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Business and National Health Care
Welcome Remarks and The Future of Employment-Based Health Insurance
Century Foundation
September 14, 2007

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RICHARD LEONE: Welcome to the conference we are having this morning on Business and National Health Care reform. It's been 13 years since President Clinton's Health Care Reform Plan fell by the wayside. I know that many of you were deeply involved in that debate. Hopefully everybody has made up since then.

There are many reasons why that plan fell by the wayside. Probably foremost among them was fairly unified opposition among the business community. Now here we are again in 2007 and many of the Presidential candidates are talking again health care reform at the national level. And the question before us today is what is different. Is the environment now significantly different than it was in 1993? And we will be looking what's evolved since then both in terms of changes such as state level reforms, innovations among companies, and at the same time we will be looking at the problems of basically have only gotten worse that existed in the early 1990s. That is very high levels of uninsured and under insured Americans, high rates of health care cost increases for the private sector as well as really every sector of the public sector as well.

So, we are very pleased to have you all here today. The Century Foundation has a deep concern about the condition of the health care system. We've published a number of books

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on the subject of late including Arnold Roman's Second Opinion: Rescuing America's Health Care, Charles Morris's Apart at the Seams, Leif Wellington Haase's New Deal for Health as well. Leif is the individual who really conceptualized this conference and pulled it all together. He was a fellow at the Century Foundation for many years until just a short while ago moving on to become the head of the New America Foundation California Program where there is a great deal obviously going on in the health care front that he is deeply involved in. So we are especially grateful to him for all of his work on this conference. Replacing him at the Century Foundation has been Maggie Mahor [misspelled?] who some of you may know as the author of *Money Driven Medicine.* Maggie is actually going to be bargaining about this conference today on her blog healthbeatblog.org for those of you who have laptops and want to see what her, what she is saying about what's going on today.

I particularly want to thank our co-sponsors for this event, AARP and particularly Cheryl Matheis who is here and will be moderating one of our panels later on. And the Commonwealth Fund, which has been enormously helpful to us in many respects over the years and particularly Sarah Collins there was very helpful to us throughout the planning of this conference. And finally, the President of the Commonwealth Fund, Karen Davis who's been an enormously effective leader at

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an institution that provides all kinds of valuable analysis and information about America's health care system. I'm going to turn it over to her now.

KAREN DAVIS: Thank you Greg for that lovely introduction. The Commonwealth Fund is delighted to be co-sponsoring today's forum with the Century Foundation and AARP. I think it couldn't be a more timely moment to come together and discuss the issues that are on the table today. Just this week we learned that employment based health insurance premiums are going up 6.1—percent. There were many people who welcomed that, congratulated that including I'm sure some in the audience but when you think about it's still much faster than wages are going up, it's still much faster than overall inflation, one's enthusiasm for the slowdown is subdued. It was even more subdued when I saw *The Boston Globe* headline that they are expecting ten-percent increases next year. So, I'm not sure we totally tamed this tiger. And just a few weeks ago, I think more distressing we saw a five-percent jump in the numbers of uninsured. We are now at 47 million uninsured. That's up 2.2 million from just a year ago. And most of those people are members of working families. So we have health system that's under stress.

So, it's a pivotal moment in consideration of the role of employment-based health insurance in our nation's health system. And I really look forward to today's discussions and

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learning more, particularly from those who are really on the front lines of providing health insurance coverage to workers.

But before we turn to the panel on the future of employment based health insurance, I would like to take a moment to take stock of the accomplishments of employment-based health insurance and congratulate the employers who for the last 60 years have stepped up to the plate to ensure that their workers have access to needed health care. In fact, employers are the backbone of the US system of health insurance more than any other source of health insurance in the US; Americans under the age of 65 depend on employers for the coverage.

Just to remind ourselves there are 160 million people under age 65 who now get their coverage from employers. And in fact nearly all companies with 200 or more employees do provide health benefits to their workers. You know one way I think about that 160 when I think of about the 47 million uninsured, if employers weren't making sure 160 million people had coverage we would have 200 million people uninsured. I think that's a future none of us want to envision so we need to make sure that we have options to continue coverage for people whether it's under existing arrangements or new arrangements.

Employers also step up to the plate by putting dollars on the table and make a substantial contribution to the financing of health benefits. Total employer premium contributions for coverage of active employees and their

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dependents amount to approximately $420 billion. That's over one in five of every dollar spent on health care in the US.

From an efficiency and an equity prospective the advantages of employer based coverage are considerable. Employer groups are natural risk pools, people enrolling coverage when they take a job rather than when they are sick, reducing the potential for adverse selection that characterizes the initial market. This means that premiums in the employer group market are closer to actual medical expenses and it also means that administrative costs and insurance reserves are lower. The lack of underwriting in the employer group market also helps ensure that employees are not excluded from coverage on the basis of age or health status.

Employment-based health insurance has happened in the past both because employers and employees place a high value on employer health benefits. In a survey of employers by Kaiser Family Foundation and the Commonwealth Fund, nine out of ten firms offering health insurance viewed health benefits as either very important or somewhat important in attracting and retaining highly qualified employees. Similar-percentages of employers viewed health benefits as very or somewhat important in improving moral and job satisfaction and the health of their work force. Three quarters of workers also are supportive of the choices that are offered to them and in fact to the extent, according to an Employee Benefit Research Institute study

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headed up by Dallas Salisbury who is here today, would prefer to keep employer sponsored health insurance rather than receiving the equivalent premium in cash income.

So, before we turn to the future, let's just say congratulations to the employers who at least have gotten us to this state. Having said that, I think we also need to recognize that there are important weaknesses in the employer based system that exclude many workers from affordable group coverage and are the primary driver behind the growing numbers of Americans without coverage, as well as instability in the coverage that creates anxiety and worry among even insured workers that coverage may not be there when they need it. Most of those who are working on uninsured are employed in small firms or they earn low wages and they do not qualify for coverage from their employers. We do particularly need to find better mechanisms for offering and financing coverage for these workers.

With the 2008 Presidential election on the horizon, health care reform has jumped to the top of the nation's domestic policy priorities. Policy makers at the state level are taking the lead in expanding coverage. Several Presidential candidates and members of Congress have unveiled proposals to expand coverage and improve quality and efficiency.

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Many of these strategies build on the employer-based system but they offer new affordable group options that help fill the existing gaps in the system. Given the key role played by employers today with her current system it's critical that they be part of any new deliberations or discussion of new policies to expand and improve coverage as well as improve the overall performance of the health system. And indeed surveys show that both the public and employers agreed on this.

I would just like to stress that without shared financial responsibility and commitment among stakeholders, recent analyses have shown that it's difficult for the US to achieve universal coverage. In the coming years, as we focus as a nation on solving our uninsured problem and on bringing coherence and rationality to our highly fragmented and under performing health care system, regardless of the strategy pursued, the only way forward will be together.

So let me extend my thanks to those of you who have joined us today, a particular thanks to the speakers who are willing to share their expertise with us as well as those of you who are seeking to find better solutions to our nation's pressing health system performance problems. I would also like to thank the staff. Greg mentioned Leif at Century, I'm making it hard but I would also like to thank Sarah Collins and Chapin Wyatt who prepared some of the materials that are available to you and helped to organize today's session.

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And with that I would like to welcome the first panel on The Future of Employment Based Insurance to join us.

[Applause]

DALLAS SALISBURY: Good morning, it's a pleasure to be here. I'm Dallas Salisbury with the Employee Benefit Research Institute. I want to thank the Century Foundation and Karen Davis and the Commonwealth Fund as well as AARP for putting a very important topical session together.

This is the on the front lines section of this session looking at the future. And if one takes the words of the two introductions employment based insurance being the backbone of coverage in the United States most particularly in the private sector. If one looks at data just released this last week from annual surveys relative to the form of that coverage and the relatively small, thus far, expansion of so-called consumer driven health plans, health savings accounts, it is more traditional employment-based coverage that's still very readily dominates the employment-based system.

I think as we move into a discussion of the future, the dynamic really revolves around two issues I would suggest for employers. These would be what we might expect for the future and then we will hear from Carl and Michael, these would be the corporate adjustments in what they are currently doing what they think for the future. One is just the transition that we read about and we have been watching. And many of us in this

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room experiencing for many years in the nature of this so-called social contract between employers and employees. That has led to modifications over time and programs more employee, front end premium payment changes in co-pays, deductibles, and as note, I just noted more recently the introduction by a growing number of employers of the option of a consumer driven health program, which the most recent data suggests that when an employer does that as one of many options, they are now finding in the neighborhood of ten-percent of employees that are choosing that option.

That social contract however appears from research that will be released in the next few weeks. A large sample survey of employers to very much be intact with employers still feeling a very strong commitment to the desirability of being the agent for the provision of health insurance. Since they see it as so crucial both to employee's satisfaction, to the ability to hire and retain, and to issues related to presentism [misspelled?], and job stress and financial stress for individuals.

Employees themselves overwhelmingly, as Karen noted, want an employer involvement and our value of benefit surveys over the last 20 years; a consistent 80—percent of employees when asked what they would want as one thing from an employer besides cash and vacation, 80 plus-percent say health insurance. Another third when said what is the second thing

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you want it was more health insurance. Only 15—percent say a pension plan today, only 17—percent say any type of a savings or retirement savings program. Those numbers are down somewhat over the last 20 years but not significantly. Health insurance has been and continues to be the number one thing employees want.

The second feature of that is surveys that we have taken over the years, a health confidence survey, multiple times, where when we ask individuals preference for health insurance or a significant cash payment, even when that cash payment would be as much as $10,000 individual employees overwhelmingly say I want the risk protection of the health insurance versus cash.

And as importantly when individuals who are offered that payment or told well, what if your employer just gave you that money, gave you no choice, and said buy health insurance. Nearly 40—percent suggests that they would choose to use that money for other life necessities as opposed to buying health insurance. Not surprisingly, that group has dominated by individuals who are young and individuals who are in good health. So if these are risk pools it would have fairly significant implications.

The second issue, and one which is very active in the current Washington debate and each of the states that are looking at health reform aimed at expanding health coverage, is

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the issue of ERISA preemption. The Employment Retirement Security Act of 1974 quite explicitly said that employers could rely on federal law and not have to deal with state laws if they provided, in essence what we're term self-insured employment-based programs. And self-insured programs since 1975 have dominated the way in which most employers, particularly employers of size, have engaged in the system.

The issue of ERISA preemption is central to whether or not the Massachusetts program will ultimately be able to go forward. It is central to whether California, even if they were to enact either the legislative or the governor's proposal, would be able to go forward. And the only state currently that has an exception from ERISA preemption provision is Hawaii, which got that as part of the original passage of the statue.

So, ERISA preemption visa be the state initiatives is central. It has not been challenged thus far with litigation in Massachusetts but is recently at last week at a meeting several large Massachusetts employers said while they had not yet filed suit and they were currently supportive of the Massachusetts statue they were in essence reserving the right to file suit under ERISA in the event that they decided that they in fact after the fact didn't any longer like the Massachusetts program and they felt that they had a strong basis under ERISA that they would be able to overturn

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Massachusetts if they did make the decision to pursue that issue in court.

So ERISA preemption is central to federal policy making and decision making and it is central to, I would argue an impolite urge role in the future related to what happens.

So I have attempted to make both of those statements to see if in the course of Q and A and/or their comments, either Michael or Carl would like to add a footnote on either of those issues, the social contract issue or the ERISA preemption issue.

With that, Carl Canden from Kelly Services and Michael Critelli from Pitney Bowes will present what Karen described as the on the front lines report on the future. Gentlemen.

CARL CANDEN: Thank you. Good morning and again, thank you for the, you know, for your introductory comments. It's a pleasure to be with you all here to talk about health care reform. I was noting with Dallas that we served together a decade ago on ERISA advisory board. We talked about these same topics a decade ago; nothing in particular has changed except that the number of the uninsured has gone up by about 50—percent.

Now I would like to acknowledge very quickly at the beginning the importance of the work done by EBRIs. It's highly valued by everybody interested in health care and health care in other workplace issues. That's a good set of objective

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data. Delighted very much to be in the company of Pitney Bowes chairman, Michael Critelli. He has been one of the strongest voices in the business community on health care reform. And of course, thank you to the AARP, The Century Foundation, and The Commonwealth Fund for today's sponsorship.

I think what is different now than a decade ago when we last worked together is that the business case for health care reform is being made very forcefully, very frequently by business community leaders. We are increasingly very vocal on the issue and we are finding very surprising allies. For many companies reform of health care financing has become a strategic priority and perhaps that is not surprising since for many of us the cost of health care exceeds the amount of profit that we generate in the course of a year.

Health care costs are escalating even if it's slowed down to a 6.1-percent that's still significantly higher than wages are going up and for many of our employees any increase in compensation is basically just enough to cover the increase in their share of health insurance premiums. In 2010, we have a current projection of health care spending will exceed $2.47 trillion up just a mere trillion since 2003 or 4.

I have to tell you that as a business leader I find the price value relationship to be appalling. the United States spends more per capita on health care than any other country in the world, 22—percent more than second place

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Luxemburg, 50—percent more than third place Switzerland. Understand that on a per capita basis we are spending 50—percent more than the third place country.

As a result, at minimum the United States is spending 50—percent more per capita than the rest of the industrialized world. And with such a poor price value relationship people are abandoning the system and perhaps more importantly the system is abandoning its people.

Now despite this outrageous level of expenditure, I think we need to admit to ourselves that US health results lag other industrialized nations in terms of their outcomes. According to the World Health Organization, 34 nations have longer life expectancies, 41 have lower infant mortality rates. You could pull from many different speakers, from many different speakers, you know, conversations, many different advertisements, a long list of health care outcomes in which we ranked near the bottom.

I would put it this way to you as a CEO bottom line the American people are paying at least 50—percent more to get about 50—percent less than the rest of the industrialized world. That again is unacceptable to us.

It is no wonder, in my opinion, that we are rapidly reaching a political tipping point. There is a growing recognition across the political spectrum that the status quo is not economically sustainable nor is it morally defensivable.

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And today I won't talk a lot of about the social cost and the social impact on those who are uninsured and tend to focus instead on some of the economic issues. I have to tell you that as a country to have as many uninsured as we have who incur the consequences that they incur for being uninsured has to be unacceptable and viewed as morally reprehensible by those of us who are charged with providing leadership.

Obviously Americans are very concerned about the health care system. They are more focused on it than anytime since our last attempt at reform in early 1990's. Topped only by the war in Iraq health care is the primary domestic issue now on the minds of Americans. The ability and willingness of states to address health care reform is a very tangible indication of the shifting political landscape and the will that is being exercised by business, community, and by individuals.

Massachusetts and Vermont as we all know have enacted programs. In Pennsylvania and California the governors are pushing hard again on their own plans. The business community is stepping up its involvement. Kelly Services is very proud to be a founding member of the broad based health care reform coalition known as the Better Health Care Together. Other corporate founding members include AT&T, Intel, and Walmart and perhaps surprisingly labor unions have joined us. The SCIU and The Communication Workers as well as leading think tanks have become founding members of this coalition.

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We have set up four broad principles that we think will guide health care reform. We believe that every person in America must have quality, affordable health insurance coverage. We can't tolerate having over 40 million Americans without coverage especially large numbers of working Americans. We believe that individuals do have a responsibility to maintain and protect their health but we believe that America must dramatically improve the value that it is receiving for every health care dollar. This paying 50—percent more to receive 50—percent less must stop. And we believe that businesses, governments, and individuals all should be required to contribute towards managing and financing a new American health care system.

As individual members of the coalition we are educating our individual stakeholders on the health care reform issue and we have agreed to work together regardless of our political differences to keep the topic at least front and center in the Presidential campaigns of both parties. As an example on our websites we have recently offered all the Presidential candidates three minutes of video time to explain their position on health care reform. And each of the individual coalition members are working to make these responses broadly available to our employee and our other constituencies.

This type of effort represents I believe a very critical difference between today's environment and the early

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'90s which was the last time we made a significant effort at comprehensive reform. Ten years ago, I believe too many in the business community were content to remain on the sidelines if not act of opposition. But today the business community is engaging broadly as an active participant in the debate. And there is wide spread agreement among us that reform must happen.

We are not Pollyannas. We understand that bringing about meaningful and positive health care reform is going to be difficult and will take quite a while to achieve. The ultimate outcome is of course going to be heavily influenced by the 2008 Presidential election and I wouldn't be surprised at very little happened then until 2009. We will have lots of conversation but probably very little action at the federal level until we get past the election. But one of the reasons that we have formed this business coalition is that we believe we should do the work now so that come 2009 we would be in a position to put forward aggressive legislation and aggressive reform.

In addition to the importance of this issue both morally as well as economically, there is another factor that drives Kelly's particular participation in this effort. Despite all of the intellectual capital that you can see around this room and elsewhere that's been applied to health care policy there is a very important piece of the puzzle that's

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being overlooked. Twenty-five to 30 million working Americans are free agents, non-traditional workers who basically are left out of the current employer based system. Call them freelancers, contract workers, temporary employees, independent consultants, entrepreneurs, no lack of you know, no lack of names. You still have 25 to 30 million people who don't fit into the current policy debate. They are generally highly skilled, better educated than the work force in general. They work in a wide array of disciplines, lawyers, nurses, accountants, scientists and so on.

We have spent a lot of time studying these individuals at Kelly's since they are our core constituency. Let me tell you a little bit about them. They are very independent minded and they don't view any particular company as home for a lifetime. The social contract is irrelevant to this group. They reject it. They view it as naïve to believe in the social contract and I have got a speech in two weeks at Chicago HR conference talking about their attitudes. They laugh at those of us who believe in a social contract. They have great websites. You should go see some of their websites. They have about the wage slave community, as they would call us. They place a very high value on the flexibility that the free agent lifestyle affords them. Things to pursue educational opportunities, to provide elder care and child care, or to step

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back from a 40 hour workweek, I wish it were only 40 hours, to devote time, you know, to raising families and so on.

The current health care system doesn't meet their needs. It doesn't even recognize they exist in most regards. They are largely ignored by the insurance community. They are often driven into the highly expensive individual market. And then they get the pleasure of purchasing that insurance with fully taxed dollars.

They need portability. They want affordability. And most importantly they want equality with how we treat other workers in the system. The Bush administration has made proposals that would equalize the tax treatment and there are association health plan proposals that would provide them with access. All those arguments have detractors and advocates. None of them is going to happen in the near future. And so the free agent community continues along basically being non-participants in the current system.

Ultimately, we need to recognize as policy makers and those who influence the policy makers that we can't view a reform as successful unless it takes into account the needs of this free agent community. We need to understand. It's critical that we do so for several reasons. Lots of people are choosing this independent work style more so today than ever before. Sixteen million people that work in a solo capacity, 13 million who are micropreneurs and again more people in

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aggravate than who work for federal, state, and local governments and we of course could never leave those individuals out of the health care financing system. We can't leave this group out.

Twenty-five to 30—percent of the work force, and understand that they are there because they choose to be, 81—percent voluntarily choose their status as free agents, 62—percent said they are not going to consider going to work as a, you know, as a wage slave or as a traditional employee. And their numbers are going to continue to increase. Shorten job cycles, the growing shortage of workers, all of that is just going to hasten the number of people who will choose to work in a free agent lifestyle. In fact I can tell you, we are falling behind Europe and Japan in the adoption of this work style which I view as a critical loss of competitive advantage. And we are falling behind because we make health care insurance a condition of an employer relationship rather than a condition of employment.

Driving to a solution is going to be hard work and we should make certain that if we are going to engage in that hard work over the next year that we do so in a way that includes the free agent community. I believe that we are going to suffer a loss of entrepreneurial spirit if we keep making health care insurance a barrier to being an entrepreneur rather

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than access reform in a way that encourages entrepreneurship and the creation of new industries.

I believe that the free agents are at the heart of America's creative edge. They drive the start ups and we need to engage in a system that is going to encourage participation in this work style rather than discourage it.

It's probably a little silly to bring political observations from Michigan to Washington but let me make just one. Good policy is of course good politics and I'm sure that there is great political advantage to be gained by whichever policy makers achieve the wisdom and courage to step forward on behalf of the free agent community. They are basically ignored by both political parties. They feel disenfranchised. They feel nobody speaks for them. And they feel incredibly maltreated by how we are approaching health care financing in this country. They are not natural joiners; otherwise they wouldn't be free agents. All right? But they are well educated. They are relatively affluent. They are highly effective and the first political organization that speaks well for this group, understands their motivation and approaches, I believe health care reform which is their number one political issue, from a prospective that shows you understand the needs and the psychology of the free agent worker, I believe will gain great political advantage as well as taking the steps

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necessary to provide fundamental reform of the system in a way that will be long lasting and good for the American economy.

Thank you.

DALLAS SALISBURY: Thank you.

[Applause]

DALLAS SALISBURY: Mr. Critelli.

MICHAEL CRITELLI: Thanks very much Dallas and Carl and I want to also thank the Century Foundation and the Commonwealth Fund and AARP for this conference and for inviting me here. I find myself often speaking a very different language from the other people talking about this topic. So here goes.

First of all, the debate is misplaced in this country. What we should be talking about is maximizing health and production capacity, not health care but health. Health care is a means to an end. And it is the end in and of itself. I get the feeling that although politicians give lip service to prevention, wellness, and health, they think of health as almost something that is randomly visited upon the population. And one of the worse examples of that is the recent Department of Labor, Treasury, and HHS regulation that put limits on wellness programs for self insured employers.

One of the most misguided programs. It will go into effect next year. And it puts a 20—percent limit on the amount of the wellness incentive you can give whether, how they got to

that, I don't know, but I think its evidence of how misguided this whole discussion is.

Affordable coverage is one of five pillars of moving people toward health but let's think about what is costing us money. Carl's statistics are very compelling. But in this country our biggest source of health costs are preventable chronic diseases, preventable chronic diseases. Twenty, 25 years ago it was acute conditions. Today it's lifestyle driven, preventable chronic diseases.

So what do we do about problems like diabetes, cardiovascular conditions, asthma, and behavioral health? Clearly affordable coverage that is universal and prevents catastrophic process from hitting American citizens is a prerequisite for any health system. But that's only one of five of the pillars of getting to health.

The second is access. Access to screenings and immunizations, to primary care providers, to technology, and to information. And on information I mean an electronic health record that's portable and private and comprehensive and patient controlled. Let me talk briefly about this access issue and give you a real life example of its implication.

We have affordable and comprehensive coverage for all of our New York City best employees including those who work in our, in many of those management services divisions which in many respects resemble a collection of small business, groups

of ten to 20 employees that work in over a 100 sites in New York City. They spend $4 million a year that we pay for in emergency room visits. Why? Although they live in Manhattan they work on, I'm sorry they work in Manhattan and they live in the outer boroughs. If they get sick on the evenings and weekends, they go to an emergency room. Go to many parts of the America and try to go to an urgent care walk in clinic after hours and the answer is there are none. There are three in Manhattan. There are virtually none in the outer boroughs. There are none in many communities of America but it is a basic gap in our system so we spend ridiculous amounts of money putting people in emergency rooms when they should be going to a walk in clinic for a routine infection or a treatment of a minor injury.

We've addressed that issue in our facilities by having walk in clinics that are convenient in terms of location and hours. They have reasonable waiting times, adequate time with providers, and where we do not have language and cultural barriers. But we must address the access issue. We must address access to pharmaceuticals, to information, to primary care, and to screenings and immunizations.

The third pillar is to do things that maximize quality of care. Now by quality of care I mean results as opposed to a process driven approach to evidence based medicine. We need to reward the people that are doing a lot of a particular

procedure and doing it well and not reimburse the same amount if someone goes to a provider who hasn't done the procedure or who is not getting good outcomes.

Fourth and this is what we have spent a lot of time on it at Pitney Bowes, we need planned designs that incite both the right provider and patient behaviors and disincent the wrong provider behaviors. One of the things that we did in behavioral modeling relative to chronic diseases is we took down the cost of tier one drugs for this chronic conditions to incent people to stay on the treatment programs. One of the most short-sighted techniques of taking out costs in health plans is to raise the price of drugs for chronic conditions. The problem is not seen in the same year but by the next year and the year after you are inviting some acute conditions. We've actually seen reductions in the rate of increase significant reductions for diabetes, behavioral health, and asthma and cardiovascular precisely because we took a counter intuitive position and made those tier one drugs virtually free of charge.

And finally, how do we create an environment, an environment where people engage in healthy lifestyles. We work as Carl said more than 40 hours a week. The place where people spend most of their waking hours is at the workplace where we have control of that workplace we create a health environment in the workplace in terms of the food we serve, how it's

priced, the availability of exercise programs, the focus we have on healthy lifestyles, and there are subtleties here. In America unfortunately because of Department of Agriculture and Congressional programs unhealthy foods are subsidized and healthy foods are not. Commodities that are the ingredients of junk foods are heavily subsidized in the agricultural arena with the result that poor people who are thinking very rationally about limited amounts of budget money for food and they say how can I get the most calories for the least amount of cost end up gravitating toward junk food.

It's very instructive. I go to Philadelphia a lot and I'm in downtown Philly. And I went to a supermarket in Central City, Philadelphia where a lot of inner city people shop, huge family sized packages of junk food at very low costs. I couldn't find fruits or vegetables in that store. I couldn't find healthy organic food in that store. And if I did it would have been very, very expensive. So if I'm the person where going to that supermarket that's conveniently located I'm going to gravitate toward the junk. If I thought about exercising, it's safe for me to walk around those neighborhoods. I decided that I would work out in the fitness center of the hotel rather than venturing out after hours to do a walk when I would say if I had a chance to do so in the evening. Go to many communities in America and try to take a walk somewhere or try to bike somewhere and you find it very, very difficult.

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We also have subtle but very important drivers of increased health care costs. We are not as of aggressive as we should be in dealing with the consequences of excessive alcohol use on the roads in terms of taxing alcohol that is consumed by teenagers or in addressing the issue of teenage driving which adds costs to our health care system in terms of accident rates. Our environmental focus on traffic congestion is inadequate with the result that we end up with higher incidence of asthma because of motor vehicle pollution.

So we are not looking holistically at how do we maximize health. There are too many other factors that enter into the public policy debate. So my view on this subject is that we have to recalibrate and focus on health and productive capacity is the primary goal. And we have to look at all five of these drivers if we are going to achieve the price value equation that Carl has talked about.

As far as this issue of whether the employer should be the primary driver, think about this for a moment. Does the government care about whether you are productive? Does the insurance company care? No, their goal is to cut costs.

Now about consumer-based health care? Sounds intuitively appealing and I think in many respects aligning people to what is good healthy behavior is a good idea. The idea that people should make decisions to save money as opposed to spending on certain kind of health is a bad idea. We need

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to design a consumer-based health system that does not reward people for delaying or foregoing preventive screenings and immunizations. I think if we incent people to engage in healthy behaviors and we do text related incentives to get them affordable coverage, that's a good idea but the idea of leaving it completely in the hands of the consumer without any information to enable, to compare them across providers, without good access, and without good tools for healthy behaviors is another incomplete solution to the process. So my view is employer based health is a critical component but we got to align these other factors if we are going to solve this problem.

Thank you.

[Applause]

DALLAS SALISBURY: Thank you gentlemen very much. On one issue which I mentioned but neither of you came back to but it does come into some of the later discussions and the current public policy is how either of your companies been directly involved in the Massachusetts and California situations?

MICHAEL CRITELLI: We have not in either of those because we do have sufficiently large employment basis given our size to do so. I obviously am going to figure out a way to weigh in on that but we have relatively limited leverage in those states.

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CARL CANDEN: We are involved only in the process of trying to help them define what's an employee. You know given the employer and employee base that we represent, there is no clear definition on that. There's no you know, no understanding as to who participants and how in this free agent community.

DALLAS SALISBURY: And then the second which there is a coalition in town that has been, that is quite large of associations and individual companies that's responding to discussions on Capitol Hill and drafting that is taking place on legislation that would to a substantial degree eliminate ERISA preemption in order to allow states impose either costs or date requirements or direct benefit mandates on self insured employers. Would that, would those types of federal lot changes affect your behavior as an employer sponsor of health care or not?

CARL CANDEN: I don't yet have enough data. I'm watching, I'm learning, I'm reading.

DALLAS SALISBURY: Okay.

CARL CANDEN: Ask me in six months.

MICHAEL CRITELLI: I have zero trust in state based health care. I just give you one experience we had in Connecticut. We had legislation in 1990 to allow pre-employment drug testing. It was very controversial piece of legislation. And it was going to get down to one or two votes.

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A pivotal legislator whose vote was needed offered an amendment to the bill on the floor to prohibit discrimination against smokers because he was heavily contributed to by the tobacco lobby. And that unrelated rider with no notice passed in Connecticut and insurance plans were not allowed to put in programs for wellness that incented non-smoking behaviors.

There are a lot of quirks in state legislatures and although they are wonderful laboratories for experimentation, they are also wonderful laboratories for dysfunctional behavior in the health care field. I don't have confidence in 50 different experiments in this area and our ability to manage a health care system within that.

DALLAS SALISBURY: Both of you mentioned issues particularly of data transparency and current absence of that type of information. In the context, particularly Michael your comments of those issues relative to direct consumer driven health care. Do I interpret into some of what you've said; I fear that if there is too rapid a movement in that direction of putting everything on the individual, in the absence of technology that you think it could actually do more harm visa the cost and wellness as opposed to good.

MICHAEL CRITELLI: I think consumer health care with the proper structure around it is the way to go. One of the reason we incorporated consumers or employees paying premiums and co-pays which we didn't have until the late '80s. I

actually implemented them when I ran HR at Pitney Bowes, was to make them a partner in improving their own health. I think when somebody gets something for free they don't but there are many health conditions that are symptomless and where the spending is, the spending is a burden immediately. The benefit is less clear, and the procedure may very well be an unpleasant procedure. If you look at the adherence to recommended screenings for particularly colonoscopies and conditions like hypertension, you see a pattern of very low adherence. So we upped the combination of symptomless conditions with slow moving or long-term problems. The consumer probably needs to have the playing field artificially lilted toward doing those expenditures in a consumer system so that the financials or there is a level playing field between what they are spending and the benefit they get. Where you hear the deferred spend and somebody's financially strapped they will probably forego those short-term expenditures and then pay the consequences later on. And if we've provide catastrophic coverage, we are going to end up paying a lot for that acute care condition later.

So I think consumer driven health care is the way to go but with the proper set of incentives around it and particularly one of the other attributes I would say is that we need to move away from a single year elections to health plans and also I think at the state level, if we are going to do

something like SHIP or Medicaid we should have some form of continuity of care whether it's through the electronic health record. If somebody drops in and out of health plans the providers and the payers have very limited incentives to invest in things like we have done.

So, I believe very strongly is that we have to create aligned set of conditions where people do the right things for their long-term health.

CARL CANDEN: I do think also that the technology based in terms of transparency that you asked about is critical. You can't have consumer driven health care if they don't have a knowledge base from which to make decisions. You can tilt the playing field to get them to make the right type of decisions but then when they look at an array of doctors, look at an array of choices or health care options, if the outcome measures, if outcome information is not transparent, not easily understandable to a non-medical audience you know then it's an uninformed consumer driven process which isn't going to be any better than you know a non-consumer driven process.

DALLAS SALISBURY: Questions or comments. Yes. Could you wait for the mic there? Thank you.

MALE SPEAKER: I'm a former wage slave. [Laughter] Now a free agent.

CARL CANDEN: Congratulations.

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MALE SPEAKER: And I happen to live in Massachusetts. I'm old enough to know that I need health insurance but one of the unusual features of course in Massachusetts is the combination of guaranteed issue and mandatory individual coverage and I wonder what you think about that and whether it should be extended to either to other states or on a national basis.

CARL CANDEN: I don't know if it should be extended to other states or not because we are trying to reach clarity with Massachusetts as to how do we deal with individuals like you. Do you feel that you have great certainty of knowledge as to how you are suppose to participate in the system?

MALE SPEAKER: Yes. [Laughter] But only because I've co-written a —

CARL CANDEN: Well, that provides intense clarity.

MALE SPEAKER: [Inaudible 51:56]

CARL CANDEN: Right.

MALE SPEAKER 1: I would like to comment as someone from Massachusetts. Thank you. Guaranteed issue turns out to be extremely, extremely expensive. They lean over to say if I can't do experience rating, I'll experience rate everybody. As far, as hard as I can.

MICHAEL CRITELLI: Can I comment? Although I'm not specifically familiar with the details of Massachusetts and a play of laws, one of the other problems we have in states,

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which I didn't address in my earlier comments, is the incidence of mandates. And where the states through the pressure from special interest groups mandate not only coverage in an area but the details of how that coverage will be delivered. So, I think that before we start thinking about universal coverage, we got to again have a results base approach rather than having legislators under the influence of special interest groups micromanage either legislatively or through regulation how care will be delivered and through mandated coverage. I think saying that a coverage plan has to have certain areas is appropriate but getting into the details to the degree that states do is part of the reason we have issues like we have when we try to extend guaranteed coverage. And I know that's an issue in Connecticut over the years that there is one mandate after another has been layered on to insure plans.

DALLAS SALISBURY: Yes?

FEMALE SPEAKER: I have a question about wellness plans and about using penalties such as having overweight people pay more for their coverage or smokers pay more for their coverage. How do you feel about that?

CARL CANDEN: As someone who is overweight and one that smokes the occasional cigar, I'm against it. No, [laughter] the — you know, my wife is a nurse so I am biased by the fact that she, that and a whole bunch of RAND studies which show that obesity as an example is a far greater contributor to

health care costs than smoking. And I always thought smoking was a really devastating, you know, contributor to the cost.

I think that if you have employers who are responsible for paying the portion of health care expense that they have that they should be capable of offering incentives that are going to bring down there own self insured costs. And an experiment or two in order to provide incentives for those who are engaging in the wrong behavior to come back to comments being made earlier, to provide incentives to reduce that behavior I think is an appropriate response whether it's going to be effective or not is a different question that I don't have a good answer to.

MICHAEL CRITELLI: I have different opinions on the two points. Relative obesity itself, or being overweight, there are many contributors to someone's condition of being overweight. I don't think all of them are within the control of the individual. I think we can incent participation in exercise programs or in dietary programs but the, penalizing people that are overweight to me is, I don't think we know enough on how to get people back to good weight to feel comfortable with a penalty in that regard. What we do however is stack the deck in our cafeterias so that you pay considerably more for the junk relative to our costs than the healthy food.

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Smoking is different. I think we have, there are work, there are proven smoking cessation programs. We offer them either free or at very low costs. We actively manage them. If you decline to participate in those programs and continue to smoke, I feel there very comfortable imposing penalties. And again, I'm distressed that the US Department of Labor, Treasury, and HHS micromanaging us away from those kind of incentives and penalties to the degree that they did. If you look at their regulations, they are ridiculously overreaching and misguided.

CARL CANDEN: On the weight issue, I am talking with other CEOs who are having good experience which I'm debating, instead of providing penalties, you know for those who hit, who are at certain weight levels, are providing incentives for those, providing paying them to, paying them to lose weight and keep it off for a specified period of time in a fairly specific amount. And a couple of them actually claim they have been able to document over a two to three year period a reduction in health care related costs. So I'm intrigued by that because it has less of a, it feels less onerous, less social, you know less socially negative to provide those incentives than it does to provide the penalties there.

MICHAEL CRITELLI: Yes, but my one concern about weight loss, just to be, just to complete the subject as, I think that there are unhealthy ways to lose weight. You know people get

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on diets where they stop eating or they do you know, we are only going have protein and no carbohydrates. And they end up doing damage to their kidneys or other organs. So, this is one that I think we need to give careful thought to as to how you go about doing it.

I agree with Carl. I think there are good ways to do it. There are also a lot of bad ways.

DALLAS SALISBURY: My tailor for example who and I only have one because tailors describe me as a body shape of a prominent seat. [Laughter] And my doctor points out to me that none of the body mass index scales that frequently get used in these weight programs have been adjusted for in essence body frame, bone style, body shapes that are quite different, etc. So it's just I think the implementation of any of these things. And smoking, you either smoke or you don't smoke but with something like weight and weight loss where there is so much controversy about techniques of losing weight and there also are the measures are not, if you will, customized measures. BMI is a very generic measure that says I am obese by any of those measures. And whereas in general my mother still says when are you going to put some skin on your bones or something on your bones.

The other issue that I would be curious to hear your gentlemen's reaction to is for my colleagues is working on a paper and he has been going through statements of just the

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current calendar year including of some of your coalition members that head a couple of the organizations that you mentioned in your coalition. That have in recent months described the employment-based system and the employer commitment to health care. one union leader two weeks ago saying the employment-based systems was already dead who is in your coalition; others describing it as withering rapidly declining, and statements with that suggesting employers just absolutely don't want to be in the business. They just happily have the government or somebody else take it over or would prefer that it be totally the responsibility of the individual.

As major corporate sponsors of employment-based programs, do you think the system is dying or dead? Do you, would you prefer to be out of the business? Would you prefer that it simply be individuals without employer involvement or would you simply prefer the government take it over? All of which are characterizations carried in the media in the last 30 days as to what business is thinking and what the state of the system is.

CARL CANDEN: I think Mike might have a slightly different opinion so I will go ahead and start here and give him a shot then too respond.

I think the problem that I have with the employer based system is that it's a system that already is excluding our failing 40 some million people and is covering inadequately

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this group of employees that I have talked about or workers who don't fit any traditional definition of employee or employer. They are kind of off to the side.

So I think, as a country we need to acknowledge in policy debates that an employer based system is incomplete. Now we can argue then do employers want to continue to participate or not and I think that some employers would choose, and listening to Mike, he's got a great prospective and a good activist tradition, it would surprise me to see even if alternative systems were available, that companies like Pitney Bowes and so on would choose to maintain a highly active employer based system. There are many companies, there are many CEOs who I talk with who have said to me very directly quotes like you said. They do not want to be in the business of managing health care or managing even health care options for their employees.

I think a fair number of businesses would in fact opt out of the current employer based system if an alternative was provided. A good number of businesses would not to choose to opt out but I think that one of the biggest things we could do is that if we could change our thinking from the employer based system as being the system to it simply be one of the channels in what's going to be a complex set of systems that will provide coverage, we would be much better off in policy debate and prospective.

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And when Andy and others are saying the employer system is dead what he is very correctly saying is it is dead and has been dead for a long time if we think it's going to be, if it's going to be able to continue as the solo way that we go about providing care to the majority of working Americans.

MICHAEL CRITELLI: I actually agree with Carl's comment about the fact that is a component of multidimensional system and it isn't complete. Let's keep in mind and I use us as a laboratory. We have two populations, a large business population that works in, and reports to our work sites every day where we can deliver a very wide range of services. And then this collection of mobile and customer sited workers where we look more like small business America. And I think there we can be very effective in the plan design and in the incentives relative to that plan design. We cannot provide access and we do not control the environment in which our employees work every day. And many small businesses or whether they are free agent workers or mobile workers which is an increasing amount of our population, the government has to along, work with other stakeholders to design systems that provide appropriate access, good quality, and have intelligent plan designs and create an environment for healthy lifestyles. A large employer can play a role under certain kind of conditions where you have critical masses of people in single locations or campuses. If your super, if you have in your work force, you know, a hundred

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thousand people scattered in a thousand locations it probably, what we do probably doesn't work in that kind of setting.

CARL CANDEN: Even my permanent work force only ten-percent of it is aggregated anywhere in groups of more than 50. so 90—percent of my work force is in pockets of two, three, five, ten and many of the programs again that you are talking about and many others just have to concur with you, don't work in that context.

MICHAEL CRITELLI: Yes.

DALLAS SALISBURY: Questions? Yes?

JOHN GREENE: I'm John Greene with the National Association of Health Underwriters. Curious, I heard what your comments were with respect to continuing in this system but what happens if you get an employer mandate that dictates how you are going to do this, what happens to wellness programs for example, certain levels of effort, you know I mean instead of — what happens to your desire to continue to play in that scenario then. I mean politicians are talking; Presidential candidates are talking about player mandates and that. That's a little bit different than the individual mandate.

CARL CANDEN: I have no clue. [Laughter]

MICHAEL CRITELLI: Well, it depends on what the mandate is. If it's to help wellness programs then they give us a lot of flexibility. I don't have a problem with that because it's consistent with our desire to deliver health in productive

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capacity. But knowing what I know about politicians and their distrust of employers they would most likely either in legislation or by regulation micromanage how it's done and I think that would be a very bad outcome.

DALLAS SALISBURY: Yes? Microphone over here.

FEMALE SPEAKER: Hi, over this way. I work for a Ascension Health, which is the large not for profit health care system, and while we certainly have wellness programs one of the other things that we have done at our national office level is to tier premiums so that employees at the lower salary levels pay a much more affordable premium versus the higher salaried employees. Is that something you, other companies have done? Is that one way to address affordability because we do the same sort of thing with prescription drugs? So it's not about chronic diseases but it's about making sure whatever someone needs it's paid to what they can actually afford. And I do see a growing number of individuals who say they are offered health insurance but can't afford the health insurance. So maybe there is something that employers need to look at to make sure that if there is a big enough pool where you can actually tier premiums that might be one option.

CARL CANDEN: You know the participation rate of employees in the plans that companies offer is going down every year which is another one of the drivers of the increase. So, when you hear statistics that 90—percent of the companies offer

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plans I always say but what percentage of the people are opting into the plan and it's decreasing every year. And I think that's important.

Yours is the first of the, that's, your company is actually the first that I have heard that actually I would like, if you could send me the details of that plan, I would be very interested. Did it change; did it increase your participation rate post implementation?

FEMALE SPEAKER: You know I'm not exactly sure that it has. It's been in effect the five years that I have been with the company so the company actually was only started in 1999 so that was the policy from the beginning. But the premiums I did look at them recently for a family at the lowest level, salary level is $5 a month. And if you don't take coverage you only get a $15 credit. So the incentive is really to take the coverage than not take the coverage.

MICHAEL CRITELLI: We have a flexible benefits program and we give more credits proportionally to lower paid employees with more seniority so in effect we are doing what you describe. We also have multiple levels of plan coverage so someone can opt for a less expensive plan which has less coverage. And we work as well to try to get people into flexible spending accounts as part of their strategy. So we do a lot of things to help lower paid employees get into the plans. But as I mentioned what we do not control is what

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happens to them after hours when in the lower income community in which they live they don't have an urgent care clinic or a primary care physician they could visit when they go home at night or on the weekends. And that's the, one of the big gaps in our health care system today.

CARL CANDEN: Thank you.

HARVEY SLOAN: Harvey Sloan, a number of you have mentioned the importance of the electronic record and I certainly concur with that. Has there been any work on how much that is going to cost as a nation? And I assume we can get some examples from the VA which has done it. And then the second question is the length of time it might take to implement that with the majority of the physicians in the country.

CARL CANDEN: You know Intel who is one of the members of our coalition is in fact working on understanding you know what an implementation costs and of course is always going to be a big number whenever you switch any system. For those of us who run companies switching from a Legacy system to a new system is one of those painful events you only want to do once as a CEO. And I'm certain we are only want to do this once in the health care system too. How long it will take to implement is much longer than we all want and it will cost much more than we want. But the-percentage of the health care budget that we spend on overhead that we spend on administrative costs, data

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transfers and so on is again higher than we see in almost any other country. And, the non-portability of the information or the inability to access it is just one of those really sluggish you know things that slow down and make the system much more inefficient. But I think it will become a very critical part of the debate and it's going to be a big number and we will have to talk about you know its pay back.

MICHAEL CRITELLI: Go ahead and then I will comment on—

HARVEY SLOAN: Yes I would only say for those of us who have been working in this field for 40 years, it's time for a whole new generation. If you were to look at web 2.4, if you would look at the new data mining techniques. If you look at inter-operability, I would push toward enterprise PHRE MAR systems and Kaiser probably is the best example. It took them 55 years to do it after five failures. But it's up and running and having quite enormous impact on their capacity to both serve patients and with declining costs and manage the enterprise with quantitative metrics that other industries can do. So, I would just try and not look backwards but look forward.

MICHAEL CRITELLI: I'm sharing an incentive called DOSO which Intel actually started for the, what you call the permanent portable patient controlled health record. Three comments, one is there is certain data points you can get into a health record relatively inexpensively. Pharmaceutical, lab

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tests, and claims data can be put in reasonably well. When you start to get to hospital and doctor's notes that gets to be much more complicated. So, we have to decide is the, I think the good is – the perfect is the enemy of the good. There are things we can do to create affordability but they will be incomplete and over time we have evolve to add those other records.

Secondly, there are serious privacy issues that we have to think about as to whether the patient or the provider decides what goes in the record to get adoption. And there is a trade off. If you make it a provider-controlled, the patient will be not as able to use it when the patient changes providers. If you make it patient-controlled, and patients have some decisions on what goes in, then it's usefulness to providers is limited. So, that's the second issue.

The third is and this is a huge cost issue is what information do you put in and for long. If you want a lifelong health record which theoretically is great, the computing costs are astronomical and the maintenance costs over time are astronomical. So I think we will evolve toward better and more portable systems. I don't think we will ever see the perfect comprehensive portable record that will keep, will do everything, and solve everything in our lifetimes.

DALLAS SALISBURY: The one comment that I would add is that if you go back a couple of years when David Brayler

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[misspelled?] was running the office dealing with this at the Human Services, the Health and Human Services Department, his estimate on time line was that if all the money that was needed was available then it would take about 15 years.

Jerry Grossman mentioned Kaiser Permanente. Kaiser Permanente is still not complete from an overall system standpoint. They are moving hospital by hospital at this point. They are on a multiple year timeline even though they are prepared to spend the money and to get it done. But it is still even for that one system multiple years.

Then there is the issue inter-operability and interconnection. I'm part of a commission The Commonwealth has on high perform Intel systems and one of our site visits to Denver Health. Denver Health within its own hospital has all "an electronic system" but all of it is essentially in a box that what you are pulling up is pictures of records. So it allows integration of delay for the doctor on site. The computers and every, I mean it makes it very efficient to treat a patient who has been your patient within that facility but those records from a zeros and ones prospective of transferability and use elsewhere in the health care system, it is not an automated system.

And many of the surveys that are out there that suggests what the level of current automation and status of health records is would take them and would categorize them as

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having moved to automated health records where I think in the spirit of the way the question was asked they are not systematically — the patient that normally goes there and finds themselves having a problem in New York while on vacation, it's not going to help them a great deal.

The VA system was mentioned. The VA system is a great system. My father-in-law has always been in the VA system. He ended up with a situation that the VA doctor said they couldn't handle. They transferred him to a private hospital. Reasonably state of the art facility. And when the doctors at the new hospital said we need to see his medical records, what did they do. Their computer feed the electronic record into what became a 77 page fax. [Laughter] And all of the advantages of that technology again on a systematic basis.

So that's why this issue of piece meal versus the full system becomes such a very large important, very expensive by all estimates, and tremendous time frame and put that in the context that was referenced to the Presidential campaigns, the number that keeps getting referenced to the Rand Corporation that one could save about $90 billion a year if one moved fully to health IT as if that would help pay for short-term health reform, whereas to get to that level of savings is a very long-term investment on the time horizon.

I think we have time for one more question, if there is anybody with one. Yes, in the back.

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ART KELLIMAN: Art Kelliman [misspelled?], I'm an emergency physician. First I want to compliment both of you on emphasizing the importance of primary care and injury and disease prevention because my colleagues and I see daily and nightly the human toil and the incredible economic toil that occurs when prevention and primary care fail.

Second, I want to point out, I co-chair the Institute of Medicine's committee on the consequences of uninsurance. And while we always focus I think appropriately on the personal costs and the family costs of being uninsured, I also want to emphasize there are tremendous community and national costs. You can be well insured. You can be a CEO but if your community's trauma center or your ER is on diversion, when you have your heart attack or your teenage son wraps his car around a phone pole, it doesn't matter how good your coverage is. And we are paying a national price for failing to deal with the systems issues that are threatening the health care system on which we all depend.

Third, I would comment that if we expand coverage dramatically as we are trying to do, without dealing with the cost issues that you described it will like throwing gasoline on a fire. And we will take our already frightfully expensive system and drive it out of sight.

So, my question very simply but to set the stage perhaps for later discussions today for the two of you or the

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three of you in the business community, if your respective companies delivered half the value for twice the price [laughter] how long would they last in your respective industries?

CARL CANDEN: I would have to go back to being a professor. [Laughter]

MICHAEL CRITELLI: Amen. [Laughter]

CARL CANDEN: I do think very quickly though your observations are you know very important. I do believe that the emergency care system is in the process of being overwhelmed and one of the significant contributors is that we've made it the primary health care delivery system for the uninsured. You go there to get, you go there to get treated. It's just a, it's a big burden on the system. And along with Mike, the lack of urgent care centers, the lack of treatment post the nine to five environment, other than the emergency room is dreadfully limited in big parts of the geography. And I do think that any part of a solution has got to be how do we get non-emergency care out of the emergency rooms and into other forms of health care delivery.

And I don't think that any of the coalition members that I'm involved with, none of us would be interested in preceding forward where we would continue to deliver more health care at this ratio of twice the cost, half the you know our 50—percent more for 50—percent less. It's just not going

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to work. We are going to have to bring down the underlying costs as we go about expanding the coverage.

MICHAEL CRITELLI: One of the broad comments I make and I talked about a lot of ideas to change things. We looked at; we talked to New York based hospitals to see if they would do what the Stanford health system did in Connecticut and provide an urgent care center. The economics of them doing that were not favorable to them. They preferred to have the people come into the existing clinics and emergency providers. And one of the things we got to ask ourselves, we think about reform is who benefits from the existing system because I don't believe we all set out on this path of self destruction here [laughter] without somebody benefiting. We are spending a couple of trillion dollars on health care. People are making money off of that couple of trillion dollars. And if we are going to seriously attack this problem we have to ask ourselves who is going to oppose the things that need to be done. And when we set up our urgent care clinic inside our facility we did get some push back from local physicians. Now my medical director was smart enough to reach out to them and actually invite some of them to come in and set up office hours once a week, one day a week in our facility to get their buy in for us to be a gateway into the community. But absence that, there are tremendously entrenched forces that are afraid of the future. As you are thinking about health care reform think about who is

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benefiting from the dysfunctional way things are today and how are we going to transition to make sure that they don't become roadblocks to changing things moving forward.

CARL CANDEN: I like Newt Gingrich's comment that 200 billion dollars a waste of somebody's profit stream and when you start messing with it, the opposition is going to rise quickly.

DALLAS SALISBURY: I would like to thank also the employers for taking the time for being here today and for their excellent comments. In spite of the fact of the definitional way and words are always magic, under the definition you are provided if employer based system was intended to provide universal coverage that makes a dent then I guess one would say it's dead relative to something that it was never intended to do.

And I think that is part of the dynamic of the day visa via the type of desegregation that Michael just mentioned in the introductory comment that it was mentioned that business was fairly uniformly opposed to the '90s health reform. Having lived through many of those discussions, I think that is a bit too strong a statement. There clearly were segments of the business community and, to Michael's point, primarily those that were the principle recipients of the revenue stream as opposed to those who were the producers, the payers of the revenue stream. And in all of these things, I think as we go

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forward adjudging the future of the employment based health system the issue of what should it be judged against, what can it actually achieve, and is it achieving what it can achieve. A universal coverage would not be one of those things and was not one of the goals.

Please join me in thanking our speakers. [Applause]

We now have a break on the schedule and we will reconvene for the next panel at 10:30. Thank you.

[END RECORDING]

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