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**Getting to Universal Health Insurance Coverage Conference –
Day 1
Session II: How Should the Private Insurance Market Be
Structured in a Universal System of Coverage?
National Academy of Social Insurance
January 31, 2008**

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JENNIE CHIN HANSEN: Good afternoon. We're going to start the afternoon session. Thank you very much for coming back and I hope you had a good lunch. My name is Jennie Chin Hansen, I'm the President Elect for AARP and I'll have a chance to moderate this particular session. It's an absolute delight and honor to have a chance to be here to address this particular issue. I think we've had a good setup relative to the issues that we know about quite well in terms of the numbers of people who are uninsured and underinsured, and we know this very much so from the standpoint of what exists now, as well as kind of projecting ahead. Perhaps not thinking about 2050, as Dr. Reinhardt said, to let folks worry about it, but I think we have fairly imminent issues to be concerned about.

So I'm really pleased also to help launch this session, as a member of AARP, representing an issue that we actually have been fighting for, for 50 years. It happens to be that this year, 2008, is the 50th anniversary for AARP, just as NASI is celebrating its 20th conference right here. But we know that clearly, even after 50 years of our doing this or some discussion of President Truman trying to do this 60 years ago, we still have the dilemma's that Dr. Altman brought up. There are no shortage of ideas, there's a lot of talent and brain power here, but at the same time, I think its opportunities,

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and I appreciate Dr. Altman indicating that it's good to have NASI have this kind of an assemblage. So one of the things that we hope that, perhaps, whether it's 2009 or beyond that, that this will be a critical point in order to begin to have this dialogue. And frankly, the illusion to what we all know from the news, and I am a Californian, and hugely disappointed as a citizen of California, but certainly as a key member of AARP, that much of the effort for the kind of give and take, and the kind of collaboration, you know, did not materialize relative to a state like California.

So we know that in order to have not just the coverage, it is really about the delivery system which, as a side bar, is something I personally know a lot about just because I was involved in that for 25 years. And so some of the culture change issues that were brought up are so significant; so one thing is to have access, one thing is to have coverage, but then the whole thing is, is their "there" there, the ability to really deliver, when we actually have the system to provide. And the hurdles there, I think as many of you know, are tremendous.

The whole aspect of understanding how critical this issue is and seeing the graph at lunch about healthcare finally hitting kind of a number two spot, relative to concerns for people at this point, and health not only in terms of the cost of care, but the economic side of it. So that ties in so well

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to the fact that some of you may have seen our initiative called Divided We Fail, and that, in fact, was and is this whole attempt to bring together disparate parties include the Business Roundtable and many of you know that that is the group that represents the 160 largest employers in the country. The Service Employer's International Union ISEU, which was represented this morning as the fastest growing union. We also have now the National Foundation of Independent Businesses, which is the small business community. And as you can imagine, normally people operate in their different domains, but this is truly an attempt to really look at these two large areas, and that is healthcare, as well as economic security for the long term in a way that we could really agree on principles. And so we've joined together to say that politically and from a leadership standpoint for this country, these two areas really must need, really need this kind of collaboration. And frankly, we thought we were this close in California because we got to the point, as many of you know, that everybody had to give in some form or the other, and that nobody was going to be left untouched by this, but it's that kind of artistry and the give and take that occurs. But AARP has really chosen to take this role in many ways to bring together these different parties for where we do have common needs.

If you are interested, as we have started to continue to bring in other organizations in this attempt for looking at

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what we have in common to these core issues for the country, there is now a group of us of 60 organizations in addition to these initial core four of us that have started to really say this is an initiative that says divided we fail, and that's what our website is. So if you're interested, please don't hesitate to go there; it's kind of a bittersweet irony that this is the title of what our initiative is and the fact that we had assembled in California quite a collaborative. But now, in the meantime with the Senate voting it down, we once again are in some divisive part. So our effort is to pick up the pieces and move toward the role of incrementalism until its clear from a national leadership standpoint, as Dr. Altman says, is what are the core priorities and the principles that guide this.

So now let's begin with what promises to be a very thoughtful discussion on how to restructure and simplify our healthcare system so that we can hopefully bring coverage to all, while at the same time controlling costs. I'll introduce the four speakers and then we'll go in that order, and then after they have a chance to speak, we should have about 15 minutes for questions, and so when we do have that, I think I was asked to really request of people, when you go to either one of the microphones, or if you choose to actually use a handheld mike from your seat, please identify your name and the

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organization, if you're connected to an organization, before you ask your question or make your comment.

Our first speaker is Cori Uccello, was a senior health fellow at the American Academy of Actuaries. She will discuss risk pooling and necessary features that make those risk pools viable. Secondly, she'll be followed by Elliot Wicks, Senior Economist with Health Management Associates. He is going to discuss administrative issues and expanding healthcare coverage to individuals and small group markets, and then he'll outline some specific strategies for restructuring health insurance markets. Our third speaker will be Larry Brown, who is Professor of Health Policy and Management at Columbia University. He will explore federalism, the whole challenge of federalism in the whole aspect of healthcare reform in the United States. And then he will also bring some illusions to what is happening in some of the other European and other markets different from ours. And then finally, Frank Neuhauser from UC Berkley, excuse me from the Survey Research Center will talk about why universal health insurance makes sense when it comes to the whole issue of occupational medical treatment. So let's look forward to an interesting and provocative session, and let's begin with Cori.

CORI UCCELLO: Thank you Jennie, and thanks for having me to NASI. As we've already heard today, many health reform proposals would rely, at least in part, on some kind of

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restructuring of the private health insurance system. Some would set up regional health markets, others would allow for association health plans, or AHP's, and others would allow for purchasing insurance across state lines. Well, to better understand the impact of these different types of proposals, it's important to first understand the fundamentals of the private health insurance system. So my charge for today is to walk through some of the basics, and then this will help set the stage for the other speakers.

So just a brief overview of the private health insurance system. It's really a complex system with many interrelated components, each of which face different regulations and regulatory bodies. In terms of sources of coverage, there is medical insurance, and this is what we typically think of when we talk about health insurance, but even this can be further subdivided into different markets. There's the large employer group market, the small group market, and the individual market. And there's some interactions between these markets, for example, through portability provisions and other types of provisions as well.

There's also the worker's compensation system and Frank is going to be talking about this in a lot more detail, but this is a state based program, but it is part of the private insurance system. And although we won't be talking about these in this session, there's also long term care insurance and the

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medical liability insurance, that underlies all these different sources of coverage.

In terms of regulatory authority, states are the primary regulators of health insurance. They set the rules regarding insurance solvency standards, issue and rating regulations, different consumer protections, and so on.

However, the federal government does have a role, as well, and this is especially true of the large employer group market, or self funded plans. Because of federal ERISA roles, self funded plans, that's mostly large employer group plans, are exempt from many of the state regulations. So there's both the state and the federal government that does regulate the insurance system. And, again too, all of these sources of coverage also not only overlap with each other, but also overlap with public coverage.

I'm going to focus, though, the rest of my presentation on the medical insurance side of things, and I'm going to focus on risk pooling basics, issue and rating rules, different benefit package considerations, as well as some other issues, as well. And although I'm really focusing on this market in particular, a lot of the principles that I'm going to talk about will apply to other sources of coverage, as well.

So in terms of risk pooling, for the purposes of my presentation, I'm going to define risk pools as large groups of individuals or groups whose medical costs are combined to

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calculate premiums. Pooling risks together allows the cost of the less healthy to be subsidized by the healthy, and in general, the larger the risk pool, the more predictable and stable the premiums can be. That's because, of course, if you have a large pool and you have just one or two people who have very high medical expenditures, those costs can be spread over everyone in the pool, with really only a marginal impact on the average cost. However, if you have a small pool and you have one or two people with large costs, that can really impact the average cost of that group, and therefore, you can see large premium fluctuations from year to year.

However, creating larger risk pools does not necessarily mean that premiums are going to be lower. You have to consider not just the size of the pool, but also how it's comprised. If a pool attracts those with higher expected claims, then premiums are going to be higher, and this is typically referred to as adverse selection. Now, in the health insurance market, adverse selection will occur when people, individuals, are going to know more about their future healthcare needs than are insurers. And therefore, they are going to be more likely to purchase coverage when they think they're going to need it and they're going to get more generous coverage in particular. However, if you have pools that are created as by-products of membership in a group, that is the group is created for a purpose other than purchasing insurance,

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than those group pools are going to tend to be less subject to adverse selection.

So let's look at the different market types and the adverse selection implications. For large employer groups, a large employer can create its own pool as it offers coverage to its workers. Workers automatically join the pool as a side benefit to employment, and the employer makes most of the decisions regarding the level of benefits and the choice of benefits, therefore limiting the choices to the individual workers and therefore limiting their ability to adversely select. In contrast, in the individual market, when people purchase just coverage there, they're doing so for the express purpose of purchasing coverage, not because they're already members of some other group that gets coverage as a side benefit. Therefore, pools that are created based on individual market coverage are much more prone to adverse selection.

In between these two extremes are pools created by small and medium sized employer groups. Now these groups are too small to go out and create their own pool, so what insurers will do is combine many of these groups together and form one larger pool. Now this really does reduce selection, adverse selection, compared to the individual market, but there's still an opportunity for small groups to adversely select against insurers. They can move into and out of the market, they can

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move from carrier to carrier, so that market is still prone to adverse selection concerns.

So just kind of oversimplifying and summarize all this, if we have, let's consider, we have two pools; each has the same number of members. In Pool A, that has fewer groups, but more members per group, and this is akin to the larger employer group. In Pool B, there are more groups, but fewer members per group, and that's akin to more of the individual market, or the small group market. Well, Pool A is going to likely be more stable, and that large group has, in effect, one purchase decision. Whereas in the individual pool, or that Pool B, there are scores of separate purchase decisions and each one of those decisions presents an opportunity for adverse selection.

So let's move on to issue and rating regulations. Now these regulations attempt to balance the goals of access to health insurance and premium affordability. And in terms of issue rules, there's guaranteed issue. Of course, this means that everyone who applies for coverage is guaranteed that they'll have access to a plan. Now the plus side of this is that it does provide access to a plan for people who may already be in poor health. On the flip side, however, this is really prone to adverse selection as people may decide to forego purchasing coverage until they think they actually need it.

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Now if insurers are allowed to underwrite coverage, that means they're allowed to, say, reject or decline people who apply for coverage if they're already in poor health or are excepted to have high health costs. Well, this will reduce adverse selection because it can provide an incentive for people to purchase coverage while they're still in good health. But, on the other hand, if people who are already in poor health, they may find it difficult to purchase a plan.

In terms of rating rules, there's pure community rating, and this means that everyone who gets coverage faces the same premium, regardless of their age, gender, health status, and so on. Now the advantage to this is that it spreads the cost most broadly among people in the pool, and it could potentially lower premiums for people who are in poor health, relative to what they might otherwise face in terms of premiums. However, this too can result in adverse selection as the people who are in better health are still going to face higher premiums than they may normally face, and therefore may choose not to purchase coverage. And that, in the end, may actually result in higher premiums for everybody.

Modified community rating would allow some variation in premiums by age, gender, and some other types of characteristics, but health status would still not be allowed as a premium factor. Now this can reduce adverse selection compared to the pure community rating case.

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Then there's experience rating, which in addition to all these other factors, health status would be allowed as a rating factor. Now the plus side of this is that it can reduce adverse selection because the people who are at low risk for high health costs are going to face lower premiums. Of course, on the flip side, people who are already in poor health may face very high premiums and may find those two unaffordable.

Now, as I said earlier, there are lots of different types of pooling arrangements that are being considered; regional health markets, purchasing insurance across state lines, and so on. Now these alternative pooling arrangements are created to operate alongside of already existing markets, adverse selection could result if these issue and grading rules are not the same in both markets. So, for instance, if a regional health market is created to operate alongside already an existing state market, and that regional health markets roles are very favorable to those in poor health, say there's guaranteed issue and pure community rating, then the people who are in poor health are going to gravitate towards those regional health market plans. That adverse selection that's resulting is going to cause premiums to go up, which could cause more adverse selection, and ultimately, the viability of that regional health market system, may be threatened.

Of course, the opposite could occur if that existing state market has rules that are more favorable to those in poor

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health, so really just the bottom line here is if you have two markets that are operating alongside each other, if their rules are not the same, you may be threatening one of those markets, the viability.

So, in addition to looking at different alternative pooling arrangements and issuing rating rules, it's also important to consider benefit package design and those kinds of issues. I know that this is going to be talked about in the next session, but there are a couple of things that are important to consider because we want to insure that coverage is meaningful and provides access to needed care, but at the same time, we want that coverage to be affordable, both to the individual and to society as a whole. So what should coverage look like? If there's an individual mandate, what do people have to purchase in order to meet that mandate if there are tax incentives that are available, what does coverage need to look like in order to qualify for those subsidies?

Well, in terms of setting some kind of standard or benefit plan, which some proposals do, there are various components of that, that need to be examined, you know, what's covered in that plan, what types of services, what are the cost sharing requirements, what's the provider network? Is it a strict network, is it a very loose network, how do all these different components are defined is really going to impact the premium for that plan.

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Now proposals can define a specific benefit package and then what insurers could do is determine the premium based on that specific package. Or some other proposals could instead set a dollar value, and then allow some flexibility around that where insurers can decide different types of benefits that would meet that dollar value. But I think it's really difficult for a proposal to define both the coverage and that premium, or that value. One of those, I think, really needs to be left a little more flexible.

Other benefit design issues relate to whether there are going to be non-standard plans available. Lots of times you'll have some kind of standard plan but that allow enhanced coverage beyond that. Well, how should premium subsidies be calculated in those instances, and also when there are enhanced plans that are available, you also have to keep in mind any adverse selection concerns. Are people going, who are less healthy, going to gravitate to those more generous plans? We have to consider these kinds of things, as well.

And briefly, just a few more considerations; risk sharing, especially if plans are designed to cover previously uninsured people, insurers may face some financial risks regarding pricing, adverse selection, and things like that. So are any risk sharing mechanisms needed to address those financial risks, reinsurance, risk adjustment, risk quarters, those are the types of mechanisms that could be available.

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In terms of competition, especially if there's a regional health market, what is the criterion for plans to participate in that market? Is there some kind of fitting system, can everyone participate if they want? And then how is competition work within that regional health market? And then also, not only within that market, but how do plans that are participating in that regional market competes with plans that are aside that market?

And finally, transition rules. When new rules or regulations are implemented, there may be some people that are made much better off; other people may be made worse off. Is there any reason to phase in changes, rather than doing them all at once? And finally, special rules may be needed to ensure that carriers who are needed to a market don't have any advantage related to pricing or market, compared to carriers that are already in the market. I think this is also something important to consider.

So that's it for me and I'm going to pass things along to Elliot who's going to be talking more about some different purchasing arrangements. Thank you.

ELLIOT WICKS, PH.D.: My task is to talk about how we might go about improving the performance of the insurance system. And, for the most part, when I'm talking about that, the challenges that we have in our insurance markets, I'm really talking about the individual and small group market,

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because, as we've heard it on a number of occasions this morning, the large group market solves the problems pretty well because there's natural pooling for the most part. And so I will be concentrating mostly on the individual and small group market.

There are two basic problems that we have to deal with. One is making coverage affordable, generally. That is, the cost of insurance is high and how might we go about trying to make it less expensive. Well, there are two solutions to this. Either you find a way to improve the efficiency of the insurance system, or more likely, the underlying medical delivery system is a way of lowering the cost; or you provide subsidies to people so that their net cost is lower, and that would increase the number of people who could afford coverage.

The second problem is the affordability for a particular segment of the insured population, the high risk people. And an awful lot of the things that we have to do in a healthcare system and in the insurance system, relate to these people. These are people who could afford average priced coverage, but can't afford a premium that's sufficient to cover the risk that they represent as individuals or small groups.

Now how might we go about improving market performance at either the state or federal level? Well, one approach, as Cori mentioned, are insurant rate reforms, either moving toward community rating and guaranteed issue, which are both designed

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to help make coverage affordable for high risk people. The other approach is high risk pools, which separately insure these people and subsidize just their care. A third approach, which involves a kind of subsidy as the previous one does, is publicly funded reinsurance to have the public absorb some of the costs of the highest cost cases. The next approach is Section 125 or cafeteria plans, which allow people to have a reduced cost, and I'm going to talk about those in some detail; and finally, insurance exchanges, purchasing pools, connectors, all involving a similar kind of concept of obviously varying details. I'm going to concentrate on these last two.

Mandating Section 125 plans, as you know, Massachusetts, as part of their reform, required all employers to have, to set up a Section 125 plan, or cafeteria plan, and that was a major part of the proposal in California, as well. The approach here is designed to reduce the cost of coverage because of the federal subsidy, the tax subsidy, that is involved, even when employers don't contribute anything to coverage. The approach is that the employee voluntarily reduces their income and they set this aside and have it allocated, then, to pay the premiums for health insurance, when then they may be paying the entire cost. Well, that means that they're paying with before tax dollars, and that substantially reduces, could substantially reduce the cost. Since they are not taxed on that income for either personal income taxes or

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FICA taxes, the savings could be substantial; FICA savings is roughly seven and a half percent and the federal marginal tax rate for people who have a taxable income varies from 10 to 35-percent. And then state income taxes are added in on top of this where they are in the present, and so there could be substantial savings for people, and the subsidy is coming from the federal government. So this is appealing to states because they don't have to require employers to do much of anything and they don't have to pay anything. States can apparently mandate that employers establish Section 125 plans without running into problems of a risk. This hasn't been fully tested, but most of the lawyers who are experts in this area think probably this would escape a risk of problems because these are not considered to be employee benefit plans. It costs the state almost nothing, except the administrative cost of mandating and then enforcing such a law, and it's not onerous for employers. There are very few requirements attached to doing this. You just have to say that you meet the requirements, it doesn't even have to be filed with the federal government, and of course the employer doesn't have to pay any premiums, and it also saves the employer because the employer doesn't pay their share of FICA tax on the reduced amount that the employee sets aside for that purpose.

But one could argue that if these became very widespread, it might induce some employers to drop coverage

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because they might just say, look, I want to get out of this business, I don't want to tell you what insurance plan you have to have, so I'm going to give you the money that I would have spent on increased wages and you go choose your own plan. Now that might be a possibility; of course employers can do that right now, it isn't as if they couldn't do it just because its not mandated that they have that kind of coverage, but some people worry that this might occur.

My next approach that I want to talk about is an insurance exchange, and again, this could be used as a way of trying to solve problems for small groups and people buying individual coverage. And those problems are pretty clear, high administrative costs, it certainly costs more to market and service small groups and individuals than it does for large groups, and these people buying this kind of coverage, the small employers and individuals, have no single place to go buy coverage and see the full range of offerings and to get objective information.

And there is no standardization of products if people are choosing from things that are so difficult and so different and so complicated to understand that it's hard for them to make good judgments about the value of one plan relative to another. And, of course, small employers and individuals purchasing coverage have no bargaining power whatsoever with insurers compared to what large employers have.

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Well, the insurance exchange is being seen as one way to solve this problem. It is an efficient single, of course, of coverage, it's a place that people can go to see and choose plan alternatives to compare plan values, especially if the exchange provides some kind of report cards, and it's a good place to use subsidies because since it reduces some of the administrative costs and makes it possible for people to make wiser choices, the money that is set aside for subsidies goes more for providing medical services than for paying administrative costs.

In addition, this kind of approach can put plans on head to head competition every year for the business of each individual making a choice because they, every year, the employee has a chance, if it's a case of employee choice, to choose a different health plan if they don't like what they have. And good examples of this kind of approach, while we don't always think of them as being insurance exchanges, are FEHB and CalPERS, which allow people to make these kinds of choices. Putting that kind of pressure on insurers because of the ability to choose a different plan every year, hopefully would encourage them to make sure that they are offering good value.

And, of course, we would hope that these exchanges could achieve some administrative economies of scale over the case where people buying as individuals, small groups, or as

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individuals, because some advantages in collecting premiums, paying insurers, some of the marketing costs and so forth.

Well, what have we learned about experience of exchanges or connectors or purchasing pools? Well, we've known that unless there's a captive audience, it's hard to attract customers. We have lots of experience in the 90's with states trying to establish these things and that was one of the difficulties. Just because you built it didn't mean people would come. It's also hard to attract and keep health plans. One of the reasons that a number of these early attempts failed was because the health plans bailed out once they realized we were not going to have national exchanges or exchanges as part of a national health plan. And, of course, if you don't have a lot of customers, it doesn't pay for the insurers to be involved. So this is a difficulty.

And we've learned also that in order to achieve the objectives of administrative economies is to scale the bargaining power, you have to be big, you have to have lots of clout in order to be a success at doing this. And unfortunately, we've also learned that simply having an exchange is unlikely to lower prices appreciably without complimentary policies that are a part of that.

And finally, the point that Cori made with some clarity, pools cannot separately pool or exchange as pool risk unless they have a captive audience. If they are competing

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against a market outside the pool where people have great latitude in rate setting, and the pool tries to do community rating, they will not succeed; they will end up with adverse selection. Now that's different if you have a captive audience if, for instance, CalPERS, you know, that people go who are employed, state employees and municipal employees, go only to CalPERS because they would lose the employer contribution if they went someplace else. So they can separately pool risk.

Well, there are a number of issues involved in designing exchanges. The question is should they be public or private or something in between that is something that has maybe a private, essentially a separate from state government, if it's state exchange, but have considerable control through governance by a commission that's established publicly and so forth.

Another question, and this is one that's been a hot issue always is whether the exchange should be a price taker, that is it simply says submit us, to insurance plan, submit us a proposal and whatever the price is, we'll just set that out and people can decide whether they want to pay it. Or, and that's sort of every willing health plan, or should instead they negotiate, be a selective contractor in saying, look, that isn't a good enough price. If you want to have our business, you've got to do better than that.

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And then there's the question about the degree of benefit standardization. I think in the early days, people thought there should be very few health, different benefit plans, so that people could really make good comparisons of places of price, it's I think been a movement away from that, but I think most people would argue that we don't need anything like the degree of the number of plans that is common in a small group and individual market, and then some reasonable number would make it a lot easier for people to make wise choices.

And then another question is should an exchange be a required source for some populations? I think one could make a strong case that subsidized populations should have to go through an exchange because you get more money for the subsidy you provide, but one could argue that the way to make this work since the problem was really with small groups and individuals, was that the state could say if you're going to buy health insurance coverage and you're a small group or an individual, you have to go through the exchange. And that would help to make give it clout, make it large enough to achieve economies of scale and so forth.

Well, obviously the notion of federal exchange has been a part of a number of policies that have been proposed, both now and in the past, several of the presidential candidates have included them, and this involves some different kinds of

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issues that have to be considered. I'm assuming here that there will be some substantial subsidies to purchase private coverage and that these are part of reform and that include the exchange.

But general subsidies alone are not adequate for high risk people because they would still face high premiums that would make it unaffordable for many of them. So the question is how do you deal with those people? Individuals and small groups would still need an efficient source of coverage. And an exchange could help level the playing field for people in different parts of the country. And obviously a federal exchange would be a strong source of leverage in trying to bring changes in the delivery system in the practice of medicine, as Medicare has started to do.

Well, what are the problems with federal exchanges? In the first place, it seems to me in order to be politically acceptable, an exchange would have to have some form of community rating that is close to pure community rating in order to be acceptable. And people couldn't be turned down for coverage. If you had an exchange that's part of national reform and then you apply for coverage to the federal exchange that says, sorry, you're too high a risk, we can't help you, that's not going to work.

But many states do not provide coverage on that basis, especially in the individual market. They don't have

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guaranteed issue and they certainly don't have community rating in many states. Well, the question is then what do you do about that because if people have different rules than the states, and the federal exchange provide community rating and guaranteed issue and the states don't, well, what's going to happen, is what Cori pointed out. The federal exchange is going to end up with all the high risk people and that's going to be expensive, at the very least. Well, what can you do about it? Well, I suppose the federal exchange could just eat the cost of adverse selection, we have to subsidize high risk people in one way or another. And you could say, well, this is a sensible way to do it. The problem is that if you do that, you create very strong incentives for states to change their rating rules to make it cheaper for people who are low risk, they would go to the state, and the federal exchange would not only get the high risk, they'd get the medium high risk, and pretty soon you'd have a system that wasn't working very well.

The other option is to require uniform rating rules in all states, essentially substitute federal rating rules for state rating rules, because we did, not in rating rules, but with respect to prime guaranteed issue in the small group market through federal law. The problem with this is it could create sticker shock for low risk people who are now in states that have a lot of rate variation and they're getting a very low rate because they're low risk and suddenly you're going to

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move toward this kind of national system where everyone is rated on a community rated basis, and these people will suffer sticker shock.

Well, another thing to keep in mind is that an exchange is likely to be most effective if its combined with other reforms, as they did in Massachusetts, subsidies, rate compression, standardized benefits, mandates, and so forth. And it is, as I indicated before, these were all parts of the proposed California reform, obviously I wrote this before, I should have substituted the failed California reform, but those elements were all included and the exchange was a part of it although it was limited in a way that I think I wouldn't have limited to who could go to it. And, as I've said before, it's included in several presidential candidates.

So the exchange idea is one who's has had a lot of currency for many years now and I suspect that any kind of comprehensive reform relies on private markets will include it. Thank you.

LAWRENCE BROWN, PH.D.: Hi, I'm talking about federalism and I argued to the organizers of the conference if you're going to talk about federalism, you should have at least 50 minutes, at least one per state, but I wasn't persuasive and I ended up with a number smaller than the original 13 counties, so here goes anyway. And I've wasted 30 seconds of the precious time in this stupid attempt at humor.

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Federalism clearly is one of the glories of the American republic, you know, 50 states, decentralization, close to the people, laboratories of democracy, all that kind of thing, but undeniable also it complicates national health reform in at least 50 different ways, and it's already complicated enough without factoring in the federalism variable in on top of all the other complications, philosophical and other.

But though that may seem like bad news, the good news is that other western nations with federal systems have achieved affordable, universal coverage. It hasn't always been easy, it isn't always easy to maintain those systems, it's not easy to maintain the inter-governmental collaboration that they require, but they do it and they make it work. And they are, on the whole pretty stable.

Other good news is it isn't one size fits all. American reformers looking to other countries can see that they differ in approach, for example, Canada is a federal system, does single payer approach. Germany is a federal system, social insurance approach. Switzerland, federal system now an approach variously that has got individual mandates, consumer driven, managed competition. Switzerland is getting its 15 minutes of fame belatedly because of these ocoron [misspelled?] features that it displays.

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So this is hopefully good news, I think, for you as health reformers, that federalism can be perfectly compatible with achievement of universal coverage, but though these other federal systems differ from one another in many important respects, they also share at least five features with one another that are all lacking in the United States. It sets the bar high for achieving universal coverage, and these five factors, at least these five, the five that I want to choose to mention are, first of all, a strong, solid eristic ethic, health care is a right, Uwe talked about this beautifully this morning, and the redistribution and the cross subsidies that enable all citizens to have healthcare is a matter of citizenship and as a matter of right.

Secondly, while employers are variously involved in these other foreign and federal systems, none of them views healthcare principally as a fringe benefit of employment, it takes the view that that's what healthcare fundamentally is, and it's government's role to come in and fill gaps in a largely employer based or private system. It's not how they look at it.

Thirdly, they have insofar as they use insurance institutions for basic coverage at all; they have tightly regulated insurance markets. In Canada, they use insurance companies for its basic coverage, but the Germany and the Swiss have tightly regulated insurance markets, and in particular

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they are careful to try to eliminate the opportunities for the temptations for preferred risk selection, so they've opened up enrollment on that sort of stuff.

Fourthly, in these countries, providers view themselves, grudgingly oftentimes, to be sure and unhappily oftentimes, they view themselves as part of a social enterprise, national health insurance is a social undertaking. There is a kind of social contract and they bargain collectively over prices.

And fifthly, they have at least some, I was going to say semi-serious, I should say more than semi-serious, effort at cost containment. Obviously in all these systems, their costs, while well below ours, they rise faster than they would like to see them go up, but they make a serious shot at it to bargaining over prices and otherwise.

As I say, the US basically has none of those five features, and so to emulate the affordable universal coverage of these foreign federal systems would be quite a stretch. But, then again, hope springs eternal, its 2008, an election is coming, reform is in the air, it's a moral imperative, it's got to happen, it's going to happen, blah, blah, blah. And so it might. So what really is on the table now?

Well, interestingly enough, those good old laboratories of democracy in our federal system have yielded up a model that's really quite different from anything that was around in

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the Clinton days, and it's generated, at least on the democratic side, which is where I'm going to concentrate, if not consensus, at least a high degree of comedy. And not comedy, wrong word. I wanted to say comity, but I guess, come to think of it, I guess I'll leave it where it was, it's probably true, too. But normally, aside from all the opposition to reform proposals, the proponents are usually at each other's throat from the get go. Well, I'm sure they'll get there, but they're not there yet and there is a kind of consensus that is hopeful, in its way.

And let's just call this for the sake of shorthand, the Massachusetts model, what they're doing in that state, which is several basic elements that have been alluded to several times today already. The individual mandate, employer mandates; in Massachusetts they're touchy about calling them mandates, but employer shared responsibility, as the cliché goes. Third, Medicaid expansions; fourthly, income related subsidies; and fifth, some fairly amorphous kind of savings or promises of cost containment, like the Section 125 plans that Elliot mentioned a couple of minutes ago, and other things, too. And they're going at it; last I heard, they've covered over 300,000 previously uninsured people, which is a little over half of the number that they initially estimated to be uninsured. I mean, their estimates said basically five percent of their population was uninsured, people have objected that's too low, but anyhow,

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it's pretty cool. I mean, they've been able to do something important there and I think they deserve credit for it.

Now the question is, is it generalizable, either state to state, diffusion of innervation across the federal system, or is national policy? I think when you ask that question, you really see how much federalism really does matter when you talk about health reform in the US. Arguably, Massachusetts is highly distinctive and possibly unique, and I'll just very quickly mention some of the ways in which I think that's so, and we can argue about it later if you want to. There is interesting history there; Massachusetts passed a universal coverage plan in 1998, and it never was implemented, it was ultimately repealed, but there are a number of people that were on the case this time who were kind of go back and actually make it happen. So there's important history here.

Economically they started off with a high base of private sector coverage and a broad base of public coverage through Medicaid and other public programs, which is important.

Culture, I have Tax-achusetts, there is a liberal, political culture; that counts for something. Just a quick aside, in the '80s and '90s I would sometimes participate in evaluations with Robert Wood Johnson Coverage Expansion Programs through the states that David Helms, who is seated here a few feet from me, was the national program officer for and that would go to Massachusetts. And inevitably, the first

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interview that they would have about some exciting thing they were doing, somebody would sit back and they would say wait a minute, to understand this we've got to put it in context. Remember this, we voted for McGovern in 1972. That's a dated example, but you know, political culture counts for something here.

And finally, politics. There's a degree of cohesion among the interest groups in the Massachusetts effort. The business community, the provider community, the insurance community, other elements that are oftentimes at swords points to one another, and I cannot explain it, I've not seen it in any of the other states to anything like the same degree, but it was there in the '88 effort, it fell apart, subsequently they put it back together for this effort. All that stuff counts for something. I mean, this isn't just health policy analysis in the narrow sense, this really is history and social science that I think you have to look at. And when you do, you have to ask the question about the differences among the states.

Mississippi is not Massachusetts; we learned a couple of days ago California is not Massachusetts either. If I had to guess, maybe there's five out of the 50 states that I think could possibly do the Massachusetts model and make it work well. But that's just pure guesstimation on my part. What this suggests is what I think Drew Altman said, you remember

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when the California thing collapsed a couple of days ago, he was quoted at all the newspapers saying what this shows is the states can't do it themselves, you need a national solution. And I was very careful to work in a quote to him because I knew he was going to be here, he's a luncheon speaker, I figured I'd flatter them and then maybe he'd give me a grant or something, but he left for the airport before my talk. And I've wasted another precious minute of my talk.

I think it's true the states can't do it alone, you need a national solution, I would say, especially since he's not here I'll say this, yes, but on the other hand, I think national policy faces the same political dilemmas as does the states. Yes, it's very nice that you have a larger resource base from which to do your redistributions at the national level, but it's not just a question, it's not just a fiscal or economic question. It's a question of political economy and is the political will there to do it? I don't think there's any particular magic in elevating the issue from the state level to the national level, so I think the Massachusetts model is not a panacea, it's not really an answer; rather it's, maybe except for five states, but it rather restates the questions, I think, in a particularly instructive and helpful and possibly, I think, constructive way.

If that model were generalized nationally, or if it was done in other states, if it were done well, I think it could

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achieve equitable, affordable, universal coverage. if subject to that individual mandate, you kept the out of pocket payment costs down for the groups least able to afford it to the blue category, I don't know if the charts this morning, which were very, very helpful, if there was some teeth with respect to some shared responsibilities of employers, if you expanded Medicaid in some generous fashion, if you did this income related subsidies on a sufficient scale, and if you did something after doing all of that about the growth of costs, which will be very important and possibly an Achilles' heel for Massachusetts or others. But if it were done poorly, it could be an inequitable kind of cruel charade of universality under the auspices of individual mandate; you could end up obliging lower income, hitherto uninsured people, to pay a lot of money out of pocket in order to buy lousy coverage. And as Uwe would say, A or B, in which category do you suppose you would more likely to be in. I don't know, it's a good question.

Well, we've given up the grandiose, Bill Clinton reform plans for comprehensive reforms that will yield huge savings and enable us to cover everybody, while breaking the back of healthcare costs, inflation, and squeezing \$300 billion, or whatever, waste out of the healthcare system. We're not talking that way anymore, and that's probably a good thing from a political standpoint at least. The question now is in the absence of grandiose designs for those huge savings, will we,

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as a nation or citizens of the 50 states, be willing to cough up the money needed to get to universal coverage? That money is not all that huge, but it's not tiny either, and it raises all these tough issues of who's taxes are going to be cut or increased that have preoccupied the American public since Ronald Reagan, at least, in 1980. Are we going to move beyond that? I don't know, I think a look at what's going on in the federal system sharpens the key questions very nicely and, at least for me, it give me sort of roughly equal parts of the encouragement, and a sense of buyer beware.

FRANK NEUHAUSER: Good afternoon. It's, as always, it's a privilege and a pleasure to address the Academy, its many members and today, obviously, its many friends. So I think the crowd here is a credit to the Academy's ability to put together an important and useful conference, and I thank them for that.

My job today, we've been talking about different ways to form a universal health insurance coverage market. I'm going to talk about one way in which that market could be constructed if we had universal health insurance that would go a long way to rationalizing the worker's comp market, and the group health market at the same time, and possibly save money that would allow us to get to universal health care, maybe more quickly and inexpensively.

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So in the early 1900's when Upton Sinclair wrote these words describing a vile and dangerous work place, that the early industrialized America was becoming, occupational injuries were common and they were often dangerous. And what this did was it created a group of people that were certainly deserving of medical treatment and care. But that care was not always available, it was only available if the employer volunteered it, and if they didn't, there wasn't other opportunities for workers. They didn't have access to health insurance, that was rare at the time, and there really were no other major social insurance and social safety net programs in existence at the time. Those were decades away. And one solution was litigating to obtain your benefits, but that litigation could come out with the worker being destitute because they didn't get benefits, or the employer facing an onerous jury verdict.

Consequently, in the early 1900's, we adopted what amounts to a universal health care program. It only covers occupational injuries, but it was adopted state by state, certainly a successful example of an employer and employee cooperation on developing universal health care at a time when there weren't any model programs for this in the United States. We were successful then on a state by state basis, and maybe we can be successful again.

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So objectives, what am I going to cover in the next 12 minutes? I'm going to say something about worker's compensation system and why it's so inefficient as a medical delivery system, specifically as a medical delivery system. Second, I'm going to argue that the worker's compensation system now covers conditions that we call occupational, but that discrimination is somewhat of an anachronism. Third, I'm going to talk about the level of savings that we could obtain if we integrated occupational and non-occupational medical treatment. And fourth, in a sort of serendipitous confluence of cost and benefits, I'm going to show that the cost of extending universal health care is going to fall on precisely those employers and workers who are going to get the most benefit if we integrated occupational and non-occupational care. All of that in just 12 minutes, so here we go.

First off, many of you might be familiar with group health insurance and health markets, but may not be familiar with worker's compensation, which is a bit surprising. Worker's compensation is one of the largest social insurance programs in the country. NASI is going to come out with a publication that they come out with each year from 2006 totals, which, I think, will suggest that employers will pay about \$85 billion for worker's compensation insurance. Worker's compensation insurance covers both wage loss and medical benefits, but those medical benefits constitute the liabilities

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for the medical portion of it are about two-thirds of the cost of worker's compensation, or about \$55 billion. Small by comparison to the whole medical care system, but real money.

The worker's compensation system is supplied mostly by property casualty insurers, not health care insurers. And employers pay a premium based on a percent of payroll, and that premium varies dramatically across employers, depending on the risk of their, faced by their work force. And this is just an example of how those premium look for different employers, this is for California, but it's not dissimilar for other states. So many employers pay substantially less than one percent of payroll to cover worker's compensation. But another portion of work of employers pay, 10, 20, even 40-percent of payroll to cover their worker's compensation liabilities. To put this in perspective, I think group health costs for employers now are about seven percent of payroll, on average. So you can see that there's a substantial fraction of employers that pay something that's many times what they would pay for group health.

And medical treatment is delivered in a very different way than most of our group health plans, there's no copays or deductibles, and it's entirely fee for service. But the point that I want to focus on here is that worker's compensation pays for medical treatment up front and the employer pays for that treatment for the life of the worker for whenever that

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condition arises again. So if a worker has a back injury and several years later that back injury reoccurs and can be attributed to an occupational cause that occurred years ago, the employer is still liable, or the employer's insurer is still liable. A knee replacement many years in the future, where work contributed something to the degradation of the knee, again, the original employer is liable even 20, 30 years in the future. And that's going to be important here.

Okay, now I'm going to give you the punch line, what are the punch lines of the talk, although punch line might be the wrong metaphor? There's nothing really very funny about this joke. On the left, I'm going to compare the administrative costs in group health to the administrative costs in worker's comp. On the left is group health. In the metric I'm using here is what does it cost us to deliver one dollar of direct payments to physicians, hospitals, pharmacies, etc. What does it cost in administrative costs? Well, it's pretty well; most people think that group health pays about 15 to 20-percent of a premium in overhead and administrative costs, or in this metric, about 20 to 25 cents to deliver a dollar of medical benefits. Now you may not believe this, but in worker's compensation, delivering that same dollar of medical benefits costs about \$2.20. This is data from about 37 states, 38 states, for 2006. So get that metric right here. It costs 25 cents, we think that's a ridiculous level of

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friction costs, you know, in group health and nobody ever describes group health as being efficient in most talks like this. But worker's comp costs about nine times that much in administrative costs. Employers are really paying about two-thirds of their premium, that's dedicated to the medical portion of worker's comp, in overhead and administrative costs.

And one of the reasons for this is that the world has changed in the last 100 years since we adopted worker's compensation broadly. In 1900 when Upton Sinclair was writing, everything was a traumatic injury that clearly happened in the work place. That's very different today. Two-thirds of the conditions in worker's compensation are non-traumatic injuries and illnesses; cumulative injuries, non-specific back pain and sprains, and occupational illnesses. And they consume a much bigger portion of the total medical costs because they're more complex and expensive to treat. And one question would be how well do we do it, defining these conditions as occupational, when they're non-traumatic conditions?

Well, we took the Medical Expenditure Panel Survey conducted by AHRQ and we divided the worker's into the survey in three different groups based on their risk, their occupational risk, essentially their worker's compensation premium. And then we balanced the groups by their characteristics that might affect their likelihood of having particular conditions. And then let's look at the incidence of

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fractures among this population, so the red bars are the number of fractures per hundred were workers that are reported, and you can see that across all occupations are balancing of the controlling for the characteristics is done pretty well. The non-occupational fractures are virtually identical in number per hundred workers and the occupational fractures do just what we want. They increase by about a factor of four as the risk and the occupation increases. So worker's comp does a great job.

The problem is that these are very infrequent in terms of conditions in worker's compensation. The big kinds of conditions are things like back, and this is an example of how we do on backs. This is a completely different story. Across these three categories of workers that have very different worker's compensation premiums and very different risks, there is no difference in the frequency with which they are treated for back conditions in a period of the medical expenditure panel survey. But the frequency with which it's defined as occupational increases by about a factor of four across these groups. So it's not clear that we can discriminate effectively on conditions that are non-traumatic like this and assign occupational and non-occupational causation. But we may spend a lot of money to do so.

Okay, I'm going to skip, I'm going to change the order here. So paraphrasing something from the Nixon administration,

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how much would employers save and when would they save it? One of the things that, if you remember earlier, I said employers pay up front for the cost of worker's compensation, so they pay it already to insurers or self-insured reserves for all of the past injuries. Now if we had universal health care, we completely integrated these two systems and we went forward on a pay as you go basis, like group health where we have policies every year for conditions that occur every year and we don't care when the condition started or when it ends. It turns out that in worker's comp, only about 10-percent of actual medical costs are paid out in the first year of the policy. About 20-percent are paid out in the second year, and then it declines after that with substantial percentages of the cost being paid out as much as 30 years in the future.

So in that first year, employers are facing about 10-percent of the underlying, direct costs of medical treatment. So if we're eliminating the direct costs of, if we're only costing employers 10-percent, and we're eliminating the excess administrative costs by integrating into the more efficient group health model, it turns out in the first year, the cost for employers for the direct cost to what we pay providers, hospitals, pharmacies, would be about \$3 billion in the worker's comp market for new injuries occurring in the first year of this plan. And over time, that cost increases to \$17 to \$20 billion, but in the first year, we're saving about \$50

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billion, and eventually we're saving about \$30 billion. And if you remember those numbers that Uwe talked about earlier, that goes a long way towards accomplishing what we're trying to pay as the incremental cost of going to universal health care.

Now I said the last point was that there's this very serendipitous confluence of the fact that the people that bear the cost of universal health insurance would also be precisely the employers and workers that experience the greatest savings from integrating occupational and non-occupational care. And we could assume for a second that the universal health care would be based on some kind of employer mandate. That doesn't have to be the case, but it's a useful simplification. So the cost of expanding coverage to be universal are going to fall primarily on those employers and those workers of those employers that don't either offer health insurance or workers that don't currently take it up.

And this is a look at, from the current population survey, the percent of workers covered by health insurance supplied through the place of employment, and I'm splitting the group into two groups. Those on the big red bar, which are workers in occupations that have lower workers compensation costs, two percent or less per payroll, that's about half of the workers fall into that group in California. And the higher portion and workers in high risk occupations where the premiums for workers comp average three to 40-percent. And you'll see

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that for workers in low risk occupations, they're covered by employer based health insurance about 66-percent of the time, 65 to 67-percent, this is nationally, its non-union workers in this case. But for non-union workers in high risk occupations, where employers are paying high workers compensation costs, coverage is 20 percentage points lower. And this holds true across the US and high cost states and low cost states. Workers in high risk occupations have about a 20 percentage point lower coverage for employment based health insurance than workers in low risk occupations and low risk employers.

So if we go to universal health care, and we integrate occupation and non-occupational medicine, and we get the efficiencies of group health care, it's precisely those employers that we'd be asking to extend the benefits that are the high risk employers, and they would be the ones getting the most advantage from integrating occupational and non-occupational, maybe something close to the size of their additional costs or the incremental costs of going to, of covering the care.

So, summing up, I'm arguing that we could integrate the occupational medical treatment into group health. First off because workers compensation is somewhat of an anachronistic system and we can't really identify conditions, the majority of conditions, accurately as occupational or non-occupational. The medical treatment under comp is extremely expensive and

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integration has an opportunity to save us a substantial amount of money, an amount of money that's very, you know, in the ballpark to the kinds of incremental costs we're talking about of extending care. And finally, that these savings are going to accrue, in the main, to employers that are facing the additional cost of coverage, and workers who face the additional cost in the form of reduced wages or co-payments of some kind. Thanks.

JENNIE CHIN HANSEN: Okay, we covered a whole territory in terms of framing to something as specific as moving together workers, compensation with regular coverage. So I really welcome anybody to have a chance to come up to the microphone, or if you would like to speak from your seat, please just raise your hand. Okay, start with the right here.

BERNADETTE FERNANDEZ: Hi, Bernadette Fernandez from the Congressional Research Service, and I'll admit I have a comment first and then a question. Cori, I appreciated your comment that even if you can get good pools, that that doesn't necessarily translate into premiums; I think the idea of pools, just with the enthusiasm that you've seen discussed and certainly evident in a lot of proposals, its been oversold, so that's my comment.

Okay, so my comment aside, my question to the panel is, is if you believe some kind of pooling mechanism is a not necessarily sufficient component of any health care reform that

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attempts to achieve universal coverage, and if so, how would those pools, or how should those pools be structured?

CORI UCCELLO: I guess I'll start. Pooling is fundamental to insurance so just, you have to have it, and like you said; my point is that it's not necessarily the case that larger pools are necessarily better or lower cost. So with that said, I think that pooling, yes, is a vital component to any kind of reform, I guess how these different reform proposals would implement different pooling arrangements. And they are not necessarily good or bad in and of themselves. Like I said, it really depends on how they're implemented and one of the main things that I kind of want to get across is the rules we're applying to those pools compared to what's already existing, and that's a really big deal. You don't want pools, different markets with different rules, because that causes all the adverse selection and I think that's really the main thing to be looking out for. Is there a level playing field between different markets? Is everyone operating under the same rules? And I think that's a pretty critical component.

ELLIOT WICKS, PH.D.: I think I interpreted the question to mean something different than what you were saying, that she was talking about what I refer to as exchangers or connectors and so forth, and whether those were a key element. I mean the whole notion of insurance is pooling risk, so you have to have risk pools, but the question is do you have to

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have something like a connector in exchange? You know, a few years ago the group I worked for, you know I'm at the Social Research Institute, put together a series of we asked experts to put together proposals for national health reform covering the uninsured. And I don't remember the exact proportion, but I would say at least two-thirds, from the right and the left had something like a purchasing pool as part of it. And I think it just makes sense. You need someplace where people can go to and where they can compare plans and where you can reduce some of the administrative cost of selling the small groups and the individuals, and you need something. And if you think about the federal employees health benefit plan or CalPERS or any state employees plans, why are they organized that way? That's partly because they can do these things. So I think the answer is yes if you're going to rely primarily on private insurance markets for people who are not low income.

CORI UCCELLO: Okay, I'll jump in again and say, yes, interpreting the question that way, which is probably the correct way, I agree with Elliot.

JENNIE CHIN HANSEN: Okay, thank you.

LOCKLAND TAYLOR: I'm Lockland Taylor with the California Commission on Health and Safety Workers Compensation. Given the complexity of trying to reach to universal health care, would tying it to the politically

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sensitive areas of workers comp help to fund it or just doing it to become even more complex?

FRANK NEUHAUSER: Well, that's a tough question. Actually I think this is interesting. Now remember we did this in workers comp 100 years ago, and every state adopted it, and we got the universal health care just on the agreement between management and labor over this process. But the timing here is critical. I don't think that it's possible to integrate these two programs without something that's very closely approximate to universal health care. So it can't, you know integrating can't come first, but it's also not clear that if we integrate, if we got universal health care, Tom might correct me here, Tom Ranken in the back of the room, but I'm not sure that labor would be willing to give up at that point the advantages of workers compensation that they see. So I think labor might be willing to join with employers on this if it's clear that universal health care on this side and some changes in workers comp on this side, and I think they would make the changes to get the universal health care. But I don't know that they can happen not simultaneously.

GEORGEANN CHAPIN: All right, my name is Georgeann Chapin, I run the Hudson Center for Health Equity and Equality in the Hudson Valley of New York. I really appreciate Professor Brown's comments on the problems inherent in the connector model. One thing that hasn't been mentioned today

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when talking about the uninsured, we all sort of take it for granted, is that we don't have the same uninsured from one day to the next and that vast numbers of people churn in and out of coverage, and that seems to be inherent in the insurance model where everything is temporary, everything is up for grabs at the end of a year, or at the end of a coverage period. And what I'm getting at is some kind of comment, both from the actuarial side and from the other people in the panel, of the cost of administering arguable thousands, if not tens of thousands, of different options across the country as a result of not wanting to compromise in any way on offering people some kind of standardized benefit package and really, truly large pools of standardized benefits.

JENNIE CHIN HANSEN: Does anyone have a comment here?

CORI UCCELLO: I guess the one thing I would almost tie this back into the other question, in terms of portability issues, too, if you do have this churning and some of these purchasing pools are markets that combined a small group, an individual or something. There may be some more portability opportunities with those kinds of things, which could potentially reduce some costs. But in terms of turning, too, one of the administrative costs, especially for the individual and small group markets, one of the biggest first year costs are the brokers commissions and that kind of thing, and so that

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could be reduced with some kind of more portability, I would think.

MALE SPEAKER: I'd just add, I think one of the issues about the pools is people are going to want to be in them, and one of the distinctive features of American history, I think, with respect to insurance is it's very different across nationally. In other countries the attitude has been that cross ups of these redistribution, everybody in one pool, and the better off taking care of the not well off, that's the essence of equity and justice. In America there's a very large tradition of saying, look, if I'm a good risk, I should have a better rate. If I'm healthier, than I should pay less and it's not by accident that we evolved from community rating to experience rating in so many markets. And to this day there's still that issue, so just getting the kind of, I don't know how you would say it, the solidarity or the philosophical consensus about the large pools that permit the kind of redistributions that you want without egregiously high administrative expenses, that's a heavy lift, I think.

SALLY ANN PEYTON: Sally Ann Peyton, University of Michigan Law School. I have a question about the workers comp and the whole issue of folding property and casualty insurance, or at least the health care, the medical component of the claims in many property casualty areas turns out to be very substantial and could be folded into a regular first party

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health care system. I have a caution about that and just a question for you. It turns out that a lot of property casualty insurers are part of our informal enforcement system for various torque standards and occupational, safety, and health standards. For example, they do inspections, they do underwriting, they want to make sure that the people who run the building site have abided by the safety regulations and all of that. that all of done through the insurance system and therefore saves us a great deal on enforcement costs, and may be why we have as few occupational injuries, the more catastrophic ones as we have, and I wondered if you've thought about the loss in that enforcement system, that informal enforcement system, as you think of folding the property casualty into the first party health system.

FRANK NEUHAUSER: Actually that's an interesting insight. I usually think of the problem here and the challenge that's sometimes raised, is that we think of workers compensation in that discrimination in the premiums and the experience rating that goes along with it as an incentive to improve safety in the work place independent of the enforcement process. I think everybody thinks that workers compensation plays that role of premium pricing somewhat in line with your safety record, and to some extent that won't be lost because most employers are currently experience rated for the group health plan. So the extent to which your occupational health

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care costs are higher, your group health care costs will be higher, and employers have the incentive. But you're raising another issue, which is along with that process goes some enforcement mechanisms. I don't know if I share your confidence in the strength of those enforcement mechanisms, supplied by the property casualty insurers. Certainly that loss control effort and things like that was a subject of work in California, and it's not clear that they do as much as they claim to do. OCEA does, of course, but that's separate from the insurance, but that's a very interesting comment.

SALLY ANN PEYTON: The question and the function is there, and we understand that the function is there.

JENNIE CHIN HANSEN: Thank you.

STAN DORN: I'm Stan Dorn at the Urban Institute, and I have a question about health insurance exchanges. The question is which employer should be allowed to use them? Usually people think of them as a vehicle for small employers because the case for health insurance exchanges is that it answers the problems in the small group market and in the individual market, but it seems to me there's an important benefit to health insurance exchanges that applies to larger employers, as well. And that's the issue of portability and continuity of coverage that we were talking about a moment ago. If I can access coverage through the health insurance exchange, regardless of who I work for, that means I can stay in the same

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plan year after year after year. Today it's very hard to make a business case for quality in long term wellness. Why should my insurance company invest in my long term well being if three years from now I'm going to be with another insurer? This is my current insurers investment will be down to the benefit of their competitor, but if instead I keep the same insurance for an ongoing period of time, suddenly the incentives for quality and cost control change, and that applies to large companies as well as small. So I guess my question is do people think it makes sense to look at health insurance exchanges for large employers as well as smaller employers?

LAWRENCE BROWN, PH.D.: I think that's a good point and certainly some people have thought of it that way. There is a concern, of course, that you might get adverse selection against the exchange because the higher risk large employers might choose it and the lower risk ones might not. There are probably ways to deal with that by doing some kind of premium related to risk. I think there's also another advantage and that is if you believe that people care about the cost of their coverage, if people in large firms also had the choice of health plans and the insurers had to deal with the fact that they would be choosing a new plan whenever they wanted to, not depending on the employers decision, there would be more pressure for them to try to be really efficient. And so I

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think a strong case could be made for them. Of course, that's what the Clinton alliances were, and we know how they fared.

JENNIE CHIN HANSEN: Thank you.

HARRY SHUFFER: Okay, I'm Harry Shuffer, I didn't introduce myself before. I'm an economist with the National Council on Worker's Compensation and Insurance. And my first request is, Frank, I would really like to see a copy of your paper because some of those numbers surprise me. Two or three comments, because my initial reaction is that the savings are not potentially as great as you indicated, but I need to look at the paper. Two or three things; worker's compensation was created in part of social insurance by the Progressive's; it was really torque reform on the part of the firms. So I think you can argue almost that worker's compensation was not torque reform because litigation was creating these almost 100 years before we had these issues with medical malpractice and now the awards fair and stuff like that. But let me just put that to one side; two or three other observations. Worker's compensation companies typically do not charge a premium that is equal to or greater than their anticipated claims payments and administrative costs. Frank showed a panel that indicated that the payments extended over many years and insurance companies take that into account and then states like Florida, they're required to by statute to estimate potential investment income from the premium they receive and use that as an offset

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when they establish the premiums, so when you see benefit payments you have to understand that they don't, they price off of that, but they also take into account the time value of money.

Third observation is that, and it can probably be dealt with in universal health, but the incentives in worker's compensation are very different from group health, and we do know that worker's comp claims costs medical are significantly higher early in the life of the claim compared to group health and what I say informally is, well, they're different business models. An awful lot of people get well on their own, so there's an incentive in group health to wait until natural healing identifies the folks who are most in need of treatment. Worker's compensation also pays for the amount of time, wage loss, when people are not able to work, so they use a sports medicine kind of model to try to get people back to work sooner. So there's been this attempt at 24 hour coverage in the past, and Blue Cross/Blue Shield, for example, has tried to set up some incendiaries to deal with worker's comp; it has not worked as effectively as people wanted because the incentives are very different between traditional group health and the medical and worker's comp. So you gave some numbers that are, really make me want to take a look at it because I'm intrigued, but perhaps a little bit of overstating the case.

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FRANK NEUHAUSER: Well, actually if I showed you the slides for California, Harry, they would look even more exotic because California has been a really quite unique market for the last several years. I'm glad to send those to you; I've sent these to a number of insurer association's and I can't believe I didn't send them to NCCI, and most of them cast dispersions on myself as a person, but not on the methods that I used to arrive at the numbers. And all your points are well taken and also I wouldn't want to oversell this. That's sort of a best case scenario if we integrated and got savings, but no doubt, pieces won't be integrated and we'll chip away at this and that, and the transition will be expensive. But fortunately, in the original transition years things are, there's greater savings because of the long tail on worker's compensation, they're very different insurance products.

JENNIE CHIN HANSEN: Okay, we'll have two more questions and we'll have a break.

ANNA REP: Anna Rep [misspelled?] for, in any population, there might be five percent or seven percent of the people that account for an awful lot of the claims and my question, sort of regardless of the size of the pools, is if people can make voluntary choices, how do we get the healthy people to be willing to join pools that have a fair share of the sick people in effect to pay for some share of the sick people, or do the sick people fall out into special pools and

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we still pay for them by taxes? That seems to me to be really hard questions; structuring pools that will work for everybody.

LAWRENCE BROWN, PH.D.: Well, I think that's a strong, the argument you've made is a convincing one and it's, of course, part of behind the arguments for people who favor a mandate, that unless you can be assured that the low risk people are in the pool, then you'll have a difficult time subsidizing the higher risk people, and that's essentially the argument behind the mandate that pretty much applies in the individual market. In other markets, people are much more likely, even high risk people, to be in a pool because they are subsidized by their employer, or it's just part of the system that they're in. It's the individual market where that really becomes a problem. But the point you made is a good one because no matter how you do it, high risk people have to be subsidized. They can be subsidized by other people in the pool if the pools are a variety of pools, or they can be subsidized by the taxpayers as a whole, or some subset of taxpayers, that is through government programs, like government reinsurance or high risk pools and so forth. Those are partially subsidized by government funds. So either one makes sense, it just depends upon which one you think you can get public support for.

JENNIE CHIN HANSEN: We have two more questions here, all right.

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JOHN BURTON: John Burton from Rutgers's University, I want to go back to the worker's comp topic. One of my concerns is the history of trying to integrate workman's comp with the general health care system as part of an overall reform. The Clintons, Clinton 1 proposal did that, and it managed to unite the property casualty insurance industry against reform, partially because the argument that we just heard, which I think is a legitimate argument, mainly that worker's comp carriers have a strong incentive to get people back to work and so the so-called sports medicine model is important to get that care in quickly, and this was said over and over again by the private carrier's in the Clinton efforts in the early 90's. The Clinton administration totally blew that issue, just didn't deal with it, and I have no reason to think they've got the capacity to deal with it now. So I think you'd be better of disassociating it. Now let me add one other comment, I don't happen to believe that argument very much because if you look at the Canadian system, and I've look at the Ontario system, and the entire worker's comp and the entire health care system is essentially uniform or unitary system for both occupational and non-occupational diseases and injuries. It is one that I think works quite well, they have lower health care costs overall than we do, they also have lower expenditures on cash benefits through their workers comp system. There is a charge back system from that health care system into worker's comp, so

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that to the extent you're worried about experience rating, the Ontario model is one, I think, provides us some assurance that you can have both experience rating, find incentives to safety, and at the same time, the unitary health care system. But I don't think we've got time to work that out between now and this health care reform effort of the next 18 or 24 months, and I'm really concerned that if we start to move down the integration of worker's comp in this thing, we're just putting in another obstacle to getting something passed.

JENNIE CHIN HANSEN: Thank you, John.

FRANK NEUHAUSER: John is about the smartest person in worker's comp, so listen to what he has to say. And I agree with much of what he has to say and I think integrating these two, they're very different systems, and integrating them is very difficult. And Judge Taylor from California said do we want to sacrifice universal health coverage for worker's comp, and I think it kind of works the other way, you know. There are savings here, you could argue about the size of the savings, but it's a very inefficient way to deliver medical treatment. And that could help us get to universal health care, the question is, is it too complicated, does it bring too many enemies to the table in the form of different interest groups that are tied too workman's compensation?

JENNIE CHIN HANSEN: Thank you. Final question.

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MALE SPEAKER: I just wanted a brief observation on that last exchange, would be the Ontario example might be a good one for you to look at, Frank, because there's a case where the worker's comp was not the means to get universal health insurance in Ontario. The integration to the extent it happened, happened in the different process. My question, really, is directed to Larry Brown in the most friendly possible fashion. And that is to say I just would want to explore, Larry, whether there is some tension in the two tales that you told about the experience of Europe and the experience of Federals in the United States and the comments you made about Massachusetts being a distinct political structure and culture. I would say the same thing would be said about Europe, and was indeed said by you, that there is variations across the world of Switzerland and Holland and Germany and the UK. So it goes to this issue of the contrast you made between the common sense of solidaristic sentiment in Europe versus the absence of, if I heard you right, in the United States. But the paradox for me is if that were true, Medicare would have been impossible. That is the pooling device you're talking about, the sense of disconnecting what you pay from the expected risks you've got is built into the Medicare program for vast numbers. I'm not contending that the issue doesn't stand for some Americans, but we have a series of different Americans just like there's a series of different European

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countries with more or less mixes, as you were suggesting, in the differences between Mississippi and Massachusetts. So if there's differences between Mississippi and Massachusetts, there's differences in the distribution of solidaristic claims in the United States, you know?

LAWRENCE BROWN, PH.D.: I'm not sure I follow what the question part is.

MALE SPEAKER: The question is are there differences in the degree of solidaristic thinking in the United States, or are you going to hold to your view that in the United States there does not exist that view, which is the way I heard you say it?

LAWRENCE BROWN, PH.D.: I think the glass is half empty and half full; it managed to achieve solidarism for one distinct population group in a pattern that's not seen in any other country. As far as I know, no other country ever came along and said we're going to do universal coverage for the elderly, and then we'll sort it all out for everybody else. I think Medicare is a marvelous achievement. I think it's also somewhat context dependent, and it's basically we've said, and still believe, I think, contrary to the evidence on government's role that basically this is still an employer based, private health care system in which government's role is to fill major gaps, and then we had a big debate about which were those major gaps. And in quite unusual political

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circumstances, we finally were able to agree that the elderly were the major gap and we passed a program around it. We looked at, as you've demonstrated better than anybody, we looked at social security and very consciously decided that this could work, that social security had the legitimacy of social insurance, the day you get back what you pay in and so forth and so on, and it worked then, and it's worked since. But on the other hand, I think we've not been able to expand it in the 40 years subsequent, we haven't been able to take that model to other new groups, except for what people suffering from renal dialysis. In '72, it took us almost 40 years to get the drug benefit passed, and that's a mixed blessing in itself. So I think we have a very partial kind of solidarity, and it has a great deal to do, I think, with the nature of the group in question. Now when you get, basically what we've done is we've created a system where you've got employer based coverage for much of the population, most of the population, you fill in the gaps through Medicare/Medicaid and you've got 15-percent left who don't fit any of those categories, who've had 40 years of debate about what we do with them. And so I mean that's the temperature [misspelled?] on solidarity, I think.

MALE SPEAKER: No, that's fine. I just was only concerned about the over statement of the absence of any solidaristic statement. So you clarified it, thank you.

LAWRENCE BROWN, PH.D.: The glass may be a 1/3 full.

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JENNIE CHIN HANSEN: Thank you. Well, please join me
in thanking the panel for this. And I believe we'll see you
back in about 10 minutes. All right, thank you.

[END RECORDING]