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PANEL DISCUSSION

RECENT DEVELOPMENTS IN SOCIAL INSURANCE IN THE UNITED STATES AND CANADA

Panel Members:

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CECIL G. WHITE
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ALLEN L. MAYERSON:

We divided the topic "Recent Developments in Social Insurance" into four parts, and each of the four gentlemen on my left is going to discuss a particular aspect of the subject. Cecil White, of the Metropolitan Life in Ottawa, is going to talk first about recent pension legislation in Canada. He will be followed by Albert Pike of the Life Insurance Association of America, who will speak on financing social insurance; by Morton Miller, of the Equitable, who will talk about health care for the aged in the United States; and by George Watson, of Crown Life, who will speak about health insurance developments in Canada.

CECIL G. WHITE:

I am sure that for many of you who practice in the United States and who have a limited amount of time to devote to developments in Canada the general area of pension planning in Canada in recent years must seem rather mixed up and confusing. Well, it has been pretty confusing for Canadians too. A pattern, however, does seem to be emerging now.

It would seem that in Canada we are to keep the present universal flat amount government pension of $75 a month payable to practically all Canadians aged 70 and over. On top of this, there is to be a wage-related contributory second deck, including retirement, survivors', and disability pensions. This second deck will probably be operated by the federal government for Canadians in nine of the ten provinces and will be called the "Canada Pension Plan." A plan with similar provisions will be operated by Quebec for the people of that province. Also, the provinces are accepting their responsibility to supervise private pension plans and are trying to adopt legislation for this purpose that will be as uniform as possible.

Canada Pension Plan

The moderator has asked me to bring you up to date on developments in the general area of pension planning in Canada since the excellent report presented to the Chicago regional meeting last spring by Mr. Harold R. Lawson. The third version of the Canada Pension Plan, to which Mr. Lawson referred in his report, has now been described in some detail in a letter from the Prime Minister of Canada to the provincial premiers and in a white brochure entitled "The Canada Pension Plan," published by the Canadian Department of National Health and Welfare last August.

Since August, we have been awaiting the reintroduction of the necessary legislation for this version of the plan. Two weeks ago, the Minister of National Health and Welfare placed a "Notice of Resolution" on the order paper in the House of Commons, this action being the forerunner to the introduction of the legislation. When the legislation is introduced into the House of Commons, it is expected that it will receive two readings and then be referred to a joint parliamentary committee made up of members drawn from the Senate and the House of Commons. At that stage, individuals and associations will probably be allowed to present their views on the legislation.

The proposed Canada Pension Plan will do nothing for those Canadians presently aged 70 and over who are receiving the flat pension of $75 a month under the Old Age Security Act. Coverage under the Canada Pension Plan will include almost all employees and self-employed people. Employees will be taxed on earnings in excess of $600 a year, and self-employed people whose total earnings are $800 or more a year will be taxed on their earnings in excess of $600. The tax rate will be 3.6 per cent of all earnings in excess of $600 per annum up to a maximum of $5,000. This tax will be paid entirely by the self-employed and will be split equally between employers and their employees. The tax will be deductible from income subject to personal income tax, as are the contributions under private pension plans. Collection of taxes is to begin in January, 1966. Taxes will not be collected before age 18. Taxes will stop when a benefit begins to be paid. These taxes are for the wage-related second deck and are in addition to the taxes already being collected to finance the flat amount pensions under the Old Age Security Act.

Any province that prefers to have a plan of its own similar in terms to the proposed Canada Pension Plan will be free to do so. The province of Quebec has already chosen to follow this course. The province of Ontario, whose Pension Benefits Act did originally require employers with fifteen or more employees in the province to have private pension plans that provided pensions at least as great as stipulated minimum levels, has now

emasculated its legislation by removing this compulsory requirement. This was necessary to alleviate duplication of costs for employers and to allow them some flexibility in their efforts to integrate their pension plans with the Canada Pension Plan and the Old Age Security Act. Although theoretically other provinces could follow the path chosen by Quebec, fortunately the province of Ontario is on record by word and deed to the effect that the most important consideration is to provide a nation-wide plan, a view supported by the other provinces.

The principal features of the Canada Pension Plan may be described as follows: There will be an earnings-related pension of 25 per cent of average adjusted earnings available to a contributor, commencing at any age between 65 and 70, provided he is retired from regular employment. At age 70, this pension will be available whether the contributor is retired or not. Under the pension formula, a contributor who fails to pay the required taxes in some years will get a smaller pension. However, there will be a dropout provision by which his years of lowest earnings up to 10 per cent of the total number of years for which taxes are paid may be excluded from the calculation of average adjusted earnings. Also, there will be an incentive to go on working after age 65, because for each year so worked he will be able to exclude an additional low-earnings year from the calculation of his average adjusted earnings.

The present flat amount old age security pension will also become available at any age between 65 and 70 and will be subject to so-called actuarial reduction. For example, the old age security pension, if taken at age 65, will be $51 a month.

The full widow's pension will be paid to widows with dependent children and to women who are widowed at age 45 or over. This pension will have a flat rate component of $25 a month and an earnings-related component equal to 37½ per cent of what the husband's pension would have been if based on his earnings to the date of his death rather than on his earnings to the year in which he would have reached age 65. These amounts will be reduced on a graduated scale of 10 per cent per year for women, without dependent children, who are between ages 35 and 45 when their husbands die or when their children cease to be dependent.

The widow's pension will cease on remarriage. However, if a widow continues unmarried, at some age between 65 and 70 she may elect to start to receive her old age security pension. At this point, she will give up the flat rate component of her widow's pension. Also, at this point she may be eligible to receive a retirement pension based on her own earnings. In that event, the widow will be able to combine her widow's pension and her

retirement pension, using whichever is the better for her of two formulas provided for this purpose.

The disability pensions will have a flat rate component of $25 a month and an earnings-related component of 75 per cent of what the retirement pension would have been if based on earnings to the date of disability. This pension will be paid to a contributor for as long as he continues to be disabled, up to age 65, but will cease on his death or recovery. At age 65 it will be replaced by the retirement pension.

It is worth noting that a contributor will be regarded as disabled if an examination reveals a medically determined impairment in which physical or mental disability is so severe and prolonged that he is unable to secure regular substantially gainful employment. This does not mean that he has to be completely helpless to qualify; it means he must be unable to support himself financially by reason of his disability.

A flat pension of $25 a month will be paid to each child of a deceased contributor until the child reaches age 18, or age 25 if attending school. Total payments to the children of one contributor cannot exceed the maximum retirement pension payable for one contributor, which is $104.17 per month when the Canada Pension Plan begins.

A lump sum payment will be made when a contributor or a pensioner dies. This payment will amount to six times the monthly retirement pension but will not exceed $500 in the early years of the Canada Pension Plan.

The first ten years of the Canada Pension Plan will be a transition period, during which the rates of retirement pension will increase gradually. In 1967, the retirement pensions will be 2½ per cent of average adjusted earnings. This will build up at the rate of 2½ per cent a year until the top rate of 25 per cent of average adjusted earnings is reached after ten years. The gradual buildup of pensions over this ten-year transition period will not apply in the case of survivors' or disability pensions, which will be payable in full beginning in the third year and the sixth year, respectively, after the plan starts.

To give you some idea of the benefits that will be provided in Canada after the transition period, Mr. Lawson mentioned that the combined retirement pension from the Old Age Security Act and the proposed Canada Pension Plan for an individual earning $100 a month will be $76 a month if the individual retires at age 65 or $100 a month if he retires at age 70. A person earning $416 a month—the initial earnings ceiling under the proposed Canada Pension Plan—will receive $155 a month at age 65 or $179 a month at age 70. If this person's spouse is old enough to obtain the Old Age Security pension, the couple will receive $206 a month at age

65 or $254 a month at age 70. In considering these sample benefits, one should keep in mind that average consumer spending in Canada is $230 a month for a couple, compared with $320 a month a couple in the United States.

To these illustrations, one can add the following: An individual earning $100 a month, becoming disabled at any age, will receive under the Canada Pension Plan $43.75 a month. A person earning the initial maximum limit of $416 a month will receive $103 a month, as a disability pension, for disability occurring at any age.

A widow whose husband earned $416 a month and who had four children dependent on her when he died will receive $164 a month, including the children's benefits.

The ceiling for earnings under the Canada Pension Plan has been set at $5,000 for the first two years of the plan. During the rest of the transitional period, the ceiling will be adjusted upward if there are increases in the cost of living (measured by the consumers' price index) but not by more than 2 per cent in any year. After the ten-year transitional period has ended, a long-term moving average of wages and salaries will be used to adjust the ceiling. The contributory floor for earnings, which is $600 at the beginning of the Canada Pension Plan, will also be adjusted.

In the calculation of a contributor's average adjusted earnings, his earnings for each year will be adjusted by the ratio between the average earnings ceilings in the three years before retirement and the ceiling for that year. This will be done for each year in which he contributes. In this way, his past earnings will be revalued to their current equivalent before his average earnings are calculated to determine his pension at retirement.

All types of pensions in the course of payment under the Canada Pension Plan will be adjusted annually on the basis of the consumers' price index.

These various indexing adjustments for salaries and pensions could have the effect of producing automatic windfalls for many Canadians, and the largest windfalls would always go to the Canadians with the highest salaries or the largest pensions. Besides the upside-down nature of such automatic adjustments, there is a real danger in providing automatic adjustments of this kind in that the citizens acquire a vested interest in inflation and the government's will to control inflation may be weakened. The government cannot for very long arbitrarily try to protect one segment of society against inflation without being forced to extend similar protection to other elements. There has already been a suggestion that indexing should be applied to federal civil servants' pensions. This is an indication of what we can expect if indexing is used in the Canada Pension

Plan. There will be pressure to extend indexing to annuities sold by the Government Annuities Branch, to Canada Savings Bonds, and then to other government bonds.

The income under the Canada Pension Plan, over and above that needed for current operations, is to be made available to the provinces for investment in provincial securities and securities guaranteed by the provinces. Allocation of funds to the provinces will be in proportion to the amounts paid into the plan by the taxpayers in each province. It is estimated that an average of some $400 million a year will be the net increase in funds available under the Canada Pension Plan, exclusive of Quebec. It is reasonable to add 50 per cent to this figure to allow for the corresponding accumulation of funds in the Quebec Pension Plan, so that for all ten provinces approximately $600 million a year will be made available as a result of the compulsory savings feature in the program.

Quebec Pension Plan

The Quebec Pension Plan will also come into force on January 1, 1966. At the time of writing, the Quebec Pension Plan has progressed to the point of a government motion which appeared on the agenda paper of the Quebec Legislature on June 10, 1964. This government motion serves two purposes: It describes the Quebec Pension Plan, whose terms and conditions are almost identical with the proposed Canada Pension Plan but apply in general only to residents of the province. It also provides for the supervision of private pension plans, such supervision to be vested in a Pension Board. I propose at this point to comment only on the Quebec Pension Plan and to deal later with the supervision of private pension plans.

The government motion followed the submission in April and May of the two volumes of the *Report of the Interdepartmental Study Committee on the Quebec Pension Plan*. This report is available in both French and English. A study of it by the members of the Society would be well worth the time involved.

The Quebec Study Committee felt it necessary to draw attention to the disadvantages of the ten-year transition period included in the Canada Pension Plan. In the words of the Committee, "Such a short period may appear more attractive to the first beneficiaries, but it is hardly justifiable." The Committee then goes on to say that this aspect of the Canada Pension Plan is subject to strong criticism because it burdens future generations with a disproportionate share of the cost of the plan. It gives a greater benefit to contributors in the higher-income brackets by reason of redistribution effected in their favor, and it allows a certain number of

beneficiaries who have contributed to private pension plans to receive total pensions larger than their salaries. The Quebec Study Committee came to the conclusion that transition based on a twenty-year period would be preferable.

The Quebec Study Committee wisely approached the problem of disability pensions with some caution. The Committee not only recommended that the contributor receive a disability pension only if he had attained his sixtieth birthday but also recommended that taxes for disability pensions be separate from taxes for other benefits and paid into a separate fund.

There are several statements in the report to show that the Quebec Study Committee looks ahead to the day when the province of Quebec will administer the flat amount pension presently payable under the Old Age Security Act in addition to the wage-related second-deck payable by the Quebec Pension Plan. The Committee is of the opinion that it would be desirable for the federal government to entrust the Quebec government with the full administration of the Old Age Security Act in the province. The fact that this latter program comes under the federal government's jurisdiction creates serious difficulties for the Quebec Plan and, more generally, for the elaboration of a coherent social security program. Under the present arrangement, the burden of social security on the economy of the province is affected by decisions over which the government of Quebec has no control.

The Committee recognized that the problem of modifying private retirement plans to integrate them with the Quebec Pension Plan and perhaps with the basic old age security pension is an enormous one. The Committee suggested that a reasonable length of time be allowed for this purpose but recommended against allowing any employer to contract out of the Quebec Pension Plan. At the present stage, there is no contemplation of contracting-out under either the Quebec or the Canada pension plans.

The report of the Committee makes it very clear that one of the main purposes for instituting a Quebec Pension Plan is to create a public fund for the economic expansion of Quebec. The Committee's view is that the choice of a financing system for the plan must be made in relation to the social and economic situation of the province. The Committee emphasized that the funds built up will enable Quebec "to exert a more peremptory authority over the direction of its economy."

The Committee devotes some twelve pages of its report to a rather unconvincing rationalization intended to allay any fears about the effects of the Quebec Pension Plan on the stability of the price level. The argu-

ments in this part of the report contain the greatest potential danger to the economy. The Committee rejected completely any idea that gradual inflation can be checked or controlled. The Committee also refuses to believe that, once the government has tried to protect some pensioners from the effects of inflation, it will be unable to resist demands for similar treatment from other recipients of government benefits of any kind or from the holders of government bonds. In this connection, although the Committee's report does not mention it, it is significant that Sweden, which has provided government pensions on an indexed basis for some years, has now found it necessary to study the possibility of indexing government bonds, and the view of the Swedish committee was that indexing of bonds should probably be adopted.

Ontario Pension Benefits Act

Mr. Lawson described the developments in Canada between 1960 and 1963 which led up to the passing of the Ontario Pension Benefits Act in the spring of 1963. Originally, this act would have required that every employer with fifteen or more employees in the province have a private pension plan providing benefits not less than a prescribed minimum. There were three alternative benefit formulas, but the basic idea was to build up a pension by age 70 of about $80 a month. The Ontario Pension Benefits Act also required that all pension plans, even voluntary plans supplementary to the required minimum, should be made portable subject to certain minimum service and age requirements. Moreover, all pension plans would be supervised by a pension commission, which would pay careful attention to solvency, funding, and investments.

When it became clear that the federal government intended to proceed with the Canada Pension Plan, the Ontario government amended the Ontario Pension Benefits Act to remove the compulsion on employers with fifteen or more employees to have private plans providing benefits up to the required minimum level. This change in the Ontario legislation means that Ontario is going to concentrate its attention on the supervision of private pension plans wherever they are in use to supplement the benefits under the Canada Pension Plan and the Old Age Security Act.

The Pension Commission of Ontario recently issued the regulations under the Pension Benefits Act. These regulations included some definitions that are of special interest to actuaries, especially those directly involved in pension planning; for example,

"Initial unfunded liability" means the amount by which, on the first day of January, 1965, or the date on which the plan qualifies for registration, or subsequently as the result of an amendment, the assets are required to be augmented to ensure that the plan is fully funded;

"experience deficiency" when applied to a pension plan, means any deficit, determined at the time of a review of the plan, that is attributable to factors other than,

(i) the existence of an initial unfunded liability, or
(ii) the failure of the employer to make any payment as required by the terms of the plan or by the Act or this Regulation;

"fully funded" when applied to a pension plan, means a pension plan that at any particular time has assets that will provide for the payment of all pension and other benefits required to be paid under the terms of the plan in respect of service rendered by employees and former employees prior to that time;

"provisionally funded" when applied to a pension plan, means a pension plan that at any particular time has not assets sufficient to make it fully funded but has made provision for special payments sufficient to liquidate all initial unfunded liabilities or experience deficiencies. . . .

The payments by an employer into any pension plan or fund must include all current service costs, including any contributions made by the employees. In addition, in the case of a plan with an initial unfunded liability existing on January 1, 1965, special payments of equal annual amounts must be made to liquidate this liability over a period not exceeding twenty-five years. In the case of an initial unfunded liability that arises after January 1, 1965, the special payments of equal amounts can be spread over a period not exceeding fifteen years. In a case in which a pension plan throws up an experience deficiency, the special payments must be of equal annual amounts sufficient to liquidate such experience deficiency over a period not exceeding five years. This last provision leads to the requirement in the regulations for actuarial valuation at least once every five years. Any pension plan which is "fully funded" or "provisionally funded" will be considered to be solvent.

The investments and loans of a noninsured pension fund, or an insured pension fund using the segregated fund principle, are subject to the same limitations as those applicable to the investments of a life insurance company under the Canadian and British Insurance Companies Act, subject however to certain modifications: The "basket" of unrestricted investments and loans may not exceed 7 per cent of the total assets of the fund. There is no over-all limitation on the aggregate percentage of common stocks held by the pension fund or on the investment in real estate for the production of income. Not more than 10 per cent of the total assets of the fund shall be invested or loaned with any one corporation, partnership, association, or person. This 10 per cent limit applies also to the employer's own securities and loans.

There are broad restrictions to avoid conflict of interest, under which the funds of a pension plan cannot be lent to certain persons, for example,

the pension plan administrator or trustee, a union, an employee of the employer (except by way of residential mortgage), the wife or child of any of the above persons, or the wife or child of the employer. Moreover, no commission, fee, brokerage, gift or other consideration for investing the funds shall be paid to the employer, or to an officer, trustee, administrator, or employee who would otherwise be connected with the pension plan.

The Ontario Pension Benefits Act requires every employer with a pension plan in effect for Ontario employees to file a copy of the plan for registration by February 15, 1965, or within sixty days of the establishment of the plan, if later. To qualify for registration, a pension plan must provide not later than age 45 and the completion of ten years of service for full vesting of all benefits in respect of service since January 1, 1965. There is to be full locking-in of the employee's required contributions at the same time as full vesting occurs, except that the plan may provide for an employee to receive in partial discharge of his rights under the plan as a lump sum, upon termination of employment prior to retirement, an amount not exceeding 25 per cent of the commuted value of the vested deferred life annuity. The pension plan must also provide for funding and investments in accordance with the regulations, and for a written explanation of the terms and conditions of the plan to go to each member.

Attempts for Uniform Legislation Regarding the Supervision of Private Pension Plans in All Provinces

I have already mentioned the government motion in Quebec that relates to the establishment of the Quebec Pension Plan and to the supervision of private pension plans. It appears that the province of Quebec and the province of Ontario are trying to use a uniform approach to the supervision of private pension plans.

The province of Quebec intends to make reciprocal agreements with other provinces for the supervision of private retirement plans covering participants in the province of Quebec and one or more other provinces.

In early 1964, the province of Manitoba introduced Bill 107 into its legislature. This bill would have become the Manitoba Pension Board Act, if it had been passed. However, Manitoba's Bill 107 used an approach to the supervision of private pension plans that was quite different in a number of important respects from that in Ontario. Fortunately, Bill 107 was subsequently abandoned, and the premier of Manitoba indicated that a new start would be made on legislation for the supervision of private pension plans in the province.

On October 16, a meeting was held in Toronto of officials from all of the provinces who had come to discuss the feasibility of uniform legislation on

private pension plans. At the meeting, the Ontario representative outlined the salient features of the Ontario Pension Benefits Act and indicated that Ontario is prepared to consider any amendments required to insure uniformity with the other provinces.

The reciprocal arrangements that might be made between the provinces in regard to firms operating in more than one province were discussed. It was acknowledged that arrangements were desirable so that pension plans, if possible, should be examined under only one jurisdiction rather than in several provinces in which there were employee members. It was agreed that a model uniform pension act should be drafted for study.

Quite aside from legislation aimed at the supervision of pension plans for funding, solvency, and vesting, there are presently in force two provincial statutes relating to registration and disclosure under private pension plans. These are the Saskatchewan Employee Pension Plans Registration and Disclosure Act and Ontario's Welfare and Pension Plans Registration and Disclosure Act. It is not clear as yet what the final relationship may be between these two acts and the Ontario Pension Benefits Act and comparable legislation in the other provinces. However, the Saskatchewan Act seems to have been used up to the present mainly for the gathering of information and statistics about pension plans in the province. A similar purpose has been served by the Ontario act, at least with respect to noninsured pension plans.

ALLEN L. MAYERSON:

I was very intrigued by the differences between the Canadian and United States approaches to social insurance. I remember very many debates before this body in the past, when some of our members raised the question of which was better—the United States system of wage-related benefits or the Canadian flat old age pension. It is very interesting that Canada now seems to be adopting the United States system, though with a wage-related benefit on top of a flat one. It is also interesting to note that with this flat $75 pension at 65, which reduces to $51 if taken at age 60, they are able to achieve the objective of paying larger pensions, relative to wages, for lower-paid employees, as we have done through a complicated formula.

I am intrigued by the differential in benefits between those the Canadian plan provides and those of the United States. The United States contribution rate is considerably lower, and I think we might want to discuss the question of financing and whether the tax will support the benefits.

Another interesting departure taken by the Canadian plan is the indexing of pension benefits. In France it is quite common to index fire insurance and theft insurance policies. In Sweden, pension plans are indexed, and now Canada is entering this field. Also, the incentive to work past age 65 by providing a higher flat amount pension and some additional dropout years is an interesting experiment.

I think many of us would like to see the deductibility of both pension and social insurance contributions, which is the case in Canada, extended to the United States. In Canada an individual can deduct from his income tax his contributions to the social insurance scheme or to a private pension plan; this cannot be done in the United States.

We will now hear from Albert Pike, who will talk about financing social insurance.

ALBERT PIKE, JR.:

At first blush, it might seem to be stretching things a bit to talk about social insurance financing in the United States in terms of "recent developments."

There is, however, something new in this area. Besides the obvious new problem of financing medical care for the aged (if that should become a part of the social insurance scene in this country next year), there is a further current development in that styles have changed as to what is called "sound" social security financing and what is called "unsound" financing.

Heretofore, most of us have regarded the financing of social security in this country as pretty soundly conceived and therefore fixed in form. This seems no longer to be accepted by many. What I have to say on this panel will be directed to the proposition that the present payroll-tax financing of cash benefits under social security, particularly OASDI, is soundly conceived, the critics to the contrary notwithstanding, but that, when these critics direct their attention to proposed payroll-tax financing of service benefits, such as medical-care benefits for the aged, they have a good case.

As to the basic soundness of social security financing by means of payroll taxes, I think three eras of actuarial thinking can be identified. The first I will call the Hohaus-Watson era of the 1930's; the second the Ray Peterson era centering around 1960; and the third the medical-care-for-the-aged era, which is basically a present-day extension of the Ray Peterson era. Before I explain this, let me first show my colors as a representative of the Life Insurance Association. A short while back, the Society's immediate past president, John Miller, was chairman of our Social Security Committee, which is joint with that of the American Life Convention. After the opening discussion of some meeting on social security—I

do not quite remember on just what phase—had proceeded rather aimlessly, John tried to achieve at least some degree of order in the discussion by summarizing what had already been said. He did it this way: "It seems from this discussion that opinion on Social Security within the life insurance business is divided along a broad spectrum, all the way from those on the extreme right who would repeal the Social Security Act entirely to those on the extreme left who would just leave it as it already is." These are the people I work for.

Getting back to the first era of actuarial attitudes toward social security finances, I would recall for those of you who have been around for quite a while the Hohaus-Watson debates of the middle 1930's. Their argument, you will remember, was whether old-age-insurance financing should be on a level-premium, full-reserve basis, as advocated by Watson, or on a step-rate-premium, contingency-reserve-only basis, as advocated by Hohaus.

Judging by what Congress did in establishing payroll tax schedules for financing old-age benefits, Hohaus won. His thesis, implicitly at least, was that level-premium financing would be financially unsound, because it would create large reserve funds available to be spent irresponsibly for politically motivated benefit increases. Pay-as-you-go financing, because it produces no great amount of reserve ready to be spent, would provide some measure of financial control on possible political overexpansion of benefits. In line with this thinking, Congress established an initial combined employer-employee tax rate of only 1 per cent, scheduled to rise by easy stages to 3 per cent by 1949. It seems hard to believe now, but the original tax rate of 1 per cent was deliberately frozen after it was scheduled to be increased for ten long years, from 1940 through 1949. That shows how much they really believed, in the good old days, in pay-as-you-go financing.

Watson's thesis of the need for large reserves was thus defeated, at least in the thinking of those in Congress in control of financing. Implicit in this defeat was acceptance of the proposition that it is sound to take the future taxing power of the federal government into account as an offset to full reserves.

The second era of thinking about financial soundness is what I call the Ray Peterson era, as touched off by his 1959 paper entitled "Actuarial Anesthesia." Peterson argued for full-reserve financing, or at least so it seems to me, but he did not go so far as to say that pay-as-you-go financing is actually unsound. What he did say was that pay-as-you-go financing sacrifices a financial assist from interest on reserves, to the point where payroll tax rates must be so high as to produce something less than bar-

gain rates for young entrants into the Social Security system. If this were better understood, said Mr. Peterson, a tax rebellion would be in the making and benefit overexpansion would be controlled.

This was really a study in contrasts. On the one hand, it was argued that the lowest possible payroll tax rates are necessary in order to avoid the accumulation of easily spendable reserves, while, on the other hand, it was argued that high payroll tax rates will control political overexpansion of benefits by creating a tax rebellion.

The present-day thesis of some opponents of medical care for the aged extends the Peterson theory to the point where it is held that all pay-as-you-go financing is unsound. Arguments used are sometimes so broad that they constitute an attack on all payroll tax social security financing, not just medical-care-for-the-aged financing. I hope and believe that the overwhelming majority of members of the Society will not accept this overstatement against payroll tax financing.

In my view, pay-as-you-go financing out of earmarked payroll taxes has been an eminently "sound" method of financing as far as OASDI is concerned, but it would not be a sound method for medical care for the aged. To support this thesis, I can do no better than summarize a recent talk by Chairman Wilbur D. Mills of the House Ways and Means Committee. Mills first makes the point that official cost estimates of King-Anderson have been unrealistically low (HEW has not always asked Bob Myers first what proposed benefits will ultimately cost.) But his main point is that the traditional cost assumption of no further increases in employee earnings level acts as a financial safety factor for OASDI financing, but it would act in just the opposite way if medical care for the aged were financed by a payroll tax modeled after the OASDI payroll tax.

It is not hard to see why this would be so. As employee earnings levels in the country rise, the OASDI-system financing must improve because the benefit scale is weighted at the lower end. Additionally, higher earnings levels produce higher taxes immediately, but higher benefits are produced only on a delayed schedule because of the averaging of earnings over the years in determining benefits. Together, these act as a safety margin for OASDI financing, adding conservatism to middle-of-the-road cost estimates. However, if a service type benefit, such as the hospital care benefits under the King-Anderson bill, were financed by payroll taxes of the same type, the safety margin would be a negative one. If earnings levels go up, service benefit costs will necessarily go up with them. But earnings as a base for payroll taxes would be dampened by the $4,800 tax-base ceiling, whereas service benefits would not be dampened. Just as future improvement of mortality will work in favor of insurance com-

panies as far as life insurance is concerned but against insurance companies as far as annuities are concerned, so will future improvement in earnings levels act in favor of the payroll tax financing of cash benefits but against the payroll tax financing of service benefits.

I therefore think it fairly safe to predict that if this new, liberal-minded Congress does get around to enacting some sort of medical-care-for-the-aged program into law, Congressman Mills will see to it that the financing is not under the present Social Security Act because of this negative conservatism inherent in financing service benefits. That is not to say that the financing of benefits could not be on a payroll-tax base outside the Social Security Act, with a separate reserve fund. As a matter of fact, if the day ever comes when a federal medical-care-for-the-aged program is enacted into law, I would hope that it would be financed by some sort of payroll or other stable-type tax base, outside the present social security system, and not out of general revenues. Financing by a payroll tax base is more conservative than financing out of general revenues. General revenue financing can too easily be turned into deficit financing.

A word about the so-called 10 per cent peril-point ceiling for social security financing. Former HEW Secretary Ribicoff started this 10 per cent limit idea in reply to questioning by Senator Byrd of Virginia at a Senate Finance Committee hearing about two years ago. Senator Byrd asked Mr. Ribicoff how large a payroll tax, employer and employee tax combined, he thought this country could stand. Mr. Ribicoff said 10 per cent. He did not even say what the 10 per cent tax would be on. He has since become a senator himself and a member of the Senate Finance Committee, and he has supplied this missing piece by saying that he was thinking in terms of a tax base of $5,400 a year.

While it seems hard to believe that anything so casual as an offhand answer such as this could set national policy, this 10 per cent theory has apparently caught hold. I suppose that if our number system were based on the ancient Aztec duodecimal system, the figure would have been 12 per cent. Anyway, the 10 per cent limit, valid or invalid, figured in the recent impasse over putting medical-care-for-the-aged benefits into an OASDI benefit-increase bill. The advocates of medical care for the aged opposed all OASDI benefit increases and other liberalizations, because of the fear that they would use up all of the ¾ of 1 per cent which now remained of this theoretical 10 per cent limit. The opponents of medical care for the aged, on the other hand, pushed for full OASDI liberalizations, just to keep this remaining ¾ of 1 per cent unavailable for medical care benefits. Strange consequences can thus result from strained theories as to what is "sound" social security financing. However, whatever the validity

of the 10 per cent limit is, its consequences are good because it introduces a new degree of financial discipline; this is pleasing to a liberal like me who wants to keep social security just as it is.

ALLEN L. MAYERSON:

Now that Albert Pike has told us about the problems in financing OASDI and the possible influence of Medicare on the financial soundness of OASDI, we will hear from Morton Miller on the problems of health coverage for the aged and the effect of the Medicare proposal.

MORTON D. MILLER:

Activity in connection with proposals for the federal government to assist the aged further with their health care needs rose to unparalleled heights during the last Congress. Literally dozens of bills on the subject were introduced.

By far the largest number were those which would have added medical care benefits to the social security system to be financed through a combined increase in covered payrolls and the tax rates. Among these were the King-Anderson bills, supported by the Administration, under which hospitalization, convalescent nursing-home care, home care, and out-patient diagnostic service benefits would have been provided for all those 65 and over who are or become eligible to receive social security or railroad retirement benefits. (Similar benefits were to be available to old age assistance recipients and others not under social security to be paid for from general revenues.)

Included here were several bills, such as the one introduced by Senator Ribicoff, which would have offered an option to the individual to take monthly cash benefits in lieu of the medical care benefits. Parenthetically, the option under the Ribicoff bill was heavily weighted in favor of choosing the governmental health-care benefits. The proposal backed by Senator Javits and several other liberal Republicans would have authorized the establishment of what would have been a national plan patterned after the state 65 plans and supervised by the Secretary of Health, Education, and Welfare, through which insurance carriers would underwrite the cost of medical, surgical, and related services complementary to and apart from the hospitalization and other King-Anderson benefits the government would be paying.

A second group of bills was based on the federal personal income tax structure. Principal among these was Congressman Bow's bill, which would have allowed an income tax credit of $150 for the purchase of qualified health insurance policies by aged taxpayers or by relatives or other interested persons on behalf of individuals 65 and over.

A third category of bills, such as those introduced by Representative Gubser and Senators Scott and Saltonstall, called for the direct subsidization of health insurance premium payments of the aged. These envisaged state plans of qualified health insurance policies to be offered to the aged on a voluntary basis, to be paid for by government funds—wholly or in part, depending upon the income of the retired person—and to be financed by the state and federal governments from general revenues.

Congressional deliberations on Medicare began with extensive hearings before the House Ways and Means Committee in November of 1963 and January of 1964 that produced over two thousand five hundred pages of testimony. After failing to agree on any health care provisions, the Committee voted out a bill providing for a 5 per cent increase in monthly cash social security benefits which had been passed by the House and referred by the Senate to its Committee on Finance. After hearings in August, the Senate Committee on Finance voted down the Administration's health care proposals and reported out the cash benefits bill of the House with some modifications.

The debate then shifted to the floor of the Senate, where a package including both cash benefits and health care benefits was put through by a 49 to 44 vote and sent to conference with the House. The health care benefits were of the King-Anderson variety, with the addition of the Javits idea permitting a national 65 plan. As we all know, the conference committee could not agree, so no social security bill whatsoever was voted by the Congress. This was the first time since 1950 that the Social Security Act failed to be liberalized by Congress in an election year, except in 1962 when there had been an earlier liberalization in the same Congress in 1961.

While these deliberations were going on, existing means of helping the aged provide for their needed medical care were not standing idly by. On the contrary, the two governmental programs—old age assistance and medical assistance to the aged—and voluntary health insurance were being expanded rapidly.

Those states and jurisdictions without vendor payment medical programs for old age assistance beneficiaries were stimulated to action by the more liberal allowance of federal funds afforded by the Kerr-Mills Act of 1960. Now, all fifty states and the four jurisdictions—the District of Columbia, Guam, Puerto Rico, and the Virgin Islands—have such programs, under which in total about 2.2 million OAA recipients, one out of every eight aged persons, are eligible for a broad range of hospital and medical services. In 1963 the aggregate cost of these health care benefits amounted to over $415 million.

In addition to improving the state health care programs for the needy

elderly on public assistance, Kerr-Mills also established a new category of medical assistance through the states with federal matching funds designed for low-income aged who are ordinarily self-supporting but who may be unable to meet the costs of serious or prolonged illnesses. Considering the newness of the concept and the lack of enthusiasm for the idea at the Department of Health, Education, and Welfare, remarkable progress has been made in the implementation of medical assistance to the aged.

At this date just seven states have still to authorize medical assistance to the aged programs, including Texas, where a constitutional amendment that was necessary has just been voted. Medical assistance to the aged is in actual operation in thirty-eight states and the four jurisdictions; only five authorized state programs have still to be put into effect. According to the Department of Health, Education, and Welfare, by June of 1964 the benefit costs had risen to more than $35 million a month—a sum already equal to the cost of old age assistance medical benefits, even though a number of the states have yet to set up their medical assistance to the aged programs.

The number of persons who might be considered eligible for medical assistance to the aged is not easy to estimate because the eligibility requirements are complex and vary greatly from state to state. The sponsors of the Kerr-Mills legislation had indicated that as many as ten million persons over 65 might become eligible for these benefits when they become fully established. Senator McNamara's Special Committee on Aging, which believes that this approach is not sufficient, acknowledged in a staff report that the number of eligibles could be of the order of six to seven million. Accepting this figure and adding the two million or so under old age assistance, we can say that some eight to nine million, or almost half of the eighteen million aged, will be under the protection of the two federal assistance programs when medical assistance to the aged is effective in all states.

Voluntary health insurance has also been making big strides among the aged. The latest figures show more than ten million, or over half the aged, with some form of health insurance, demonstrating a substantial gain over earlier figures.

The use of the number of aged covered by health insurance in this way as a measure of the protection in force and an index of the progress being made was vigorously attacked by Senator McNamara's Special Committee on Aging at hearings held in April in what was obviously an unfair effort to discredit voluntary health insurance. Unfortunately, data concerning the scope of the existing benefits are not available. We do know that many older persons have good benefit plans encompassing a wide

range of hospital and medical services, and admittedly others have much more limited benefits. At the same time, we can point to the increasing availability of broad scope coverages under individual policies, group insurance, and other plans, and to the extension of the state 65 plan idea into eight states now whose combined population includes nearly 40 per cent of the aged.

All in all, the two governmental assistance programs, along with voluntary health insurance, have been moving ahead steadily. Much is still to be done in both areas, of course. Bugs in the administration of the medical assistance to the aged programs have to be worked out, benefit provisions and eligibility requirements improved, and the remaining states without programs brought into the fold. Efforts to spread sound plans of voluntary health insurance more widely and particularly to improve the benefits of those with marginal plans must go forward apace. Rising hospital and medical care costs must be faced up to; here the general improvement in the economic circumstances of pensioners should be of help.

I hesitate to couple the eight to nine million figure for those in the lower half of the retirement income scale to whom the assistance programs are directed with the ten million figure for those who have helped themselves through voluntary health insurance, because I do not want to be charged with misrepresenting the situation. Nevertheless, it seems to me that the figures suggest how these governmental and voluntary efforts complement each other and can do so even more effectively if given time to perfect their development.

Regardless of this, those in favor of broader participation of government in this area refuse to accept the progress and potential of the present programs. Thus we will see Medicare become perhaps the top priority item for the new Congress.

Those urging social security as the vehicle will be pushing their proposals more strongly than ever, and the size of President Johnson's election victory, together with the more liberal complexion of the House of Representatives, gives them great encouragement. All the old bills died with the close of Congress, so reconsideration will begin anew in the House Ways and Means Committee.

Chairman Wilbur Mills took pains to make his position clear in an extremely well-thought-out speech before a Kiwanis group in Arkansas in September that he later inserted into the *Congressional Record*.[1] He has been and will continue to be opposed to the social security approach, his overriding concern being the continued preservation of the financial soundness of social security.

[1] October 3, 1964, p. 23, 224.

Mr. Mills's talk brought out the extent to which he sees social security Medicare as a threat to the OASDI cash benefits program. He pointed in particular to the fact that, starting with the Forand Bill in 1957, each of the considerations of Medicare before his Committee saw the cost estimates revised substantially upward. What is more, he went on to state, hospitalization benefits of the semiprivate room-service type, such as those contemplated in King-Anderson, have built-in inflationary cost aspects which extend indefinitely into the future as hospital charges continue to rise. He indicated further that this inflationary factor must necessarily lead either to the total program's becoming actuarially unsound or to a commitment into the indefinite future to a steady but wholly uncontrolled increase in the amount of wages taxed for social security purposes due to the hospital part of the program.

In restating his awareness of a problem to be met and his interest in finding a solution in the best interests of the aged, he said, "I think one of the difficulties that has actually impeded the reaching of a sound solution is the insistence by the proponents of medical care on proceeding toward a solution through the existing OASDI system rather than in an all-out effort to solve the problem itself with some flexibility in their approach." He added, "I suggest that we move forward a solution with less emphasis on the method of solution; let us look through and behind slogans of the opponents and proponents with less emphasis on the Madison Avenue approach."

So far the efforts of those opposed to Medicare under social security have been focused more on the immediate need to defeat such proposals. With the greater likelihood of some additional enactment, along the lines of Mr. Mills's suggestion, attention will undoubtedly be turning more acutely to alternative possibilities.

Ideas worthy of consideration will be found among the other health care bills already introduced. Others may be suggested by examination of existing programs in related areas. Among the questions to be answered in formulating a plan are the following:

1. What types of hospital and medical services should be provided? Should they be on a service basis or with limited cash allowances?
2. Who among the older persons should be eligible? Should there be an income or retirement test, or should eligibility be considered in terms of age alone? Should the program be compulsory for all those eligible or be on a basis of voluntary individual participation?
3. Should the program be run by the federal government or the states? What should be the relationship between federal and state responsibility in the administration of the program?

4. What place is there for the voluntary insuring agencies in any such program? Can a satisfactory program be devised through existing insurance mechanisms with government supervision and financing but without the government's becoming involved in the provision of benefits? What benefit standards and other regulation of the carriers would be necessary?
5. How is the program to be financed? Through a payroll tax? Through general revenues? With a sharing of costs among the state and federal governments? Partly by the individuals affected?
6. Is genuine prepayment of the postretirement costs during the active working years (as opposed to social security pay-as-you-go tax financing which has been represented to be prepayment) practical? Mr. Mills alluded specifically to this, saying, "I would be hopeful that the basic prepayment concept would lead us in the direction of sound approaches to this matter."

It must surely be obvious to all that meeting the recognized health care needs of the aged is by no means a simple matter. Whether agreement could be obtained for a set of principles on which to base a broader governmental program for the aged or, and perhaps more importantly, whether a program embracing such principles could be made politically attractive remains to be seen. In the same vein as Mr. Mills, let us hope that more light than heat will be brought into the discussions of this entire question in the ensuing months. This will certainly be necessary if a more reasonable answer is to be found which will stand the test of time better than the social security approach.

ALLEN L. MAYERSON:

Like pensions, health insurance problems know no national boundaries, and, again like pensions, the Canadian approach is different in many important ways from the route taken in the United States. George Watson will now tell us about the Canadian legislation on health insurance for the aged.

GEORGE N. WATSON:

Health insurance developments in Canada have been numerous and are of major interest to actuaries. On the one hand, we have the socialist development in Saskatchewan, under which all residents of the province are covered for medical care benefits under a compulsory government plan, whereas in the immediately adjoining province of Alberta we have seen the first major experiment of a comprehensive plan of medical care insurance operated by the voluntary agencies but made available to everyone in the province regardless of age, health, or financial condition. While both these developments have been going on side by side, a Royal Commission was undertaking hearings from one end of the country to the other

and has only recently delivered the first volume of its report. These are the three developments which are the basis of my remarks today.

The Report of the Royal Commission on Health Services

On the twenty-fourth day of July, 1961, the government of Canada appointed a Royal Commission that was asked to inquire into and report upon the facilities for providing personal health services, the methods of improving these, and sundry other related matters, including the methods of financing health care services as they presently exist and the methods to be recommended to be used with respect to any new or extended programs which may be recommended. The first volume of the report of this Commission was released earlier this year, and the second volume is still to be published.

In brief, the Commission makes two hundred separate recommendations related to the subjects of (1) health services; (2) health personnel, facilities, and research; and (3) financing and priorities.

The first recommendation of the Commission is that the federal government should enter into agreements with the various provinces to provide grants on the basis of a formula to assist the provinces to introduce and operate a comprehensive universal program of health insurance. Basically, the recommendation is that the federal government would pay one-half of the cost of this program, including one-half of the administrative costs. As a part of this first recommendation, it is recommended that the administration at the provincial level should be through a government Commission representative of the health professions and the government who would report to the Minister of Health. The general idea is that this Commission will operate all such insurance benefits in the province, in addition to the existing hospital insurance program and, if desirable, that the existing voluntary prepayment plans existing in the province could be used as an administrative vehicle to accomplish this end.

The proposal is that the insurance program would be compulsory for every resident and would be financed through a combination of premium contributions and taxes. It is assumed that the program would not be in full operation, according to the recommendations made, until 1971. At that time, it is estimated that the proportion of the gross national expenditure spent for health care would be 6.1 per cent, compared to 5.5 per cent if the present system were continued.

By 1971, the projections made by the Commission indicate that the annual cost of continuing our present system of health services would be just over $4,000,000,000, or $178 per person. If the recommendations of the Commission are adopted, the cost of health services in 1971 would be

increased by $466,000,000, or by an additional $20 per person, according to the estimates made in the report.

The first volume of the report of the Commission is a very comprehensive document extending to over nine hundred pages. It treats all aspects of the provision of adequate health services, including medical education, which is recognized as being of prime importance. The report has received a mixed reception, applauded vociferously in some quarters and criticized in others. The difficulty for the average citizen is that it is such a tremendous piece of work that it is almost impossible for him to understand it or grasp its full significance. I will, however, make a few comments in regard to this report as it relates to our particular sphere of activities.

The report is very definitely biased in favor of a compulsory government plan. Every argument for this point of view is marshaled with great care and usually overstated. Scarcely, if ever, are any negative elements in the argument brought out. In chapter xviii, the voluntary insurance agencies are examined in detail to determine whether they would possibly meet the needs of the situation. This chapter is written in such a way as to damage the whole image of voluntary insurance. It omits, for example, any reference to the Alberta medical plan which embodies completely new ideas first proposed in the submission to the Royal Commission by the Canadian Health Insurance Association. In its discussion of medical insurance, it all but ignores the group insurance mechanism which has been so successful in this field. In short, chapter xviii is very unfair in its assessment of the very fine job done by voluntary insurance in Canada in this field. The report tends to mislead the reader throughout an examination of the voluntary insurance system in several ways:

1. It states that some persons cannot afford medical insurance because of its cost but neglects to state that group insurance most often depends upon a substantial contribution from the employer.
2. It omits the fact that uninsurable persons in the population would be covered by a group insurance program if employed.
3. It overstates the comparison of the expenses of operation of a voluntary insurance program with a government-operated program by including in the expenses of the voluntary agencies such items as taxes, reserves for policyholders, experience rating credits, and so forth; and, furthermore, it neglects to state that the cost of operating the voluntary plans includes first-year commissions which, of course, would not be repeated year after year if a government-sponsored plan were installed, as in Alberta.
4. It dismisses suggestions by the industry in regard to subsidy of those persons in the population who are financially unable to pay premiums by concluding that, out of a population of eighteen million, fourteen million persons would have to be subsidized. For example, it suggests that a married person with an

annual income of $6,800 per annum would need some subsidy for health insurance and yet totally neglects the fact that such an individual must pay to the state an amount in excess of $800 as income tax, assuming he is married with one child.

5. Whereas the industry suggested a method of subsidy based upon an "income test" similar to the tests performed each year in the payment of income tax, the report equates the term "income test" with "means test" and then criticizes the latter on the basis of all the usual criticisms leveled at a "means test."

A much longer list could be compiled of the omissions of this part of the report, but the above will be sufficient to illustrate the fact that this chapter is grossly unfair to the industry for the simple reason that it offered in its testimony the only alternative to the compulsory government plan which the report advocates.

In chapters xix, xx, and xxi, there is an extensive treatment of the projection of health care costs for the period 1961–91. In several instances, there is the usual tendency to understate the projected costs.

The essential conclusion of the report is that the voluntary system has failed in that, in the year 1961, only 56 per cent of the population had some form of medical care coverage. The report omits a provincial analysis of this figure which, if it were completely unbiased in its conclusions, would have made the following points in order to give a truer picture:

1. The percentage of the population which has been covered by the voluntary agencies continues to increase each year, and in two provinces, British Columbia and Alberta, it exceeds 80 per cent.
2. In the province of Ontario, the proportion of the population covered exceeds 70 per cent. It is confidently expected that this proportion will increase beyond 80 per cent if the program now being considered by the Ontario government is put into effect.

Needless to say, the same results could be accomplished in the other provinces if a similar program were instituted there, as has been recommended by the industry.

The second point that the report tries to make is that the voluntary approach is too expensive. It states figures to try to establish that, if the job were done by the voluntary agencies, the expenses incurred would be approximately 35 per cent of the claim payments. This includes items not properly considered as expenses; it omits some very basic considerations, as has already been stated; and, in addition, the statistics on which this figure is based are not yet available and cannot be checked by us. As I have already said, this particular comparison is grossly unfair, but the statistics are used to make the point that, if the voluntary agencies were

used, the plan would cost a great deal more and this would be wasteful from a national standpoint.

Finally, it is argued that, if the program is instituted on a voluntary basis, it would be necessary to develop a system of subsidy. Great pains are taken to establish the fact that this would be an impossibility and, in addition, would depend upon a "means test" that is "contrary to the dignity of man," to quote from the report. This rejects the submission made by the Canadian Health Insurance Association and twists it to such an extent that the degree of bias becomes very evident in reading these particular passages of the report.

The report, therefore, concludes that the only alternative would be a comprehensive compulsory government plan, and the whole report is written from that particular point of view.

One essential attitude which is fundamental to an analysis and consideration of this subject is evident in the report. As I said earlier, the estimate of the per capita expense for health services in Canada at the present time is $178. The report estimates that, if its recommendations are implemented, this would increase by approximately $20. It is, therefore, concluded that since we are already spending $178 the actual cost of implementing this entire plan is only $20, or a total amount of $466,000,000. By presenting the statistics in this way, attention is directed only to this latter item and not to the former, which, of course, represents an expenditure of approximately four billion dollars.

The reasoning behind this approach is that, since we are already spending $178, this does not represent additional expenditure by the country as a whole. However, it assumes that the country would not be in any different position if this amount of money were expended through government channels rather than through private resources. In other words, the fact that this huge amount of money would have to be raised through additional taxation is not regarded by the Commissioners as any particular problem. It would simply mean that more money would be in the hands of government to handle these particular services and, consequently, less money would be in the hands of the public, since they would not require so much money, this portion of their normal expenditures having been transferred to the public sector.

This is the kind of argument necessary to justify a compulsory government plan. It ignores the fact that excessive taxation would have to be implemented, which would undoubtedly have unexpected results in terms of the effect on the economy and the export trade. However, it seems to suggest that, if this is the most practical means of dealing with this kind of problem, a similar argument could be adduced in other areas, such as

food, shelter, and clothing. Because this is considered the best means of operation as compared to private initiative, it would seem logical that an extension would be even better. Carrying this argument to its natural conclusion, it seems to me that we develop a type of society in which the government takes care of all the normal needs of its citizens, and very little money is required by the individual to look after his needs other than any luxuries that he feels he can afford. In this type of society, it would seem that the individual becomes the complete slave to the state. Individual initiative is completely destroyed, and the state becomes a monster reaching into every avenue of private life. The question is, "Is this not the natural conclusion that one would reach from this type of reasoning?" If we assume that this result is to be abhorred, then it seems to me that any step in this direction is also to be abhorred. As a consequence, we must reject the conclusions of this report—however plausible they may seem to those who do not take the time to examine the precise arguments on which they are based and which in many cases, as I have said, gloss over the facts to a degree which renders the basic conclusions of the report wholly unreliable.

It is expected that next spring the federal government will convene a meeting of provincial representatives to discuss the report and decide what action, if any, should be taken.

The report says practically nothing in regard to the major development in Alberta, which will now be described.

Alberta

On October 1, 1963, there was introduced in the province of Alberta a comprehensive plan of health insurance, operated through the voluntary agencies, which is unique in its conception and represents the only possible alternative to a comprehensive government scheme that could be devised. Its success, therefore, was a matter of great concern to the industry and of even greater concern to those of us who believe that compulsory government schemes are to be avoided at all costs.

The Alberta Medical Plan makes comprehensive coverage for the costs of physicians' care, both in and out of hospital, available to every resident under standard contracts that may cover an individual adult, a family, or a group. Regardless of age, sex, condition of health, or any factor that might affect the insurability of the residents to be covered, an insurance company or prepayment plan taking part in the Alberta Medical Plan must issue on application a standard contract at a premium rate that may not exceed the appropriate maximum limit specified under the plan. However, below the maximum limits on premiums, the various carriers are free

to compete on premiums and, for this purpose, each carrier is free to ask for whatever information it deems desirable. These arrangements ensure that the residents of Alberta are able to reap the advantages of competition and yet are guaranteed that they will not, in any event, have to pay more than the maximum limit on premiums. There are about fifty approved carriers taking part in the Alberta Medical Plan.

The Alberta Medical Plan retains all the flexibility of the voluntary approach to meet the needs of the residents of Alberta for medical care insurance. In addition to the standard Alberta Medical Plan contracts, the carriers continue to issue medical care insurance or to arrange medical care prepayment in the wide variety of forms now in use. In other words, the Alberta Medical Plan does not disturb existing coverages or the right to continue to develop improved benefits. For example, carriers are free to add benefits to the standard contracts to cover the costs of drugs, nursing services, and supplementary hospital expenses.

According to the latest information, the total number of lives with standard coverage under the Alberta Medical Plan is approximately 770,000, or almost 60 per cent of the population. In addition, there are other residents of Alberta with medical care insurance of various kinds written by approved carriers, with the result that a total of approximately 1,100,000 Alberta residents is now protected by some type of insurance or prepayment arrangement for medical care, including those in receipt of public welfare benefits, armed forces, and persons under miscellaneous federal and municipal plans. This figure represents over 80 per cent of the population.

The maximum limits on the monthly premium for the standard Alberta Medical Plan coverage is as follows: individuals, $5.25; families of two persons, $10.50; families of three or more, $13.25. However, these maximums apply only to applicants who, by reason of health, age, or size of family are likely to be substandard risks or considered entirely uninsurable according to normal standards of selection.

Each carrier licensed to conduct a medical care insurance business in the province of Alberta must offer the standard contract to any applicant, regardless of his condition of health or age, as a condition of conducting that type of business in the province. In addition, such carrier must participate in the pooling arrangements which have been set up through an organization known as Alberta Medical Carriers Incorporated. All policies issued at the maximum premium rate must be reinsured in this pool. The losses suffered by this pool would be allocated to each of the carriers in proportion to the number of lives that are not pooled which that carrier has insured in the province for medical care insurance. In this way, the

losses suffered by the pool will be assessed back against the healthy lives insured for medical care insurance in the province. The level at which the maximum premium rates are set will determine the extent of this loss. It was our hope and expectation that the loss to be assessed back against each life would not exceed 10 cents monthly. The early indications are that the experience of the pooled risks for the first year has been satisfactory and that the incurred claim ratio for some of the companies, at least, will be 80–85 per cent of the maximum premiums charged. It is too early to state whether this will be the over-all result, but I believe that the final result will indicate that the pool has made a loss as expected and that the amount to be assessed back against the various carriers at the end of the first year of operation will not be more than expected. At this stage, the statistics are being collected and summarized, and therefore no final or reliable statement can be made as to what the total result will produce.

The Alberta Medical Plan also provides that the government will pay a subsidy to any individual or family that qualifies on the basis of an income test. At the present time, for residents who were not required to pay any federal income tax in the preceding year, the annual subsidy payable by the Alberta government is: for a single person, $18.00; for a family of two persons, $42.00; and for a family of three or more, $72.00.

In other cases, where the resident was required to pay income tax on less than $500 of taxable income in the preceding year, these subsidies become: for a single person, $9.00; for a family of two persons, $21.00; and for a family of three or more, $36.00. Almost 180,000 lives are covered under standard contracts subsidized by the Alberta government.

These subsidies can be obtained on a simple declaration by the applicant. This process avoids a number of undesirable features of the usual kind of means test, including expensive administrative machinery. It is based on the mechanism of personal income tax, a mechanism that most people in Canada have come to accept.

Less than 15 per cent of the people with standard Alberta Medical Plan coverage pays premiums at the maximum premium level. The remainder, with the standard plan, is charged premiums that vary by age, sex, family composition, or other factors. In most cases, these premiums are substantially less than the maximum limits. Companies decide upon the premium rates which they wish to charge according to age, sex, and other factors and are restricted only with respect to the maximum premium that they are allowed to charge. Consequently, there is no standard premium rate applicable to the vast majority of the people covered by this plan.

At the end of the first year of operation, it would seem, on the basis of the present evidence, that this experiment has been a great success. The

enrolment has been as much as we could expect through a voluntary process, and we expect that the percentage will continue to increase as the plan proves itself. The operation of the pooling arrangement seems to have developed according to expectations, and the amount to be assessed back against the various carriers would not seem to be in excess of expectations.

Ontario

In Ontario, a bill was presented to the legislature in 1963 that introduced a plan of medical care insurance along similar lines to those just described for Alberta. This bill was given first reading and then referred to a committee for study. It is expected that the committee's report will be made available either late this year or early next year and we might expect that Ontario, if favorable to the legislation, would proceed along these same lines rather than follow the plan advocated in the Royal Commission's report.

Saskatchewan

The medical care insurance plan was inaugurated in Saskatchewan on July 1, 1962. It provides prepaid insurance coverage to Saskatchewan residents for physicians' services and physiotherapy. It is a compulsory government plan and is financed partly through taxes and partly through premium contributions. The total number of persons covered is approximately 886,000, as of August 31, 1963. The monthly premium required during 1963 was $1.00 for each individual and $2.00 for each family. These contributions for the year 1963 represented 24.6 per cent of the funds required to meet the total payments. The balance was contributed by the government out of general revenue.

A good deal more could be said about Saskatchewan and how this plan operates. Its introduction produced a severe reaction from the medical profession, leading to a partial withdrawal of services for a period until the difficulties were resolved. This is in contrast to the result in Alberta, where the plan was installed with the full co-operation of the medical profession and with less expenditure of government funds.

Other Provinces

Other provinces of Canada are considering the problem of health insurance because of the publication of the Royal Commission's report. This study is being done in anticipation of possible federal action. At this stage, it is too early to state what the attitude of the federal government may be.