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HEALTH SECTION DEBATE ON NATIONAL HEALTH ISSUES

Moderator: DAVID V. AXENE
Panelists: HOWARD J. BOLNICK
LYNN ETHEREDGE*
DAVID HIMMELSTEIN**
Recorder: DAVID V. AXENE

MR. DAVID V. AXENE: This session is part two of the continuing saga of how to get members of the Health Section more aware of health care public policy and health care public issues. At the General Session, you heard Alain Enthoven. He was invited by the Health Section. I hope you enjoyed his remarks, as I did. This session may be even better.

We have a distinguished panel. In addition to fellow actuary Howard Bolnick, president of Celtic Life, we have two guest speakers. We're going to start off with David Himmelstein. He is an internal medicine physician and an assistant professor at the Harvard Medical School. He's on staff at Cambridge Hospital and is in charge of the community and social medicine effort at that facility. David is an expert on the Canadian system. Our second speaker was going to be David Nexon, who is Senator Kennedy's number one staffer. He called me earlier in the week and said he couldn't make it. He had to do a hearing in Washington on health care. Since he's at the hearing, he sent Lynn Etheredge. Lynn has served as an expert on health insurance and health policy issues at the OMB, the Office of Management and Budget, under four different administrations. He's an independent consultant whose clients include employers, insurance companies and health care providers in government agencies. He's a frequent speaker and expert witness on health policy financing issues before congressional committees.

Our last speaker will be Howard Bolnick. He's on the Board of Governors of the Society, a former Health Section chairperson, a president of a life insurance company, and a concerned citizen.

DR. DAVID HIMMELSTEIN: The first thing they taught me at Harvard was that an expert is someone who comes from out of town and brings along slides. So, I did. I'm going to say much that's conventional and a little bit that's unconventional.

The rising cost of our health care system remains as prevalent today as 15 years ago despite 15 years or more of intensive efforts at cost containment. The costs of the

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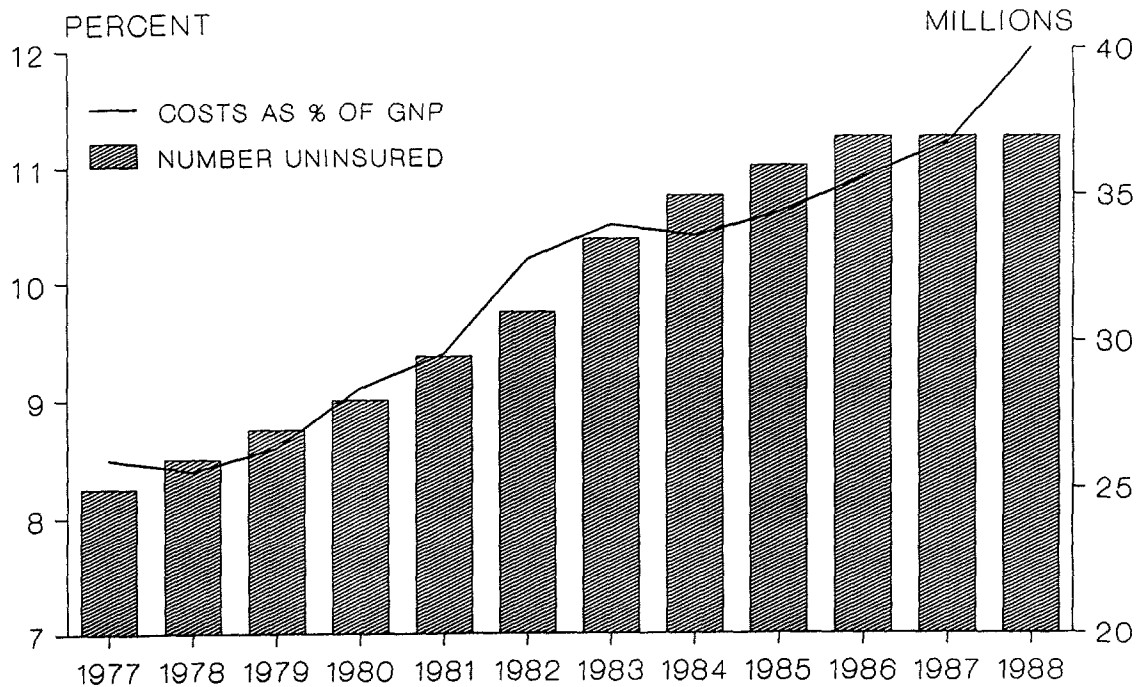
system are rising as rapidly now as they were 15-20 years ago. Graph 1 shows the cost of health care as a percent of GNP (line) and the bars indicate the number of people without any form of health insurance in our system, and as you see, these two disturbing elements of the system rise in tandem and in parallel. Currently 37 million Americans are without any insurance by some estimates; some other estimates are as low as 31, but it certainly is several tens of millions. Many of those are employed people. About half are in families headed by a full-time worker, and about three-quarters are in families headed by someone working at least part time. So it's a problem that cuts broadly across society. And one of the problem areas that receives less attention than the problem of uninsurance is the problem of underinsurance. In many ways this cuts even more broadly across society: for the elderly, for instance, who despite Medicare are paying more than 50% of medical care bills out of pocket at present; for middle class, many people with insurance but with inadequate insurance. Five million young women of childbearing age, for instance, have insurance that wouldn't cover maternity benefits. A random sample survey of the U.S. population shows that 12% of people with insurance said that they'd had a major financial problem due to illness within the past 12 months, and you see other indications of problems in access to care for the insured in our country. I have a hospital chart from a public hospital. It's a typical doctor's handwriting. I'll tell you what it says: "Twenty-one-year-old woman in a motor-vehicle accident last night seen at private hospital and transferred here (here being the city hospital) secondary to no insurance." This is a woman who suffered a ruptured aorta, about as serious an injury as one could get, and was transferred 35 miles across the county in an ambulance because she didn't have insurance. She died on the operating table after transfer. Three hundred thousand people are refused care each year in this country when they're sick because they don't have insurance.

There are a lot less dramatic cases but in many ways no less important. Graph 2 shows for instance, that the uninsured, the solid bar are about 50% more likely not to get routine screening tests than the insured for these routinely recommended tests for middle-aged women: PAP smears, blood pressure checks, breast exams and glaucoma checks.

Graph 3 shows the percentage of black women in our country not getting any prenatal care before the third trimester. You see steady improvement until about 1980. After decades of steady improvement our postneonatal mortality rates for blacks and, in fact, for whites as well, have by and large stopped going down (Graph 4). The maternal mortality rate is similarly flattening out and in some recent years actually deteriorating (Graph 5). The overall death rate for black men has actually risen in four out of the five most recent years for which we have data, an unprecedented development in any developed country (Graph 6). The conventional and bad news part of my talk is that we're presently rationing medical care in this country. Roughly a quarter of Americans are either completely uninsured or markedly underinsured. They're often denied care, and they're sicker and die younger because of it.

The other side of that really tragic problem is that we don't have a shortage of resources. One of my friends, when I was giving a talk like this, said to me, "Rationing is the egalitarian distribution of scarce resources." We don't distribute our resources in an

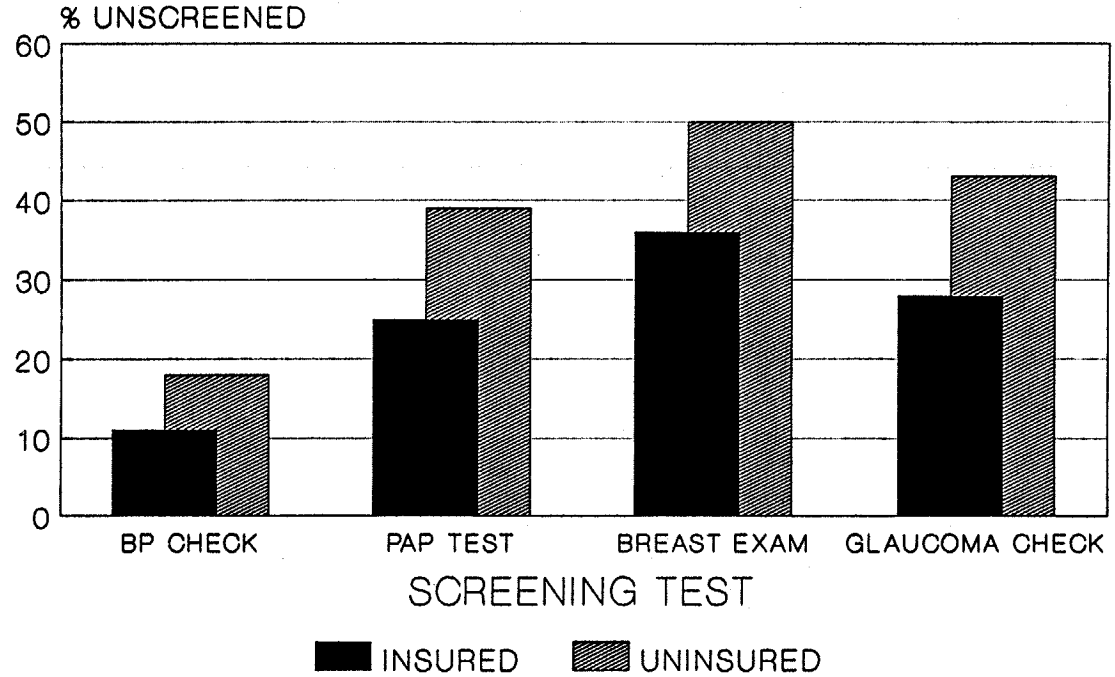
HEALTH COSTS & NUMBER OF UNINSURED AMERICANS: 1977-1988



GRAPH 1

Source: Data from NCHS/Census Bureau

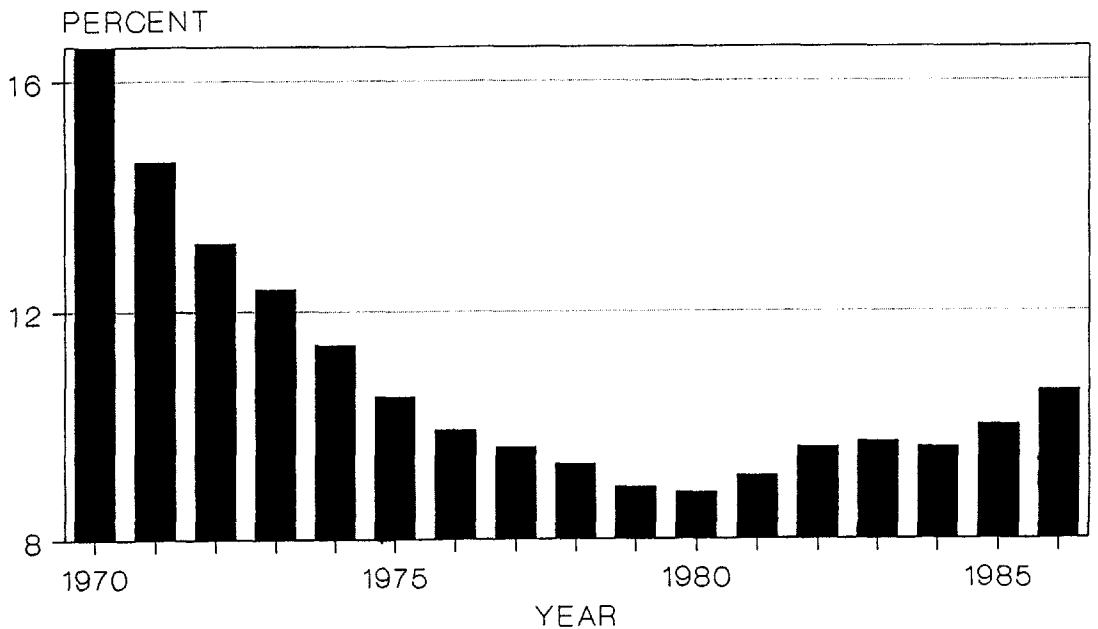
LACK OF PREVENTIVE CARE FOR WOMEN 45-65: INSURED v. UNINSURED



Source: Woolhandler, Steffie, MD, MPH, Himmelstein, David U., MD, "Reverse Targeting of Preventive Care due to Lack of Health Insurance", *Journal of American Medical Association*, May 20, 1988, Vol. 259, pp. 2872-2874, Copyright 1988, Americal Medical Association.

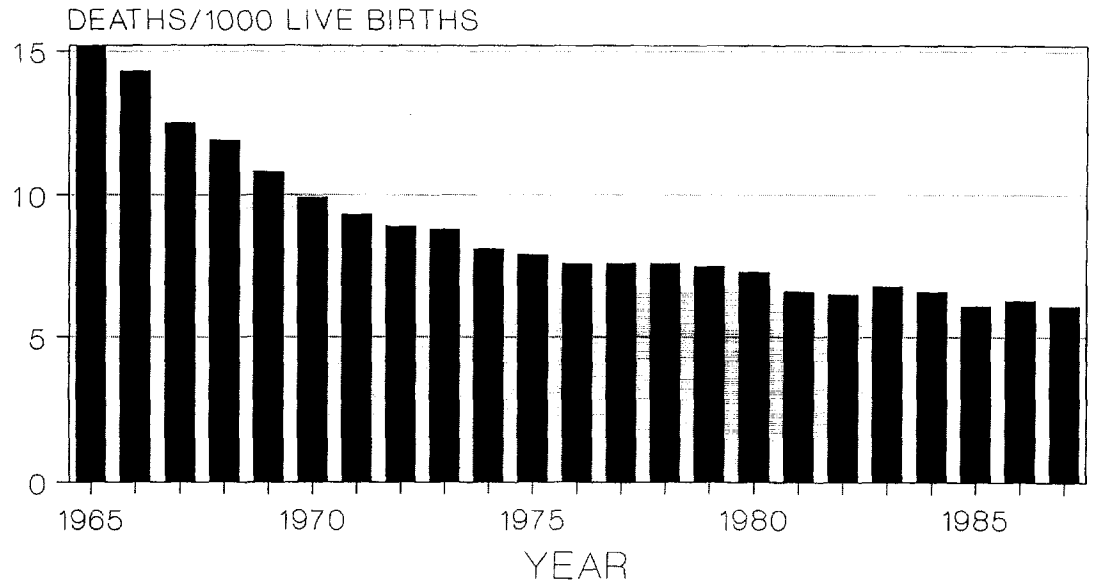
GRAPH 3

PERCENT OF BLACK WOMEN WITH NO PRENATAL CARE BEFORE THE THIRD TRIMESTER, 1970-86



Source: Hughes, D., Johnson, K., Rosenbaum, S., Liu, J., "The Health of America's Children: Maternal and Child Health Data Book, 1989, Children's Defense Fund, Washington, D.C.

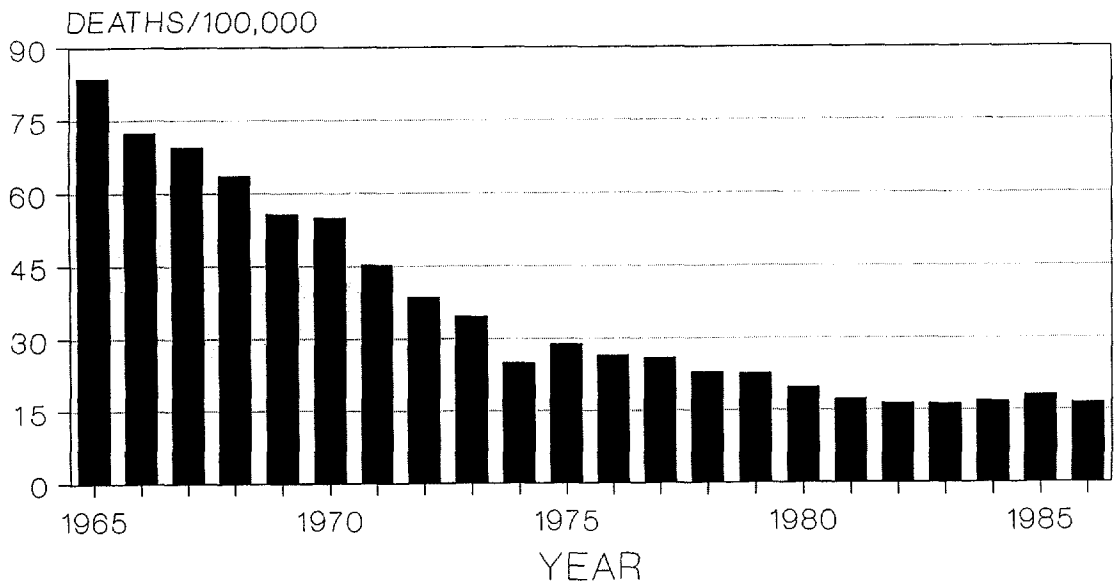
POST NEONATAL MORTALITY
BLACKS, 1965-1987



Source: Data from *Health USA*, National Center for Health Statistics, Hyattsville, MD.

GRAPH 4

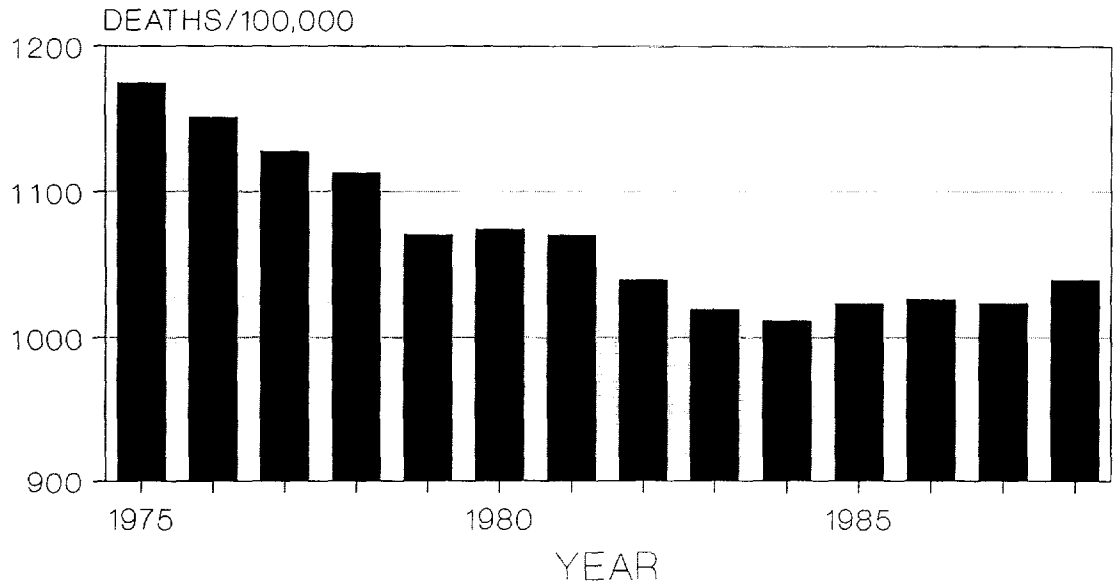
MATERNAL MORTALITY
BLACKS, 1965-1986



GRAPH 5

Source: Data from *Health USA*, pp. 33, 1978-1990, National Center for Health Statistics, Hyattsville, MD.

BLACK MALE DEATH RATE
1975-1988



GRAPH 6

Source: Data from *Health USA*, National Center for Health Statistics, Hyattsville, MD.

egalitarian manner, and the other side of it is that our medical resources are not scarce. Any day in this country there are 300,000 empty hospital beds, and we're told of an impending surplus of physicians and many other kinds of health personnel. Huey Rheinhart from Princeton has said that the central preoccupation of American health policy is with rationing the surplus which, if you think about it a minute, is rather silly. Now, it takes a lot of effort to keep sick patients out of empty hospital beds. We've heard a lot about the growing surplus of physicians but relatively little about the growing surplus of administrators in our system (Graph 7). We have, in fact, the most bureaucratized health care system in the world. That's the bad news part of my talk.

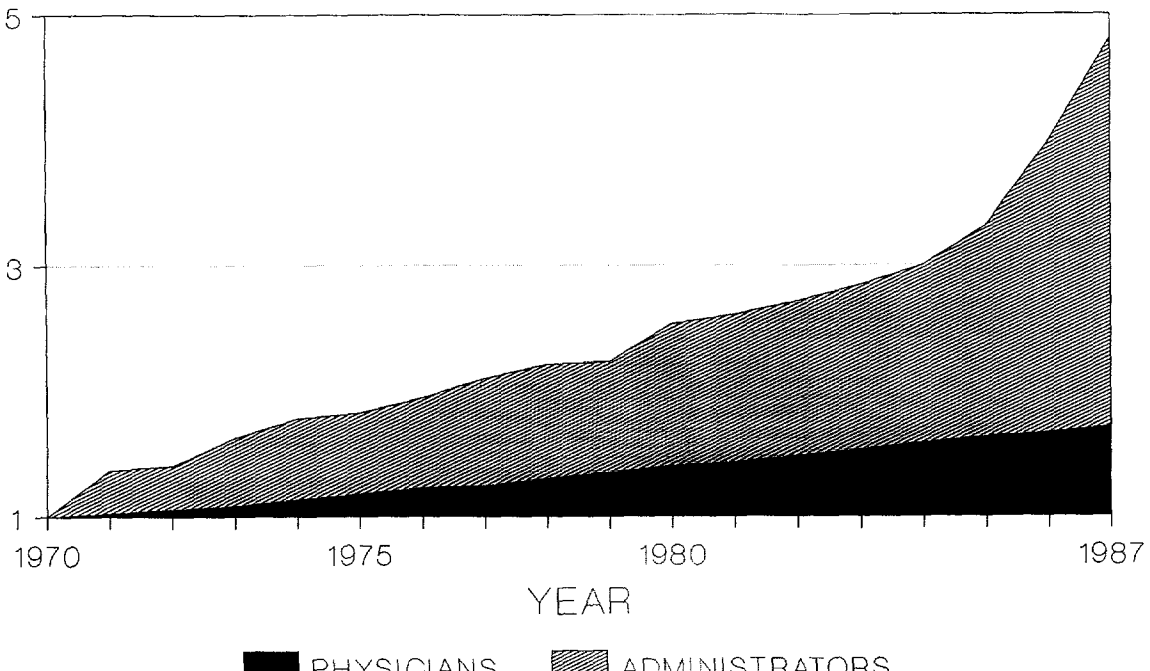
The good news is that I think actually something useful can be done about the situation. Over the past 20 years in North America, we've been carrying out two parallel health policy experiments, one in this country and the other in Canada, and what I'd like to tell you is that theirs has largely succeeded and ours has largely failed. The failures I have already talked about. The Canadian program is really a very simple one. The federal government offered matching funds to the provinces if they would pass programs meeting four basic criteria. One is universal coverage which meant that more than 98% of the residents of each province picked up their insurance card and registered with the system. That does not impede either directly or indirectly by charges or otherwise reasonable access, and what that means is no copayments or deductibles. Second is portability of benefits. If you're from Quebec and get sick in Ontario, you have to be covered. Third is coverage for all medically necessary services, and the federal government didn't define that further, but the provinces have offered, without exception, a comprehensive package of acute care benefits. There's a fair amount of variation in the long-term care side. And fourth is a publicly administered, nonprofit program, and I'll get back to some of the justification for that later.

Some of the results are fairly clear. Graph 8 shows the percentage of the residents of Quebec with serious symptoms who sought care the year before and the year after the passage of the program. There is a rather dramatic one-year increase in the percentage of those who were ill who sought care for their illness.

There was a random sample survey of the Canadian and U.S. populations done by the Harris organization last year. They asked, "Have you had trouble getting needed care within the past 12 months?" Seven percent of Americans said they had trouble, and 1% of Canadians said they'd had problems, (and actually it was 0.7%). We rounded it to one. The more interesting part of the results is that twice as many Americans as Canadians report nonfinancial barriers to getting needed care. We've heard a lot in the last year from the American Medical Association (AMA) about rationing care within the Canadian system. The AMA has spent $2.5 million on an ad campaign for that, but apparently the Canadian people are by and large unaware of that problem.

If you look at hospital admission rates in Canada (Graph 9), there's been a lot of talk about problems in coronary artery bypass surgery, (that's CABG in Canada), and if you look at the U.S. bar and the Canada bar, you'll see why the AMA has picked out that one procedure. Graph 9 shows hospital admission rates for cardiac procedures and diagnoses, and you'll see that they are comparable or higher for every category except CABG in the U.S. and Canada. In fact, Canadians have higher hospital admission rates

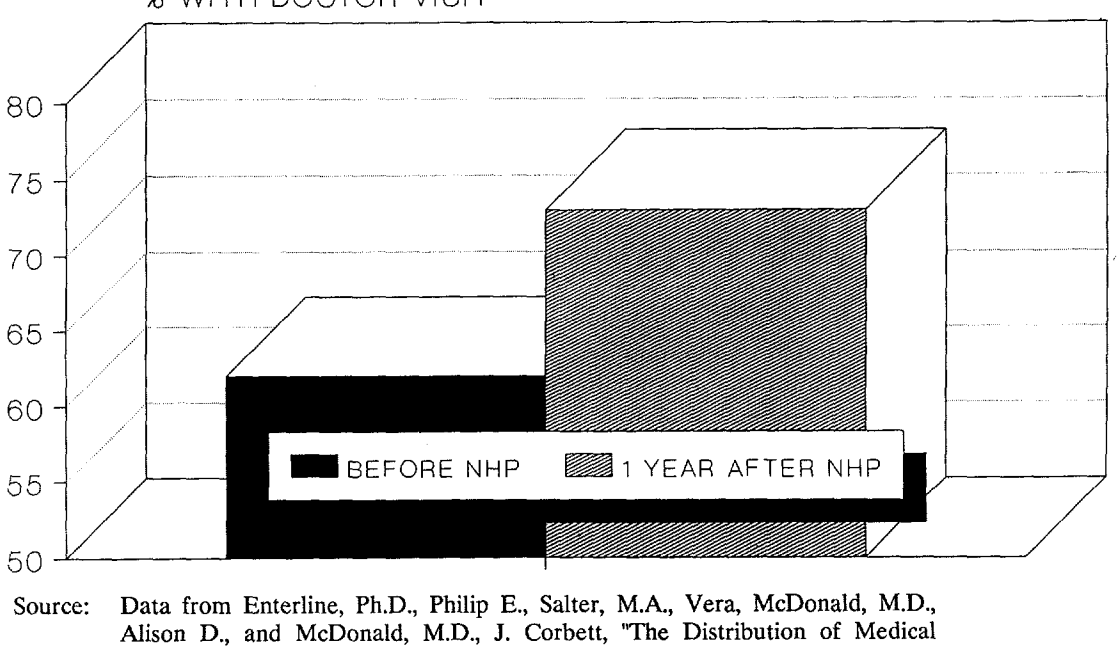
GROWTH OF PHYSICIANS & ADMINISTRATORS 1970-1987 (1970=1)



Source: *Statistical Abstract of the U.S.*, U.S. Bureau of the Census, Washington, D.C.

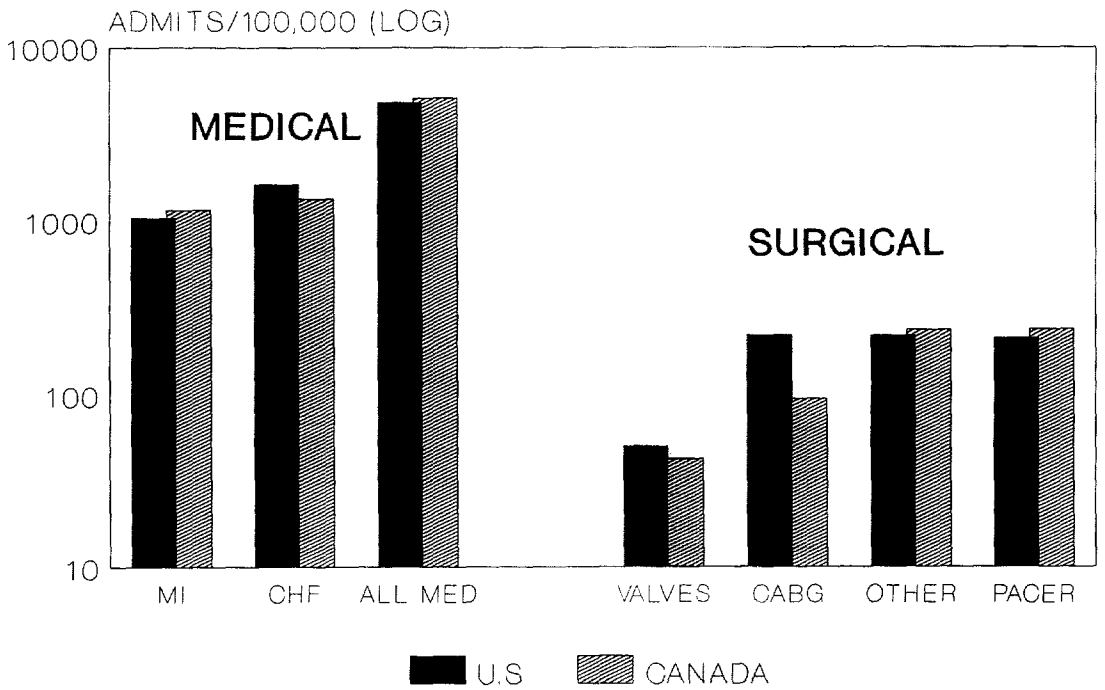
% OF PEOPLE WITH SERIOUS SX SEEING A DOCTOR BEFORE AND AFTER PASSAGE OF NHP IN QUEBEC

GRAPH 8



Source: Data from Enterline, Ph.D., Philip E., Salter, M.A., Vera, McDonald, M.D., Alison D., and McDonald, M.D., J. Corbett, "The Distribution of Medical Services Before and After "Free" Medical Care - The Quebec Experience", *New England Journal of Medicine*, November 29, 1973, Vol. 289, p. 1174.

HOSPITAL ADMISSIONS OF ELDERLY FOR CARDIAC DISEASE: U.S. vs. CANADA, 1985



Source: Data from Anderson, Geoffrey M., Newhouse, Joseph P., and Roos, Leslie, L., "Hospital Care for Elderly Patients with Diseases of the Circulatory System: A Comparison of Hospital Use in the United States and Canada", *New England Journal of Medicine*, November 23, 1989, Vol 321, No. 21, pp. 1443-1448.

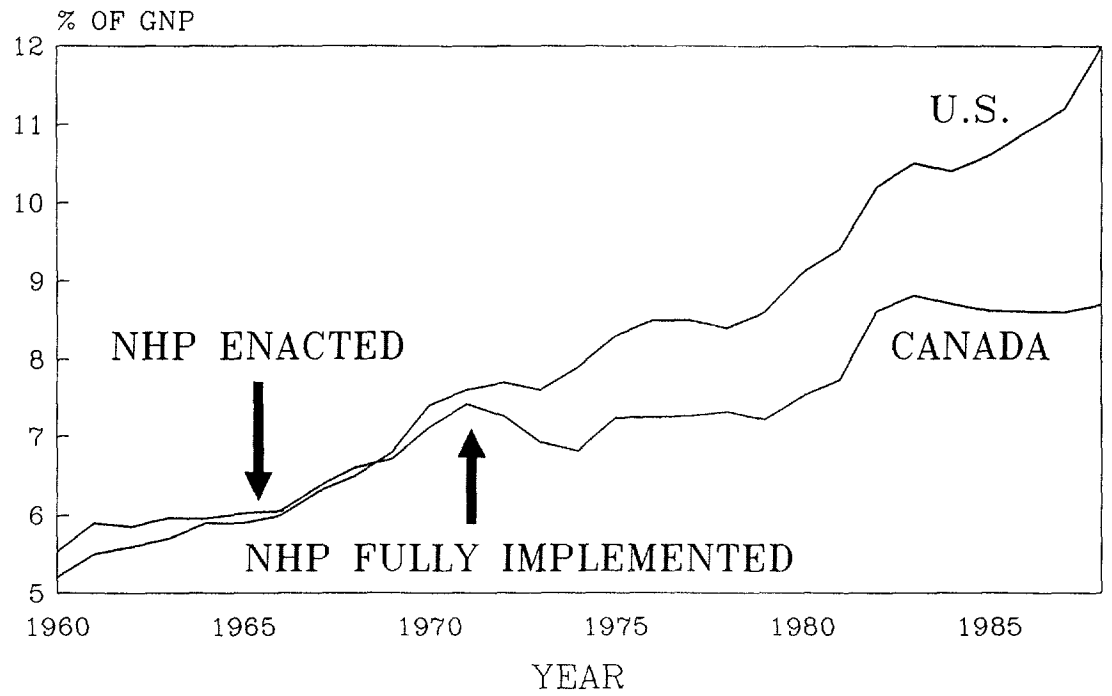
and higher physician visit rates than Americans. They live longer. Their neonatal and infant mortality rates are lower than ours.

If you look at the cost side of the equation, the results are equally dramatic (Graph 10). In 1971, the last of the Canadian provinces implemented their program, and you see that the costs as a percent of GNP were almost directly in parallel until that time and have diverged sharply since then. The Canada line levels off at about 8.7% of gross national product and U.S. line now exceeds 12% of gross national product and continues to rise. Huey Rheinhart has said that we'll soon have it all, that is, we'll have a hundred percent of the GNP. One of the interesting features of this system is that half of the cost differential in the two medical care systems is accounted for by the excess administrative costs of our current system here. Twenty-three percent of total U.S. health care cost is due to billing and administration; it is only 13% in Canada. Put another way, 2.6% of our gross national product in this country goes for health care administration, 1.1% is allocated in Canada. It's a fairly substantial expenditure. Insurance overhead is interesting (Graph 11). The striped bar shows the trend in insurance overhead as a percent of GNP in the U.S., and the solid bar shows it in Canada. The other side of the insurance companies, of course, is the necessity for those of us who provide clinical care to bill in the current system. Canadian hospitals bill on a lump-sum basis. They negotiate what their budget for the year should be with the health program in their province, and they get a check for 1/26 of it in the mail every two weeks. Each week would be nice.

I guess the place it hit home to me was when I was visiting a friend hospitalized at Toronto General. He was an American and asked us to settle up his bill in the basement. The billing department at Toronto General Hospital, a 900-bed hospital, consisted of three people and a filing cabinet, and their job was to send bills to Americans who wandered across the border. When we got back to Boston we went down to Massachusetts General which is a 900-bed hospital, but has 275 people in its billing department and $3 million worth of computer equipment. They spend more on stamps to send their bills out than Toronto General does on its entire billing operation for the year. The way we bill in our hospital, all equipment and supplies have one of these little billing tags. If an intravenous line is put in a patient, a nurse puts the tags on her dress, and when we're all done she goes and puts them in the patient's chart. There are six people in the basement putting those tags on each supply as it comes in and another seven typing in the billing numbers when the patient is discharged. Then, of course, it is sent to the insurance company who tries not to pay it and gives it to the patient who comes to complain to me about it. It's an enormously expensive way to run a hospital, and, as a result, 18% of total spending in U.S. hospitals and 8% in Canadian hospitals is for billing and administration (Graph 12).

There's a fair amount of other waste in our system. There was an ad that ran in medical journals. I once counted 27 of them coming into my house in one week. There was real sandpaper on it, and it cost, I'm told, a nickel a piece and was sent to 500,000 doctors. Multiply by 27 a week, and you've got some real money. I actually thought this was an example of waste, but I subsequently realized I'm a woodworker. I haven't bought a coarse grade of sandpaper in a long time.

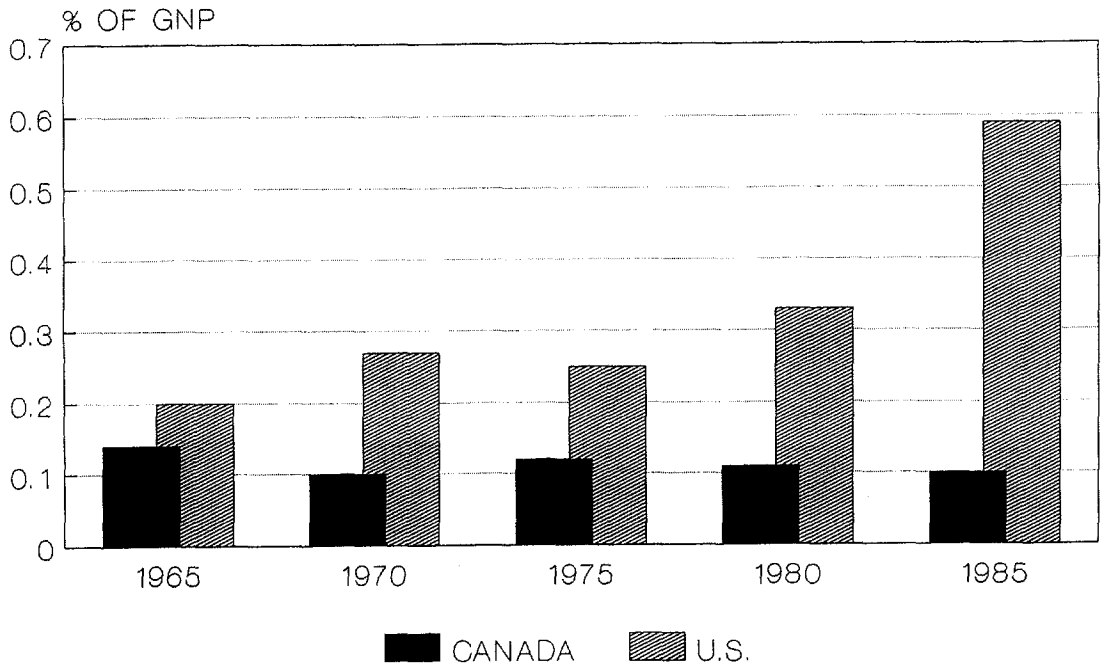
HEALTH COSTS AS % OF GNP:
U.S. & CANADA, 1960–1988



Source: Data from *Health USA*, National Center for Health Statistics, and unpublished data from Statistics Canada and Health Care Financing Administration.

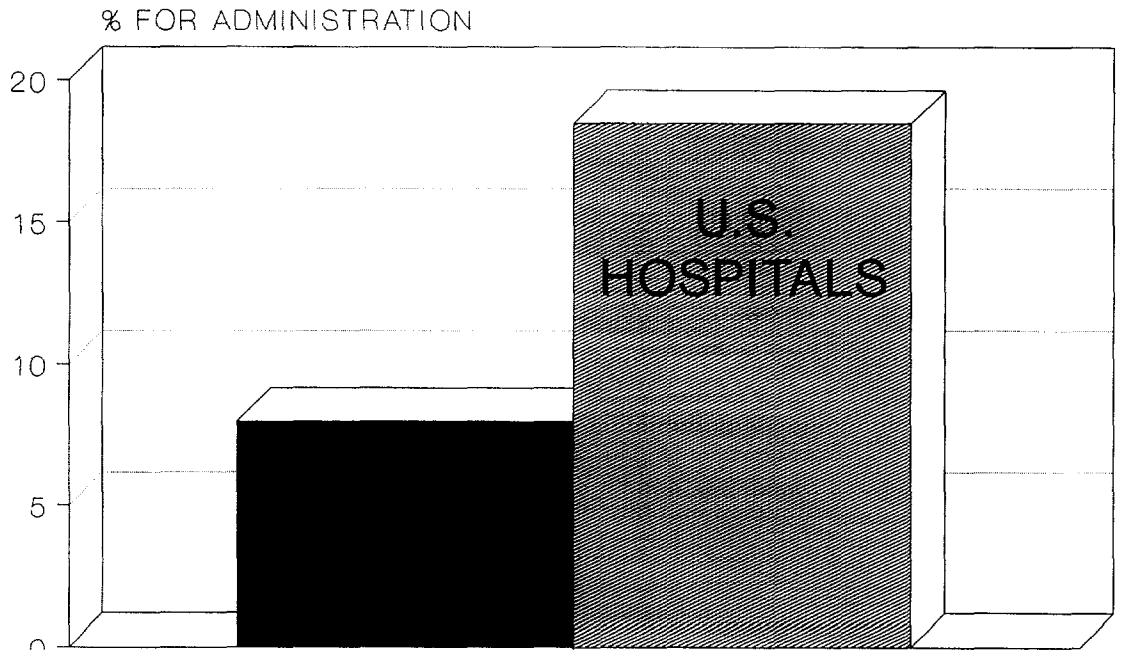
GRAPH 11

INSURANCE OVERHEAD AS A % OF GNP
U.S. v. CANADA, 1965-1985



Source: Data from Evans, Robert G., "Tension, Compression, and Shear: Directions, Stresses, and Outcomes of Health Care Cost Control", *Journal of Health Policy, Politics and Law*, Vol. 15, No. 1, p. 114, Spring 1990.

ADMINISTRATION AS A PERCENT OF HOSPITAL COSTS: U.S. v. CANADA



Source: Data from Himmelstein, M.D., David U., Woolhandler, M.D., M.P.H., Steffie, "Cost Without Benefit", *New England Journal of Medicine*, February 13, 1986, Vol. 314, No. 7, p. 443.

We'll hear some about employer-mandated proposals which are really a patchwork attempt to fix the system by leaving in place all of the existing insurance arrangements and adding some additional insurance. The problem with these proposals is that they expand access to care, which I'd like to see, but they cost an enormous amount, $40-68 billion the first year, and cost escalations continue after that. They have some supporters and opponents. The one thing I'd point out to you is that these kind of programs do almost nothing for big business, which is currently seeing its costs rising very sharply, and they do almost nothing for the underinsured, the middle class and the elderly who may have sympathy for the uninsured who would be covered under this kind of approach but don't stand to gain themselves.

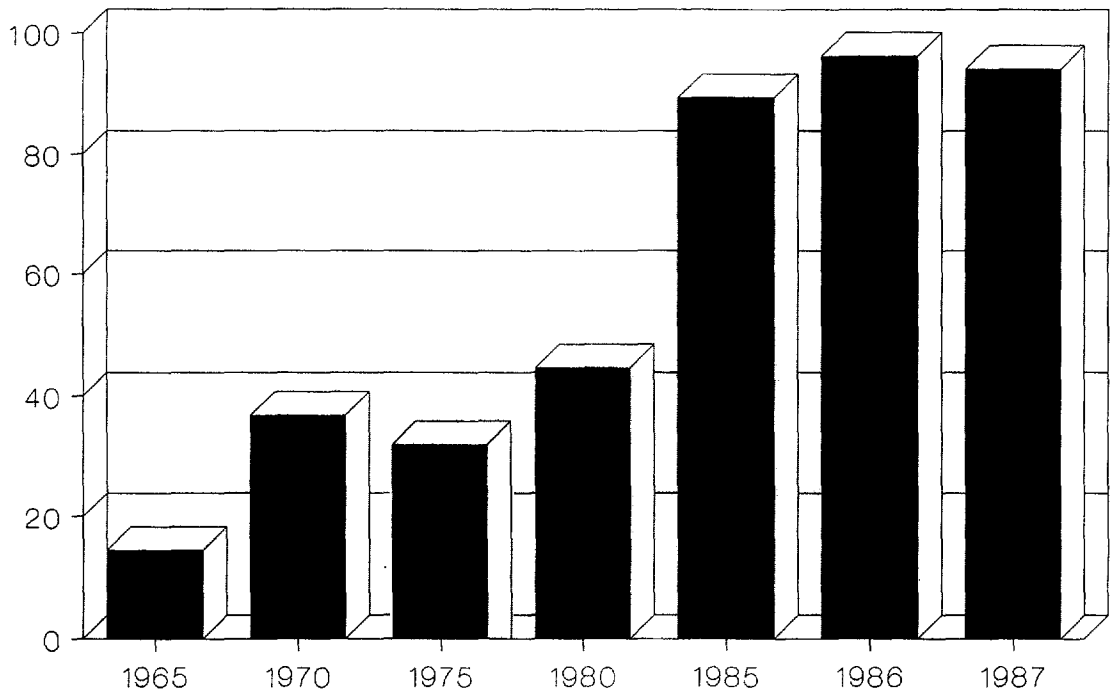
What we've proposed is very much along a Canadian system, with everyone being covered under a single publicly-administered plan with the elimination of competing private or parallel private insurance market that would pay hospitals in this kind of lump sum, budgeted way that I've talked about with one important proviso. That is that capital payments be separated from operating budgets so hospitals can't just skimp on patient care in order to accumulate a surplus and build a new building at the end of the year. They have to spend their operating budget to take care of their patients. It's essentially the way the Canadians have done it. Capital payments, as I say, should be separated and be allocated by health planning boards based on some reasonable assessment of need, so you don't end up with the situation we have in Boston where there are 10 magnetic resonance imaging scanners within a three-block area, but enormous areas of our city have no access to that high technology at all.

Physicians should be paid in any of three ways. One is a fee for service but with negotiated, binding fee schedules so that, as in Canada, one is able to predict and circumscribe the total physician reimbursement under this kind of system -- no out-of-pocket expenditures, no extra billing. Second is capitation for HMOs, and third is salaried physicians in hospitals and clinics. We think the potential support for this is quite broad. It would help not only the uninsured but also the middle class and elderly, many of whom are underinsured and would see significant improvements in their coverage. We have no reason to believe big business costs would be contained, because the Canadian example shows that if one has a single source of payment in the system, one can limit the flow of dollars into it effectively.

Just to show that I'm not completely naive, I'll show a shot of the Boston skyline with the two tallest buildings, Prudential Center on your right and John Hancock on your left. We're essentially proposing to eliminate the insurance industry from the health care system. We think that would save roughly $65 billion in unnecessary administrative costs this year and would allow us to contain costs in subsequent years, and we expect some opposition. Just to indicate that there are also some potential gainers among powerful forces in our country, I'd like to give the health care costs per car for the Chrysler Corporation. They are about $700 per car in the U.S., and at their plant 17 miles away in Ontario, $223 per car. This hasn't gone unnoticed. There's now more health care than steel in a U.S. automobile. Some of you who've driven one recently may have noticed that. In Graph 13 you'll see health spending as a percent of total corporate profits rising from about 14% in 1965 to over 95% currently.

CORPORATE HEALTH SPENDING AS A PERCENT OF PROFITS, 1965-1987

GRAPH 13



Source: Data from Levit, Katharine R., Freeland, Mark S., Waldo, Daniel R., "Health spending and ability to pay: Business, individuals and governments", *Health Care Financing Review*, Spring 1989, Vol. 10, No. 3, pp. 1-11. U.S. Department of Health and Human Services, Health Care Financing Administration, Office of Research and Demonstrations, Baltimore, Maryland, May 1989.

And, finally, opinion polls show that this kind of fundamental reform is broadly popular among the U.S. population. In the same Harris survey I mentioned earlier, 89% of Americans, when asked, said the health care system needs basic change or complete rebuilding from the ground up. That same survey asked Americans if they prefer the Canadian National Health Program to what we have; this was the question they asked: "In the Canadian system the government pays most of the cost of care for everyone out of taxes and sets all fees charged by doctors and hospitals. Under the system people can choose their own doctors and hospitals. On balance would you prefer it?" A reasonably accurate description of the Canadian system. Sixty-one percent of Americans said they would prefer that kind of system. They asked the Canadian group the symmetrical question: "In the U.S. system government pays most of the cost of care for the elderly, poor and disabled. Most others either have insurance paid by their employers or have to buy it from an insurance company. Some have no insurance. Under this system people can choose their own doctors and hospitals. Would you prefer it?" And remember that Canadians are well-familiar with this system. It's what they had before their current program was implemented, and 3% are prepared to go back to it. Another poll shows, as virtually all have, that no matter whom you ask in this country, this kind of fundamental reform enjoys majority support. In fact, in this poll they couldn't find any group that didn't, in a majority, support a tax-funded, universal, national health insurance program. Interestingly, 30% favored extending Medicaid to cover the poor, and 18% favored extending Medicaid to cover the unemployed. So, those kinds of incremental steps enjoy much less popularity than a more fundamental reform.

I'll close with two thoughts. One is that I hope we can prove Winston Churchill wrong when he said that Americans can always be relied on to do the right thing, after they've exhausted all the other possibilities. I hope we don't need to exhaust all of them this time around. And the final thought is an observation that a Canadian colleague made to me. He said, "Watching you folks make health policy is a little bit like watching a fellow perfect a mousetrap that's essentially a bad design." He said, the guy works on it for 10 years, and he takes it to his patent lawyer, and the lawyer says, "What have you got there?" The guy pulls out a big block of wood, and it's got a red arrow painted on it and a razor blade at the end of the arrow and a big piece of cheese on the other side of the razor blade. And the lawyer says, "Now how is that going to work?" And the fellow says, "It's fabulously simple. The mouse sees the arrow, runs down the arrow to the razor blade, looks over the razor blade, and slashes his throat looking at the cheese." And the lawyer says, "That's not really much of a design. You need something different there, some sawing action on the razor blade or something." The guy takes it back. He works 10 more years on it. He brings it back to this same lawyer, and he's got this same block of wood, and he's got the razor blade but no piece of cheese, and the lawyer says, "Now how is that an improvement?" And the guy says, "It'll work perfectly now. The mouse sees the arrow, he runs to the razor blade, he looks over the razor blade and says, "Now where's that piece of cheese?" What I would suggest is we have a mousetrap that has a fundamentally flawed design, and it's time to get on to actually redesigning it in an effective way. We have, fortunately, next door to us, a system which has been working well for 20 years and which provides good guidance on how we ought to go.

MR. LYNN ETHEREDGE: As one of those who's been designing mousetraps for a while, I think I find it a little hard to know how to get into this. I'm actually going to

talk about the leading mousetrap proposal which is that proposed by Senator Kennedy and Representative Waxman -- the basic health-benefits plan. It's become the major vehicle for debate about national health insurance here in the United States in the last several years, and its basic concepts have recently been picked up by the Pepper Commission and from there are going back into Congress for further consideration. In fact, that's why Dave Nexon couldn't make it. There are hearings already starting on the Pepper Commission proposals. What I'm going to do is to describe for you the key problems the Kennedy-Waxman bill tries to solve, their basic structures, the pros and cons as we've seen them, and how they've been picked up in the Pepper Commission proposals.

Let's start with the fundamental problem we're dealing with, and agree we're not trying to deal with every problem that's in the U.S. health system. We are trying to deal with 37 million people who aren't insured and with expenditures in the neighborhood of $10-30 billion to provide insurance. So it's quite a major undertaking. The key problem is that the number of uninsured has grown from 25 million in the mid-1970s to 37 million today. It has reversed the 50 years of progress before that in assuring basic health insurance protection to all Americans, and inevitably these numbers are going to continue to rise as health costs continue at about a 9% per capita increase compared with 5.5% in average wages.

The second major problem that the Kennedy-Waxman bill is designed to deal with is the collapsing small-business insurance market. The ability of this market to broadly spread risks is now seriously compromised, and that's a problem that's cutting deep into the middle class. Not only are there excess costs for small employers as there have been for years, but the increased application of aggressive medical underwriting is leading to denial of coverage, preexisting condition exclusions and massive price increases for firms and individuals that once thought they were protected. Logically, we have to fix this problem at the same time we fix the uninsured problem, because if we're going to require people to buy insurance, we need to make sure it's available.

The basic structure of the proposal is summarized here. Let me spend a few moments on this. As you know, through the 1970s Senator Kennedy was the leading exponent in this country of a British-style health system. We have no shortage in this country of good ideas on what to do about health care. We have a Canadian system which has many advantages and some drawbacks. We have many other ideas of what to do about health care. But the plain and simple fact is that, for all the debate and all the argument, no health insurance bill, even with the support of three presidents in the 1970s, Nixon, Ford and Carter, ever made it out of a congressional committee. What Senator Kennedy has tried to do here is to adopt a proposal that will, in fact, be enactable and that will no longer hold 37 million people hostage to interminable political debate and will get on with the job of addressing what part of the problem in a broader agenda can now be addressed to improve our health care system. The basic strategy as I would describe it is a gap-filling approach. Think of our health system as having a Medicaid program for low income and most of the population getting coverage through their employers. A gap-filling approach basically closes the gap in the number of uninsured by requiring employers to provide coverage for their full-time workers and then by expanding public programs to cover those who still remain outside the employed network. This has an

advantage of being right in the center of the American political debate, and it allows us to address the problems of the uninsured without having to take on the much more controversial and problematic political efforts of trying to enact fundamental reform in a $600 billion system.

Let me briefly describe each of those pieces for you. Under the plan here's what employers would be required to do or how their coverage would change. Most employers would be required to provide basic health insurance to their full-time employees and dependents. Today, that's two-thirds of the uninsured. There's a list there of the things that have to be required. The basic conceptual message I would get across is that this is an attempt to define a basic package and to provide for actuarial equivalency tests. That means that most large employers will not be affected by this mandate. The second major component of the employer requirements is to restructure the small employer market. That would be done by requiring a community to set up a structure that involves community-rated insurance for all small employers managed as part of a new regional insurer program, that it be a community-rated program with open enrollment and defined benefits. And finally, there would be some subsidies to small businesses who face extra costs of implementing the plan. Moving on to the public plan, it would be phased-in starting with low-income women and children and then phasing in the rest of the people outside the full-time work force over the next several years (by 1999).

The basic structure that's being proposed is to start out in 1991 with a coverage that includes everyone who's a full-time worker and their dependents, which is 61% of the uninsured, plus the first phase of the public program which is another 11%. Then the rest of the public program would be phased in over the rest of the decade. This is an attempt, frankly, to keep down the budget costs which would be a major problem in the public side. The costs of the plan? I imagine they're somewhat less than the other proposals. The net cost is about $18 billion when you net out all of the requirements and net out particular savings, but the total cost is somewhat misleading. Obviously, the costs fall primarily, if not almost exclusively, on those companies that do not now offer basic insurance protection. Most employers would find, in fact, a much different outcome. Many small businesses that offer insurance would now find they had sort of a guaranteed access to group coverage and community rates, some administrative savings by a structured market, and managed care in competitive savings from the fact that the insurers participating in the new regional arrangements would be asked to provide HMOs and PPOs and other competitive alternatives. Also, large employers, of course, would not have additional costs but could look to some additional benefits.

First, they would get some assistance for their low-income workers and dependents. They would find a level playing field, vis-a-vis their competitors, with increased costs for their businesses that are not now offering insurance. They would have the prospect of fewer future provider costs shifting for the uninsured.

Finally, perhaps one of the most important benefits is there would be fewer labor-management disputes on health issues. Last year, 80% of the strikes in the country were over health benefits. For insurance companies this would create an expanded market in which about 22 million more people would be added to private health insurance roles with benefit premiums of $15-20 billion. You'd also find in the small employer market

that the chaotic marketing practices and the socially undesirable underwriting would be sharply curtailed and that the competition would be able to take place on the basis of cost and quality rather than by the medical underwriting or selection of the risk pool.

What do we think the American people would think of this? Obviously, as David has already pointed out, the American people are getting pretty fed up with the problems we have in health care. The polls are showing a 40-year-high level of response on people who want change. What we have a problem with is getting a specific proposal agreed to. Of all the proposals, the one that enjoys the broadest support everywhere is the concept of an employer mandate. The results of two polls that asked whether the employer should be required to provide health insurance for their employees show ratings of 73% and 74%. Those kinds of ratings are seen in many other polls as well. The support cuts across both ideological and regional lines. For the political ideology, we have the support of 73-77% among those who view themselves as conservatives as well as liberals and the support of over 70% across all regions of the country. So, it's a set of proposals that offer a lot to many members of our society as a way to put together a new and badly needed health insurance system. Those are the key elements of Kennedy-Waxman. They have been picked up or superseded now within the last few weeks by the Pepper Commission report.

Let me briefly outline for you the key similarities between Kennedy-Waxman and Pepper because the Pepper Commission is now what you'll be reading about in the hearings and the legislation that's moving through Congress. Basically, the two bills share four basic similarities. One is they both build on the gap-filling strategy that I outlined for you -- a combination of an employer mandate to cover the employed work force and an expanded public program to cover those outside the work force. Second, both would restructure the small employer market. Both are based on concepts of community rating for that marketplace. Third, both would be phased in terms of coverage, starting with small employer market reforms in the Pepper Commission and with expansions of Medicaid for mothers and kids. Fourth is the agreement I just mentioned on the top priority being Medicaid for mothers and kids because of our 22-in-the-world rating in infant mortality, and the restructuring of the small employer market which is a necessary part of trying to make insurance assured and available for that one-third of the work force.

There are two key differences between the Pepper Commission and Kennedy-Waxman's original proposal. First, in the private market, the Pepper Commission adopted the concept of pay or play. That means an employer would be required either to provide basic insurance coverage or to pay a certain percentage of payroll into the government plan, a particular advantage for lower wage companies. The second change in the private insurance market is that there will be some special rules for employers with under 25 employees, including a 40% subsidy of their health insurance costs for the first five years. On the public plan side, the Pepper Commission has provided more money than KennedyWaxman. They would federalize Medicaid and make the entitlement a federal plan. Second, there would be more support for low-income persons up to 200% of poverty.

But the key point I would leave you with is that I think there's a remarkable coming together in the American political process of a formula that can be enacted to deal with

the insurance needs of the 37 million people who don't have insurance, and the center ground now is occupied by the Pepper Commission, Kennedy-Waxman, and the National Leadership Commission on Health Care. The AMA has come out to support this kind of position. In total about 160 different organizations around the country are now supporting the concept of an employer mandate plus an expanded public plan as the basic structure for dealing with our health insurance needs. If we can proceed along those principles, I think we will get the basic benefits that are proposed in Kennedy-Waxman and these other bills.

First, we will be able to build on our current system in a way that allows us to address these problems, which are not the only problems we have, but allows us to enact something in our political system so that we don't hold 37 million people hostage to a continuing and seemingly endless debate on more basic reform. Second, we would be replacing the current system and trends where everyone tries to pass costs off to other people. The federal government ignores the uninsured. State governments shun them off on the local governments. Local governments, in turn, refuse to provide the coverage and leave it up to providers. Providers, in turn, shift costs to employers. What we would have with any of these plans is a principled set of agreements about who is going to be responsible for whom and who's going to pay with assigned, clear responsibilities to employers, employees and the taxpayers to produce a fairer system. Third, we would have equity among employers where all employers would be required to provide the same benefits. Finally, and most important, we would be making some real progress toward the long-held dream of guaranteeing every American a basic right to health care.

MR. HOWARD J. BOLNICK: There are three problems that have been alluded to that have been bringing us to the point of discussing these proposals, and those are something discussed in the National Leadership Commission report. Anyone who hasn't seen the report probably ought to get a hold of it. The problems are, broadly, cost, access and quality. I've prepared a summary of a number of the proposals which I think are on the table at the federal level. There are many other proposals which did not make the cut list and I'm sure some will be coming out, such as the AMA proposal. On that summary list are: the Kennedy-Waxman proposal, which Lynn just talked about; Dr. David Himmelstein's proposal; a consumer choice health plan for the 1990s which was really the proposal that Alain Enthoven talked about in the General Session; and, the report of the National Leadership Commission on Health Care, which is really a blue ribbon commission that did its work the last few years and presented a report last year. I am going to put on the list a comprehensive proposal for access to health care for all Americans from the Health Insurance Association of America (HIAA). Also on there is the Pepper Commission, and I think really this forms a good range of proposals that are out there to be discussed. I, as some of you may know, have been involved with the HIAA proposal, and I am really pleased to say that it's been well-received by a lot of people both on the Hill and in the administration. However, I'm really not here to tout the HIAA's position. What I'd like to do is compare the proposals that you see before you to try and draw out some common characteristics which seem to me to form a politically acceptable framework for reform in this country, and it is this framework which I'm strongly advocating, not the specifics of a proposal. I'd then like to talk a little bit about what I see as some of the issues that are hindering the agreement on what to do so that we can get some legislation through Congress. Again, I'm going to be

referring now to the handout that you have, and we'll talk briefly about the characteristics I see in them.

The first and most important item is the type of health care financing system that we're going to have in this country. I believe this idea of what the fundamental direction we're going to take is of utmost importance. We've heard from Dr. Himmelstein about Dr. Robert Blendon's research showing how much the Canadians hate our system and Americans love their system. However, I think if you look at the proposals, Lynn's comment about where a political center is relatively true. There is little indication yet in Congress or on the Hill that there's a movement towards the radical change to the Canadian system and a lot of support for continuation of a mixed public and private system. Now, as we know, this means there are some costs involved with our system. A mixed public/private system, for instance, really does cost more than a unified public system such as Canada's, but really what we see is that there's more concern about the single government-run health care system rather than the opinions that Dr. Blendon seemed to have found in his surveys.

The second piece of it is more how do people get access to the system? Access for poor Americans is the primary. There's a fair amount of agreement among everybody that access to health care for the poor is really uni-versally recognized as a public problem. All the proposals recommend a tax-supported, public program be made available without any premiums to all Americans below the federal poverty level. This is a big change from where we are today where only a small portion of the people under the federal poverty level can get access to health care through Medicaid.

Access for working Americans and their families is the second characteristic, and with the exception of the proposal that David Himmelstein talked about, all the proposals talk about employers providing health care, and that they subsidize the provision of health care coverage for employees and their families, but there are significant differences about the extent to which employers fulfill this responsibility. For example, the Kennedy-Waxman proposal requires employers to provide coverage. It's a mandate. Others, such as the Pepper Commission, use a pay-or-play approach which really requires the employer either to buy private health insurance or to pay a payroll tax toward public coverage. At the other extreme is the HIAA proposal which basically is a pure voluntary employer purchase of health insurance from the private sector.

In all these proposals the employer-provided health coverage is a cornerstone. In between the employer-provided coverage and the poor is this area, this gap, that Lynn did talk about. A lot of people fall in it. I'd call it on this sheet the access for disadvantaged Americans. These are Americans who don't receive coverage either through the expanded public sector, programs for the poor and the elderly, or employer-based coverage. All of the programs recognize the need for the disadvantaged to be provided partially subsidized coverage through either public and/or private programs. While they all agree on the need somehow to cover these disadvantaged, the size of the population differs among pro-posals. The sector in which the disadvantaged Americans obtain coverage varies, and there are differences in the amount of premium subsidies among the various proposals.

The last area under access is the private insurance reforms. Once again, aside from the physicians' proposal, which is outside of the private insurance system, all the proposals envision a viable private sector health insurance market. Some proposals, most notably for our discussion the Pepper Commission and Kennedy-Waxman, address the issue of reforming the private health care market, and in particular these reforms are focused on the small group health insurance market where the majority of today's working uninsured are employed. I'm going to talk a little bit more about this later, and if I can get through my talk in enough time, I'm sure Lynn and I will have some conversation. I hope I'm not going too fast, but I'm really trying to leave some time at the end so that we can have some discussion here.

Another category of concern is the issue of cost, and we have to keep in mind that the primary focus of the proposals we've been discussing is to provide access to health care for the 37 million uninsured Americans. All the proposals, though, in one way, shape or form recognize that there is a need to rein in the rapidly rising cost of health care, and I believe, along with many others, the high cost of health care and its rapid increase is the primary reason for large numbers of uninsured Americans. So, all the proposals address this cost issue, and they generally based their hopes on controlling cost increases on continued development of managed care systems. Some of the proposals go beyond this, such as the Pepper Commission, which extends public sector-negotiated provider prices to the private sector.

Quality is the other issue that keeps coming up, and here the future cost effectiveness of managed care is based upon a belief that there's a great deal of unnecessary care which we've heard of from everybody, particularly now in the unmanaged segment of the medical economy. Acting upon the knowledge of what constitutes high-quality medical care is the fundamental tenet under which most managed care systems expect to contain cost. So, all the proposals recognize and need to provide for a better means to research, through clinical trials, and develop better guidelines for cost-effective, high-quality medical practice. These, then, are the general characteristics that I think are driving our political debate. They're much the same as what Lynn had, the mixed public/private system, a public sector solely responsible for the poor, private sector working through employers that are going to be responsible for insuring most working Americans and their families, the public/private sectors jointly responsible for the people who fall in the gap in some way, shape or form.

Lynn touched a little bit on what was going on in the political debate and what has center stage. Despite all these proposals and these similarities we just talked about, there seems to be a gridlock at the federal level. There doesn't seem to be any one proposal right now that is widely accepted or widely on the political agenda which looks like it's going to pass in the near term. I think this would probably surprise a man from Mars who came down to visit the Earth because he would see, first of all, the surprisingly high degree of consistency among the major proposals and wonder why we couldn't settle the issue.

I'd like to discuss and pay most attention to some of the reasons why I don't think this problem is going to be solved in the short term. I think the first and probably the most important consideration at the federal level is a lack of dollars to fund an expanded

federal roll. The Pepper Commission estimates its proposal to expand federal programs for the poor and to subsidize coverage for the near poor and subsidize certain small businesses that will receive a premium subsidy will cost the federal treasury $23.4 billion per year once it's fully implemented.

Another study done by some people from the Harvard Public Health School was in the *New England Journal of Medicine* last October. They looked at Medicaid expansion, and depending on what kind of concurrent reforms are made in the private sector and how much of an expansion is made in Medicaid, they determined between $11.5 billion and $51.7 billion will be the annual cost to the federal treasury in 1989 dollars. So there's a healthy debate about some of these cost estimates and still a healthy debate about what form of benefits and restructuring there's going to be, but there's just no doubt that what we're talking about is public expenditures in the magnitude of tens of billions of dollars. At the same time that we're talking about how to take care of the underage, acute health care marketplace, there's also a debate going on about long-term care which we haven't been able to get in. The Pepper Commission, for example, has thrown a proposal on the table which, again, is a mixed public and private sector solution to the problem, and their price tag is $42.8 billion annually. Well, what's the problem with this? The problem is, quite simply, that no one's willing to propose a means to raise the funds that are needed for the federal contribution to these proposals, and the federal government really can't find such large sums of money in its already underfunded budget. So, that remains a major problem.

The second major problem among the proposals is really a lack of agreement on how to close the gap that Lynn talked about between the public and private sector programs. In a mixed public/private system, and this is another cost that we pay for having a mixed system, there is necessarily what I'll call a ragged edge between the two financing systems. As people change their employment status, their income changes, or their family situation changes, and they might find themselves bouncing around back and forth between public and private coverages and maybe even within the private sector between various types of coverage.

This causes two pretty significant problems. First, it's not easy to design programs and administrative rules to make certain that there's no gap at all between the public and private sectors. If the line between the two isn't really seamless, a significant number of Americans still may not have health care coverage. Second, at the margin, there's still significant differences among the proposals about who's responsible for certain classes of disadvantaged Americans. For example, there exist significant monetary differences among proposals concerning how much subsidy, if any, is needed to enable small businesses that really can't afford health care coverage, to be the public or private sector responsibility. Then there are a lot of different pockets of uninsureds with whom these same types of issues pop up. It's really not too surprising that an agreement among everybody is elusive.

The third issue is one that Lynn has referred to and is what I call a clash of principles underlying small business coverage. Replacing this ragged edge with a seamless continuity of coverage between the public and private sectors is really hindered by different viewpoints of what can be done in the private insurance market -- in particular, how the

small business health insurance market should function. Much continues to be made about the perceived failure of the small business insurance marketplace, and anecdotes have been circulating about insurance companies' experience rating, about capricious terminations of coverage, about the inability of small businesses to get coverage. As with most anecdotal evidence, there's certainly some truth to most of these charges, although there's little or no adequate research or evidence about either the real underlying problems or the true extent of the problems that are being bandied about in the federal government right now. So, in lieu of searching for the real problems and devising appropriate solutions, the political process is revolving around what I call a "clash of ideologies," where critics of the private insurance industry are demanding the small business market operate like a social insurance system; that is, kind of guaranteeing all small business coverage at community rates. These critics argue that if Americans have a right to health care, that insurance companies have an obligation to provide health insurance to everybody.

On the other hand, proponents of the private insurance system note that both the small business insurance market and the individual health markets are true residual markets subject to biased selection. There's little integrity in the small business employment process which effectively substitutes for insurers' risk selection in large businesses. People tend to ignore the fact that large businesses do, in fact, select risks. They just do it in a very subtle manner. There isn't really much interest among small businesses in either fully cross-subsidizing each other or bearing the full cost of their own risks as do large businesses. So, forcing insurers of small businesses to operate on social insurance principles has some very counterproductive outgrowth. It will open significant, new opportunities for biased selection in the marketplace, and this will, in turn, increase costs for the vast majority of insured small businesses and drive additional insurers and businesses from a market which has seen more than 30 insurers and many thousands of small businesses hang it up in the last few years.

There's also a lack of agreement over employer responsibility to provide health care. Various proposals clash over the extent of an employer's responsibility to provide coverage to employees and their families. Small businesses, in particular, argue they cannot afford the cost of health insurance, and some of our economists will agree that forcing small businesses to provide coverage is going to cause a loss of jobs and these vulnerable small businesses to fold. It will also hinder the growth, in a part, of the economy that's created a majority of jobs in the past decade. This leads to deep-seated differences between those who demand employers offer insurance (the mandate proponents -- the pay-or-play advocates and proponents of subsidies for vulnerable small businesses and low-income individuals) and those who are advocates of somehow enhancing the private insurance market to improve the affordability and voluntary purchase of insurance.

Another major area of disagreement among these seemingly similar proposals is the differences over government involvement in the private sector. As I mentioned, the Pepper Commission and also the National Leadership Commission proposals extend private sector negotiated contracts with providers. What they're doing is recommending that the private sector be able to access the public sector negotiated contracts with providers (for instance, being able to use Medicare rates). These suggestions have been

causing some widespread concern among providers and third-party payors about the government's involvement in the private sector. Proponents of single negotiated provider contracts argue that they are an effective and even necessary tool to slow future cost increases and assure that one sector's negotiated gains do not add to other sectors' cost increases through unintended cost shifting.

Lastly, there's concern over the effect of improved access to health care on cost inflation. The American health care system continues to experience cost increases well in excess of general inflation. All the proposals depend on managed care and research and cost-effective medical practices to control future health care cost increases. However, there's a growing feeling that these proposed solutions will not, in effect, rein in cost increases as is hoped. In fact, universal access to health care may well exacerbate the problem by adding new demand to a health care system which is already out of control. Another thinker who's not here with whom I'm very intrigued is, Daniel Callahan. He says that if the real problem caused by rapid health care increases is, as he would argue, that Americans value unlimited medical progress to meet every individual's needs but at the same time somehow expect affordable prices, then all the ideas that we have on the table simply won't work. All of these problems, a lack of funds, closing the ragged edge, the clash of social and voluntary insurance principles, disagreement over employer's responsibility, disagreement over public involvement in the private sector and concern about fueling health care inflation are hindering a legislative solution.

My argument, though, has been that, despite all of these differences, we do have a broadly accepted framework for reform of the American health care system. The framework reduces the number of people without health insurance (35-37 million) by expanding both the public and the private sector involvement by placing the burden equitably among government, the employers, the third parties and providers. The problem, though, is that we can't seem to agree upon where to draw the line between the two sectors or decide on how to fairly control and share the cost burden that goes along with the resolve to offer all Americans access to health care. Solving major problems is not easy, but it's the price that we pay for a democracy, but I believe we have reached the critical mass needed to place the health care reforms firmly on the political agenda. Health care will remain a visible political issue over the next few years, but whether we have the political will and enough agreement to actually solve the problem in the next few years remains to be seen.

DR. HIMMELSTEIN: My objection to the employer-mandate approach, which Howard has correctly said is essentially the same in all of these proposals, is that while it may be possible to pass these things legislatively because they seem like mild, incremental steps, they can't actually be successfully implemented in our country. We've seen that, unfortunately, in Massachusetts. We passed an employer-mandate bill in 1988 which is scheduled to finally be fully implemented in 1992. It is almost certain to be repealed before then, because the costs are so high that very quickly the cost crisis drives the access aspect of the bill back into the woodwork. While the political coalition for the kind of more fundamental reform I've proposed is going to be difficult to build, it is actually a program which cannot only be passed legislatively but can actually be implemented in our country successfully and can finally solve the crisis we've had festering for more than 20 years now. I think the employer-mandate approach essentially rests on the

assumption that George Bush doesn't know that if you spell a tax p-r-e-m-i-u-m, that it actually is a tax. If you require employers to pay $48 billion a year in mandated premiums, they will understand eventually that is the same thing as a tax, and if you raise that amount of extra money without streamlining the system in any other way, you will have a crisis on your hands that continues. I think that's the essence of why we think a more fundamental reform at this point is a more viable proposition even in the relatively short term.

MR. ETHEREDGE: I somewhat disagree with that. I think one thing we learned in the 1970s is that trying to combine a health insurance bill and a national health cost containment bill based on government regulation is fundamentally unworkable for both agendas. The coalitions that you can put together for expanding health insurance are very much at odds with those that favor cost containment. Specifically, while health care providers, labor unions and even insurance companies will support an employer-mandate approach, they tend to walk out the door once you tell them that part of this deal is for the hospitals and physicians to agree to expenditure caps or price regulation, that there's going to be a cap on the tax treatment of employer-provided benefits, and the private insurance industry is going to be eliminated. Politically there's absolutely no way that you can put together those two agendas in the same bit of legislation. The Kennedy strategy is to break them into two parts, dealing with health insurance now because you can, in fact, get voters to support that, particularly because of the problems in the small-employer market. Once you have a well-defined set of responsibilities for everyone in the health care system to pay basic benefits so they can no longer shift them to someone else, then I'm convinced that within two years we will have a very productive national debate on health care costs, and we'll make a lot of progress on that agenda. I think politically one has to proceed with where one can get the votes in the American political system, and so far this is a strategy that's working.

MR. BOLNICK: How about a plague-on-both-your-houses approach? I agree with Lynn that what is politically acceptable is to work through the employer-based system. There are a lot of good reasons to do that, particularly if we're going to depend on managed care as the sole source or the major source of cost containment. Without the employer involvement and interest in controlling costs, we're really going to have some problems making that system work. On the other hand, I disagree with him that it makes sense to separate those two agendas. There are 30 million people on Medicare, 20 million people on Medicaid, and about 35 million uninsureds. That's 85 million out of a population which just exceeded 250 million. That's over 30% of the people in this country who one way or another can't afford the fairly allocated cost of health care today. And if you wonder why we have that gap, it's my strong impression that it's because of the high cost of health care today. So, to duck the problem and not address it I think is a travesty and is only going to exacerbate the problem that we're being faced with today by adding demand into a system that's uncapped and uncappable.

MR. JOSEPH W. MORAN: I'm fascinated by this apparent obsession with the concept of community rating. It's very ill-defined in many of the forums and presentations in which it's used. To me, community rating implies two things: (1) there will be a maximum price that anybody will have to pay, which sounds good, and (2) everybody has

to pay the maximum price that's charged to anybody else. Nobody can get a bargain no matter what they do to warrant getting a bargain. Can we have some comment on that?

MR. ETHEREDGE: The basic approach is not that every insurer would charge the same, but that any insurer who is offering benefits in the small employer market would have to offer a rate that's available to anyone who applies. You would actually have under competition different rates and in competition among HMOs, PPOs and other forms of managed care as Alain Enthoven's plan would provide. I think what we're aiming for is a system in which the insurance industry competes on the basis of achieving savings and achieving improved quality rather than on the basis of trying to select the risk pool.