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Defining the Problem and Searching for Solutions: Insurers, Employers, and State Government

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Jones, Day, Reavis and Pogue

Powell Woods

Nestle Enterprises Corporation

John Polk

Council of Smaller Enterprises

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Recommended Citation

Charles D. Weller, Powell Woods, John Polk, & Kenneth F. Seminatore, Defining the Problem and Searching for Solutions: Insurers, Employers, and State Government, Symposium: Ohioans without Health Insurance: How Big a Problem - Are there Solutions, 4 J.L. & Health 181 (1989-1990)

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Defining the Problem and Searching for Solutions: Insurers, Employers, and State Government

Cover Page Footnote

Climaco, Climaco, Seminatore, Lefkowitz and Garofoli

VII. DEFINING THE PROBLEM AND SEARCHING FOR SOLUTIONS: INSURERS, EMPLOYERS, AND STATE GOVERNMENT

CHARLES D. WELLER
POWELL WOODS
JOHN POLK
KENNETH F. SEMINATORE
Moderator: JAN E. MURRAY

A. PROFESSOR WEINSTEIN

Our second morning session is titled: "Defining the Problem and Searching for Solutions: Insurers, Employers and State Government."

Our main speakers are John Polk, Executive Vice President of the Council of Smaller Enterprises; Kenneth Seminare, a partner with the law firm of Climaco, Climaco, Seminare, Lefkowitz and Garofoli, who is representing Blue Cross & Blue Shield of Ohio; Charles Weller, an attorney from Jones, Day, Reavis and Pogue representing the Health Policy Coalition; and Powell Woods, Vice-President for Human Resources of Nestle Enterprises Corporation. Our moderator is Jan Murray, Director of Legal Affairs for Southwest General Hospital and an Adjunct Assistant Professor of Law here at Cleveland-Marshall College of Law.

B. JAN MURRAY

We are going to start out with those of our speakers today who are representing employers in the private sector. I am going to ask Mr. Charles Weller to begin, followed by John Polk and Powell Woods, and then finally we will hear from Mr. Seminare. So without further ado, I am going to ask Mr. Weller to come up to the microphone.

C. CHARLES WELLER

Good morning. It is a great privilege and pleasure to be here to discuss a very challenging issue to the community and the nation. The basic thrust of my comments this morning is that there are staggering realities that I think we need to face and that require bold new directions. Fortunately, I think some of the most innovative new directions are taking place here in Cleveland. In other words, I've got a bad news speech and a good news speech. The good news is that some of the best ideas are starting here in Cleveland.

1. THE NEW REALITIES: MEDICARE/MEDICAID AND THE PROBLEMS OF THE UNINSURED

What are these staggering new realities that have to be faced squarely to solve the problem of the uninsured without worsening the problem?

First of all, when Medicaid was passed in the 1960s, it promised to

cover the poor. Here it is, twenty-four years later, and there are 30 million people that are uninsured, a substantial number of whom are poor.¹ In other words, Medicaid did not keep its promise.

Second, Medicare was also passed in the mid-60s. As many of you know, projections on the future of Medicare are very bleak. By the turn of the century, which is almost tomorrow, just ten years away, projections indicate that Medicare will be bankrupt. When my generation reaches retirement age, I've seen projections that to provide the kind of benefits promised to my generation in the 60s would require a payroll tax of forty percent.

Third, doctors and hospitals and patients are caught in an increasing web of regulations and restraints. Future realities indicate this will only get worse, without some new direction being taken.

Those are some of the health care realities I think we have to face. There are others. You are all familiar with those. But I also think you have to look beyond just the health care setting.

The other new realities include, first, the savings and loan crisis, which is going to take more than \$300 billion out of the American economy to fix. Secondly, the costs of saving the planet from global warming could reach an annual cost equivalent to the defense budget, \$300 billion in the United States. These are totally new realities that didn't exist twenty-five years ago when the Medicare and Medicaid promises were made.

And third, what about the U.S. economy? Is it strong? Do we have the ability to deliver on these promises and other social needs? In the 1960s, when Medicare and Medicaid were passed, believe it or not, ninety-five percent of the automobiles sold in the United States were made in the United States. I think that statistic is indicative of the general challenge, and the new reality, of what has happened to the U.S. economy. The U. S. economy has gone from world dominance in the mid-60s to an enormously competitive reality today. Indicative of the weakening of the American economy in world markets since the 60s is the following fact—American manufacturers today make less than sixty-five percent of the automobiles sold in the U.S., down from ninety-five percent in the mid-60s.

What does the future hold for the American economy? One important indicator is the educational performance of the United States compared to our worldwide competitors. As many of you know from reading the newspapers, the United States educational system is no longer educating

¹ See generally Chollet, *Uninsured in the United States: The Nonelderly Population without Health Insurance*, Employee Benefit Research Institute (1988); Kasper, Walden & Wilensky, *Who are the Uninsured?*, NATIONAL HEALTH CARE EXPENDITURES STUDY, DATA PREVIEW 1, NATIONAL CENTER FOR HEALTH SERVICES RESEARCH (1989) [hereinafter *Who Are the Uninsured?*]; Short, Monheit & Beau-regard, *A Profile of Uninsured Americans*, NATIONAL MEDICAL EXPENDITURE SURVEY, RESEARCH FINDINGS 1, NATIONAL CENTER FOR HEALTH CARE TECHNOLOGY ASSESSMENT (1989) [hereinafter *A Profile of Uninsured Americans*]; HOUSE COMM. ON EDUCATION AND LABOR, HEALTH INSURANCE AND THE UNINSURED: BACKGROUND DATA AND ANALYSIS, H.R. DOC. NO. 100-Z, 100th Cong., 2nd Sess. 94 (1988).

students so that they can compete in the international economy. On virtually every measure of educational performance—math, science and so on—U.S. students rate in last place. Thus, the future of the American economy, quite frankly, is not overly encouraging.

These are some of the realities. This is the bad news. Unless we face it squarely, we could very easily worsen the uninsured and other problems.

There is one statistic that I think summarizes these new realities best. It best indicates why I think we need to move so strongly in new directions. In 1965, before there was a Medicare/Medicaid program for the elderly and poor, the average American worker had three percent of his or her compensation go to pay for health care. In 1987, that number had risen to fifteen percent. The average American worker now has fifteen percent of his or her total compensation deducted to pay for health care. That's a 500 percent increase since 1985. That's obviously not a trend that can continue. We need to do something different. We need a new direction.

That's the bad news. What is the good news? The good news is that there are exciting new directions taking place in Cleveland. One of those new directions has been in place for some time: the COSE program for the small employer. John Polk will be describing that to you in some more detail. The second new direction is called Cleveland Health Quality Choice. Some of you may have seen it referred to in the *Wall Street Journal* today. Powell Woods from Nestle's will be describing this initiative, which takes place in Cleveland, but is also a national model. The third new direction from Cleveland is the Health Policy Coalition, which I am here today to represent.

Basically, the mission of the Health Policy Coalition is to take to Congress some of the new ideas from Cleveland. For example, John Morley, the CEO of Reliance Electric, testified to the Pepper Commission in July. The principles that he announced then, I would suggest, can serve as the basis for the new direction we need to take to provide health benefits to the uninsured as well as the insured. Those principles are based on the statistic I spoke of earlier, the fifteen percent. Fifteen percent of the average worker's compensation goes to pay for health care. What John Morley announced to this Congressional Committee was that there are three principles of opportunity to give the patient and the employee, choice. They might be called "patient's choice" principles. First, we must change the incentive system so that patients directly have a way of working with their doctors and hospitals in choosing the quality, cost, and type of medical care that they, the patients, receive. Second, we must improve research on quality, so that patients, hospitals and physicians will have technical information on what works. Third, we must return patient choice to the employee, the family, and the patient. That's the Health Policy Coalition's message. Powell Woods will now describe what the Cleveland Health Quality Choice Program is all about.

D. POWELL WOODS

The name of the program that we have launched in Cleveland, which I would like to spend just a few minutes describing, is Cleveland Health

Quality Choice. I would like to start by talking a little bit about my understanding, which is far from an in-depth one, of the problem of the medically uninsured in the United States as we view it. And then I will talk about why I believe Cleveland Health Quality Choice can be a key to a solution to that problem both locally and regionally. Finally I will move on to why I believe it can furnish a model for a national reform of our health delivery reimbursement system which can help us solve the problem nationally.

1. ACCESS TO HEALTH CARE FOR THE MEDICALLY INDIGENT OR UNINSURED

I assume you've all heard these numbers this morning, some 31 to 37 million persons not covered by insurance, sometimes called the medically indigent or uninsured.² The number, I know, in and of itself is somewhat controversial in terms of what portion literally lacks coverage or lacks access. Those words are sometimes used as synonyms, and they are not synonymous. We certainly have hospitals locally that run up significant uncompensated care bills every year for treating people who do not have coverage, so there is access to health care in that sense. But, of course, the first question that has to be asked is whether health care is delivered in the most productive way to the indigent, and the answer is clearly "No."

2. REDUCING THE NUMBER

Whatever the number, and however many of those people who are actually covered under spousal policies and yet are listed as uncovered, whatever the size, I think we can all agree that it is probably an intolerable number. This is simply for the reason that a humane society does take care of all its members' medical needs. That's not only humane; it's clearly the right and the smart thing to do. But we need to do that at a price that society can afford. We hear numbers from 11.7 to 11.5 or 12 percent of Gross National Product dedicated to health care. I used to say, well that's an intolerably high number, and I guess I stopped saying that. Whether that's too much or too little, with today's problems, I don't know. It would appear to be too much, on the surface of it, compared to what other countries are accomplishing for significantly less, and to our best ability to determine, with similar results or even, in some cases, better results. It is very difficult to make apples to apples comparisons when we're talking about that kind of thing country to country in terms of health care delivery results, and there are a great many opportunities for misrepresentation and simplification that do not serve the purpose of an intelligent understanding of the problem.

So, in any event, I'll start out with the premise that whatever the number of uncovered people, it certainly would be to our benefit to reduce

² *Id.*

that number—ideally, to zero. Then I would like to move on to talk about the program called Cleveland Health Quality Choice, and how we believe and hope that it can furnish a key to the solution.

There are really three problems, as I view it, in health care delivery. One is the cost trends that we are experiencing which are significant problems for Nestle and for other payers. The second is the variable or indeterminate quality of medicine from community to community and from provider to provider. We know very little about that other than that there is variation. That much the medical profession has told us and we can believe that. The third problem, which I have already mentioned, is the problem of coverage itself, sometimes called access, properly called coverage.

3. CLEVELAND HEALTH QUALITY CHOICE

Cleveland Health Quality Choice is based upon the principle that if we figure out a way to reward high quality and cost efficiency as the twin lynch pins of reimbursement in our health purchasing system, we can drive both quality and efficiency gains in the system which can help produce savings which will in turn help underwrite the problem of coverage for the uninsured. That is not our only objective. I am not here talking about corporate philanthropy; I'm talking about corporate self-interest in that we have a very severe cost problem which we would like to deal with. But I believe the potential savings that could accrue with this kind of approach would be significant enough to produce the results which we need and then exceed those to yield savings which can help fund the coverage problems.

4. THE NEED FOR SUPPORT FROM VARIOUS CONSTITUENCIES

This program has been joined by three of the most important constituencies in town, at least in terms of their ability to influence its implementation and its outcome. These constituencies are the hospitals and Hospital Association, the Academy of Medicine and representatives of the physician community, and the business community itself; so we have payers and providers involved. There are other constituencies which we need to attract to support this program, among them organized labor, and the American Association of Retired Persons (AARP) and several others, in order for it to be a success. The opposition of any one of those groups would be very detrimental and could hurt us. We think we have a win-win situation here, and so that's the way we are representing it to people. Of course it will take us some years to prove that because measuring the savings which can accrue to this kind of a plan is going to be a difficult thing to do, but we hope and believe it can be done.

5. MEASURING THE QUALITY OF CARE

What we really want to do through measurement of the quality inpatient care in medicine, on a uniform basis among all hospitals, is to find a way of identifying the best among them. That will probably be by line of service, but we don't know for sure yet. We do not expect any one hospital to be best at all things. We are pretty sure that some would be better at certain things than others, and we are limited at this point to inpatient care, because to do this kind of measurement, we obviously need a large enough statistical base in order to draw valid conclusions from it. It is difficult enough, even with a large statistical base. When you begin to reduce that base, you run into the small numbers problems, and as a result you can more easily reach invalid conclusions than valid ones.

If we can do that, if we can measure, in some sense, where the best lines of service of health care are taking place institutionally within Cleveland, then, in turn, the business part of this bargain is to establish incentives within our benefits plans that will furnish strong encouragement to our employees and their dependents to select, through their physicians, the high performance hospitals, where the best health-care is being delivered.

6. IDENTIFYING COST-EFFICIENT CARE

Once we have identified the top quality providers, we would also attempt through our own analytical methods claims to identify that care which is done most cost-efficiently. We know there is a wide variation in cost-efficiency as well as in quality provided by providers, and we know the cost part; the providers will tell us about the quality part, and so we will attempt to get our employees to select the high quality, cost-efficient providers. By doing that, we will reward those hospitals with patients, which is what they need economically; and by the same act, we will divert, as best we can, patients from the hospitals where lower quality or less cost efficient care is being delivered. We believe that would establish very strong incentives in the system for a focus on health outcomes and also, perhaps the most important part of this, for a strong focus on continuous quality improvement within the hospitals. That is probably, ultimately where the real solution lies. It is what we call in the industry the "total quality management" approach, where statistical evaluation of product and service outcomes is used to go back and examine the process itself and eliminate the cause of defects, in order to improve product and service quality.

7. THE INCENTIVES FOR EFFICIENT DELIVERY OF QUALITY HEALTH CARE

We hope to establish very strong incentives for both of those things through the way we purchase health care. In that way, we hope to shift from the current perverse incentives, apparent to almost anyone who has

ever dealt with health care claims payment or purchasing, which place strong emphasis on the quantity of services delivered, to an emphasis on outcomes and improved patient health. By using the word "efficiency," or "an efficient organization," sometimes we appear to imply that hospitals are, in some way, inefficient. I spent a brief time working in one hospital, and I think I can say in good conscience that I met in that hospital some of the most highly dedicated and motivated people I've ever met in my life. Health care workers, not just doctors and nurses but all the health care workers right down the line, were extremely dedicated people. I think it was a hospital director who said that hospitals tend to work very efficiently in spite of the fact that hospitals are extraordinarily complex organizations; far more complex than the world I work in-manufacturing. And yet there seems to be a very high level of dedication on the part of the average health care worker that tends to derive superior results for the patient. So, I am not one to accuse hospitals of being, in that sense, inefficient because I don't believe they are, but I do believe that there are more or less efficient ways, as well as more or less appropriate and necessary ways, to deliver health care itself. And that's the kind of efficiency, indeed, that I think we're really talking about. Finding out, truly, on a scientific, statistical, clinical, epidemiological basis, what actually work bests, focusing then on doing away with some of the medicine that we are less sure of.

8. COMPLEXITY OF HEALTH CARE MEASUREMENTS

There are a few caveats in this I'll mention before I sit down. One is the complexity of measuring health care itself. Anybody who has had any experience with it knows that it is a very difficult, very complex, very heterogeneous product, very hard to measure. Some real advances have been made in that regard in recent years which we believe hold the seeds and are the embryo of methods that we believe can be rapidly sophisticated. And we believe by furnishing an incentive for their application, we can help strengthen and encourage forward movement in this process. But that is one caveat, and as Dr. van Heeckeren reminds me as often as he has a chance, we have to remember to keep the community focused on the quality issues as well as on our cost problems, and he's absolutely right. We also have to keep focused on the measurement systems themselves as we move forward.

9. MEASURING THE SAVINGS

The second problem, which we haven't solved yet, is the actual mechanism by which we could measure savings and dedicate those savings to underwriting the problem of the uninsured. I'm not a community structure kind of guy; I don't know tax policy very well and I do not know the best ways to do that. I know there is a willingness to do that, which seems to me to be the major hurdle. That having been accomplished, it would seem to me we can find a way to do it responsibly which will not furnish

incentives for dumping into the public system nor "creaming" the private system. If we can arrange such, it would be ideal. We will be working on that very hard within the next few years. That concludes my remarks. I want to pass this on to John Polk.

E. JOHN POLK

1. COUNCIL OF SMALLER ENTERPRISES' (COSE) APPROACH TO MANAGING HEALTH CARE

A friend of mine who is an attorney called me up, having been invited to this program, and said "Say, I notice you're speaking at this program at Cleveland-Marshall School of Law." I said "Yes." He said "It's a fairly high profile group. Some very knowledgeable people are going to make presentations. How did you get on there?" I asked myself the same question more times than once. I'm not a lawyer or a lobbyist or a technician. I run a small business division of a local Chamber of Commerce, the Council of Smaller Enterprises (COSE), and we're the largest such organization in the country. We have nearly 9,000 companies listed in Cuyahoga County which are members of our organization. We offer a wide range of services to the various small companies that are our members. Among the most popular is the opportunity to participate in one of the numerous health care programs that we make available to our member companies. About 6,700 of them currently participate in health care programs that we offer. Those 6,700 companies currently provide coverage to 50,000 employees and their families, as a result we have 125,000 individuals all total, here in Greater Cleveland. And this year our members will invest about 110 million dollars in new health care premiums in the programs that we sponsor. The average company participating in our plans is a company with about seven employees. So when you talk about small employers, we're talking about very, very small employers.

There are a number of things about our program which I think are important to the discussion of how we insure the uninsured. One of the things that I'd like to focus on quickly, is that our programs—despite the fact that all the experts tell us they should not be successful—appear to be working quite well. Participation in our plans has increased by about thirty percent over the course of the last year alone, and our costs have been remarkably stable, particularly remarkable, given the small group market place. In the last five years, the cost of commercial insurance coverage available to small employers in our area has increased by a little bit more than a factor of two, about 106 percent on the average. COSE members who have participated in our plans have seen their cost increase a combined total of only about 21.5 percent in the past five years.

2. PROVIDING ACCESS TO HEALTH CARE FOR SMALL EMPLOYERS

Why do I think that's important? Well, about thirty percent of the groups that participate in our plans are small companies that tell us that

for one reason or another, they did not have access to health care coverage prior to becoming a member of our organization and participating in our plans. They were either brand new companies so that the search for health care coverage was new for the company, or they were sole proprietorships, one person "groups" to which group coverage is, generally speaking, not available. Or they were companies which, for various reasons, were simply unable to obtain health care coverage at a reasonable cost for their owners and their workers. And when you consider that about two-thirds of the people in our country who have jobs but do not have health insurance are individuals who have some connection to workplaces which employ fewer than 100 people,³ we think that our experience might add something to the debate with respect to the best manner in which to make access to affordable health care coverage available to small employers in community and in our country.

It's clear that the impact of health care reform is going to be particularly significant on small employers in our community. And one of the things that I think that COSE brings to this debate is a very clear sense of the market place; of how health policy which is enacted up here (gesturing above the speakers' head) has an impact on real live people in real live companies in our community.

3. ELIMINATING MORALISTIC POSTURING IN THE HEALTH CARE DEBATE

A lot of the debate focusing on insuring the uninsured carries an unfortunately moralistic tone. Employers who do not provide coverage for their workers are generally categorized in a political discussion as greedy and exploitive of their workers, and the actions of government, we are told, are meant primarily to punish those employers by forcing them to do the right thing. Our experience is somewhat different, and that is that small employers, everybody on earth frankly, wants access to group health care coverage, and is prepared to pay just about anything in order to obtain it. The problems are problems of access and are related to the dynamics of the market place. These problems cannot be adequately addressed merely by passing laws. Of course that moralistic tone is generally reinforced by groups like ours when we are on the defensive, talking with our state legislature or with members of Congress about the latest group health care reform initiative whose purpose is primarily to enable government to use our money to solve the problems of various constituencies. We often tend to be categorized as negative or as obstructionists in the discussion. After all, the essence of the discussion over mandated benefits, as the old joke goes, is that the easiest thing to get two people to agree on is how a third person should run his life or spend his money.

³ See also *Who are the Uninsured?*, *supra* note 1; see also *A Profile of Uninsured Americans*, *supra* note 1; see generally GENERAL ACCOUNTING OFFICE, *HEALTH INSURANCE: A PROFILE OF THE WORKING UNINSURED* (1989).

But, we'll be talking about politics later. The majority of our afternoon is focused on political issues. What I'd like to do now is to take a look at some of the market factors which conspire to create problems of access to affordable health care for small employers and their workers. COSE's plans have grown and flourished because we've tried to keep focused on solutions to these problems in the market place. No attempts to address the health care problem, particularly as it affects small employers, will succeed unless these issues are faced squarely and decisively.

4. STATE MANDATED BENEFITS AS A COST FACTOR

When you do obtain it, health insurance coverage costs a lot more for small companies than for large employers. The costs, relatively speaking, can run up to forty percent more for small employers than for larger ones.⁴ And one of the reasons for those excess costs, at least, the reason that is most commonly referred to, is state mandates of various kinds. It is a unique problem at the state level because, of course, state initiatives to mandate coverage for certain types of procedures or reimbursement of certain types of providers can impact only fully insured plans which are regulated at the state level. Large employers are, generally speaking, as a practical matter, exempt from those mandates. In the State of Ohio, we currently operate, I believe, under fourteen separate state mandates providing reimbursement or requiring insurance carriers to include in policies which small employers buy, reimbursement for certain types of procedures and certain types of services. We estimate, although no one can tell us exactly so we can be sure, that the small companies which are members of our plans will spend about 10 million dollars this year to cover the costs of those mandates. Some of them are arguably necessary and important; many of them are not. COSE members have no way to buy the ones that are good and not buy the others because the state law says that our insurance carriers have to offer all of those programs,⁵ and we have to buy them.

5. SALES AND ADMINISTRATIVE COSTS

Another factor is sales and administrative costs at the small group level. The administrative costs established with our programs run about 11.3 percent of annual premium. That is a good deal larger than the administrative costs attached to large commercial accounts where the average cost of administration is about 6.5 percent. However, even at a level of 11.3 percent our administrative costs are a bargain in comparison to conventional, small, fully-insured plans where administrative costs can easily run somewhere between fifteen and thirty percent, depending

⁴ *Id.*

⁵ See also *Laudicina, State Health Risk Pools: Insuring the "Uninsurable"*, 7 HEALTH AFF. 97 (1988); see generally GENERAL ACCOUNTING OFFICE, BRIEFING REPORT TO COMM. ON LABOR AND HUMAN RESOURCES, U.S. SENATE HEALTH INSURANCE: RISK POOLS FOR THE MEDICALLY UNINSURABLE (1989).

on the carrier. A big factor in those costs on the market is, of course, the cost of reimbursing agents who are, by and large, the primary sales channel for fully-insured plans in the small group market. They'll add, easily, ten percent to the cost of coverage. Our plans do not rely upon agents, and so our members save that money.

Cost-shifting is also a particularly pernicious problem in the small group market place. Of course, as big purchasers of health care coverage become more aggressive in negotiating directly with providers, providers have a tendency to shift excess costs wherever they can. The primary target for those excess costs are the commercial insured plans which reimburse on the basis of charges as opposed to on the basis of some negotiated level of cost. Those who purchase commercial coverage on a fully insured basis are, by and large, small employers. And since most health maintenance organizations and preferred provider organizations, alternative delivery systems, do not market to small companies, small employers are sort of stuck at ground zero in this increasingly difficult challenge.

6. THE IMPACT OF INSURANCE INDUSTRY PRACTICES

Then there are the practices of the insurance industry. The insurance industry is very often singled out for abuse in this area, and in many cases they deserve it, but there is an old Russian proverb that, somewhat, loosely translated, says: One cannot fault the wolf for being a wolf. The insurance industry is performing, in the manner in which it has grown used to performing and it responds to the demands and priorities of the market place. They are doing what they believe to be right and there "ain't nobody" to tell them different. And so, that's the way it works. Medical underwriting, which will, by and large, deny coverage to about ten percent of the groups that apply to any insurance carrier for coverage will enable an insurance carrier to reject an entire group that applies for coverage if even one member of the work force is ill. This causes a significant problem in access and affordability. The sort of retail marketing orientation of the insurance industry, which relies primarily on agents for its distribution channel, and which essentially provides small groups with off-the-shelf products at off-the-shelf prices, which a small group either buys or doesn't buy, is a problem. The low margins that the insurers enjoy on health care coverage make them very nervous about establishing long term relationships in the small group market place. Most commercial, fully-insured plans are essentially cost-plus plans so that the combined cost of utilization is merely passed along to subscribers. This has resulted, of course, in a provider-driven sellers' market where no one, not providers, not insurers, and certainly not government, has any particular incentive to control the cost, the price, of health insurance coverage available to small employers. And a small company consisting of seven employees is up against all that, all by itself.

7. WHY COSE'S APPROACH HAS BEEN SUCCESSFUL

There are a number of reasons why our plan works a little better. We are very large with 125,000 people with 110 million dollars in annual premiums. We have a little more leverage with our carriers than our individual members would have by themselves. We do have a philosophy of aggressive management of our plans on our members' behalf. We have a very strong focus on controlling the cost of administration established for our plans. We pride ourselves on our long-term relationships with creative carriers. Blue Cross/Blue Shield is not always accused of being the smartest insurance company in the state of Ohio, but it is certainly among the most creative and has demonstrated tremendous willingness to work with us to meet our members' needs as we have defined them. In a very real way, COSE has empowered a small business constituency in the health care marketplace. Small companies save money, the rate of working uninsured people in our community is lower than in other metropolitan communities around the state of Ohio. Our carrier makes money on our business. Everybody wins, and it *works* without a great deal of help from the government and in a legislative and regulatory environment which is essentially hostile to our success. For the past ten years, the experts have been waiting for our plans to blow up. And they are still waiting. There have been some tremors, but we're still doing pretty well. We believe that we have something positive to offer to the debate, maybe an effective alternative, certainly a refreshing one, which is based on the voluntary participation of the private sector. We *hope* to be able to get off the defensive on that, to be able to develop that in a cooperative and creative way.

8. THE UNINSURED - NOT A SINGLE CONSTITUENCY

Before we go passing laws, we should remember the uninsured are not a single constituency. They are a heterogeneous collection of groups whose only real common ground is that they lack health care coverage. And a mistaken alternative for dealing with the problems of the uninsured is to ghettoize them, to create programs that are available only to indigent uninsured people which tend to isolate the uninsured from the remainder of the community. *Our* program, we believe, has dealt successfully with the problems of the uninsured, at least on a partial basis, because we have attempted to integrate people who have not been able to acquire health care coverage into the insured population, and spread that risk across a much larger group that has much more integrity from a rating standpoint. No single broad initiative will *ever* address this problem effectively. We need an integrated approach which relies on solutions by addressing the reasons *why* the uninsured are uninsured. And unless we are all prepared to face these issues squarely and deal with them decisively, we'll never really succeed. I think that groups like COSE demonstrate that such creative approaches can be successful if we want to use them. The real question is, do we really want to try? Thank you.

F. KENNETH SEMINATORE

That's a tough act to follow, because John Polk and COSE have solved more health insurance problems in this country than have all fifty state legislatures put together. Let me start by disclaiming who is speaking here. The materials in your outline are position papers of Blue Cross, including the landmark study of high-risk and uninsured persons throughout the nation written by the accounting firm of Laventhol & Horwath, and a copy of remarks made by William Silverman, spokesperson for Blue Cross, to the Ohio Legislature. I'd like to have a more creative discussion with you, so let these remarks be catalogued as mine personally.

1. NO SUCH THING AS UNCOMPENSATED CARE

First, let me make three points. The first is a data point: there is no such thing as uncompensated care, except for a few hospitals that show actual negative operating results on their operating statement in a given year, and there are but a precious few of those throughout the United States. Every hospital is compensated for every dime of care it provides to the medically indigent. They cover it in their charges to third party payers, to self-insurers, or to direct pay customers. Unless they're going into the red at the end of the year, hospitals are compensated for every dime of care that they render to the medically indigent.

Second, if the prices charged by hospitals and doctors for health care delivery are not driven backwards—not contained, but driven backwards—there is no solution for the uninsured or anybody else.

Third, because I do not believe that the federal ERISA statute will be repealed or significantly modified during the next twenty years, a residual of the uninsured, whom the states and the private sector will be unable to provide for, must be taken care of by the ultimate source of the law of large numbers, namely the federal tax base.

2. ACCESS AND AFFORDABILITY: PROBLEMS WITH THE PRESENT SYSTEM

Let me give you the background of why I make these three points. The access and affordability problem is not a crisis of health care because the fact of the matter is that most people in this country, including the indigent and the working poor, do have access to health care. That hospitals "book" uncompensated care on their balance sheet simply means that they're not collecting from the person who is the recipient of the care itself, but they are collecting. Nevertheless, there are gaps in the system's coverage, particularly for the high-risk population that have medically advanced conditions. And the system seems to be headed towards pricing many more people out of the market place, and pricing much of American industry out of its competitive position world-wide.

3. THE CANADIAN ALTERNATIVE - NOT AN AVAILABLE ONE

I'm not going to dialogue with you about the Canadian health care system alternative. It doesn't work in Canada; it won't work here. If we adopted it in Ohio, the one-third of the marketplace in Ohio that is still insured will try to figure out some way of escaping, under ERISA, to self-insurance to avoid the Canadian system. What would be left under the Canadian plan on a single state basis would be the uninsured, the direct pay population, which already has a disproportionate share of the uninsured and high-risk, and the very smallest of businesses which could not afford to or otherwise figure out some way to self-insure.

Does that mean that the price spiral and the concomitant access and affordability questions must go unresolved? The answer is no. There are steps that we all can take here in the state of Ohio that will largely address these problems and would solve the access and affordability problem, not only for the general population, but for a significant portion of the 1.4 million of Ohio citizens who are uninsured, including the 140,000 high-risk uninsured in the state. The portion of the marketplace that cannot be taken care of locally is, as I said, a problem that can only be addressed by the federal tax base.

4. WHAT SHOULD BE DONE?

What should be done? The current situation is the result of two parallel phenomena. The first is the price escalation in provider charges that has many causes, has been well documented, and has resisted every solution, save one: unrestrained, raw, in Henry Manning terms, Darwinian competition. I am Henry's Neanderthal, and you have met the Darwinian competition model that he was referring to.

Second, there's been fragmentation in the marketplace which has fractured the long standing covenant that existed, and which for fifty years in this community at least, permitted the healthy people to absorb the expenses for the sick without much difficulty. Commercial insurance companies began "cherry-picking" the healthy groups that had previously been Blue Cross customers. Then ERISA came along and gave medium-to-large size groups an incentive to escape the mandated benefits and other state regulation by self-insuring. The old community rating system evaporated, and those who perceived themselves able to obtain lower prices by becoming merit rated commercial insurance customers, or self-insured plans, did so. The spiral continued, the "Blues" lost market-share, the insured and self-insured marketplace abandoned the previous coverage provided for the high-risk and the unwell, and did so, in large part, because the spiraling cost of providing health care made it prohibitively expensive.

5. STATE RISK POOLS - AN UNSUCCESSFUL APPROACH

What can we do? We can turn to a state high-risk-pool solution for the high-risk. Every state that has enacted one has seen a gross failure. The

needs of the uninsured in those states have largely not been addressed by the state risk-pools, even though the state risk-pools in each of the states which has adopted them see mega-million dollar annual underwriting losses. Who has been served? The tiniest fraction of the uninsured high-risk population with the highest incomes because they were the only ones able to afford the premiums under the other states' risk-pool approaches.

To his everlasting credit, State Representative Mark Guthrie solved that problem with a piece of legislation, House Bill 188, that passed the House and is currently in conference committee before the Ohio Legislature. He solved that affordability problem by putting in the bill a sliding income scale so that Ohioans who could not afford to pay the high premiums required by other states' risk-pools would have their premiums subsidized by the state. But that does not solve the whole problem. Our best estimates are that only 40,000 persons in the state of Ohio, out of 140,000 high-risk uninsured, would still be able to afford the premiums under Representative Guthrie's bill.

The real tragedy is that H.B. 188 has a 50-60 million dollar annual underwriting loss associated with it, and the legislature was faced with a budget appropriation of about two or three million dollars for it. When we called these facts to the attention of the Senate, the Senate stalled the bill because the Senate did not believe that Ohio should allocate 55-60 million dollars to the problems of only 40,000 Ohioans. We believe that the legislature should appropriate that 50-60 million dollars annually of state taxpayers' money, because that is a small price to pay under current circumstances for adequate health care for those persons.

But that obviously doesn't solve the whole problem. Obviously if the prices that were charged by doctors and hospitals for those high-risk persons' care were driven backwards, that 50-60 million dollars would cover a far greater number of that 140,000 high-risk uninsured than merely 40,000. You must understand that a high-risk individual in this state uses, on average, three times the services that an average healthy or sick person uses. If the prices for those of us who are in that normal curve are outrageous, the prices annually for those who are high-risk border on the obscene. If we don't solve the price equation, and we can't deal with all the high-risk in our state, we can't deal with all the high risk in our country, we can't even deal with the small groups which John Polk represents.

6. WELL-MANAGED COMPETITION - THE SOLUTION TO THE PRICE PROBLEM

What is the solution to the price problem? Well-managed competition, in my judgment, is the largest part of the solution. Well-structured competition here in greater Cleveland, after the passage in 1987 of Senate Bill 124, the Health Insurance Reform Act, resulted in a 35 million dollar reduction in the prices that Blue Cross would otherwise have paid to the hospitals in greater Cleveland. That's proof positive that the system works

in solving the problems of the uninsured. During that same period of time, through COSE, John Polk's group has been able to take a large number of small employers who were previously offered no health insurance whatsoever to their employees, and give them affordable health care coverage.

There are still bugs in the system. There is still an awful lot of gaming, and we still have to deal with that. But that's not the major assault that needs to be addressed in the future because we have done nothing, in my judgment, to address the real culprit, which is the physician part of the equation. That needs to be addressed. It needs to be addressed by a frank recognition that competition is not working amongst the ranks of our doctor peers. It is an unfortunate experience that we all read about recently with the shift of a major physician group from one hospital locally to another. That tells a story. I've talked with hospital administrators and some of their lawyers in this room. They say why don't you do something about doctors' prices? If we [hospitals] tell the high producing doctors that are filling our empty beds to lower their prices, the doctors say, your neighbor down the street is a hospital with just as many empty beds who will pay our prices, and we'll take our patients there.

That is competition turned on its head: it is a provider-driven perverse system that can be altered, and the solution is within the state legislature's command. Tell hospitals that their license will not be renewed next year unless they conspire with their competitor down the street to drive backwards physician prices, and give hospitals state-action immunity from the anti-trust laws when they do it. In other words, clean up the perverse competition that presently disables hospitals and which ought to be the source of price regulation for doctors, and permit it to work to drive the prices backwards.

7. THE CURSE OF MANDATED BENEFITS

Private buying can do part of the job; COSE can do part of the job; and hospitals not constrained by their empty bed surplus when it comes to dealing with doctors can do part of the job. But there's another part of the job that we all must do, and John Polk referred to it with mandated benefits. Mandated benefits are a curse to the uninsured. A study by Dr. John Goodman of Dallas indicates that perhaps 20 percent of the uninsured nationally are uninsured because they're priced out of the market by mandated benefits they neither want, their insurance companies don't want to offer, and they can't afford. Here in Ohio, Blue Cross spends, on a group like COSE, 10-15 million dollars a year, and 10 or 15 percent is due to the mandated benefits that are in place. Why should I, if I were a 25 year old single male buying health insurance coverage from Blue Cross as a direct-pay customer, have to pay for pregnancy benefits?

The most insidious of these pieces of legislation has not yet been passed. Its nickname is "CHIRP." It is billed as the pediatrician's solution for cradle-to-grave, or at least cradle-to-age eighteen, child care and early childhood preventive care. It sounds like motherhood and apple pie. It

will increase the number of uninsured in this state, by my estimate, by a half million people, because it is the most expensive mandated benefit ever considered by the legislature. It is obscene to require small groups, such as an employer with seven employees, to have to drop their coverage because CHIRP increases the premium by fifteen dollars per person a month. If CHIRP passes, those employers will not be able to afford it. It is insane to require that increased child care coverage and enable the pediatrician to have a second Mercedes in his garage, while half a million people in this state become uninsured who are not uninsured today.

All of us will have to do something about mandated benefits. State representative Mike Stinziano has a bill that will establish a commission to review these kinds of cost-benefit equations before the legislature would consider them. We wouldn't have the situation we faced with CHIRP, where it was put into the legislative hopper one day, the hearing was held the next day, those of us who showed up to testify were denied the opportunity to testify, it blew through the House, and now it's awaiting action by the Senate. You should write your legislators to support Mike Stinziano's bill, H.B. 568, because every mandated benefit is a pile-on of fat. And while CHIRP may only add fifteen dollars a month, the next one, for mammography, and the cost for the next one for infertility, will add a cumulative total, and the net result of which will be to escalate the numbers of uninsured in this state in the next few years.

8. MEDICAID BUY-IN FOR THE WORKING POOR

Nationally, we must permit Medicaid buy-in for the working poor. And we must recognize that no matter what we do at the state level, so long as we let those who can escape under the ERISA umbrella escape state regulation and mandated benefits, the ultimate residuum of the high-risk uninsured have to be taken care of by the national tax base.

What I've said here may contain some controversial thoughts, but if there's any purpose that these kinds of seminars can serve, it is to stimulate thought among those of us who are colleagues at the bench, at the bar and in the industry to try and come up with some solutions that work. I want it so badly to work, and I can tell you, I'm going to try to persuade my clients at Blue Cross, and at the Department of Insurance and in the commercial industry, that these are the ways we should go. I hope they'll tell me where I'm wrong, and I hope they'll tell me where I'm right. Thank you very much.

QUESTIONS AND ANSWERS

Q. I would like to direct some questions and comments to Mr. Seminatore. This matter of mandated benefits, I wish you would spell it out a little more because I am not quite certain what all you are talking about. You did put your finger on one, however, this matter of maternity pregnancy benefits. As I understand the cost of prenatal care in Michigan, if they spend one dollar there, they can save six dollars down the line from the

amount it is going to cost you after the birth has taken place and maybe avoid a lifetime of being an invalid in some way, or mentally deficient.

A. Ken Seminatore: Hogwash!

Q. In Colorado, I understand that one dollar in preventive care saves nine dollars down the line. Now it seems to me that this is rather short-sighted on your part here not to be willing to put that money into preventive care.

A. Ken Seminatore: There have been studies that have indicated that these preventive care estimates are hogwash. The fact of the matter is, if John Polk's customers (those 125,000 Clevelanders and 50,000 small groups) believe that, they would tell Blue Cross we want x, y and z benefits in our coverage. Let's assume for the moment that it is not hogwash, let's assume I'm dead wrong on that. What you are really saying is that for a small number of people that are benefitted by a particular preventive care, we're going to say that a large number of people should have no health insurance coverage whatsoever. My personal judgment is that's wrong morally, ethically and as public policy. We should not have 1,400,000 people in this state uninsured, and if we drop those mandated benefits that are on the books today, we could probably cover the better part of a million of them because they'd be able to afford the basic plan of health care insurance. Infertility is the classic example. There are a large number of people who are really concerned about infertility because, for the small number of families involved, it's a tragedy to want to have a child but be unable to. But for that infinitesimal fraction of the population, should we be depriving a substantial number of families of any health care insurance whatsoever? I think the answer is no. At least that's the judgment I've drawn, and I realize that is a legitimate debate.

Q. I thank you for mentioning the matter of infertility, and I agree with you on that, but on this matter of prenatal care, I think that you are the one that is wrong there because I think that a great many of the medical journals that I have read say that a little bit of money spent in checking the woman over while she is going through pregnancy allows the doctor to pick up the problem and save a lot of money after the birth has taken place.

A. Ken Seminatore: And I am saying that if that is actuarially true, the industry would recognize it by offering it as a standard element of coverage. Mandated benefits are supported through the legislature by those people who have a perceived need for the service, but the dollars that finance the mandated benefits campaigns are provided by the doctors and hospitals that would be the economic beneficiaries and, therefore, I'm always suspicious when I see a mandated benefit. I ask, why are the doctors and the hospitals who are saying that this is such great preventive care putting all these dollars into a legislative process to pass it? If it

was such a great thing, why don't they build it into their fees? But they don't. It is a profit motivated business, this business of mandated benefits, and profit motivation is destroying our country's ability to deal with the working poor who are un-insured, in my opinion.

Q. This is for Mr. Seminatore. Could you explain in more detail how you would propose that hospitals should conspire to keep physicians and physician groups from moving.

A. Ken Seminatore: Sure, the answer is, the state would set up a licensing system that would be run by the Department of Health, and in addition to current licensing requirements, you would annually be measured on the physician prices generally charged in your catchment area. You would be required, I think, to deny admitting privileges to any physician or any member of his group who had a price schedule that was greater than that which would lead to, say, a ten percent reduction in five years in currently charged prices. If you didn't accomplish that, you would be out of business the next year. You would be able to, in conjunction with all the hospitals in your community, agree that none of you would grant admitting privileges to that physician unless his price schedule went down, say ten percent a year for five years, and you would be insulated from anti-trust scrutiny by state action immunity.

Q. Could I follow that with one question? Blue Cross has sought and has eventually gained the right to, in effect, force hospitals to bid against each other to be allowed to provide services for Blue Cross insured. What attempts, if any, in light of your remarks about physician costs, has Blue Cross made to have hospitals treated in a similar fashion? It sounds to me like you are willing to take the hospitals on the record, but you are not willing to take the physicians on the record.

A. Ken Seminatore: I told you these are my personal views not Blue Cross's views.

Q. Well, is that an answer? A comment on the notion of making the hospitals hold the physicians' prices down. It sounds to me like you are against mandates from the states on insurers, but you are in favor of them on hospitals. Blue Cross and Blue Shield deals directly with doctors. They are the dollars that you control in trust for your subscribers. Why should not Blue Cross do this as opposed to the hospitals?

A. Ken Seminatore: I told you that maybe it should. I was making a personal proposal that I believe would be effective because I believe that, ultimately, most of the consumers in the community look to hospitals as the ultimate source of wisdom on who is and isn't a good physician, and what is and what isn't a good price. I would clean-up the competitive model so that it works. I believe it can work in competition. I believe there's a structural barrier right now. Because of all the excess capacity in hospitals, the physicians are gaming the hospitals now as badly as the

hospitals used to game Blue Cross. I am trying to figure out a way to break that structural barrier.

Q. I have a question about your view on mandated benefits. Do I understand you to say that you would reduce the benefits for certain people and give that money to people who are uninsured.

A. Ken Seminatore: Not really. I'd say that the premium that is charged.

Q. Let me finish the question.

A. Ken Seminatore: Oh, I'm sorry.

Q. And, conceptually, if you reduce those benefits for people who presently have them, or eliminate them, don't those people, to the extent you've eliminated benefits that were present in their policy so they will no longer be covered, become uninsured, so you've just shifted the burden around to somebody who is partially insured to provide more for the totally uninsured?

A. Ken Seminatore: The answer is yes. When I was twenty-five and single I would have been uninsured against the eventuality of my becoming pregnant.

Q. I think that it is fair to say that there are other benefits that the legislature mandated other than pregnancy for a male, who, by the way, may be responsible for the prenatal care of a child conceived out of wedlock, but other than that, aren't there benefits that can't be dismissed so lightly?

A. John Polk: Let's talk about this from the stand point of a plain old customer. There are a number of problems from my standpoint with state mandates, one of which is that any single one of them will have a very powerful and compassionate constituency. So we can't really separate them all and talk about which ones are good and which ones are bad. Most of the political discussion, particularly at the state level, is kind of dishonest because state mandates don't solve the problem. They do impose significant additional costs on fully-insured plans which small employers must purchase and leave large employers scot free either to ignore them or to negotiate their own levels of reimbursement. From my standpoint as manager of COSE's new health care plans, for example, the imposition of those state mandates means that ten million dollars which we might have the ability to negotiate with is directed to programs which might benefit some of our members are of limited value to our broad membership. One can always find individual constituencies which benefit from specific mandated benefits. But our interest is in maintaining the integrity of our plans for the long term interest of our broad membership.

Chemical dependency is a wonderful example. We would like to have, in the context of our plans, the ability to negotiate a managed care ar-

rangement for the treatment of substance abuse for all our members who participate in our plans. But because the state has imposed a fairly rigid standard for the treatment of substance abuse services, we are unable, as customers of fully insured plans, to negotiate more creative approaches to solving the problem. We think we could do it more efficiently and more cost effectively but for the imposition of that state mandate.

So while individual mandates do have powerful constituencies and those constituencies are by and large composed of the needy and those who will benefit financially from the imposition of those mandates, the total range of mandated benefits does impose some significant and not always altogether necessary costs on the total group, and that is why I think they are unfair. And the small business people in the state pay for them. The remaining half of the work force is not shackled by them.

Q. Are you basically saying that you have a utilization issue as opposed to a price issue?

A. John Polk: I think that it is kind of hard to disassociate one from the other. One of the things that we do know is when benefits are mandated, utilization of mandated services tends to rise and the reimbursement schedules tend to rise as well. When we are free to negotiate our own rates or our own levels of reimbursement, we will probably have more freedom to control those costs in a meaningful way.

Q. It is refreshing to hear Ken talk because we all at least know where he is coming from. I think he owes an apology to the pediatricians of Northeast Ohio. There are ample studies that show that pediatricians are among the lowest compensated people for the hard work they do. And I think that was kind of a cheap shot about the second Mercedes.

A. Ken Seminatore: I won't apologize because if they are poorly compensated, they are using CHIRP to try to catch up.

Q. As far as competition is concerned, medicine appears to be one of these unique situations where cost doesn't necessarily compete well. I remember, when I was in training in another community, what the cost for veinstripping was. There was a guy who charged twice as much as anybody in town, and I ask you to guess who had the biggest practice. It was of course the most expensive guy. So there are many areas where the model you propose might not work in medicine. We have seen it here on the billboards along the roadway where hospitals advertise that they have more lasers or CAT scanners than hospital x, y, or z and this is where they are going to compete — on the basis of service, not cost.

A. Charles Weller: I think the message we are trying to send is that the best approach has not been tried. Any system where, in the example you gave, a guy charged twice as much as the going price, is simply not a private competitive system. We have just not had a real private system.

In a real private system, the patient says, "That man charges twice what the going rate is; I won't go to him." It is the choice of the patient. It has never been tried in the United States.

Q. The point, of course, is that since the bill was paid by insurance, the patient didn't care about costs, but in an area that no one covers, which is plastic surgery, you find that price is not one of the things that we compete on; it's the prestige, or whatever that's involved with paying the highest price.

A. Charles Weller: The point is that, even with insurance, there is a tremendous opportunity to let the patient choose in a private competitive system. But we've never put that in place in the United States.

A. Powell Woods: In fairness, I believe when Mr. Seminatore mentioned competition, he called it well-managed competition, and well-managed competition is what we're obviously striving for here, and your analysis of what is lacking in terms of making it well-managed competition is really knowledgeability of consumers of what they are actually purchasing. He knows in a broad way what he is purchasing, but it is like buying a painting with a blindfold on because there is no real way accessible to him or available to him through any channels to find out about the quality of the services he's receiving. And so that is why well-managed competition to me would include a way to get at where the best is as opposed to the rest.

Q. Of course, there's the caveat because, so far, the dollar has created perceived value and the attempt you are making through the Health Action Council to try to analyze quality as a primary issue is hopefully going to help solve that. But until you can show that quality is not dollar-related, people are going to perceive expensive care as quality care.

A. Ken Seminatore: If I can interrupt, there will always be a Rolls Royce market, and if the people who can afford Rolls Royces want to go to the highest-charging plastic surgeon because it gives them status to pay the highest price in the marketplace, God bless them. They are not the subject of my social policy concern.

Q. For Ken Seminatore. Having gotten over the shock of your talking for somebody other than Blue Cross and recognizing it as your own opinions only and also understanding that Blue Cross in this competitive market is losing market share and no longer is the insurer of last resort for individuals who could not historically get health insurance elsewhere, I wasn't clear about what positive things you were suggesting from your personal perspective about what might be done other than the risk-pooling. Did I miss something or did you miss something?

A. Ken Seminatore: I think there are three things. Risk-pooling needs to be done and well-funded. Secondly, we need to recognize that the physician's side of the equation must be addressed by a fair, competitive system. Third, we have to address the subject of mandated benefits, which are pricing a substantial number of people who could otherwise afford health insurance out of the marketplace and into the ranks of the uninsured. Those three comprise the thrust of my argument.

Q. But it sounds like, on a very practical level, you would say personally that risk-pooling is the basket you would put your eggs in, at least with regard to the uninsured in Ohio. Is that correct?

A. Ken Seminatore: Only if you didn't hear the other two.

Q. You did not explain how the other two might work, Ken.

Q. I would like to make a couple of comments on the issue of mandates. What we have built into the equation are public costs, such as non-private prenatal care, or drug abuse treatment or mental health services, which are among the fourteen benefits mandated by the state of Ohio. If we don't provide prenatal care to women, the statistics show there is a much higher degree of premature deliveries and these serious cost hospitals in terms of intensive neonatal care services for those children, but, just as importantly, those children survive and are developmentally disabled. We, as taxpayers, and the legislature then have to insure care and education for those children. And so there is a public aspect of this that is not being addressed. By the same token, in terms of drug abuse or mental health services and some of the other mandates, I will admit I don't place a great deal of utility on them, but on the other hand, some of those mandates do effect public savings.

A. John Polk: My only comment is that while everything you say is of course true, and there are public costs entailed, I think that it is either naive or cynical on the part of our state legislature to assume that, by establishing mandated benefits, we are solving the problem for any more than the most already economically disadvantaged constituency in the health care business, and that is those small companies that are purchasing fully insured plans. Mandating insurance coverage of certain procedures does nothing to help those who have no insurance, and also drives insurance costs up further. And of course, as long as large companies which are self-insured are able to escape the impact of those mandates, you are raising prices in a highly discriminatory manner.

Q. Absolutely. I'm glad you said that because that was the third thing I was going to say. We've got to understand this should be a federal issue, and we in the state legislatures are trying to send that message to the federal government. Today, we know that when we enact a mandate, one-third of the plans out there are exempted from that mandate and that must be addressed.

Q. I also wanted to comment on the issue of mandated benefits. I think that the problem is not so much the state mandate as ERISA. Without the mandate, what you're saying about a twenty-five year-old single male not having to pay for maternity coverage, this basically argues for increasing segmentation of the population into smaller and smaller risk groups in which each person who has a need has to pay the full freight for coverage for that need. What you do, when you say the whole population shouldn't pay for prenatal care, is to say that all of the costs of prenatal care, therefore, should be paid by those families with women in their child-bearing years. And that seems to me both unfair and unjust and so impractical because you are raising the costs of prenatal care coverage dramatically for those people who need it. The second point I want to make was that when you talk about managed competition, I wonder what it is you really mean when you use the word competition. When Mr. Woods described his proposal that is a tool to give consumers and purchasers of health insurance information which they would use in a competitive situation to select providers, so when you talk about competition, it sounds to me that what you're really talking about is not competition at all, but regulation. As somebody who's not an advocate of competition, I'd like some clarity about what it is you mean.

A. Ken Seminare: I think it is competition, and in the same sense that all competitive systems are subject to certain restrictions by government that government deems to be appropriate for the general welfare. What I see now is a structural barrier to the kind of competition that will reduce prices and that is what I would like to cure. But to address your earlier issue, I agree with you, there is a legitimate debate on mandated benefits. Let me give you the flipside, which is sort of a different question. I believe the data which says the most effective alcohol treatment program in the world is Alcoholics Anonymous, which is proof that you do not need more than three or four days in a hospital for detox, and all of those programs that run twenty to fifty days and cost \$15,000 to \$40,000 a month for inpatient rehabilitation have a higher recidivism rate than our prisons. Yet, I'm required to provide coverage for that if I'm an insurer in this state, even though I know, as a matter of fact, that I'm pouring money down a rat hole because it doesn't work. Now, why shouldn't I be able to negotiate on behalf of my customers for a program that works? Why shouldn't I be able to spend all that money and give it to Alcoholics Anonymous that has a program that works? I can't do that as an insurer in this state. COSE's companies can't do that as employers in this state. We have to pay thousands of dollars for treatment that we know is a boondoggle. It is a waste of our money, and it's a use of resources that we'd be better off giving to things that do work.

Q. This is addressed to Ken Seminare. In talking about competition, you raised two main issues; one was the doctors moving from one hospital to another down the street which also had excess capacity. The first part of the question is that I'd like you to talk about managing the excess

capacity as the cost-driving mechanism. Second, the other image you evoked was the physician wanting to pay for his second Mercedes, but what about the hospital community acquiring its fifth CAT scanner, its seventh heart transplant unit, and how that drives costs?

A. Ken Seminare: Sure, the excess capacity, including the CAT scanners, to me is good so long as companies like Blue Cross and like COSE have the right to negotiate for price and choice because excess capacity improves price competition in a free market. The reason that we don't have price competition on the physician side of the equation today is that it is not a free market. It is an artificially constrained barrier for a lot of reasons. So, I see the problem of excess CAT scanners as short term. What we need to do though is remove the ultimate barrier that exists in this and every other community. There has been, to my knowledge, one hospital failure in the last thirty years in this community. There have been hospitals in this community operating at less than thirty percent of capacity, generating a black bottom line. Now, that is not true today; it was true a few years ago. What that tells me is that it is impossible to fail in the business of medicine if you are a hospital in this community. If you do not have the ultimate price of failure, there is an artificial barrier to free competition working, and the cost of eliminating that barrier may be too high for any community to pay. I'm willing to concede that, but you don't have free competition on the hospital side of the equation today. I can't look at any industry in the world, except in the Soviet Union, where you can operate at thirty percent capacity and make money. In this community today, the entire industry is operating at about sixty percent of capacity, and seven-eighths of the participants are making money. There obviously are some barriers on unrestrained competition that we have to address.

Q. For Mr. Seminare. Do I understand that as long as, at least in your perspective or perhaps Blue Cross' perspective, that as long as Blue Cross is able to have hospitals compete for its business, Blue Cross will in a sense be willing to see certificate-of-need legislation fade into the sunset?

A. Ken Seminare: Well, I can't speak for Blue Cross, but for myself, the only people who will get hurt if CON legislation goes away are lawyers and lobbyists. It's a boondoggle of magnificent proportions, in my judgment, that adds nothing but cost to the system. It has not produced a socially utilitarian result since its inception. It has not prevented construction of any project of any moment that I am aware of. But it is a wonderful way for us as lawyers and lobbyists to make a fortune and then add those costs back into the price of health care.

Q. As Blue Cross' lawyer, do you know Blue Cross' present position on CON legislation?

A. Ken Seminare: No.

Q. For John Polk. John, I think your modesty is becoming, but isn't it the case that COSE is unique, or nearly unique, in its success? You spoke about people who are waiting for your pay-off. I guess I'm the first. I am waiting for the success to spread and am not aware that it has. Could you comment on that?

A. John Polk: Well, I think that one of the things that has contributed to our success, which I haven't mentioned yet, is that we have been in this business for fifteen years on behalf of our members. Probably, one of the reasons that Cleveland is arguably a little more innovative on the corporate side in dealing with these issues is that we have been dealing for a much longer period of time with a level of health care costs which are exponentially higher here in Cleveland than in other parts of the country. We've been panicked as a business community over the rising costs of health care for a longer time, so maybe the innovation which has taken place over the course of fifteen years is a response to our unique market circumstance. In the last year I've probably talked with representatives of forty-five to fifty Chambers and small business groups, health care coalitions all around the country who are looking for a way to have what we have. The difficulty is that, while many communities are anxious to have a COSE in their community, few of them are anxious to make the difficult economic and political decisions required to put a program in place. If you're the Spiders Web, Arkansas Chamber of Commerce, and you want to put a COSE program in place the first thing that you find out is that the thirty members of the Chamber who are agents won't be allowed to sell the plan. That has a tendency to throw a little cold water on the implementation of those programs. We are working right now on plans that will enable us to fulfill the needs of other communities that wish to replicate our programs. But right now, the fact that we are unique I don't think means we are unreplicable; it just means that we are unique right now.