October 23, 1991

TO: Senator Dole

FROM: Sheila/Vicki

RE: Blue Cross/Blue Shield Speech

You are scheduled to address the Blue Cross\Blue Shield executives tomorrow morning. The group will be made up of their state plan presidents and their government relations directors. I spoke to the government relations staff this morning as did Debby Steelman.

The Association has been actively trying to put together a proposal to address comprehensive reform as well as reforms in the small group market. As a general matter they support mandating larger employers to provide coverage to their employees and to help pay for it. Small employers must offer coverage, and if they choose not to contribute to the cost of the coverage, they would have to pay a "tax" which would be less than the actual cost of coverage. The funds from the tax would be used to help employees buy coverage on their own. This is clearly a variation on the Democrat's pay or play plan -- but not as economically destructive to small business. They ought to be congratulated on joining in the debate and putting forward a proposal.

On a smaller issue -- they have also put forward a proposal on reforming the small group health insurance market. This issue, which Senators Bentsen, Durenberger, and Chafee are also interested in addressing, deals with a number of proposals designed to make insurance more affordable for small business. The provisions include limits on how large premium increases can be; mandates that require insurers to take everyone that comes to them; limits on pre-existing condition exclusions; and requirements that plans be renewable at the option of the employer, except in cases where they have failed to pay their premiums. Blue Cross\Blue Shield would prefer that the states put these requirements into place, while we generally prefer the Federal government, so there is some similarity nationwide.

Ultimately, I think we can agree on a small group reform package. The question is whether we can do it without having to take on the full reform debate, which is unlikely before the elections.

You are likely to get questions on :

1. When will the Administration put forward a plan?
2. Will we see major reform before the elections?
3. Will you (Senator Dole) support the Bentsen small market bill? (I would answer that you're reviewing it and have not yet decided -- major provisions very similar to the Durenberger bill look good and we have to do something to improve coverage of employees of small businesses.)

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COMPREHENSIVE HEALTH CARE REFORM: BCBSA POSITION

Position: In September 1991, the Board of Directors of the Blue Cross and Blue Shield Association unanimously approved a comprehensive health care reform strategy. This strategy has three broad goals: 1) universal coverage, 2) portability of coverage, and 3) affordability of coverage.

- **To assure universal coverage,** large employers would be required to provide coverage to their employees and to contribute to the cost of premiums. Small employers would be required only to offer coverage, but those that did not contribute to premiums would be assessed an amount that would be used to help their employees purchase private coverage. The amount of this assessment would be less than the cost of coverage. Working individuals would be required to accept employer-based coverage. Non-working individuals would have incentives to purchase private insurance and those that could not afford private insurance would be covered under an expanded Medicaid program.

- **To assure portability,** coverage gaps that can occur when people move from one job to another would be eliminated. For example, waiting periods and exclusions for pre-existing conditions would not be needed under a system of universal coverage. Private market alternatives to current COBRA coverage also would be explored.

- **To assure affordability,** incentives would be created for employers to contract with insurers that can demonstrate their ability to contract for high quality, cost effective services. Other recommended steps include: reforming the small group insurance market; working with government to manage overall health care costs, such as the costs created by the medical liability system and new technologies; and an expanded role for providers in managing costs and assuring quality.

Background: In the last two years, assuring universal access to health care coverage has been the focus of multiple bipartisan task forces, commissions, and Members of Congress. There is no consensus, however, in Congress or in the health community on how to accomplish the goal of assuring access to health care for the over 30 million uninsured, or how to control the cost spiral.

To assure universal coverage, some members have proposed **Single Payer or National Health Insurance** proposals. These initiatives would replace our current, employment-based system with a government program, and many are modeled on the Canadian system. Even more popular are the **Pay or Play** proposals. These proposals would require employers to provide insurance directly to their employees or pay a tax to fund a public program.

Our position is that we should preserve the strengths of our current system, by building on employment-based coverage, and providing public coverage for those not able to purchase private insurance. We oppose a national health insurance model. We also oppose a play or pay model because we believe it would evolve over time into a single payer system.

To control health care costs, many congressional proposals would rely on global budgeting or all-payer systems. Once again, our position relies on the dynamics of the competitive marketplace to contain costs. And it asks insurers to change business practices that have contributed to the high cost of coverage. It also stresses the need for a coordinated approach to containing overall health care costs -- working with providers, government and consumers.

October 1991
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SMALL GROUP REFORM: BCBSA PRIORITY ISSUES

Position: The Blue Cross and Blue Shield Association (BCBSA) supports state action to reform the small group health insurance market to:

1) assure availability of private insurance for all small employers;
2) stabilize premium rates charged to small employers; and
3) promote offering of lower-cost benefit packages to small employers.

BCBSA has identified a number of key issues that we believe must be addressed in reforming the small group health insurance market.

- **Federal Regulation:** We believe strongly that states should continue to have responsibility for regulating health insurance, including efforts to reform the small group market. States should have maximum flexibility to develop approaches to assure availability that are most appropriate for their environments.

- **Inclusion of Self-Funded MEWAs:** All carriers doing business in the small group market, including self-funded entities such as Multiple Employer Welfare Arrangements (MEWAs), should be included in the scope of any reform proposal. If all entities are not included, more and more of the insured small group market will move to self-funding, thereby rendering any reform meaningless.

- **Rating:** States should not be required to enact rating reforms that are more restrictive than the NAIC limits. The NAIC model would limit the extent to which a carrier could use a small group's own experience in setting the group's rates and would limit annual rate increases for experience to 15 percent. The NAIC model carefully balances the goal of eliminating aggressive carrier rating practices with minimizing rate increases which result when carrier rating practices are limited.

  Federal action to limit rate adjustments beyond the NAIC model -- especially proposals for community rating -- would result in substantial rate increases for many small employers, and thus actually could increase the number of uninsured small employers in many states. States would have the flexibility to require tighter limits if appropriate in their competitive environments.

- **Options for Assuring Access to Private Insurance:** States should have the flexibility to adopt a range of approaches for assuring access to private insurance. Guaranteed issue (all carriers accepting all groups) should not be relied on as the only approach. Many carriers believe that guaranteed issue is feasible only if a reinsurance mechanism is in place to redistribute the costs of high-risk small employers.

  Yet, reinsurance is highly complex, it has not been tested in any state, will be costly to administer and difficult to enforce, and likely will require additional subsidies beyond the small group market.

  Approaches other than guaranteed issue that meet the goal of assuring access to private insurance should be permitted, including:

  + An allocation approach, whereby high-risk small employers would be distributed equitably among all carriers in the small group market; and

  + A voluntary guaranteed issue carrier(s) approach, whereby a carrier or carriers would voluntarily provide coverage to all small employers on a guaranteed issue basis.

- **Reinsurance:**

  + Carrier Participation: In states where a guaranteed issue requirement with a reinsurance mechanism is appropriate, carrier participation in reinsurance should be voluntary. Allowing carriers to decline participation in a reinsurance mechanism would encourage these carriers to manage the cost of high-risk cases on their own and would avoid the need for such carriers to use medical underwriting to screen risks. Allowing carriers to opt out of reinsurance also would help keep the reinsurance pool -- and the subsidy needed to support it -- small.

  + State Design of Reinsurance: The design of any reinsurance mechanism should be left to each state. In this way, states would have maximum flexibility to design approaches that best meet their needs. For example, some states have designed their reinsurance programs to reinsure claims on a prospective basis with carriers using medical underwriting to screen for high-risk enrollees, while other states have adopted a retrospective model that reinsures only claims that have passed a specified dollar threshold.

+ Reinsurance Subsidy: In deciding how to finance losses from the reinsurance pool, states should be provided authority to assess self-funded employers. Without this authority, the ERISA preemption would mean that only insured large groups -- and not self-funded groups -- would be assessed.

  But, until ERISA is amended to permit assessment of self-funded groups, assessments should be limited to the small group market. If additional financing were necessary, it should be as broad-based as possible.

o **Group Size:** We believe that small group reforms should apply to groups size 3-25. The upper limit recognizes that the problems these reforms are intended to address -- lack of availability and wide variations in rates -- are concentrated in employers with 25 or fewer employees. The lower limit protects against the adverse selection problems associated with very small groups.

  We are especially concerned about federal proposals to pool groups up to size 100 which would increase rates to larger groups.

o **Benefits:** To meet the objective of guaranteed availability of private insurance, insurers should be required to offer at least two standardized products -- a basic and a comprehensive product -- to all small employers regardless of the medical status of their employees.

  If all products were available to all small employers, carriers could experience severe adverse selection as groups (and individuals within groups) switched coverage to meet the changing needs of their health conditions. As a result, the range of coverage choices could be diminished as carriers sought to reduce adverse selection.

  States should develop the standardized products and these products should be freed from state mandates.

o **Anti-Gaming Provisions:** Adequate enforcement is essential to the success of any effort to reform the small group health insurance market. Enforcement measures that would minimize carrier gaming could include:

  + Requiring all entities selling small group coverage to register with the state insurance commissioner and publishing a list of these entities for distribution to small employers;

  + Requiring all carriers in the small group market to actively market coverage to groups as small as three -- not just provide coverage to larger, more stable groups; and

  + Prohibiting carriers from "redlining," i.e., carving out high-cost, high-risk geographic areas.

- **Carrier/Employer Pooling:** Some proposals have suggested lowering administrative costs of small employers by requiring small carriers to use a common, separate state entity for purposes of paying and billing providers. We are concerned that such approaches would lead to competitive imbalances in the market.

  Other proposals would encourage small employers to join together for purposes of purchasing health insurance. The Council of Small Enterprises (COSE) in Cleveland is often used as an example. BCBSA believes that the private sector should continue to develop these arrangements, as appropriate. However, these arrangements should not be given legislative or regulatory preferences; such preferences would represent an unfair competitive advantage in the market.

September 1991
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Blue Cross
and
Blue Shield
Association

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Thursday - Oct. 24
Capitol Hilton Hotel
Wash. D.C.
8:30 am

OK

honorarium: $2,000

April 17, 1991

The Honorable Bob Dole
Minority Leader
United States Senate
S-230 Capitol Building
Washington, D.C. 20510

Dear Senator Dole:

The Blue Cross and Blue Shield Association will hold its third National Leadership Conference on October 24-25, 1991 at the Capitol Hilton in Washington, D.C. If your schedule permits, we would be highly honored to have you address the conference as our keynote speaker at our session which begins at 8:30 a.m. on Thursday, October 24.

Approximately 150 people will be in attendance, including the Chief Executive Officers from Blue Cross and Blue Shield Plans throughout the country, and senior management at each Plan who have responsibility for federal and state government issues which affect our 80 million subscribers.

Your key position as Minority Leader in the United States Senate will make your insights particularly valuable for our organization. We would like you to address "The GOP's Priorities." We have reserved 30 minutes for your presentation and questions from the audience.

We would like to offer you an honorarium or make a contribution to the charity of your choice. Thank you for considering our invitation. I hope you will be able to accept and look forward to hearing your response.

Sincerely,

Barney

Bernard R. Tresnowski

cc: Tom Miller, Blue Cross and Blue Shield of Kansas
Jay Lohman, Blue Cross and Blue Shield of Kansas
Nancy Zogleman, Blue Cross and Blue Shield of Kansas

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9-2 confirmed w/Brenda

SENATOR DOLE
SPEECH TO
BLUE CROSS/BLUE SHIELD
LEADERSHIP CONFERENCE
OCTOBER 24, 1991

It looks like Elizabeth and I are covering all the bases today -- She's at the Red Cross and I'm here with the Blue Cross.

Washington is a city full of agendas. But if one dominates the

list, it is health care reform. After countless years of neglect, its time has come.

The U. S. health care system is admired throughout the world for its outstanding quality. We don't have long waiting lists. We don't ration care. We have the best trained health care providers in the world. But, poll after poll

tells us that the American people are concerned, particularly about costs, and want us to do something. In fact, I heard it at nearly every town meeting I attended in Kansas over the past months.

For all the benefits of our health care system, many Americans feel -- and rightly so --

that health care in the U.S. is on the critical list and needs intensive care. There is something fundamentally wrong when, in a country as rich as the U. S., there are so many citizens who lack access to affordable health care.

As you know, the nation now faces bloated outlays for health -- more than 12% of the gross

national product. We spend more than $2,000 per person per year, which is more than the total per capita GNP of some countries. $660 billion per year -- more than any other economy in the world.

That's why it's perplexing that we lag behind in key health indicators -- like infant mortality and life expectancy. And that

we've seen a recent outbreak of measles and mumps -- very preventable diseases -- simply because parents can't afford or don't understand the immunizations their kids need.

Add this to the cries from employers battered by soaring costs and you have a crescendo that we can't help but hear. These

cries are matched by the dread of more and more working Americans as they helplessly watch their coverage dwindle, or even disappear. The result: an overhaul of the health care system looms as a major -- maybe the major domestic -- issue in the coming years.

Dozens of proposals to

revamp the system are kicking around Capitol Hill, ranging from comprehensive government-run plans backed by liberals, to totally private sector plans sponsored by conservatives to proposals dealing with only limited issues like small business market reform. But no reform proposal, whether large or small, will be perfect or painless.

Private insurance still remains the primary source of coverage in the U. S. In 1988, 212 million people had private insurance for health care. Health insurers appear to be in pretty good shape. Blue Cross/Blue Shield is a case in point -- going from a $1.9 billion loss in 1987 to a $1.1 billion gain in 1988, and a net margin of

almost $800 million for the first half of 1990.

But beneath those reassuring numbers lurk enough problems to make private health insurance the target of attacks. There is now some debate about how well our largely private, pluralistic approach to insurance works even for those who are insured.

Because of the shortcomings of our current approach to health care, some Americans have become increasingly fascinated with a national health care system, like Canada's, thinking its's the cure-all for our financing problems. Some of my colleagues on Capitol Hill are captivated by facts and figures that have

emerged from Canada -- 8% of GNP compared to our 12%, lower administrative costs, universal access.

If the Canadian system seems too good to be true, it is. Long waiting lists, equipment shortages, rationing, and tension between providers and the government are ways that the Canadians really pay

for their health care. Not to mention, much higher taxes than most Americans would be willing to pay.

A national health care system is a government monopoly. Although it might achieve some savings initially, it would become as unresponsive, inefficient, and ineffective as any other monopoly.

It's been said that a national health care system would mean the efficiency of the post office, the compassion of the IRS, and the cost control of Pentagon purchasing.

This is not to say that the U. S. does not stand to learn from the experiences of other nations. It's just that health care models are

not like chameleons. They are not simply adapted as they migrate from country to country. America is distinct. We have different customs -- different expectations -- a different history -- and different problems that need fixing. There are no ready-made answers out there. What we need is an American solution -- one that is

custom made for American citizens -- all citizens -- young and old, rich and poor, working, retired, healthy and sick.

Of course, even among Americans, finding the perfect fit for health care reform won't be simple. But, we need at least a basic formula for health care that includes broader access to health

care combined with decisive cost containment measures.

The way I see it, there are basically two solutions to our health care cost and access problems -- the right way -- the way that is responsible and realistic -- or the easy way.

It's easy to support providing health insurance coverage for all

Americans. It's easy to do as some liberals suggest and create a new public program. Or, we could pick the pocket of small business by placing another tax on them. That's easy. It's also easy to point to Canada or West Germany -- or even Massachusetts -- and say, "If it works for them, it'll work for us." I'm not convinced it works all that

well -- even for them. I've had meeting after meeting. Seen expert after expert, exploring ways to give more Americans affordable access to health care. And I've come to the conclusion that the only way we're going to see unlimited care at no cost and with no questions asked is by watching old reruns of Ben Casey and

Marcus Welby, M.D.

In real life we have fiscal constraints, deficits, and crime and drug problems that are also straining our thinning budget. Like I said earlier, Washington has many agendas. There is no single magical solution that will always result in a happy ending. Reality is that we have neither the support

nor the resources to enact a solely government-run proposal. And frankly, it simply wouldn't be good policy.

Perhaps no one knows better than you, the people in the insurance industry, that improving the nation's health care system means everyone has to work together -- employers, employees,

doctors, nurses, drug and insurance companies, consumers, and the government. I am convinced that reform can take place. And it can be done without creating yet another government program, huge deficits, more regulations, or massive tax increases on the American people.

As a nation we are living

longer. We have more chronic illness, more uninsured individuals, more children going without the immunizations they need. The challenge of meeting these needs is greater than ever before. So while the problem is a daunting and complicated one, we simply cannot throw up our hands because solutions aren't easy or

cheap. I certainly don't pretend to have all the answers, but I think there are practical things we can begin to do right now.

First, we must keep an eye on the big picture -- on fundamental, structural reform of our entire health care system. Second, because reform will take some time, we must continue to make

incremental improvements.

Senator Packwood and I introduced a long-term care bill in August that calls for the combined efforts of the public and private sectors in affording access to long-term care -- both community and nursing home care -- for a greater number of our seniors.

The White House, last spring,

issued a proposal that calls for a more sane approach to practicing medicine by reforming medical liability laws. The hope is that a lot of the unnecessary defensive medicine that is being performed out there will be eliminated, along with all the costs that go along with it.

Senators Durenberger and

Bentsen, as well as Congresswoman Johnson, all have proposals for small business market reform. This is an area that I think has a fighting chance of passing. As long as the Democrats refrain from pushing for "all-or-nothing" reform, a small market insurance proposal can significantly improve access to

health care by making insurance affordable for small businesses.

We can invigorate competition and improve access by providing tax credits to individuals and small businesses to use to purchase health insurance. It's been estimated that this approach could reach nearly two-thirds of the uninsured.

We also need to find ways to ensure that innovative and creative alternatives to traditional health plans are given a fair opportunity to evolve.

I'm not suggesting that all of our nation's health care problems will be solved in one swift wave of a magic wand. I'm also not suggesting that we'll have all the

answers this year, and probably not even next year. Undoubtedly, there will be a lot of posturing before the '92 elections. But what I am interested in, is a reform proposal that will actually pass -- that will have the support of the President, as well as Congress -- from members on both sides of the aisle.

By making changes in federal policies, we will free the private sector to make improvements in the provision of health care services and coverage.

Success will depend on the key players in the system -- And Blue Cross is one of those players, along with business, the government, and individuals.

The political climate is ripe for action because reform has become just as crucial to the middle class as the poor. Contrary to popular belief, the uninsured are not dominated by welfare recipients or deadbeats; More than 85% of the thirty-some million uninsured Americans are workers and their dependents.

Unless Congress takes some action, costs in the medical marketplace will continue to speed out of control, while coverage continues to creep to a halt.

I think that's a bitter pill no American should have to swallow.