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Summary: Health care, managed care in particular, is once again in the political spotlight. Managed care, once almost universally seen as the answer to the nation's health care woes, is now being viewed in a very different light. What does the public fear? What does the public know? What opportunity does this provide to different political forces? How is it all playing out in Congress? What other health care issues are likely to become political fodder in this election year?

Mr. Thomas F. Wildsmith: First, I'd like to extend apologies from Raymond Berry, who was scheduled to be a part of this panel and was unable to attend. We are very fortunate to have with us Dr. Kenneth Thorpe from Emory University. He is a nationally recognized expert on health care issues in the U.S., and I think you will find his presentation quite interesting and informative.

Dr. Kenneth E. Thorpe: Economists and actuaries often work on many of the same issues, but sometimes we come at them from different angles. My goal is to lay out some of the ongoing health policy issues that Congress is currently dealing with. I'll talk a little bit about some state issues, but my focus is going to be on the health care debate in Washington and the issues that are largely in play right now.

Before we start with the specifics, let's start with two overarching, crosscutting issues, both of which, I think, are obvious to everybody in this room. They're important to start out with because they shape the debate in Washington, about what issues are on the table as well as whether those issues actually get resolved in this congressional session. The first and most obvious issue is that we're in a presidential election year. That always raises some really interesting dilemmas in Washington in terms of passing legislation. On the one hand, it reduces some of the interest in actually passing legislation in the current session because you don't want to undercut your candidates, particularly if you have a good issue in play that you think that you can score some political points with. As we'll see, certainly from the Democrats standpoint, what they think their strong card is in this presidential election is the health care issue, and secondarily the Social Security issue. There

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are clear divisions of where the Democratic and Republican candidates are in terms of how to approach the issues of health care and Social Security.

The second issue, which is a real wild card, actually provides some incentive to actually pass something. The estimates that continue to come out from the Office of Management and Budget (OMB) and the Congressional Budget Office (CBO), most recently in OMB's development of the mid-session review, project that on-budget surpluses will continue to grow. So it looks like we continue to, at least in the short term, slightly underestimate the size of the on-budget surplus. Those numbers are continuing to rise. They're certainly much bigger than they were at this time last year, when CBO and OMB did their projections of the ten-year, on-budget surplus projections. Again, that's a real important consideration because it is virtually impossible for Congress to, in one way or another, leave those dollars on the table, in terms of what they do with federal programs. The availability of a budget surplus creates a tremendous motivation for Congress to pass legislation, in the forms of tax cuts, new entitlement programs, new discretionary programs, etc. So there will be a real push to spend, refund, or redirect those dollars, particularly as the size of the on-budget surplus grows. That will raise some pressure, particularly on the Democrats who may want to push some substantial pieces of health care reform through. Those are the two crosscutting issues. I think, absent a large and growing on-budget surplus, what you'd likely see in a session like this is very little congressional action, but a tremendous amount of rhetorical debate about the issues, largely to set up the presidential discussions later this summer and early this fall.

What are the key issues, in terms of having a chance of passing, that are on the table right now in Congress and have a chance of passing? The first one is the issue of the Medicare prescription drug benefit. That one is very much in play right now. Let me talk a little bit about some of the key issues so you can understand the parameters of the debate, beginning with some background on the Medicare population and prescription drugs. From the best that we can tell, more than one-third of Medicare beneficiaries have no outpatient prescription drug coverage. The two-thirds of Medicare beneficiaries that do have drug coverage really get it from a variety of sources. The best source, in terms of comprehensiveness of coverage, would be Medicaid. Employment-based coverage is generally not too bad, as these things go. Some of the other forms of coverage, particularly some of the Medigap plans, can be very expensive. You're really not getting any type of "subsidy" when you buy a Medigap plan for prescription drugs; you're largely paying for almost the entire marginal cost of the drug benefit when you buy a Medigap plan, and the coverage is a little bit spotty unless you buy the most comprehensive plan. The issue there is that while two-thirds have some kind of coverage, if you look ahead five or ten years, those numbers, absent any type of changes, may actually shrink. Certainly, access to employment-based coverage is not increasing. It's not clear exactly what'll happen in the next couple of years with respect to the generosity of HMO coverage for prescription drugs. Medicaid, may not be quite as generous in the future as it has been. So I think that there is some residual concern about the stability of the access to this market for the two-thirds that actually have it today.

Let's think now about the distribution of spending, because understanding a little bit about the distribution of expenditures within the Medicare program is going to be very important to understanding how the Democrats and Republicans are dividing

themselves up on this issue. Not unlike other forms of health care expenditures, it is highly skewed. If you look at some of the CBO and Health Care Financing Administration (HCFA) projections for the year 2002, about two-thirds of Medicare beneficiaries spend, in total, about $2,000 or less on prescription drugs. Now that's from all sources, whether it's insurance paying for it or out-of-pocket. Turning this around, one-third of the beneficiaries are spending more than $2,000 a year. Of course, the dilemma is that the one-third that spends more than $2,000 a year accounts for 77% of total prescription drug spending Medicare beneficiaries. So the bulk of the Medicare prescription drug expenditures are in the tails of the distribution. Keep that in mind when we start looking at some of the proposals that the Democrats and Republicans are putting on the table.

Let's now look at the four issues that, I think, underlie the discussion about a Medicare drug benefit. The first issue that's distinguishing the Democratic and Republican proposals in Congress right now has to do with plan design. There's a very vigorous debate going on about whether Medicare should establish a maximum Medicare benefit—for instance, having Medicare pay 50% of all expenditures up to a cap of, say, $2,000 in total expenditures, thus creating a maximum exposure for the Medicare program. That's largely the Democratic approach. President Clinton, Vice President Gore, and the Democrats on the Hill have all coalesced around an approach that would do that. From a Medicare standpoint, it limits the liability to $1,000 per capita for those who are choosing to benefit from it. It would provide first-dollar coverage for people who don't have health insurance prescription drug benefits today. It would obviously be particularly helpful for the two-thirds of Medicare beneficiaries who spend less than that cap. So if you think in terms of just the aggregate number of people who would benefit from this, most existing Medicare beneficiaries would receive some type of benefit from a drug design like this.

The dilemma, of course, is what happens to the three-quarters of the expenditures that are above that $2,000 cap. Who pays for those costs, and how do Medicare beneficiaries receive financing for services like that? Well, in today's market, Medicaid pays many of these catastrophic costs already. Many of these high drug expenditure individuals are institutionalized Medicare beneficiaries receiving some type of long-term-care (LTC) services. However, there are some uninsureds who are paying a lot for their prescription drugs and aren't receiving any type of benefit payments. The Democratic approach to dealing with this is to limit Medicare's exposure by simply adding on top of the design I already talked about—a maximum benefit, an additional $35 billion that would be used to pay for catastrophic expenses to be determined and designed by the states. Now how those dollars would actually be distributed out to the states is to be left to the discretion of the Secretary of Health and Human Services, but their approach to this is really a two-part plan—a maximum benefit plan combined with a $35 billion catastrophic plan.

The Republicans on this side have gone in a different direction. Their approach, more recently, seems to be focused on catastrophic expenses and, indeed, trying to focus benefits on the 5% of individuals who really have very high catastrophic expenses. The orientation here is a little bit different; it would focus the benefits in tails. Obviously, it would benefit fewer individuals, but it would really finance the high prescription drug expenditures. One big difference is the plan design. The

Democrats have a capped benefit design while the Republicans seem to be moving a little bit more in the direction of focusing on catastrophic expenses.

The second issue is, "who is eligible for these benefits?" There is a tremendous debate in Washington about who should receive a Medicare outpatient prescription drug benefit that is subsidized, in part, by general tax revenues. The Democratic proposal would make any Medicare beneficiary who voluntarily wanted to purchase drug coverage eligible to do so and, depending on the proposal, pay about 25–50% of the underlying premium associated with the benefit that they put on the table, i.e., anywhere from a 50% to 75% subsidy of buying the plan. The Republican proposal is quite different.

Indeed, you can see in this a breach in the debate that started back in the Medicare Bipartisan Commission. Senators John Breaux (D-LA) and Craig Thomas (R-WY) thought that they had an agreement put together on Medicare reform, which, at the last moment, really did fall apart precisely on this issue of who's eligible for drug benefits. The Breaux/Thomas original proposal would have made Medicare beneficiaries up to 135% or 150% of poverty eligible for a subsidized benefit. Then, if higher-income individuals wanted to buy it, they'd have to buy it on an unsubsidized basis, e.g., pay the full actuarial value of the premium. Again, that's a real fault line in this discussion; it is difficult to see how a compromise can be constructed. The Republicans are fairly insistent on limiting benefits, or at least limiting subsidized federal benefits to those that are lower-income. The Democrats are insisting that all Medicare beneficiaries should be eligible for the subsidies regardless of income. So that's going to be a tough issue to breach.

A third issue in the debate that's going on in Washington on the drug benefit is one that doesn't get much attention, but I want to point it out to you because to me it really is underlying a lot of what's going on in terms of the Republican and Democratic debate about restructuring the Medicare program. The issue here is who administers it. This is, again, something that started in the Medicare Bipartisan Commission, but the Republican proposals have largely attempted to redirect authority over Medicare in general—and over this issue, a Medicare prescription drug in particular—to an independent Medicare board, redirecting regulatory power away from HCFA. That is a very major part of the debate that's underlying this ideological breach that we're seeing with the Republicans and Democrats about who should govern the future of this program. Should it be done by a Medicare board that has reporting authority to Congress the way that Medicare Payment Advisory Commission (Med-PAC) does? Or should it continue to be administered by HCFA the way it traditionally has? Again, that's not one that gets a lot of press attention, but it's an important ideological divide in Washington about the future of what the Medicare program should look like and how it is governed.

The fourth issue is one that, I think, has a little bit more of agreement between the Democrats and Republicans; namely, the issue of how you control the growth in prescription drug expenditures. We've all seen the underlying trends here. There is budgetary concern, obviously, that having a trend of 10–15% per year in pharmaceutical expenditures is going to be a very difficult financial issue for the federal budget. There is a lot of attention and discussion on who should actually administer this program and control costs. Traditionally, this has fallen into two directions. The old Democratic proposals and the old Clinton proposals would call

for direct price regulation of the industry—an approach that certainly in the 1992–93 floor debate wasn't well received by the pharmaceutical industry, among others. As a result of that debate, the Democrats have reshaped their focus on trying to control cost not by using directly a government pricing program, but rather by relying on private sector pharmacy benefit managers to administer the programs on a competitive basis and essentially cede the authority for the administration and formulary development to the private sector. I think with that there's a little bit more of a potential agreement about how the prices and the cost containment would be administered.

The final issue then, in terms of where the drug benefit is going, has to do with cost. Obviously, in the budget resolution that was passed in the House and Senate, there were dollars put in the 5-year budget plan in the Republican proposal in the $40-billion range, maybe going up to $100 billion over 10 years. That is not going to be anywhere near large enough to pay for a program like the Democrats have on the table. Those numbers are going to be closer to $300 billion over 10 years when you include the catastrophic pool, so we have some major financial discussions that have to go on as well to see whether a program like this could actually work. I think this will be a very key political talking point this summer and fall. Vice President Gore's plan looks very much like President Clinton's plan, and Governor Bush's plan is going to follow very closely to what the Republicans have on the table. At least in the near term, given the breach on the key issues here, I do not see an easy opportunity for resolving some of the major philosophical differences in terms of plan design, eligibility, and who administers it. Therefore, this could actually turn out to be one of those issues in Washington that is tremendous fodder for political discussions in the presidential elections this fall and may be less amenable to actually passing legislation this year. But, again, additional money in the on-budget surplus always greases the wheel and makes things that seem to be impossible sometimes possible, so keep your eyes on what those on-budget surplus numbers look like. More money always has a way of resolving even the most difficult conflicts.

The other big issue which has gotten a lot of attention and that I think will pass, in some form, is the ongoing debate about a "patient's bill of rights." Here I think the political dynamics are very different from the dynamics in the Medicare drug proposal. Most importantly, again thinking about the congressional elections coming up as well as the presidential election, Republicans know very well that this is an issue that the Democrats (at least for right now) have very high, favorable ratings on. Democrats lead by two to three times in terms of public perception of who would be in a better position of handling health care issues. It is certainly the biggest gap in the polling data on a particular issue that provides a very favorable rating to the Democratic candidates. The Republican leadership is well aware of this, and it is going all out as much as they can to make sure they pass a patient's bill of rights bill this year to take some of the legs out of that issue from the fall elections. It could be, I think, absent a resolution, a very powerful Democratic tool to beat on their Republican friends in the elections, both nationally and in congressional districts. That, in and of itself, provides a great incentive for Congress to try to pass legislation before we get too far into the give-and-take of the presidential debates. So I think there's a little bit of a hope here to pass something this session. As you know, it's in conference right now, with Senator Don Nickles (R-OK) chairing the conference committee. Going in, there was some

concern by advocates of this legislation, particularly on the House side, that the construction of the membership of the conference committee wasn't particularly amenable to passing a piece of legislation that looked like the House bill.

Where are they in this debate? There are some minor issues and there are some major issues. The minor issues, I think, can be easily ironed out. They really aren't fully articulated right now, but in terms of a decision there are at least three issues from the Democratic and the Republican standpoint that aren't fully resolved. One is the ability of patients to get a review of medical decisions outside of their health plan; what decisions would be eligible for outside review? A second issue is the constitution of the reviewers on the outside; who selects them? Are they selected by the plan or are they selected by some other authority that would put together an independent review board? The remaining issue and the stickiest to me, one that would be well-advised for both sides to pass and move on, is the issue of the circumstances under which women can get access to OB/GYNs without having approval in advance of a primary care physician. I would have thought that this one would have been put away first in the debate, but it is still very much in play. I think those are issues that are relatively easy to resolve when they get into some of the more major horse trading in the two remaining areas I'll talk about.

The first of the two real key sticking points—and these are sticking points that have always been there between the House bill and the Senate bill—is the issue of the patient's right to sue health plans and/or their employers. This is one of the major distinguishing features between the House bill, which had advocated this, and the Senate bill, which had advocated more limited liability. That one is not yet resolved. The second issue, which also is a very difficult one to come to some resolution, is scope, or who would be covered under a federal patient's bill of rights piece of legislation. In many areas of health care, the states are not waiting for the federal government to lead. This is true on the liability side, the patient's bill of rights side, and the health insurance side. The states are moving much faster, in many situations, than the federal government. In all of these areas, many states have already legislated patient's bill of rights proposals that look like some of the federal proposals in play, but, obviously, those proposals are limited to health plans and individuals where a state has jurisdiction—meaning that ERISA-covered plans and individuals are outside of the scope of those state regulations.

The debate going on in Washington is, should we have a uniform, national, federal patient's bill-of-rights set of legislation that covers everybody? One that would include and override existing state law, for the most part, and have a uniform set of requirements both for ERISA, as well as state-covered health plans and individuals? That's the House legislation. On the Senate side, the proposal is that we should largely leave the state sets of laws in place where they exist, and the federal legislation would deal primarily with just those individuals who are not currently under the jurisdiction of state legislation. So, again, there is a very major difference of approach and opinion here about how to proceed; for instance, the issue of litigation, potentially, on the employer side, and on the health plan side. Those seem to be as big of breaches as we see in the Medicare prescription drug benefit. My only sense here is how it relates to the two laws of congressional politics and budgeting. Law number one (as I see it) notes that how these issues are resolved will have very little effect on the cost to the federal government for this legislation; that is, these are not largely federal budget issues. There are some federal budget

implications of these proposals, certainly, but for the most part we're not talking about big differences in federal outlays that play into the federal budgetary discussion that is going on right now in Washington about how to allocate the on-budget surplus. So that's one thing that a piece of legislation like this has going for it. There are not big federal dollars on the table that are distinguishing these proposals.

The second thing that's on the table with this one is that I think the Republicans know that in terms of their internal polling vote that on the congressional district level, as well as the national level, that this is an issue they have to take off the table. Now this is not an issue, if I were a Republican pollster or consultant, that I'd want to have hanging around in August, September, or October for the Vice President to use in a very aggressive way against Governor Bush in the general elections, because it would be a very powerful one. So even though there's a big breach in policy, I think that fact that it's not a big federal budget issue, combined with the Republicans' need to take it off the table, will lead to a push for some final closure on this issue sometime this summer.

Let me end by talking about two issues that are going to appear on the national scene, once again, and have already appeared on the state scene. There is going to be a major refocusing both in terms of the federal effort, but also from the public standpoint, about health care costs. I think the real issue is whether or not we're going to see some slowing down, in the years 2001 and 2002, in the growth in insurance premiums. In other words, whether or not these last two or three years really just been the swing side of what we've seen in typical insurance underwriting cycles, in which case we'll see a little bit of slowing down insurance premiums in the next couple of years? Or, are some of the underlying fundamentals are just so different that the steady state of growth in premiums is going to be shifted up somewhat higher than it has been historically?

I think there is some concern about that second point, largely because of what people have seen in the last three years and what we're projecting in the next five to ten years about the growth in prescription drugs. You've seen the double-digit increases in prescription drug costs. If you look at prescription drugs now in a typical health plan, they account for anywhere from 15% to 20% of the underlying premium dollar, meaning that these double-digit increases in the pharmaceutical piece are causing, in and of themselves, 3–4% increase in premiums. That is, even if you capped everything else—steady state on the hospital side, the physician side, and so on, just the underlying trends going on—in the near term the pharmaceutical industry is putting a lot of upward pressure on insurance premiums.

The concern here is that the types of innovations that we're going to see coming out of the human genome project have the opportunity for expanding the number of therapeutic targets in the pharmaceutical industry by anywhere from 6 to 20-fold over the next 5 to 10 years. This is a cause for some concern about downstream increases in spending on pharmaceuticals. I think it's buoyed by the fact that many of these types of things that will soon be on the market are for things that we don't really treat right now, or don't have very effective medical or other types of interventions for, so they really will be new costs, rather than an opportunity for substituting for existing expenses. A good example would be slowing down the progression of Alzheimer's, something that we don't have

established therapeutic surgical or medical intervention for right now. The drug industry, perhaps within 10 to 15 years, may be able to offer a well-established approach for dealing with issues of Alzheimer's and other chronic-care diseases—approaches that are very expensive and may serve to be pure add-ons in terms of the health care bill. But that's at least the concern. So that's going to be back on the agenda.

We may also soon be faced with a downturn in the economy. We've already seen some initial signaling for some of the forecasters for next year. Certainly the last interest rate increase by the Fed has changed some of the economic forecasts that are coming out in terms of real GDP growth, real wage growth, and growth in employment. It could very well be that we have a confluence of the two bad things happening within the next three years—rising health care costs and the slacking off of the economy which, again, in terms of the public's concern about this issue, could lead us back to the discussion that we had in 1992 and 1993, which, as you remember, was when we were still coming out of a recession. Certainly some residual concerns about a recession and very high health care costs did reshape the national discussion about health care reform. There may also be an increase in the number of uninsureds as the economy turns down. Keep that on your radar screens for the next three years. I don't think the projections on the premium side are going to improve very much, at least in the near term; in fact, they could hit exactly at a time when the economy is starting to turn down. Those will be the issues no matter who is elected president; they're going to be ones that either candidate is going to have to take on and take on very aggressively.

Mr. Wildsmith: Let's talk about the pure politics of health care. Public policy is very important, but politics determines what actually gets done in Congress. A good example of this is the health care proposal that President George Bush made in 1991. A number of commentators have suggested that, in real-dollar terms, it was more expansive than what Governor George W. Bush or Vice President Al Gore is proposing, at this time, to do to address the uninsured. Since you had a Republican president and a Democratic Congress at that time, if anything, you would have expected it to be bid upwards. Even if that hadn't happened, it would seem that we had an opportunity to pass, at a minimum, the equivalent of the Health Insurance Portability and Accountability Act (HIPAA) of 1996. In fact, nothing happened. Former Senator George Mitchell (D-ME) killed the Bush proposal in the Senate, apparently because he wanted a campaign issue for the 1992 elections. It's much easier to kill things in the Senate than it is to force them through. Whatever the motivation, the politics killed an opportunity to make some real public policy changes that—if you look at the proposals that are in place today—everybody would say needed to be done. During the Clinton debate, the Democrats focused on the uninsured—the millions of people who lacked coverage. Their message was need to guarantee access to meaningful coverage for everybody. It was used to justify a substantial increase in government involvement in American health care. Choice was the reason used by the Republicans to kill it.

In the current debate, the words are absolutely flipped. The Democrats are talking about choice, and the Republicans are talking about the uninsured and the need to provide more coverage to more people. What's happening? We've entered an age of the politics of the word, if you will. The everyday process of how you "do" politics, has turned very mechanical. The key question is, "how does this phrase

poll?" The trick is to find a phrase or a theme or a message that polls well and then use it to justify whatever it is you want to do. All of the phrases that are now being used, "coverage," "choice," and the "uninsured," poll very well. The one that doesn't poll as well, "cost," (the one that actuaries and policymakers want to talk about) may or may not hit pay dirt in any given debate. Perhaps the key reason for this is that employers are the ones who see most of the cost, rather than the individual consumer. But, mechanically, if you can find a good message and secure it for your camp, then you can use it to justify whatever it is you need to do on the policy level.

I believe that at least two of the errors that the Democrats made in 1993 and 1994 relate to this. First, they let the mechanics of their public policy get ahead of their message and rhetoric. That's a very key mistake. Short of war or an equivalent national emergency, there's simply a limit to how fast the American public is willing to move. Politically, it is vital to build the support you need for your legislation before you move. Frankly, I think that's part of what's behind the Senate rules on filibustering—the rules that make it much easier to kill legislative action than to force it through by political muscle. Second, they used rhetoric that was targeting the "have-nots," if you will, the uninsured, to justify policy changes that would have affected (if you take the Republicans' message, would have disturbed) the coverage of the millions of "haves."

There are two important characteristics of the way the public is thinking about things, and this gives important background for the current health care debate. First, the public wants something more, but they don't want to give up what they already have. Second, managed care has gone a long way toward addressing the cost issue for employers, but it's done relatively little if anything to address the desire of the individual consumer to have it all to have more access, more coverage, better care. Now there's been a substantial change, as I think you can see, in Democratic tactics on health care. The defeat of the Clinton care plan was quite demoralizing, but the debate over HIPAA bought them some time on the health care issue to realize that with managed care they had a very powerful potential message. Frankly, Democrats have now taken "choice" and beaten the Republicans up with it. This is quite astute. It targets the haves rather than the have-nots, and it convinces them that they're not getting their fair share. This allows the Democrats to regain many of the people they lost in the Clinton care debate. Secondly, it takes the Republicans' key message, their words, and uses it against them, which is a very powerful political tactic.

Now the Republicans are pretty much stuck here. They've talked about the uninsured, but they've never really courted those segments of the population who don't have health insurance coverage. While the idea of covering more Americans polls well, the haves are largely looking out for themselves. Their concerns are more with their families, their pocketbooks, and how things affect them. This leaves the Republicans stuck with only their cost message, which isn't playing particularly well. First of all, it takes too long to explain. As the lobbyists I've worked with try to teach me constantly, for a message to be politically powerful it needs to be five words or less, which really doesn't let you explain complicated trade-offs. Most voters don't see the full cost of their health care coverage anyway. Economists can explain to you how ultimately the cost of your employee benefits are passed on to you, but you don't see it as a line item on your paycheck.

In the current environment, while the employers are going to see the cost, the labor market is so tight that they're pretty much going to have to absorb it because they're having difficulty attracting the workers they need.

In short, the Democrats' message is very, very powerful because they're not promising a vague new program. What they're essentially telling consumers is, "Look, you have an insurance contract. What we're going to do is enforce your contract rights and guarantee that you get what's coming to you." Ironically, I believe what they're doing makes, in many ways, the private coverage harder to provide, harder to afford, and less likely to be viable over the long term. This may be laying the groundwork for government coverage. Of course, that's something that would not be terribly upsetting to most Democrats. Please understand that I am oversimplifying the positions of the different political parties. You have to do that because there are lots of nuances and variations as individual politicians try to distinguish themselves, but even an oversimplified model can help us understand, overall, what's going on. Broadly speaking, the Democratic ideological bias is to presume the government can fix most anything. On the flip side, the Republican ideological bias is to presume that the market can fix most anything. Now the members of both parties, when elected to Congress, are in charge of what? The government. So which party has an ideological conflict with the tool they're trying to bring to bear? The Republican party. This, I think, creates some of their difficulty in finding an effective message. Whether you have a private system or a public system, there have to be controls in it. In fact, the Clinton proposal depended on many of the same managed care techniques that the Democrats are currently attacking. The core issue underneath all of this is the question, who do you trust to impose the controls on the system? Bringing things under government control does several additional things. First, it justifies your role as a legislator. You've done what people elected you to do; you've taken action to make their lives better. Second, it tends to justify your faith that government can fix things.

I think that overall, the Democrats are better at using the right words to catch the attention of voters. The Republicans—and, I think, especially the House Republicans—are having a hard time with their message. The message they were using originally has been taken over by the Democrats. The messages they're trying to use now are too complicated. Their use of them is too mechanical, and they're having a hard time getting together on the same playbook. I think Governor Bush is doing a much better job of this. He seems to understand that the voters are in the middle. Right now, Americans are comfortable and want to stay contented. There's a belief that government has a role and, in fact, in many ways government's doing OK. The voters tend to think that government could do a better job, but they don't believe that it's inherently evil. What this means is that much of the "Contract With America" language that was used fairly effectively by the Republicans in the past just isn't getting any traction because it has this overall implication that government is somehow evil and the voters need to be saved from it.

What are the Republicans' problems? First of all, their ideological bent that government cannot, in fact, do everything makes them uncomfortable on domestic issues where, quite frankly, most of the government infrastructure has been built by Democrats over the last several decades. Much of Medicare and Medicaid has been built and constructed with Democratic Congresses and is consistent with the

Democratic worldview. This puts the Republicans in a position where they have to get comfortable with the public policy infrastructure on domestic issues is such that they would have to make more changes than the public is comfortable with in order to get a system that would be entirely consistent with their ideology. Now to be fair, they tend to do better on issues like taxes, trade, foreign policy, or defense issues where you don't have the same kind of infrastructure in place.

There are three rules of politics—not public policy, but politics—as they have been explained to me by the lobbyists on all sides of the issues that I've come in contact with. First, you define the playing field; second, you take the other person's weapon away; third, you beat the other person up with it. Any two out of the three is very good. If you manage to do all three, you win. It looks as if on health care, the Democrats are coming very close to doing all three. On the patient's bill of rights, what's currently in play is number two—who gets the other person's weapon. The key issues, as Dr. Thorpe pointed out, are liability and scope. Now the message the Republicans are trying to put out is: "Look, the Democrats are willing to sacrifice all the other good things in this legislation we're trying to put together for the benefit of the trial lawyers." The Democrats, on the other hand, are trying to make their team's message appear to be: "Look, the Republicans are denying the right of Americans to go to court when someone wrongs them." Then they have a really nice left hook to add to it: "And the Republicans don't want to protect all Americans." A very smart Republican move might be to give on the scope and apply the legislation to everyone while holding firm on liability. That would disarm the "you-don't-want-to-protect-all-Americans" message while leaving in play the "Democrats-want-to-give-the-trial-lawyers-a-deal-here" message. I don't think the House Republican leadership is in firm enough control to pull something like that off.

There are a lot of developmental pains with managed care, as we're moving to better and more cost-effective ways of providing health care. One way of looking at it is that the Democrats are promising Americans that they will deal with that market developmental discomfort—all of the dislocations and pain that we're getting as we move toward managed care. I don't know what's going to happen. The Republicans, particularly the House Republicans, are vulnerable. And I think they're politically quite frightened. That's one reason why you had what's essentially a Democratic bill passed out of the Republican-controlled House. It took some very focused, very intense lobbying on the part of 15 or 20 Republicans to get the margin you needed to pass the House portion of the bill of rights. Once that critical mass was reached, you had a landslide because Republicans simply could not afford to be seen opposing this bill once it was going to pass. When they are in serious political danger and have a near-death experience, politicians tend to do what they think is necessary to survive politically. That makes things very hard to predict, because each politician's situation depends on the local politics of his or her district and what their particular challenger is saying and doing. It also isn't clear in my mind how it's going to play out in the fall campaigns. I think that in a very real sense, what's important for the campaigns is not so much what actually passes legislatively, but how the messages are framed. Right now it looks as if the Democrats are trying to frame the message that "you don't care about patients, and that's bad." The Republicans seem to be trying to frame the message that "you're in the pocket of the trial lawyers." Both probably poll pretty well. My guess is the "you-don't-care-for-patients" message is a little more powerful on the gut

level and a little easier to explain. Again, I think the public policy is very, very critical. One thing I've found, though, working in Washington, is it's amazing the extent to which politics truly drives what happens and, in many cases, trumps what you would think is very good public policy.

Mr. Ronald E. Bachman: This question is directed toward Dr. Thorpe. In looking back as to why the Clinton bill failed back in 1993–94, people were worried about having government bureaucrats handling health care, but now I think the debate's changed. While we don't have government bureaucrats, the public looks at industry bureaucrats and sees them as being no better. The other thing that's changed in the dynamics is that I think the industry has lost the confidence and support of the provider community, because they feel that between providers and patients, and that they've certainly lost the patients because of lack of access and the difficulties of the implementation of managed care. You talked about the increasing costs and the potential increase in the uninsured over the next few years, especially if the economy turns down. I'd add one more factor to that. If people start to move toward defined contribution (DC) plans where costs are shifted to the employees, it seems to me that the dynamics on the pressures grow even more. What is your belief about the changes that we might see over the next few years, in maybe moving more toward, again, the discussion around a single-payer program if Gore is elected? Also, if Bush is elected, what do you think his response is most likely to be with that kind of a growing pressure?

Dr. Thorpe: Good question and good observations. Now I think, clearly, on the cost side that there's certainly a lot of discussion in the employer community about keeping an eye on moving toward DCs. It's a little early yet, both in terms of the dynamics of the labor market today and in that the full part of the cost piece hasn't been fully manifest, but certainly three to four years out, higher costs and a little bit of a slackening in the labor market may provide an opportunity for employers to take a serious look at a DC approach—at least a little bit more frequently than they're doing today. So I think that's probably right. In terms of how the next four or five years plays out, on the single-payer side, and I know that a lot of people disagree with this, but my sense of that is that it's a non-issue at least in the next decade. The left wing of the democratic party has almost uniformly abandoned it. If you look at the two largest stalwarts of introducing legislation like this in the Senate, Senators Paul David Wellstone (D-MN) and Edward Kennedy (D-MA), neither have recently introduced a plan like that. Senator Wellstone's current plan, which is still in formulation, will not be a single-payer plan, but rather an employment-based one. It will look more like moving a little bit to the right. I guess that's a relative move, but it'll look a little bit more like some of the old Kennedy mandate programs; it is building on the employment base, albeit with a mandate built in. So I think that the extremes of the debate have been redefined and shifted to the right, meaning that in some form or another, employer and employee contributions in private insurance will remain in play.

Certainly a piece of the vice president's proposal is to build on the Title XXI program, with the expectation that states, as that program expands further up the income stream, will use private insurance. I think if the vice president is elected, depending on what happens with the surplus and the extent of the problem, he will use the Title XXI program as a foundation to expand coverage beyond parents. So, for example, to extend the same type of program that the states have already

administratively developed is very doable politically. This is a program that we have federal agreement upon in terms of the structure. We have congressional buy-in, and we have, most importantly, the governors, in many respects, moving ahead of where Washington already is on this program, extending coverage to single adults and childless couples. New York is the best recent example of a very major expansion to single adults and childless couples using a Title XXI-type framework. So, I think that will be the vehicle that the vice president would use to really start expanding coverage where the bulk of the adult uninsured problem is, which is single adults.

It's hard for me to tell exactly where Govenor Bush will go with this. He's put out a tax credit proposal. The perception of his proposals is that they are much more deftly crafted politically than are the details and the actual impact. I think they've done an excellent job of leaking out and slowly getting media attention to incremental proposals and tax credits for LTC that, when you look at them, really have a very minor, if any, effect on addressing the issue, but certainly seem to be responsive to Americans' concerns. He doesn't seem very well predisposed toward a Title XXI program. That may change; I don't know if that's true or not. It's perception. I think that he'll continue to expand on a tax-credit type of approach which, from my standpoint, I think raises a lot of issues about how you can administer a Title XXI program and a tax credit program simultaneously and whether you want to do that. But I think that they're both recognizing that this is a viable issue and an important political issue. But I don't see anything that would lead us back to a discussion about single-payer.

Mr. Dwight K. Bartlett III: Just a comment for Dr. Thorpe and a question for Tom. I met with one of the senior staff for Senator Thomas to discuss the Republican leadership prescription drug plan a couple of weeks ago, and what he told me was that, in fact, there was a substantial indirect subsidy for higher-income individuals in the prescription drug program in the form of a federal reinsurance program for catastrophic claims, and it was intended that the federal government, through this reinsurance program, would pay about 25% of all prescription drug claims, so that would be, in effect, a 25% subsidy for all individuals. How they can afford that level of reinsurance along with the direct subsidy for low-income individuals and yet have only a $40 billion price tag over 5 years? The numbers just don't seem to make sense. My question, for Tom is that you were suggesting that a political compromise for the Republicans would be to concede the scope issue. That, of course, would be one more nail in the coffin of state regulation of health insurance, and I wonder how the membership of the Health Insurance Association of America (HIAA) might feel about that.

Mr. Wildsmith: We would oppose it. On a policy level, that's not where we're at, at least not yet. I was just talking about the pure politics of it, and I think it would help the Republicans to hone their message and disarm one of the Democratic messages. I guess I should introduce this caveat: Nothing I said was intended to represent desired policy positions or what the HIAA is advocating politically. It was just my understanding of how, setting public policy aside, the mechanical politics of the issue is being worked out.

From the Floor: I have a question about the way these estimates are developed typically, such as for the prescription drug benefit. Who is doing the estimates and

are they reviewed at some point by either actuaries or other third parties who are trying to verify what's reasonable? I think people have a view that actuarial review is important.

Dr. Thorpe: Who develops these cost estimates on prescription drug expenditures? Well, the two sources that Congress and the administration uses are HCFA (the actuaries there develop the estimates for the administration) and the CBO (which uses their internal analysts). The CBO analysts are largely economists, so maybe we need to get some more actuarial input into the CBO estimates. The source of the data is, unfortunately, as inexact as the source of the data for national health expenditures. They largely rely on the Medicare current beneficiary survey, augmented by other data. There is a substantial debate that is going on between OMB and CBO and others about the extent to which the current beneficiary survey undercounts drug expenditures, particularly among the institutionalized population. The belief is that there's a very serious undercount there, as well as an undercount of drug expenditures among those who are not institutionalized. If you actually tried to take my $2,200 per capita estimate of current law drug spending in the year 2002 and trace it back to some data set, you couldn't directly do it because there are, as my friends in HCFA and other places tell me, actuarial judgments that go into augmenting and changing some of the underlying estimates. But they're there for anybody to go in and take a look at. I know certainly that in the pharmaceutical industry, actuaries and others have taken a close look at the numbers. I don't think that they're too far out of line with the range of HCFA and CBO and their sets of projections.

Mr. Wildsmith: To be fair to the CBO, while I don't believe they have actuaries on this issue, on other issues in the past it has brought in consulting actuaries from time to time.

Mr. William R. Jones: It seems to me that the employer community probably has the most to lose with the right-to-sue provision in the patient's bill of rights. I'm just wondering if they have begun to really coalesce around a message of some sort that this provision might have a major impact on benefit plans and what they would be willing to offer in the future.

Mr. Wildsmith: I think they have, but they're not pushing it very aggressively. Part of the reason, I believe, is that in the current tight labor market, making their health plans more expansive is something that's happening right now. The other reason is, I think, that what they're trying to do on a lobbying level is much more subtle. They seem willing to take the average cost increase that would result if the health plan can be sued. What they want to avoid is the employer being sued directly. So my impression, of what they're trying to do with their targeted lobbying is to fix the language so that health plans can be sued but not the employers that sponsor the plans.

Mr. Scott M. Snow: I deal a lot with HMOs, and what we've all seen over the last three years are annual premium increases in the 10–12% range, not that many years after everybody said we'd never see double-digit rate increases again. Of that 10–12% rate increase, about 4%, as was mentioned, comes from prescription drug coverage. I'm talking about HMO coverage for the under-65 population, particularly as it relates to small groups with less than 50 employees. In this

market we've seen a gradual watering-down of the drug benefits where, about a year-and-a-half ago, some companies started to introduce a fourth tier of drugs not covered and, all of a sudden, instead of having 4 drugs on that list, you have about 200. We also have much higher copays. Many HMOs in California have $500 maximum annual benefits for drugs. They may also throw in a $100 deductible for drugs with 80% coinsurance. Basically, it's an illusory of prescription drug benefit. I was just wondering what the political fallout might be if and when HMOs start to actually drop prescription drug coverage for small groups. In my opinion, dropping drug coverage has to be, economically, a strong possibility to keep premium rate increases at a reasonable level, and to keep insurance affordable to the small group.

Mr. Wildsmith: Just to start, I think that this is complicated politically by the debate over the Medicare prescription drug benefit. One of the reasons Congress is having a hard time coming together on it is they're facing the same cost considerations. If Medicare already had a prescription drug benefit that was fairly generous and, in a time of surpluses, Congress was able to continue that benefit, I think what you're talking about would be politically much more powerful. I don't discount its power, but while Congress is struggling to come up with the money for a fairly limited drug benefit, it's going to be a little harder politically to make an issue out of the erosion of private-sector drug benefits.

Dr. Thorpe: I think the other thing that's going to be important—this is something, I think, both for actuaries and researchers to get into—is trying to make the case, or at least understanding what the case is, for whether the 10–12% increases in prescription drugs is truly adding to your underlying trend in per capita health care expenditures. Certainly, the pharmaceutical industry wants to make the case that higher drug costs are substituting for existing dollars that would have otherwise been spent in terms of longer hospitalizations, more hospitalizations, increased physician charges, and so on. You really almost have to get to a case-by-case examination of whether or not some of the drug innovation that's coming through is reducing the cost of treating asthmatics, diabetics, those with cardiovascular diseases, and so on. A case can be made that you can't simply look at the trends in the drug piece without looking at the underlying trends elsewhere because, I think, in the best of all worlds, a lot of it is substituting for other types of expenditures. I think that's an important question for us to address and have an understanding of before we go and try to address the drug industry individually from other types of health care expenditures, when we don't really understand how it's actually fully playing out in the treatments of some of the underlying diseases that they're designed to treat.

From the Floor: My question is about the patient's bill of rights. It appears that it may be somewhat of a distractive piece of legislation and, potentially, a pretty detrimental piece of legislation. It seems like it's kind of a phony issue in that we have employer-sponsored health care moving quite well. The economy is going extremely well, but the real issues of affordability and accessibility don't really seem to be addressed. Affordability will certainly be hindered if we have more mandated benefits, restrictions on providers, and litigation increasing the cost of the overall plan. I just wanted to get your general thoughts on that issue.

Mr. Wildsmith: I believe that increasing costs, together with the more than 44 million Americans who are uninsured, constitute what is perhaps the most important challenge facing the American health care system on a policy level. Having said that, you should not underestimate how real these issues are politically. They're giving the Republicans in Congress fits, and there are people who may lose elections as a result of it. That's as real as anything can get in politics. On a policy level also, there are two issues. One is, can everybody get affordable coverage? The second issue is to say, OK, once people get coverage, is it the coverage they need? I think it's fair to characterize this as a second-tier issue from a policy standpoint, because having great coverage doesn't help if you can't get the coverage to begin with. But it is a legitimate issue. I think that one of the reasons that it resonates so well politically is that it allows politicians to speak to the haves as well as the have-nots.

Dr. Thorpe: Yes, I'll just add to that by reminding us where we were in 1992 and 1993 and how we got here with this debate. In 1992 and 1993, we still probably had about 50% of the population in some form of fee-for-service plan. That had some management associated with it and so on, but it was largely either an indemnity-based plan or some type of fee-for-service plan. Thereafter we went through a three- or four-year period where we basically took a third of the working population and moved them into managed care—a very substantial shift by any measure. That was the first point. The second point is that the people who were shifted into managed care were those people who liked fee-for-service plans, and they chose fee-for-service plans for a specific reason; they wanted freedom of choice, and they were sticking to fee-for-service plans. They weren't the early migrators to managed care. The third factor to keep in mind is that most people at that time had choice of many plans. Not 20, not 50, but they certainly had choices of 3, 4, or 5 plans that were very eclectic: fee-for-service, PPOs, point-of-service, HMOs, and so on. That changed with the shift to managed care. Consumers, for the most part, were now dealing through their employers with only one vendor who was offering one or two varieties of plans. That was a very important transformation, because if you look at the people who are objecting most to what's going on right now, in terms of having freedom of choice, it's as much because they only can choose from one or two plans which are either managed or "managed-lite." These are not the same types of choices that they used to have before, which had a very heavy sprinkling of managed care plans. If you look at—and I think it's very telling—the polls of employees in private-sector health plans that are sponsored by large employers, and stratify that by how many choices of plans they have, and then look at something like the Federal Employees' Health Benefit Program (FEHBP) and the plan satisfaction there, (again, this is just classic selection and sorting); the people in FEHBP who are in managed care programs like them. They like them because they had the choice of going into them, or into the Blue Cross standard option, or into something else that was less well-managed. The people, obviously, in the standard option plan, generally like the standard option plan. The choice piece of this, in terms of the restriction of the number of plans, has as much to do with the underlying malaise here as the patient's bill of rights discussion, in terms of managed care. What the public is saying is, "Look, employers, if you're only going to give us two plans, the median plan is not going to be heavily managed; it is going to be slightly managed and hardly managed. So they're going to redefine the debate in terms of what the two choices are, if there are only two choices that are being made available.

Mr. Bachman: Dr. Thorpe, this is a cost question. You've sort of crossed over in your career between the economic modeling and some of the actuarial areas—those gray areas you talked about previously. In most of our traditional actuarial models, we recognize geographic differences. Rural areas have, historically, had lower cost and lower utilization in many areas. But it seems to me that as we move forward, the "local standard of care" that rural areas might have received previously is going to change as we are now on the Internet and consumers, regardless of where you live, become aware of best practices. They're just as likely to get on the Web site as to go to their local community hospital and accept maybe a lesser standard of care than what they historically have had before. So, I guess, the question is, how do you see that impacting cost as this lower-cost area, historically, now begins to recognize and access a much higher cost that might be part of more sophisticated levels of care?

Dr. Thorpe: Well, I guess part of the answer depends on what happens in the higher-cost areas, using the same type of logic and the same type of underlying forces. I think you're right that as you look at the landscape out there, in the next five years, many consumers are going to be directly tied into their physicians for receiving medical care treatment, whether it's prescription refills, medical care advice, care plans, and so on. That could lead to—I wouldn't call it more standardization, but it's certainly going to lead to different influences in terms of care processes in areas that traditionally have not had access to those, either in terms of the Internet or others. I take that, though, as a positive tool. My sense is that if the managed care industry, for the reason that we talked about today, five or ten years from now is in a position to really provide a viable product to the employers, they're going to have to come up with a different set of tools for managing health care benefits than they've used historically. I say that for two reasons. One is that the tools that they've traditionally used to manage care are largely going to be (not completely, but largely) redefined both by state and federal legislation through the patient's bill of rights. A lot of those traditional tools are going to be moderated if not outright legislated out, meaning that the industry's going to have to figure out a different way of attacking this problem, other than looking at discounts and deploying some of the traditional tools they've used. I see this as an opportunity, both in terms of understanding and focusing on what are the most cost-effective, best-practice ways of treating asthmatics and diabetes and cardiovascular diseases, in a way that really tries to provide an integrative view of managing benefits. We talk a lot about this, but in reality we do relatively little. We have some disease management programs and pieces that are in play, but I think the tendency, too much, today is still the focus on the pharmaceutical benefits and trying to manage it, as well as on negotiating discounts with hospitals. We're going to have to look horizontally across the care pattern. I think using the Internet is a tremendous tool and a tremendous opportunity, not only in terms of the cost of administering things, but to effectively manage the treatment of diseases such as diabetes. So will it increase costs in some areas? Perhaps. I think if it's used effectively by physicians to manage their practices in alliance with managed care plans, it has great promise for providing more cost-effective care. Notice I didn't say cost-reducing care; I said cost-effective care, which is ultimately the standard we want to look at. I don't think anybody is going to be concerned if we spend 5% more on health care if we're getting 6% more in terms of benefits. That's the case that has to be proved, and I think that refocusing the attention in the managed care

industry away from individual elements of the benefit package and negotiating those on a price basis or on a discounting basis, and into understanding how we treat people effectively, and getting into some of the longer-term investments in terms of modifying risk behavior and prevention, has to be the shift and the direction that we take.