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PANEL DISCUSSION

SOCIAL INSURANCE PROGRAMS FOR HEALTH CARE IN CANADA AND THE UNITED STATES

Panel Members:
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J. HENRY SMITH
GEORGE N. WATSON

C. MANTON EDDY:

I consider it a great honor to be asked to moderate this panel on what is a tremendously important subject. I consider it a deep privilege to be associated this morning with three such distinguished actuaries as appear at this table. They are men who are always in the mainstream of events, and they have great knowledge to express and fortunately a great ability to express it.

Today, gentlemen, we are the guests of Canada. It seems to me that it is most appropriate that we start our discussion with an eminent representative of Canada. Our first panel member to speak is George Watson, who is vice president and director of group insurance for his good company, the Crown Life. He is a native of Toronto, he is a graduate of the University of Toronto, and he has spent his entire business career with the Crown Life.

He has served on many industry committees. He is chairman of the Group Committee of the Canadian Institute of Actuaries, chairman of the Subcommittee on Income Tax on Group Life Insurance Premiums of the Canadian Life Officers Association, and a member of the Experimental Developments Subcommittee of the Health Insurance Association of America. But, most importantly, he is currently president of the Canadian Health Insurance Association, and so, gentlemen, his remarks to you this morning will have the full weight and authority of that fine institution. It is a great pleasure to introduce George Watson.

GEORGE N. WATSON:

I last reported on the developments in Canada in the health insurance field at the meeting at the Greenbrier in November, 1964. Since that time, there have been several important developments, and the subject of medical services insurance is in a very fluid state in Canada at this moment.

On July 19, 1965, a conference of the Premiers of the ten provinces was held in Ottawa. At that conference, the federal government offered a grant of $14 per capita to any province that adopted a plan of Medicare, provided such plan met four criteria. The $14 per capita grant was stated to represent 50 per cent of the per capital cost of physicians' services in Canada and was said to be based upon statistics taken from the Saskatchewan Medical Care Insurance Plan. Since then, it has been recognized as being too low. In order for a province to qualify for this grant, the Prime Minister specified four conditions which the plan in the particular province must comply with, and these were as follows:

1. The coverage must be universal.
2. The plan of benefits must be comprehensive as far as physicians' services are concerned.
3. The program must be administered by a government agency.
4. The benefits must be portable as between provinces.

Although most provinces expressed the desire to receive the federal grant, they were not so sure that they could raise the necessary amount of money internally in order to make the plan effective, and, in several instances, they felt that other public services, notably educational requirements, should take precedence over medical care insurance. Certain provinces expressed the hope that the type of plan which the province already had in effect could be continued and that the federal government would modify in some respects some of these four conditions.

At the subsequent conference held on September 23–24, the federal government changed its position slightly with respect to two main points, items 1 and 3 above. These were the only points that gave the industry any concern, because the other two were already being carried out by the companies in their normal business.

In the matter of universal coverage, it would seem that the federal government would consider eligible any province which succeeded in obtaining an enrolment percentage approximating 90 per cent. It was even stated that something less than 90 per cent might be acceptable at the outset, provided the eventual percentage that was reached was at least 95 per cent. It seemed that there was very little change in the federal government's position with regard to the point requiring that the plan be operated by a government agency but, since that time, it now appears that, provided the provincial government will accept the responsibility for auditing the plan, the federal government would accept in place of a government agency a nonprofit plan. This particular decision is giving the industry grave concern, because it is handing over to our main competitors this whole field for reasons which are not fully understood.

The federal government is, presumably, taking this stand because it argues that, if a government subsidy is to be paid, it cannot be paid to a privately operated insurance company. The argument on the other side is that the subsidy is not intended for each person in the province but, rather, would be used by the province for the subsidization of those in need. It would not, in fact, be paid to any of the insurers who would continue to conduct their businesses mainly through the group medium and would not expect or accept any federal subsidy.

This is the position at the moment, and very few, if any, developments are likely to occur prior to the federal election called for November 8. However, following that election and depending upon the party elected to power, developments of one kind or another are bound to come quickly. The Liberal government is committed to a policy of making Medicare effective July 1, 1967, throughout Canada or, at least, in those provinces which accept the federal grant.

In Canada, health insurance is considered a provincial matter and, at the present time, there are in effect three provincial Medicare plans, which I will now describe briefly.

British Columbia

This province has announced a plan of Medicare which is partially government-operated and partially privately operated. The government has restricted its field of operations to individual policies only and, for this purpose, has set up a government agency operated partly by representatives of the medical profession and partly by government officials. The rates charged by the government agency are less than the economic value of the coverage and, to that extent, the plan is government-subsidized. At the present time, there is no interference with the group insurance business, and private companies conduct their business in this area as before.

The plan includes provision for subsidy of the needy according to whether they have earned sufficient income in the previous year to be subject to federal income tax. If they do not earn sufficient income to be required to pay any income tax, one-half of the premium for the family is paid by government. If they have reported $1,000 or less of taxable income, they receive a subsidy of one-quarter of the premium. The plan is voluntary and is available to any resident who applies, regardless of age or physical condition. The plan was effective September 1, 1965, but it is too early, at this time, to state how successful it has been in the matter of enrolment of individuals.

Alberta

The Alberta Medical Plan became effective on October 1, 1963. The entire program is operated by the voluntary agencies, including the insurance companies and the doctor-sponsored plans co-operating together and offering medical services insurance to any applicant regardless of his age or his condition of health. In the case of applicants who have not sufficient funds to pay the required premium, there is a government subsidy to the insured. The companies and the doctor-sponsored plans operate a pooled risk arrangement to take care of the aged and the high-cost risks which cannot be insured for the maximum premiums which a carrier may charge and which are specified by the plan. This is a model plan as recommended by the Canadian Health Insurance Association and which, it was hoped, would be the model for similar provincial plans across Canada.

The result has been that a total of approximately 1,100,000 Alberta residents are now protected by some type of insurance or prepayment arrangement for medical care, including those in receipt of public welfare benefits, the armed forces, and persons under miscellaneous federal and municipal plans. This figure represents over 80 per cent of the population.

For further details on this plan, you may refer to my remarks in the *Transactions* of the Society of Actuaries, Volume XVI, beginning at page D337. This is a successful plan operated entirely by private enterprise and, as far as I know, is the only plan in the world where a social insurance need is met through this means without the intervention of government except to provide the subsidy to the needy and to provide the necessary legislation requiring all licensed carriers to participate in the program and share in the pool losses.

Saskatchewan

This province has had in effect since July 1, 1962, a comprehensive medical insurance plan on a compulsory basis for all residents. The monthly contribution required is $1.00 for each individual subscriber and $2.00 for each family. This is only approximately 25 per cent of the actual cost of operating the plan, the balance being raised through general taxation and, specifically, a sales tax. The introduction of this plan produced a severe reaction from the medical profession leading to a partial withdrawal of services for a period until the difficulties were resolved. At the present time, it seems to be working satisfactorily although, in examining the costs, it should be kept in mind that it pays only 85 per cent of the medical-fee schedule and it requires the contributions specified from each family regardless of whether they have the means or not. To this extent

it is, therefore, not as satisfactory as the plan in Alberta which contains a provision for subsidy to the needy.

Ontario

In Ontario, the legislature has passed Bill 136 which provides a plan of a similar type to that in Alberta. The bill has not yet been proclaimed, but it was expected to be effective June 1, 1966, and may still be proclaimed before that date. This bill provides that the entire plan except for the subsidized group (i.e., those who are in need or medically indigent) will be operated by the voluntary agencies, including the insurance companies and the doctor-sponsored plans. In the case of the needy in the province who are entitled to a subsidy, the government has set up an agency to provide the insurance coverage to that group. Persons entitled to subsidy are treated somewhat more generously than in Alberta. For example, a person who is not required to pay any income tax because of a low income will receive 100 per cent subsidy in regard to his medical insurance premium and persons paying tax on a larger sum not exceeding $1,200 will receive a smaller subsidy.

This program involves also the requirement that the voluntary agencies participate in a pooling arrangement to insure the high-cost risks and the aged where the cost of the coverage exceeds the maximum premiums stipulated by the plan. Payments for services are on the basis of 100 per cent of the medical-fee schedule, which may be contrasted with the system used in Saskatchewan and the basis used in Alberta.

Administrative Costs of Medical Services Insurance in Canada

One of the main arguments in favor of the use of government agencies as against private insurance companies is the question of the profit made by the insurance companies. This looms very large in the minds of the public and great emphasis was placed on this in the Report of the Royal Commission on Health Services. This Commission quoted from a study by Mr. C. H. Berry entitled "Voluntary Medical Insurance and Prepayment." Because the study was not, in fact, in existence as a public document at the time the report was prepared, many people have come to rely on the statements made in the Report of the Royal Commission as being absolute facts. A little over one year after the Commission's report was released, the Berry study was released. It is quite a reasonable attempt to set forth what the real administrative costs are in Canada for this type of insurance. However, it is written by someone who is not intimately connected with the business and, therefore, overlooks one or two rather important facts, with the result that it is easy to quote from this study and

produce a very unfavorable image of the job done by the industry—both the insurance companies and the so-called nonprofit plans.

The approach that the Berry study took in investigating the subject of administrative costs and profit was to develop the incurred claims ratio and then assume that everything in excess of the amount paid for claims could be classed as either profit or expenses. This assumption, when applied to any one calendar year, could produce extraordinary conclusions, depending upon whether the claims ratio in that year was higher than normal or lower than normal. For example, if the claims ratio for medical services insurance in the year 1961 had been, say, 100 per cent, a very different conclusion could have been reached than was actually stated in the Report of the Royal Commission on Health Services. It was, apparently, not appreciated by the author that such a situation could, in fact, arise and in some areas has arisen. This would suggest that this particular approach is not reliable or meaningful and something more direct in the way of determining the actual expenses of operation would have been more to the point.

However, if we accept this approach with all its limitations, we can draw a different set of conclusions than that stated in the Report of the Royal Commission which has received wide acceptance throughout Canada.

In Table 4-1 of the Berry study, it is stated that the loss ratio for all surgical and medical coverage for all carriers, considering only group coverage, was 80.5 per cent. This leaves a balance of 19.5 per cent, but, of this amount, 5 per cent has to be deducted as representing premiums returned, dividends credited, and increases in policyholders' reserves. The balance remaining is, therefore, 14.5 per cent, and this the author acknowledges as a reasonable estimate of the cost of operating a group insurance plan (see p. 63 of the Berry study).

However, there is still another adjustment to be made in order to determine a factual figure following this line of argument. The companies have made substantial provision in their accounts for experience rating refunds not yet declared. This is certainly not an expense item and is required by good accounting practice in order to reflect the true facts for the period under review when a substantial amount is expected to be disbursed to certain policyholders following the date of the statement. The amount of the adjustment for this item, taking the figures from the author's Table 4-2, is 2 per cent, which gives us a resulting balance of 12.5 per cent.

In comparing this cost with the cost of administering a public program, such as that in Saskatchewan, two further adjustments have to be made.

In the first place, in a public program there is no taxation and, hence, the item relating to premium tax must be removed with respect to the premiums paid to insurance companies. There is no similar item for the premiums paid to the prepayment plans. This adjustment amounts to approximately 0.8 per cent. A second adjustment has to be made to remove the amount of acquisition expenses which is contained in the 12.5 per cent figure. This is because, in 1964, the expenses of operation of the Saskatchewan plan do not include any item for acquisition expenses since the plan is being administered solely and the initial expenses of setting it in motion are not repeated in that year. However, in the insurance company figures, there is an item each year having to do with the acquisition expenses of new business. In order to make a true comparison, such acquisition expenses should be removed. I have estimated that these amount to approximately 3 per cent, and, hence, after adjusting for both of these items, the net figure applicable to group business would be reduced to 8.7 per cent.

If we were comparing this rate of expense which, of course, includes profit with a government-operated plan, we would have to make two other adjustments:

a) If every contract were the same, savings in expense would obviously result. The expense factor quoted, of course, relates to the expense of operation of many hundreds of different types of plans and many individual situations that have to be allowed for.

b) If there were some degree of compulsion, as there is in Saskatchewan, the cost of collection of premiums would be reduced.[1]

If both these factors are allowed for, this would produce a figure well below 8 per cent—possibly 7.5 per cent.

This is the conclusion that I draw from the statistics quoted in the Berry study. It is admittedly based upon the statistics relating to the group side of the business, because any plan embracing an entire population on a compulsory basis, such as in Saskatchewan, would undoubtedly be operated on that basis. Any voluntary plan would, of course, involve individual policies as well as group policies. This figure may be contrasted with the conclusion that the Royal Commission drew from the same set of statistics. They stated that the cost of private companies' operating a Medicare plan was 28 per cent of claim costs.

I do not claim that either Mr. Berry's statistics or his method is correct, as I have already stated; but I do say that, if this is the method to be used, all relevant factors ought to be properly allowed for, and, in that event,

[1] This is not to suggest that I advocate a compulsory plan, but, if comparisons are to be made, they can only be made comparing equals with equals.

the final conclusion to be drawn would have been that the private companies and the prepayment plans can operate a Medicare plan at a cost which is, evidently, similar to that of operating the Saskatchewan government plan which was, in 1964, about 7.2 per cent of claims plus expenses.

Of course, this is the conclusion that one must come to knowing the expenses of operation of large group insurance plans and, also, the expenses of operation of some of the large doctor-sponsored plans which are operated very efficiently at the lowest possible cost. Knowing these facts, it is disturbing to see these statistics used to prove that which cannot be proved. It is thought that the foregoing analysis may help to establish the true fact that the voluntary insurance agencies are, in fact, well managed and that, given an equal opportunity, can operate a Medicare plan just as efficiently as any government agency and, in my opinion because of their many years of experience, would most likely do somewhat better.

C. MANTON EDDY:

Thank you, George, very much for that very thoughtful discussion of the Canadian situation.

With respect to the United States, the Society has before it a paper by Robert Myers which is a very excellent factual report of the legislative history, the cost calculations by the government, and the resulting statutes under the so-called Medicare Bill, more broadly, the Social Security Amendments of 1965. I would suspect that there will be some vigorous discussion of this in the Society's meeting, but I have a colleague who is next to speak who himself has some interesting comments on costs of social security programs. This next speaker, who will discuss Medicare in the United States, is Dan Pettengill, vice president of the Group Division of the Aetna Life Insurance Company of Hartford, Connecticut.

Dan joined the Aetna Life after his graduation from Bowdoin College in the state of Maine in 1937 and has served faithfully and risen through the ranks to his present position of eminence. He is chairman of the Society's Committe on Experience under Group Health Insurance, he is chairman of the Group Task Force of the Health Insurance Association Subcommittee on Overinsurance, he is chairman of Connecticut 65's Operating and Policy Committee, and he is a member of the Central Committee of the Health Insurance Council and of the Canadian Health Insurance Association's Committee on Medical Services.

Dan has orbited a great deal of his time in Washington since last November, and I am hopeful that he will tell us of some of his problems and, even more hopeful, of some of his solutions. It gives me a great deal of pleasure to introduce to you Dan Pettengill.

DANIEL W. PETTENGILL:

So much has been written and spoken about social insurance in both the United States and Canada that it is with real temerity that we face you this morning. We shall be amply rewarded if something we say inspires you to take a more active interest in the social insurance system of your own country and encourages you to act to prevent unwarranted expansion thereof.

In Canada, the medical expense portion of the social insurance program currently applies to essentially all people but provides hospital benefits only. The threat to private enterprise is that the benefits will be expanded to include physicians' benefits and then other types of medical expense benefits. In the United States, the situation is reversed. Here, the medical expense benefits are fairly comprehensive but apply only to persons aged 65 and older. In the United States, therefore, the principal danger lies in the extension of the Medicare program to persons under age 65. In both countries the voluntary health insurance agencies have demonstrated a clear capacity to provide adequate benefits at reasonable costs except for that small segment of the population which is indigent. Thus, the problem is to persuade the government to provide assistance for the indigent without taking over the whole health insurance business.

As actuaries, we have a special responsibility to advise both the lawmakers and the general public with regard to the cost of any proposed social insurance scheme. This is often an unpopular task. Of even greater significance, however, is the fact that it is an extremely difficult task because of lack of exact data and the large number of variables involved. As evidence of this, let us take a brief look at the pricing of the Medicare Act in the United States.

In his latest paper, entitled "The Social Security Amendments of 1962–1965," Mr. Robert J. Myers, actuary for the Social Security Administration, states that the estimated level cost, over the next twenty-five years, of the Part A benefits of Title XVIII of Public Law 89–97 will be 1.23 per cent of taxable wages, assuming the maximum annual taxable wage remains at $6,600. Mr. Myers calls this a conservative estimate, perhaps because it is so much higher than any of HEW's prior estimates. Mr. Myers is entitled to his opinion, but I do wish he had mentioned that many of his fellow actuaries feel that this estimate is low. Specifically, a group of actuaries, working on behalf of the Health Insurance Association of America, have estimated that such level cost is more likely to be 1.55 per cent rather than Mr. Myers' 1.23 per cent. Such differences in opinions are inevitable as long as man is free to express himself. However, they do con-

fuse the public and the lawmakers. Therefore, they need to be carefully explained.

While I have not had an opportunity to discuss this particular difference with Mr. Myers, I believe that the reasons for it are analogous to the reasons for the even greater difference that existed in the cost estimates for the original H.R. 1 Bill from which Part A of Public Law 89–97 was derived. This latter difference was explained, thanks to the Hon. Wilbur D. Mills, Chairman of the House Ways and Means Committee, who, when Mr. Myers and I presented differing testimony as to the cost of H.R. 1 benefits, requested that we get together and prepare an explanation of our differences. This explanation is printed on pages 436–41 of Part 1 of the Executive Hearings of the House Ways and Means Committe on H.R. 1, which document, by the way, is reference number 7 in the legislative bibliography of the paper which Mr. Myers presented to the Society earlier this week.

While the cost of H.R. 1 is now an academic matter, a brief review of the differences that arose in pricing H.R. 1 would seem worth while in order to point up both the variables involved and the problem of costing them. Mr. Myers priced H.R. 1 at 0.96 per cent of taxable payrolls, assuming that the maximum tax base was to be $5,600 in 1966 and 3 per cent higher each year thereafter. The HIAA estimate was 1.38 per cent. It should be realized that each of these estimates would have been 12½ per cent higher had the constant tax base of $6,600, which applies to Public Law 89–97, been used instead.

One of the key variables was the rate of utilization. In the case of a hospital benefit, this is actually the product of two other variables, namely, the incidence of hospital confinement and the average length of stay.

Mr. Myers based his estimates primarily on the 1957 survey of a small sample of social security beneficiaries. This was an interview type survey and, therefore, is no sounder than the human memories involved. Mr. Myers made some allowance for human forgetfulness. The question is, Did he make the right allowance? The HIAA used a composite of insured experience. This experience was derived from cases with both favorable and unfavorable experience and was intended to be representative of the entire population aged 65 and over. Both sets of data are based on samples and, therefore, may or may not represent the whole.

There is some evidence that uninsured people use less care than insured people. The question is whether these uninsured people will increase their utilization rates to equal those of insured people once a government plan is introduced. At the time the comparison of the two cost estimates was made, Mr. Myers felt that any increase would be gradual, whereas

the actuaries for HIAA felt that the increase would be almost immediate. It is of interest to note that Mr. Myers' later cost estimates did assume an immediate increase in the rate of utilization by those currently uninsured.

It should be noted that neither Mr. Myers nor the HIAA attempted to take into account any change in utilization rates that the government program itself might bring about. Another imponderable is the supply of hospital beds. A shortage of beds depresses the utilization rate, while an overage normally increases it. Furthermore, the government could introduce regulations which would curtail either admissions or durations of confinement and hence affect the utilization rate.

There is also the question as to what effect other concurrent benefits will have on the utilization rate of any given benefit. For example, Mr. Myers felt that the fact that Medicare was going to provide an extended-care benefit and a home-care benefit would result in a lower rate of hospital utilization. The HIAA actuaries felt otherwise, especially since there are relatively few extended-care facilities and home-care programs now in existence.

The second major variable is the average benefit, which, in the case of the H.R. 1 hospital benefit, was the per diem cost of hospital care. Here again, Mr. Myers had a lower estimate. One reason for this was Mr. Myers' interpretation of the bill to the effect that hospitals would not be allowed to recover losses due to undercharging or to bad debts. The HIAA's interpretation was that the bill would permit the hospitals to recover these "losses" and therefore HIAA assumed a higher per diem cost. (I might add that the Congress appears to have sided with Mr. Myers on this point.)

Mr. Myers also assumed a lower hospital per diem cost because he felt that the longer average stay of aged persons would result in a lower per diem cost than that being experienced by persons of all ages, which was the HIAA's assumption. To my knowledge, there are as yet no significant data which would prove or disprove either point of view.

Both parties agreed that hospital costs would continue to rise in the future, with Mr. Myers using a slightly greater total percentage increase. However, since this percentage was applied to a smaller 1966 base cost, even his ultimate 1990 cost was still lower than that of the HIAA.

All the types of differences mentioned above with respect to hospital costs were equally applicable to the cost of extended-care facilities. Here there were fewer statistical data for either side to use, so that the relative magnitude of these differences was even greater.

It should be noted that all the foregoing factors relate just to the

value of the benefits themselves. The HIAA actuaries did not attempt to study either the population assumptions or the taxable wage assumptions. To the extent that Mr. Myers' estimates of income are high, then, of course, the cost of the benefits as a percentage of taxable income will be greater. Conversely, if his income estimates are low, then the percentage cost of the benefits will be less.

Perhaps the greatest significance of Mr. Myers' lower cost estimate is the pressure it inadvertently puts on the government to keep the actual cost in line therewith. This could result in rigid controls on medical care. No comparative cost estimates were made by HIAA with respect to Part B of Title XVIII of Public Law 89–97 because of the fact that it was introduced without hearings after the testimony with respect to H.R. 1 had been completed. Since the cost of Part B will be reviewed every two years and the beneficiaries required to pay half of any increase over the initial estimate of $6 per month per person, the likelihood of government controls is even greater.

This ever present threat that government regulation will interfere with the best practice of medicine suggests another area in which actuaries should take an active part. This is the area of administration. Actuaries need to advise on the statistics which the government should collect in connection with any social insurance program that may be adopted. This advice is needed both to keep the government from spending too much money collecting interesting but unnecessary statistical data and to be sure that the necessary data *are* collected. After determining what items of information are necessary for measuring the effective performance of the plan, the actuary then needs to determine which items need to be obtained on all claims and which can be obtained less expensively from a small sample of claims.

With respect to the United States Medicare plan, Social Security officials have indicated that they intend to require hospitals to use a special detailed billing form and to have a copy of this hospital bill sent to Social Security's Baltimore computer center for each and every claim. It is not certain, however, that all the data from these hospital bills will be recorded in every instance. With respect to Part B, there has likewise been no decision as to what the statistical program will be. Here certain government officials are torn between their innate desire for reams and reams of data and the possible doctor revolt that such statistical demands might touch off. The taxpayer is faced with the very real possibility that a huge statistical empire will be built unless pressure to the contrary can be exerted. There is the further danger that even such an empire will not give the administrative agents all the information

needed to control claim costs rationally. Thus, there may have to be additional statistical requirements imposed by the carriers themselves.

I have implied that insurance people are attempting to advise the Social Security Administration with respect to the statistical program. I might just take a moment to indicate how this is being done and also the other areas in which insurance industry advice is being given in a similar manner. In August of this year, the Social Security Administration requested some sixteen insurance executives to meet with them to discuss problems which had arisen in connection with planning the administration of Medicare. Soon, however, other interested groups wanted representation on these informal advisory sessions, so early this month the Social Security Administration set up ten informal work groups.

One deals with physician participation and how to determine a "reasonable charge." A second group deals with the qualifications that a hospital must have to participate in the program. Their work also includes the qualifications of an extended-care facility and a home-care program. A third group is concerned with what constitutes "reasonable costs" for each of the three types of providers of services. A fourth is concerned with the criteria by which HEW should select the carriers that will administer the claims-paying portions of the program. A fifth group is dealing with the costs of administration, that is, which of the many items of expense that a carrier may incur will actually be reimbursed by HEW and which will come out of the carrier's own pocket. A sixth group is concerned with the statistical systems that will be used, including what EDP programs will be necessary. A seventh group is studying the special problems created by reason of the inside limits imposed by the law on both psychiatric hospital confinements and psychiatric services. An eighth group is working to solve the crisis created by virtue of the fact that the law has covered under Part B, rather than Part A, the services of the four medical specialists whose fees are often an inseparable part of the hospital's charge. These specialists are the radiologists, anesthesiologists, pathologists, and physiatrists. A ninth group is concerned with information—that is, how to be sure that beneficiaries, providers of services, physicians, insurance companies, prepayment plans, and other interested parties are notified of key decisions. The tenth group, on which there is no insurance representation, deals with the special problems of the group practice plans.

These work groups are made up of representatives not only from the insurance business but from the American Medical Association, the American Hospital Association, the National Blue Shield Association,

the Blue Cross Association, and some twenty-eight other interested parties. It should be clearly understood that these groups are strictly unofficial advisory groups. The Social Security Administration itself will draft the regulations. These regulations will, however, be subject to the approval of the sixteen-member Health Insurance Benefits Advisory Council which was established by the law itself. It is expected that one of the sixteen Council members will be an insurance executive. The Law also establishes a committee of nine members to review the utilization of the plan. It is not yet known whether the insurance industry will have a representative on this group. However, it is hoped that it will.

While relatively few of us may be directly concerned with the administration of Medicare, all of us should be concerned with its effect on medical care for persons under age 65. One key area to watch will be the work of the hospital utilization committees which the law requires each hospital to have. These could set a pattern of controls that would affect not only the experience of the federal program but all insurance plans for hospital patients. A second area of concern is the physician's usual and customary fee, of which Part B of the program will pay 80 per cent after a $50 annual deductible. It is important that the several different carriers who will be engaged in the administration of Part B develop a harmonious relationship one among the other in the determination of usual and customary fees. Such a relationship would benefit not only the government program but persons under 65 as well. This is so because Medicare is certain to stimulate demands on the part of active employees for similar or even better benefits. Fair and consistent determination of usual and customary fees by all carriers will be essential. If private carriers are unsuccessful in this regard, the government will almost surely take over the complete administration of Part B. Furthermore, they might do so by invoking a national relative value fee schedule, and this could be the end of the physician's freedom to set his own fees.

C. MANTON EDDY:

Thank you, Dan, for a most effective and provocative analysis of our Medicare legislation, the cost, and, more particularly, the magnitude of the problems that Washington is facing, and the great concern that many of us have regarding the decisions that may be forthcoming.

Our next speaker, J. Henry Smith, is vice president and actuary of the Equitable Life Assurance Society of the United States. He joined the Equitable in 1930 and has spent his career with that company except for an interlude, no doubt a happy interlude, of seven fruitful years in the city of Hartford, Connecticut. I think his developing experience and

ultimate success may be in great part due to what he was able to learn in that fine city for which I have some fondness.

Henry has always been active in our trade associations—the Life Association of America, the American Life Convention, and the Health Insurance Association. He was president of the Health Insurance Association in 1957 and 1958 and chairman of the Medical Information Bureau in 1961. Currently he is chairman of the Insurance Committee of the New York Chamber of Commerce and has also served recently as a member of the Insurance Committee of the United States Chamber of Commerce. In the spring of 1963 he appeared as a panelist on the United States Chamber's Aircade-Crusade for Citizenship Action.

Whenever there has seemed to be a problem developing in the field of social insurance, I have found that Mr. J. Henry Smith was usually there with wisdom and effectiveness. I think I first identified him at the time when New York State was establishing DBL benefits under the chairmanship of Mary Donlan of the Workmen's Compensation Board. Mr. Smith served on her Advisory Committee with distinction. Later on, during the Eisenhower administration, Mr. Smith appeared in Washington as one of a small group of consultants to HEW. About the same time he served on an advisory committee to the government in the development of the Federal Employees Group Life program, and it was inevitable that he followed that with service on the Advisory Committee with respect to the Federal Employees Health Benefits program.

Finally, I want to call your attention to his recent appearance in Washington when he was chosen to represent the industry as chairman of the industry's Task Force on Alternatives to Medicare.

Henry, I am proud to introduce you to this group for the next topic.

J. HENRY SMITH:

The Health Insurance Association has estimated that about 11 million people over 65 in the United States are covered by the various forms of insurance against the cost of health care. In some instances the benefits are small; in most, substantial coverage is provided. No direct measures of the adequacy of the insurance are available, but it is significant that premiums for those 11 million are estimated to run about $1 billion a year.

Medicare will destroy much of that coverage. The insurance companies alone, leaving out Blue Cross, and so forth, have premiums approaching half a billion dollars a year in jeopardy. And, even as we lose premiums, we must make tremendous outlays of time and expense in reconstructing benefit plans and contracts in order to accommodate to Medicare. One cannot even guess at the cost of this recasting operation.

Part of my purpose today is to outline briefly some of the considerations in the recasting problem and some of the likely solutions. The matter is terribly complex because of the many forms of benefit now being used and the several types of contracts employed. Almost all conceivable combinations are in existence, made up of a selection of benefit elements out of a long list, including hospital, surgical, medical, laboratory and X-ray, nursing home, and major medical coverage; and each of these combinations may be associated with a selection of contract types—group (employee and association), individual, family, cancellable, noncancellable, guaranteed renewable, lifetime, and term forms. Furthermore, each combination has widely differing benefit amounts and limitations. Remember also that where there is family coverage, those family members under 65 need different benefits from those applying to the over 65. Furthermore, Medicare provides one set of benefits for those who elect the voluntary Part B but a much more limited set for those who do not.

Similar problems are faced by Blue Cross and other types of plans, although possibly their solutions are fewer because their business has fewer variations. One of the strengths of the voluntary health movement has been its great flexibility and variety. Now, unfortunately, that very strength becomes a heavy weight to carry in accommodating to Medicare.

The natural desire of the private insurers is to salvage as much of the market over 65 as possible. We want to reconstruct our contracts in such a way as to avoid loss of business and to forestall further government intrusion, insofar as it is sound to do so and plans can be made attractive.

As we approach this problem, however, there is a general principle which it is important to bear in mind; that is, we should avoid duplication of benefits between private plans and the government plan. This is a basic principle that needs no elaboration here, but it is one which the health insurance business seems to be learning the hard way. I think the actuaries can and should play a leading role in seeing to it that the duplication is minimized as we refit our coverage over 65. If we are not careful, duplication will not only result in poor experience for ourselves but will lead to criticism from the government if its experience turns bad and duplication can be called a factor.

A related question is whether newly designed private plans should pay for the deductible and co-insurance elements which Medicare assesses to the individual. At least as to co-insurance, many private plans depend to some degree on it to help avoid overutilization, and presumably the federal plan was designed with the same idea of protection in mind. We

should be careful about vitiating that protection, just as we must be careful about duplication.

With this background, let us look at what Medicare leaves uncovered. It is roughly estimated that of the total health cost of the aged (excluding dentistry and eye care), Medicare will cover about 65 per cent. The remaining 35 per cent is made up mostly of private duty nursing, drugs and medicine obtained outside the hospital, private hospital room and other luxury care items, deductible and co-insurance features of Medicare, and hospital and nursing-home care beyond Medicare's limits.

The major part of our whole problem is, which of these elements and how much of each can be welded into an insurance package that will be sound and attractive. The answer will depend on the type of policy and the conditions under which the insurance is effected, and, therefore, there is a wide variety of answers. Let us look briefly at the major types.

First, with regard to employee group insurance. During the last five to ten years, insurers, unions, and general sentiment have combined to induce extension of many group health insurance plans to retired people, sometimes with rather limited benefits, but often with quite adequate plans. A large part of the 11 million over 65 now covered is carried under group plans. The wide variety of benefit provisions and the fact that each contract is a law unto itself, make it necessary to undertake case-by-case recasting to meet Medicare, with standardization likely only with respect to small employers having standardized policies. What we will have to do is offer a set of alternatives to each employer which he will have to choose among and adapt to fit his circumstances and requirements. Then the policy, certificates, booklets, premiums, and so forth have to be revised accordingly.

It is likely that the resulting benefit patterns will take four general forms:

1. Some employers will decide that no benefits should be provided under the group plan for persons over 65 (whether or not continuing in employment), inasmuch as Medicare taken as a whole provides a relatively generous benefit pattern. This will surely be the choice for most employers who have heretofore provided no protection to retired persons. Also, it would be difficult to quarrel with any other employer who wanted to discontinue his protection for those over 65.

2. Some sort of so-called envelope plan may be provided. This may be appropriate where the employer desires to provide a rather comprehensive benefit greater in most respects than Medicare. The group claim equals the excess of the comprehensive benefit over the costs paid under Medicare. This type of plan will permit those employers who have broad and deep plans now to con-

tinue the comprehensive protection with the group plan acting as the supplement to round out the total provided. The drawback may be that the group claim cannot be computed until the federal benefit is determined and its components are known to the insurance company.

3. The policyholder may wish to provide a set of benefits that might be characterized as a "jig-saw" variety. Recognizing elements omitted from Medicare, the group policy may provide specific benefits described in such a way as to fill in the major part of the gaps left by the federal law. The benefit-provision language of the policy, however, would make no direct reference to Medicare benefits, and each claim could be paid independently of Medicare administration.

4. A flat-amount indemnity plan may be provided for those over 65. For example, $25 a day could be paid during confinement to a hospital, and some lesser amount might be paid during confinement to a nursing home under certain conditions, each being subject to some duration limit or maximum amount. This type of plan runs the risk of providing inappropriate amounts in different circumstances or of providing nothing where there is no confinement, even though help is needed. It has little to recommend it except simplicity.

Of course, many variations and unclassifiable solutions will be reached before we are through adjusting to the ideas of thousands of group policyholders. What will most employers decide? How much group business over 65 will we salvage? At the moment there is little basis for guessing. Some large groups will take a generous approach, particularly where unions are insistent, but many will feel that the government is taking the load and that's that. In any case, there is a momentous task ahead in getting the group business renovated.

Association groups present a different and widely varying picture. Some of them resemble employer-employee groups and probably are subject to the same considerations as outlined above. Others, such as associations of retired people, "golden age" groups, and so forth, sit in a different psychological environment and have some of the aspects of individual insurance. It would be enlightening to hear from those companies that have specialized in this type of coverage as to how they plan to deal with it. I imagine that in many cases an effort will be made to continue the group using some sort of a flat-amount indemnity basis such as that described as my fourth category available to group policies.

State 65 plans, such as those erected with so much ingenuity and travail in Connecticut, New York, Massachusetts, are another class of group coverage; and, as I understand the evolving sentiment, they probably will simply disappear. Even here, however, there are some troublesome problems in closing off the plans, particularly with regard to those dependents under 65, some of whom may have looked forward to many

years of protection under a particular plan. Perhaps they can be handled through some kind of take-over arrangements with individual companies.

Turning to individual and family policies, we encounter so many different sets of conditions that a comprehensive discussion is neither feasible nor profitable at this point. Companies are considering various solutions, some of which match those I have listed above for group policies, and the choice will depend in large part on the form of policy and the company's assessment of what it can do soundly and what will be attractive.

As to soundness, where outstanding policies are cancellable, the soundest thing to do is to cancel all coverage over 65. This may be considered harsh treatment, however, and many companies will strive to find a better solution. Furthermore, where coverage is guaranteed for life, an alternative must be found. In arriving at that alternative, companies face the serious threat of severe antiselection as far as present policyholders are concerned. Many policyholders may feel that the government's benefits are sufficiently comprehensive as to make it unnecessary to carry private insurance any longer, and their decision in this regard may be heavily weighted by their health as well as by the attractiveness of the benefit structure and the premium rates which the company offers for continuance of coverage. Companies are up against the dilemma of designing a benefit package which will be attractive but not too high-priced, and, therefore, may not be too sound, or of designing a benefit structure and premium rates which may be conservative but attractive only to those in bad health.

As for future sales, it seems to me that there will be little or no satisfactory continuing market as to new individually offered insurance for people after they have attained age 65. Up to now, we have been trying desperately to sell insurance at the advanced ages, but I think that a sound policy structure, with benefits limited enough to avoid duplication with the federal plan, would have relatively low pure claim costs and such high marketing and administration costs as a percentage of the gross premium, as to make the portfolio unattractive except possibly for sale on some kind of a group basis. It may be that a flat indemnity plan, as explained in my category 4 above, will be useful here, but it looks like a close question at best, especially as we look to the future.

On the other hand, it may be possible to provide that policies sold at the younger ages can be continued after 65 on a reduced basis, using benefit structures similar to those described above for group insurance. In determining what that reduced benefit plan must be, however, and

in other respects in our planning, I think it behooves us to be realistic in looking ahead to the possibility of further legislative developments.

Of course, we are hopeful of containing Medicare and keeping the field for private insurance as wide as possible. It seems to me, however, that we must expect irresistible legislative pressure for expanding and extending Medicare, at least to the full extent of the area over age 65. We must expect moves to simplify and unify the benefit structure and to reorganize the financing. The inherent inconsistencies in coverage, the benefit limitations, the dual nature of the system and of the financing (with the voluntary contribution under Part B certainly subject to important increases), will soon engender strong charges of inconsistency, discrimination, inadequacy, and demand for revision, including alteration of the financing device to put it all on a payroll-tax basis or perhaps a payroll tax with general revenue subsidy.

There is an emerging consciousness of what may well be an axiom in social insurance. I would be tempted to call it "Smith's Law" if it were not likely that a thousand people have discovered it previously. It is this: The closer an insurance or welfare plan, whether private or public, comes to 100 per cent coverage, the greater the pressure for expansion to cover the remaining gap. Parenthetically, we see this law at work in New York State right now. Citizens of that state are better protected than those in most areas, but suddenly we are faced there with a strong move to legislate compulsory health insurance of some form at the state level. Those not covered stand out in such stark relief that legislative compassion for them easily takes the form of compulsion.

These considerations suggest that, at best, we must expect a series of modifications of the coverage we are to provide over 65 as Congress takes successive steps to fill in all the gaps. Eventually there will not be much left. I do not mean to suggest by this that we should turn over the field immediately to the government—I think we have to fight the rearguard action all the way, for reasons of grand strategy, if for no other reason. It behooves us, however, to design our package of benefits with as much built-in protection against more federal benefits as is feasible and with flexibility and control devices which will make our future recasting problems less troublesome.

All these points dealing with the considerations in revising policies and devising benefit structures are being fully explored by industry committees and are being reported by the trade associations in the form known as Medicare Bulletins to member companies. They are, of course, much more complete than I can be today. Hence, if any listener is interested or needs full information and advice as to what is involved, it is recommended that he obtain and peruse the several Medicare Bulletins.

Finally, we now come to the all-important question of the eventual impact of Medicare on the health insurance business as a whole, particularly as to the area under 65. It is rather easy to be pessimistic about the outcome of the massive forces that will come to bear on Congress, just as I am pessimistic about containing the government within present limits in the over-65 area. On the other hand, the age-65 line is no doubt as good a line of defense against further governmental intrusion as we could hope to find. If we are to have governmental insurance, and we do have it, we should take comfort in the definition of the area covered by the government. Any other kind of delineation I know of would be much harder to hold.

Furthermore, we have made so much progress below age 65, so much more can be done, and the climate is so favorable now, that I think we should take heart and renewed determination as to the possibility of making further governmental programs patently unnecessary. Medicare itself will help set some new standards in extent and quality of coverage, and it will help develop mechanisms for controlling utilization which we can adapt with advantage to coverage under 65. It also relieves us of the heavy burden of an expensive segment of people, permitting premium money to be diverted to the task of rounding out coverage under 65. On the whole, I think that there is rational hope that if we exert ourselves intelligently in every conceivable way to enlarge and perfect our vehicles, we can fill the gaps with private insurance, assuming only that the federal and state governments adequately take care of persons who are unable to obtain private coverage for various reasons.

In the meantime, between rewriting our contracts, revising our sales portfolio, and at the same time trying to find ways to help administer Medicare, we're busy!

C. MANTON EDDY:

Thank you, Henry, for such an able and thorough commentary.

I am told that one of the duties of a moderator is to sum up or tie in the statements of his panel members. My panel members here are so able that I can think of very little that I could add to what they have put before you.

Certainly, George, for me to attempt to speak with respect to problems in Canada would be presumptuous indeed, and will you forgive me for not attempting to gild the lily that you have painted for us?

But, with respect to the United States, I could make a few general observations. The insurance companies in the United States consistently opposed Medicare legislation, but I have said in many places that this

opposition was based not on a narrow point of self-interest, not on a narrow desire to build an empire of business for ourselves, but truly on a very deep conviction that the public good and the interest of the American people would be best served under a voluntary system of insurance.

At the same time, we now have in effect Medicare legislation, and our insurance companies have been attempting to co-operate effectively with government and with the government forces—Dan Pettengill has given you some insight of work behind the scenes—to the end that a working arrangement can be developed under the regulations to make Medicare work effectively and efficiently in the best interests of the American people. I think that insurance, health insurance, will suffer the most harm if the outcome of the current operations, if you will, results in programs that do not work well for the American people.

We all know that insurance is primarily a risk-sharing business. In the administration of Medicare, the carriers, agencies, and fiscal intermediaries are not sharing risks; they are not bearing risks. Their duties are pretty clearly spelled out in the legislation, and these include matters much more than payment of claims or payment of money. They include duties which are not in some ways too close to the operation of insurance companies, but the legislative history of the amendments indicated very clearly that the Congress wished to have agencies and fiscal intermediaries chosen from a wide range of insurance carriers and from prepayment organizations.

The Health Insurance Association has adopted a formal statement of policy that it believes that, to the extent that there are reasonable conditions, the health insurance business can be of great assistance to the government in helping Medicare work efficiently and effectively. The policy states that any monopolistic approach to one sole form of health insurer is not in the best interest of the American public, and it charges its staff with the responsibility of working as closely as possible with government and with those insurance companies which are interested in becoming intermediaries, to work closely with them to the end that regulation will be such that it will permit insurance companies to provide the help which they think they can provide.

There is one factor which needs further statement. Dan Pettengill spoke of it and I want to underscore it. There is a very grave concern on the part of those who are dealing in Washington that the determination by the government of what are reimbursable expenses of the fiscal intermediaries will be so narrowly determined that an insurance company can do business as a fiscal intermediary only at the expense of its other

policyholders or stockholders and such a result will make it very difficult for insurance companies to provide the function that they think they can provide in the public interest.

We should mention one change in the Amendments, in Section 303, the Disability Amendments. We know that benefits for permanent total disability were added to the Old-Age Benefits a few years ago, with a limiting age of fifty. Subsequently, the limiting age of fifty was dropped. The previous definition of what was an eligible disability, "one of long-continuing and indefinite duration," has created some complaints to Congress from the people back home who on occasion were turned down for claims because the disability, while it might have continued for one or two years, was not one from which the individual could not be expected to recover. The current law has changed that definition, has dropped out "long-continuing and indefinite duration" to provide that it "must have lasted or be expected to last for at least twelve months." Coverage is effective from the end of six months of such disability. This is a very definite intrusion of government into the long-term disability field, which the health companies have felt that they have covered adequately and with distinction and with reasonable cost. The intrusion into this field is on a basis which can provide a very substantial payment. I believe the top figure for a $550 a month average wage is a disability payment of $336 monthly.

I am sometimes puzzled as to what is the correct definition of social insurance. I realize our panel was told to speak on social insurance, but social insurance seems to be flexible enough to include many things a government does by way of assistance. So I want to call your attention to Title XIX, which is a new title in the Social Security Amendments, which brings in grants to the states for medical assistance. If you are interested in detail, the *Social Security Bulletin* of September of this year outlines it quite well, but I would like to read the introductory paragraph of an article which recently appeared in *U.S. News and World Report* under the headline "An Old Medicare Plan Is Growing":

> The groundwork is laid for a vast program of medical aid for the needy, all in addition to Medicare under Social Security. Older programs for medical health are to expand. One of every four children may get doctors' care at Government expense. The money comes from state and federal treasuries, not from payroll taxes, and there is no limit on what it may cost.

In essence, the medical aid programs must cover as a minimum physicians' services, in-patient and out-patient hospital services, laboratory and X-ray services, and skilled nursing-home care for adults. The program extends to the blind, to dependent children, and to all recipients of

Public Assistance. If a state is to qualify for federal grants after 1967, it must have patterned its own welfare laws according to the prescriptions and the minimum standards of the federal Act.

In one sense we can say that such medical assistance under welfare programs is compatible with our own deep convictions. We have always felt that insurance could cover the American public to the extent that the American public could afford to pay for their premium costs. We have constantly said that insurance could not care for the needy who do not have the means for payment of premiums.

Perhaps the deepest concern that many of us have is this: What will be the impact of all these programs on medical practice? What will be the impact when the shortage of skilled medical and ancillary personnel becomes very apparent? These are problems that only the future will identify, and I am sure that the solutions to them will lie only in the future. For ourselves, I want to underscore what Henry Smith said, that if we make our own voluntary insurance system work well we will be serving the American public best and we will be preserving our own field of endeavor, which is something in which we can take a proper and appropriate self-interest.