Employer-Based Coverage: Shore It Up or Ship It Out
Alliance for Health Reform and Robert Wood Johnson Foundation
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ED HOWARD, J.D.: My name is Ed Howard, I'm with the Alliance for Health Reform, and I want to welcome you to this briefing on behalf of our chairman, J. Rockefeller; our co-chairman, Susan Collins; and the other members of the board. Briefings on one of the most difficult of the big picture questions in health policy today, and that is, what is the proper role for employers to pay in getting coverage to Americans? Our partner today is the Robert Wood Johnson Foundation, which is the country's largest philanthropy dedicated to health and healthcare improvements in this country. Nobody does more work on the subject of coverage and how to expand it than RWJ does. And you're going to hear from Andy Hyman in just a moment.

Employers are the major source of coverage in the United States, but it's a source that's been receding somewhat in this decade, and we're going to talk today about whether that trend is going to continue or accelerate or recede or level off, and in addition to what might happen, what should happen. That is, there are strengths and weaknesses to having most of us get our health insurance through our jobs, and we're going to explore those, hence the title, Should We Shore the System Up or Scrap It and Start Over?

I mentioned that the Robert Wood Johnson Foundation is co-sponsoring and supporting this briefing, and I want to

recognize the Foundation's representative today, its Senior Program Officer Andy Hyman, who will be sharing moderator duties with me as well. Andy, thanks for being here, and thanks to RWJ for their support and co-sponsorship.

ANDREW HYMAN: Thanks, Ed, and thanks to the Alliance for setting this up, working with us on many issues, and next year, your colleagues, your staff. So shore it up or ship it out, I see there's no middle ground; you didn't offer a third option. Well, with this outstanding panel, we have here today; we look forward to beginning to unravel this conundrum. Now, of course, this isn't a new question. The Robert Wood Johnson Foundation, and many of our grantees, many of you, have been studying the role of business in the role of health care in employer sponsored insurance and its sustainability for years in the context of healthcare reform. But this is a particularly exciting time to consider the issue, for indeed, it's not just a theoretical exercise. Policy makers, elected officials, political candidates, are confronting this question for real now. Governor Romney recently struck an important compromise to seal the deal in Massachusetts. It's at the heart of the debate in California, as Governor Schwarzenegger negotiates with the state legislature, and, of course, it's a question that Senator Clinton struggled with just before coming up with her plan this week. Now all of these folks, of course, opted to keep and build on the system in some manner. Now

others, such as Senators Wyden and Bennett, in their proposed legislation, the Healthy Americans Act, have chosen to abandon the employer-based insurance system. It's worth noting that the fate of ESI is critical in the SCHIP debate, as opponents of the Senate and House bills have argued that SCHIP crowds out employer sponsored insurance. A debatable claim, but it seems politically useful.

So what is the wiser course? To bolster this system and erect a reform plan on the shoulders of business, or abandon it, while finding an alternative, but soft landing for the 160 million Americans who rely on their employers for coverage? And today, our panel will help us confront these questions. What are the trends in ESI? Is it going the way of employee pensions? What are the options in terms of reform, what's the perspective for employers who are saddled with inflated health insurance costs, but who enjoy a health work force? And, of course, enjoy the flexibility of that tax treatment of health insurance affords. And what of employees who wear health benefits like a warm blanket, but are waiting for someone to pull that loose thread and unravel it? So this will certainly be a fine, interesting discussion, Ed, and you have the honor of introducing our folks up here.

ED HOWARD, J.D.: Thanks, Andy, and it is a terrific panel we have. Before I do that, I want to just go through a couple of logistical items that some of you have probably heard

a few hundred times. You have, in your packets, more extensive biographical information about each of our speakers, and we're going to have time to afford them in the introductions. I encourage you to look through that, and also through the rest of the materials. Lisa Swirski [misspelled?] and the others on our staff have done a terrific job in assembling things that are going to be useful for you in following up on the thoughts that are triggered by the discussion that you'll be sitting through today.

By Monday, you'll be able to watch a webcast, and with any luck, you'll be actually able to hear the people talk, thanks to the slight delay we had for mechanical corrections. On Kaisernetwork.org, along with electronic copies of all of the materials, you can look on our web site, allhealth.org for those materials, as well, and a link to the Kaiser webcast. There will be a transcript in a few days that you can use that many people find very useful.

At the appropriate time, you can pull out those green question cards and come and hold them up, and we'll let you be part of this conversation, or alternatively, you'll find microphones that you can use to ask questions directly. And, of course, we always appreciate your filling out the blue evaluation form that's right at the top on the right hand of your packets. Andy Hyman suggested that we keep the candy bars until after the discussion, and hand them to you as you hand us

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the filled out blue evaluation forms. So we may try that idea out. Or you can give us your comments about that idea on the evaluation form.

But we do, indeed, have a terrific panel, and I, let's get started without any more frivolity with Paul Fronstin. Paul is a senior research associate at the Employee Benefit Research Institute, which is a non-profit research and education group that's such a great source of information on economic security and employee benefits issues in this town. They are the "choose to save" folks, if you have heard some of, and seen some of those ads. Paul understands the employer sponsored healthcare situation as well as anybody in this town. He's been holding a series of conversations with top corporate officials on the very topic of our discussion today, so his knowledge is both extensive and intensive and timely. And thanks for sharing it with us today, Paul. Paul?

PAUL FRONSTIN: Thanks, Ed. I've been thinking about this a lot and asked about it a lot, so I wanted to get this phrase into the title of my presentation, the tipping point, Is the Erosion in Employee-Based Coverage the Tipping Point? Everyone thinks it is, and they've been characterizing it a number of different ways. They've said that the employer based coverage is vanishing, employers are fleeing the system, employer-based healthcare is ending; it is dying in front of our very eyes. And this is my favorite. Employer-based health

coverage is melting away like a Popsicle on the summer sidewalk. These are all quotes, I was hesitant to title this slide Headlines, because it's not the headlines yet, but for those of us that think about this on a regular basis, these are becoming the headlines. And anyone who is interested in where these quotes come from, just send me an email, I'll send you the exact citation. These are the exact quotes, I didn't make them up, I didn't paraphrase them.

But this is what we're hearing, and the reason why we're hearing these quotes, is because of charts like these, where you see that the percentage of small businesses, especially, that are offering health benefits, has dropped. It's a steady drop, falling from about 68-percent in 2000, to 59-percent in 2007. I purposefully used a scale on the Y axis that goes from 57 to 69-percent to make a point, because it looks like a huge drop when you use the scale. When you use a scale that goes from zero to 80, it doesn't look as large.

That's not to minimize the fact that about, you know, there's about 10 percentage points fewer employers offering coverage amongst small businesses. But it's to put it into context, and also to put it in context of what happened before 2000? That part of the story is also often ignored, and you can see that between 1996 and 2000, the percentage of small businesses offering coverage actually increased. It increased from 59 to 68-percent. So essentially, we're back where we

were back in 1996. So it took about 11 or 12 years to get back to where we were.

Does that mean this trend is going to continue down or, at some point, reverse itself? Well, certainly it seems to have flattened out the last few years. I would argue that it's flattened out because we're back to a very strong economy. In the late 90s, one of the reasons why coverage expanded, offer rates expanded among employers was because we had unemployment rates around four percent. If I'm remembering correctly, the unemployment rate actually reached 3.8-percent in late 2000. And small businesses were doing what they had to do to compete for workers. They were adding health benefits.

I think we're at that point where if our unemployment rate gets down to about four percent, I think we're at about 4.5 or 4.6 right now, we may see a reversal of this trend.

In terms of worker eligibility and take up rates, if you look at the bottom line on the chart, you see that eligibility for health benefits has fallen some. If you go all the way back to 1988, which we can do with this time series, you can see that it's almost a four percentage point decline. If you start in the early 90s, 1993, where most of the data goes back to, you see that it's less than a two percentage point decline, so two percentage point decline over the course of about 14 years.

You can see a similar trend with respect to worker take up rates falling from 88-percent back in 1988, down to 83.5-percent in 2005. One thing to note is that of the 17 or 16 percent or so of workers who don't take coverage from their employer when it's offered, only about five percent go uninsured. Most of those workers, myself included, get their coverage from somebody else, in most cases a working spouse.

When you look at the percentage of workers who have coverage over this long time frame, you can see it's been relatively constant, between 1994 and 2000, bounced around between 73 and 75-percent. Since 2000, it's fallen down to about 71-percent. Again, when you use a scale that goes from zero to 90, it doesn't look like much of a change. When you ignore the data prior to 2000 and change the scale from 70 to 76-percent on the Y axis, it looks like a huge erosion in coverage among workers.

There has been erosion in coverage in other ways, it's not just about whether or not employers are offering coverage, or whether workers have coverage. Employers can erode coverage not by changing offers, but by changing what they're offering. And we've certainly seen erosion in the benefit package, as well as, to some degree, employee shifting costs on to employees in terms of premiums.

In this chart, we compare increases in premiums for employee only coverage, family coverage with increases in the

current price index, and you certainly see that the worker payments for family coverage have been increasing faster than overall inflation. You don't see that for individual coverage, it's about the same rate of increase. But when you start to look within the benefits package at things like deductibles, you do see increases in deductibles.

Back in 2000, only 14-percent of workers had a deductible of $500 or more. By 2006, that was up to 38-percent. When you look at co payments for office visits, over a shorter period of time, 2004 to 2006, you see the percentage of workers with a copayment of $20 or more, increased from 39-percent to 53-percent, and you see a similar trend when you're looking at co-payments for prescription drugs.

So going back to the characterizations, with the headlines, on employment based coverage, what you believe really depends upon what you think about the data, at least as far as where we've been so far. Not trying to minimize the fact that there's some real issues with the system, in general, people like their health benefits, but they're very concerned. They think the system has some major problems, and they're very concerned about the future of that system. And we're all starting to hear about various employer associations that are offering proposals to essentially change what we've known as a status quo when it comes to providing health benefits in the work place.

At the same time, we're seeing employers, you can call it investing in the system, or positioning themselves to help workers in the future, basically navigate the system on their own. You've got organizations like the Leap Frog Group, like The Consumer Purchaser and Discloser Project, the Human Resources Policy Association Purchasing Coalitions, as well as the AQA Alliance, that are all investing at tremendous amount of money to try and provide more tools and resources for workers to make informed decisions about health benefits, about healthcare, and to give people options when it comes to purchasing coverage.

So there is a lot going on, I know the rest of the panel is going to address sort of where we're going. I think it's unclear at this point whether or not, and you'll hear more about this, whether or not employers think we've reached the tipping point. They're starting to think about it, I'm not sure that they've concluded that we're there yet, but it's certainly on their mind.

ED HOWARD, J.D.: Great, thank you, Paul. We're going to turn now to Bob Galvin. Bob is Director of Global Healthcare for General Electric. He is a physician, who also holds an MBA, which I guess is a combination that comes in handy when you're managing $3 billion worth of health benefits for GE's employees. Paul mentioned the Leap Frog Group, Bob is a founder of the Leap Frog group; he also is the founder of

Bridges to Excellence, and these are two, I think, shining examples of how employers can help improve the quality of healthcare that their workers receive, as well as hold down the costs they have to pay. And Bob has been responsible for hauling a lot of his colleagues in the corporate community down toward looking at those factors, as well as holding down their own costs. So thanks for all of that work, and thanks for being with us today.

ROBERT GALVIN, M.D.: Thank you. You know, I think we'd all like to think that you came to listen to us, but the free lunch probably had something to do with it. But I'm glad to see everybody here, and thank you, Ed.

Just a kind of a piece of explanation first, the company for which I work, GE, has one of its businesses is in the healthcare space. So we sell engineering equipment and IT. The part of GE I work in, and the decisions I make, actually have nothing to do with that business. I'm there to protect the employees and manage kind of what we spend in the quality of care. In some of the other businesses in GE, we still make refrigerators, appliances, and light bulbs, and they're very interested in watching healthcare costs controlled.

You can see I put up there a piece I wrote recently that talked about the employer mindset being between a rock and a hard place, and I'm going to base my comments on that piece. If I had chosen a different title today, it would have been one

of my favorite quotes from Abraham Lincoln, and I've always used this. And his quote was, "If I had eight hours to chop down a tree, I'd spend the first six sharpening the ax." And I think reform is in the air, I think those of us that care about healthcare are very excited about it. But I think how we frame the discussion and how we go in to having the debate, which I really hope we have over the next couple of years, is important.

So you can see the points I'm going to focus on today. I'm going to talk about stratify or die, I'm going to talk about you break it, you own it, I am going to give a little bit of a heads up about messing with ERISA, and then just a minute about framing how we ought to talk about reform.

So I think that, I think that after listening to Paul, you know, there really has the erosion, I think he gave very good data. so the question is, at the end of the day, if we were to poll employers, and I'm with them all the time, the question is, do they themselves want to preserve employee sponsored insurance, ESI, or do they want to find an exit strategy? And I think the answer is important, because the answer is yes. And that's the point is that you have to stratify. I think if you approach employers as a monolith, as we talk about reform, reform is going to die. And I think that, although employers agree on a lot across the board, one place where they differ, and it tends to be based on their

size, is on whether they want to stay in this game or whether they want to exit this game. And I think the larger employers, who, as Paul showed, have been steadily offering this, are more reluctant to get out of it, and are really questioning whether whatever would replace it would be better, whereas those in the very small businesses, I think would like to find an option. So I just, it's nothing that we don't all know, but it always impresses me, up until very lately in some of these new proposals coming out, how much the fact that we all know it, very few of the reform efforts and proposals in the past few years, have recognized it. So that's what I think I mean by stratify or die.

Now let me take off kind of my employer hat for a second, let's just talk about health policy, because I think this is crucial, which is, is employer sponsored insurance good or bad for the healthcare system, because I think it's important that we do the right thing going ahead. And again, I'm going to give you a definite maybe. I think it is both good and bad for the healthcare system, and let me talk about that a little bit so we can use that to get to something. We clearly know the negatives and they're real. I'm not here to defend ESI today, I'm here to frame the debate that we ought to be having, and there are clearly negatives. I mean the fact that it's voluntary leads to uninsurance. We know that, it leads to issues with portability, leaving work if you don't

think your next employer is going to cover, particularly if you have a disease when you leave.

And third, the administrative complexity, we all know this. I think what tends to get kind of less appreciated is that there really are some positive that I think employer sponsored insurance bring to the table. I think people, the 160 million people covered under ESI, certainly the 90 or 100 million who are in self-funded and self-insured plans, find that the responsiveness they get is pretty impressive. Satisfaction surveys are high, you know, there's an argument that making a risk pool smaller than the entire country can lead to more responsiveness. People email me all the time, we still have about 170,000 employees in the states, and I, and my team, are getting emails all the time, and part of me keeping my job, depends on how responsive I am, and whether our employees and their families like what we offer.

I think it really has led to some innovations. I don't, when you look at other countries, the number of integrated delivery systems, like Kaiser Permanente, or Group Health at Puget Sound, are much fewer. The whole valued purchasing agenda, in terms of not just focusing on cost containment, but really kind of morphing that into thinking about value. The payment reform efforts at Bridges to Excellence started the transparency efforts from Leap Frog, I think, are all examples of some unique contributions that

employers bring, and it's partially because those of us that are in this game, and large enough to be able to address it, realize that how healthy our workers are makes a difference in how productive they are. So we really have an economic interest in making the benefits good.

And I think the third is, and it's important that we're not bound by politics. Medicare part D which I, just so you know, I happen to be in favor of, has so many options in every market, that we would never do anything like that. In fact, our employees tell us they want a few different options per market, and that's what they get. And those of you who either worked on the policy, or have parent's who are in this, will know how difficult it is. When I go visit my parents, they live in a very nice assisted living facility down in Florida, it's as if someone sends out a blast email that I'm in the house, and I spend most of the first day working on the broadband computer there, helping all of kind of the Smith's and the Gottlieb's, and the families, try and figure out what to do. And it's actually not simple to do.

So I think it wouldn't be to me intellectually helpful and constructive to say it's just negative. I think there are real positives we have to think about.

Now that's the big picture. Let me kind of move down from the big picture to ground level. And I am going to kind of use a quote and with respective, this is not kind of a

military discussion we're having, but I'm taken with the concept about kind of, if you break it, you own it, and let me tell you what I mean by that. You know, employer's in healthcare has often been called an accidental system, and I think most of you know the history of how it happened in World War II, et cetera. You know, there's a counter veiling idea, my wife happens to be an emergency physician, and among people who work in that area, they have a quote that there are no accidents. There is no such thing as an accident, that things happen for a reason. And you think of the quote that's just below it, it's one of my favorites from Don Warwick, which is every system is perfectly designed to deliver the results it delivers. And what do I mean by that? I think the fact that employer sponsored insurance has existed for 60 and almost 70 years, means it isn't just large interests that have stopped it from changing. I think it does something in this country that meets some of our values. I think the kind of suspiciousness of government control, I think the idea that people believe in markets, and I think the third thing is very important. I think, and certainly my employee base, and I haven't seen anything different, people want to use our capacity as a country to come up with innovations, and medical innovations, and medical discoveries. I'd be surprised if almost everyone in this room hadn't either benefited from it, or have a family member that benefited from some of these innovations. And so I

think that we ought to be careful about taking 160 million people who are personally satisfied, and if you believe the system has existed as long as it has because it's meeting some needs of the country, I think one ought to be cautious.

And the chart up there is something the Lewen Group [misspelled?] made popular. It's called the cost shift hydraulic. And what it basically shows is that government programs tend to underpay doctors and hospitals. And for doctors and hospitals to be able to have a margin, they shift the cost to the private sector. Now we argue on the private sector that we don't particularly like that. I don't hear it much, but my understanding is I don't think Medicare would be as popular without this cost shift. But I would argue this isn't by chance. There are very good reasons why this dynamic exists, and I just think we ought to be very cautious and have some good answers before we break it.

The third piece is pretty simple. And that's don't mess with ERISA. I think what you're going to find, where employers might be split on staying in the game. They're not going to be split at all about maintaining ERISA. Again, you have this 80, 90, 100 million people who are under plans that are truly self funded, are largely satisfied. From our point of view, it's going to make our ability to focus on stuff like quality and value, much more difficult to do if we have a whole number of administrative, add more administrative complexity.

You might not know it, but when Massachusetts makes a law, and then California does, and Vermont does, and then Pennsylvania might, even if it sounds similar that it's a percent of payroll, you know they want you to have a benefit designed that meets a certain percent of payroll. You know, payroll is defined differently in every one of those states. And that means that we, then, have to kind of hire workers and spend money saying, well, in Massachusetts, a full time worker is 19 hours or more, in Pennsylvania, it's a different number. These count variable instead of compensation, those don't. So I think that would really be a nightmare for us, and if you go back and look at the testimony, which I've done, when ERISA was voted in, things really haven't changed in those 35 years.

And I think my third point is pretty direct, but I do think that eroding what works to fix what doesn't, is just not going to end up, I think, as a policy approach that's going to have legs. And I think employers are really united on this topic.

Let me speak real briefly about reform. And I mentioned I'm very excited about it, and I think a lot of employers are, but you know, addressing access alone really isn't health reform, its access reform. And I think the private sector employers are unanimous on this too, that you really can't do one without the other. Now offering access into a system that has as many flaws as ours does in terms of

value, cost, and quality, is going to be a short term solution that's going to end us in trouble. And that kind of talking about cost and quality, I mean, some of the reform proposals do it say form a committee at the state level. And that always worries me, because I'm never sure what's going to happen with that committee. But it's just broadly one of the ways I think you're going to see employers look at reform proposals over the next couple of years, is going to be whether they truly wrestle with the system. The quality and cost issues, in addition to access, which is obviously very, very important.

Now one of the things that we champion on the private side, and you know CMS, and this last administration, we've really been partners in this, is how important information is. And I just show this slide, it's an old slide, I put this together years and years ago, and it's President Clinton, obviously, and what that shows is when he needed his heart surgery, remember that years ago, he actually had his choice of hospitals in the New York area. And New York State happens to have some of the best data on quality, around quality, of its hospitals, and actually for a couple procedures of its doctors. It's actually physician done, the state, it's been around for about 15 years. That kind of fancy talk to the right, the risk adjusted mortality rate, it is just basically to say, you know, an 82-year old that comes in is obviously going to be more complicated than a 56 or 58-year old that comes in. So you

risk adjust for that. Those numbers are simply showing you what percent of people are going to be alive, or what percent of people are going to be dead 30 days after the surgery. It isn't the greatest measure we have, but it is dramatic that in an area where these hospitals are just a few miles apart, these are not, other than a rush hour, are actually easily accessible to each other. You had huge differences at this time between Columbia Presbyterian, which by the way has subsequently improved its numbers quite a bit, and Cornell. You can see the surgeon down below. The issue is not to me who's doing well and who isn't doing well. But if we don't have an addressing quality and cost, some kind of staple that we need to get information out, and that we need to pay differently, I think you're going to find employers kind of less warm than they would otherwise be when it comes to looking and backing reform.

So finally, just to end this, how are employers going to decide? It's going to be very specific. And so at the end of the day, kind of, we're going to look particularly for shared responsibility, for the fact am I better off, and at the end of the day, it really has to help run the business. And with that, I'm a little over, so thank you.

ED HOWARD, J.D.: Thanks Bob. Next we're going to hear from Gerry Shea, who is the Assistant to President John Sweeney of the AFL-CIO, and before joining the AFL in 1993, Gerry spent 21 years with the Service Employees Union. He's the labor

movement's thoughtful voice on, in such forums as the National Quality Forum, the Joint Commission, the Hospital Quality Alliance. He's been a member of MedPac, which advises congress on Medicare issues and he's here today to advise us on how workers view the employer sponsored insurance system as it exists today, and how it might look in the future. Gerry?

GERRY SHEA: Thank you, Ed, and good afternoon. I'm pleased to be joining my colleagues on this panel, and I want to congratulate both the Alliance and the Foundation for sponsoring this and so many other terrific programs to bring information to people who, like you, have to wrestle with the difficult policy decisions around health care.

Like the two preceding speakers, Paul and Bob, I have a basically positive view of employment sponsored health benefits. But I want to give you a slightly different perspective, I think, from the ones that they presented, and that is that even though we continue to see high levels of coverage, we are paying a bigger and bigger price every day for this system. And frankly, from our experience, the system is deteriorating rapidly and is at pretty high risk.

And the reason is pretty simple. From workers' perspective, and workers' experiences, this is just costing us more and more money. It's more money out of individual's paychecks, out of the family budgets, it's also more and more money out of employers, and it is having a direct impact on the

standard of living. You see the difference in this chart, it's been shown before, it's commonly used, and it just states the obvious fact that we have an imbalance between healthcare costs, inflation, and the other major economic trends.

Now unions bargain health benefits for about 15 million active workers and four to five million retirees. It's a total population of about 50 million covered lives, and we do that in bargaining situations, very large, like the auto workers are now doing with the three large automobile employers, and small, you know, 50 to 100 person units. And all of those negotiations, though, for a number of years, healthcare has been the most vexing problem in terms of the economics of bargaining.

And as union members will tell you, we're the lucky ones. We have maintained comprehensive benefits with very modest contributions, rates, by and large, for union members, but that's come at a real price. I mean, in some cases, we haven't been able to maintain good benefits at modest cost to workers and families. We've had to pay through the nose like a lot of people outside of our ranks have done. But in those cases where we have maintained benefits, we've traded off wages, and in some cases, we've traded off jobs and plants. You'll hear the stories from union negotiators who said the employer said to me across the table, if you insist, we don't want to go through a strike situation, if you insist, we'll

maintain this level of health benefits, but we will simply increase the number of jobs we ship offshore.

So there is really a dramatic impact on the experience that people have, and it has, as Paul points out, even where the premium contributions, although they have been rising, even where people have been protected from that impact, everybody is paying more and more in terms of out of pocket costs. And that's where the real impact is made, and for some people, that's just a discomforting shift in how they have to align the budget. For other people, it means that they go without care in many situations, particularly when you look at low wage workers.

But even if you look at people at the sort of high middle range of hourly payment, you're looking at a significant impact on their economic situations. And the total result of this is a very high degree of anxiety, economic anxiety, among workers. That's sort of widely recognized, but I think its worth reflecting, as you think about sort of the policy decisions in your case, it's how big the ramifications of this are. We've lost entire industries. Now in many industries, apparel, toys, even food, we can import these things, we import them fairly easily.

If you put aside all the safety issues, which you know, recently have come to the fore, you know, maybe that's just the global economy at work, there's no big deal. When you think

about, though, what it means in terms of certain industries that are integral to our national strength and securities, specialized steel, technology, where we no longer have the production capacity, it takes on a sort of different dimension. And I think this anxiety level runs so deep that you see it in the trade discussions that the people you work for are actively involved in.

Are we going to add trade pacts to increase the global, the openness in the global economy? Well, there's a lot of resistance, a lot more resistance these days, and I want to suggest to you that one of the reasons is the high health costs that American workers are paying, and how they fear that they could go to a job, if their job doesn't exist next year, the one they had. They could be going to a job that doesn't provide health care. And this is, after all, the backbone of our health insurance system.

A lot has been written about the costs that employers pay who do provide benefits in terms of competition, and I just want to make the point that that's both a global phenomenon, and a domestic phenomenon. You look at what's happening in the retail food industry, it is similar to what's happening in basic manufacturing in terms of the intensity of the competition, based on whether or not you're providing good wages and good benefits.

Despite all this, we maintain a very strong attachment to the notion that health benefits should be tied to the work place. For good or for ill, that is really deeply embedded in the way that workers look at their own situation and their economic benefits, and its also, as Bob points out, embedded in the way many employers, if not all employers, look at their responsibilities. And this, I think it's worth sort of spending a minute looking at why this it. And I would say some of it is not complicated, it's inertia, this is the system that we grew up, again, as Bob points out, since World War II, it's what we know, it's what we're comfortable with. But I think there's a, and workers, looking at the ideas that are being bandied about, I think workers, at least in my experience, often relate this to what's happened to private pensions. We made a huge shift from the traditional so called defined benefit pension plans, to the defined contribution plans. And while we've had a lot of success in building up 401K individual accounts to supplement basic pensions, it has not worked very well as a replacement for defined benefit pensions, for those people up to even high average wage levels, I would submit to you. It just doesn't work to replace the amount of, the people that are able to take advantage of this, as all the studies show, really aren't very many until you get into the upper end.

But I think the most significant thing is that employment based healthcare coverage is part of our culture

about healthcare. It's local, it's something that happens at my work site, or at least with my employer, and my union, if there is one. You have the family doctor, the personal physician, the local hospital, even. In Washington DC, we all have our local hospitals, whatever one you choose, the one that you would want to go to. And that's the same with the employment based health coverage to a certain extent now. those of us who have had experience with the vagaries and bureaucracies of big insurance companies, you know, tend to think differently about this, but still there's a notion about sort of a local connection, and certainly, as we talk to our members, and we talk about the idea of changing the way healthcare is financed and delivered, they totally support the notion that everybody in this country ought to have healthcare. That's a moral value. But very quickly, the follow it by saying to us, but we want to know what that means for those of us who have insurance, who have coverage now. What is it going to mean if you go to a stronger government role? We hope you're not talking about turning us over to the government to run our health coverage in all the ways that have been talked about in the political debate.

So where does this leave us in terms of the policy situation? Well, I wanted to suggest to you a couple of things, which might be useful to your thinking as you sort of go forward, and as Bob points out, this issue is obviously back

at the center stage of the national politics, it's going to be a major part of the presidential and congressional debates leading up to 2008 elections, and we're going to face, I think, a different situation in the 2009 Congress when it convenes. I would suggest to you that the sum total of what we know about employment based coverage, both its frailty and its standing, its good standing with people, suggest a policy force which should be judged by what we, judged by whether or not a certain policy strengthens employment based coverage, and helps a change process that would be gradual, or it threatens employment based coverage by training to turn it upside down. That's certainly the approach that we're taking.

You know, a lot of us, frankly, if we had our druthers, would be in a single payer kind of system. It's not going to happen in terms of getting support across the American population. But on the other hand, there is a way of looking at policies that reinforce and strengthen the coverage that we now have, through things like large pools. We're supporting the notion that people should be able to buy into a Medicare like kind of program, or have a range of options, patented after the FEHBP [misspelled?] kind of formulary, and administered in a similar kind of way, as one option.

And then secondly, I think that, and very immediately, we need to focus on what can be done to help this very important process that has been going on for a few years that

has involved employers unions, consumer groups, and government, to improve the way healthcare is structures, and make it much more value based and quality oriented. This is enormously important because, from our point of view, this, if the battle is over who's paying the bill, we all lose, because nobody can afford the current system that we have. We have to be working together on how we can restructure this to make it a more efficient, less wasteful, and more effective kind of system. And you have before you, or your bosses do, proposals along those lines, whether it's the investment and information technology, or it's the funding for the resource, the quality resource infrastructure that's going on. And I think that's just really, really important.

And I would say second, lastly, this is important not only substantively, I think it is very important politically, because this collegial effort that goes across government agencies at a federal and state level, employers, providers, physicians, is really different from the tradition we've had over the past couple of decades about coverage and access. It is not a polarizing discussion, politically. And that is really a precious thing, and we should do what we can, I think you should do what you can, to reinforce that and to help move it along, because I think it could give us the foundation for maybe tackling the very tough issues about how do we get the universal coverage without having us go into this zone which,

unfortunately, I've already seen in some of the presidential debates where, you know, one persons universal coverage is somebody else's socialized medicine. That's just a killer way to define this discussion, and I hope we can do better in the coming 15 months. Thanks very much.

ED HOWARD, J.D.: Thank you, Gerry. Gerry noted that he and Paul and Bob generally find some favor in the employer sponsored insurance side of this. Lest you think that our panel is not diverse, let me point out we have four people up here with beards and two without, gray suits, blue suits, black suits. But seriously folks, we're going to hear from Len Nichols, who directs the Health Policy Program at the New American Foundation. Len is an economist who's been looking at healthcare from a variety of positions over the years, academia, in some of the most prominent think tanks in town, at senior levels of OMB, as part of the health reform effort in the early 90s, he testifies at more congressional hearings than I've ever attended, and he, in the interest of diversity, has published a health reform plan himself, as part of the Hamilton Project at Brookings, that recommends less reliance on employers as a source of health coverage, he is the leavening, perhaps, in this discussion, and we'll open up some question lines that might get us into a lively discussion. So, Len, take us away from all this.

LEN NICHOLS: Well, thanks, Ed, and it's a privilege to be here, and let me just say that, to make it clear, I'm not here to bury the employer health care system, I'm here to praise it. But think of this, perhaps, as the first of many retirement dinner speeches, about how we ought to think about praising it so much it does go gently into that good night.

Basically, what I want to talk about specifically is why are we having this discussion now, why is health reform suddenly pumping up? A little bit about the competing visions, and the nightmares those visions engender, and then I'll just offer some facts, and a few arguments for your consideration, as we think about the role of the employer going forward, and then I'll lay out what I think is a fairly reasonable, and arguably emerging, consensus pathway to the future.

Now Paul did a great job with the numbers, so I'm going to skip a bunch of these.

ED HOWARD, J.D.: Oh, I just wanted to say, you won't find Len's slides in your packets, but they will be posted on our web site immediately after this, so you don't have to scribble down every thing you see on the screen.

LEN NICHOLS: It's okay, and it's my fault they're late, it's all my fault. But let me just say, this is the graph that I think you definitely want to think about, because this is the reason we're having this discussion now. What this shows is the relationship of a family premium to median family

income. And in 1987, and don't ask me why 1987, it's a year for which we have great data, I don't know exactly what the year was, the Cardinals won the world series, I'm still researching why '87 was this year, but we have this data.

Anyway, family policy then was about seven percent of median family income. Remember, that's an income in the exact middle of the distribution. Today it's 17, and it's rising every year, and it's fundamentally that divergence in growth in health care costs per person, and productivity in the economy per person. That divergence is what's driving this widespread concern. And I say we'll skip all these, as Paul hit them in many ways. I want to make sure you have them.

So what's different today from '93, '94? Well, that premium income ratio is huge. In '93, '94, you might have heard this rumor, health care was an issue in the '92 campaign. And, in fact, there was a lot of solid polling, showing support for health care reform and for coverage expansion. But that was because the middle class feared affordability of health care because of the deep and recent recession. Once the recession went away, which fairly early in the Clinton administration it did, support for that wholesale reform kind of dropped. It was even before the 1,500 page bill hit the street, that reform support was beginning to decline.

People feared affordability because of the recession. Today, we have the strongest macro economy. I was taught in

graduate school we couldn't sustain unemployment rates this low, this long, right? DePaul's, you were taught this, too, okay? So what's the deal? We now have the strongest macro economy in the history of man, and people are afraid of affordability? Why? Because costs are growing so much faster than income, that is what's driving this conversation.

The second big difference today then, is that employers and businesses in general, are much more focused on international competition. They're much more worried about it, I'm going to have some specific details to say about that. I will just say this is the single biggest reason you see so many business coalitions forming, so many businesses thinking hard about how to get behind a constructive piece of that conversation Gerry just called for.

Finally, our third, I would say there's much more awareness of spotty quality. You know, 15, 17 years ago, we didn't know much about differential infection rates in hospitals, we didn't know hospitals killed you with medication errors. Bob knew and he was trying to fix it ahead of all of us. But most of us didn't know that, and that awareness has spread. And I would say the good news is that awareness has spread and we're much more focused on that.

And finally, I would say the stress within the system. And it's not just the 47 million uninsured, although they clearly are important, and a fundamental moral issue. But it

is also the fact that emergency capacity is shrinking. It's also the fact that you have to wait longer, that ER diversions are very common, and I, you know, trauma surgeons all across the country will tell you people are dying in ambulances, going from hospital to hospital. So fundamentally, the stresses in the system are much more clear, much more widespread, and it seemed to be driven much closer to home.

So what are the visions, and then the nightmares? I submit to you that there are three rough competing ideas here. And when I say free, I mean free markets, that would be the pure form of this, and that would be to relieve all, all market participants from any possible encumbrance the crazies can come up with in Washington or state capitals.

And I would submit to you the quantification of this is in the Shaddick Dement [misspelled?] bill, which would allow insurers to sell anywhere in the country, based upon the rules of any single state so that you could, in essence, find a state with no regulation and sell anywhere in the country. I can think of no more consistent vision, with the pure market ideology than that idea. And I can also think of no quicker path to single payer than having 180 million Americans suddenly find out that their health condition matters a lot to what they are going to be paying for health insurance. It would be the single quickest way to pull this off.

The alternative vision, of course, is 180 degrees opposite, is single payer, and I won't belabor the point, Gerry already said it ain't going to happen. It is interesting how many people think it could happen, and I would say its useful to have visions, and its useful to think about what single payer could do, but I would say if you really think it could work, come with me one time to a senate finance mark up, and what you will see is a description of a program that's designed for the most vulnerable, who cannot buy insurance in our population, which is really an income support program for mediocre providers. And that is the fundamental deal.

The third, of course, is the way we're going to go, and that is some combination of individual and shared responsibility, but note it also has its concurrent nightmares. And they are what if the regulations get too complex, what if, indeed, we end up with something close to, God forbid, rationing by bureaucrats. So we've got to be careful about the rules, write this down, both God and the devil are in the details of the rules going with this thing.

Okay, now, I'm going to ask you a little polling question. What do these people have in common? Romney, at least when he was governor; Schwarzenegger; Edwards, the senator running for President; Senator Clinton; Wyden-Bennett; Federation of American Hospitals, lest you forget, this is run by Chip Con, Chip Con who invented Harry and Louise. And if

you don’t know about Harry and Louise, meet me at the bar afterwards, I’ll tell you all about it. But it had a lot to do with defeating the ’93, ’94 ERISA industry committee. Bob is absolutely right, they are going to fight hard to prevent ERISA from being eroded, but they’ve been, they’ve offered their own plan, and what these folks all have in common is they embrace the concept of individual plus shared responsibility, which means really, what? It means we’re going to try to cover everybody, it means we’re going to build new market places at work for everybody, it means there is a fundamental centrality of individual responsibility, responsible for your own health, and participating in your own health insurance somehow. It means that the employer is one, but not the main; it is one of many different financing alternatives, okay? And there’s lots of ways to play the game, and there is in all of them, although to some lesser and greater degrees, a focus on long term cost containment. Because Bob is absolutely right, if we don’t figure out how to buy health care smarter, if we don’t figure out how to make our system more efficient, trust me, none of us is going to be able to afford health care in the long run, with the possible exception of Bob and Ed himself.

And so, at the end of the day, we’ve got to pull this off. Now why am I skeptical of continuing the employer financing role, as great as it is? And it comes down to my simple economist hat. I’m worried about competitiveness. You

know, I'm a lucky guy, I get to give talks about health care all across the country. And that leads me to listen to questions that are actually amazingly profound sometimes. And one of them came from one of those classic, flinty eyed, Midwestern businessman. You know, he listened to my little keynote really, and he goes, okay, I get it. I know how to solve my problem. I'm moving my jobs overseas. But my question is this. Who is going to buy my stuff? I mean, this guy did the math, the played the chess, he said if everybody moves their jobs overseas, what's going to be left in America to buy the stuff I'm going to build cheaper in china or wherever? So I submit to you, if we don't figure out how to get this health care cost animal under some kind of control, we're all going to be working at Wal-Mart, not buying what's coming in over the borders.

Now, interestingly, and I must say, I take some responsibility for this since I am an economist, and most days I'm proud of that, but my profession, let's just be frank, is wrong on this point. Because my profession says, oh, competitiveness can't be a problem, it cannot be a problem. You see, economists are people, you know, who see things happening perfectly clearly in real life, and rush breathlessly back to the office to work out the math to see if its possible, you see. And so, economists say, it can't possibly be a problem because ultimately it just comes out of wages. We know

in long term equilibrium, that's true. So it can't be a problem. Well, but CEOs say, wait a minute, sports fans, this is a big problem. Now unlike most of my profession, I am humble enough, and just sort of, you know, country enough, to be timid about telling people who make between 20 and 1,000 times what I make, if they're stupid, I just have a hard time doing that. These guys are not stupid, and this proves it.

Okay, what you have here lots of numbers, and there's a paper that will be coming out, we'll have a site for it later. But fundamentally, what this shows is, look on the right hand column. Hourly costs of health benefits and manufacturing across some of our, these are, the parenthesis, by the way, are the number one trading partner, number four, number five, et cetera. So United States is here, the trade wage average across all countries is 96 cents, and we're at 2.38, that about sums it up.

Now interestingly, wages are fairly comparable, I was kind of surprised, actually, the Brits are not doing as bad as we think. You know this, because you manufacture over there. But look at their health care costs versus us. Germany and France are the two closest to us, and France just elected, you know, basically a conservative guy who is going to emphasize the economy. And Germany had a very serious debate of the role of employers going forward in the last election year.

So I submit to you we're paying a heck of a lot more than other countries, and it turns out, it's really hard to shift. This is the source page, and again, it's going to be on the web site, so you can have it. If you can't get it, you can send me an email.

But here's what I want to get to, these are the arguments. The burden of health care costs is not being shifted from employers completely; they're not fully shifting it. The theory works in the long run. You might have heard this rumor, we live in the short run. And CEOs really live in the short run; they live just about three months at a time. Basically it's hard to push it backwards into wages, because of the labor market norms. If health care costs are growing way faster than productivity, then to push it all into wages, some years, you'd have to make wage growth negative. And you can ask Gerry how fun that is. That is not going to happen in most situations.

So fundamentally, what employers may say when economists work out in their little models is, oh well, they push it through in the long run, so it may take three years to do this. Yes, the problem is, next year it comes again, next year it comes again at 12-percent, and wages and productivity are growing at four percent.

So at the end of the day, what you've got is a sequential problem you can never solve. You're constantly

bombarded with high differential growth rates in health care versus productivity, and so we never get the long run equilibrium where the economists drink their Kool-Aid.

Now, international competition prevents you from going forward in the prices. So if you can't go backward into the wages, and you can't go forward into the prices, in the short run, what's happening? It's coming out of profits. Hello, that's why employers and CEOs are really focused on this problem. If this were, if the burden were zero, if it wasn't coming out of profits, they wouldn't be dropping coverage as we just saw they were. They wouldn't be reducing generosity; they wouldn't be cutting back that generosity benefits, et cetera. And leading employer organizations would not be trying to formant a real conversation about reform. And you can talk about that now.

So competitiveness is one thing, but I would also say, financing is easier. Let me just make clear, I am totally in agreement with Bob Galvin. I do not want to personally take on the community that's happy providing employer sponsored overage to their workers. Leave them alone, and I would just note, Senator Clinton's proposal, in a fundamental sense, gives them the right to stay where they are, and gives others an option to come in. That may be the cleverest version of this thing that we've seen so far. There may be others coming, but that's a pretty good one.

But the reason to think about getting employers out, in general, or at least partially, is because it allows you to finance health care reform much simpler. The Wyden-Bennett version, for example, basically uses the tax exclusion money to finance the subsidies. Instead of today, let us not forget we subsidize the top two-thirds of the income distribution through our current tax exclusion for employer contributions. What Wyden-Bennett does is turn it into a credit, and subsidize the bottom two-thirds. Note the middle third is left alone. And you fundamentally make the system far more progressive, you don't have to raise taxes or repeal the Bush tax cuts, and you get all the money you need to cover people. Now that is what you call clean. Clean is not going to happen; America is a complicated place, okay. We're going to have to go slow. But if that turns out, every way you get, you use a tax system to do that conversation at cash out, you fundamentally save yourself money.

Portability, Bob talked about that. Comparative advantage, I would say, look at this. This is the, basically if all industries are at 100, that's sort of the index, this is the relative burden of covering workers in manufacturing, retail, and so forth. Look at the variance. Why should where you work make such a difference in how much of your income is tied up in health insurance compensation? And look at the differential burden for retirees. By the way, we all talk

about manufacturing, we know about auto, look at information, which is publishing and broadcasting stuff like that, and look at transportation. These aren't the only guys with legacy cost issues. This is a non-trivial question. Now my simple point is the variance of this makes it seem to be unwise to continue as a wholesale.

And finally, I would say the political philosophy of personal responsibility, if you move to a system where everybody is responsible in one good, big market, then that's much more consistent with certain conservative views and how you think about the world.

So what's the pathway to a better future? Build a market that works for all, key word, all. It's got to work for everybody. Delink coverage from employment so you have portability. Financing income based subsidies how you want, even in Wyden-Bennett; they end up having a tax on employers to partially finance this thing. It's not that they complete eschew employer financing. They just reduce the relative burden from 75-percent of the premium, to 20-percent of the premium going forward.

And finally, I would say, if you want to use the marketplace to make value added, in the clinical level, far more profitable than value added excluding risk and segmenting populations. Thank you very much.

ED HOWARD, J.D.: Terrific, thank you. Now we get to the point where you folks can talk. Andy and I were just chatting, and it sounded as if we gave our panelists a chance to offer rebuttal comments or ask questions of each other, that might be an interesting exercise, too, and I'd like to offer that opportunity to any of the panelists who would like to chime in on anything they heard, since they had a chance to talk. And while we do that, you have a chance to write your questions on green cards, and the chance to walk to the microphones and actually make sure that the question gets phrased exactly the way you want it instead of the way we might reinterpret it. Hold it up, and we will have somebody come by and pick it up. In the meantime, some of you have submitted questions in advance that give us a chance to try that.

This one is an academic oriented question, clearly. Enthoven and Fuchs argue in a Health Affairs piece from December 2006, which by the way I think you have in your kids, that the existence of Medicare and Medicaid has actually allowed employer based coverage to survive because in the absence of these covered systems, employer coverage would have been replaced by some sort of universal health insurance by now. I wonder whether that is a valid premise, and if it is, what does the fact that both Medicare and Medicaid are under substantial financial strains mean for the future of employer based coverage? Speculation? Paul?

PAUL FRONSTIN: I'll respond to your second part of the question, what is the financial situation in Medicare in particular mean for the future of employment based coverage? We heard from, you know, across the table, that we won't see single payer. But I think in about 10, 12 years, we're going to see some type of universal coverage. And that's because that's when Medicare program hits the fan. That's when the trust fund, the part of the trust fund, is expected to be insolvent, around 2019, 2020, right now. The number moves around a bit each year. And I think what's going to happen in the years in between, is that employers are going to continue to push forward with things that they would like to see, or hope to see, that they would see help to manage their costs, things like health savings accounts. And a number of people would argue that the experiment with consumerism and health savings accounts has a limited time period, and probably within four or five years, there is going to be a backlash when employers move away from those kinds of plans. And that's when we get to the point where employers are using the type of information that Bob talked about to give to workers to really make informed decisions, combine that information with a different type of benefits program than what we're used to seeing, where cost sharing and incentives, financial incentives, are really built into the benefits package in a sophisticated way.

Whether or not that is enough to, I'll say save employment based coverage at that point, is to be seen. I think there is still some real challenges, even if we had that kind of information. and if employers get to the point where they just get, you know, more and more frustrated with the cost increasing as fast as they have been, and they start to pick up on the fact that Medicare reform is on the horizon, and I've already heard this from some employers, and I'm starting to hear it more and more, which is that they'll see Medicare reform as an opportunity to get out from providing coverage.

So, you know, what we've seen so far if this is true that Medicare and Medicaid allowed it to survive, Medicare may be what causes it not to survive.

ED HOWARD, J.D.: Of interest, yes. Please identify yourself if you will.

BARBARA CAHUNEN: Yes, I'm Barbara Cahunen with the National Military Family Association, and I'm going to ask you a question that neither one of you touched on to. It has to do with the National Guard and the Reserve. What we're seeing is that when they get activated, they move into the Tricare system, they have the option of bringing their family with them. But sometimes they lose continuity of care because the provider doesn't necessarily want or take Tricare. What can be done as far as you all see, as far as allowing the family to be able to stay with the employer sponsored program during the

whole entire process, while the service member is activated, so we're looking at continuity of care?

ED HOWARD, J.D.: Good question. Len?

LEN NICHOLS: I don't think anybody wants it, but I'll go first. I would say, as I understand it, the difficulty with the Tricare access is because Tricare payment levels are below market levels, and in a sense, it's an extreme version of what Bob showed in the cost shift hydraulic graph, which I think, by the way, is the answer to the question Paul addressed as well, and Paul said it, I mean, fundamentally. But so the reform would be, it seems to me, allow the service member to use a Tricare premium payment that the government makes to keep the employer payment. That would be one thing, and kind of like allowing SCHIP bennies to take the money and buy their parents coverage, and et cetera. You know, you could think about many ways to make it far more seamless.

But in the long run, if we don't fix the payment rate differential, you still have this problem, and it seems to me there's no question. You can't sustain access in a program where the differentials are great. Now, you know, what's great is kind of in the eye of the beholders, but I would submit that for physicians to walk away from treating our service men and women and their families, the differential has got to be great for that to be going on so clearly one could also demand that

that be increased. But those are the two things I can think of.

ED HOWARD, J.D.: Somebody has written a question on a card to this effect. Would anyone like to discuss the world trade subsidy implications? Actually it says world trade organization subsidy implications, of having universal, federal coverage in the United States versus not having it. How about that? Bob, you are the only one we have here with direct global experience.

ROBERT GALVIN, M.D.: I believe you need a Ph.D. in economics.

LEN NICHOLS: You need an M.D. and an MBA to answer that question. I don't think I know enough about what the world trade, what the implications of this rule are. Are you implying that it would be a subsidy, kind of like a farm subsidy that would be, in some sense, different? In fact, it would bring us in compliance with the great bulk of the world, so I don't see how that makes, but if I'm understanding, if someone wants to articulate what the world trade rule is you're worried about, I'll be glad to comment on it more. Yes, sir.

MALE SPEAKER: [Inaudible].

LEN NICHOLS: Okay, got it, and the answer is yes, if, remember both God and the devil are in the details, if we don't finance it with a complete reliance on employer tax. So it all depends on how you finance it. It's totally dependent on how

you finance it. so, for example, if you look at the democratic version in California where they want to put a tax on employers versus a more balanced approach, you could make it worse if you want to, it's possible. Or you could make it better, depending on how you finance it.

MALE SPEAKER: [Inaudible].

LEN NICHOLS: Right.

MALE SPEAKER: [Inaudible].

LEN NICHOLS: Well, I would submit, you know, again maybe this is why Bob wanted an economist to answer the question; I would submit it depends upon how you think about subsidy. In the United States, we subsidize employer sponsored coverage to the tune of $180 billion. We just do it stupidly, and we do it in a way that ends up not, for no, and our system is so expensive, we end up paying a lot for in addition to that. So you can subsidize it smartly or you could subsidize it stupidly. I don't think there's a subsidy differential. The dream would be to make employers everywhere, physicians everywhere, compete based upon their comparative advantage of producing quality and cost for the products that they're transmitting across borders. That's the theory for the world trade organization, and I would argue that would be where you want to go.

GERRY SHEA: This argument about subsidies in this kind of a vein has come up in some other areas about public service,

where there's been some complaints that other countries subsidize public services in a way that we do not in the United States. I think a lot of people react to that by saying, well, isn't that kind of like blaming the victim? But the other thing, just besides subsidies that goes on, is other countries have controlled their cost. Now you may argue with how they did it, or what the result of that was, but when we just look at the numbers, they spent a lot less than we spent on health care, and that's not because they subsidize the health care, it's because they've got some sort of a social understanding about sort of what's appropriate and what's inappropriate. And I wanted to go, this takes me back to the differential payment question like I talked about a little bit ago, it is true that we have these differential payments and they need to be reconciled, but the basic point here is that unless we can do something to address the cost structure, the underlying cost structure of the way we deliver care, and our rather dysfunctional way we administer the financing of care, you know, there's no reason to sort of equalize the payment rates if you're talking about sort of raising everybody up to pay for the stuff that we shouldn't be paying for. It's just, you know, we've got our tactics from the point of view of there's a lot of waste, a lot of inefficiency in the system, and we can't accept it, we have to do something about it. That's the encouraging thing about a lot of the value based purchasing

issues that Bob has referred to, and that GE, and ourselves, and a bunch of other people are involved with.

ED HOWARD, J.D.: Gerry, this one is for you, if you could answer this. Is California health reform actually progress, and why is organized labor opposing an individual mandate in that context?

GERRY SHEA: We have, until recently, focused our activities, I would say for 10 years, on state health reforms. One, because nothing significant was happening, or significant enough was happening in Washington, D.C. And two, from the explicit strategy that we think promoting state reform forces the national discussion and reform. We believe there should be a national reform, not state by state reform. But if we can't get a conversation going, and we can't get to do something nationally, then why ask the states to wait? And that's been the, sort of, energy behind the state reform tactics. In regard to the trend that started last year in Massachusetts with this notion of individual responsibility, when you look at it from the perspective of shared responsibility as Len was talking about, that's a totally acceptable concept. If you look at it from our perspective, you look at it as the basis, the primary way that we get universal coverage, it is a backwards way of looking at it from our point of view. So what we've done in the California situation, in which got reflected in the bill of the legislature passed, is to put individual

responsibility in some affordability context. So they put it in as a percentage of income, a cap on what people will have to pay. Yes, everybody is going to have to have coverage, yes they are going to have to pay a certain amount of money, but no, it won't be in the unaffordable range, as opposed to Massachusetts, where their solution to running into the realities of people having to buy coverage, has been to exempt a large number of people because they can't afford to do it, and the state doesn't want to confront that little problem about how can you force people with a tax penalty to buy coverage they can't afford? The obvious answer is, well, we put more state subsidies into it, but that leads it to a very expensive proposition for the state of Massachusetts. So they are simply exempting people now and postponing dealing with the problem until further down the road. But if we can get this into sort of the notion of shared responsibility, it's exactly where we need to be.

ED HOWARD, J.D.: Thank you, Gerry. The next question is for Len Nichols. If the burden of health insurance is shifted to profits, as you said, why is capitals share of GDP rising, and labor share falling?

LEN NICHOLS: That's a great question, and I would say it would be even worse if it wasn't, or it would be even more dramatic if it wasn't for the health care reality. But the fundamental driver, it's really interesting, it's a great

graph, by the way, if you take the shared GDP, it goes to labor, and you can add up wages, non-wage benefits, and do this over time in the commerce. And if you send me your email, I'll send you the chart; I use it all the time. You see that between 1960 and today, it basically fluctuates between 56 and 59-percent. So you can move this baby a heck of a lot and it doesn't really change much. It's a very, very stable barometer. But it does, in general, go up, that is to say labor share goes up when democrats have power, and it goes down when republicans have power. I don't know why, you can draw your reasons, but anyway, the data are pretty evident, they're pretty clear.

What's going on, though, in recent terms, I mean in addition to the tax cuts, really, is fundamentally the international economy. We are competing against labor around the world, and Gerry can do this much more emphatically than I, that it's fundamentally a heck of a lot cheaper. And there are lots of reasons, our productivity is high and we compensate for that, and that's why we maintain the jobs we've had. But fundamentally, that slope is ugly, and that differential is huge, and we are basically losing market share to those countries, and therefore capital is gaining in the short run.

MALE SPEAKER: I'll give this one a shot. For those who support maintenance of the employer sponsored insurance system, you know who you are, how do you propose to address the

situation of working people who are forced to leave their jobs and insurance, due to serious illness? And what reforms can preserve the ESI system, while addressing the needs of the sickest members of the population?

GERRY SHEA: Let me take a whack at that one. We, if we had our, I think many of us would agree, if we had our druthers, we wouldn't replicate the system that we've grown up in since World War II. It's dysfunctional in a number of ways, but it is what it is. So my comment earlier about being very careful about what you do in terms of threatening a fragile employment based system, are from the perspective of dealing with the reality of the hand that we're dealt. But the simple answer is we, in that vein, is that we need to mix the public and private programs for providing coverage, and at the moment, we believe we need to strengthen public programs in a number of specific ways. SCHIP is an obvious example, and the argument about what sort of, where to go on the income scale is kind of academic when you look at the census figures that showed, you know, this dramatic drop in coverage, 22-percent from 2006, a nine percent drop in the coverage for kids over the last year, and a lot of that when you dig into the numbers, is not among low wage workers, or at least what it's traditionally called. It's in the 50 to $75,000 annual income range, sort of the middle class, or at least some section of the middle class.

And so we've got to, this is becoming increasingly unaffordable for people who make fairly decent wages, and so you've got to sort of strengthen those government programs in terms of general coverage.

The second thing which is what I was suggesting before, is that we should look at ways to take the cost pressure off employment based coverage, unless we want to scrap it entirely and replace it with some sort of a guaranteed universal coverage system, which you could do in a number of different ways. But that is the big change, and unless we want to do that, I think the obligation is to come up with ways to take some of the pressure off. One obvious area is on the tremendous burden that companies have, who traditionally provide good wages and good benefits, and now have to fund those benefits for pre-Medicaid retirees. This is an area crying for some sort of socialization of cost and risk. And you've seen innovative proposals, and Senator Clinton had one the other day in terms of a tax, a limited period of tax credit, which would help companies with the catastrophic costs of some of those retirees covered.

I think the other area is in this whole value based purchasing, and look at the waste and inefficiency in the system. But that is an enterprise which purchasers and providers are tackling, but which requires a strong government role. Right now we're seeing that role as leadership, from

federal agencies, from HHS, from CMS, from AHRQ, who are really providing very strong leadership in this area. But the other, sort of, there's a whole, there's a much broader range of the government as sort of a watch dog standard setter and enforcer of standards that get us there, when you look at, you know, just the processing of data claims, and you know, pull out of your wallet your health insurance card, and one of your credit cards, and look on the back and notice the difference. One has a magnetic stripe that has a lot of data on it, the other one does not. We've had standards for what ought to be on health ID cards for seven years, nationally devised, consensus standards. And they have not been voluntarily adopted. I think this is a perfect example where the governor's ought to say, okay, you know, we do this for whatever, TV, we'll give it a couple of years, but then everybody has to use this standard form for doing health ID cards that has this kind of capacity that we know can be done, because it's being done on credit cards. We just need that kind of a government, as a reasonable regulator and watch dog for the system.

ROBERT GALVIN, M.D.: And I'll add to that, if I will, which I think is a good question. I agree, really, just across the line with what Gerry said. To me, though, it's also an example of that chart I showed about kind of access, quality, and cost. And if I had added at the bottom access and funding, I think we have, it's what this question makes me think of,

which was to the extent of who's going to pay? And as costs go up, you know, we call it, you know, hiding the peanut, who, where, what are you going to do with the money? Who's going to pay? There are fundamental flaws with the delivery of health care in this country. Now it's technical, it is difficult to get into, it's daunting, there's lots of four syllable words in it, but I would argue that at the end of the day, if we don't put our collective brains together to think about how policy can support less waste and better quality, then your, I don't care who pays or what the cross subsidies are, it's, the pie is going to grow and grow and grow. Thirty percent of what we're spending is due to waste, and I would say that is a small number. We know about the quality issues. The Institute of Medicine said up to 100,000 of our citizens are dying unnecessarily in hospitals. I think CMS has done a nice job, and I think HHS has really done a nice job of trying to address it, but I think we need the brain power of everyone in this room to figure out how policy can support, no matter how its funded, the idea that value increases in this country.

ED HOWARD, J.D.: Bob, can I just say how would you draw the line between a voluntary standard that may or may not get adopted, and the kind of everybody pitch in when you're told you have to, or you don't get paid kind of approach?

ROBERT GALVIN, M.D.: Look, I'll give you an example, it's not an exact answer, but it's just something that's been

on my mind lately. You know, remember that slide of President Clinton I showed, and I am not in any way going to say that if you show data like that, it would solve the problem. But I think that most people from Mark McCullem to many people who think about this agree that it's really an important kind of a pillar to get there. You know, it was just two weeks ago that a consumer organization called Consumer Checkbook had to sue to try and get CMS to release data based on doctors, the data that you saw there at the bottom of that chart. And I would submit to you from a policy perspective, that I'm much more worried about protecting patients and their right to know that I am about protecting doctors. And I am a doctor, but I think that is just one of many, many policy issues I could bring up where you in this room, and we, could do a lot to help support value.

ED HOWARD, J.D.: We have about 10 minutes left, so as you're listening to these last few questions, would you fill out that evaluation form, even though you already have your candy bar in hand? Yes, go ahead.

ANDY CHASIN: Hi, I'm Andy Chasin from the Republican Policy Committee. Obviously, one of the central reasons why we're talking about moving towards a system where individuals have more responsibility for their health care is to reduce health care costs, because they'll make more efficient purchases. But I wonder, Mr. Galvin, from what you've seen and what your employees has actually purchased, can you tell us

like what they do opt for and if you do, you know, offer them kind of a gold plated PPO, expensive plan, whether that's what they want, or they do move to something that's a little bit more price conscious that would help us reduce the cost.

ROBERT GALVIN, M.D.: I'm sorry; I just didn't hear the last part of the question. You wanted me to tell you—

ANDY CHASIN: About what you've seen from what your employees have actually purchased. Is there evidence that if you are giving them a choice between a very expensive plan, and something that, you know, had maybe higher deductibles but a lower premium, that would, you know, give us evidence that this would reduce the cost of health care overall, would they move toward that model?

ROBERT GAVIN, M.D.: Sure, and good question, and I'm not sure you're going to like my answer, but I think that we've all had limited evidence, and I think what we've found is clearly that economic incentives in health care are no different than economic incentives out of health care. So if you have someone pay more for something, they'll get less for it. the problem that we're contending with, and because God and the devil are in the details, is they do that for things they don't need, which is, I think, an economic benefit. But they also do it for things they need. So we have really kind of evolved to an idea that we're calling managed consumerism. So the idea that kind of individuals, other than, and we have

pretty smart people, we have people that like develop jet engines, and these are from some pretty smart engineers, other than a small cohort of people who are really that intelligent and that computer avid, you know, we do think that we have a big responsibility in providing them with information. The fastest growing kind of industry, on the private sector health care side, are these health coaches. And we have invested in that as well. So we believe if we're going to put more financial responsibility on employers, which we do think we have to engage them, and we offer them more choice, that in health care versus plasma TVs or whatever other purchase you want to talk about, you do need an educated intermediary. Call it whatever you want, we happen to call it health coach. Now we're early in this process, we've been doing it about a year. The industry is just starting to develop, but what we have seen there is with a reasonably short interaction, we're actually studying this with some Harvard researchers to see if these observations are going to, you know, show up after we use some good methodology; we are finding that people are not only responding to the financial incentives, they're responding to the information. But they have to have it explained to them. So this isn't, I think, a purely economic role in the part of employers, or insurance exchanges, if those start to arise across the country. So that's what we've found, and we're calling it for a better word, kind of managed consumerism.

ED HOWARD, J.D.: There was someone standing there who disappeared on us. Right before he left, Paul Ginsburg filled out a card and directed a question to Len Nichols, asking you to discuss what has to be done to structure insurance markets to support a widened kind of approach. And I should just say for those of you who don't know this for sure, that Dr. Nichols has been helping Senators Wyden and Bennett think through that approach.

LEN NICHOLS: Basically the idea there is to make an insurance market that actually works for everybody. So the first condition is you would have guaranteed issue and modified community rating, and all that kind of stuff. Everybody has to be able to buy, regardless of health status, you know, use health status to vary the premium. You would allow age rating or geographic rating or reasonable things that a lot of states allow now when they go to that context. But the linchpin that makes that sort of work is two fold. One, there's an individual mandate to purchase, so everyone has to come in. So fundamentally, the adverse selection problems should be very significantly reduced by the fact of that mandate. You know, we often focus on the horror stories of very sad tales of woe that are real, about people who are very sick, who are uninsured. But the vast majority of the uninsured, frankly, are healthy. They are the healthiest people on the planet; they're making a bed every single day that they can live

without it and not have a problem. So if you bring them all in the pool, you actually would improve the overall risk pool. So you have guaranteed issue, you have insurance market reforms, you have structures. But then you also have a lot of competition in the sense that this is going to be the game. In the Wyden-Bennett structure, everybody is going to get their insurance through this exchange. Now the exchange would be organized on a state basis, if you could imagine states like California choosing to have three different ones, so it could be sub-state if the state was large enough. Or it could be multi-state if Idaho wanted to join with Montana, or something. But the point is, they would be organized regionally or state, so they would be small enough to be local, because markets are local, I learned that from Paul Ginsberg very clearly a couple of years ago. But I would say, so you organize it at the state level, everybody is in, and you have insurance market reforms, like guaranteed issue and modified community rate.

MALE SPEAKER: Let me actually, if I can go to you, Paul, you began the conversation by talking about whether we are at a tipping point, and you showed some very compelling slides showing that, in terms of ESI, we're not far off from where we were from say, 15 years ago. But could you just comment on the extent to which you believe ESI affords the same financial protection of employers that it did back then? Can you somehow quantify that?

PAUL FRONSTIN: The financial protection for employees?

MALE SPEAKER: For employees, right.

PAUL FRONSTIN: Well, I think, if you look at national health accounts and the percentage of private spending that's out of pocket, it's pretty much at a record low. So even this day, with all the—

MALE SPEAKER: At a what?

PAUL FRONSTIN: At a record low. You know, it's about what, 15 or 18-percent, maybe 22-percent. Regardless of what the numbers, I forget the number, the trend has been down since about 1960 and it's probably flattened out in the past few years. So in that respect, insurance is paying for a lot more now than it was even 10, 15, 20 years ago. I mean, think about all the things that insurance covers that didn't exist 10, 15 years ago. So that's one way to look at it. I'm actually surprised given how fast the cost of health care has gone up that we haven't seen a greater erosion in coverage, either in terms of the percentage of people covered, or in terms of the benefits package, because we have seen deductibles go up, we have seen co-payments go up. I try to look at how those cost sharing have gone up relative to inflation, we don't have a great way of looking at it yet. But certainly, from a national point of view, out of pocket expenses are at the lowest point they've ever been.

ED HOWARD, J.D.: Bob?

ROBERT GALVIN, M.D.: There's actually an interesting phenomenon going on, you saw it on some of the graphs, but none of us highlighted it, and I think it is, in a funny way, a threat to doing substantial reform. And that's a fact that the health cost inflation is really coming down, and there's a very clear trend, remember that chart, and I think, Paul, you showed it, over the last several years, that it went from the historical high of 10 or 12-percent after the balanced budget amendment, and this kind of spate of kind of new pharmaceuticals coming out, and a bunch of breakthroughs, it has now been in the mid single digits for several years. And the projections are of next year, the cost of health care is going to be about what it is now, about five and a half or six-percent.

Now some would argue that's really still too much, it's two times kind of the consumer price index, et cetera. When I talk to employees and we kind of talk it through, it isn't clear to me that they're not pretty comfortable with having health care grow faster than the cost of staplers, for example, or commodities. So if you reach a point where companies are doing well in terms of their profitability, and instead of health care costs going up, 8, 10, 12, 14-percent, it's down to two times CPI. I think, it's a worry, because I do think we need fundamental reform, but some of the impetus for employers who are now talking about competitiveness that we've heard, it

suddenly doesn't stay as high on the screen, and I think Len said it, you live three months to three months to three months, and it's even kind of a shorter time in the Congress. And I have seen it before and again, it's too early to say, because if the memory of the 14, 12, and all the accumulated and the compounding problems we've had over the last 15 years is still real. But it's something I keep track of and I talk about it with the GE CEO and our board. At this point, there's still a lot of interest. It will be interesting to see what happens if it stays at 6, or 5.6, et cetera.

ED HOWARD, J.D.: Okay. I think our time has elapsed here. And we've actually come back to sort of the central point. I guess to sum it up, the health care system may not be in perfect health, as Bob Galvin, the doctor, would tell us, or reaching optimality, as Paul and Len might have observed, but there is still life in the old person yet. But if we want real reform, we need either a recession or an explosion of health care costs, or both. Is that a fair summary? So we may not have reached a complete conclusion on this and we will revisit this question as the debate continues. You're going to be able to follow this debate, not just in sessions like this, but in debates in Iowa and New Hampshire and in other places, perhaps. And we urge you to do that. I want to just reiterate our thanks to both the Robert Wood Johnson Foundation and to Andy Hyman for his direct participation in the foundation's co-

sponsorship of this. I want to thank you for your hanging in through some pretty technical and conflicting conversation, and ask you to join me in thanking our panelists for a very useful and elucidating discussion.

[END RECORDING]