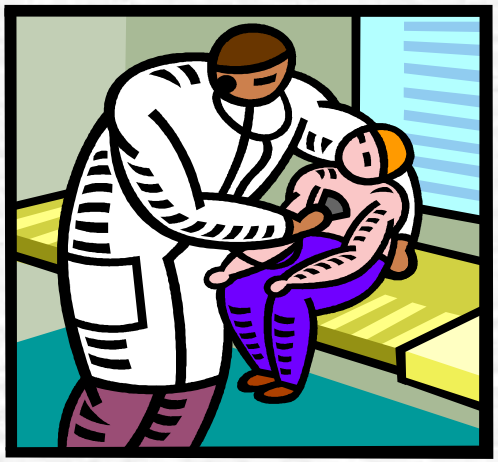
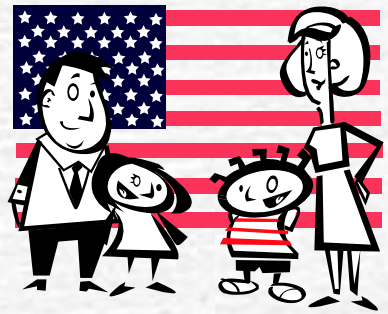
UNIVERSAL HEALTHCARE DE SOLUTION OR DEBACLE?



A. Where the US Healthcare System is Now

I. Approximately 43 million uninsured (2002)



- 16% of <65 population
- 66% of <65 population have er/ee coverage
- tax favored status of such coverage (er/ee)

A. Where the US Healthcare System is Now (cont'd)

- 11% of <65 population Medicaid/SCHIP
- over 70% of uninsured work part/full time
- uninsured voluntarily or because of price

A. Where the US Healthcare System is Now (cont'd)

II. U.S. System Comparatively

- leads in healthcare expenditures as % GDP (14.9%, 2002)
- Japan 7.1%, U.K. 7.6%, Canada 8.6%
- WHO measures health quality by DALE
- DALE = life expectancy adjusted by disability/infimity

A. Where the US Healthcare System is Now (cont'd)

- "world class health system" = DALE >= 70 years
- Japan ranks #1 in DALE (74.5 yrs.); U.S. #24 (70 yrs.) of 191 countries
- most world class systems heavily public funded
- Japan 80.2%; U.K. 82.6%; U.S. 44.1%

A. Where the US Healthcare System is Now (cont'd)

- greater public spending alone is not correlated with a higher DALE
- per capita spending of $1,000 (1997 $) needed to produce a world class outcome (DALE >= 70)
- U.S. ranks 72/191 WHO ranked countries with respect to health performance

A. Where the US Healthcare System is Now (cont'd)

- health performance is actual health attainment (DALE) versus capabilities based on resources
- U.S. is #1 in "responsiveness"
- respect for persons/client orientation
- people "feel good" about healthcare encounters but DALE is not affected

Current World Healthcare Data
Selected Countries - 2000

Country	% GDP	Per Person	DALE*	PS/THS
U.S.	13.9	$4,887	70.0 Yrs.	44.1%
Switzerland	10.9	3,248	72.5 Yrs.	69.3%
Germany	10.7	2,800	70.4 Yrs.	77.5%
U.K.	7.6	2,000	71.7 Yrs.	82.6%
EU Avg.	8.2	1,868	71.4 Yrs.	N/A
Japan	7.1	2,373	74.5 Yrs.	80.2%
Canada	8.6	1,783	72.0 Yrs.	72.0%

*All qualify as "world class healthcare outcomes" (DALE $\geq$ 70 yrs.)

B. Why the System Is Where It Is Now

- goals for most systems involve cost, access, quality
- Hammurabi (Babylonian 1700 B.C.) had laws on healthcare
- system is shaped by ethical, political, social, economic environment
- no “one size fits all” system

B. Why the System Is Where It Is Now (cont'd)

- U.S. system characterized by liberty/autonomy
- U.K./Canada by equality/social solidarity
- in U.S. delivery is almost exclusively by private sector
- appears to be a disconnect between what people "want" from system and what they "need"

B. Why the System Is Where It Is Now (cont'd)

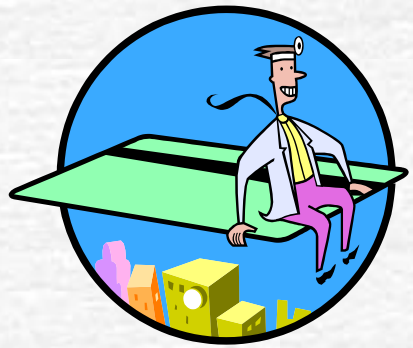
- DALE measures "needs"; responsiveness measures "wants"
- U.S. system more toward "wants" than "needs"
- perhaps the result er/ee system of availability
- leads to an insulation from cost of "wants"

B. Why the System Is Where It Is Now (cont'd)

- this responsiveness to "wants" adds significant cost to system
- especially in system so dependent on private sector
- supply can lead demand, not vice versa
- leads to a wide range of care based on ability to pay

B. Why the System Is Where It Is Now (cont'd)

- U.S. system ranks low on financial fairness
- "all the care we want and need when we want it"
- U.K. system has less variation in outcomes but is low in responsiveness



B. Why the System Is Where It Is Now (cont'd)

- studies show private/voluntary health insurance markets are generally market failures
- inability to shift all of the risks of an economic event
- partly caused by information asymmetry
- meaningful difference in information between buyer/seller

C. Prospective Proposals/Actions On System

I. Change focus from "wants" to "needs"

- more cost-sharing to focus on costs
- HSA's (HR-1) – level tax playing field
- HR-1 new higher cost share Med Supp Plans K and L
- technological changes to lower administrative costs

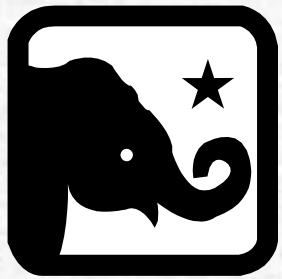
C. Prospective Proposals/Actions On System (cont'd)

II. Changes to reduce uninsured population

- HR-1 Medicare Part D PD coverage
- increase public outreach programs to reach those eligible
- administrative language/cultural factors are barriers
- SCHIP expansion

C. Prospective Proposals/Actions On System (cont'd)

- Bush proposals:
  - $89 billion (over 10 years) – low income subsidies for health insurance
  - HSA's – tax deductible contributions



C. Prospective Proposals/Actions On System (cont'd)

- Kerry proposals:
  - creates catastrophic (over $50,000) loss pool
  - pool pays 75% off excess losses
  - cost estimate $895 billion over 10 years
  - would expand SCHIP program as well

C. Prospective Proposals/Actions On System (cont'd)

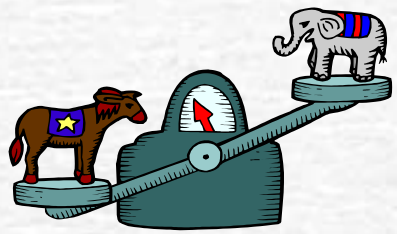
- only HSA program deals with "needs" versus "wants" issue (choice)
- other proposals deal with redistribution of costs who pays for the costs
- if process continues, government will become more involved, "needs" will take precedence

C. Prospective Proposals/Actions On System (cont'd)

- they have in Canada and U.K. as costs of public system have soared
- in Canada, cost of system is 22% of all taxes raised

C. Prospective Proposals/Actions On System (cont'd)

- Actuaries responsibilities/opportunities
  - make private system more responsive to "needs"
  - educate public that "wants" system is too costly to support



C. Prospective Proposals/Actions On System (cont'd)

- actuaries can communicate costs and consequences to relevant audiences
- if private system fails, "needs" system will predominate with all of its problems
- lack of choice, bureaucratic, high tax burden, inadequate facilities