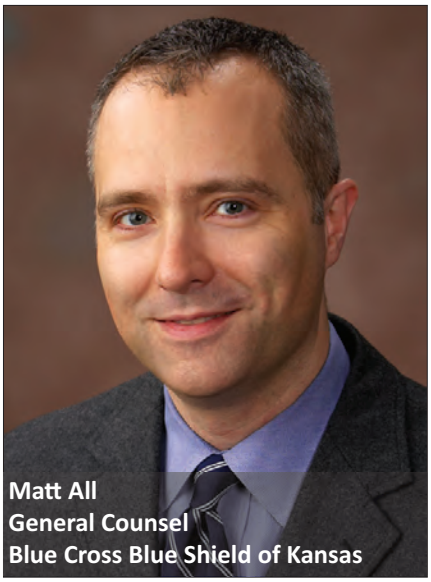
Wednesday Luncheon

Our Health Care Quandary

Editor's note: This article is condensed from the presentation made at the Wednesday luncheon, March 31.

I grew up in the metropolis of Augusta, down the road. My family comes from towns like Stockton, McPherson and Altoona. And I'm proud of that heritage. And although the state of Kansas is changing, we are fundamentally, culturally, economically, a rural state. We could not retain that heritage without all the things that you do. And so I want to begin by saying, "Thank You" for that.



Matt All
General Counsel
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I've had the opportunity to work on health care and health care policy at different times in my career. That has been a real privilege as it is obviously very important to us and our families, that we live a good life – and to our economy.

I have become very passionate about this issue over the last year, as I've tried to get the new health care law implemented here in Kansas with Blue Cross Blue Shield of Kansas and just as citizens of the state. I wish I had good news for you, and that I know what's going on in health care right now. But what I hope to do is raise your consciousness about the nature of the problem that we have in health care, what the health care law might do, and really to start to think about this in a different way. I want to discuss our health care quandary.

We spend twice as much per capita as any other industrialized nation on health care. We are not twice as healthy.

Our health care quandary

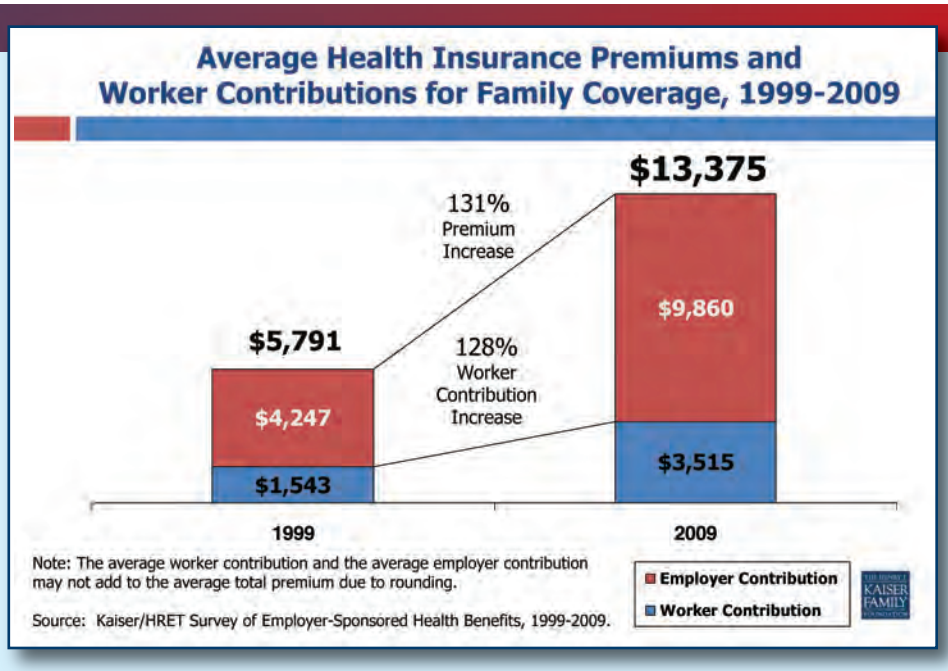
The word "quandary" is one I use on purpose because the word "problem" doesn't quite seem to cover it. It's more than just a problem. Sometimes you hear about the health care crisis. I don't think crisis is quite right. I am calling this a quandary because what it suggests is that this problem is puzzling. And it's hard to know how to get out of it. I hope to convince you this is a puzzling problem. The easy stories you might hear how we might solve this, whether it is from one party or the other, one interest group or another, are misleading. It is going to be very puzzling and difficult for us to fix as a society.

So what is the problem? The core issue is that the health costs – the amount that we spend on health care – what we spend on hospitals, doctors, pharmaceuticals, equipment, – all that kind of stuff – are rising at an unsustainable rate year after year.

And it's been doing that for decades. What I mean by rising is that what we spend is rising faster than prices in the rest of the economy, faster than the consumer price index, and it's consuming more of the economy year after year. The health care sector is growing faster than the other parts of the economy. And we cannot go on like that forever.

It would be one thing if we were getting more out of it. We spend twice as much per capita as any other industrialized nation on health care. We are not twice as healthy. We are not getting twice as much out of our health care system. It's just more expensive.

I believe this is the most important domestic public policy issue of our time. We can probably come up with some new global issues – terrorism, nuclear proliferation, and the environment – things like that are more important because they really threaten our existence. But as far as domestic issues, this is the most important one. And that's because it is becoming unaffordable for families. Every time you get your bill for health insurance, or expenses, it's likely more expensive – and sometimes by a lot. So it's becoming harder for families to afford other things.

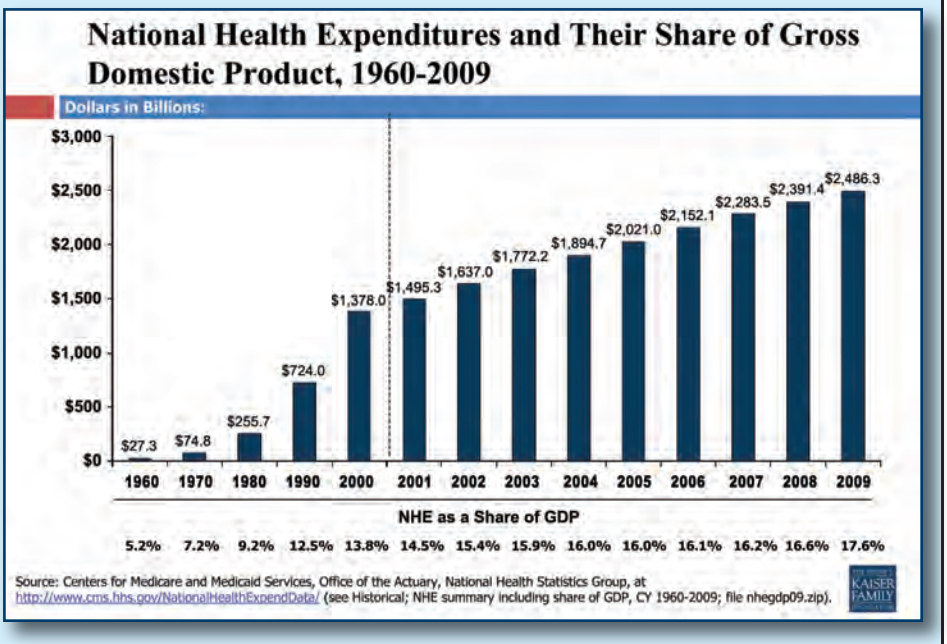


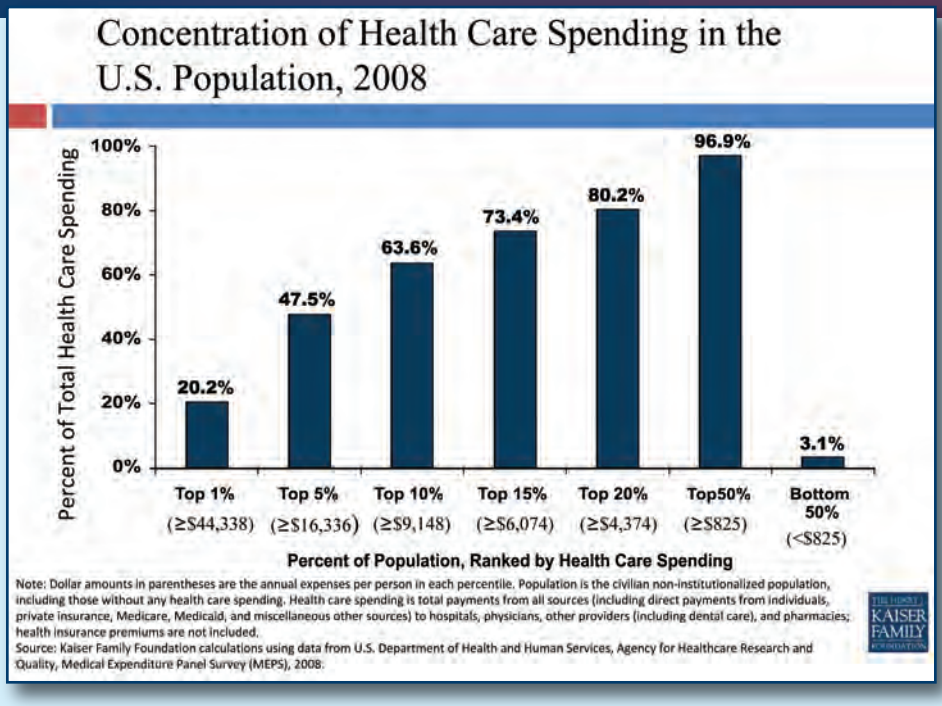
The best journalism that I've heard on health care reform came from an unusual spot back in 2009. It was a public radio program called *This American Life*. They had a two-part episode on health care reform right in the heat of the health care debate. I downloaded it, went to the gym, put on my earphones and as an insurance guy, was expecting to get hammered by this story. But instead it was a really clear-eyed, honest, concise, careful look at health care. The first voice you hear on that program is a guy named David Frum who worked in the Bush White House. What he said was that during the Bush years, if you assume away the financial crisis up until about 2007, were the worst years since WWII for the growth of family take-home income. Families on average were actually taking home less at the end of those years than they were at the beginning. And yet, employers were paying twenty-five percent more per worker. It is twenty-five percent more expensive to hire somebody. All of that went to health care. Which means, it's harder for employers to hire more people. It's harder for employers to invest in other things. It's drowning out other things in our economy. And again, we're not getting more out of it.

It's also the primary cause of our federal deficit. There's a lot of useful debate going on in Washington now; you hear it on the news about cutting spending. And we should cut all we want in what they call the discretionary budget. But if you look at the two main causes of our long-term deficit, which really threatens future generations to live the kind of life that we have been lucky enough to live, are social security and the federal health care program. Social security is actually relatively easy to fix. You can adjust the retirement age, or shift this or that around – and you can fix it for many decades to come, as far as the eye can see. Health care is different. Health care is different because demographically, it's upside down, but more importantly, health care costs – what we spend on health care every year, increase every year and we don't know how to fix that yet. It's unsustainable. And unless we fix that problem – unless we figure out how to spend less on health care, we are not going to fix the long-term federal deficit problem. This is an economic, national security issue for us.

To give an illustration of what I'm talking about, the above graphic "Average Health Insurance Premiums" shows a ten-year snapshot: 1999 to 2009. The average premium more than doubled. Contributions by employees also more than doubled. In 1999, we were spending less than $5,800; in 2009, we were spending more than $13,000.

And as you can also see in the graphic below, entitled "National Health Expenditures", it's consuming more of our economy. Back in 1960, we spent about five percent of our national economy on health care. By 2000, it was up to almost fourteen percent; in 2009, it was almost eighteen percent, and it's probably going to consumers about one of every $5 we spend before long.





Now what you need to understand about health care expenditures is that we are not talking about the average consumer who is spending all this money. We have a lot of competing sources out there saying that if you just give an incentive that when someone has a cold that they not go to the doctor, that'll take care of the problem. Well that's not what we're spending our money on. The graphic "Concentration of Health Care Spending" shows us that the top one percent of health care consumers spend about a fifth of our total health care expenditures. About five percent spend almost half. About ten percent spend almost two-thirds, and the top fifty percent spend almost all of it. From your average health care consumer on down, the least expensive half spend about three percent of our health care expenditures. So, what that really means is that what we are spending our money on is very expensive therapy, very expensive treatment for chronic disease, or serious illness and at the end of life, and sometimes at the beginning of life. And the reason for that is important. Some of the easy answers are about giving someone the incentive to not go to the doctor. "That's fine, that's good, exercise a little more, that's great – that's important..." but what we are really talking about are the moments when people are really sick chronically or seriously ill. And we all want those kinds of expenditures for ourselves and for our family. My point is that this is going to be a difficult problem to solve because it affects our basic values.

Now, you may think that health insurers would love for this system to go on – that everything will be great if we can just kick the can down the road. But that's not true. We are actually right in the middle of this and we understand that we're the ones paying the bills to the doctors' offices and we're also the one handing the insurance bill to the consumer. And we understand that this is unsustainable. Even before the last presidential election, the insurance industry was sounding the alarm bell that we need to do something to change the way health care is paid for. The other thing that I think is important to say is the dominant political narratives of both parties right now are really both beside the point. You've got one party that is saying that the Health Care Reform Law is a government takeover of health care – and there's been some talk about death panels. That's not a reflection of reality. This is not a government takeover of health care; it will still be largely a private system compared to other countries. And then you have the other party saying that there are just a bunch of bad guys out there, some bogymen who just want to make a lot of money. That's not true either. The nature of the problem is different than what either party is saying or what you're hearing about on cable news.

Health care is expensive because we reward health care providers for giving more care and more expensive care.

Here's why health care is expensive. Health care is expensive because we reward health care providers for giving more care and more expensive care. The system is set up primarily on a fee for service basis. So when you go to the hospital, they get paid in general for how much they do. First of all, it drives volume, so your health care provider is going to do more than they might otherwise. But there's also somewhat of an arms race out there by health care providers. There is a medium-sized hospital not far from here that has purchased a piece of surgical equipment called the "Da Vinci machine." That sounds really exciting and it apparently does a wonderful job of helping surgeons perform surgeries. But it cost more than a million dollars! And it costs several hundred thousand dollars a year in maintenance. And if you make that kind of expenditure, you've got to drive volume through it. You've got to find a reason to use it. And so, all of us are paying for that. I'm not blaming the health care providers because when you and I go to the hospital, when you and I go to the doctor, we believe that more care and more expensive care is good for us.

Personal example . . .

I have an eight-month-old baby. Healthy, wonderful experience, everything is great. My wife and I went to our baby doctor. We love her; she's wonderful with a great bedside manner, a wonderful person – and we know we are ten weeks pregnant. We go there and there's a very happy examination. We hear the heartbeat; we are all excited. And the doctor says, "Well, I think you're showing a little larger than I would expect at ten weeks. Would you like to have a sonogram? So? Of course. A sonogram when you are pregnant is a wonderful experience. If you've been there, it's an emotional experience; it's great.

So we're at this clinic connected to the Lawrence Memorial Hospital. And I know a little bit about the hospital and so when they said sonogram, I assumed that we'd go down the hall, around the stairs and go to their sonography clinic and use that one. And there would be economies of scale because lots of doctors can use it – not just this one clinic. Well, guess what? This clinic has invested in its own sonography equipment. They have hired their own sonographer – which is a good business move because there was an appointment ten minutes later. We didn't have to go down the hall; we didn't have to go down the stairs. We didn't have to use the sort of impersonal hospital setting. It was right there in the comfortable clinic where we already were. And if you were happy and comfortable and you saw the little baby on the screen, it was great – tears and everything .. and 97.2 percent of my brain was right there. "This is wonderful; I'm glad this has happened." The small insurance person inside of my brain was thinking, "I'm not sure that was necessary – and furthermore, this is a lot more expensive than it might be if we were using the hospital's equipment.

And so, it was a good business decision by that doctor to make it a better experience for us. That's part of it. But the reaction that we had as consumers was that it was good for us. The other thing is that health care is expensive because of our behavior. We as a society are heavier than we should be, we have more diabetes, we have more heart disease; we don't exercise enough. That adds into all this.

So my point here is we're not dealing with bad guys; we're not dealing with people who are doing something wrong; we're dealing with people who are doing what's right for their business whether it's a hospital or a doctor's office or a pharmaceutical company; they do what they think is right. We have consumers who do what they think is right – and it makes it more expensive every year.

A summary of the Health Care Reform Law

The President signed the Patient Protection Affordable Care Act after a long drawn out soap opera of politics on March 23, 2010. It is written in general terms and so federal agencies have issued a mountain of regulations to start to implement it. They have to. One of things that my colleagues and I do is sort of stand in the ready position for the next regulation and we read it and try to make it work.

As you know some states, including our's, have sued to have the law declared unconstitutional. We're still working to prepare for implementation and there are two and one-half waves of reform. The first wave you may have already experienced. This implementation was for plan years after September 23, 2010. If your plan year began, e.g., on October 1, you've already had this implemented. It doesn't come up until April 1 if you have not seen this in your policy yet. It's basically a series of product enhancements. It increases the amount of coverage that you have in your policy. There are no pre-existing conditions, exclusions for children – adult dependents can stay on your policy until the age of twenty-six, a restriction on decisions which is sort of an after-the-fact cancellation of the policy. There are no lifetime limits; there are phase-out annual limits so eventually there will be no annual limits on your policy, and there are added benefits for preventive care. Which is great! That's good; it does cost some money. Not as much as some of the horror stories that have been told. But it is an expansion of coverage. So we have to understand that. Which changes you get depends on whether your policy is grandfathered, which has nothing to do with your grandfather or your grandchildren. It was part of the President's pledge when he was putting this law forth that if you liked what you had, you can keep it. The policies that were in effect March 23 when the law was signed do not have all this stuff in it. They have some of the changes. I made a chart one time to show what changes were in and not in; there is not enough space here to go through that. You'll get some but not others if you have a grandfathered policy.

Now there is this middle half-wave – two big things that are going on. There is a new rate review process. The federal government can become more involved whether premium increases go into effect or not. It's meant to deter what the statute called unreasonable premium increases. What the regulation says is that when they draw a line at ten percent and if your premium increases more than ten percent, it is subject to review. They basically use what is described as the state's system unless that is ineffective and then the federal government gets involved. So if rates are found to be unjustified and you still use them, then there is basically a penalty of a public shaming process where you have to post your justification on your Web site for three years. That is literally what happens to you. That's sort of an interesting little nugget in the law.

Another issue you may have heard about is the medical loss ratio. What this does is requires insurers to spend a certain percentage of the premiums on medical claims or activity that promote health care quality. And if they don't, they have to pay a rebate to consumers. So if your health insurer doesn't meet these loss ratios, you'll get a check in the mail for fifty-two cents or whatever it happens to be. The ratio is eight-five percent for large groups, and in Kansas large groups are more than fifty employees. And eighty percent for individual policies so if you are out there on your own single policy, and for small groups, which in Kansas is two to fifty employees. There are a lot of definitional issues such as what is quality and what isn't. There are regulations that we are still combing through. I'm happy to say that our company well exceeds those ratios. We tend to run a pretty lean ship. You will not likely be seeing that $0.52 check from us.

The final wave is where the fundamental changes really begin. They begin in 2014. This is a set of fundamental and important changes to the nature of insurance. What it's meant to do is change consumers' and insurers' relationship with risk. Right now, insurers, particularly in the individual market place, because they have to, evaluate how risky you are, just as all insurers do. This is true about your auto policy or anything else. This is going to change in the new marketplace. I'll describe how. It's built around mandated coverage, which as you know is a very controversial issue, subsidies to make it affordable and new insurance rules in the new marketplace called the health insurance exchange. Let's go through the elements here.

One of the ideas is to get everyone in the marketplace. So there is the individual mandate, which is subject to the litigation – an employer mandate for large businesses, not for small businesses, and guaranteed issues. So, you got to have insurance it says in the law; if you don't you have to pay a penalty. And the insurers have to give you the insurance. They cannot deny you.

Now the mandate is a really controversial issue. The reason that it is in there, is that the people who wrote this law, and we happen to agree with this as a company and an industry, it's important that something called adverse selection. Adverse selection means that if you can get in at any time, and get a policy guaranteed, then a lot of people are going to wait until they need it. They are not going to pay premiums when they are healthy; they're going to wait until they get sick and then they are going to sign up for coverage. That passes along their costs to all of us. So we need everybody to be in the pool. The mandate is the most obvious way to do this. The problem with the mandate that is in the law right now is that there is a very meager penalty; the first year it is only $95. If you are twenty-seven years old and it costs you $7,000 to insure yourself and your family, you might very well say that I'm just going to pay the $95 at the end of the day and I'm not going to sign up for it. So it's not a very strong penalty. The other thing is that no one can be excluded because of pre-existing conditions. We cannot rate anymore on the basis of your health. We're all going to have essentially the same rates with few differences. There's a very narrow band on age, smoking, and there's some geography we can use for family size but basically, we are going to be in a community rating setting where we're all going to have essentially the same rates. That's where Blue Crosses began; we began with a community-rated system. That worked pretty well. When the for-profit companies came along a lot of that changed. So it's going to go back to that. The big difference in the way health insurance is sold today and how it will be sold in the new marketplace is the health insurance exchange. The idea here is that there is going to be a Web site that you go to, particularly at the beginning for the individual and small group market, and you're going to enter a little bit of data about yourself and you're going to get a series of options with the rates. Each state is supposed to set one of these up. Kansas Insurance Commissioner Sandy Praeger has asked us and lots of others to help think through how this exchange ought to work in Kansas. The idea behind this is that the people who wrote this law think it is very difficult for anyone to go out and shop price compare for health insurance. This will help people do that. There are also subsidies. We can give someone a policy but if they can't afford it, then that's a problem and so they have subsidizes and they go all the way up to four hundred percent of the federal poverty level. That's a lot of people in Kansas. That gets all the way up to the $88,000 mark for a family of four. There is also a big Medicaid expansion so for a lot of people not currently qualified for Medicaid will be qualified.

The big difference in the way health insurance is sold today and how it will be sold in the new marketplace is the health insurance exchange

So, alright, what's this going to do? First, in my opinion, I think it will expand coverage. I think more people will be covered than there were before but it will not make it universal. There will still be people who will not be covered. It might make it easier for some consumers to shop for insurance. If the exchanges are done correctly, the exchanges will make it easier to price compare, to shop around and see what policy is best for you. It will probably allow the sick and poor to get coverage more easily. It's pretty tough if you are poor or sick in today's economy, in today's health care market, to get coverage. It will probably lower the net premium after subsidies for those same kind of

consumers. It however will probably increase costs to many others to the extent that people aren't covered now are relatively safe. Those folks are going to be in the pool because of the modified community rating system. Like I said before, we're all going to be in the same pool. It is very likely with more generous coverage that many of us are going to pay more for health care.

But here's the point that I really want to get across. By itself, this statute is not going to fix the core problem in health care, which is that costs are going up year after year. It is not likely to stop the rise in health care costs. So what does that mean? What I'm here to tell you that real change is going to be difficult. Because of what I stated before, you've got people who are doing the right thing for their business, we have people like us, -- like me, like you -- who are doing the right thing for themselves and their families when they go to the doctors' offices and hospitals. You're not going to turn down care that you think is the best when that initiative is offered to you. You've paid your health care premiums and you assume that's better care. But the data doesn't suggest that. More care and more expensive care really isn't very well correlated with better health habits. It really doesn't make you healthier. But we assume it does. And so we're going to have to change the way we pay for health care. We're going to have to change the way we pay doctors and hospitals – less on a fee for service basis and more on a quality outcome. More about how they make you better – whether they make you well or not. What that means is that you and I are going to have to change our expectations and our assumptions about what is good for us in the health care system. We're going to have to question that very natural instinct that we have when we go to the doctor that if we don't get the best care – if we don't get that Da Vinci machine, that we're not getting good quality care. It's not always the case – it's often not the case that the newest or the stuff that was just created is the best kind of care.

The other thing is – and this is real change – if we're going to get together as citizens to change this is going to take years, if not decades. And it's not something that we are going to be able to fix quickly because it is one-sixth of our economy, it is very complex, lots of different doctors' offices and hospitals are going to have to change the way they do business.

View from the balcony of Exhibition Hall, Wednesday, March 31, noon luncheon with 1,200 in attendance.

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So here's what I'm saying to you. What I'm asking as fellow citizens is to work with me, to start asking more, from our leaders and from our media about the true nature of this problem. We have got to start having an adult conversation about health care, about the true nature of the problem if we're ever going to solve this. And so that may mean we have to turn off cable TV, we've got to start talking to each other in a different way than we are right now in our political world about health care particularly. It's going to be difficult but I think we're going to get it done. It's going to take a long time. It's going to take some change. There are going to be people who are going to resist it and I understand that. We have to fix it, because as I've said before, it's crowding out other things; it's harder for you to afford other things in your life; it's harder for you to hire people in your business – and we're not going to solve our federal deficit problem unless we fix this.

I am very grateful to have this opportunity to provide this address. I am very passionate about this issue. I love my state; I love my country. And I think this is the biggest challenge we have to maintaining our prosperity in the coming decades.