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HEALTH INSURANCE AS A POLITICAL ISSUE

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Health insurance has become an important issue in this year's presidential election campaign. What effect will this have on the likelihood of major health-care reform, on public expectations about rights to health care, about perceptions of health insurers, etc?

MR. STEPHEN D. BRINK: Our overall objective is to provide you with some observations and insights into the politics of health insurance. We want to talk about what is happening, why, and what's likely to happen in the future. Health insurance is clearly a political issue. It wasn't always true. This election marks the first time that health care is a major presidential issue. In fact, health care appears to be perhaps a number two issue behind the general economy. This interest on the part of the presidential candidates has surfaced because a majority of the people in this country are dissatisfied with the cost and access to health care. Political theory holds that candidates pick up on this unrest, and their views reflect the views of the majority of people. So politics is the instrument by which people get what they want. I think it's very clear that people want reform. Part of the problem is that the American people don't know exactly what they want, and that's why the candidates are not too clear on their health proposals either.

As actuaries, I think it's safe to say that we're not experts in the political process. We're schooled in the hard sciences, and politics is kind of soft and fuzzy, with changing rules of conduct, changing issues, and also changing personalities. The political process clearly has the potential to radically change the financing and the delivering of health care in this country. So it's important that we understand what these political forces are all about, and it's also important to recognize that if we want to shape the future and shape the political process, this is the time to do it. There are not going to be too many more chances.

I would like to introduce the panel. Harry Sutton is a long-term participant in the health insurance industry and the political process. As an actuary he worked at Prudential for 25 years and helped them get into the HMO field. For the next 20 years after that he's been a consultant concentrating on the financing and delivery of health care. Harry has worked with federal and state regulators, helping them to develop a regulatory environment for HMOs, as well as other organizations. He's also been heavily involved in the development of universal health-care programs in Minnesota and Massachusetts.

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Over the past 45 years, Harry has participated in the development of our current health-care system. He has seen a lot of presidential candidates, and he's seen a multitude of health-care reforms. Harry is going to give us insights into the health-care positions of the presidential candidates.

Our next speaker will be Mark Mellman. Mark is a leading Democratic party strategist and CEO of Mellman Lazarus, a polling and consulting firm. He's guided many election campaigns for senators, representatives and governors. Recently Mark was in the Soviet Union working with Boris Yeltsin's advisors on political tactics. Clearly Mark knows what's going on in the minds of the American public, and also, our politicians.

Last, Bruce Barlow will be addressing us. Bruce is a general management consultant, working primarily in the health insurance area. He's advised state governments, Blue Cross/Blue Shield organizations and commercial insurers on health insurance and regulatory matters. He's designed legislative and regulatory strategies for his clients. Prior to becoming a consultant, Bruce worked for seven years at IBM, designing insurance information systems. With his wealth of experience, Bruce is going to help us understand the impact of change on the health insurance industry, and more importantly, what the insurance industry can do about it.

MR. HARRY L. SUTTON, JR.: First of all, some things are happening in this economy that are different from before. Companies are laying off thousands of white-collar workers who are used to having benefits. Also big employers are increasing the employee responsibility through bigger deductibles or higher proportions of premiums. Therefore, the middle-class people, who have been fairly well covered all along, are now the ones being attacked through being laid off, retired early and having to pay their cost. And this has created a very uneasy political environment. The thing that sets this off, and I won't get into the actual political happenings, was the election of Harris Wofford, a senator from Pennsylvania. Mark may talk about some of these things, but essentially I'll discuss the positions on health-care reform of the three candidates.

It seems as if, in order to have a chance to win the Presidency, you really need to say that everybody will be covered by health insurance and the cost will be less. And if you say anything more you're going to be defeated, because as soon as you indicate how you're going to do this, you will attack the hospitals, attack the insurance industry, and attack doctors – all of whom contribute large sums of money to political action committees (PACs), to congressional representatives and other people running for office. Therefore, you have to be vague in what you're proposing to do, by just saying you're going to "do good." Then you have a chance to be elected. Before I get into a detailed discussion, I would like to dispose of Mr. Perot. His solution is a typical sound bite. I bought his book to see what he had to say about health care, and it consisted of about three pages out of a 150-page book. He will call a national meeting of consumers on television to ask peoples' opinions. Once he figures out what they want, he'll propose to do it. It's as easy as that. So that's his solution. The only other thing that he said specifically is that he does agree on increasing taxes for Medicare. Because he's concerned about the equity between generations, which is a good point, he proposes not only increasing Part B premiums, but possibly taxing Medicare benefits as an income item to retirees, the same way he proposes to tax

Social Security benefits. Perot does not talk about this at the moment because he knows it would turn everybody off, at least the senior vote. Essentially as far as I can find, that's all he has said. He does comment on the fact that many other countries have better neonatal mortality rates than we do even though we spend more money.

Let's talk about the positions of the two major candidates, Mr. Clinton and Mr. Bush. To some extent, both of their positions are relatively fuzzy for the reasons I have mentioned. However, I would say in summary that the Bush proposal will do almost nothing to change the cost of the health-care system and the structural system that we have now. The Clinton system is much more mandatory, and if you look at some of the seeds, it could cause a tremendous change in the way health care is provided in the U.S. With him the question is whether he could control Congress to do what he wants to do. Dr. Naisbitt said the national government is irrelevant, and the state and local governments are controlling everything. However, because of Medicaid and the funding problems, the states, even though they might like to do something, are going to have a very hard time. Again, Clinton has a lot of mandatory proposals in his system, whereas Bush is strictly voluntary.

Let's look at the question of access. We have, depending on how you count, 30-40 million people who do not have access to health insurance. If you have no income, you're under Medicaid, or if you're older or disabled, you have Medicare. But otherwise, there's 30-40 million people. Clinton would solve the problem with a version of a play or pay. All small employers must purchase health insurance. It's not purchase or pay a tax -- it's purchase. There will be two providers of health insurance. One will be private industry, insurance companies, or HMOs. The second will be a state-sponsored plan or a federal government state-sponsored plan which will be an "insurer of last resort." So the employer can either buy insurance from private industry or buy it from a state-sponsored health insurance-type company. All employers will be required to do one of these. On the other hand, Bush's proposal is to provide vouchers for the very lowest income people, with which they could then go buy health insurance either from a private carrier or from a state insurer of last resort. If they're higher income, they would get a tax credit which would reduce the individual's cost. In Bush's program it's voluntary enrollment. There is no mandated coverage. There's still the same problem with the voucher as there is with the current tax credits for low-income people who have children to be insured. They don't get the money ahead of time. It's voluntary so you're not sure who they will sign up with, and you're not sure whether the credits or the tax rebate are enough to purchase insurance. So in Clinton's proposal he doesn't talk much about the individuals who don't have insurance, self-employed, unemployed, and the people over the Medicaid limits. The plans could inherit Medicaid; both of them really do not discuss changing Medicare at all. But some of the proposals assume that Medicaid could be swept in as a place of last resort with the state plan. So while they don't discuss individual enrollment, you have to assume that the state plan is a place of enrollment for people of last resort.

Second, both of them are very similar with one exception -- underwriting reform of the small-group area. I won't spend too much time on it, but it's guaranteed issue. Clinton has community rating, whereas Bush has a pool adjusting between health status by age/sex cell. And while he doesn't discuss it, I've been to two meetings in

Washington where they discussed how to do it -- the health status adjuster by age/sex cells. Bush's proposal for Health Insurance Networks (HINs), and Clinton's proposal for group health-care networks are similar on the outside. The Clinton proposal has no apparent pooling arrangement in it, and there are still multiple systems that could be competing with each other, and it doesn't address that. Bush has a very complicated system. Each insurance company could form something similar to a multiple employer trust, including individuals, and compete in the same metropolitan area. Both of them, and this is my own personal opinion and not what they say, are moving toward what we call a health insurance purchasing cooperative (HIPC) which involves a local geographic monopoly that functions like a very large employer who negotiates with HMOs, or insurance companies, and juggles money around depending on the selection aspects of the different populations. Both of these have not gone that far, but they have large networks where they want to enroll large numbers of people. Clinton will have community rates. Bush will have demographic rating, and some kind of competitive arrangements keeping the private system. Both of these are built on the employers' system, because they essentially use small-group reform. One of them will have mandated coverage. The other one will have ameliorated small-group rating systems and guaranteed issue, hoping that the cost will merely go down, because of the changes made in the small-group rating system. Both of them appear to leave individual insurance out; insurance could underwrite individuals. But there's still a local court of last resort where the people involved could enroll in the state program. Each of them has a state program. What about health-care cost controls? The question here is whether any of them really mean anything, or maybe they won't state what they mean, because nobody would buy it.

If you watched the debates, they were very uninformative on health care. It is supposedly a number two issue, but I think it may be number three with one being the economy and the second attacking the other candidate. Mr. Bush did not discuss it, except for malpractice reform, that's about the only thing he ever mentioned. Both of the candidates, however, are looking at improving administrative costs, using computerized standardized claim forms and processing which doesn't necessarily fit managed care, HMOs, or coordinated care, depending on which political exercise you're going through. Bush, in my opinion, is not interested in health care, except for the malpractice, which can't affect more than a couple of percent of the health-care expenditures (expected to be $800 billion this year). There is nothing in there that creates a substantial change.

Potentially Clinton could produce a major change. Clinton has copied, or at least implies he is copying, certain parts of certain major democratic legislation. One is, he espouses an "all pay a rate" rating system where all providers will be paid the same rate through a central planning function. He sets up a national health-care commission, which will determine a limit on total national health-care expenditures. How to do that is a very difficult thing. Then they will divide the money up by state. How they will do that is a very difficult thing. Then locally these health-care networks can compete for money. You could have HMOs being paid a capitation based on the budget for their population and so on. However, if you buy the all-payer rate system, which is like Medicare, not Medicaid, you look at some of the bills produced by Congress. This is where Clinton proposes to get the money to finance the state plans to subsidize the poor, etc. Essentially he would use, for example, Medicare reimbursement rates, or a modification of them, both for the hospital diagnosis-related

group (DRG) reimbursement and for prospective payment to physicians. In effect, he would set nationwide physician, hospital and other provider reimbursement rates. The various think tank analyses of this proposal indicate that it, and Clinton has quoted a couple of these in speeches, would save $700 billion by the year 2000. By the year 2005, this would reduce our cost by $500 billion a year. Somewhere in there he's talked about saving trillions. But essentially that's a projection of a congressional bill that froze fee levels as they do in Medicare. It assumes an all-payer fee system so that all doctors have to be paid the same fee nationwide, and the government can control cost by limiting the fee increases and the hospital reimbursement rate. Clinton does at least have a smidgen of all these control systems built in. He also tends to harken back, with a few of his statements, to the old certificate of need. In other words, prevent hospitals from buying duplicate equipment, but he's forgetting the fact that in Minneapolis, for example, we have more various types of scanners, and positron emission tomography (PET) scanners, than the whole country of Canada. They're very expensive and underutilized. Every hospital is competing with each other for competitive equipment to attract doctors and so on. The other thing he tends to do is control drug prices. The fact is that Canadian and European countries some time ago decided they were paying exorbitant fees for drugs and have cut down prices that they will pay in their national health systems for drugs. My feeling is that this has pushed the drug companies to raise their prices in the U.S. where there is no limit to the prices they can charge. It's not a Medicare item, it is a Medicaid item, and there are some fee schedules there. But essentially the private system has no control over drug prices except what they can negotiate.

Bush seems to assume that his voucher plan will be partially offset by a reduction in Medicaid from the federal level. What happens at the state level is hard to say. He expressly wants to use coordinated care, which is his current term for managed care, originally HMOs, PPOs, and point of service plans. Bush really does not propose to make much change in the system as we know it. It's not clear whether Clinton does or not, but potentially some of the things he's talked about could produce huge savings. The other thing Clinton gets attacked for is the fact that if you have a play or pay system; studies by one of our big actuarial firms, as well as the Urban Institute indicate that if the pay part is too low, nobody will play, and the government will wind up covering 50-100 million people through these state plans. Because of politics being what it is, they will underprice it to the public. Therefore, it will destroy the private insurance system because all the low-cost people will drop out and buy it cheaper from the state. Then as soon as the selection effect takes place, insurance will be untenable except possibly to the very largest employers who may keep their own self-insured type of system, and keep out of the federal program.

To finish discussion of this, where do all the monies come from? Because there are subsidies, all of them propose expanding rural and inner-city health care. And essentially Clinton is going to save the money by these trillions of dollars in the next 15 years through control of prices, the government mandating fees at negotiated prices within the provider system, and a national health-care expenditure limit. So he claims they don't need any more money except possibly at the beginning. Bush really says absolutely nothing about where they're coming up with money if they need to finance anything.

MR. MARK S. MELLMAN: Harry more or less summarized what I had to say when he said, basically what people want is everything for nothing. I want to make one thing very crystal clear at the beginning. It will become very clear to you as we move on. But let it be clear to you at the beginning. Let it come from me instead of from you. I do politics, I don't do government. What that means is, I don't know very much about public policy. I know something about public opinion, I know something about politics, but I know very little, especially compared to all of you. I know very little about the intricacies of the public policy issues involved with health-care reform. I really can't speak to those very intelligently. But what I hope to be able to speak intelligently to is the politics of this issue, and the public opinion, views of voters that surround this issue, and how those work together in our system to produce some outcomes in the political sphere.

Let me start by just echoing something that Steve said at the beginning, and that is, this issue of health-care cost is a very critical issue to the American public. When we talk about the economy, and when Clinton, Gore, Perot, Bush, and your candidates for Congress and Senate, talk about the economy, the most important thing they're really talking about is the sense that people are increasingly squeezed between prices that are rising and incomes that are stagnant. It is this middle-class squeeze that animates much of the fear on the part of the American public about the economy. It animates much of the concern of the American public and it is the key, central focal point for discussion in this political year. Now this middle-class squeeze equation has an income side. How do I put more money into my pocket? There are a couple of key symbols of issues there, and we'll leave that for another discussion. There's also an out-go side to this equation. More and more money is being taken out of my pocket, say average Americans, for more and more things. There are a couple of key symbols of the out-go side of this middle-class squeeze equation. One of the two most important symbols of the out-go side of that equation is the cost of health care. It is not a case where people think they are spending more on health care than they are on anything else, because of course, they're not. But it is a case where people see the rising cost of health care as a very important symbol of the rising cost of living, the rising cost of necessities.

We did a survey about 16 months ago, before Harris Wofford's victory, and actually this is part of the material that was shared with him in developing the strategy for that campaign. We also shared with all the potential Democratic presidential candidates, including Governor Clinton. We tested how concerned people were with about 15-20 different issues. The single highest level of concern was with drugs and crime. Second, health care is becoming too expensive. Almost half of the people in this country say that one of the things that concerns them most was the cost of health care, just under crime and drugs. More important than the environment, more important than education, more important than foreign trade, more important than tax issues, more important than being able to afford a home, more important than competitiveness, take any of the 20 issues that we tested, the cost of health care is one point lower than crime in terms of the level of concern. So there is a great deal of concern about health-care cost. It is a very important symbol of the middle class squeeze that is very pervasive in our country.

Let's take one step back to figure out what it is that people are concerned about. When we look at this in some of our national polling, the basic theme with respect to

health care seems to be "I'm O.K. but you're not." Basically people tend to be satisfied with their own personal health-care arrangement, but very dissatisfied with the nation's health-care system. So we asked about quality. How satisfied were people with the quality of the health care that they received? Seventy-five percent were satisfied with the quality of health care they received and 69% were satisfied with their particular insurance arrangement. Indeed, even if we're talking about cost, almost half (48%) were satisfied with the amount that they personally pay for health care. Indeed, among those for whom the employer pays all or part of the cost, 56% were satisfied with the cost that they personally pay for health care. We get a very different picture when we look at peoples' evaluations of the national health-care system. Only about one third were satisfied with the quality of health care in the nation as a whole. Only about one fifth were satisfied with the insurance system in the nation as a whole. Only about 10% were satisfied with the cost of health care for the nation as a whole. There was a tremendous dissatisfaction with the national system, reasonable satisfaction with peoples' own personal arrangement. That immediately creates a very significant political problem, because as you move to change and reform the system, you're not only changing the system that people are very dissatisfied with at the national level, but you're changing the system with which they are personally very satisfied. Are we changing for the better or for the worse -- that's obviously the problem. In fact, people clearly do want change, but they don't know what kind of change they want.

We asked this question in a national poll: Should the U.S. health-care system be radically changed, reformed, kept the same? As most of you know, the word "radical" is not exactly a positive word in the American political lexicon. We used the word on purpose, and almost half the people in this country said, when it comes to health care, it's radical reform that's necessary. People want change. Among those people who want change, 61% said, "Gee, I want change, even radical change, but I have no idea what kind of changes I want." Fewer than four in 10 said, "We need some changes and I have some idea of what kind of changes I want." In fact, people have very little idea of what kind of changes they want.

They also spread the blame for the problems around quite a bit. This question from an NBC *Wall Street Journal* poll asked people "Which one of the following groups do you think is most responsible for the high cost of health care?" Twenty-eight percent said insurance companies, 21% said doctors and 16% said lawyers. Patients were down there at the bottom -- we have nothing to do with it. Ask the question differently and you get slightly different results. This question, "How much responsibility do each of these groups have to bear for the high cost of health care?" Sixty percent said hospitals have a great deal of responsibility, 58% said doctors, then drug companies, and health insurance companies, and then of course, the American people were down there at the bottom -- we have nothing to do with it. But no matter how you ask the question, blame is spread around a wide variety of actors in the health insurance system. People clearly want change, but they don't know what kind of change they want. They spread the blame around quite a bit, but there are certain criteria that people will apply for reform, certain things that they want out of any system. They have a good idea of that.

For example, they want choice. They want to be able to choose their own doctor and hospital. "If it would reduce the cost of health care would you be willing to go

to a clinic and be assigned to an available doctor, instead of going to your own private doctor?" And put in the context that if it would reduce the cost of health care, "Would you be willing to do that?" Only about a third of the people said, yes I'd be willing to trade off that modicum of choice in order to get lower cost for health care. What's particularly fascinating to me about this is that a lot of people, in effect, already have this system. When you go to a doctor, you go to a big group practice, and you get whichever doctor happens to be there that day. We have a three-year-old child. I don't think we've seen our doctor more than once. I mean, we have a doctor who is our doctor, but we take our child into the practice and we get whoever happens to be there that day. So we have this system already in effect. But most people are unwilling to accept even that kind of restriction on choice.

Moreover, people want access to the best, most advanced care. Again, a fascinating question -- "Would you be willing to exclude certain expensive treatments like organ transplants?" No. Only 25% would be willing to do that to save money. This is always a fascinating question to me, again if we were cutting cost. Would the health care system improve if the federal government paid for all health care except for certain treatments where the odds of success were small or would only extend life briefly? So basically the question asks, "If you could save money by not treating people who you're not going to be successful with, would you be willing to do that?" Twenty-five percent of the people said yes, 65% of the people said no. You have to treat even people who are essentially untreatable, even if that costs us additional money.

Moreover, people want immediate access to health care. We're not willing to wait a longer time for a doctor's appointment. Well, most people wait a long time already, but only a third would be willing to wait longer for a doctor's appointment no matter how you put the question. But if you have to wait longer, people say no, that's not acceptable either. So people want access, they want immediate access, and they want immediate access to the best and most advanced care possible. They want choice.

They also want, as we've seen, lower cost. Again as I said at the onset, I'm not an expert on the public policy issues involved here. I'm told it's hard to fit all these pieces together into one system. You have a better sense of that than I do, but I guess I have more or less correct information. It's very hard to put all these things together, yet that's the demand that the public puts on our political system as we talk about reforming health care.

We also see when we talk about various kinds of solutions, the civic solutions which I want to turn to. If there is a bias in the American psyche for private-sector solutions, it is really just a bias. It used to be an overwhelming sentiment. Get the government out of our pockets and off our backs, said Ronald Reagan in 1980, and he struck a very responsive core. People no longer feel that to nearly the same extent. We did ask people, which comes closer to your view? On the one hand, health insurance prices are so high, so problematic, so serious, that it's time for the government to step in, and in this formulation take over -- a very strong statement. By a 13-point margin, people said if the government gets involved, things will only get worse. What's fascinating to me though is that this question is really phrased in terms of the government taking over the health-care system completely, and even then fewer than

a majority say the government is only going to make things worse. Indeed if you ask this question slightly differently and say it's time for the government to step in and get involved with the health-care system, more people say, "Yes, it is definitely time for the government to step in and get involved, the government won't make things worse." So there has really been a change in peoples' attitudes for government involvement with the health-care system. There still is a bias against government control -- a very strong bias against government control. Indeed this is a gratuitous question almost, but we said to people, "If we had a national health insurance system in the United States, who should run it, the government, or private insurance companies?" Well, by a 9-point margin, people said a national health insurance system in this country should be run by private insurance companies rather than by the government. It doesn't make a lot of sense on its face. It probably doesn't make *any* sense on its face. But nevertheless, people's bias here in favor of nongovernmental solutions comes through once again.

People do like the idea of national health insurance though. "Do you favor or oppose national health insurance paid for by tax money?" By 20 points people said yes. However, people aren't anxious to pay for it. If you had national health insurance but it cost everyone an additional $1,000 per year, even though you no longer had to pay premiums for basic health-care coverage, people are divided about evenly as to whether that would be an improvement. If it costs money, people ask some questions about it, even if it's money that's being paid into a national health insurance system, but you're reducing or eliminating private insurance premiums. People ask some serious questions about national health insurance as a concept. One thing I should stress to you when you look at these polls, and we've looked at this very carefully, when voters talk about national health insurance, they don't necessarily mean the same thing that you, or I, or the politicians, or the press mean by national health insurance. Many people think national health insurance means everybody gets covered. Well, that's one aspect of it. But normally when we talk about national health insurance, we're talking about a government run system. Very few people in this country think about national health insurance, when they use those words, as a government run system. Most people think about it as just "everybody gets covered somehow." But nevertheless, people have questions about it. People do not believe that the national health insurance system will lower the cost of health care. They like the idea in terms of promoting access, but under a government-run national health insurance plan, 41% think that health insurance will cost more, and only 18% think it will cost less. People individually again said by 37 to 22, "If we had national health insurance it will cost me, you, them more than the current system." So people like the idea of national health insurance. But when you start getting into specifics about cost, savings, etc., people start to back away from the idea. Indeed when you present arguments on both sides of the Canadian-style national health insurance system, the 20-point margin in favor of the system melts away.

One of the things that is asked often in poll questions is, do you favor or oppose? That's not how the debate really works in American politics. There are people on both sides of this issue, and they put out the arguments. Those kinds of questions don't include the arguments. We try to include the arguments. On one hand it would reduce cost, provide coverage to all, reserve choice, so the argument in favor of the Canadian system goes. The argument in the opposition to the Canadian system is increased waiting time. It can take three months in Canada, so opponents

say, to get major surgery such as a coronary bypass. All of a sudden that 20-point margin in favor of national health insurance melts down, with just that argument against it, to an even split. We saw that same 20-point margin shrink down to an even split when we talked about the cost. The same is true with things like pay or play, employer mandates. Again people like the idea, 59 to 33 people say, "Yes, we should require employers to pay for health insurance." In this question there was an overwhelming two to one margin. People were in favor of the kinds of employer mandates that are embodied in pay or play type schemes. On the other hand, when you put some arguments on both sides, on the positive side it provides universal coverage without government control. But on the negative side it can hurt small businesses and cost jobs. All of a sudden that two to one margin in favor of a pay or play type system whips around to a two to one margin against pay or play type approach, when you put the arguments on *both* sides to the public.

One thing that we should note is that the American public sees no conflict here between quality and cost. Three quarters of the people think that we can reduce the cost of health care without reducing the quality of health care that people receive. People look at these individual systems, and they have questions about each of these individual systems. At least they're willing to be responsive to arguments on both sides of these individual systems, but somehow they retain the belief that we can have it all. We can cut costs, we can maintain quality, we can improve choice.

Just let me close with a question that we looked at that asked people what they thought the most effective thing to do would be. How would we control the cost of health care? Again, we heard about all the different systems that we proposed, and heard arguments for and against it. Well, 52% said regulating doctors' and hospitals' fees were one of the two most important, effective ways of reducing the cost of health care, followed interestingly by better preventative care and malpractice reform. You notice regulating insurance premiums, national health insurance, eliminating unnecessary tests, all those kinds of things have much less of an impact in voters' judgment on the cost of health care.

Finally, let me suggest that this issue of health-care cost is likely to be, in my judgment, a dominant political issue in the next 5-10 years. It's a very complicated issue. It's an issue on which there's a lot of public disagreement. The public disagrees with itself on this issue. They are very responsive to arguments on both sides of the issue. There are a lot of very significant interests that are affected in this town and around the country. Before disposition of this issue, and that means in our political system, we are in for an extended period of experimentation, reaction to those experiments, change back and forth before we finally settle on something.

MR. BRUCE BARLOW: In thinking about health insurance as a political issue, I want to talk about the nature of the debate itself, and the importance of the role that you need to play in that debate. I would like to offer some advice on how to go about addressing the issues. My central hypothesis is that you are critical to bringing rationality to discussions that will tend to be otherwise. My central hypothesis is also that we need you to play a role that you are uniquely prepared to play. And my theme is to help you be as effective as possible. I'm interested in the larger issues in reform. I'm interested in how we address the ethical and moral issues that underlie the proposals, how we debate them in that context, the issues we frame, how we

frame them, and how we incorporate our fundamental values into the solutions that we try to craft. The process gets severely off track if we fail to make those values explicit, and will not result in an outcome that reflects them. After all, we are what we do. Our actions are the sole evidence of what we believe. Our system of health care reflects the values we hold as a society. Let me give some examples, and I'll let you draw your own conclusions about the values they demonstrate. I've been unemployed with a family, faced with losing coverage. I've run a small business that cut medical benefits, and shifted high cost to low-paid employees because that was the only choice that we had to stay in business. I've talked in my consulting work to senior citizens who would sacrifice anything to afford the richest benefit Medicare supplemental insurance product, because they didn't have the financial cushion for a deductible and couldn't afford to pay for prescription drugs. A professor I know couldn't take another position that would have significantly advanced his career because his child has leukemia and that's a preexisting condition. I authorized $20,000 of radiation therapy even though the doctor said it probably would not prolong my father's life, in part because I wanted to believe that our medical system could perform miracles, and then in part because I knew Medicare and American Association of Retired Persons (AARP) would pay for it. I'm not going to try to tell you what your values ought to be. But I'll offer this question for you to ask yourself. If you were to design a medical delivery and financing system that would meet our country's medical needs and reflect your core beliefs and values, and the values that define us as Americans, would you design what we have? If that's too abstract, if we still believe in leaving things better for our children than we have for ourselves, do you want to leave what we have?

In January, the newly elected and reelected will come home to roost, and reform will begin again. There is no question in my mind that health insurance and health-care reform are going to happen. As a matter of fact, we just surveyed your bosses. Seventy-one top executives in the health insurance and health-care delivery business picked health-care reform as the single most important strategic issue they face – more important than medical cost control. Ninety-five percent of them believe small-group reform, at the very least, is going to happen. And 90% of them think that it should happen.

We at Towers Perrin have been involved in health insurance and health-care reform in several states. We have observed, sometimes painfully, the efforts of several others. One headline we used in a presentation was "major interests don't understand the health care and health financing system." Large businesses didn't understand the effect of the uninsured on charity-care cost. Health advocates didn't understand Medicare or Medicaid's inner relationship with private payers. Doctors, as much as this may surprise you, didn't understand that medical care was expensive. Did you get the impression, as I did from Mark's work, that the general public doesn't really understand the problem. Just because a majority of people who lack knowledge believe something or want something doesn't make it right. State legislators are, for the most part, woefully lacking health care and insurance expertise, putting the quality of the reforms that they attempt to craft in serious question. Further, we find that they rarely pause to think about goals that they're trying to achieve. I spent a lot of time with a legislative aide responsible for writing small-group reform legislation, helping her clarify first that there should be specific public policy goals for the legislation, and then helping articulate what those goals should be, what was reasonable to

achieve, and what the bill should say. We started by slowing down and taking a deep breath. We have a lot of state legislators who are well intentioned, poorly informed people trying to reform the health-care system on which all of us depend, to a greater or lesser extent, to stay alive. They operate under intense pressure, short staff, with little objective information, and even less of the framework in which to evaluate options against well thought out, clearly stated public policy goals. They hear a lot from others -- from the hospitals, doctors, drug companies, and others who may not understand the system and who may have no vested interest in doing so. Here's where you come in. You have as comprehensive an understanding of the health-care system and its financing as anyone. You can articulate the complexity of the system and its problems, and propose and analyze specific solutions. We need you in the debate. We need you to bring rationality, to be constructive malcontents, going beyond stating the problems to offering carefully considered practical solutions. We need you to take a broader, more active, and constructive role than you may have taken before.

We need you to bring your heart as well as your head. Many of you haven't been there before, so let me offer some advice. We have some basic tenets for the nature of the solutions that double as rules for managing the inevitable conflict. Think of these as starting positions. First, there are no heros and no villains. Approach discussions as among equals. And besides, finger pointing usually leads to diversions from the real issues. Similarly, all participants have legitimate interests, valid concerns and good intent. If you genuinely believe this, listen hard, and try to walk in the other guy's shoes. You can get some interesting insights, as well as find common ground. Fraud, greed and waste should not be the primary rationale for solutions. While they exist and consideration of them should be incorporated into our thinking, just fixing them doesn't fix the core problems. There are no perfect answers, we will make mistakes, sometimes fail and our solutions will always fall short. We must be willing to recognize when it happens, make corrections as best we can, and move on. Falling short of perfection isn't an excuse for doing nothing. There are no silver bullets. The problems are complex in many facets, so simple answers are suspect. There will be bullets bitten, there will be losers as well as winners, which will make the process difficult and very contentious. The best solutions, therefore, may be those that equalize unhappiness across all the parties and prevent any one group from being perceived as a big winner over others. Remember as a fundamental principle that you aren't trying to convince majority, you are convincing powerful minorities. Those who have the clout to stop your solutions from being adopted should stand aside and give what we call their grudging consent. The arguments you target specifically to your opponents in this process will, by their nature, preach to the saved and cement their support.

Finally, to be a constructive malcontent and take responsibility for having a better idea means taking a leadership role, and acting to make that idea into reality. The most compelling leadership emerges from and returns to the fundamental needs, aspirations, and values shared by the leader and the led, and requires leaders to take responsibility in accordance with them. Basic concepts of public participation say that you can be effective if you do three things. Gain agreement that a problem exists. It doesn't necessarily mean that we agree on what the problem is, just that one exists. Be recognized as someone who has the knowledge to be involved in seeking solutions. In other words, earning a right to be involved. And finally, follow a process for

solving the problems that is reasonable. In other words, be fair. Do you see the connection? Most everybody agrees that there is a problem. And you can make a strong case for the legitimacy of your participation as experts in the field. If you follow the tenets I laid out before, you're undertaking a reasonable and fair process. Finally, if your actions and proposals are consistent with your values, and you want to make things happen, you'll find yourself a leader. And we need that.

George Bush once wanted a kinder, gentler America. And he was right in saying so. Ross Perot asked us what we wanted to leave our children. But neither drove it home, nor expanded the metaphor. Bill Clinton's acceptance speech touched on the relationship and mutual obligations between leaders and the members of an extended community with his new covenant. But he dropped it because the media thought it was a clunky phrase. They all seem to want to get at it, but they don't quite make it opting into a core of shared values. And that's sad. Health-care and financing reform is a watershed event in the history of our country. That, through its process, but mostly by its results, will tell us a lot about ourselves. I believe we have obligations as individuals and as an extended community to have the wisdom and courage to act in accordance with our core values. To compromise these values reduces our humanity and destroys the community we have. I refuse to be cynical. I still have faith in us, our system and these values, and believe we can and will reform health care and financing for the sake of our children, and our grandchildren. We need all of you. Please help us get it right.

MR. BRINK: Mark, I want to ask you a question. To what extent has the health-care issue really affected this election? Has one candidate or another gained ground as a result of it?

MR. MELLMAN: It's a good question. I think that it has not been the core issue that's driven this election. There's no question about that. However, people perceive a huge difference between George Bush and Bill Clinton on the issue of health care. It's on the order of a 40-50 point difference. When you say, who's more likely to reduce health-care cost, who's more likely to reform the health-care system in ways that you find attractive, there's something like a 50-point difference between Bush and Clinton, with Clinton having the advantage. Importantly it's not the issue itself. But health-care reform, health-care financing reform is a metaphor for a broader set of concerns. First of all, about this middle-class squeeze that I tried to address before. But also a metaphor for this notion of who really cares about you? Who really cares about the average American? Who understands their problems? Who is concerned about their needs? Some people say, "Clinton has a better plan than Bush, therefore I'm voting for Clinton." But Clinton's use of health-care issues, among many others, reinforces a difference that people perceive between the two candidates on the character dimension of empathy.

MR. JOHN A. HARTNEDY: I'm trying to piece together what you said. It sounds to me as though if we really do radical change, we will probably grossly upset the American people. They will be slightly upset if we do change in a piecemeal step-by-step basis. So I hear Clinton say, radical, more radical change. I hear Bush saying, we'll do less, but that's really hurt him. I'm trying to pin into an opinion on that. Living in Washington, will you comment on that observation.

MR. MELLMAN: Separate the reality from the politics for a second. The politics of this says, you have to be for change, you have to be for big change. And if you say you're only for small changes, you're going to get booed off the platform. There's no percentage in saying, we want piecemeal or small kinds of reforms. The question then is once you're in office what do you do? The fact is, I believe that Clinton is very likely to win. I'm 90% certain at this point. I believe it's about 98-99% certain that we're going to have a Democratic Senate and Democratic Congress who are going to be extraordinarily frustrated at not having been able to do anything as far as they're concerned for the last 12 years. They're going to send Democrats into Congress to look at the last Reagan/Bush years as sort of like Breshnevism. I mean it's just ossification, petrification. There's been people sitting there doing nothing for years. They are anxious to make something happen. So, I think you will see a lot of things start to happen very quickly come January. The question, of course, is exactly what they're going to do. I can't pretend to tell you I know exactly what they're going to do. My sense is there are going to be some significant reforms. And that there will be public reactions to those reforms that will require further changes in them -- reforms of the reforms. We're going to be going back and forth for some period of time before we really settle on what it is that we're going to have as a health-care system for the long term.

MR. BARLOW: The public reaction has a lot to do with the context in which we frame the issues. You know, isolation with all of the questions that Mark has asked, you get some interesting and very contradictory responses. But nobody has ever really brought them up against each other, and presented them in terms of the trade-offs that we may well have to make. No getting around it, as Ross might say. I don't exactly know what the level of public response is going to be, if that is handled properly. What do you think? You're the expert.

MR. MELLMAN: I think there is going to be one. Again it depends on exactly what's done. But I think you're likely to get a reaction, in part, because some organized interest ox will be gored no matter what happens. That organized interest will find it in their interest to go out and generate a public reaction. That's the way politics works in this country. But I think we're going to have action and reaction for an extended period of time.

MR. SCHUYLER W. TOMPSON: To quote a very old tired-out phrase, there's no free lunch. It seems to me that government money, pardon the expression, has to be involved here. I know a very little bit about the Florida plan. In Florida, they're experimenting with a health insurance program that I believe involves a substantial investment of state funds. It's still experimental, but there's quite a bit of government money in it. How can we get a program that's workable without putting in a substantial amount of money and also not burdening the small employer? It seems like Clinton's program is ready and willing to saddle the small employer with heavy costs which I don't think they're able to handle. Nobody seems to be willing to say this is going to cost money, and we're going to have to tax you to do it. Nobody wants to say that. But isn't that part of it?

MR. SUTTON: I guess I'll address this. Let me first of all say I strongly agree that without substantial funding in each state, they really cannot make much headway in covering the uninsured population. Half of them do not have incomes, and more than

half of them (60%) work for small employers who do not have the earnings or the wherewithall to purchase insurance. Experiments have shown that maybe only 5-20% of the small employers, even with the prices reduced by close to 50%, would still be able to purchase it. In Minnesota we passed a law that is supposed to spend about $250 million per year when it's fully implemented. And phasing in, even that only tends to cover half the uninsured population. It's not a very good bill because in order to be eligible for the state plan you have to drop your group coverage for 18 months -- and be bare. Or if you had individual coverage, you have to be bare for four months. So much for continuity of coverage! But it's the only way they could prevent people from massively dropping their small-group coverage where they have low incomes, and applying for a state subsidy to buy insurance at 30-40% of the cost. It's really difficult for the state to come up with the money to cover everybody. My own personal opinion, and a lot of people will argue, is that I'm not sure that the individual insurance market and the small-group market are viable as they function now with writing small groups individually or even through multiple employer trusts.

The HIPC arrangement, which is mass purchasing and can select HMOs or carriers, makes the arrangements and adjusts approximately for a selection between carriers or HMOs, is a much better approach. First of all, it would cut the marketing cost dramatically since essentially the HIPC is a monopoly and everybody gets covered through that one agency. Each one of the big carriers has to bid on an identical health plan. They can eventually negotiate other ones. Interestingly enough, if you've followed what's been going on in Great Britain for the last two years, the changes there sound very similar to that. They split the national health service into regions which already existed and allowed them to purchase services outside the national system to create competition because the bureaucracy had stifled change. No one had any incentive to do anything other than spend the minimum amount of time trying to do their best to deliver health care but did not worry about the result because they had a fixed budget. No one had any incentive to work. So I really do not see much future for the small-group business even though it will take possibly up to four years to get all this legislation in place. I see even less market for individual business although I don't think it needs to be stamped out, because individuals can still buy, can still take physical exams or whatever. Maybe it will ultimately come back, and lessen cost shifting and things like that. But originally it's going to require large sums of money in my opinion.

MR. BARLOW: The core public policy question is how do you want to share medical costs? If you agree that good public policy spreads those medical costs over the widest base, it takes you down a certain path.

MR. GEORGE CALAT: I was interested by Bruce's comments about us getting involved and the expertise that is in this room and I agree with that. I was also intrigued by what Mark just said about letting some various flowers bloom at the state level. I guess when I hear Bruce's comments about us getting involved and sharing our views to create some solutions, what crops up in my mind is, how do you do that? What's the vehicle for doing that? For example, I could foresee large consulting firms like Bruce's or others getting their people together and coming out with either solutions or criteria in which solutions would be framed. I could see the Society or the Academy or one of our organizations getting involved to help the Congress or the states develop those solutions. What typically happened, or has

been happening, is that proposals come out, and we all boo them for various reasons. We're trying to offer road maps to the various legislatures, the state and federal level, by saying, don't do this, and don't do this, but we never come out and say what they should do. Or rarely have I heard that said. I think there are people who are thinking about that and creating those road maps and criteria. But then they don't really get much attention. I think what's needed perhaps is a vehicle via the Society, or via some of the larger consulting firms to come out more publicly with those criteria and those road maps, that can help the crafters, the legislators at the various state and federal levels to develop those solutions. That's really another question, but I'd be interested in anybody's comments and reactions.

MR. MELLMAN: I think a lot of the initiatives are happening at a state level. For instance, your service area is your state and depending upon what your market share is, you are either a 900-pound gorilla in that marketplace, and in the health-care system, or you are a 50-pound gorilla, and you're probably more like a 900-pound gorilla. So the fact of the matter is, when people start talking about reform in Rhode Island, it almost becomes a survival issue for you particularly. So at that point, you better be involved. If you look at Clinton's plan, if you look at Bush's plan, there is so much wiggle room in there that you have the ability to step in and begin to craft reforms, begin to solve some of the public policy problems, as well as insuring your own survival. I would say that's probably true of anybody whether you're a 900-pound gorilla in a specific marketplace or not. There's so much gray area out there, and there's so much generality out there, that you have the ability to take a leadership role and try to make some of the things happen that will help ensure your own survival while, it would be hoped, fixing some of the public policy problems. I said I wasn't going to be cynical. But the fact of the matter is, what we advocate is taking the moral high ground. Because most likely you're going to be able to line up a lot more support that way than coming at it, quite frankly, as Health Insurance Association of America (HIAA) has. I think they've blown off their foot.

MR. HARTNEDY: I probably should have said this in my question originally. I guess another concern I have in the back of my mind is that I don't have any idea what the time frames are going to be for whatever solution comes out. I could foresee a scenario though. Maybe Mark could comment as to how realistic it might be. If Congress has this pent-up demand to do something, as Mark said, would a Democratic President (if Clinton does get elected) do something very short term, perhaps in the next 12 months. I've heard people say that significant reform is very likely. Maybe that will be the first step, maybe that will be the only step. There is the possibility some broader-scope solution might come out in the next 12 months. And then where will we be? We'll have no real chance for input in the next 12 months, unless something happens at a national level now. I agree with you wholeheartedly, that in Rhode Island, or in any particular state, we each have the opportunity to have some input. I guess what concern I have is that there's potential out there for some action, whether it be a good thing or a bad thing, at the federal level. There's not a vehicle that I personally have open to me to serve, to be able to offer some solutions.

MR. SUTTON: I'd like to add a few comments. We all seem to think the small-group reform is going to be almost universal. Both the Republicans and Democrats have had all kinds of bills and most of the states have passed some part of them. It's likely the federal government would mess it up. Because whatever version they

come up with, the federal requirements may not mesh with the laws that states have already passed. If Clinton would let each state do its own thing, as long as they did something that met the major points, it would make it simpler. I would like to second something that Bruce said, and that is, that you should participate, and I can talk about some of my experience in Minnesota. We've been working for five years to get our kind of universal health care, and it has a lot of imperfections in it. The benefit plans aren't right, the taxing system may be illegal, and a few things like that. Yet I think the people recognize, as we said before, that this is the first step, and it's going to require changes because we are feeling our way along, and we don't know what will work and what won't.

We had a governor's commission on health-care reform. I was active on that as a carrier. We had another full commission that went almost a year and a half, and I was on subcommittees trying to estimate costs and giving input into legal problems, benefit design problems and pricing selection, etc. After awhile, as long as you play it straight, you can't represent a very narrow interest and appear to be lobbying for them. If you do, no one will pay any attention to you. If you work for a Blue Cross plan which is usually the largest single carrier in each state, it's doubly difficult because it's presumed you have such a vested interest that you can't be impartial in giving an opinion. But you have to do that. It's somewhat easier for a consultant to do that, as long as some of their clients don't know what they're saying. Even if you are a Blue Cross plan, or an HMO, or an insurance company, I think you have to take a position that you're willing to consider changes. But you need to explain how your system works, and what has to be done to enable you to be a part of that. So you don't get excluded, but you have to be willing to look at the other people who have vested interests and see how you're going to help solve their problems as well. If you can't take that position, you're better off staying away. But they really do need help, and once they know that you're open, and you don't know all the answers, that you're willing to look at all sides, they really appreciate the help. You gain a lot of credibility in our industry. Our professional industry will gain a lot of credibility at the local level. It would be great if states will eventually have control. Even Clinton's bill proposes ultimately handing the money down to the states and letting them set up a system that fits their needs. So we might have a single-payer system because we're socialists in Minnesota. And we're near Canada. But some other state might have a completely different kind of a system. And those ought to be tried as long as you can get the finances. I personally think (and again I'm biased) the federal government should tax employer contributions to health care and feed those monies back to the state to let them finance experimenting with their system. Others have said the same kind of thing. That would ease the state's problem and come up with the money to restructure their system the way they think they want it.

You have a real advantage being from a small state and you should have relatively easy access to your key legislators. You probably have folks within the plan that are doing that already. At the national level the association is doing a lot of things. But to the degree that you can position yourself as a resource to your own elected officials, that is probably the best that you're going to be able to do. And quite frankly, that's not bad.

MR. MICHAEL J. COWELL: I was speaking to an undergraduate college group a couple of weeks ago on the actuarial profession, and we discussed a number of

topics. They asked me who I thought had the best health-care plan. I said you have to realize I'm not a health actuary as most people would define the term. I'm a financial reporting actuary with a disability income company. But at least I have more knowledge than the average payer. I said from my perspective none of the three. They reminded me of the three monkeys. See no health-care solutions, hear no health-care solutions, speak no health-care solutions. I said I saw chicanery from Perot, apathy from Bush, and demagoguery from Clinton. To my knowledge the only public official who has spoken with anything near the truth, and pointing out the things that Mark described, was former Surgeon General Everett Koop. Everyone wants immediate access, complete choice and lower cost. As I say, I'm not a health-care actuary, but I have studied mortality and morbidity, and why people die, and what they get sick of, from a micro perspective, particularly as it relates to the smoking issue. We all know the macro issue. We spend $650 billion on what's called health care. I personally don't think it's health care, I think it's a sort of sickness maintenance problem. Because 90% of that $650 billion doesn't go to health, it goes toward trying to get sick people well. Half of all Medicare payments are spent on keeping people alive in the last six months of their life. Not even 10% of that $650 billion goes to keep people healthy. I have a solution, I've discussed it before. It is simplistic. It does not meet your criteria of complexity, Bruce. There is only one solution to the health-care problem in this country, or any country, and that is to stay healthy. If people stay healthy, if they take a personal responsibility for their own health, and don't go running down to Doc for a pill after they've either over-eaten or smoked too much, or drunk too much, or got their cholesterol or blood pressure up high, if they exercise regularly, they control their stress, they wear their seat belts, then maybe over a long time, just like the education problem, as a solution to our productivity, maybe that 12% will gradually come down to the point that we can control it. I have to ask the question, is it fair that I, who go out sometimes at lunchtime to exercise, (we have a nonsmoking building) have to run through a gauntlet of smoke as I pass all the smokers to get through. Is it fair that I subsidize their health insurance? I'm not going to ask. I think fairness is a very fuzzy word.

I have to conclude this quickly by saying, until this issue is addressed (people taking personal responsibility for their own health), all the solutions I've heard from any of the political candidates are just so much rearrangement of deck chairs on the Titanic, and it's going down.

MR. MELLMAN: How about whole health? Has anybody ever thought of that? Would that begin to give some incentive for that? When you think about whole life, and it's a savings vehicle for retirement, when you know that you're going to need money to spend. It's also a protection against some catastrophic event. How about whole health?

MR. ANDREW DAVID SMITH: Mr. Sutton has spoken about the Clinton plan and the Bush plan, and it was said that, other than the malpractice reform, George Bush's plan would basically continue the system that we have now. I understood you to say you thought that the savings might be 2% if he got everything that he wanted. However, when I listen to what they claim, it would be a far larger savings. What I want to know is how you get your value of 2%, and how they get their number which apparently is larger.

MR. SUTTON: The 2% I got was from a study done by Brandeis University. Essentially Mr. Bush assumes that a small-group reform would lower the cost of small group automatically. The only other specific savings he cites is cutting insurance carrier administrative expense by 25%. Presumably he means in the small group and individual markets, not necessarily in the large group. Malpractice premiums amount to only about 2% of total health-care expenditures. Even if he reduces those in half, there's not a monumental saving. I don't see how small-group reform and guarantee issue are going to lower the average cost of small group since you're picking up all the uninsurable people. If you could get all the people who aren't sick to sign up at the same time, it would be a lot better. In other words, universal mandated coverage would have a far wider and better spread of risk than just leaving it wide open for people to come in when they get sick, even if they do have to wait six months before they have full coverage. There's nothing except squeezing administrative cost and the malpractice that I can see, and perhaps the vouchers offsetting part of Medicaid expense, if they give the voucher to a Medicaid eligible. But Medicaid costs might be more. In other words, the voucher might be less than the Medicaid cost for the same family. My feeling is that any savings you produce with that system are very low.