it for a long time, despite all of the distortions that it has created, but it is 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 are just going to keep building on a very unstable foundation that is not really appropriate.

It is sort of like I used to like 8-Tracks, for people who are a little older than me. Then they moved from 78s to 33s to 8-Tracks to CDs. Now, they have downloadable music. I liked all those things. This downloadable music is confusing. I can't figure out how to get there quite yet. It is like the health care system. I understand all the old systems, and it really was nice and I enjoyed it, but we are not there anymore. That is not the world we are going to, so we have to solve this health care system.

As someone I talk to a lot from the Boston Consulting Group says successful organizations are ones that leap into the future and hope the world catches up with where they are. We keep trying to catch up to this health care system, and we really need to make a bet farther into the future and then have the system catch up with us.

We have to get rid of the employer-based health care system. It is not going to work. For employers, there is a good reason why it won't work. By 2008, according to McKenzie, employers will spend more on health care than they will make in profit. That is just not sustainable. You can't pay more for your health care than you are going to make in profit anymore than GM can be a health care company masquerading as a car company. This is just an unsustainable economic situation. It is killing our economy. It is hurting families. It is pretty crazy.

Now, my biggest concern is this. We have tried to change this health care system by a lot of moral preaching. This is bad for America. It is 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. In education, we made a decision: Everybody is in, but we are going to tinker with how much you get. Whether you get the music teacher or you get the computer lab, that we don't ensure, but we ensure everybody is in.

With health care, we should have started with that premise of everybody is in, and we are going to tinker with how much you get. We have a problem when we started with the wrong premise: Only some people are in, and others are out which makes working the system totally impossible because some people can make different choices in terms of whether they cover their employees, don't cover, or they ask the government to do it. So we have a system that was constructed in the wrong way. We are simply not going to just talk our way out of it. We have to fundamentally make that change.

Here is my concern. My concern is I can't figure out where are the employers in America. The only way this health care system is 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 right now. Everybody in America knows who to blame. We just finished the poll. People would like to rip out the President's and people in Congress' eyes in the whole, not individually, because they are just so sick of nothing happening about the problem. We all know nothing is going to start here in Washington, D.C.

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 look up say there is a real crisis 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?

I am here today to say I think the employer-based health care system is dead. I think we need to find a new system that is not built on the back of the government. I am here to also say I don't think we need to import Canada or any other system. We are going to build an American system because we are Americans and we don't like anybody else's system. So we are going to build our own. We will import what we like from anywhere else, and we will create what we like from the best that we have. We can travel all over this country from FEHBP to Tricare in the Defense Department to Vermont or Massachusetts. There are all kinds of ideas about what to do in America to build a new American health care system. At the moment, there is just not much political will.

Since we are at Brookings, maybe we can have the Brookings compact or the New American Foundation compact where today in America, a group of people come together and say, "Let's kill the American employer-based health care system, and let's build a new American system." Most importantly, may the employers, may unions, may good people of policy just come together and do something about it. We have waited way too long to make this decision.

But this decision will not arrive until American business leaders make that call for change. I am not sure what they are scared of. They may not trust Washington, neither do I, to solve this problem. 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 dependent upon

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

Let me end by saying this. We had a convention at SEIU 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. I will never forget it. Lisa was a 33-year-old single mom who worked every single day of her life. She lived in Iowa Lake, North Dakota, a nice little, small town, and did everything everybody would expect for her to do. She had a daughter named Janelle, and Janelle got sick. 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 health care bill, and she wanted an x-ray. They told her they wouldn't do the x-ray until she paid the bill, so she went back to her doctor. Her doctor said, "Let's just take some antibiotics and see if it goes away on its own." Three days later, this 18-year-old girl died because her mom couldn't pay \$800 worth of healthcare.

I walked across the Golden Gate Bridge with her. Her life is a tragedy, and too many lives are tragedies. Too many countries with economic systems like ours are becoming tragedies all because of our health care systems.

This is now simply a question of leadership and political will. It is not a question of policy. No more policy conferences. What we need is more leadership, and that means American businesses, American unions, American Government, American policymakers have to step forward and say, "End this employer-based health care system now and build a new 21st Century one that is affordable, that has quality, and everyone is covered." If not us, if not the business leaders of America and the policy leaders in Washington solving this problem, then I am not sure

who is. God, if not now, after all these years, after all these trends, after everything we see going on in front of our eyes, then when? Thanks.

(Applause)

MR. STERN: She has the microphone. I know the only rule I was told was wait for the microphone.

MS. TITLOW: Now that I have the microphone, my name is Karen Titlow. I am with the Leapfrog Group 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.

What I would like to 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 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 am wondering how you think your union could help encourage your providers, and I am assuming you are 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.

MR. STERN: I will say two things. Clearly, a lot of people now and there is a lot of focus on what you are doing, and Leapfrog is probably as far in front of this as anybody is in terms of how do we provide quality. Actually, we are having a discussion in our union about stopping bargaining for some of the crazy things we sometimes bargain for in unions and starting bargaining about why can't people be seen in the emergency room in 15 minutes and what we can do to work

as a team to help and how do we provide quality care.

The truth is, until the people that buy health care demand it, we are going to have uneven distribution of the results because volunteerism doesn't work. It just doesn't work. Profit works. Incentives work. Tax credits work. 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 going to change.

People of good will, who actually have answers to the problem, say, if this was a business and someone had an answer to a problem on how to do something with higher quality, everybody would adopt it overnight as a competitive responsibility. It is unbelievable that in America, we actually have better ways to do things and people don't have to adopt them and we keep paying them.

It is like your kid. If you don't keep giving your kid an allowance when he 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 are not paying them anymore to do it, life will change almost instantaneously. That is why we need system reform as well as people sort of incubating the next generation of ideas. 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.

MR. BROWNSTEIN: Ron Brownstein, *LA Times*.

I guess the obvious question is if you want to replace the employer-based system, talk a little about what you think are the options and your sense of which are more attractive.

MR. STERN: The easiest thing to imagine for me is taking the FEHBP system and

expanding it outward. Some people like to say if it is good enough for Congress, it should be good enough for all Americans. Nine million Federal workers, I believe, have the FEHBP. I don't mean to say it is the perfect system. I am just saying it is a platform that meets a lot of desires that people have in America. People make an individual choice with providers and the public and private sector being able to compete and employers shedding the responsibility of a defined contribution. You could add all kinds of quality ingredients to the system that it currently doesn't have. It is such a big platform. It is easy to imagine expanding that up and then creating something new.

You have Tricare in the Federal Government. You have a bunch of other, I say, examples of broad-based national health care that work. Or you can do what you are doing now, not doing now but could do differently which is to set some national standards and allow states to somehow construct their system.

Former Governor Kitzhaber of Oregon started what he calls the Archimedes Project. He says, "If you just give me all the money that is being spent on health care in Oregon, I will have universal coverage." He did a pretty good job with the Oregon health plan almost 10 years ago. He simply says, "There is enough money in the system. Just give me enough flexibility."

That means there is 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 about saying I don't think the Medicaid program is sustainable 10 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 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

are going to have to think about money and programmatic things differently.

We could set a series of standards like they do in Canada in some ways. Forgetting how it is financed, then 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 people in Washington, D.C. I don't know if it is the water here or something. People go to state capitols, 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 work is done on difficult issues. I think that is certainly a possibility.

There are people who say let's just go to Medicare for all.

For me, this is a situation where I think there are a set of principles. We have adopted 10. 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, control costs, electronic records, full transparency of results and other information. We need to figure out the long term care. This could be multiple payers. They are not going to be single payers, I think, in America.

The question is: What is the mix? We are at a mix question, not an "if" question. How much is government? How much is individual? How much are employers going to pay into the system? Or are we just going to do something like the Center for America Progress talks about, a back tax, and just take it off everybody and put it into social insurance on a larger basis. I think the single payer issue is a stalking horse for I am not sure what because we are going to have a multipayer system or some kind of system that is built into the cost of goods in America.

MR. KLEIN: Ezra Klein from *The American Prospect*.

I would like you to talk a bit more about what the leadership will entail. It has been my read over the past couple of years of health care reform that there is in fact a lot of leadership on it, but you always crash upon the shores of your specifics. Clinton had a lot of leadership. The polls were very good. Everybody knew we were about to solve it. Then when the actual plan came out, the very stakeholders in the health care system and the 85 percent of people who do have care were scared they would lose already had, and that was what they were able to demonize, not the actual less determined belief that we needed a universal system. How do you move beyond that? How do you have the leadership that allows these specifics to emerge unscathed?

MR. STERN: I would say a couple of things. One, this isn't 1993. It is 13 years later. 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 HHIA. Everybody thinks so. We thought we were going to get something done, and we thought we were going to have another chance, so we all had a big fight. I think everybody admits they were wrong. Even a lot of the discussions that some people are involved in privately amongst different bedfellows, there is just a lot of sense that we can't do this again. If we get a shot at it, we have to do something. The question is: What?

I think there is a much more sober reality facing us because the numbers are so appalling and the trajectory is so bad. While we are fighting about what we are going to do, we are not going to have much left to fight over. I worry not only are we morphing into catastrophic insurance but employers are pulling their money out of the system. Once the system loses money in any system, it is harder to get it back. And so, we better make these changes. I would say that is one.

Two is we did not have one American business leader get out in the middle of the 1993 debate and call. We were looking for that. The President of the United States was looking for that. Everybody was scared. They are going to go back to the country club, and people are going to say, "You were out talking about that universal health care. You must be some kind of socialist communist Clintonista." I am not sure what it was.

This will not change until the employers demand it. That is my personal opinion. I have watched everybody else in America demand it, and nothing has happened. With all due respect, they are responding to business constituencies, and this is a business crisis now. The only question is: Does business get out of it, so it is not their crisis anymore by either going to defined contribution or just dumping insurance or outsourcing or restructuring the way work is done which many people do between contingent, part time and other people who therefore don't qualify? Everybody in the college, I understand, is not a tenured professor anymore. They are all lecturers. It is all structured in a way that we distort our job market and labor market by our health care costs.

I just think until the business community gets up and does something, and I don't mean like in little private rooms, I mean something dramatic. Where are Lee Scott and Howard Schultz? I can imagine the lineup in this room that would probably be one in which you wouldn't have one more camera here, you would have the entire world when they said, "The employer-based health care system is dead, and we want American politicians to fix it."

I ruined you. I took your job. In unions, we don't take people's jobs.

MR. AMATRUDA: Will Amatruda, Catholic U. Law School.

I have been in the Federal Employees Health Benefit Program for over 20 years. So I have some knowledge personally of how it works. There is a very large government subsidy for the

employees. It is in the neighborhood of 70 to 72 percent. My question is: How do you politically get around the issue of the allergies that so many people have to that five-letter word, taxes?

MR. STERN: I will tell you three things. One is I think people have an allergy to the five-letter word, when it is generic, when it is just given to the government. I don't think people have the same feeling when it is the six-letter word called health — the six-letter word called health. There is a lot of polling data that says people will pay more for something as opposed to pay more for generics.

Two is there is a government subsidy. There are government subsidies everywhere. There are government subsidies in the tax cord. There are government subsidies in Medicare and Medicaid, VA, and Tricare. The government, you would think, as a purchaser — we are the only government in the world that as a purchaser doesn't believe in market principles, so we don't bargain for prescription drug costs. We like the market to work, except it doesn't work right for the people who are on the other end of it.

To me, I think people are ready to do something. There is a lot of money in the system. There is 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 are right, and they want some security.

MR. SMITH: Bruce Smith of George Mason University.

This is a very fascinating debate.

MR. STERN: Usually, when people start like that, they have a real hard question. That was a really point you made. Then is it an "and" or a "but"?

MR. SMITH: I am serious. It was a great talk. Aren't you still stuck somehow with some role for the employers? You don't like single payer. I don't know how you collect if you did something like mandating everyone have a policy like evidently the Massachusetts plan. How do they collect there? Won't the employers sort of have to play some role in deducting from the paychecks and giving it to the government? You can't put the whole thing on the IRS or doing it as part of tax collection. That is beyond them.

MR. STERN: My issue is basically the system that is built on employers is sustainable. They should not all be out talking to their favorite insurance company and their favorite HR director about this new design of their health care plan, but they should contribute, I think, unless we are going to go to some value-added or other kinds of national taxation basis. They obviously have and should have roles in trying to help people who have issues find decent care, all the things that employers, I think, believe in, that they don't want their employees to be sick and uncared for and untreated. To me, it is just a question of what is their role, but it is not providing health care.

MR. SMITH: Could I just add a footnote to that? Whatever kind of scheme you have, you are going to need to have, if not a single payer, some government that is either defining what is a minimum set of services and coverage that is out there or administering somehow and deciding what plans are eligible or determining what is going to be reimbursed or what drugs are going to be reimbursed like the British centralized thing. Who is going to —?

MR. STERN: I am not a libertarian or an anarchist. I am just trying to get the right role for government, which I think is setting standards. It is dealing with financing. It is helping organize the system. I am just saying how it is then provided once the political process organizes it. For the sake of argument, FEHBP, the government is very involved in organizing the system, but then

private companies provide the services.

MR. DOUGLAS: Scott Douglas from Bampak.

You said that the major problem is with business leaders not coming forward although the problem affects them the most. Firstly, why are they not if a major effect is on them, and how do we get that message to them that they really do need to stand up and lead?

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

I would say there is another problem, a bigger problem, and health care is only a part of it. As we change into a global economy, people all of a sudden don't think of themselves as American business leaders. I am not saying they are being disloyal to their company. I bet you that Jeff Immelt, when he gets up every morning, isn't just checking on the American results of GE. He is looking at the global results. People tell me, who run companies now that they spend enormous amounts of time traveling around. Running a global economy has all kinds of issues about national loyalty. We live in a world where companies, not countries, are making the rules, and business leaders are becoming global leaders.

I am concerned we are going to lose their leadership in America because so much of America's greatness came from our business community and entrepreneurial spirit, and it was applied to our Country. When it is applied to the world, it makes you nervous that we are just going to be another market. "America, they were doing pretty good for a long term anyway. They

just didn't make the change. I am moving on to worry about what is happening in Poland or developing a market in Indonesia." I think the Country is suffering right now from the lack of business courage and leadership, and I am worried that it won't get better but worse.

MS. SMITH: Hi, I am Barbara Smith.

I wanted to ask you a question about the role of price containment in the context of the larger system because I think that ultimately one of the things that that killed the plan in 1993 is it died from delay and lack of speed in getting it to the Hill. The fact that business leaders, in an ideological way, took the view that, well, if they start regulating prices for health insurance, then the next thing you know they are going to be regulating prices for software. They are going to be regulating prices for cars, or they are going to be regulating prices for seatbelts and on and on and on. On a real ideological level, they really view it as the camel's nose under the tent.

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?

MR. STERN: I am not an economist. There are smarter people here than me. Some people say, well, if you do this and everybody is covered, the market will drive things in the right direction. The problem with the market is we have so much public money in the system. 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 it controls directly or indirectly and said we are just going to name three people to purchase health care for the Federal employees, we would probably do really well in the market because we would have huge purchasing power.

So, one is to try to think about the government, not as a regulator but as a purchaser which should give them more opportunities with a lot of political pressure. Then we have base closings and lots of ways we try to deal with complicated situations where people don't have the political will. So we give it to a group of other people and tell them: You are the purchasers. You are the Medicare purchasers. You are the government purchasers. You get hired. You are immune. You get one report. We vote it up or down, or we don't even get involved because you are the purchasers. That is your job to purchase health care for all of America.

Or some people would say if you give everybody a certain amount of money and they can buy things, the market again will work.

Some people say we should make people do the things that work like Leapfrog has proven because that will bring down costs. If we do manage diseases, if we do evidence-based medicine, it certainly is going to help both get better outcomes and better quality. We have to get out of nursing homes and into home care because institutional care is just too expensive. We don't have a system right now that rebalances the role of nursing homes and home care because more people can spend more time at home. Technology has improved. Capability has improved. We give more money to be in an institution than we do to stay in your home. So there are just a lot of adjustments that need to be made in the system.

MR. GABEL: John Gabel, Center for Studying Health System Change.

MR. STERN: Someone who really knows something, now I am really in trouble.

MR. GABLE: For decades, organized labor supported the highly regressive employer exclusion which is the fundamental basis of the employer-based system. My question for you is: How representative is your opinion on the employer-based system of the rest of the labor

movement. My second question is: Do you think union members, who right now enjoy some of the best union membership, would be willing to give up and to have less rich policies in order to obtain universal coverage?

MR. STERN: Some people would say I am not in the mainstream of the labor movement, but I find that unusual. I would say, listen, people are getting to the appropriate conclusion that this system is unsustainable. I think all of our tax breaks and our ability to bargain, we would all like to be rid of it. Just like employers want to be rid of it, we want to be rid of it because it is just too hard. To 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 interests of one group of people, and they are trying to protect the interests of other people, shareholders, and Wall Street. From the sides of the table you sit, the world has different adjustments to it. It is just a difficult moment in history.

I would say people are ready to move. What everybody is scared about is you don't want to get dumped out in the process. So, moving is different than ending. We are transitioning out of the employer-based health care system. We just have to say it is ending, but that doesn't mean we are ending it tomorrow. It means we have to note from where you go to where you are going. I think that is the first process in change.

Two is, in every country in the world that has a universal system, not every country but many countries of the world that have a 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. We are ending certain tax breaks for employers in return for getting employers out of the system.

How much they are going to pay is obviously an interesting issue that I don't think they solved well in Massachusetts.

Then the question is: What is the basic benefit and what do employers do for themselves, their union employees or their non-union employees, to wrap around the basic core benefits? We need a basic core benefit in America. That is the next step we need, and we are 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 will pull them out of a hat and be done with it and go on because you have to move on here. While we are debating it, we are all dying lousy in terms of the current system.

UNIDENTIFIED SPEAKER: You have 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. So, my question to you is a simple one. What advice would you give to a candidate in 2008 about how to address this question?

MR. STERN: Probably not much different than to say to people the system is dying, and we all know it. People are insecure. 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 wrong decision about health care where some people are in and some people are out, and we have to readjust back to the education model. We need something that you are guaranteed for the rest of your life.

The problem we have in America with self-managed work lives, if that is where you believe it is going and I do, is we don't have the entities, intermediate organizations. In Massachusetts, they created connectors to make up for the lack of ways to make connections. You look at

America and say: How do I have TIAA-CREF for health care or how do I have TIAA-CREF for pensions for all Americans? I can move from job to job and not have a pre-existing condition, resign up, put my 401Ks all back together again when I am trying to retire. Who is going to advise me? Where is my personal economic self-managed work life trainer or the entity or union or organization or AARP or someone that is going to help me manage my work life?

People are going to manage their own 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 at it. People are moving their way through life by changing jobs. A lot more employers are changing a lot more.

These are extremes. I don't talk in grays in case you don't notice. These are extremes, but we are moving to a self-managed work life, and we don't have institutions to really help manage your way through. That is a challenge for unions and everyone else about where are the institutions of the 21st Century that are putting a drag on employers' competitiveness and where are employers' responsibilities to the Country as a whole as well. I think that is the balance we are trying to find here, but we need to do it as Team USA.

I will just end by saying this: When Ireland was in trouble, when Ireland's largest export product was people, business and labor and government came together and they made some really hard choices about that economy. They made one big plan, not lots of incremental little plans, and now it is 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 is what candidates should run on because this is a very complicated moment in history where the huge economic transformation is one no one really

knows. Bill Clinton at least had the framing of it right: We are 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. How would he have ever known it? Who would have ever known that the world was going to go flat? All the reasons that the Berlin Wall was going to fall and all the things Thomas Friedman talks about, no one could have known. The world is changing. So you make bets 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. We like to kill the person who made the last bet, rather than thinking about what is the future.

We need an American plan about our future because this is not our fathers' and grandfathers' economy. It is not the New Deal. It is a brand new civilization that we are 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)

MR. NICHOLS: I have spent enough time in this town to know when a hard act to follow has been before me. So I will cut straight to the chase here. My name is Len Nichols. I direct the Health Policy Program for New America. I am quite honored to be co-sponsoring this set of events with Henry, and I look forward to even more interesting discussion as we go forward. Andy, thank you very 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 something not entirely or completely different but somewhat different in that we are going to hear from business and two quite distinguished representatives of that corner of the world.

First, we will hear from John Matthews who is the Senior Vice President of Human Resources and Risk Management for Costco Wholesale, the Seattle-based retailer that pioneered the membership club concept. John's responsibilities include the full array of human resource functions, including personnel policies, employee development, benefits and retirement plans, and labor relations. He also oversees risk management functions of insurance programs, safety laws, control, general liability, and workers compensation.

I note here in the bio — you have it in your packet probably — that John also spent 20 years in the Navy, and it is pretty clear that only a Navy guy could actually handle all of those responsibilities because he is used to going on three hours of sleep one week at a time. I am very impressed with all that. He will tell you about Costco, but you should know that it is a \$52 billion company, growing at the rate of 25 to 35 units a year.

I will go ahead and introduce Todd, and we will go in order in that way. Todd McCracken, who I am quite pleased to have before us today, is the President of the National Small Business Association, and he has been in that capacity since 1977. He directs all the activities of this advocacy-oriented association. Todd is a registered lobbyist who represents the organization in myriad settings and, as director of the government arm, plays a key role in developing NSBA's policies on issues and strategies in implementing them.

I had the privilege of testifying with Todd now I think a couple of times on association health plans, most recently about the Enzi bill. I must say that last hearing we had was quite intriguing in the sense that we were talking about all the fine arcane of the Enzi bill. I think it is 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 it was a three and a half hour marathon,

and they kept coming up and asking more and more questions.

Finally, because the Senators wanted to do something positive for small business, they said to Todd, “We have two minutes left, Todd. What else can we do for you?” Todd whipped out of his pocket 45 seconds each on taxes, pensions, and regulation. I must say they all wanted to co-sponsor that bill that afternoon. I was very impressed with how he managed to pull off that bipartisan compromise.

I also know Todd actually has a degree in economics.

I am glad to be joined on the podium with these two gentlemen. Let’s start with John. Thank you very much.

MR. MATTHEWS: Thank you very much. Good morning, everyone. Members of the audience, before I get started, how many of you are Costco members? Can we have a show of hands? Thank you very much. We appreciate that.

Costco is 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 U.S. and about 120,000 worldwide. Our model is pretty simple. We try to bring goods to our members at the lowest possible cost. So we use our leverage and purchasing power to try to bring those economies to members. We do the same thing for executive members, and we offer health care to small businesses in the same fashion. We can use our purchasing power to go out and buy products that small businesses can use to offer to their employees.

The company was built from the very beginning on a desire to try to grow from within. We typically bring college kids in early on and work them in part time hours while they are going to

school and classes, and many of them stay with us. We have very low turnover rates in the company. Overall, it is about 20 percent which is unheard of in retail. For people who have been with us a year or more, our turnover is about 7 percent. I don't know of any organization in retail that is coming even close to that. It is very much an issue, from an HR standpoint, of once we get people plugged in and understand what the career opportunities with Costco, more than likely we will keep them.

We have taken a very broad view of compensation from the very beginning. We have always wanted to pay wages that were demonstratively better than the competition. So we have always stepped up and had what we feel is a good wage package. In fact, a cashier working for us on a full time basis at the end of four years is making about \$40,000. It is fairly competitive.

We also try to do the same thing with health care. Today about 86 or 87 percent of 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 percent of the people who are eligible for health care accept health care and take it within the organization.

For some time, we had not made any changes to our health care model. We had (Interruption) is 94 percent of the premium burden for employees who are picking up 6 percent. We realized that was a mistake because we were taking the employee right out of the consumer model. They didn't know what the costs really were. We needed to bring them back into it. So, a few years ago, we made some changes and we did some cost shifting, not dramatic. We shifted to 90-10. It is still much better than a lot of plans in the marketplace today.

Just to give you a sense of the environment, I am on the hook to our CEO, Jim Sinegal, that if I go over that 90 percent or take 89 percent and the employee slips from 10 to 11, he has me in

his office and his question is very direct. He says, "How are we going to give it back?" It is not like I can drop it to the bottom line and we are then going to take advantage of this thing. It is, 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 have established a loyalty with the work force that has 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 it is a great company, strong, well run but way too generous. You are giving way too much to your employees in terms of pay and benefits, and you really need to tune that up.

We are 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, so that they can raise families, own homes, and be just what we all want to be, and that is contributing Americans working within the system. We think it can work.

Costco took a lot of heat for taking that stance, and they held our price down for quite some time in the marketplace. We held our position. If you look at what has happened in the press over the last five years, all the pressure that has been brought to bear on organizations like Wal-Mart to do something different than what they are doing now, I think what you can see is a role of companies that Andy was talking about earlier in a leadership role, not by words necessarily but by our own actions, day to day, every single day, taking care of our people. That created a model that others can follow. We are very proud of the model that we have. We think it is successful; we

think it is sustainable; and we think it can be a force to cause others to do similar things.

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

America fails at primary care. Todd and I were talking earlier about some of the things that what would you do differently and what is it that really needs to be looked at. We talk about health care, and health care is a big apple. 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 of that is primary care. It is the one we do the poorest job of in the United States. When kids can't get physicals and can't get inoculations and eyes checked and teeth checked, when parents can't get physicals and routine checks and all the preventive things that are necessary in order to get ahead of the health care curve down the road, America fails in that area.

One of the things that I think we can do today, if we are going to go in the direction of a mandate, if we are going to set a model in place, is to mandate primary care coverage. Mandate that every employer provide primary care for every employee and all their kids. That is a very doable piece. We are already doing it. We already take care of our health care for part time workers, for full time workers, and we take care of all of their dependents. We are already doing that model in our health care plan to take care of the primary care issues.

If we can solve that, get ahead of that, and if we continue to work in the Country on personal responsibility of our own health care and taking a more responsible position individually about health care, I think that, over a long period of time, will put us on a more solid track.

Clearly, there are things that need to be done in the health care model that exists today. I think in government, although I have heard reasons not to bite on this, I think Shadegg's 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 buy health care. There are too many rules around it. There are too many barriers and restrictions held within states. I think you can open it up as a product, as are most other insurance products available in the Country today. Life, auto, home, I can buy those wherever you want to buy them. If it is health care, I have to buy it in a certain locale. I think we need to get away from that and get rid of some of those barriers. 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 to continue to foster the research and development that goes on. I think there are 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 of health care services, customer service of bills and response to that. I don't know of any 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 are just coming into an era of data, of putting data together in a way that we can make sense out of it. Costco has been working for probably seven or eight years on this.

Because I wear both the risk management hat and the HR hat, we have been working to put workers comp, short term and long term disability, all the return to work programs, and all the ADA together with HR, so that the employee is served from one piece, rather than from several pieces. Our idea is that we can provide a better service to the employees who are out for whatever reason and help them more effectively in a return to work format. We are just now getting to the point where we can merge that data and put that together. I hate to ever see that component of data for health care taken out of that model, and that would reduce our ability to handle that part of the problem.

I think that is probably about it for me.

MR. NICHOLS: Thank you, John. We will go to Todd, and then we will take questions as a group.

MR. MCCRACKEN: Thank you very much. It is a pleasure to be here today. When asked to participate in this panel, one of the things I was supposed to do was to respond to what Andy Stern had to say this morning. I have to tell you I guess I could pick a few nits, but I don't think there is a very wide chasm of disagreement, certainly among the small businesses we represent and what he presented here this morning. We think that the employer-based system is fundamentally broken, especially broken for small businesses and the employees that they employ. While we certainly 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.

You have also heard a great deal today about the overall cost pressures in the system and why our system is leading to this breakdown, and all of that is true. Even there, I think it has mostly been presented thus far from the larger business perspective, and the reality is it is even

worse in the small business community because they not only have to deal with those costs but they also have to live within the health insurance marketplace that is currently regulated by the states that they have to function within. That system, in addition to the overall cost pressures on employers, I think it is fair to say is coming apart at the seams.

There are many reasons for that. I happen to believe that the beginning of that probably was ERISA. While ERISA has done some very good things for the larger business community in being able to control their costs and manage health care plans and self-insure, for small businesses, that meant they were the ones left behind with actually buying insurance from insurance companies. I think that began to make insurers much more risk-averse 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 pre-existing exclusions in all the rest.

We saw that getting worse and worse during the course of the eighties and early nineties until all of the states acted on some kind of insurance reform and put into place rating bans and various other mechanisms, some of them as far as community rating, others didn't. The whole idea behind what the states did was to create something like a pool and tell insurance companies that you can't exclude people for that reason. You must have people together in some kind of grouping, sharing costs, not just paying what you think the real cost of care is going to be in the system.

That had some moderate success, but the reality is it has a downside too because when you community rate in a voluntary marketplace, the people, who feel like they don't really need coverage that much because you raise the average price by doing that, are going to opt out of the system. That is kind of what we have seen happening steadily over the last 30 years in the small

group marketplace. It has gotten to the point now where for the first time, certainly in the last 30 years, most small businesses do not offer health insurance. There is no reason that I can see to expect that is going to change.

It leads to a whole range of problems. The insurance marketplace, as it is currently structured for small businesses, leads to enormous volatility for small companies that the 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 premiums can go up another 20 or 30 percent on top of that when you have really not done anything differently. You can literally see your health insurance bills going up 40 to 50 percent a year.

Small business owners know that. They realize that. It injects a level of unwillingness, I suppose — I guess that is how I would say it — to start health insurance in the first place. They are not currently offering it. Employers are very reluctant, especially for small businesses, but I think it is true across the board. They are very reluctant once they have the benefit in place to take it away. That creates a very bad feeling with your employees, which is not what you want. They don't want to start offering because they don't feel like they can keep offering it.

In this marketplace, as volatile as it is today, it really creates a feeling of: I don't know what next year is going to bring. I want to offer this benefit, but I can't pay 50 percent more than what it is costing me now. I don't want to tell employees in a year, guess what, this thing that was a big benefit is going away now. It creates all kinds of incentives — I guess is how I would say it — for small employers not to begin to offer.

What do we do? All the folks who called for employer mandate, well, just tell them they

have to offer it then. The economic dislocation, I think, that comes with an employer mandate is enormous. Not only does it hurt our global competitiveness, but it also squelches the start-ups of many of those small firms in the first place, and I think we all know they employ almost half of the private workforce now.

The economic dislocation that is caused by an employer mandate is huge. Not only that, but it is extremely inefficient if you just look at it from a tax dollar perspective. Whether it is because of politics or policy, almost every responsible proposal to impose a mandate on employers comes with some way to subsidize some of those employers for health care coverage. We frankly just don't think there is a good, effective, efficient way to subsidize employers for the provision of health insurance.

Do you subsidize low wage employers? Well, any economist would say that would encourage low wages. I am not sure that is 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 to try to hide profits. You don't want to do that either.

Do you subsidize small companies? Well, those of us who operate small companies might like that, but the reality is some small companies might need that subsidy and others frankly don't. Many small businesses are highly profitable.

There is not an efficient way to target those subsidies in a 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 are plenty of low wage workers who don't live in low income households. There is not an insignificant number of people 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 have been talking about is to require individuals to have coverage. Then you can require the insurance companies to sell insurance at something like a community rate, so you don't have these huge fluctuations. You can target your subsidies by household income. You can subsidize the people for coverage, who actually need the help. You have also done something that is too often overlooked. You have 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 everyday. You know their stations in life. You know their wants, needs, and desires. The reality is in some companies, and I don't want to this to be construed as most people. In some companies, especially those that are relatively low wage and have relatively young workers, those workers really would rather have the money than health insurance, thank you very much. So that employer provides them the money, not the health insurance. But if they are required to have health insurance, suddenly the provision of health insurance through that employer is a benefit that they see and that is visible to them.

If I can help you get the coverage that the government says you must have, that is something that 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 then they don't pay the premium because a lot of insurance companies, for adverse selection reasons, say, well, we won't sell it to you, the small business, unless you pay X percent. That is a real roadblock for many companies to even get the coverage available to their employees. If we had the requirement on those individuals to have the coverage, then suddenly there is that incentive for companies to make it available, to facilitate the coverage, and all the rest.

Obviously, in addition to the subsidies, we have to figure out a way to equalize the tax treatment and all the rest of it. There is a whole bunch of things that we need to do to make a system like that work.

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 the small business community is maybe at some point unique, but it 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 diverted into proposals that really aren't going to do a whole lot to improve the situation. If we could much more prominently in this Country focus those attentions on real reform that will really change in the long term, we think we can actually solve this thing.

MR. NICHOLS: Wonderful, thank you both for a great way to start it off. Let me turn to the same audience. We will use the same rule that Andy had. You are in charge, but I will help you along if I need to from time to time.

MR. HELMS: Good morning, David Helms with Academy Health.

Over my life in this field, I have actually gotten to administer programs that offered subsidized insurance to small employers, and I commend you for how you are looking at this issue because I do think it is very hard to target those subsidies efficiently.

I heard a commentary a minute ago about why big business doesn't get around this issue. I just want to repeat a story from a very senior member of a major U.S. corporation, General Electric, who was presenting to his boss the analysis of the Clinton plan and talking about how much money that was actually going to save General Electric. Jack Welch, it is reported, pounded

his fist on the desk and said, “I don’t care if we save money. That is just too much government.”

The question I want for you both — I think we ought to be moving toward some kind of individual mandate, and I don’t care whether it is state collectors or FEHBP or some other mechanism. It is going to require government to be in this game to structure the rules and give us incentives to do things right. 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 and other things that are needed?

MR. MATTHEWS: I will start, and I will go back to the point which I commented earlier, that we will take government in small bites, but let’s start small and let’s start with something we can do and be successful with that. Let’s solve primary care. We can do that in the United States. If Cuba can do it, we can do it.

MR. MCCRACKEN: I think our view on the proper role of government is really to set up the framework. I think if you are going to mandate people to have coverage, you have to define what that coverage is. You have to tell them what it is you are mandating. Somebody has to do that. Our view is that that mandate should start off at least as minimal as possible and not be a huge comprehensive package of every benefit that is currently offered. I think that would be more affordable at the outset for folks. We think they should be buying private coverage.

We really see government’s role as you can’t do this without a government role. That is very clear. But we think it should be as sort of a traffic cop, not the actual hands-on in the health care system itself.

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

MR. MCCRACKEN: Something like that might work for folks who don't have a connection otherwise through their employer for health insurance. It is also our sense that things like that may arise in the private sector. If you have a requirement for all individuals to have coverage, you shouldn't assume that the health insurance marketplace will look tomorrow like it looks today. There will be some pretty dramatic changes in the way health insurance is sold and marketed, I think, if we have that requirement. 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 that. Sometimes the marketplace can do more efficiently than the government FEHBP model would.

MR. MINARIK: Joe Minarik with the Committee for Economic Development.

For John Matthews, I have two questions. Number one, you mentioned taking your employer share down a little bit to make your employees more cost-conscious of the margin. What did you do with that margin to make your employees more cost-conscious? If you believe that you had to take your share down further to get real cost-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?

MR. MATTHEWS: When you start talking about products with the HR guy, that is a nonstarter.

To your first question, we worked real hard at tying together an education and communication program to our employees that helped them understand what is going on in the marketplace just to be aware of things. Number one, what are other companies paying? What is

the value of the benefit you are receiving here? What is the cost when you go do certain normal, routine things on a day to day basis? 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 to visit a doctor. If that is the case and if that is what we are dealing with, then they can't be really effective consumers in that.

We failed as an organization by being too paternalistic in this process. I shudder at some of the plans that are still in existence today where organizations are hanging onto 100 percent employer-paid health care, and there are still a few around there. I think it is crazy, but I also think there is a very radical shift. We have some retailers in Seattle that have simply said, hey, we are not in the health care business; we are in the department store business. So cost sharing there is 50 percent. I think that is too onerous, and I don't know that families can handle that kind of a share.

I think there needs to be something. We picked 90 percent. I don't know that that is right, but what we are trying to do is to help our employees become more sensitive, more aware, and we are going to do that by talking to them, not whipping them with steep prices on the cost of health care. We are hoping that is going to work.

MR. NASSAR: For John Matthews, I am David Nassar with Wal-Mart Watch here in town.

My question is this: Costco's plan covers about 82 percent of your employers.

MR. MATTHEWS: It is a little higher than that.

MR. NESSARA: You can correct me. Wal-Mart's plan covers less than half. Costco has clearly made a decision that happy, healthy employees are more productive and, as you quite accurately said, stay longer. What do you think it is going to take for other companies to come to that same conclusion?

MR. 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 has happened in the last five years about this subject, about business ethics, has had dramatic change in the boardrooms. 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 10 years from now, but I think there is a very gradual shift around.

When you look at the younger generations of people coming into the workforce, they are interested in ethics and they want to talk ethics. They want to know fairness, whether it is environmental or whether it is health care, but they are 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 and the dialogue that is 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 and collectively.

MR. SMITH: Bruce Smith, again.

I wonder if we could go back to this issue of the individual mandate which seems to be an attractive notion. If you do that, presumably you are not going to touch Medicare. You are not going to tangle with that one. Presumably, you are not going to touch the Federal system. You are not going to touch veterans. So you have a bunch 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. Let's say you are going to try to work Medicaid into this system. If the employer kind of administers or collects, or something, the individual mandates, that is a part of it. What about those that aren't employed

then? How does that mandate work? How do you 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 fuse or merge or reconcile or absorb Medicaid in the process?

MR. MCCRACKEN: I will take a stab at that, I suppose. First of all, I am not sure that I 100 percent buy into the premise that all of the government programs be exempt. That may be the more politically expedient thing to do, to leave those alone. The other, I think, attractive thing about an individual mandate is it does at least allow you the option of taking the money you are spending on those people there and pooling them into a private system if you want to do that. That is above my pay grade, so I am not going to tell you whether you should do that or not. But at least with that kind of a model, unlike other employer type mandates, it creates a framework for a system where you actually could privatize some of the systems that you have now. Whether you want to do that or not, of course, is always an open question.

Probably with Medicaid, though, you have an even more likely chance because with Medicaid, you have people who are moving in and out of the private workforce. It probably would make a little bit more sense, even in some of the other areas, to fold them into the larger, more privatized individual mandate system.

Enrollment, obviously, people with lower incomes in our vision at least, people with lower incomes would be completely covered. Insurance to 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 who don't enroll. Clearly, it does happen.

Right now today, there are many providers, hospitals for instance, who actually employ companies that sign up patients who are eligible for Medicaid or some other government program,

so they can get paid. I would certainly see something like that continuing. If people don't have insurance, let's sign you up for insurance. I have the form right here. You are 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, is then once people who are of higher income and who aren't getting all their insurance paid for by the government, what if they choose not to be covered? Our suggestion, and we are open to other ones, is along the lines of what Massachusetts is beginning to implement. The IRS is a logical enforcer. You must have some kind of not insignificant tax penalty for people who don't show proof of coverage, and it has to be enough that it is meaningful.

MR. GRUENBERG: Mark Gruenberg(?), from Press Associates.

A 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 is to prevent the insurance company from offering, in order to meet the employees' mandates so to speak, a bare bones policy such as that offered by Wal-Mart or by Golden Rule or somebody like that which is high cost and low coverage and they don't pay for your doctor bills?

MR. MCCRACKEN: As I said before, if you are going to have an individual mandate, somebody is going to have to define what that mandate means, what the package is you must have. To us, one of the main reasons to have an individual mandate is so you can impose some rules on the insurance companies that they can't exclude people from various kinds of coverage and to ensure the coverage they offer is real. Right now, that is a hard thing to do, especially in the individual and very small group market because you can create a system where people just wait until they are sick or wait until they are about to go to the hospital to go buy insurance. You can't

buy fire insurance when your house is on fire. It is a similar thing.

But if you are required to have the coverage, then you can begin to tell the insurance companies, you have to do it this way, and you can begin to put some more parameters on that than you can in sort of the wild west individual market we have today.

MR. NICHOLS: Should we move to the would-be policy wants? Just come on up and join us and please join me in thanking our business leaders.

(Applause)

MR. AARON: We have heard a number of differing points of view. Now you will perhaps hear yet another.

It was a long time ago when Winston Churchill quipped about democracy that it was the worst form of government, except for all the others. That is 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 they would lose health insurance. Unfortunately or fortunately, that is the system we have, and it has been shrinking.

The question is: Is employment-based health insurance really dying? Another quote that I am fond of is Mark Twain's remark that rumors of his death had been greatly exaggerated. The simple hard fact is that most Americans still get health insurance where they work. Employment-based health insurance covers 175 million workers and their families. That is 60 percent of the population. To be sure, that fraction is down from the year 2000. In that year, 64 percent 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.

Why the rollercoaster? Well, the answer is simple. If labor markets are tight, 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 am not here and I don't think anybody you have 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 and bad risks are insured as part of a single group. That is the only way that a fair insurance system can work.

Think about it. Suppose each of us had to go every year 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 expenses are going to be over the next year. They add some extra charges for selling costs, maybe a lot for selling costs because they would be trying very hard to attract us as customers. They add something for administration and profit. We would discover that, lo and behold, 55-year-old workers who had chronic emphysema would be charged more than healthy 30-year-olds were charged. Well, 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 it is 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 are charged. Yes, it is true, some insurers do behave outrageously, but I think on the average, 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. 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 is 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 is called pooling. You have heard that word repeatedly today.

It is a historical accident that we in the United States pool through the workplace. 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 is why I believe, and this is a subject that hasn't come up today, but it is one reason why I believe that the proposals now being advanced by the Bush Administration are a step in the wrong direction. Those proposals would narrow or reverse the tax advantages that 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, is quite likely that a great many Americans would find health insurance unaffordable.

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

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

So, right now, we have a deadlock in Washington on what to do about health insurance. Come to think of it, we have had a deadlock for about seven decades in Washington about what to do about 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 have heard about Massachusetts and Oregon. Well, there is 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 principle that is embodied recently introduced into the Senate by Senators Voinovich and DeWine to Republicans and Senators Bingaman and Akaka to Democrats, a solidly bipartisan team that is co-sponsoring what they are calling the Health Partnership Act to give financial support to states seeking to extend coverage. At the same time, there is a bipartisan group in the House, working on drafting a similar bill.

States could, I believe, break the deadlock that has ossified the health care policy in this Nation for one more year than I have been alive, and today happens to be my 70th birthday.

(Applause)

MR. AARON: I didn't say it for that reason. I said it to underscore there is a long time that things have been on hold here, and I said it in order to urge us all to work to try to find a better system to assure coverage for the mass of American workers than the one we have. I hope we succeed, and I hope we do it soon. I would like to see a new and better way of providing health insurance for all Americans. Until we do, I would really urge those 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)

MR. 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 is fair to say, while we have this paradigm in America that 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 is just that 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 co-workers who made more money, and that was indeed the model we used to hold more or less labor peace, the proverbial janitor at General Motors.

I submit to you that Brookings used to have janitors. New America is too young and we never had janitors, but Urban where I worked before, did have janitors. Now none of us have janitors. Why? They work for janitorial services which do not offer health insurance. Fundamentally, those low wage workers got a good deal if they happened to get a job in a large or relatively high wage company, and that is fundamentally one of the dynamics that is going on.

Let me give you just a couple of facts that make it sort of, I think, compelling as to why the sense of urgency about doing something about this problem is indeed building. I must say, 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 it has been endorsed today. So, thank you very much for all that.

I think it is important to remember that small, low wage firms are the ones least likely to

offer 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 I won't belabor those facts much. The problem with that is 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. I don't think we have them loaded, so we will just give you the basics here. Just think about the relationship between family premiums and median family income. In 1987, I am not sure why, maybe Henry knows, but we know a lot about 1987. It is really interesting. It must have been a boring year, and we studied the health care system to death.

In 1987, we know that a family premium was basically equal to 7.7 percent of median family income. That is the income exactly in the middle of the distribution. Half of the families make more, half make less — 7.7 percent in 1987. The most recent data would suggest it is 18 percent of median family income today and obviously rising. Let's think about this.

By the way, this premium includes both employer and employee share because I, like most economists, believe fundamentally the employer share comes out of wages because it comes out of productivity and compensation. I will 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 percent in order to achieve a family policy. I submit to you that it is not sustainable.

A very famous Harvard economist made quite a reputation, saying some years ago, after Social Security but not too far after, John Dunlop, "If something is not sustainable, it won't be." For this, they give you tenure at Harvard. I think it is fair to say he is right. To put it even more bluntly, go from income to wages because at the end of the day, health insurance comes out of individual job productivity.

Think about this. In 1996, a family premium was one-third of the 25th percentile workers' wages, that is, a worker who makes less than 75 percent of all workers. For them, they would have had to pay a third. Well, you think that is a person at the bottom of the distribution. Today, the median worker wage is equal. It would cost one-third of the family premium to buy.

What I am trying to tell you all simply and what Andy says we now know, and I think it is bubbling up around the Country is the unaffordability of health insurance is coming to a job near you. It is coming more quickly than you may think.

Let's think about these facts and look at the statistics. There are lots of them. Some of my favorites come out of the Agency for Healthcare Research and Quality. John Gabel does a great employer survey which tells us premiums in real time. AHRQ takes a little longer but drills 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.

For example, what fraction of firms is mostly low wage — by low, I mean \$7 an hour or less in real terms — and what fraction of workers work in firms that are mostly low wage? Basically, we are now up to a third of firms and roughly 30 percent of workers now work for firms that have more than half of the workers with them being low wage. Those are firms that can't offer. They are never going to offer. What I am trying to say is by moving those janitors out of Brookings and Urban and putting them into the janitorial firms, they are still not offering. We are fundamentally segmenting our market in ways that are just going to exacerbate the trend.

Let me state the obvious. We have to figure out how to control health care costs. We have to keep pooling risks. Some dimensions of the employer system are surely going to be with us for quite some time, despite Andy's beautiful vision 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 a while. Firms like Costco seem to be doing quite fine. I am just going to leave them alone and hope they keep appearing in public and inspiring people.

I will say it is interesting when you get down to the question from the gentleman from George 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 existing programs for a low income population, i.e., Medicaid. To do that, it seems like we have to finally maybe be honest about our making these subsidies more seamless.

Consider the following: For SCHIP in virtually every state, if you make less than twice poverty, society has decided you shouldn't pay for children's coverage. Children's coverage should be available to everyone making less than twice poverty, but you are only eligible for SCHIP if your employer doesn't offer. Let's think about what that is about. We are 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 workforce. That assumes high wage workers are both able and willing to absorb the cross subsidy required. I am looking at these guys, and I am suggesting in real life that is less and less true, and in many small businesses, it never was true, and that is why they don't offer. We have to think hard about our willingness to subsidize people based on income, regardless of their employer situation.

You go back to Todd's statement about how it is much more efficient to subsidize individuals than it ever will be to subsidize firms for all 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 a requirement for everyone to buy, the requirement being focused on individuals and with subsidies. What we have a hard time seeing is the transition. How do we move from here to there? Transitions are notoriously difficult and can stymie change.

Let me pose the question: How do you guys think the business community, and I realize it is quite diverse and that is why we wanted both of you here to give us some nose in that distribution. How do you think the business community would respond to the following concept? Once we have the purchasing entity, that can be a connector like Massachusetts. It can privately run. I totally support the proposition that this can be organized outside the government. The government might want to start it and get it going.

Once it is there, what if you said to businesses, "Look, 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. After that, health care costs and risk is between government and individuals, where I would submit it is ultimately always going to be. Thank you very much.

(Applause)

MR. MCCRACKEN: Something like that probably would work. You are going to wind up dislocating somebody no matter what you do because when you tell somebody you contribute this year and you have to contribute next year, you don't know what the economic situation of that company is going to be next year or whether it is going to exist. You have a whole host of issues. We also think of it as an opportunity if you tell people to have coverage.

I am not sure the transition is quite so traumatic as I think some people think it might be

because having employer-based coverage would satisfy the requirement. You don't have to go out and buy it all on your own. I think the transition, conceptually, could happen naturally. For people who don't have the employer-base, you might want to subsidize them a bit more for a short period of time than you do other people. 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 sort of a span of, well, if you are paying now, you have to keep paying for the next five years, but if you are not paying at all now, you are good to go. I think that has always been at the heart of the equity issues of employer-paid health care.

MR. MATTHEWS: I was just wondering, in your model, if an employer is already providing health care for those employees, what does that look like then?

MR. NICHOLS: Well, my model would be to leave the employers alone if they are happy. So you get a permanent exemption. You don't have any kind of requirement as long as you are doing it. I think that gets to 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 a 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.

What I am trying to do is to create a home or a haven, a place to go for those who are having a hard time out there and/or are finding the costs prohibitive.

MR. MATTHEWS: I wouldn't see that transition as being very difficult in that sense.

MR. HELMS: Then would you set a core for what that employer plan has to provide?

MR. NICHOLS: I would, and I would go back to both Todd and Andy. There is a lot of

very useful coincidence in thinking here today. There has got to be some kind of core definition of what we require. I think John's point of starting with primary care, that is a no-brainer. We start there. Maybe you add this or that around the edges, but certainly, you start there and then you build up to what, I would submit, you can afford or are willing to pay for. Yes, in my view, you need to have some kind of core defined. That will be where the rubber meets the road in Massachusetts, where they have to define what that is.

MR. MCCRACKEN: 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 a requirement that they have coverage themselves extremely burdensome or simply impossible to meet. This would involve very large transfers which to a significant degree we now finance through cross subsidies from wealthy employees to poor employees in the workplace, but we would have to find a way of doing it independently. That would imply, let's use the word, that five-letter word, taxes, in time, which is not a small barrier to be overcome.

The second obstacle that would need 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, get unbiased information and are helped to wade 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

presence in a previously private government activity.

You have two big mountains to climb, subsidies for those who can't afford and regulation of the market for insurance. 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 confront, are able to make informed choices.

That was not meant to be a conversation killer, by the way.

MR. AARON: Can I jump in on that?

I guess we are still back on the same issue of we are trying to bite the whole apple. We are looking at this, and our mindset is we are going to go after this. To your point, those who are below a certain level, we must cover them and for certain groups, we must be able to solve these things. What you are saying we need to solve is the whole thing. Right now, they don't have it, and we are somehow solving health care probably through emergency rooms. Why can't we start smaller?

MR. MCCRACKEN: I agree with you completely. There are some problems here that have to be overcome to make it real. I share your view which 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 the whole thing.

I think it is very difficult if you look at the political history of any democracy, certainly one with 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 evolve and change in response to pressures.

I actually found your emphasis on primary care to be quite intriguing in an area where I think a lot of progress could be made. It seems to me entirely plausible that certain parts of primary care ought 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 percent of the population covered strikes me as just kind of bizarre. I think there are a lot of areas where we could take small steps that would be definitely real successful.

MR. AARON: Have some success. Find a model, right.

MR. MCCRACKEN: Build some confidence that this is something where we know what we are doing.

MR. NICHOLS: If I could just jump in because I do think I gave you a little bit of fora there. I would say go back to Andy's characterization, which I think most of us who do this for a living share, and that is this system is creaking. If you look at the objective barometers on the system as a whole compared to 1991-1992, they are virtually the same 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 is the strain.

I agree with Henry. States can be great laboratories, great examples, and great catalysts. Massachusetts, there is no question. The Massachusetts conversation has transformed the way people perceive it. The American Medical Association — hello — this week proposed universal coverage with an individual mandate. They have never been willing to go that far toward government. Government is inevitably involved in this sort of thing.

All I am trying to say is I am all for incremental, but I don't want to wait until I am 70, and I

am closer than I would like to be. I also say, right now, there is this moment where more and more people recognize there is a compelling mutual self-interest in trying to reform.

Let me say one last thing. Who would have thought, a year before the Medicaid Drug Bill passed, 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 and Medicare beneficiaries had drugs. What really is going out the door is money for people who didn't have them and a substitution for what Medicaid was doing.

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 politicians' interest. I submit to you that what people are hearing out there on the hustings is telling those politicians, "You better solve this problem, or we are going to pick one that does." That is what will get us there.

MR. AARON: Let's hear from somebody who has not spoken.

MR. SMITH: I am emboldened by my colleagues referring to me earlier. I probably should just shut up at this point.

To pick up on what Len and Henry both have just said, I am kind of amazed and struck by this whole drug prescription thing under Medicaid for a number of reasons. I don't know whether the Democrats were playing some kind of game here. 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 suggests to me and maybe it reinforces Henry's point that if you can get the thing down at the states, maybe you could do more because that whole prescription was just an unbelievable pile-on and melee. It seems to have simmered down now. But when we look at it, was that a success or was it a debacle? The rhetoric and the political

nonsense that went on were just way out of proportion to what was done. How do we —

MR. MCCRACKEN: Address the question?

MR. SMITH: How do we replicate the kind of civil expert dialogue that we have had here and still get the politicians in the act?

MR. MCCRACKEN: Campaign finance reform. Next question.

MS. MARTINEZ: Hi, my name is Cecilia Martinez. I am with the Reform Institute. We work primarily on campaign finance reform. That is one of the issues that we are looking to work on as well.

My question is about physicians and how the current system, given the debacle in the eighties and the nineties, how specialized physicians are just not coming to the system anymore. Medical schools are seeing a shortage in doctors wanting to go into specializations because of all the issues that we have talked about today. I wonder how the individual mandate could help encourage and invigorate the young people who 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, with specializations.

MR. NICHOLS: Well, let's start with the AMA because they just supported this and must think something good is going to come out of it. I will defer to their overall judgment. 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 to include internal medicine. I see Greg nodding. Maybe he can add detail. Certainly, it is true that individual specialties are having trouble recruiting faculty in certain parts of the Country or recruiting physicians.

I think it is 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 have to go through to become one, and I think it is fair to say the malpractice cloud, if you will, is real. I think and I have looked at all the studies that have been done, the data would 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 is in the doctors' heads, it matters a lot. 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 I don't hold my breath for Mississippi. We will do it state by state, or we will do it as a Nation, and malpractice reform will be part of it. That is how we solve that problem.

MS. SMITH: Hi, I am Barbara Smith.

With respect to some of the financing issues that were raised, I have two questions. This will be the first one. I wonder if you perceive or believe that there will be some continued role for employers in the form of payroll taxes or some other form of business tax to contribute to the subsidies or some form of play or pay in the sense that employers who are providing substantial benefits then don't have to contribute to that, so they are not hit twice. I wonder what the future role of business is in the context of the individual mandate.

Secondly, with respect to the primary care benefit package, given the fact that roughly 85 percent of expenditures, medical expenditures, are driven by roughly 15 percent of the population that have very serious health care problems, does a primary care benefit package or a package that is built pretty much exclusively around that, at least in the first stages, really get to the major cost drivers in the system? What does that do for your ability to effectively manage chronic illness

which has been shown to really require a lot of specialty care?

MR. MATTHEWS: I will bite on that one. Why do you brush your teeth? So you are not part of that population that has major restorative work done on things. It is that idea that we need to go after.

I know our focus has been about trying to get these things done 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. If you look at the kids in America today, they are overweight. Their tendency towards diabetes is higher than it has ever been. They are going to have very serious problems with bones and joints and medical issues that are going to be on the table, and it is 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 we are going to find a way that we can get past that curve.

Until that time, we are going to continue to have our generation screw up and be part of that mess 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 population, a part of our population, and be successful with it and change the way we think about this.

MR. AARON: Could I just add one point? Let's grant the skepticism in your question, which in fact I largely share, the reason being that unlike our teeth, we are all going to die and we are going to fight hard not to. That is going to be expensive. Like the old gas commercial, you pay me now or you pay me later; that is true of health care.

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 and all vaccinated, their eyes are corrected at an early stage so they can learn to read, their

parents can go to work because they are not at home with illnesses that could be taken care of, and all the rest? That is a real plus, even if at the end of the day, it doesn't save anything.

MS. SMITH: The purpose of the question was not to denigrate the importance of primary care, but rather to say that can we really —

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

MS. SMITH: And it may not solve the health problem.

MR. AARON: It does a lot for a part of the health problem. I think the force of what Mr. Matthews was saying, and I think it is 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. Therefore, it is intrinsically valuable, and it does something for our ability to take the next step later on.

MR. MCCRACKEN: I will try to address your financing question. Our view is that the government is paying a lot of money right now to subsidize health care, primarily through the tax exclusion on health insurance. That exclusion needs to be extended to more people, that is to say, people who would be buying on their own in the individual market, but it needs to be less generous than it is, and there needs to be some kind of a cap on it. That will pay for part of it.

To the extent that we need to raise taxes beyond that to pay for the balance of the benefit, we don't think a payroll tax or anything like that would really make sense. That is relatively regressive and a tax on jobs. We think it should be a broad-based as possible kind of tax.

MR. CLEMENTE: Frank Clemente at Change to Win.

All the support for the individual mandate is troubling for me. My question is: Is that one of political expedience because you don't think anything essentially more, I guess, democratic

could be achieved, or is it really what you believe?

In other words, we have Medicare for 40-odd million people. Say, we move the entire Country under a Medicare-like system. It feels right to me. It feels like something the population would understand and has a lot of experience with it. It is more equitable and doesn't have all the excessive costs of the insurance industry. Jumping to the individual mandate, is that purely it is the way to achieve comprehensive coverage?

MR. NICHOLS: Great question. Others should chime in. I will 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. The third is the individual alone.

I think, as a technical matter, as a sort of policy matter, Medicare for all could work. You are 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 is really where I come out there. I think it is just not feasible.

I also would submit if you have ever really watched a Senate Finance markup closely, a 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 program for providers. Let's not forget that.

Then you have the employer. The employer in many ways is appealing. It is simple. We understand it. 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 have made a business model that works. Those who don't offer now are not immoral or mean; they are low wage employers. To put a requirement on them is, in 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 is about financing, I would rather design, as Todd just said, a more broad-based tax that did not penalize employment and did not penalize low wage workers. To me, the way you do that, I mean I would do it through a progressive consumption tax. You could do it through income tax rates, whatever. What is interesting is the amount of new money we really need to make an individual mandate work, I mean realistic estimates would be between \$100 and \$200 billion a year. That sounds like a lot of money in today's political environment, but we spend \$2 trillion on health care now. We are talking about a relatively small injection of funds.

I submit to you that those could be achieved in a more reasonable way. I look at individual mandate as the practical alternative that preserves American preference for choice and gets us universal.

MR. AARON: We will just take a couple more questions.

MR. GUSSMAN: My name is Monty Gussman(?). I came from Europe, and I am not related here, but I plan to engage.

As you know, in Europe there are a lot of sustainable plans which do work, and there were

huge funds allocated for this which you probably don't cover here which is disability prevention and rehabilitation funds. I have a question. During the health reforms in the future in the States, are there any plans to go about it?

MR. MCCRACKEN: Plans to?

MR. GUSSMAN: Rehabilitation and disability prevention because that is a part of European health care systems. For example, the case of Poland was very successful. There were huge funds allocated for these particular issues.

MR. MCCRACKEN: If the debate on acute care is in a primitive state in this Nation, the debate on long term care and rehabilitation is really —

MR. AARON: Unborn.

MR. MCCRACKEN: — unborn. I was looking for an appropriate adjective. There is, at the present time, I think no serious national discussion on the issue of how we would handle long term care which really encompasses what you are describing. It is something that is handled to some degree 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 are hypnotized, focused, and immobile on the issue of what to do about acute care.

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

MR. MCCRACKEN: Well, the one thing that I think there is attention now developing about is the early stage health habits that produce long term disease. 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. I promise you, by the time I am 71, I will have lost 25 pounds.

MR. MATTHEWS: There is another part of that too, and that is again going back to the education of the American population. What we found with our employee base is that we talked in terms of most of them who own homes all had homeowner's insurance, but the risk of a fire in a home is about 1 in 500. All who drove automobiles had automobile insurance, but the risk of damage to your vehicle is about 1 in 240. The risk of needing long term care and having some form of coverage is about 1 in 4 over the age of 55. Sometime between that age and the age of 75, 1 in 4 will 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 have purchased life insurance because people died. Now that we are able to keep them alive longer, there is not a means to provide the coverage for that type of condition. I think that is a part of the obligation too, where we need to become more aware of what these conditions are and address them early, but they can't do it if they don't know.

We set a program in place within Costco where 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 in through our purchasing power and buy it. Any employee that has been with us for 10 years or more, we buy it for them and put it in place. You can use purchasing power like that to make good deals and very affordable deals. 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 when we got going on this thing. I can

contribute to that for 25 years. If my wife or myself ever needs it, my payback is about four months. When you look at that, it is kind of a no-brainer. Why wouldn't you do it? Yet, most Americans are not even beginning to think in those modes.

MR. AARON: Are there any other questions?

Then, on behalf of all of us at the New America Foundation and Brookings, we want to thank our two speakers in this panel and, although he has left, our speaker in the first panel as well, Andy Stern, and all of you for coming.

Len, is there anything you would like to add?

MR. NICHOLS: Thank you for coming and keep singing the song of individual mandates.

(Applause)

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