**Keynote Remarks of Matt Miller to America's Health Insurance Plans (AHIP)**

**"A Challenge to Health Insurers"**

**October 22, 2009**

Thanks for that kind introduction.

You know, when we originally arranged this talk I had planned to talk to you mostly about what I call "dead ideas" – I have a book out called *The Tyranny of Dead Ideas* – and about how dead ideas are hamstringing the health reform debate – and maybe we'll get to some of that. But then a few days ago all hell broke loose with AHIP – something about a report you all put out, I gather? – and you could feel the blowback all the way in Los Angeles, where I live.

It's always nice to be with a group that arouses no controversy – just another calm day in Washington with a trade group holding a routine meeting…

So, given what's going on, in order to be most relevant to what's on everyone's minds, I want to use our time together to share some perspectives about this remarkable moment we've reached, and what insurers should do to push toward the right outcome for the country – and, in the process, for your industry.

Some of what I say may be welcome; but I suspect much of what I say will not leave you cheering… Our hosts have assured me that it's constructive at this critical hour to have a frank assessment of where we are in the health reform debate and what that means the insurance industry should now do, and I'd like to offer just that. I hope you'll keep an open mind as we proceed.

Before I plunge in, it's useful to let you know where I'm coming from so you'll have some context for my remarks.

I served in the Clinton White House at OMB from 1993 to 1995, which means I've been waiting 15 years for the nation to have another bite at the apple of systemic health reform – to end this scandal of the uninsured – of people routinely going bankrupt in a wealthy nation because of medical costs – and of thousands literally dying because they lacked coverage. It's equally vital to begin bending the cost curve.

My family has been scared by the inability to get coverage ourselves. My wife and I discovered a few years back we were uninsurable in the individual market for health coverage – despite our doctors assuring us we were healthy people. As a result, we did a Sunday *NYT* Magazine piece on how the individual market could never be the answer, touching the nerve of "uninsurables" everywhere who can't start their own business or

have more entrepreneurial career structures without putting their families at risk of medical bankruptcy or worse.

This is bad for the economy. It's awful for families. And it's insane in a rich nation like the U.S.

In 2003 I published a book called *The 2% Solution*, which showed how both parties could get their arms around a deal for universal coverage that would create an American-style version of the Swiss or Dutch system of competing private insurers – with subsidies for folks who needed it, and an individual mandate. It featured a mock negotiation between Jim McDermott and Jim McCrery, both of the House Ways & Means Committee – one with a 90% liberal rating, the other a 90% conservative rating – showing how they could reach a deal that wasn't either's first choice, but which would get the job done for the country. From that work, I know Republican principles are all over the emerging health care bills – so I'm disappointed (if not entirely surprised) that Republicans as a party have made the same choice they did in 1994 – to put the quest for power above supporting many of their own principles.

Only in America can Barack Obama push Mitt Romney's health plan and fund it partly by adapting John McCain's best idea from the presidential campaign and be called a "socialist"!

During the 2008 campaign AHIP invited me to offer a Democratic perspective on health reform at another meeting. I told folks then that if a Democrat won, the industry would be offered a deal – billions in new premiums each year in exchange for giving up the cherry picking and related risk selection practices – and that health plans should find a way to view this as good for the country – as viable for the industry – and that you should find a way to <u>not</u> go off and Harry and Louise it this time.

I've also urged my colleagues on the left to keep their eyes on the prize – and to understand that even without a public option, getting universal coverage via an American version of Swiss or Dutch system would be biggest progressive achievement in decades.

I've written often about radical inefficiency of our health system – and the national imperative of addressing cost growth.

And finally – like every veteran of the 1994 fight, with a memory of the role the insurance industry played back then in killing reform – my blood boiled when I saw news of the Price Waterhouse report – and I felt that déjà vu sense of "Here we go again..."

Some friends said to me, "How can you go talk to the insurers now, when they're doing it again?" And I thought about whether to skip this event. But in the end, I decided this time <u>is</u> different – I may be proven wrong, but I don't believe you are ultimately trying to sink reform – I pray that's the case – and maybe I can make some small contribution to your thinking and to a more positive endgame by engaging at this moment.

That's too much about me – but I hope it helps place what I'll say in context.

I know I come before a group that feels bruised.

Your stock prices are down.

Covered lives for many are down – because our employer-based system means that millions have lost coverage in this recession.

And after coming forward with positive reform initiatives these last couple years, under Karen Ignagni's leadership, you feel you're being demonized just like you were before you engaged constructively in reform.

Well, welcome to Washington. As you know, not everything that happens in politics is fair. The President, to cite one prominent example, isn't a socialist and is an American, and doesn't like being demonized on those scores either – but that comes with a public role…which health insurers inevitably have – and you'd be in a far worse position had you not engaged as you have these past few years.

So, though you may feel under siege – especially this week – I'd like to challenge you with this thought: the root of the industry's public problems has to do with its inability to offer a compelling answer to this question: "What value does the health insurance industry add to society today?" I believe that thinking hard and honestly about that question also offers a potential path forward for the industry, if you have the vision and the fortitude to size it.

Let me share a story to show what I mean. A couple of years ago I had a chance to spend an hour with major health plan CEO, who at one point complained about the political challenges the industry faced. I asked him how he would articulate his company's, and his industry's, value to society.

He grew quiet. After a few moments he said, "I can easily articulate our value to our customers" (by which he mainly meant employers…)

I said – "That's not the question – that's not at all the same thing." He struggled, and didn't have a compelling answer. Maybe in the Q & A some of you can offer your own – but I think the inability to have a compelling answer to that question is *the* underlying source of the difficulties the industry faces.

The pharmaceutical industry, by contrast, which faces no shortage of public criticism, does have a compelling answer that everyone understands – "We discover new medicines that enhance people's lives."

I believe that if there's a good answer for health plans, it has to be that health plans are the entities who will drive the reengineering of health care delivery so that it's more cost effective – that you will become *the* engine of boosting value for the health care dollar in America – using data and information and research to drive best practices, etc. But if you're honest, despite some modest early attempts in some areas to play this role, that's not the role you're playing today.

If it was, then America's health care system – which features the greatest private sector role of any in the world – wouldn't be at 17% of GDP headed toward 20%, with huge regional variations in the intensity and utilization of procedures and services.

It's this lack of good answer to the "value in society" question – along with (1) repeated instances of indefensible behavior by the more unsavory health plans, (2) too many examples of outlandish CEO pay, and (3) the legacy of your behavior in 1994 – that together breeds the deep well of suspicion that produced the reaction to the PWC report that you issued the other day.

Now, let's spend a moment on that report. Every thoughtful observer knows that health plans have legitimate concerns in what's emerged from Senate Finance. If you have community rating and no preexisting conditions and related reforms, but you don't mandate that all folks get in the pool, and with adequate subsidies for those who need them to assure the mandate is affordable, you risk creating a premium spiral, as has happened in several states.

Let me read from a recent report from the left-leaning Center on Budget and Policy Priorities on this point – and CBPP is hardly a shill for the health plans:

> Without a sufficiently strong mandate, many healthy individuals likely will elect to remain uninsured rather than pay a substantial amount for coverage. If those who buy insurance are significantly less healthy as a group than the population as a whole, the health costs of those who purchase insurance will be higher than average, and insurance premiums will have to rise to cover those costs. If that occurs, a "spiral" can set in — as premium costs rise to higher levels, more of the healthy people may decline to buy coverage rather than pay the higher costs, which in turn would cause the pool of insured beneficiaries to become even less healthy on average and thus push premium costs still higher….
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> ….If the mandate is too weak — because the penalty for not having coverage is too small or the exemption from the penalty is too broad — and the premium credits to make coverage affordable are not adequate, a substantial number of healthy individuals may decline to purchase insurance and remain uninsured. Meanwhile, less-healthy individuals without coverage will likely take advantage of the premium credits available and obtain coverage in the exchange. Over time, if the population enrolling in the exchange is in significantly poorer-than-average health, this will drive up the cost of the plans in the exchange — forcing both individuals and the federal government to pay more for coverage and possibly causing the exchanges to unravel.

My point – even we Democrats and liberals understand these economics.

But, in my view, AHIP chose a needlessly inflammatory and skewed analysis through which to raise these legitimate concerns. And it thus made everyone who lived through 1994 feel like you're trying to bring down reform once more. The fact that White House folks felt blindsided makes matter worse.

Now, I don't want to dissect the whole report here. But from my point of view, the most disappointing part of the analysis was the assumption that any savings in Medicare will get translated dollar-for-dollar into higher private premiums.

Why do I say that? Because that assumption assumes that you can never play the role I mentioned as the engine of value and cost reengineering. A reasonable person looking at the report would say *you don't even aspire* to play that role.

Now, I know such cost shifting often goes on today. But there are two facts that can't be squared. It can't be that, on the one hand, we're the most inefficient system by far on the planet (we're at 17% of GDP vs. other advanced nations at 10-11%, while mighty Singapore achieves first world outcomes at 4%) – and that, on the other hand, slowing Medicare growth from 6.6% to 5.9%, which is all that the Democratic proposals do – can't be done without those exact same costs emerging elsewhere. Your public argument amounts to an admission of cost control helplessness, or even nihilism – "we can't do anything," you're saying – when improving system wide cost effectiveness should be the thing your industry contributes most to society!

I'm not saying the politics of cost control aren't hard – as you well know, the iron law of health care politics is that every dollar of health care "waste" is somebody's dollar of income – that's why we never get around to dealing seriously with costs.

What I am saying is that by making the argument you did – that savings in Medicare automatically mean higher premiums for private payors – you negate the most promising potential claim you can make to add value to society – by reengineering the way care is delivered.

So – suffice to say, I think it was a dumb thing to do… even though you have legitimate concerns to address, this wasn't the way to do it.

I don't want to guess at the complex internal politics that lead AHIP to issue this report when it did. But I think the nerve it touched – for legitimate reasons – is hardening opinion around town against insurers in ways that hurt your interests.

But what's done is done.

The question is, where do we go from here? And where do you go from here?

So -- for what it's worth – here are some thoughts on what you should do now:

**First: AHIP needs to lead the fight for higher subsidies**. The $900 billion box, with a subset of that devoted to subsides, isn't enough. You need to help change the political viability of crossing the magic one trillion dollar threshold. At $1.2 or $1.4 trillion over 10 years, it's still barely more than .5% of GDP. You and everyone you can round up need to make this public argument: "For less than a penny on the national dollar, we can get health reform done right for average Americans." Yes, critics will say you're calling for subsidies in order to line your own pockets – but we all know the subsidies need to rise for this to work, so those are lumps you'll have to take. That's part of the nature of this debate.

**Next: Stand up for broader revenue measures as part of what's needed to make this work**.

My own view is that McCain had it right in the campaign, and deserved credit for talking about revisiting the tax exclusion for employer-provided care. Indeed, one of the many losses of Ted Kennedy's passing as we approach the endgame is that he's the only person in America who could have gone to the unions and told them this was the right way to fund the reform we need as part of finally getting universal coverage for everyone. This was a position one of his advisors told me he never ruled out…

But whatever measures get in the mix to fund higher subsidies, AHIP needs to be a major voice combating the usual suspects who say any tax is bad and the slippery slope is socialism, etc.

**Next: Do not scare seniors about changes to Medicare Advantage, or about Medicare savings in general.** I know that strictly speaking it is true that Medicare Advantage changes will mean some extras may be reduced for those who've enjoyed the bounty of what MedPac says have been overpayments for years. And I know that for some in this room, who've made it a profitable line of business, these changes may be hard. But in my view, you will be doing the wrong thing for your country and for yourself if you try to protect an anomalous sweetheart deal at a time when major reform is at hand – and if you do so by scaring seniors. As a practical matter, the wrath you bring down upon yourselves will be overwhelming if you pursue this angle. This isn't 1994.

As an aside, some of the hypocrisy regarding Medicare managed care private plans is remarkable. The right policy answer for how this gets priced is competitive bidding for Medicare's business, an idea which gets killed in the cradle whenever raised – and the original killer I recall was Senator Jon Kyl a decade ago, who apparently likes "market competition," except when it might make some companies in Arizona actually compete.

**Next: Change practices on CEO pay.** To be sure, excessive CEO pay is a problem across industries, not just in health insurance – and I say this as a capitalist. It is bad and corrosive for capitalism when many banking CEOs and senior executives walked away with $100 million while presiding over the demise of their institutions – and left taxpayers holding the bag.

Likewise, in an industry where people are dubious about the value the industry adds to society (and even health plan leaders have trouble articulating this value), outsized CEO pay is particularly unsavory.

When a health plan CEO like Bill McGuire can become a billionaire – and many others build entrepreneurial-style wealth without taking entrepreneurial-style risk – while their firms boost profitability in certain markets by shunning people who are sick – in my view, it's just wrong.

What's more, as a business matter, you'll never sustain public support without addressing this. This isn't a rant against getting rich – it's an argument about what makes business sense in a societal context – and my main message to you today is that aligning the

trajectory of your business strategy with society's best interests is the only way to put yourselves on a sustainable long term footing.

Let me also be clear – up until last week you'd taken important, serious, positive steps in this direction by championing reforms these last two years, even if political reality means you didn't always get full public credit for it. Until last week, where it matters in the corridors of power, you did – you helped to fashion the political molecule that's gotten reform closer to reality than it ever has been – that's why now is the time for you to repair the damage of that report and go the extra mile.

**Which brings me to my final – and perhaps most controversial – suggestion. I want to suggest why it's in health insurers' best interests to support a public option "trigger."**

I hope you'll keep an open mind while I lay out how I came to think this way – and we can discuss it in the question period.

In my younger and more vulnerable years, as an aide in the last Democratic White House, President Clinton said something that I've been turning over in my mind ever since. It came during a health care meeting in the Cabinet Room in 1994, during which Clinton shared a conversation he'd had with Senator Sam Nunn of Georgia. Then, as now, the question of how to "bend the curve" on health costs was the seminal issue in health reform; Nunn had spent several days caucusing with assorted provider groups in his state in search of an answer. Nunn told Clinton the consensus among his industry leaders was clear. "Just give us the number," they'd told Nunn, meaning the slower growth rate of health costs the country could afford to spend. "We'll figure out how to divvy it up so it works."

*Just give us the number*. Unlike many advanced nations, which run health expenses through the government's books, the United States doesn't have a global budget for health care. This, and the fact that Americans pay directly for only a small portion of their own health spending (and thus have little incentive to be smart shoppers), helps explain why costs are out of control. As we've discussed, everyone agrees that U.S. health care is radically inefficient.

Yet despite irrefutable proof of inefficiency, any proposal to slow the growth of health costs is met with doomsday cries from hospitals, doctors, insurers, medical device makers, drug companies, nursing homes and more. As I said, the iron law of health care politics holds: every dollar of health care "waste" is somebody's dollar of income. Reformers concede that efforts to clamp down on costs this year seem likely to have only moedest impact. The pilots of new payment systems and similar innovations in the emerging health care bills may unearth some promising directions in the decade ahead. But it's hard to think they'll save real money anytime soon.

This, as you know, presents a dilemma. If we emerge from this year's epic health legislation without having done anything to re-engineer the cost of health care delivery, today's achievements will be short-lived. Lawmakers are already having to fudge the

numbers to create the illusion of insurance affordability and deficit neutrality. As health costs continue to climb, we'll either bust the budget in order to lift subsidies for health insurance ever higher, or the government will exempt more and more Americans from a mandate to buy coverage, destabilizing the risk pool and sending premiums through the roof.

The only way to avoid these grim scenarios is to get serious about costs. The most politically viable way to do this is what Nunn counseled Clinton fifteen years ago: "give them the number." The device for doing this, I've come to think, can be the so-called public option "trigger."

How might that work? The government would define what affordable coverage means at differing levels of income. For example, families earning less than $25,000 might be expected to spend no more than 4 percent of their income on premiums for decent health coverage; those earning $50,000 no more than 6 percent; and so on. Each state or region would be required to offer some minimal number of competing affordable options for citizens following the implementation of the new insurance exchanges. If a state or regional exchange failed to offer these affordable options, a new public program would be launched that meets these criteria.

The idea is to create, for the first time, a forcing device that compels the entire health sector to organize and compete around meeting newly defined metrics of affordability. The collective fear of an actual public option would lead the industry to rethink current practices in order to avoid the dread "trigger."

I'd like you to consider that as insurers, who've generally vowed to fight any version of the public option to the death, you should in fact welcome this forcing device, because it's the only way to halt the industry's descent from merely being demonized today to facing the regulatory equivalent of lynch mobs tomorrow. It is insurers, after all, who will be blamed as health premiums continue to soar. Yet this blame will be in part unfair. The dirty little secret of health care is that it is not the market power of insurers that mainly fuels health costs, but the local market power of doctor groups, hospital chains, and other local provider oligopolies. Insurers wanting to play in many markets today lack the clout to fight the terms offered by the big local provider groups; you'll never persuade ambitious attorneys general to crack down on doctors and hospitals, since they're "respected pillars of the community"; and from what most health plan executives tell me, you're too timid or scared to aggressively publicize the way provider power skews costs and prices across the system.

The public option trigger would thus give health plans the tool they have lacked to force an entirely new set of conversations and negotiations about cost-effective care delivery in every market. The fear of God – of at least, the fear of Uncle Sam - would empower health plans to deliver value to society by boosting the value Americans get from every health care dollar.

Now, I can imagine what you're thinking – why us? Why do we have to take this on when no one's been able to crack the code on health costs in the U.S. before? And I know, even if we abolished health plans tomorrow, it wouldn't change the fundamental forces behind surging health costs at all.

No matter. America's unique health care history has brought us to a moment where this is your assignment – someone has to make American health care more cost effective – it's now a national economic imperative – and it's either going to be you, or the federal government. Or perhaps both, in a constructive partnership.

So much for the politics and policy of this crossroads – which I appreciate your listening to.

Let me close with a few brief thoughts about **what insurers need to do in this new emerging world re your businesses.**

Even though few Americans look likely to be eligible for exchanges to start (unless Senator Wyden gets traction), I believe that one way or the other, the creation of the exchanges will mark the beginning of a long term shift to individual versus corporate coverage. The exchanges can become a safe place over time, as comfort level grows and enough business leaders and senators realize employer-based coverage is a huge part of the problem, to migrate more folks there. If there are 20 million in the individual market today vs 180 million in employer-based, in 8 or 10 years I bet we could be at 75 million vs 125 million. Who knows?

(As an aside – I'd urge you to support Wyden's proposal re choice – because if not, the 180 million now in employer based coverage won't get anything new – and this will hurt chances of long term reform succeeding politically. It's also the wrong thing to do to lock people in to employer plans – it's a Dead Idea)

As individuals become the focus, this means the basis of competition in your industry will change – from risk selection and distribution to – what else, given our theme? – boosting value in health care delivery, and as part of that, developing value added relationships with individual customers.

These are skills and muscles most health plans haven't developed – because the focus has been on selling and administering in the employer context, or on risk selection and segmentation in the individual market.

- Ask yourself this -- or better yet, do market research on it – if the individuals you now cover via employers had access to group coverage via an exchange with dozens of choices, would they stay with you? Why or why not? You have until 2013 to craft winning answers to this question – some firms will figure this out better than others – it requires a new way of thinking about the value you provide – and it should be a huge opportunity if done right.

Thanks for letting me share these thoughts, offered in what I hope you know is a constructive spirit. I look forward to dialogue and questions – and happy to talk more, if you want, about those Dead Ideas…

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