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Health Matrix: The Journal of Law-
Medicine

Volume 13 | Issue 2

2003

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Recommended Citation

Ronald Pollack, *2002 SCHROEDER SCHOLAR IN RESIDENCE LECTURE -- Gaps and Inequities in America's Health Care System*, 13 Health Matrix 415 (2003)

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SCHROEDER LECTURE

GAPS AND INEQUITIES IN AMERICA'S HEALTH CARE SYSTEM

Ronald Pollack[†]

I want to talk to you about a subject I care a great deal about and that is probably the most significant area of the work that we do at Families USA and that is the question about what I think is the biggest failing in America's healthcare system, namely, the very large and growing number of people who are uninsured. I want to talk a little bit about that issue and our failures and prospects for dealing with that very significant concern.

I think the point of departure for this is if you look at the latest Census Bureau report about the uninsured. It is a report that provides data concerning the year 2000. What that report tells us is that in the year 2000 there were approximately 39 million Americans who were uninsured. Now, obviously, since the year 2000, some things have changed and I think have made that statistic even worse.

We released a report or analysis about three weeks ago that just examined what happened in the year 2001, in terms of people losing health coverage as a result of layoffs in the economy. What we found was that more than 2.2 million Americans lost health insurance coverage in the year 2001 as a result of layoffs. Think about that for a moment. By the way, this does not count figures that we can't really determine – how many people might have lost health coverage due to other factors, which I'll talk about in a moment. If you just take those 2.2 million Americans who lost health coverage due to layoffs, plus the approximate 39 million, we're talking about 41 million Americans. How can you really get a feel of what 41 million is like? Forty-one million is more than the total, more than the aggregate population of 23 states plus the District of Columbia. If you add up

* Edited from the 2002 Schroeder Scholar in Residence Lecture sponsored by the Law Medicine Center at Case Western Reserve University School of Law on March 7, 2002. The Schroeder Lecture is conducted on an annual basis. This version has been edited for publishing purposes and does not contain the lecture in its entirety. The full transcript is on file at the Law Medicine Center and at the offices of the Health Matrix, Journal of Law-Medicine (publisher's note).

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the population of the 23 least populous states in the United States plus the District of Columbia, that is a total fewer than 41 million. Unfortunately, I think that this situation about the uninsured is likely, in the short term at least, to get worse. It is likely to get worse because the figures for the Year 2000, obviously, were during a time the economy was more robust and so more people had coverage through the employer-based healthcare system.

Over the last few years, we've seen a rise once again in healthcare costs and now we're experiencing double-digit increases in healthcare costs. A lot of that is fueled by increases in prescription drug costs, which rose in the last two years 17 percent and 19 percent, respectively.

We have a very different labor market. Not only are more people being laid off but, because the labor market is looser than it was before, employers are much more inclined to pass on these increased costs to their workers and, as a result, more and more workers are finding that health coverage is unaffordable.

Lastly, you can't help but notice, if you read the newspaper, that in state after state there are huge budget problems and the biggest program in almost every state is the Medicaid program and the Medicaid program is really under the budget ax in so many different states.

So all of these factors, I think, are contributing to make a very bad situation worse.

Before I start talking more statistically and start reasoning with you about where we are and why we've failed to make progress and what we might be able to do about it, I think it is useful perhaps to personalize this a little bit, because sometimes you don't really appreciate the personal circumstances that fall behind these statistics. I want to share one of many stories that we encountered in our work. It's a story that means a lot to me personally.

In 1994, in the last stages of the failed effort of the Clinton health plan, we were trying to rally the country, unsuccessfully obviously, to achieve healthcare reform. One of the means we tried to do that was we sponsored bus trips where we had caravans of buses. One caravan started in Portland, Oregon, another one in Texas, and another one in Minnesota. As the organization that was organizing these, I actually started most of these trips and I met a very memorable person in the bus trip we started in Fort Worth, Texas, a fellow by the name of John Cox.

We got on the bus together. It was a bus full of people and I sat next to John. I had never met him before and John started to tell me the story about himself and his wife. It was a very emotional story.

Tears were rolling down his cheek as he took out a photograph of his wife, Jan, and he started telling me their story.

John worked for a small Christian radio station in rural Texas and that small radio station did not generate sufficient income to pay their employees in the way that probably they would have liked to pay and they did not provide health insurance coverage. John, with his salary, could not afford health insurance coverage. One day Jan had a terrible pain in her stomach and John said, "We've got to go to the doctor." And, as John told me the story, Jan was a very strong woman, they couldn't afford the cost of going to a physician, and so they didn't go to a physician, and the pain kept on recurring and recurring and recurring. Months later, after this pain had continued for a long time, she passed out, was taken to the emergency room and she was diagnosed as having stomach cancer and the cancer had spread sufficiently that she was going to die. John told me that, the night before, he was with Jan in the hospital, on her deathbed, and I was wondering, "John, how can you be on this bus with us?" He said, "Well, Jan's last wish was: She wants me to go to Washington to make sure that this never happens to anyone else." We took a bus up north and the inevitable phone call came: she died. He buried her and he came back to Washington and I tell the story, not just because it, obviously, affects me emotionally, but when we talk about the uninsured, I think we have to have some understanding about what the consequences are for being uninsured.

They're essentially two consequences. One consequence is that people defer care. That's the common way people deal with their healthcare problems, and if you're John and Jan Cox, it may result in tragedy. If you're lucky, it doesn't result in tragedy. For other people, they may not defer care, but it results in extraordinary medical bills, and it is not surprising therefore, as a researcher at Harvard Law School has demonstrated quite recently, that healthcare costs have become the number one cause of bankruptcy in the United States.

So the consequences of what we're talking about are very substantial and it really does speak to a very significant failing. Now, when we talk about the failures of our healthcare system, it's a set of failures that have their roots in both the private and the public sectors, and I'd like to explain that just a little bit.

I think that when you look at who is uninsured in the United States, the persons who are typically affected by that phenomenon are people in low-wage, working families. They tend to be in small businesses. Those small businesses do not feel they have the wherewithal to provide health insurance coverage. As low-wage workers, they don't have the capacity to buy health insurance on their

own. Let me just describe briefly what I think some of the failures are in the private sector and then look at the public sector.

With respect to the private sector, the way the United States provides healthcare coverage is typically through our employer-based system. If you look at people under 65 years of age – I use that age because at 65 years of age, you're eligible for Medicare – if you look at people under 65 years of age who have private-sector health coverage, 90 percent or more of them have their coverage through an employer, so that is our way of providing coverage. Yet, if you take a look at people in low-wage jobs versus those in high-wage jobs, you'll find that the differences are startling. If you are a higher-wage worker – arbitrarily defined now as a worker earning at least \$15 or more per hour, not exactly a wealthy amount – if you are earning \$15 or more per hour, you have more than a nine out of ten chance of having health coverage offered to you in the workplace.

On the other hand, if you're a worker and you're earning \$7 or less per hour, you have only a one in two chance of having health coverage offered to you in the workplace. I underscore the word "offered." It doesn't mean you actually receive coverage, it is offered. In addition to that problem, surprisingly, a recent study funded by The Robert Wood Johnson Foundation found something that I – that at least surprised me – and that was: There was an examination of people in high-wage firms versus low-wage firms and what this study found was that people in low-wage firms pay more or are asked to pay more in premiums than people in high-wage firms.

Now, I am not saying the obvious: that people in low-wage firms pay a higher percentage of their income. That would be obvious, because the denominator is lower, so they would pay a higher percentage. I'm saying in actual dollar terms, people in low-wage companies pay more in premiums than those in higher-wage companies. In effect, therefore, lower-wage workers in the United States, when it comes to health coverage, suffer from triple jeopardy: one, they're less likely to have health coverage offered to them in the workplace; second, when it is offered, they're typically required to pay more in premiums; and third, of course, they have less discretionary income with which to pay for that coverage.

So as a result, the folks who are uninsured in the country are disproportionately low-wage workers. What are the comparable failures in the public sector? In the public sector, interestingly enough, our public sector system of coverage has its roots in the 16th Century Elizabethan Poor Laws. That sounds like a rather strange comment, but let me explain what I mean by that. The 16th Century Elizabethan Poor Laws of England essentially said that if you're going

to receive the benefit of England's social welfare system, you don't just have to be poor but you had to fit a certain deserving category. Now we picked up the precepts of the Elizabethan Poor Laws when the United States enacted its social welfare system in the mid-1930s with the enactment of Social Security. We said in order to qualify for our social welfare system, you have to be poor and you have to fit certain categories.

Now, what kind of categories are we talking about? One category is children. Actually, the category we chose was dependent children and that was the derivation of Aid to Families with Dependent Children, the major welfare program in the country until 1996. The other category included you if you were permanently or totally disabled or you had to be blind or you had to be over 65 years of age.

Then, in 1965, Congress enacted the Medicaid program and the root to eligibility in Medicaid was by virtue of participating in one of these welfare programs. So it engrafted on to our public health system this category that did not render you eligible based on need alone but on the happenstance of certain characteristics. Now, what are the manifestations of that today? In order to answer this question, you have to look at our public health programs, and I refer particularly to two of them: The Medicaid program, which is by far the largest health program for people who might otherwise be uninsured, and the second one, of relatively recent vintage, the State Children's Health Insurance Program (SCHIP).

What you'll notice with relationship to the issue of the uninsured are the three categories of people who are treated very differently from one another. One category is children, another category is the parents of those children, and the third category includes other adults, those non-parental adults – singles, childless couples. We treat these three groups totally different from one another under current law and the public does not understand this. The public believes that we take care of the poor and if you're poor, irrespective of what your family status is, we take care of you. It is untrue. With respect to children, as a result of the 1997 passage of the Children's Health Insurance Program, in the vast majority of states, children are eligible for health coverage if they're in families with incomes below 200 percent of the Federal Poverty Level. Two hundred percent of the Federal Poverty Level, just as a point of reference, for a family of three, is approximately \$30,000 of income a year.

By way of contrast, for parents of children, the median income eligibility standard for parents among the 50 states is 69 percent of the Federal Poverty Level or approximately one-third the eligibility level that children have. Here in Ohio, it is better than that, it is

approximately 100 percent of poverty but the median income eligibility standard among the 50 states is 69 percent of poverty.

Then you deal with non-parental adults, they get virtually nothing. In 43 out of 50 states, if you're a non-parental adult, you're single or you're part of a childless couple, you can literally be penniless and you do not qualify for public health coverage. So we treat lower-income, working families, those who may not have a job very differently from one another.

So you can see that our failures in terms of coverage have their roots both in failures in the private-sector system and in the public-sector system. So, I guess, the question for many is so why is it that we as a nation have not made progress on this issue? The typical question I get asked from reporters or others is what happened, why did the Clinton health plan fail? One of the things I like to remind people is that President Clinton was not the only president who failed in this respect. If you just look at what happened in the 20th Century, you'll see there are a number of presidents that really tried to make progress on this issue and failed: Franklin Roosevelt tried to do it; Harry Truman tried to do it; Lyndon Johnson tried to do it; John Kennedy tried to do it; Richard Nixon tried to do it; Jimmy Carter tried to do it; and Bill Clinton tried to do it and they all failed.

So what are the reasons for those failures? I've tried to identify some of the factors when you look at it historically. You know, some people want to look at the idiosyncrasies of what happened in 1993 – 1994: Hillary Clinton's task force and the secrecy of the task force and all these other kinds of things. I think these are far too superficial responses. I think there are far more significant reasons that are consistent with the failures under each of these presidents. Let me try to identify some of them for you.

The first is that, in our U.S. healthcare system, a very, very substantial part of our economy derives its income from healthcare. One-seventh of America's economy is spent on the healthcare. That means there are very significant, substantial interest groups that derive their income and their resources from that system. If any proposal crosses their interest, they are, typically, very significant and ardent opponents of health reform. It becomes very difficult to pass legislation when you've got a big interest group, whether it is the insurance lobby that opposed the Clinton health plan with their so-called Harry and Louise ads or whether it was the American Medical Association that declared Medicare to be a socialist experiment in the 1960s. It is very difficult to pass such legislation when you have got such big interest groups prepared to spend a fortune. That is one problem.

The second problem, I think, in this country, it is very, very difficult to achieve major and revolutionary reform overnight. We are a much slower, we're a more gradualist, nation, I think, in making changes. I like to say, with just a little bit of tongue and cheek, that at Families USA we have two camps of people on our staff and our board: one camp that wants universal health coverage last week and the other camp that wants it earlier than that. I'm afraid that I don't think we're going to see universal health coverage overnight. I think it is going to be a step-by-step process and I take no joy in saying that. I think a lot of the previous efforts that have tried to achieve very significant improvements caused a lot of interest groups to oppose the legislation.

A third reason I think that we have problems in the United States is that people in the United States generally have a distrust of government. Distrust of government has been nurtured in a variety of different ways. It certainly was nurtured as a result of the Vietnam War; certain scandals; Ronald Reagan certainly played that card a great deal during his presidency. I think there is a very different feeling about the role of government in the United States than in other countries in the western world. If you don't mind my telling you and giving you an illustration with an off-colored joke, for which I'll apologize in advance.

In 1993 we decided to conduct a forum in the Capitol about the Canadian healthcare system. It wasn't because we were pushing a single-payer, or the Canadian, healthcare system, but we thought it would be interesting as part of a series of things to do to learn from other countries about their healthcare systems. So we had members of Congress and the press there. The luncheon speaker was the minister of health for the Canadian government and, at the time, the Canadian government was led by the so-called progressive conservatives. If ever there was an oxymoron that was it. The progressive conservatives is the most conservative party and certainly was at that time among the three parties. The minister of health gave his speech and I was absolutely astounded, it was, by far, the most liberal speech about healthcare I had ever heard in the nation's Capitol.

So I went to the premier, the former premier of the Province of Saskatchewan. Saskatchewan is the province in Canada that started the Canadian healthcare system, so they have a great deal of pride their role. I said this is an absolutely astounding speech. This is your minister of health from the most conservative party in Canada, and this was the most liberal speech about healthcare I have heard in the U.S. Capitol. I mean Ted Kennedy would have blushed to give this speech. I said, you have to tell me what is it in Canada and how do you differentiate the three political parties in terms of their positions

on healthcare? He had a smile on his face and he said, the progressive conservatives, they believe in healthcare from cradle to grave. Not bad. He said, now, the liberal party, which is the middle-of-the-road party, they believe in healthcare from basket to casket. Then he had this glimmer in his eye, he said but we of our party, we're extraordinary, we believe in healthcare from erection to resurrection.

Well, we don't have that in the United States, so I think there is a real difference in culture. I think there are some other reasons. I think in the United States support for expanded health coverage is a mile wide and an inch thick. This is an issue, I think, which is viewed with altruism as opposed to self-interest.

Often, having sat through a lot of focus groups, you hear people who are insured talk about other people, those folks, as if they have no relationship to the potential of being uninsured. I think as long as this is an issue of altruism and not an issue of self-interest, it makes it much tougher to pass something so significant.

Then there is another factor which every group in this country is going to shake their head at, whether they're liberal or conservative. I suggest to you every group has been guilty of this over the years that we have tried health reform. The history of health reform is such that every interest group whether it is the conservatives or the liberals or whether it is the special interest groups or the goody goods, like Families USA, we have all come to the table and we have had our top, our favorite proposal.

When it became clear that their favorite proposal was not going to be enacted, every one of the groups that felt their top priority proposal would not be enacted, they either left the table or they opposed what was left on the table, and, in effect – no one likes hearing this – but, in effect, every one of the organizations involved in healthcare reform was saying their second favorite choice was the status quo. Nobody likes being told that that was their position, but in terms of the impact of activity, again, liberal, conservative, any groups, the way all of us have acted over the years, is our second favorite choice was the status quo. It is not surprising that the status quo is what remained.

Finally, I guess the last reason, which is of more recent vintage, is that we have a very divided government and it is very difficult to pass legislation with a divided government, it is particularly difficult today. We have a House of Representatives that is fairly conservative but marginally Republican, a Senate that is marginally Democratic, a president who is decidedly conservative on these issues, and it is very difficult to pass legislation under those circumstances.

What are the lessons that we can learn about this as we try to correct this problem? I've picked out six lessons that I think should be learned.

Lesson number one: When those of us who care about this issue want to address the issue, it is absolutely imperative that any proposal that is developed not threaten or be perceived to threaten the coverage of people who have coverage today. That was one of the problems in the Clinton health plan. Some people perceived that the coverage they had might be in trouble or might be diminished in some way, and to the extent you tell the haves in the United States that what they have is going to be taken a way from them, is a non-start from a political point of view.

Number two: It is really important to focus like a laser beam on succeeding on this issue and not load it up with so many other things. There are so many important things to do with America's healthcare system, things that many of you – and I know we at Families USA feel very strongly about – but if we're going to make progress with the uninsured, it is very important we try to do that in a way that doesn't clutter the agenda with other kinds of issues. Because if we do, those other issues can very well sink our ability to do something about the uninsured.

Number three: I think it is very important to build on existing structures. This is somewhat controversial among some of my colleagues, but I view this as a corollary to the first admonition to not threaten coverage. What do I mean by this? If I had been around professionally quite a few decades ago, before our employer-based healthcare system was established, I can't believe I would have wanted to design an employer-based healthcare system. It doesn't really make sense to have your health coverage dependent on the happenstance of who you work for.

Having said that, today in the United States, of those people under 65 years of age who have private health coverage, nine out of ten have that coverage through the employer-based system. I am terribly fearful that if you try to undermine that system, you have to be very careful about what you're going to get in its place, and we might talk about that in a moment. I would suggest that we build on the employer-based system, as flawed as it is, and it is flawed. I think it is important to build on some of the public programs we have, as flawed as they are, and I tried to explain what some of those flaws are.

Fourth, it is extremely important that any proposal use whatever funds available as cost effectively as possible. What I mean by that is there are going to be only a limited number of dollars made available for expanded coverage for the uninsured. Think about all of the priorities of government, whether it's military or other things, whether you like them or dislike them. When you deal with all of those priorities, there is going to be some limitation about how many resources are going to be made available. We have to make sure those

dollars are spent as effectively as possible and get as many people who are uninsured today covered with those resources. There are a lot of proposals out there that are terribly cost ineffective, and I think we've got to avoid those.

Fifth, I would urge that we start with our first focus on those most in need and we focus on low-wage, working families.

Lastly, it is crucially important, particularly these days, that we try to find a bipartisan approach. We are not going to pass significant legislation that is going to deal with this problem with either a democratic or a republican approach. It cannot happen; it will not happen. We have really got to find bipartisan approaches and that is very tough work. It involves very tough compromise.

Now, let me get to the conclusion of my comments by talking a little bit about where do we start. I would suggest that I think there is a way that we can go down the road towards universal coverage, that I think is realistic, that can achieve significant expansion. It would by no means achieve universal coverage, but it would be the first building block towards expansion that takes us down the road to universal coverage.

I think there are a number of things that we can do, actually, and do them this year. One of which is we can start knocking out some of these irrational categories in our public health programs. There was a proposal introduced last year by Senators Olympia Snowe, a Republican from Maine, and Ted Kennedy, Democrat of Massachusetts, which would enable parents to gain eligibility for Medicaid or a program like SCHIP, comparable to the eligibility of our children. That is one thing we can do.

A second thing we can do is expand funding for the SCHIP program, the children's health insurance program that started in 1997. Today there are 9 million children not insured, and approximately two-thirds of them fall within the income limits established by the state for the SCHIP program, but there are inadequate resources today given to the states to cover those folks. We can make enormous headway and we can reach virtually universal coverage for children.

Third, we should do something about legal immigrants. In 1996, when Congress passed the so-called Welfare Reform Law, one of the things that was changed was that if you were a legal immigrant and you had not lived in the country for five years, you were ineligible for Medicaid or SCHIP. There is no reason we can't achieve progress on that and restore eligibility. One of the reasons I believe that we can do this, despite immigrant backlash in some of parts of the country, is that some of the Republican governors – the governor of Texas; governor of Florida; and governor of New York – and the Democratic governor of California believe very strongly in this. They've got big

immigration populations and it is costing those states a great deal of money not to have them covered. I think politically we can make headway on that.

A fourth area was an area that started to get a significant debate at the close of last calendar year, in 2001, and that is what can we do for people who are temporarily unemployed. Well, the answer that people give very glibly is, well, they can get COBRA benefits. COBRA benefits are designed to enable somebody to continue getting health coverage through their previous employer, but there is a big catch: you have to pay 102 percent of the cost of employer-provided coverage and the average cost of a family health plan, purchased by an employer today, is approximately \$7,200. That is expensive in the best of circumstances, but when you're unemployed, it is clearly unaffordable.

One of the proposals that was placed before Congress last year and almost got adopted was that the federal government should subsidize a substantial portion of COBRA benefits. In that particular proposal it was 75 percent of COBRA benefits. I think we can do that.

Another thing I think we can do this year is we can make sure that those people transitioning from welfare to work do not lose their healthcare coverage; that they have a significant transition period when they get their new jobs. I think those changes in the public sector can take us down the road in such a way that we can add coverage for significant numbers, potentially in the tens of millions, of people who are uninsured today.

Now, I would suggest to you that if we're going to do this in bipartisan fashion, we're probably going to have to do something in the tax credit area. If I may, I just want to spend a minute or two just talking about tax credits. You're going to hear more about that in years to come. The president has a proposal for so-called individual tax credits. But I'm not talking about individual tax credits. I'm talking about tax credits to businesses.

The individual tax credits, as the President proposes, would provide a \$1,000 tax credit for individuals, targeted to individuals with incomes below \$15,000 a year and tax credits of up to \$3,000 for families, targeted to families with incomes below \$30,000. The problem with that proposal is that the vast majority of people for whom this is targeted will never see the benefit of it. I mean, think for a moment, if the average cost of an employer-provided healthcare for a family is \$7,200 per year purchased through an employer, it is probably more expensive when you purchase it as an individual because you don't get the benefit of economies of scale. It means that a family, in order to get this tax credit, is going to have to shell out

\$4,200 out of their own pocket to pay for health coverage, and for a family with income below \$30,000, that's impossible. We liken that to somebody getting a ten-foot rope thrown to them when they're in a 40-foot hole; it just doesn't get you out of that hole.

But it actually also has some pernicious impacts, because what the President and his allies would like to see happen is a change from an employer-based healthcare system to an individual system, so that we wouldn't get our health coverage through employers anymore, but we would get it as individuals.

There are two problems with that. One problem is, as I said before, when you purchase coverage individually, it is more expensive than when you buy it as a group, like through an employer.

The second problem is if you happen to have a sickness or disability and try to buy health insurance on your own, companies will be very reluctant to sell you health insurance. To the extent you can find an insurance company that is willing to sell to you, it is going to be extraordinarily expensive. So I worry as we move from an employer-based system, which is far from ideal and is somewhat arbitrary, to an individual based-system, whether we might not make a bad situation worse.

I want to end by just saying I'm not pessimistic, notwithstanding some of the things I've said to you earlier. I think there are some reasons for optimism and let me just mention a few in closing.

One is, quite recently, a very interesting conglomeration of groups have come together. We call ourselves Strange Bedfellows and we are strange bedfellows. They range from the U.S. Chamber of Commerce on the one hand to the AFLCIO, the Business Round Table, the Service Employees International Union, the American Medical Association, the American Hospital Association, Catholic Health Association, the American Nurses Association, AARP, the Health Insurance Association of America (the group that brought us Harry and Louise), and Families USA. We have decided to collaborate together, to try to make sure that health coverage for the uninsured becomes a high priority.

There is a good deal of advertising taking place now among these groups, all working together to advertise about the need to make this agenda a top priority. I think in the next year, hopefully, you'll hear about a set of activities that will be fashioned after Earth Day, where we're going to undertake activities in communities all across the country about the uninsured.

I think there is reason for optimism because President Bush, actually, has put \$89 billion in the budget over the next ten years to expand health coverage. While I don't like the way he spends it, it is

for expanded coverage for the uninsured and I think Congress has equally put money in the Congressional Budget Resolution.

Lastly, I think, as the economy has soured, more and more people are beginning to identify that they could be the uninsured. They're only one pink slip away from being the uninsured. People, I think, now understand that the uninsured are not a species apart.

I hope we can muster the political will as a country to deal with this problem. I hope all of you, after you leave this place or as you work here, work together in that noble effort. Thanks so much for having me here. I'm delighted to be here.

