

## **Briefing: Effective Ways to Expand Health Care Coverage May 3, 2004**

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**MARK AGRAST:** Good morning. I'm Mark Agrast the Senior Vice President for Domestic Policy at the Center for American Progress. It's my pleasure to welcome you this morning to the Barbara Jordan Conference Center for this forum entitled, Mayday for the Uninsured, Will We Ever Achieve Health Care for All? I want to express our appreciation to the Kaiser Family Foundation for making this beautiful facility available to us and to other non-profit organizations. It's a tremendous community service, we're very grateful. And it's a particular tribute to the late Barbara Jordan who as we all know, brought such dignity and clarity of purpose to her many years of distinguished service as a member of Congress. I'd also like to express our appreciation to Congressman Pete Stark, the ranking Democrat on the Health Subcommittee of the Committee on Ways and Means who was to have been with us this morning and unfortunately was unable to attend. I'd like also to acknowledge one member of the Center's staff who's been instrumental in developing this program—the Chief Architect of our own health care program at the Center, our Associate Director for Domestic Policy, Terry Shaw.

The Center for American Progress is a non-partisan research and educational institute dedicated to promoting a strong, just, and free America that insures opportunity for all. We seek to insure that our nation's policies reflect the common commitment to those values of Americans from all

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backgrounds and all walks of life. Of the many challenges facing our nation, affordable health care for all is among the most depressing and the most difficult to achieve. But as we will hear from our esteemed panel of experts this morning, it can and must be achieved if our nation and our people are to prosper in this new American century.

A few months ago the Institute of Medicine at the National Academy of Sciences issued a challenge to insure that every American has affordable, continuous, high quality health coverage by the end of this decade. The Center for American Progress has embraced that challenge. And in coming months, we will be putting forward our own ideas as to how it can be achieved. We will draw on the work of leading experts, including members of today's panel as we seek to bring together the best thinking and advance the public debate on this issue.

It is now my pleasure to introduce today's distinguished guests. Dr. James Mongan, President and CEO of Boston's Partner HealthCare System and a member of the Institute of Medicine's Committee on the Consequences of Uninsurance. Dr. Judy Feder, Dean of the Georgetown Public Policy Institute, and a close friend and advisor to the Center. Dr. Jeanne Lambrew, an Associate Professor at George Washington University, and a Senior Fellow at the Center. And finally Dr. Uwe Reinhardt, the James Madison Professor of Political Economy and Professor of Economics and Public Affairs at Princeton's Woodrow Wilson School, and the author of many important works

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on the American Health Care System. We will hear first from Dr. Mongan.

**JAMES J. MONGAN, MD:** Thank you very much. I've been asked to come this morning and summarize key findings from the recent series of Institute of Medicine reports on the consequences of uninsurance. I was very pleased to serve as a member of this panel because based on my 30 years of work on this issue, I knew that solid evidence on the health and economic impact of uninsurance, that could help move the debate forward, had yet to be pulled together and communicated effectively to policy makers and the public.

The 6 IOM reports over the past 2 ½ years have done just that. Now having participated in numerous discussions and debates over the years, it has seemed to me that two main beliefs and concerns have blocked action on this issue. First, many opposed to expanded coverage—deep down—have assumed coverage doesn't matter. And second, most opposed to expanded coverage opposed it because the fear the additional cost and more specifically they are strongly opposed to the new taxes or mandates necessary to support coverage expenses.

So against that backdrop, what did the IOM reports show with regard to these two important points? Well first, let's focus on the impact of coverage on health. Many people assume that the uninsured get care when they need it, and in a sense they're right. After all, for an acute traumatic episode such as childbirth or a broken leg, almost everybody does get

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treatment. We as a society are uncomfortable watching childbirth in the street, or ignoring those with an obviously broken bone, and we're willing to pay the cost of moving that care indoors. But what's not well understood is that the uninsured often do not receive care for less dramatic chronic illness, and in many instances defer care until their illnesses have reached an advanced stage.

The IOM report showed that studies of specific diseases in health conditions show worse outcomes for uninsured adults. Let me give you four examples. First, largely because it delayed diagnosis, uninsured cancer patients die sooner than do otherwise comparable patients with insurance. Population based studies of breast, cervical, colorectal, prostate, and melanoma support this finding. Second, uninsured people with diabetes are less likely to receive the recommended standard care. Over time, this inadequate care places uninsured diabetics at risk for additional chronic disease and disability. Third, uninsured adults with hypertension have less access to care, are less likely to be screened, are less likely to take prescription medicine, and experience worse health than those with health insurance. And fourth, compared to insured HIV patients, uninsured adults with HIV are more likely to forego needed care, face greater delays in accessing appropriate care, and are less likely to receive highly effective medications. And finally, long term population based studies show a 25% higher risk of premature death for adults who are uninsured.

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The committee estimates that 18,000 uninsured adults under age 65 die prematurely each year as a result of their inadequate health coverage.

And now turning to the cost of coverage, let me review for you just three key sets of numbers from the IOM report on the economic consequences of uninsurance. The first finding was that we as a nation are already paying \$99 billion dollars for the care that the uninsured receive now. And in fact, the uninsured themselves are paying about a third of this sum. The second finding is that it would take an additional \$34-\$69 billion dollars to pay for the care that the uninsured are not receiving. The number is given as a range to reflect different assumptions about utilization and provider payment rates with universal coverage. And the third finding is that the value of health, loss do to excess mortality and sickness among the uninsured is on the order of \$65 to \$130 billion dollars each year. In other words, our nation bears a hidden economic cost in terms of loss productivity, lower rates of educational attainment, and other personal impacts due to poorer health among the uninsured. Given these straightforward health and economic impacts, it's simply neither morally nor rationally correct for us to continue to ignore the uninsured. Thank you very much.

**JEANNE LAMBREW, PhD:** Well thank you Jim and thank you all for coming. I'm gonna second Marks welcome to this event and say at the Center for American Progress we really do want

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to contribute to this debate in as many ways as possible. So I'm going to [Inaudible] slideshow. [Laughter] There we go. My specific part of this is to really talk about the issue of health reform for low income populations. I'd like to start with the facts. First important set of facts is that the problem is bigger for low income populations. If you are poor in this country you're much more likely to be uninsured than if you are near poor or higher income. In addition, most of the people who lack health insurance are themselves low income. About 35% of the American population has income below about 200% of poverty—that's about \$20,000 for a single person—yet 54% of the uninsured have income in these brackets so it's both a more severe problem for those individuals and they comprise most of the uninsured problem.

Going beyond that and looking at statistics that span across several years, what we know is even more dramatic. In fact over the course of 4 years 68% of low income populations all had a gap in health insurance coverage. Two-thirds of them within sometime over a 4 year period without health insurance, and that we do know—moving into this next part of this—is that the consequences are fairly severe. But I do think that it's also important to recognize that lack of health insurance is clearly a problem, but affordability of coverage is also a problem for low income people with health insurance. What this chart shows is that amongst those who are continuously insured—people who actually have health insurance—28% of low income

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populations actually experience a problem paying medical bills. So it's not just a problem of lack of insurance, there's also a problem of inadequate insurance.

Beyond being a bigger problem in terms of dimensions, we also know that the implications for low income populations are more severe. Low income people have greater access to care problems. So they're more likely to not visit a doctor for a medical problem—not thorough prescription when needed, or they're more likely to skip a recommended test or procedure when they're recommended. These problems extend beyond health care. They also are more likely to face financial problems, but when you look at low income uninsured people, we see that half of them—fully half of them report problems on paying medical bills, and 28% of them had to change their way of life in order to deal with their medical problems. That compared to higher income uninsured—which is the middle bar—which is a lower percentage. I do want to say as note, even low income people with health insurance do better than higher income people without health insurance. Low income certainly affects access, but insurance affects even for high income individuals.

Now, traditionally this population—this 35% of the population it really is the people that we don't often see on a daily basis. But I think one of the big challenges is that it's not really just somebody else's problem. As Jim described, it does result in a less healthy and productive nation. Our international health standings are mediocre at

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best.

In addition, there's all this cost shifting that goes on in the system. People who have health insurance pay up to \$35 billion dollars a year in shifted costs due to the uninsured. In addition, we know that when you become uninsured/unemployed you often lose your health insurance which is one thing of delay. And truly, as Jim mentioned as well, it is against the principle that's a core American principle of fairness and equal opportunity.

The problems that we have in our health system is kind of like saying, if your house is on fire, you need to put up your money before the fire department will come into your house. Like saying, if you send your children to school with a check because the child won't be able to get a basic education without money—that's the nature of the inequities that we have in our system that are most particularly affected or to be felt by low income populations.

There are policy and political challenges though that arise when thinking about how to address of low income populations. The truth is most of these individuals have two real low liabilities really to be helped by tax policies. They also, often, are in and out of jobs, in part time jobs, in part time years, which makes it difficult to have those people really embraced by an employer based health insurance system. In addition, many times provident insurers don't want really want this population group. The person you found at e-Health

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Insurance.com had said out in testimony that he'd rather the public programs pick the lowest income people, because really private insurance is for higher income people. If the obvious answer, which is to bill a Medicaid in the Children's Health Insurance program often runs into opposition. Opposition by states who have to fund about 43% of the cost of the program, unless the expansion comes with 100% federal funding. Opposition by some providers who would rather have the private insurance payment rates than the public payment rates, which are indeed low in many states. And there's really a conservative biased against public health insurance. In many of the speeches by leading politicians we hear the focus on private health insurance—a need to expand private coverage with no mention of public coverage in the midst.

That said, given the enormous problems faced by low income populations, there are really three levels of public policy response that we at the Center for American Progress and other folks who look at this issue think needs to happen. The first is to you no harm, we are currently in a situation where the uninsured has gone up by 4 million in the last two years, but the number of people on Medicaid has gone up by 4 million as well. In other words, public programs have really prevented an even greater increase in the uninsured in the last several years. Yet we know that's on the calendar of the legislative agenda today is—under current law there will be a reduction in federal funding for our states beginning in July. The Medicare

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law that was passed last year would—according to Congressional Budget Office—shift \$1.6 billion dollars in unfunded cost to states as a result of the new requirements that they have under this system. The budget resolution that we hear is still in the works in the House and the Senate Conference Committee would—on the outside—cut about \$2.2 billion dollars and could in the Senate said, cut up to \$11 billion dollars over 5 years in Medicaid. A massive is a set of administrative activities that really are putting what we call a “chilling effect” on states abilities to fund their low income programs. This comes in the form of both aggressive program reviews to see how states are financing their Medicaid program and so called 11-15 waivers or demonstration waivers that could reduce coverage for vulnerable populations. But they aren’t trying to address what are the short term prevention ideas to reduce—you know, to prevent the number of uninsured from increasing.

Incremental health reform actually should begin with this group of people. Again two-thirds of the uninsured really are in this low income bracket. So in the vein of thinking about incremental health reform ideas, probably the best and most effective use of dollars is to first use up that money for shoring up Medicaid. Medicaid doesn’t, for example, cover all poor children that develops. That’s a good place to begin, especially relatively non-controversial place to begin, we have many conservatives as well as liberal who will say begin with the poorest individuals—cover them first.

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In addition, we do have many improvements that we can make to the Medicaid and children's health insurance programs to make them work better—creating financial incentives to enroll those eligible, but un-enrolled individuals. There are still about 6 million uninsured kids who could be in Medicaid or CHIP, providing both simplification policies and money to do so—for example—would be a good first step.

But lastly as we think through all the policy ideas on the table, there will still need to be a major role for Medicaid or a program like it, in a universal coverage system. Why is that? WE first know that we need to have progressive subsidies for any individual in this universal health care system. Just because you require individuals to have coverage, and you give them the options to have it, if they can't afford it, they won't get it. So progressive financing is clearly and essential. But there may also be a role for a program like Medicaid beyond that, reducing premiums and cost sharing for lowest incomes, providing services not covered not covered by standard health insurance, services for persons with disabilities, or children with special needs. In addition, providing the—supporting the infrastructure that have traditionally cared for low income populations. Many of these individuals don't have access to a local teaching facility, like the one that Dr. Mongan runs maybe. Many of them are in areas where they can't get into those sites. Probably an infrastructure that supports those types of facilities will be

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important to access to care as well as coverage.

I'd just like to conclude by saying that we do have enormous challenges in our health care system, but the ones faced by low income populations are particularly severe. Addressing them first in both an incremental way and in a central way in comprehensive health reform is really important. Thank you.

**JUDY FEDER, PhD:** I'm going to begin by—in terms of perspective, raising the shocking notion that we are in the year of a Presidential election. And pointing out that today, as in the early 1990s, health care and costs and access to health care are high on voter's agenda. They find their access to care, the care they attempt to purchase or want to purchase, and their insurance too expensive. And as their employers, through whom most Americans get health insurance, cut back the kind of protection they provide. People worry that their costs will continue to go up beyond their ability to pay and that their access to health care when they need it will be in danger.

Now given that concern, does it mean that a fix is just around the corner? Indeed I wish and hope it is true, but politically—politically, not technically—this is a problem that is hard to fix. We've heard some of why, and I'm going to tell you why I think it's hard to fix, looking at how we got the health care system that we have today. And then I want to spend a little time talking about so called "fixes" that we

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ought to avoid in Jeanne's following—in Jeanne's admonition to do no harm, and then talk a little bit about what a real fix requires.

So why is it so hard to fix? It is often said—though to everyone's credit, it has not been said today—that we have no health care financing system. That our patchwork with all its holes is no system at all. I think that's a copout. We do have a health care financing system. It's not an accident. It has been created by policy and politics, and it does have holes that leave it falling egregiously short of the insurance protection that Americans ought to have.

Through tax preferences we have built a system of employer sponsored insurance. Those tax preferences cost us on an annual basis, similar to what we spend on the Federal share of the Medicaid program. It costs us an amount—an enormous amount of dollars in revenue forgone. That system grew through the 50s through the 70s, until most Americans of working age and their children have coverage. That coverage though imperfect is relatively comprehensive and it does what we expect insurance to do which is to pool risk across the health and the sick, and through some employer plans, many, especially large employers, across people of all incomes.

Well what about public programs? As the employer sponsored insurance grew over the second part of the 20<sup>th</sup> century—the second half of the 20<sup>th</sup> century public programs were built around that system. We got Medicare for seniors and then

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some of the people with disabilities. And we got Medicaid for some of the poor—populations, particularly pregnant women, and children who were not expected to work, just as the Medicare population of elderly, and then, at that time, people with disabilities not expected to work. And again, the coverage is relatively comprehensive though sometimes in Medicare not as comprehensive as we would like, and—but in Medicaid it is indeed comprehensive, and it provides full subsidies for coverage to people—without regard to health status, and without asking them to pay from their very limited income.

So how well did that approach work—that system of ours? It grew to cover about 85% of the population, but some segments of the population are inevitably left out of that so called system. Employer sponsored insurance stopped growing in the 1980s and we began to see growing numbers and a growing share of Americans without health insurance. As Jeanne has described to us, the uninsured are overwhelmingly workers in low and modes wage jobs whose employers don't offer health insurance, and who can't afford health insurance, in largely, a dysfunctional market if they have to buy it on their own.

The prosperity we saw—experienced in the 1990s didn't fix that situation. Through most of that decade we saw the number of uninsured rising, only making something of a dent after more than 5 years of extraordinary prosperity and with the addition of a new public program, the state children's health insurance program. So prosperity didn't fix—in a bad

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economy, rising health care costs are clearly making it worse.

What about our public programs? Well despite some holes, we do have Medicare for—as I said—for the people over age 65 and some people with disabilities, and we do have Medicaid for, largely, for pregnant women, and children, and we've expanded that children's coverage to some extent. But for the working aged population, it is really hard to get our public programs beyond the concept of protecting those whom we have labeled the "deserving poor"—people who are somehow outside the work place. We do cover—provide under Medicaid—we states have the option of protecting—of covering parents, but in most states the eligibility levels for those parents are so low that families living on minimum wage incomes are too rich to have access to Medicaid coverage. And adults who are not parents of dependent children are excluded under federal law from federal match for—in Medicaid programs. Only in the few states that have waivers for covering those populations is Medicaid reaching them. The vast majority of adults who are not parents of dependent children are simply considered in today's system, undeserving of public protection and private protection is unavailable to them.

So it's resulted in a situation—our system in its development and evolution over time has resulted in a situation in which 85% of Americans have insurance and 15% don't. The working aged population, poor, and not so poor, whose employers don't offer them insurance, or increasingly, who offer them

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insurance they can't afford, are simply left out.

And back to why it's so hard to fix, every time we try to fix it, we run up against some of the problems that Jim mentioned, that I think of as willful ignorance on the part of the population, that people—that insurance doesn't matter. As Jim argued, that is clearly inaccurate. We run again—up against the need to raise the money from those of us who have health insurance to subsidize, as Jeanne said, those who don't and can't afford it. And we run up against the concern that bringing everybody into an insurance system will make matters somehow worse, not better off—better for the population—the 85% of us who already have coverage.

So let me start with what not to do about it—going back to that do no harm. What the first thing not to do about it is not to replace the community risk spreading or community insurance that we have. With some concept—and that works—with some concept of individual responsibility and individual insurance that simply won't work. Some proposals aimed at—extensively aimed at expanding coverage to those who lack it and that might protect some of them would actually run the risk of making matters worse not better while reaching very small proportions of the uninsured. Employer sponsored insurance, Medicare, and Medicaid all too some extent take community—have the community bearing the risk. Tax credits to individuals to shop in the individual non-group insurance market do exactly the opposite. They provide too little money for anyone but the

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very young and healthy—and I care about them to, but it's not enough—to buy health insurance. They put them in a market place that because of its economic incentives picks off the healthy and avoids the sick. It runs the risk of giving employers an excuse to cut back the protection as they are already doing. So replacing employer sponsored insurance that pools risk with individual insurance that doesn't and it runs the risk of unraveling Medicaid which provides the real safety net. Its states who are already cutting back their coverage use it as a hook to cut back further.

Similarly, health savings accounts and other tax preference set asides do the same. They shift risks from the community—the individuals and in this case, they separate the better off whose resources we need as a community from everybody else. And the same concept of shifting risk back to individual's dies, efforts to privatize Medicare and to block grant Medicaid, again, taking left away from the communal risk spreading, and throwing the problem back onto the individuals who are a part of the community and need our help. We need that community and we need policies to promote it if we are going to get everybody coverage. That's what we ought to do—strengthen the community.

The broadest community is represented by our insurance approach—what they'll use for Medicare. Where taxpayers at least for the—for the—for not at least—for a substantial part—the bulk of Medicare—taxpayers bear the risk for the bulk of

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Medicare, and we spread it across the whole tax paying community. If we are only going to spend limited dollars, then our job is to go first for those who are least able to pay, and as a community, to take care of them. Use our resources to protect those who are left out of our current public safety net. And follow the strategy that Jeanne promoted—proposed for us, which is helping those left out, expanding our public programs to do so.

And if we want to build on the current system through a combination of employer sponsored insurance and expanded public programs, we can do that too. We can do it through mandates, as we have proposed in the past—mandates on employer to provide coverage. That has the political advantage of not requiring new taxes, or we can do it through expanded tax based support for employer sponsored insurance using progressive financing to replace what are becoming unconscionable and inequitable burdens on workers that come with employer sponsored health insurance.

Senator Kerry has proposed of the later approach, expanding public programs for the—for all the low income population, creating new insurance arrangements that do pool risk for middle income populations, and through re-insurance for employer sponsored insurance through spreading the cost of that insurance as I said, progressively across tax payers rather than having it all land on the employers and the workers.

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We can do this; the key is whether as a community we are ready to put our mouths and our money on the line for a real system that recognizes that individuals who need health care and health insurance are not on their own. We are all in this together. Thank you.

**UWE E. REINHARDT, PhD:** Well we heard 3 great presentations. I was invited here to be the skunk at the garden party [Laughter] by Congressman Stark. I think it's very good to, as Jim says, to understand the nature of the problem—what the costs are and that was laid out. And Judy and Jeanne laid out a bunch of tactics, because this is a war—this is a war we've been in for 40 years. And the way to progress is—constantly shifting a little bit, but the basic battle line have always been the same—the ideological. And it's good to have constantly review tactics and ready game war plans for small skirmishes that might tactically work. I think SCHIP was one of those; Jeanne had a lot to do with it. There was weakness on the other side and they struck [Laughter] cause they were ready, and many more people were helped than the other side, many more children—American children—were helped than the other side would have wanted to help. And that was just—it wouldn't have happened had there not been a budget impact, and had they not—in the White House at that time, been ready with this little tactical insurgence to strike, and they won.

So that's how I see the world, [Laughter] and I want to

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talk a little bit about where these battle lines—and what I think you really are up against. Why is there so little hope, I say, for the uninsured? And I think after 40 years of watching this, this is a reasonable title, and I have this paper which is part in your package, is that hope for the uninsured—on the Health Affairs website—and I say most probably not, although it is not for lack of good ideas and sound policy reasoning, and we've had this [Inaudible] most recently from the IOM, but in this very building Dr. Mongon and I are on the Commission of Medicaid and the Uninsured. We wrestle with it constantly. So tactically, any conceivable idea to do this exists—has been worked out, and could be used at any time. There's absolutely—I think—to be contributed there anymore, other than keeping these tactical plans up to date, focused at whoever the human enemy at that moment is.

I want to talk about the economics of employment based coverage which is the source of all evil in the United States [Laughter] health system. Now I've said this in many papers, that is the great spoiler, and almost any policy rank [misspelled?] would tell you if we had to do it all over again, we'd never have this system, but the employment based system is like diabetes, once you have it, you can't get rid of it, [Laughter] and you just have to learn to control it and live with it.

Then American values is a barrier to universal coverage. This will be a little rough—attack the self image we

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prefer—I don't think Americans are particularly nice people. We're powerful, we're economically productive, but we're not very kind. And that needs to be understood. That is what your up against, and then finally the fiscal policies that reflect those ethical values. I want to look at them with you because as—who was it—John Mitchell said, “watch what we do, and not what we say.”

And I think the Budget Act of 2001 was the clearest moral statement this nation could ever have made on the uninsured, and it was written down, and I'll read you the memo we wrote at that time look at employment based coverage, these are premium increases in the last 4 years. This is the Henry Kaiser Foundation and what HRT Health—something—Educational Trust it's from the AHA—branch of the AHA—John Gable, and they do a survey that's really quite fantastic in depth and—content. It's on the web and that's where I got this, and you see 14% premium increases from 2002 to 2003. But that relies—these are averages—what really goes on is if you look at small businesses, 3 to 24 employers—that's the red bars—75<sup>th</sup> percentile, that means 25% of small businesses had premium increases in excess of 21%. That's what that says—the percentile. And of larger businesses, 18%—or 25% of large businesses had premium increases in excess of 18%. And even if you look at the 25<sup>th</sup> percentile you see here that 75% of small businesses had increases—premium increases larger than 10% and then of [Inaudible]. Those are really daunting numbers.

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From that same survey it turns out in 2003, a family coverage [Inaudible] short business gives—with however, cost sharing on top of it—was \$9,000.00 and that would be \$10,000.00 now. So keep that number—it's a nice number to work with if you're an economist. Now the fact of life that not everyone understands—to economists it's second nature—all fringe benefits granted workers by employers come out of the gross wage base, which if you knew accounting, you would remember as the maximum debits that a business firm could make for an employee to payroll expense and still not lose money on that employee. That's the most they can pay you without losing money. And that's the concept we use in economics, and I have to show you a graph here cause that's what I do. Put here the workers and here that gross wage, which is the price of labor. There's the demand curve by business—if labors cheap we use a lot, it's expensive we use less. And there's the supply curve. If you wages are high, more workers present themselves, and if they're low they don't. And the equilibrium wage is the gross wage base. And out of that comes health insurance, other fringes, taxes, social security, FICA, and so on, and the rest is take home pay. So this, what you're looking at here is the little donkey that has to carry health insurance. And what ever health insurance pays—left over is that green area, the take home pay.

Okay, the gross wage for million of unskilled and semi-skilled workers will soon be too small a donkey to carry the

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load. Let me show what happens. You always hear this great all American bull-shine that a rising tide raises all boats. It's usually been said in Iowa by people who have never been near an ocean. [Laughter] As a matter of fact, rising tides do all kinds of things to boats, some go up, and some go down, and then some sink. This was true only till 73. Since then the wage distribution in America—this male workers—had female all be the same has actually spread apart so that in real dollars the hourly wages of the bottom 30% of the wage distribution actually fell. I looked it up again last night—Alan Kruger [misspelled?] gave me the numbers—the actual wage per hour worked fell for these workers. It went up a little bit in the late 90s, but Alan Kruger told me know it's going down. This is David Elwood's graph—he sent it to me, now the newly appointed Dean of the Kennedy School and Paul Elwood's son. So the problem is this bottom here that you see. These people, their gross wage base is too small a donkey to carry health insurance and that is how it is. During the roaring 90s, as the economy boomed and labor markets got tight the number of uninsured actually rose. And whatever that was. [Laughter] Here is Jeanne Lambrew's work, there was a little end road here because we covered the kids. Remember there was this insurgency from people, who cared about kids, and so it went down, but it's now going up again.

So let me illustrate my point. Think of a worker low skilled, semi-skilled where the business hiring them, the

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maximum they could charge to payroll expense is \$35,000.00.

Now that wouldn't be Wal-Mart, because Wal-Mart never goes this high. [Laughter] Wal-Mart on the average is what, \$15,000.00, maybe, you know, Senior Manager gets \$35,000.00, but let's be generous here thirty-five, and let's assume that wage grew by 4% per year it would then—10 years from now—be 52, would be that wage base. But the wages are not going 4%, they're growing 2 ½-2. I just want to be really outrageously generous here. Now this is—I downloaded yesterday from the Bureau of the Census—the median earnings for full time year-round workers for males was \$39,000.00 and for females thirty in the year 2002. That is 50% of them made more—less than 39, so I'm not using a very stingy wage base, that's my point.

Let us assume the health insurance premiums for that worker and his or her family grows by only 10%--remember it's growing 13-14-18%--let's be very optimistic here and say it grows only 10%--the net coverage which now costs \$10,000.00 will cost \$26,000.00 10 years from now. I give you the equation here cause it seems so incredible. But anyone one who can raise that to the 10<sup>th</sup> power in their head will agree what I say here it true. [Laughter] Judy can do that, cause she's a Dean. [Laughter] If it grew by 15% we'd be talking \$40,000.00 for health insurance.

Now let's look at this donkey. Here is the \$52,000.00 wage base 10 years from now. If health insurance grown by only 10%, then half of that wage base will be eaten just for health

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insurance and then social security, unemployment insurance, taxes all has yet to come from the yellow area. If it grows at 15% three-quarters of the wage base will be eaten up—and this is not a low base, it's not desperately, this is sort of lower-middle class that I'm talking about—will be eaten away.

So that's what we're looking at. Unless America's upper income groups are willing subsidize with added taxes, the health care for these low income Americans—the latter will increasingly find themselves priced out of health care as most of us have come to know it. And that's just the facts. That's not rocket science, it's arithmetic—I just showed you that.

So what I'm talking about is that about 33% of American families in 2002 had a family income of less than \$35,000.00, and that's husband and wife both working and so on. If they both work at Wal-Mart, they might be in the thirty's in their income. And I'm talking moving down \$100 billion. Jim Mongon said it would be less, but these are federal dollars I'm talking about, and we could debate that later, you can ask me why I come—that roughly to do this right, you're talking \$100 billion a year. But that's chicken feed cause our GDP is \$11 trillion and if you gave most people in Congress the task of calculating the percent only 30% could actually calculate [Laughter] the percentage right cause it's a very small thing.

Okay, so there we are. Question—will Americans in the upper half of the nation's income distribution actually step up to the cashier's window, dare to subsidize care for Americans

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in the lower third? Now I come to the enemy. These are the facts, that's the battle field as it is evolving and I come to American values. Now here I have to be careful. Fortunately I retain my Canadian citizenship so I can always go home, but Americans, I have noticed, tend to have a highly solicited self image, including the mantra routinely recited by President's and others that Americans are the most generous people on earth. That's in a way a charming feature of Americans. I have this article I cooked up for a joke—if you took a random sample of Europeans, put them on a pile of manure, and asked them after an hour how do you feel? They would say it stinks. If you put 100 or 20,000 Americans on a pile of American manure and leave them there an hour and you ask them after an hour how does it feel? They'd say it's the best manure I the world. [Laughter] And that's just how we are, you know, as a nation. [Laughter] And even to illustrate this, Alexis DeTocqueville in his notes, wrote down "Nothing is more annoying in the ordinary intercourse of life than this irritable patriotism of the Americans." [Laughter] Of foreigner will gladly agree—much agree—much praise in their country in America, but if you would likely allow to criticize at least something, and that he has absolutely refused. [Laughter] I saw this by Richard Reeves, one of the great American historians.

So it's with some trepidation that I will now tell you what I have concluded about Americans having observed them for 40 years. If I had to describe the American today—not

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Eisenhower and the people who did the G.I. Bill, and the people who fought World War II, and gave us Medicaid, and Medicare, our grandparents, they were a different cut. Today Americans, the ones I teach, but of the ones I teach [Laughter] and what I see from them, extremely hard working, highly inventive and entrepreneurial, chronically optimistic, chronically good humor, highly individualistic, and correspondingly selfish, generous to immigrants like me if they are self starters—if you can—now that's great about this country. You can come in here and compete with you guys and you allow this, and that can take a tenured slot away from an American, and that is generous, and I appreciated it very much. [Laughter] But also uniquely and self-righteously tolerant of enormous misery and injustice suffered by fellow Americans at the bottom of the economic heap. People the winners among Americans think of as losers. And we pride ourselves cause that is the source of our economic strength as we look with distain at European welfare systems where in Europe, of course, they would never leave a mother without health insurance. It would be alien to a Canadian and a European, and we Americans think nothing of it. And that is the strength of our Economy. I was telling my students there are two attributes that make you strong, a lack of shame, and a lack of compassion. If you have those two, you can be very strong. You can buy France and have it run by Disneyland.

[Laughter]

So who are the losers? People who made imprudent

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decisions somewhere along the way, in high school they got pregnant when they shouldn't have, or they married someone and got divorced and sit there with 3 kids, whatever, people who made those decisions. People who for other reasons, obsolete skills, they were rendered obsolete, not because they're fault, it's just the economy moved, intellectual limitations cannot fend adequately for themselves in our highly demanding and complex, and lets face it, corrupt economy. I mean if you have to deal with cell phone companies, you've got to be very smart not to get taken to the cleaners by them as we just found out recently. [Laughter] And—and people who have just met with bad luck. These are all losers and we indiscriminately treat them—we actually don't make a distinction between deserving and undeserving poor, they're all losers. And we don't like losers in this country.

Here is a vignette—in this room we have a whole collection of this Kaiser Foundation, a vignette, to personalize in our mind a little bit what the uninsured—there's actually a picture in the letter that I distributed, you see her picture, I didn't put it here, but Ellen is single mom with 3 daughters at home. Her annual income is \$25,000.00. The kids are on SCHIP, which of course can be taken away—I hear rumblings that Governor Schwarzenegger had been thinking of kicking some kids off SCHIP, I don't know if he's still on that, but I have to tell you and look you in the eye—it is unimaginable to me that a Canadian, a French, a Swedish, a

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German, anyone in Europe, in Taiwan, in Japan would leave a mother, the most important agent society has is a mother. There's no more important agent there is, cause they are so instrumental in raising the future children, leave her uninsured. Only in America will you see this. That is callus and that's tough. Now if you think that buys you economic strength—and economists would disabuse you of that—I think that's economically stupid, leave alone being inhumane.

These people are build by our—we say well you always hear this; well they get care when they're sick. Yeah, but on what conditions? This was in the Wall Street Journal; patients who skip hearings on bills are arrested. Here's an American mother raising 2 kids, and here's what she said in the Wall Street Journal. "Atteburry [misspelled?] who then was working as a waitress at a local pizzeria and is now unemployed says she turned herself into authorities after the shift ended. She did not want to be arrested in front of her 2 daughters over a hospital bill." Not conceivable in Canada. Not conceivable in Germany. Not conceivable in France. Not conceivable in Taiwan. Not conceivable in Sweden. Only in America will you see this—only in America.

Ironically this is the socioeconomic class we neglect so callously in health care, they happen to be the prime recruiting grounds for the soldiers we've asked to stand tall in our adventures abroad. This town is full of real macho he-man who will say, we need stand tall in Fallujah! We need to

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go in there! We need to do this, we need to do that! This—the whole White House there's only one who ever wore a uniform to my knowledge. The Congress has two kids in the four armed forces as far as I know, tough, tough guys Newt Gingrich, mmm, real tough, but they don't go, nor their kids go. This is where we find them, from the lower, basically near poor lower half of the income distribution. These kinds of people. Jessica Lynch, she didn't want to go to liberate Iraqis, she wanted to be a high school teacher. And that's what she thought was her way to become a teacher, very ambitious, maybe frivolously ambitious to want to be a teacher, but nevertheless this is what she tried. Lori Piestewa—the late—she fell in Nasiriyah as many of you know, and most of my students don't, but—and I think she was a mother of two [Inaudible] children as I recall. This is what happens to the wounded. I saw this on CBS News and downloaded it—I'll blow this up a little bit. Lieutenant John Fernandez who lost both parts—parts of both legs in Iraq knows he can no longer be a soldier, but he's not ready to leave the Army—I personally don't think it's right to be forced out of the military, and all of a sudden to live on half the pay I was getting which wouldn't have been much to begin with—Lieutenants earn very little. Ryan Kelly who lost his left leg below the knee makes about \$20,000.00 as Staff Sergeant you're in charge of something like 20 to 40 young Americans in combat. That's a serious job; we pay him \$20,000.00 because we're so generous. Once he leaves the Army

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he will receive \$8,000.00 a year in benefits. So we say thank you very much, purple heart, now please leave, and get us our tax role [misspelled?], and I sent this to my students after elector on the volunteer Army, out of 300 only one answered the rest said, will why trouble me with this cause we don't serve—cause that isn't a Princeton thing? And the one student who wrote it said—I am amazed that this man would stain his honor by begging for a handout. He got his purple heart, that's the deal he made. What does he want, a pension for life? And I could show it to you, and I re-e-mailed him back, and said, don't every say that at the Rotary Club, [Laughter] because all the Executors believe precisely they should have a pension for life, even if they trash the Company.

So, but that's the attitude, and so I say, can we reasonably expect that a nation that treat hard working mothers, and seriously wounded soldiers as callously as we Americans do would soon as ever move towards universal coverage either in large steps or incrementally? The fact is we don't have to be nice to these people to make them work hard for us, or to make them fight hard for us. They'll do that anyhow cause they're economically desperate. They'll do it to feed their family, or to get an education. And because we don't have to be nice to them, we aren't and probably won't be in the future unless we take this battle to another plane, and get very, very personal about it. And I have this letter that's being distributed out there, that say, "Next time you sit at

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one of these meetings, here's 10 questions to ask you opponent. Do you think that the child of a gas station attendant should have the same chance of surviving an ailment as the child of a corporate executive? If yes, I can tell you what policies follows from it, if no, tell me where in the Bible you find the inspiration. Get rough! That's my message here.

The fiscal values—reflect our values are in the fiscal policy. We have the 2<sup>nd</sup> lowest tax rate in the OECD before the tax cut. This is OECD revenues. We—all the taxes, sales, property, everything added as a percent of GDP was 29.6 now we're the lowest cause with the 2 tax cuts. Japan is higher than we are. So take that as a background.

Here's how we started. In 2001 we were told we had \$5.6 trillion dollars surplus. That of course was lie because \$2.5 trillion was social security and Medicare Trust Fund, but we had \$3 billion of surplus we could have used. We could have easily covered the uninsured and have half of it left over from that. Before September 11<sup>th</sup>, \$2 trillion of that had been gone, and most of that was the tax cut, farm Bills, things of that nature, nothing for the uninsured. Now that's \$4.3 trillion, but if the tax cuts get extended, we're looking at \$6 trillion dollars deficit. You see, and now the argument is, oh, but that was necessary for economic reasons. The White House had used Kantian Theory—and you've heard President Bush say that. It puts money in people's pockets, they can spend it and that creates jobs. Fair enough, I grew up with Kantian so I

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wouldn't argue with a President who's devotedly Kantian, [Laughter] but spending on health is the most Kantian thing you can do. There isn't anything more Kantian and let me tell you why. If you give people tax cuts, particularly rich people that buy another Mercedes, or Patek watch, or buy stock in the Pearl River Delta, most of that money creates jobs abroad. If you give money for health spending, health jobs are not outsourced for the most part except radiologists [Laughter], but for the most part, not! That creates jobs—the best way to create jobs in America is health care. One-third of the jobs under Reganomics were health care jobs if you think.

So there we go. How else can there be a clearer, moral statement than the budget of 2001 and 2003? Could you scream at God more clearly what you are about as a nation? That's what I tell my students—budgets are memoranda by which we tell God what we are about. This is the memo we wrote. "Dear Lord in Heaven thank you for the huge budget surplus you have bestowed on us—entrusted in spending that money on helping low income uninsured Americans get insurance or granting the over taxes rich well deserved tax cuts. We'll take a tax cut if it's all the same to you. We the people of the United States." [Laughter] That is what we wrote and there is no way you can get away from it. The rest of the world knows it. Only we don't know it. That is the memo we wrote to God, and that's where we are.

So that is—this is why it is that there's so little

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room in this nation's soul and it's federal budget—with a hard working mother in Baltimore, and her many peers elsewhere. Now I'm not saying all Americans share this ethic—most in this room probably won't. The way I see it is really like this, you have an elite—the policy making elite—by that I mean legislators, the business people who whisper in their ear or buy them, the Hill is pretty much a bizarre where you can buy legislation now. That's where I understood Senator McCain constantly talks about it. Then you have the public. Now I don't know what the public thinks, only Bob Glyndon from Harvard knows, but I always tell Bob I don't think it matters what the public thinks, because they get to pick an elite and then the elite does what it wants anyhow. And among the elite, in my sense, roughly 60% of the elite—in both parties by the way—actually favor rationing health care by income class. And the other are egalitarian, there's probably shades in between. So those of us who favor universal coverage in the elite are in the minority, and if you want to win this fight, we somehow have to grow this bigger. And if I lose my—look at my students, this thing is shrinking and the blue area is growing, looking at my—I don't know what student... [female speaking off mic] little bit different, yeah. [Laughter] Not at Princeton I'm afraid. [Laughter] We had some of course who fall into the—this pink area, but the blues have it I'm afraid, and that is really what is blocking the reform. It's really—they block the money and the technique is very simple. Actually it—this battle it's so

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far in 40 years, we really haven't won. Thank you. [Applause]

**MARK AGRAST:** Well while you're all recovering from that [Laughter] remarkable presentation, I want to thank all of our panelists for their presentation this morning, and invite you to raise any comments or questions that have occurred to you. What I would ask is that you minimize comments and maximize questions so that we can give everybody an opportunity to be heard. Are there questions? Yes, gentleman in the second row.

**MALE SPEAKER 1:** [Inaudible] Are there other groups that we should be ready to make a move to start to whittle away, even if we can't make much progress on universal coverage, might there be some other opportunities, like there was for children? Could we see other groups like that to find them some way that we could begin to—to make some inroads?

**JUDY FEDER, PhD:** I am always a believer in taking advantage of windows of opportunity where we see them and one we've talked about is trying to move to the parents of those covered children. We've expand coverage to children, we could move to parents of those children, but I have to say if you look at the history of our insurance expansions, and you look at the way we built around the employer sponsored insurance system which is, as Uwe was saying, it seems to be locked in stone, and we took care of the elderly, and we took care of some of the people with disabilities, and we've taken care of the pregnant women and some of the kids. I want to tell you, I

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think all the good groups are taken, and I think it's time that we accept that we have an obligation. If we're only going to do something, that we ought to—if we're not going to do it all, we need to take care of those who are totally left out, which are the not so politically attractive adults—working age adults.

**JEANNE LAMBREW, PhD:** I just want to add that you know, what's interesting is that we do as tough—you know, as chronic disease becomes more prevalent, as people are kind of becoming more aware of their vulnerability to being struck by an illness like cancer, or HIV/AIDS, I think there's a growing awareness among middle income people. The 50% or above the median income, about their potential vulnerability, and as a result, I think we've also seen interesting policies that have evolved. Who are the most needy? Clearly the low income, we have lots of evidence of that, but also the sick, and so I think we may also see kind of, policies like, the Kerry Plan has re-insurance to try to have the federal government pick up some of the cost of the high cost cases.

There is, I think, the real focus on persons with disability is not just about low income, clearly there's more low income individuals who have—there's a link between disability and income, at the same time, I think we see kind of an increase in the income distribution of people with disabilities. My point being is that there are different tactics you can take. One is income based, but I think also

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focusing on people at risk or with serious illness is another way to cut it.

**MARK AGRAST:** Gentleman in the front row.

**MALE SPEAKER 2:** I'm just wondering if this is going to pan out. If you look at Maine's program durable [misspelled?] health, rather than being based on values it seems like it was based on good economic principles. You're better off if you help everybody get insurance. You think that could happen in the future or you think that our values just won't push us that far?

**UWE E. REINHARDT, PhD:** [Inaudible] out there that are published in health affairs. I argue there is an economic case you could make if we were a nation, if you thought as a nation, but that's of course exactly what we don't. We don't think of—as a nation, but rather as individuals. And usually you'll find that when you have universal coverage, the people who benefit from that are not the people who would have to pay. So therefore it implies a redistribution. For example, I think it would make enormous sense to do things for business that would help business keep workers on the job. You know, that's why covering kids was a good thing—was good for business, but the people who pay and the business are not the same. And the way almost any legislation goes, the journalists for better or for worse, the minute you propose something, they come with these big tables in the Washington Post who wins, who loses. And they always have it by group, not ever the nation wins as a

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whole. The way we teach economics, who wins from free trade? When we teach it, there are losers; there are winners, overall more winners than losers. But that's not how health reform ever gets pitched. There's always this detailed micro analysis of who loses and who wins, and very often it's the powerful interests who lose, cause they have to pay more taxes or are mandated to do things like the small business community, and they win.

I think you're right; every country that has universal health insurance pays a lot less than we do for health care. We pay 15% of the GDP, Canada spends only 57% per capita on health care what we do. Judy as you mentioned, they have better health statistics, and name it, infant mortality, power's much better, longevity 65 year olds live longer in Canada. So it's very hard to argue that their care isn't any good even if occasionally they have to queue up for things. But Canadians think as a nation, or used to anyway. [Laughter] And we don't and that's the problem.

**MARK AGRAST:** Yes.

**FEMALE SPEAKER 1:** I guess—and to some extent my question's along the same line that I feature in the sound bite culture that we live in, how you can make the case succinctly [misspelled?] I guess maybe 3 sentences or less why it's the self interests of everyone who has insurance including those who have no fear of losing it today, ranging from the CEO of General Electric to the tenured Professor at

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Georgetown. [Laughter] Why it's—why it's in their economic self interest to solve this problem, but [Inaudible] rolls are in their economic self interest and we all pay for those. Why it's in their self interests, and why the federal government should deal with this rather than just the states? I mean, 1974 you had ARISA and there was a compelling reason for why the federal government should deal with employee benefit plans rather than letting each state handle it. Why—why should the federal government tackle the problem, and why is it in all of our self interests to deal with it?

**JUDY FEDER, PhD:** Surely we just can't sit here quite. The self interest is I think that first of all, a large number are at risk of losing it, so if we look at a period—over a 2 year period we 40 rough million uninsured at a point in time, probably at least 50% more, maybe double that over a 2 year period go without insurance. So essentially even though it's true—I don't have to give you the 3 sentences, you do the 3 sentences—[Laughter] even though it's true that—that the bulk of—of the uninsured at a point in time are those with low and modest incomes, it is also true that any of us are at risk not only cause you'll lose a job, but you get divorced, you get hit by a truck. I mean there are lots of things that can happen to you that put you at risk.

Second, it is also—it is true, as I believe the Institute of Medicine report shows, I think there's also—I know that there's Urban Institute, Kaiser Material that show that

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the—those of us who have insurance and particularly employers are paying a lot toward the cost of the uninsured, and that they are—that people uninsured there is foregone productivity, and extended life, etcetera. That is a value in very—in—in very class terms, economic value to the nation.

Finally, I [Inaudible] we could use disease, and epidemics, and whatever, it's better off—I'm better off if everybody else is insured, gets health care, and they don't expose me to those horrible conditions that I would like not to be exposed to. All that—we can—we can gin up that argument. I mean we have ginned up that argument and we need to, but I would tell you that to appeal only to now our economic self interests is, I think, missing much of the battle. I think really this is a—it is in our interests, it is a moral interest and we have to ask what kind of community we want to live in? And we also have to—the sound bite is because it's the right thing to do.

**JEANNE LAMBREW, PhD:** I will quickly add that you know there actually is an expression or a phrase that has been used—health security was used and mentioned in 93-94 [Inaudible] debate, and ironically, the President—President Bush used that expression in his second State of the Union. So there is a word that's used. I'll go back to what Judy said, it's not looking for the word and I would say—just kind of in slight defense of—of the American public—[Laughter] I do think that there is—well you know, Bob London may say it's fallen down to

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number 3 after jobs and terrorism, but is always has been really in the top 5 of what people care about. I actually do think people care about this. I do think that they get it. I think most people who are at that 50% median and below feel this issue on a daily basis. So I don't think that it's necessarily an absence of it, I think there is this kind of disconnect between the political elites and the people. How you break through that, I think is the big challenge.

And I'll just say we do have a couple of lessons. Health reform in 93 and 94 failed for different reasons including kind of a build up of people opposing it. President Bush passed the tax cut in 2001 in 6 months. Very quickly with a very direct campaign, very simply, and I think the media is—using a war metaphor—a tactical issue not a message that we're looking for.

**UWE E. REINHARDT, PhD:** But when you think what the alternative is, I've been on radio talks shows where people 75 and they lost their insurance and they were very upset, and then I said, well I favor set up where you could buy into say, Medicare, and the minute you say government, I think the American people fear American government even more than weapons of mass destruction. [Laughter] And the minute you hear—you could say, you know that you have—yes I'm insecure and I'm really scared and we could lose our wealth, and if you were to tell them, yeah, you know we really need a government program as a fail safe system into which you tumble, immediately then

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they shrink. I don't know who it was that put the fear of God of government into the American people this way. You always hear the savvy American consumer or voter, how often do you hear this on T.V.? And my wife, also an immigrant, says 50% of them still believe that Saddam Hussein had something to do with flying those planes into the World Trade Center. How smart can these voters actually be? [Laughter] And the same was true with Harry and Louise. It took an editorial that basically said nothing and scare the hell out of people. Humphrey Taylor tells me they did a survey where they described the Clinton Plan to people and then thought—asked them what do you think of that as an approach, and a lot of people said that's a good idea, that would work. And then just before hanging up, oh, by the way, before I leave, let me ask you about this Clinton Plan. What do you think of it? I said, the most terrible thing there is, although they described to them the Clinton Plan. So what you're up against is a savvy voter that I don't believe is so savvy. And it's not that they're stupid, they're busy with other things. If you were to ask me about a good environmental policy for the U.S. or the Kyoto Agreement, I haven't a clue. You know I couldn't possibly intelligently talk about environmental economics, and why would we assume a gas station attendant could understand the complexity of health insurance. It is a matter for the elite to solve and then to present. And it cannot be done in sound bites. What you have is 2 elites banging against each other, lying to the pledge. I

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look at Gore. We—those who advised Bill Bradley with a reasonable plan—I thought a reasonable plan except Bradley put in abolishing Medicaid, which no one, which on one advised him by the way. None of us were...

**FEMALE SPEAKER:** I'm sorry.

**UWE E. REINHARDT, PhD:** No we were just as upset. This thing, you can ask David Cutler and others. We were just as shocked to say, that wasn't even what we discussed. But to have a fail safe to the employment basis system and leave Medicaid and SCHIP there to simply, if I'm not insured by my employer, I could get it through the risk pool called FEHB, that's what we had dreamt up. That's all we wanted, something of that nature, and Gore called Bradley a "reckless spender." Right? So he did—he was the enemy, Gore was the enemy—ideological enemy by saying, he's a reckless spender. Never mind that the Medicaid was a big mistake—could have been fixed, but calling him a reckless spender is exactly what I was talk—that's why I say it's not partisan, Gore is among those blues.

**JUDY FEDER, PhD:** If I could bring you up to, you know, come out of that election, and look at this one. [Laughter] Essentially that—we—that there is a, I think Kerry has been and will be accused, and by some of his opponents in the primaries, of being a big spender. And what he is doing with that big spending is reducing the burdens on—that are coming out of payroll—and—and workers, the ones you show so powerfully in terms of what's coming out of compensation. And my argument—my

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belief is that if one wants to go forward to expand coverage to everyone, one has to make something—make those who are worried and have insurance, more secure with that, and that's what that kind of tax expenditure—public expenditure does. It will get a lot of flack, and I think that you've given us a lot of ammunition in terms of defending it.

The other thing that I would say, when you make the distinction between the elite and the public, I think it is the elite who has walked away from government as what we ought to be defending. It is government that we rely on to represent us as a community, and we need to hold government agencies and government programs accountable for doing what they do efficiently when we don't always do that. But it is the elite who have walked away from defending government. After September 11<sup>th</sup> essentially we had an opportunity, we saw government at work, and the nation clearly valued it, and we need to bring that sense back, and you do it very powerfully as you talked from the heart about the nation's soldiers, and we talk about the firemen, the policemen, and the health care workers who don't have health insurance. We are a community and government is the way we pursue community objectives and that's what we need to talk about.

**UWE E. REINHARDT, PhD:** Actually I think they're the different elites, they both actually believe in government, but to what purpose? There is an elite that just wants to milk it, and I think a lot of the privatizing that takes place including

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student loans we know learn, but we've known this all along, is much more expensive to do through banking than to do it straight. And so there is one elite simply wants government to collect taxes and then recycle them into the private sector so it could be milked, and the other one wants government to be actually doing something, and those—so the both of them believe in the elites, but to different purposes.

What the average citizens in the street say, I think they're very confused, I don't blame them, I'm confused on most issues because they're busy, but I also feel you're just powerless. It was Allan Ryan who was a Political Scientist at Princeton, now a Dean at Oxford, after the Clinton Plan failed; I asked him how does democracy actually work? I'm an economist, tell me about it. And he said, well basically the—the thing what the public thinks is really not very important. They get to vote for an elite every 4 years on a thousand of issues, and one will pick on abortion and the other one will pick on war, and yet there're 18 issues. Think about it, right, so you pick some elite one some—one criteria on 20, and then they run the show, they and the interest group run the show, and that's in a way why I—it's not that I have disrespect for the public, I just say they're out of it, basically. They're basically out of it, and when they are told things during elections, they are lied to more often than told the truth. So you have a decent people who are being lied to and are too busy to undo the lies, and that is the American public.

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And what you have is a cynical elite on top. We even say, I argue still among the Democrats that slice each other up in ways that we're—even in this primary quite un-tore. Even I wasn't a Howard Dean fan, but some of the stuff done to him was unfair, I thought.

**MALE SPEAKER 3:** We have some more questions from the public actually.

**MALE SPEAKER 4:** Okay, one of the questions I have goes back to the issue of I guess the frontiers to which we can try to push the idea of public insurance forward. And I was wondering specifically about 2 populations one is persons with disabilities. While it is true that they are covered largely under Medicare and Medicaid and/or Medicaid, there is an institutional biased which means that many have to receive the care in institutions and don't have the choice right now, of receiving it at home. And so with that, we do have some ways in which I would think that we could push things forward through coverage of home and community based services and expansion of Medicaid buy-ins. And then the second population that I see is the group in the 50 to 65 age group where a lot of people are acquiring chronic illnesses, getting less health, and they're also suffering from age discrimination and getting pushed out of the work place and thus they're at risk of losing their insurance. So can we identify those as a couple of areas where we can push forward? And if so, how do you make that case?

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**JEANNE LAMBREW, PhD:** Well I think is where you do wonder kind of what's going on in Congress given the fact that there are Bills that would really make coverage—good coverage, communities coverage more accessible to persons with disabilities have installed and I know that the Family Opportunity Act for example, has been installed now for, you know, 4 years. We worked on it when I was in the Clinton White House. So, I mean I think there's a real problem because they have widespread bipartisan support and can't really move forward. I mean I'm not sure why it's sort of stuck in the process. But in terms of the older age group, you know that's where the baby boomers are going. That is the age [Inaudible] for baby boomers right now. It might be a really good—going back to kind of the strategy on this, group to focus on. Not because they lack health insurance the most, they don't, but they're most at risk of you know, having some sort of health condition—more aware of the health care system. They're going to be going out to Medicare shortly so that some of their problems will be alleviated, but they may be the group that can help pull the train for the younger set of individuals. Variously you can address it. There's always been the Medicare buy-in out there. Others have focused on doing kind of a mini federal employees program for that group. The larger health reform proposals have it as well, but you know that is a group that is particularly vulnerable.

**JAMES J. MONGAN, MD:** If I could add a comment at the

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risk of adding to the tone of cynicism and difficulty here this morning. I think it is important to look at some of these things realistically. With respect to the disabled, I was on the finance committee staff back in 72 when the disabled were covered under Medicare. And as an example of how money trumps people in these issues, the disability coverage under Medicare was originally complete coverage of the disabled and then they put in a 2 year waiting period before you could get covered. Well in fact, at the time at least, 50% of the disabled died within the first 2 years and that's where most of their expense were. So it was a very good way to cut down on the cost of covering the disabled, but it wasn't a very good way of covering the disabled, and so I think that's a lesson that you kind of have to keep in mind.

The second thing I would say is I personally am very torn after 30 years in this business. There's a part of that is a very strong radical incrementalist, if you will, saying that by God we have to just take each step we can and not get to the final goal. On the other hand, we've become kind of proud as peacocks that we're all incrementalists now like we used to be Kings view and we get it—that the Clinton Bill didn't work and we got to be incrementalists, but if you look at the history of the last 3 decades for every step we're taking forward by covering left handed kids from 18-21 in Indiana, [Laughter] we're taking more steps backward and so you've got to be a little humble about this very pragmatic

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incrementalism that everybody can talk so comfortably about.

**JUDY FEDER, PhD:** And while we're in that vein, of latching from going backwards, and I mean we know that the Medicaid program is endangered, and that it is, as we speak, moving backwards, by virtue of waivers, and federal—and state cut-backs. And so it seems to me as we think about moving forward, one of the steps that we need to pay attention to is one that Jeanne called attention to, which is enhancing federal funding and sticking to federal requirements for Medicaid programs so we don't—while we're looking at somebody new to bring in, lose the protections that we now have.

**MARK AGRAST:** Yes.

**UWE E. REINHARDT, PhD:** You know there may be some hope in that. I would consider, this lady asked about self interest, in that particular case I could actually see it. They did get it in 1991; I think the business community got it because there were no parking places left for jets [Laughter] in Little Rock, Arkansas when President Clinton held court down there. Fred Polling of Ford, they all flew down asking to be bailed out, and then came managed cared and did it for them, and the percent of total payroll expense going to health insurance fell throughout the 90s. And they figured they had solved the problem and stabbed Clinton in the back, as you may know the National Association of Manufacturers, but I think they're desperate enough now to come to the table again.

One of the things that you find—there was a study done—

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one of my former colleagues at Princeton—who found that labor mobility in Canada is a lot higher than in the U.S. cause labor isn't tied to the jobs and business is just not saddled with that. So that's one advantage. It's a more efficient labor market. It's much easier, there isn't job lock so people are much more mobile in that regard, but also to get rid of this burden would be boom for American business cause it is really true. The General Motors unfunded retiree health care liability is \$63 billion dollars. And the net worth is \$21 billion of General Motors. There's a huge overhang, when you talk to the CEO he says all this cash I'm earning, my competitors can put it into robotics, I'm running an insurance system. And I think that is one area where I think you could talk economics. And to both big and small business, course for small business, I would say, to be able to have their employees in a FEHB like structure, where you can say you don't have to deal, you may organize for them, or they may make some contribution to it will give a tax subsidy, something like that in this climate would work.

In the plan I had once proposed, you had the right to buy, you got a voucher, you could either get into the local Medicaid, SCHIP, or you could re-enter Medicare or into a private product, whatever that voucher bought you, something of that nature I think would work. To say to business, if you don't want to be in it, we'll relieve you of it and we will take care of it with a big risk pool.

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**MARK AGRAST:** We have time for 2 more questions. This gentleman in the front row, and then the lady in the second row.

**MALE SPEAKER 5:** The panel began by talking about the consequences of uninsurance, and now we're talking about some of the advantages of universal health care. I wish there were foundation support for research on how the government policy is actually promoting the kind of privatization with inefficiencies, ineffectiveness, and inequities! So that we're not just looking at that 10-15% of the population that doesn't have public and private insurance, but we're looking at 100% of the population. I mean when LAN [misspelled?] comes out and says, one-third of the Medicare beneficiaries are not getting the quality care that they would get by the practice guidelines for the conditions they have, this is not a question of lack of insurance, this is a question of a poorly delivered system! This is where government comes in. When Uwe says to us that the public doesn't trust government, we associate government with a rationing policies of Medicaid where they have small amount of money and a large group of people who are getting nothing and they ration care in ways that look very heartless. But we need to focus on the role of government in propping up a private system which is actually screwing all of us. And when David Hemmelstein says in the Health Affairs Journal, that 60% of total health care expenditures are coming from public resources, that should be the focus of our attention. What

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kind of leverage can we use to insure efficiency, effectiveness, and inequity? Not just how do uninsured people suffer, but how do we all suffer from this ineffective system?

**MARK AGRAST:** Thank you sir, let's see if we can get a response.

**JAMES J. MONGAN, MD:** Well I'd make one comment I would agree with you that we have a huge amount of work to do in this health system to make sure that it is efficient, effective, and of high quality and that affects every American. I guess the only place, and I'm not saying you're saying this, but I'm a little concerned because I think some people take your point and in a sense kind of hold the 15% hostage to us fixing everything for the 85%, and I just want to make sure that we do both together. I think we do have to make the whole system work better for everybody, but we should never use that as an excuse to wait another few years to cover the 15%.

**UWE E. REINHARDT, PhD:** In fact you could argue you need universal coverage first before you can get the inefficiency because now the uninsured, there's always the shield that everyone puts forth, everyone that practices cost control, first thing the hospitals say, oh, if you do this, we can't look after the uninsured, and we layoff. There are two problems and the one is the Medicare problem, the Weinberg [misspelled?] variations, they really just—the stench goes to heaven [Laughter] that this has been going on for 20 years and the Congress has shown no interest in that. Now I have argued

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that Congress has explicitly forbidden Medicare to be an efficient buyer of health care. That's in the law. It could never ever be efficient. Then came the private plans, and they do promise, well we can do this efficiently, and I used to believe this in the mid-90s—I was a champion, I supported what Reischauer and Aaron had proposed, the Premium Support Model, but I think even Henry Aaron is no longer, I believe, and enthusiast for that, because what we observed is that the private health plan went to the high cost areas like Florida, and I thought that would be like shooting fish in a barrel. That they could deliver sort of Minnesota style care in Florida and become zillionaires in the process, and that would have been fine by me, but in fact, they claimed they couldn't make it with a 2% cap so they seemingly don't seem to be able to practice more efficient health care in Florida either, otherwise they would have been in there and made a ton of money. But the Pacific area in fact got clobbered, as I recall, only didn't make money in Florida.

So we don't know how to get at this thing, but I do agree with you when you Health Affairs recently had an article that shows health spending and the quality of care are inversely related. There's a graph with a negative slope. Did you see that? Yeah, it's just in the web exclusive. Was a study done and they used Steve Junks quality indicator and then looked at health spending per capita and if you plot it, you wouldn't believe it, but you get a negative line with a

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reasonably good esquire, and that is really alarming, that where the high spending occurs, the quality of care isn't any good. I think that you're right, but you've got to go with Jim's admonition. I heard this argument in the early 90s, I was debating Senator Durenberger, let's first of all get cost control, then we'll bring in the uninsured. Well we had cost control, or it looked like it in the mid-90s, we didn't do it. And secondly, that's putting the cart before the horse. Let's first look at universal coverage. Let's reduce administrative complexity. The Himmelstein [Inaudible] estimate 24% of total health spending goes for administration of government employers and the insured. Let's get a simple claims form like Taiwan and Germany. In Taiwan they have a smart card. They're way ahead electronically. Europe is passing us by in health care. We can do all of these things, but I think the most efficient way to get there is to cover everyone and then say, now how do we make this efficient?

**MARK AGRAST:** Final question.

**FEMALE SPEAKER 2:** Well I was really struck by what Professor Reinhardt said about the majority of the elite favor rationing by income class because I guess I'm seeing that increasingly in the policies that are being supported especially by this President, but I think we're gonna see some of that in the recommendations put out by the Senate Republican Taskforce on the Uninsured. Sort of looking at health savings accounts, or association health plan ideas where you let-you

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increasingly create these ideas where certain individuals who are healthier maybe get to purchase minimal coverage and let the rest of the folks pick up the tab for people who really need coverage. And it's sort of this every person for themselves, individualization of risk trend appears to be cutting across the board, and I think it's a very compelling argument because it does tap into our American values, about the meritocracy and also about, you know, well why should I have to pick up the tab for my neighbor who's sick. Shouldn't everybody have to pay their own way. And I guess I wonder, I think you've all touched on some of these arguments, but I wonder as you think about making those arguments in a public forum, how do you push back against that idea? You know where, we're hearing it, small businesses, we can't afford to pay all of these health care costs, we don't need Cadillac coverage, we just need a Ford, or people going for health savings accounts saying, well I just want to, you know, get minimal coverage cause I don't really need health care and I shouldn't have to pay for all those other folks who need it. So I guess, you know, thinking through some of those arguments, and how do you push aback against a landslide of trend that I see all across the board on this issue?

**UWE E. REINHARDT, PhD:** I man one way to approach is I walked into my class after this Bill passed, and I said, you know it was raining cats and dogs, and I was sitting in my Mercedes, [Laughter] and somebody was filling my tank, and I

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said, you know, the thought occurred to me this morning, I'm a more precious human being. Then this guy with his frozen hands filling my gas tank, and I asked my students, how do you feel about that? And what I saw in their eyes, damn right you are, [Laughter] but you can't say that in America. Remember, we're classless, and I'm an immigrant, I don't think that way, I think class all the time, I think I'm just more precious. And I said the Congress has just voted to reaffirm that once again, cause they think when I get my teeth filled, or I get a crown that I should pay less for that than this gas station guy and that's why his teeth are rotten, and I got a crown. And they still didn't get it. And I said, well look at what was just passed, the HAS. Where if you're in the top tax bracket health care will be effectively a lot cheaper for you in after tax dollars than it is for the gas station guy. And I said, here you have a United States Congress that says that a gas station should pay more dollars to get his kid looked after than a rich lawyer or professor. I said that's what the Congress just passed.

See when you cast it that way and then if you had a Congressman sitting there [Laughter] and say, how do you feel about that? I think I once asked a Senator it was in front of Priests, [Laughter] I said, if Jesus came into your office and asked you where did you find this in the Bible? What would you tell Jesus? You've got to get personal. That's my feeling of this letter. Don't be so polite—this Senator was very angry at

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me after for doing that because it's not done, to bring Jesus in, but I say you guys bring Jesus in all the time, why shouldn't I? [Laughter] And so I did. Where did Jesus say that it should be cheaper [Laughter] for a rich man who can't go through the eye of a needle [Laughter] than for a poor mother who would have to pay more? That is how Congress legislated it. I think it is an abomination.

In addition, the HAS, the Society of Actuaries years ago showed that it does redistribute from healthy—the burden of healthy to sick, that's just arithmetic. And the Rand Corporation had that, was it, Willard Manning—they had the same study. And you bring it to an ethical thing, and say did you actually believe that? This is one of the questions I ask in here. In fact, do you favor this? And if not, you wouldn't have written this law. So get personal is my view.

**JAMES J. MONGAN, MD:** Let me just add one piece to that story though that again I think makes this even more complicated. We were admonished, I think not to use nay political party terms or candidates, I won't do that. I would just say that one thing that makes Uwe's dilemma even more difficult is I'll bet you there's a 50/50 chance that, that gas station attendant is voting against his best economic interests, and that's a real problem in the United States. As long as people are focusing more on that withholding line on their paycheck, and all the benefits they get, and as long as they think they're going to be rich 20 years from now, I think

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we got ourselves a real dilemma.

**MARK AGRAST:** Well and let's let that be the final word. I first of all want to note that before this session ended, we did get Professor Reinhardt to say that there is some hope. [Laughter] And we at the Center for American Progress exist because we firmly believe that grounded in the complex of American values and ideas is a set of values that can be harnessed for this task. So we hope you'll stand by and stay tuned. I want to thank you all for coming. For those who are joining us via the World Wide Web, we thank you for listening, and if you want further information on this topic, we invite you to contact the Center or visit our website at [www.AmericanProgress.org](http://www.AmericanProgress.org). So with that, would you please join me in thanking this remarkable panel. [Applause]

[END RECORDING]

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