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NATIONAL, STATE, AND PROVINCIAL HEALTH CARE INSURANCE

Moderator: DANIEL W. PETTENGILL. Panelists: STUART H. ALTMAN, ALAN M. THALER, RAYMOND L. WHALEY

1. New or pending legislation
   a. National
   b. State
   c. Provincial
2. Current industry position regarding:
   a. Catastrophic coverage
   b. Continuation of benefits for the unemployed
   c. National health care insurance
3. Experience with government-mandated programs
   a. Canadian provinces
   b. Impact of no-fault automobile insurance

MR. DANIEL W. PETTENGILL: Even though the chances of a national health insurance law being enacted are zero for 1975 and very close to zero for 1976, the topic under discussion is of vital importance, especially for actuaries concerned with health care insurance.

The United States still faces shortages of certain types of health care manpower, surpluses of others, and a general maldistribution as far as most rural areas and some core city areas are concerned. More importantly, our people have not been properly educated on what they themselves can and should do to maintain good health. I refer to such matters as exercise, nutrition, smoking and drugs.

Without rigid self-discipline by both patient and doctor, the amount of health care this nation could consume is virtually infinite whereas our resources are finite. Thus any successful national or state health care plan must deal not only with eligibility, benefits, financing and administration, but also with cost control and quality assurance.

How should we deal with these factors? How will we deal with them? As actuaries we should be involved in ascertaining what pertinent facts are already available, what additional facts could be determined, and at what cost in dollars and time. One place to start is to examine the experience of Canada, our neighbor to the north.

MR. RAYMOND L. WHALEY: In 1919 the Liberal Party adopted as a policy the creation of a national social security system which would embrace a health care plan. It is likely that idea appealed to the federalists in the relatively new nation as one means of equalizing and unifying what was then a sparsely populated federation of diverse peoples strung in a narrow line across a vast continent. This 1919 proposal for a national health care plan came at a time

when voluntary health insurance was almost non-existent, particularly in areas where the population was scattered and where there were great distances between urban centers.

While there were sporadic discussions about a national health care plan during the two decades between the wars, there were serious deterrents. Both health care and insurance are constitutionally provincial and not federal matters. Also, during the Great Depression the tax base was seriously eroded at all levels of government, and this was compounded by a complete lack of coordination of taxation policy between the federal and provincial governments.

With the advent of World War II, two important things happened. First, the federal government was able to achieve a dominant position in taxation. Second, because of the war it was able to assume a great deal more authority in directing the country's affairs, and this was extended not only to the immediate necessities but to intensive planning for the post-war years. By 1942, the federal government was actively considering grant programs to provinces that would agree to establish health care programs satisfying federal criteria.

At the same time, voluntary health insurance plans were finally becoming more widely available. Group hospital-surgical insurance first appeared in Canada in 1928. The first doctor-sponsored medical care plan started in 1937. Blue Cross hospital plans did not appear until 1939. As in the U.S., there was very rapid growth of voluntary health insurance plans during World War II and the post-war years. Most of this growth took place in those provinces with industrial, urban development; the least growth was in the West, still largely rural and agricultural.

Out of the Depression, there had been born in the West in 1932 a socialist political party known as the Co-operative Commonwealth Federation (CCF), later renamed the New Democratic Party (NDP). This party considers itself the champion of labor, and the social conscience of the nation. It is a frequent critic of corporations in general and private insurance in particular. It quickly became an influential party in the West and remains so to this day. It is currently the governing party in British Columbia, Saskatchewan and Manitoba, and last month became the official opposition party in Ontario. At the national level, it has never formed the government, but during minority governments it has held the balance of power in Parliament and has naturally used these opportunities to its advantage. The CCF party came to power in Saskatchewan in 1944 with an election promise to provide hospital, medical and dental service for all, regardless of the ability of the individual to pay. In 1947, Saskatchewan instituted the first state-operated compulsory hospital care plan in North America. Two years later, a coalition government in British Columbia followed suit. The private carriers and Blue Cross had not been able to reach a very large proportion of the population in those provinces.

As earlier indicated, after the war the federal government established a set of 13 programs of conditional health grants to the provinces. None of these early programs covered the direct cost of providing health services, but all were generally aimed at improving the resources that would be necessary if broader services were to be provided later. The most important provided funds on a 50/50 matching basis for hospital construction. All were later phased out when they had served their purposes.

The next major step in the federal program occurred in 1956, when the government offered a new program of conditional grants toward half the cost of basic hospital services, if a majority of provinces (i.e. at least six) with a

majority of the population (i.e. including Ontario or Quebec) would agree to implement universal, publicly administered programs. Representatives of the insurance industry attempted to dissuade Ontario from joining, but they offered no imaginative alternatives and were unable to refute satisfactorily severe criticisms by the legislators of their practices of limited coverages, exceptions, exclusions, cancellations, and the apparently high administrative cost of individual policies. More to the point, the federal government, by offering to pay essentially half the costs of hospital care, presented the provinces with an irresistible program.

As a result, by 1961 all provinces had established hospital care plans and had excluded private carriers from this field except for insuring the differential cost of accommodation in private or semi-private rooms. In most provinces, the process was not very difficult, for it simply meant adopting the existing Blue Cross premium collection machinery or else abolishing premiums entirely. Payments to the hospitals are not on a per service basis, but on a gross basis under operating budgets negotiated between the hospitals and the government commission.

The subsequent expansion of government plans from hospital care to medical care was perhaps predictable, but it was not entirely uneventful. The events have been described in considerable detail at meetings of the Society during the 1960's.

It is one thing to socialize institutions with salaried employees. One would expect that there might be rather different considerations in dealing with a profession of individuals accustomed to payment on a fee-for-service basis.

During the first half of this century, the medical profession in Canada had been making rather pious but vague pronouncements on the social desirability of health insurance. During the 1940's, it became evident that governments were moving slowly but inexorably toward introducing government-operated plans. However, at the same time, the various new doctor-sponsored medical service insurance plans were expanding their operations quite successfully. Only then did the profession finally begin to refer to voluntary prepaid medical care plans. Of course, they were referring to their own plans, because there was bitter antipathy on their part toward insurance company plans, which (1) typically excluded the first few office calls, which meant that many such treatments went unpaid for, and (2) were generally experience-rated, which meant that, in competition, the community-rated, doctor-sponsored plans generally either lost the better cases or had to compromise their principles.

In 1960, the Canadian Medical Association requested the federal government to make a careful, impartial study of the adequacy of medical personnel and facilities, and other problems associated with the provision of health services. The government agreed to do this and appointed a Royal Commission. Presumably the medical profession felt that this study might provide some sobering information concerning the degree of preparedness in Canada for a national medical care insurance plan and perhaps slow things down. If so, they were mistaken.

At about the same time, the CCF government in Saskatchewan sought re-election, promising to proceed with compulsory, government-operated medical care insurance. Although they received only 41% of the popular vote, they were re-elected and the plan came into effect July 1, 1962, despite strenuous and bitter opposition from the medical profession.

On another front, the life insurers and casualty insurers had finally gotten

together, very late in the game, to form the Canadian Health Insurance Association in 1959. This new industry association quickly addressed itself to the impending crisis and to the task of meeting the public criticisms that had apparently led to the downfall of private hospital insurance. A plan was devised, which, through an intercompany risk pool, would guarantee availability of basic medical insurance to all who were willing to buy it, with premiums for persons with low incomes to be paid partially or totally by government. This plan was described to the Society by Gilbert Fitzhugh in 1961 (TSA XII, 630-637); it was submitted to the Royal Commission as a workable alternative to a monopolistic government plan.

By 1963 the insurance companies, in cooperation with the government, the medical profession and the doctor-sponsored plan in Alberta, had implemented the plan in that province, where it operated reasonably successfully. Ontario moved toward adopting this model plan in 1965 but retreated in the face of criticism in the Legislature and the press over the proposed use of private carriers to provide public insurance and over the proposed scale of premium rates.

The Royal Commission presented its report in July, 1964. It included a "Health Charter for Canadians" consisting of 200 recommendations for government action. The proposed plan of the Canadian Health Insurance Association, already working in Alberta, was completely ignored. Statistics concerning the insurance industry were presented in a biased and damaging manner, as described at length by George Watson in TSA XVI, D337-342, and TSA XVII, D382-385. The report rejected the use of the existing voluntary health insurance mechanisms and proposed essentially an extension of the existing system of federal cost-sharing for acceptable provincially-administered plans.

A year later, acting on the Commission's recommendations, the federal government announced two new conditional grant programs. The first was the establishment of a $500 million Health Resources Fund to be made available to the provinces on a dollar-for-dollar matching basis over a 15-year period to assist them in the acquisition, construction and renovation of health training facilities and research institutions. Like the earlier program of grants toward hospital construction (under which over $300 million of federal grants were made) the Health Resources Fund was no doubt viewed as a necessary forerunner to a national medical care insurance plan.

The second new conditional grant program was an offer to share the costs of physicians' services provided under provincial plans meeting federal criteria. The proposed effective date was July 1, 1967, the plan to have been, no doubt, a sort of birthday gift to the nation on the very date of its centenary. Reservations by some of the provinces over costs, and attempts by some of them to get federal agreement to the use of private insurance carriers in their plans, delayed implementation for a year, but otherwise proved fruitless. As in the case of hospital insurance, the offer of such massive federal grants left the provinces with no real choice but to establish monopolistic plans, most of which left no room for private insurers, even when medical bills exceed the amount of benefit allowed under the plan. Alberta was forced to abandon its joint government-private insurer plan. Ontario did initially contract out "administrative services only" to a consortium of private carriers and other agencies, but within a few years established its own administrative facilities and dispensed with this arrangement. By 1971, all provinces had state-operated plans in effect.

What has been the effect of these plans? From the point of view of the man in the street, "free" hospitalization and "free" doctor's care, like "free" education, have simply become facts of life. If you are treated at a hospital, either as an outpatient or as a patient in a public ward, there is no hospital bill; if you have a bed in a private or semi-private room, there is a small daily charge that you or your insurance company or Blue Cross must pay. Likewise, if you consult a doctor who participates in Medicare - and most of them do - you will receive no bill, for he has agreed to accept the Medicare fee as payment in full. If you go to a non-participating doctor, he must tell you in advance what his fee will be and how much of it you will be able to recover from Medicare; you will have to pay his full fee and will receive the approved fee from Medicare but will likely be out of pocket the difference since most provinces prohibit insurers from insuring this difference.

At last year's Society meeting in Boston, Professor A. Peter Ruderman of the University of Toronto reported (TSA XXVI, D133-136) that there has been only a modest increase in hospital utilization rates since the advent of government hospital plans. Overall, there continue to be about 5.3 general hospital beds available per 1,000 population, with roughly 80% occupancy and an average stay of 8 to 9 days. However, there are areas where, through faulty planning, over-expansion has occurred; others where there is a shortage of beds; and others where a shortage of nurses has prevented hospitals from using all their facilities.

Professor Ruderman also reported that the rate of utilization of physicians' service had roughly doubled from 1961 to 1971. Very likely much of this occurred toward the end of that period as a result of the sudden availability of free medical care on a first-call basis. The increased demand for services has resulted in increasing workloads for doctors. This has been met in part by an open immigration policy which, together with expanding medical schools, has resulted in a continuous increase in the ratio of doctors to population, to about 1 to 600.

Despite these high average rates of availability, there are often delays in getting a doctor's appointment or a hospital bed in the case of routine or elective treatment. In some places, there is apparently a very serious problem as well for persons requiring urgent treatment. In other places, there seems to be little or no problem. In short, availability of services is at present rather uneven, not only across the country, but even between neighboring communities and within cities.

Let us now consider the costs of these programs.

Under the Hospital Insurance Program, the federal government pays each province a per capita grant of 25% of the national per capita average cost of inpatient ward level services plus 25% of its own provincial per capita average for the same services. The resultant ratio of cost-sharing, which varies by province from about 48% to about 61%, is then applied also to sharable outpatient and diagnostic services. Treatment in tubercular and mental hospitals is not sharable, nor are charges for hospital capital expenses, depreciation and debt interest. A number of provinces have broadened their plans to include care in nursing homes and homes for the aged; again, these costs are not sharable.

Under the Medical Care Insurance Program, the sharing formula is simply at the rate of 50% of the national average of all physicians' services. Again, many of the provincial plans also include paramedical services such as optometry and physiotherapy, but these costs are not sharable.

The grant formulas, being related to national averages, were evidently designed to effect a form of equalization as between high-cost and low-cost provinces. However, an even greater degree of hidden equalization results from the fact that the federal grants are financed from general tax revenues, of which about 60% is derived from income taxes and 10% from sales taxes, and, therefore, arises from the more affluent provinces, which are generally also the higher cost provinces.

Six of the ten provinces also raise their share of the costs from general taxation, of which, on the average, about 30% is derived from income taxes and 30% from sales taxes. Three provinces charge premiums and one imposes a special tax on payrolls and the self-employed, but in no case do these direct taxes come anywhere near meeting the province's share of half the total costs. Three of the provinces also recoup a very small part of the costs through small utilization fees for certain services.

Because there have been differences within and among the provincial plans over the years, the most convenient figures to examine are the costs to the federal Treasury of the two conditional grant programs, as shown in Table I. In each case, the data for the first three years of the program should be ignored because all provinces were not participating.

These costs represent something less than half the total expenditures under these plans since some of the benefits included in the provincial plans are not eligible for sharing. The annual expenditure is now well over $6 billion and constitutes nearly 30% of all spending at the provincial level!

The rapid escalation in costs has been a matter of increasing concern to both the federal and provincial governments. Part of the increase is due to increased utilization and part to inflation. In the area of hospitalization, where there has been only a modest increase in utilization, the main reason for the increases has been hospital payrolls. The medical insurance side of the picture is interesting. The advent of Medicare automatically resulted in a substantial increase in the average earnings of physicians, as a result of, first, increased demands for services, and second, elimination of the problem of uncollectable accounts. Consequently, in the early years of Medicare, the doctors were reasonably content, under pressure from the provinces, to settle for relatively modest increases in their fee schedules. Doctors' fee schedules have, in fact, risen less than 20% since 1970, compared with a 45% rise in the Consumer Price Index and a 60% increase in the average income of all Canadians. Consequently, the share of the Gross National Product going to the medical profession actually decreased during the early years of Medicare. However, double-digit inflation is now creating a potential crisis in this area, and doctors are increasingly complaining about being overworked and underpaid. Within the last month, a number of the provincial medical associations have announced they will demand increases in their fee schedules for 1976 in the range of 30% to 50% or else withdraw from Medicare. Counterthreats of legislation to prevent withdrawal have in turn been met with threats of strikes.

The imposition of wage and price controls this past week changed the entire picture. Indications are that doctors will be allowed to recoup increased costs of practice, and increase their net personal income by $2,400 per year at the same level of utilization. They may earn more if they do more work. But how these guidelines will be implemented is as yet unknown.

Two years ago, concerned with the escalation of costs of both programs, the federal government proposed a new grant formula which would have allowed the

TABLE I

CONDITIONAL HEALTH GRANTS
From the Government of Canada to the Provinces
including estimated value of alternative tax arrangements with Quebec
(dollar amounts are in millions)

	Gross National Product	Hospital Insurance		Medical Insurance	
			Percent of GNP		Percent of GNP
Fiscal Year					
1959	$35,400	$ 55	-		
1960	37,400	151	-		
1961	38,400	189	-		
1962	40,500	284	0.70%		
1963	43,500	337	0.77		
1964	47,100	392	0.83		
1965	51,300	434	0.85		
1966	56,900	483	0.85		
1967	63,000	570	0.90		
1968	67,000	673	1.00		
1969	74,500	798	1.07	$ 33	-
1970	81,400	919	1.13	181	-
1971	87,000	1,040	1.20	401	-
1972	96,000	1,181	1.23	576	0.60%
1973	107,200	1,351	1.26	631	0.59
1974	125,100	1,579	1.26	678	0.54
1975	144,000	1,940	1.35	763	0.53
1976 (est.)	157,000	2,305	1.47	884	0.56

provinces to use their grants for the whole range of health services but would have related the amounts of the grants to GNP. In September of 1974, the provinces rejected this proposal. Then in June of this year, the federal government dropped a bombshell. They announced, first, that they were giving the required five years' notice of termination of the present cost-sharing arrangement for hospital insurance in order to negotiate new arrangements. Second, they announced ceilings on the yearly rise in the federal grants toward medical insurance: 13% in 1976-77, 10½% in 1977-78 and 8½% in 1978-79 and subsequent years. These limits apply to the per capita rates, so that variations in population will automatically be reflected in the grants. On the average this would add about 1½% to the per capita limits, resulting in overall ceilings of 11½%, 12% and 10%, but varying by province.

There was a prompt outcry from the opposition parties and from the provinces. Ontario, for example, has projected that its costs in the same years will rise by 23%, 21% and 19% respectively and that the federal ceilings will cost that one province more than $200 million in lost revenue before 1980.

The provinces are obviously all finding themselves in an extremely awkward position. Over the years, the federal government has, in effect, coerced them into establishing open-ended insurance plans. Now, with costs running almost out of control, the federal government has unilaterally announced its intention to cut back on its share to force renegotiation of the terms of cost-sharing. The provinces were left with the political dilemma of raising more revenue through increasing taxes, or imposing premiums or deterrent charges, or else modifying the plans by controlling or cutting back services. Whether they can successfully negotiate completely corresponding abatements in federal taxes if provincial taxes have to be raised seems somewhat doubtful. Of course, price controls add a new dimension to the situation. The problems remain severe and the politics are an incredible exercise in cooperative federalism.

Until the recent crisis emerged, there had been suggestions in various quarters that the provincial plans should be extended to include prescription drugs and/or dental care. Indeed, the CCF government promised dental care in Saskatchewan 30 years ago. "Free" dental care and drugs at $1 per prescription were both recommended in the Royal Commission report, and Professor Ruderman predicted last year that complete "pharmacare" and "denticare" would arrive between 1977 and 1987. Limited versions of both are already in effect in most provinces.

With respect to prescription drugs, the pattern so far in most provinces has been to provide prescriptions for the elderly and others with low incomes, either "free", or at low cost, or subject to deductible and co-insurance. Last January, Manitoba extended its program for the elderly to cover all residents; this plan calls for a $50 calendar year deductible per person and 20% co-insurance. In contrast, last month Saskatchewan introduced a rather more extensive plan under which any resident can obtain any approved drug at a maximum charge of $2 per prescription. The government will pay the pharmacist the balance of the drug costs plus a dispensing fee of $2.75 per prescription for the first 20,000 per year and $2.50 thereafter.

With respect to dental care, most of the provinces now provide, or have plans to provide, "free" dental care for young children. The Ontario Dental Association, which is by far the strongest of the provincial chapters of the national association, has published a position paper urging that "denticare" be phased in slowly because of the expected heavy initial demand for restorative services. They propose four phases:

(I) children to age 13 by year 5, (II) persons over 65, (III) children to age 18, and finally (IV) the general population at some undetermined future date. Their paper gives estimates of the costs for Phases I and II, but is silent on how the revenue should be raised or the plan administered.

The Canadian Association of Accident and Sickness Insurers has developed a model administrative plan which would be a joint government-private insurer undertaking. This plan recognizes that the industry is not in a position to underwrite the financial risks inherent in a universally available plan of dental care, but that it has developed claim assessment skills that could be well utilized in administering a universal plan. It would also retain most of the premiums, expenses and claims accounting in the private sector and not through public accounts.

This plan would, first of all, guarantee access by all to whatever predetermined standard benefits are agreed upon, at a predetermined uniform premium rate. Additional benefits would continue to be offered outside the standard plan. Public funds would be made available whenever a carrier's claims exceeded a maximum percentage of the premiums it collected; conversely, if claims were lower than a specified minimum percentage of the premiums, the excess would be remitted to the government. The carrier's retention for expenses and profits would, therefore, always range between the complement of those two percentages, with the underwriting risk being largely borne by the government, as it would be totally under a completely socialized plan.

If the industry can sell its concept to the government planners, I believe it would work. And with the current financial crisis in hospital and medical care, there is just an outside chance that they might be able to do so. My fear, however, is that the industry may not have learned from history and that it may lull itself into a false sense of security by riding on the crest of the current rapid growth of group dental insurance. I have not the slightest doubt but that universal dental care insurance will come in time. The question for insurance companies is whether they will be participants or once again be onlookers. Their own political initiatives or inaction in the near future will answer that question.

This concludes my review of Canadian health care, but I would be remiss if I did not draw the audience's attention to a few other events in Canada. I have referred frequently to Saskatchewan and to the CCF or NDP party. In addition to being the cradle of socialized hospital insurance and medical insurance in North America, the NDP government of Saskatchewan also instituted the first compulsory automobile accident insurance fund there in 1946. In recent years the NDP governments in Manitoba and British Columbia have also taken over the automobile insurance industry in those provinces. The state-operated Insurance Corporation of British Columbia also sells other casualty lines in competition with private insurers. It also has the corporate powers to write life insurance, but has not yet done so.

In the area of disability income, the Canada Pension Plan contains a floor of long-term disability benefits. Our national Unemployment Insurance Plan was amended in 1971 to include short-term benefits for accident, sickness and pregnancy as eligible forms of unemployment; fortunately, equivalent accident and sickness benefits may be provided through private plans. Despite these national plans, Saskatchewan apparently feels there are still some gaps, and last November, appointed a Sickness and Accident Committee to investigate this area. We understand that the Committee is impressed by the comprehensive plan of accident benefits in New Zealand, and is studying whether a similar plan

covering both accident and sickness might be appropriate and feasible in Saskatchewan. The Committee will be holding public hearings next month and the Canadian Association of Accident and Sickness Insurers will be making representations to it.

These events are all philosophically interrelated because they all deal with a very fundamental social question: How much security should the state provide for the individual and how much should he be encouraged to provide for himself through private agencies? We live in a society where most individuals seek security. The Canadian experience is that if private agencies fail to provide benefits that are seen to be adequate, or fail to provide access to benefits to all who need them, then it is inevitable that governments will move to fill perceived gaps, and, in so doing, are likely to absorb as well even those related areas where the private sector is doing an excellent job.

DR. STUART H. ALTMAN* To a sizable majority of those who strongly advocate total national health insurance, and particularly the variety which would have the government both finance and administer the plan, people like yourselves represent the "enemy." You're "bad" because you maintain that certain groups in our society cost more to insure than others, and that there are differences in utilization. Many people don't want to know these facts. Economists also have a cross to bear; we maintain that the lower the price, the more the utilization, and some people don't want to hear that either.

The rather technical considerations which underlie any national health insurance proposal really are very important and, in fact, constitute much of what the debate is all about. Three key issues involving technical considerations are cost sharing, experience rating vs. community rating, and the role of health insurance in income redistribution. If you resolve these issues in favor of no sharing in the cost of claims by insureds, community rating, and premiums based on ability to pay, you rapidly arrive at the conclusion that private health insurance is at best redundant and is probably evil. In Washington, private health insurance is regarded as second only to the federal government as the number one evil in our system. But I'm convinced that you're not that bad and your employers are not that bad. I don't really think the issue has much to do with private health insurance; the real issue at stake is the use of national health insurance for a variety of other social goals.

Some of those goals are terribly important and I have to favor them myself. On the other hand, I'm convinced that if a vote were taken today in the Congress or by the American people, both would retain a sizable, if not a dominant role for private health insurance in the funding of health insurance. The main reason for my conviction is a growing concern among the American people, shared to a lesser extent by people in Washington, about the size of government. The three key issues I listed, no matter how important from a technical viewpoint, may not in fact be the governing force, at least in the short run. Rather the issue will be how many dollars in the health system should flow through the federal purse. Once dollars flow through the federal government, they tend to be redirected. The federal government is not like a private insurance company. It will not simply collect premiums and pay bills, but will figure out ways to use the money that neither the people who put it in nor the people who take it out are aware of.

* Dr. Altman, not a member of the Society, is Deputy Assistant Secretary for Planning and Evaluation, Health, Department of Health, Education, and Welfare.

I don't think such a vote is going to be taken in the next year or so. The political situation has put national health insurance on a back burner temporarily. The Congress is preoccupied with other issues, such as energy, tax reform, and major changes in foreign policy. Our President has indicated that he is personally very concerned about the size of government and has staked his political career on a very bold and major change in government programs, with a $28 billion tax cut coupled to an equal cut in government spending. For those of us who will be working to see if this change can be implemented, finding $28 billion to cut from the budget is not going to be easy. I am rather intrigued by some of the things that the Canadian government has done. I'm not sure how we could do them ourselves but we will try.

The Administration told the states last year that the states ought to share in a greater percentage of the Medicaid program. The federal government now pays an average of slightly under 50%, although some states pay as little as 17%. The formula, like the Canadian one, is based on ability to pay. However, the Administration couldn't even get a sponsor to put this proposal into legislation. The same fate applied to the recommendation to introduce some kind of cost sharing with respect to hospital care for Medicare beneficiaries. I'm reasonably confident that the Administration will reintroduce these proposals, plus a number of others, in 1976.

There is no way that the federal budget can be reduced by $28 billion without bringing medical spending under control. Medicare and Medicaid expenditures alone are scheduled to increase by over $4 billion next year to a total of almost $30 billion. All the rest of the federal spending for health is on the order of $5.5 billion annually. If some controls are not put on the rate of increase in health costs, and therefore on federal spending for the so-called uncontrollable programs, distortions will accelerate, not only with respect to other health programs but with respect to all social service programs. We now spend more on Medicaid than we do under the welfare program, so that we give the poor people less in dollars for everything else than we do for one item, health care.

Turning to the pivotal issue of rising health care costs, I see no force other than some kind of social equity that is as strong a driving force towards national health insurance as is the rising trend of health care costs. As costs go up, people increasingly are pressured into finding ways to protect themselves, groups that lack coverage are increasingly vulnerable to being wiped out, and providers suffer increases in bad debts. Thus there is increasing pressure from many groups to get national health insurance enacted to combat rising health care costs. In addition, there is a growing feeling, which I share, that our system is out of control, and that we are eight-ninths pregnant with national health insurance already. The idea that the United States does not have national health insurance and that it may be a drastic change in the way we pay for health care is ridiculous. Third parties already pay for 90% of our hospital bills and 50% to 60% of our doctors' bills. At best, national health insurance would be incremental with respect to expenditures, although its design could drastically change the actors. One unlikely, but nevertheless real possibility, is that many of you could become civil servants.

The pressure to bring health care costs under control is great. There is a feeling that private companies, the way they do business now, just can't bring about that control. However, just because the government gets into the act doesn't mean there will be control. The government has been in the act to the tune of $30 billion and it hasn't found any miracle potion to bring the costs under control. Our friends to the north have had a much greater control over

their system and, as was pointed out, they have not found any miracle potion. Nevertheless, the feeling is clearly there that only government has a chance to bring some degree of control over the system. There isn't any question but that government could brake the system very markedly. But a valid concern is how strong a brake should be put on it. Should we bring this industry to its knees? Should we effectively turn off our health care system which is generally considered to be one of the best, if not the best, in the world? I don't think that's either desirable or likely.

On the other hand, there are people who are using high costs as an excuse for not having national health insurance. They point to a future explosion in spending if we introduce national health insurance. The Rand Corporation has done several papers estimating the elasticity of the demand for health care and it says that under certain circumstances demand could increase as much as 30% to 40%. But that is mainly for ambulatory care. For hospital care the elasticities are much smaller and the rate of change would be much smaller. But nevertheless, there are people who are shaking the dollar signs throughout the Congress, arguing that we just cannot afford national health insurance and therefore we should not have it.

A decision will have to be made by the President, and to my knowledge he has not yet made one. He may decide to put off national health insurance for a couple of years because of the other pressures on the economy.

There are problems that go along with not going to national health insurance. Some of these are continued increases in categorical programs that the government has to run, and continued pressure to add renal-type programs to Medicare, to bring children under federal programs, to bring in the near poor and the working poor, and to federalize the Medicaid program. I consider all these outcomes to be unfortunate. I don't see the need for the federal government to be getting involved in all these things, and I do see the real possibility that as we put off national health insurance into the future, the pressure for this incrementalism will grow. The Long-Ribicoff catastrophic proposal is now considered to be the leading contender. It is a very sophisticated program in that it promises a lot of things to a lot of people, but its basic feature would be to substantially increase the federal government's role. The Medicaid program, which is now shared with the states, would become an all-federal program. The Long-Ribicoff Bill allows catastrophic insurance to be sold by private companies but the payment is all on a payroll tax and therefore based on ability to pay. So even though employers could continue to purchase catastrophic coverage (defined as more than 60 days of hospital care, or more than $2,000 in family medical bills) from your companies, they would have to pay the full 1% payroll tax less a credit for the actuarial value of the premium they pay. Ultimately their financial contribution to catastrophic coverage for the whole country would not be related to their own experience at all. The further the debate goes on about a comprehensive type of national health insurance, the more likely that some incremental approach may take national health insurance down a road that you would not like to see it go.

I realize that there are many other important things you have to do as actuaries, not the least of which is to keep your company from going broke. Nevertheless, I would ask many of you to join with the few that I know very well, and with the few economists who are working in this area, to see if there is not some way that we can design a system which maintains private initiative, keeps a lot of the programs out of the government, yet recognizes that a pure experience rating system is not necessarily a socially desirable way to go and that it's unlikely to continue. We need to reduce experience rating in areas

where it is socially undesirable, yet keep it in areas where it does provide efficiency and some degree of self-initiated cost control. In addition, we need to develop a sophisticated cost sharing system, which recognizes that health care is not a free lunch and causes people to be concerned about their own utilization, without designing it in such a way that denies care to some people. We must draw the proper balance between experience and community rating, between no cost sharing and cost sharing, and between income redistribution and no income redistribution. As technicians, we have a very important role to play in telling the policy makers that it can be done, that you can do all these things that are socially equitable and yet not overly penalize one group or another. So I leave you with the thought that this battle is not just for the politicians, but also for those technicians who recognize the political aspects of health care.

MR. ALAN M. THALER: During the past few years we have been deluged by changes in state health insurance legislation. Most of these changes have been minor, but in 1974 legislation was enacted in Arizona, Rhode Island, and Hawaii which has major implications for the way health insurance business can be conducted, and at this time it seems very probable that there will be much more such legislation proposed and possibly enacted in the coming year.

The bill passed in Arizona required that every health insurer transacting business in the state offer catastrophic medical cost insurance to all existing as well as new health insurance policyholders. The bill was hurriedly drafted and enacted at the close of the legislative session and proved entirely unworkable because of technical defects and ambiguities. The result was that health insurers, with the support of the Health Insurance Association of America (HIAA), sought and obtained a temporary restraining order to prevent the bill from becoming effective until these defects were remedied. The insurance industry was asked to provide corrective amendments along stipulated lines, and these were furnished to the Arizona legislature. This corrective legislation was introduced in 1975, but the legislators could not agree on the details and, in the closing hours of the 1975 session, acted to defer the effective date of the law passed in 1974. So again in 1976 we will begin the year with the original unworkable law on the books and scheduled to take effect October 1, 1976. This, unless amended, will force most health insurers to withdraw from the state of Arizona. There is little question but that the Arizona legislature will again consider this legislation and attempt to correct the defects in the bill, but the amount of time and effort that has so far been expended by the health insurance industry in trying to help resolve this matter is already very large and especially so in relation to the amount of health insurance business conducted in this one state.

The Rhode Island bill also provided for catastrophic health coverage, but, unlike Arizona, the cost of the coverage is assumed by the state. The state-funded major medical coverage becomes payable only after exhaustion of private insurance benefits and a graduated deductible based on an individual's income. Individuals with no insurance must satisfy a deductible of the greater of $5,000 or 50% of income. Persons with insurance coverage have a graduated lesser deductible, depending on the extent of their insurance coverage. For example, those individuals insured for what is described in the law as a "qualified program" qualify for the state-funded catastrophe coverage after incurring out-of-pocket covered expenses of the greater of $500 or 10% of income. The state law as originally enacted required companies offering any plan of health benefits to make such coverage available to all who apply. In this connection, the law also provided for what was described as a "facility reinsurance pool" for purposes of sharing losses among insurers on uninsurable risks. What the law did not recognize was that such a reinsurance facility is impractical

unless there is standardized coverage. Thus, companies had to face the alternative of offering each of its policies to everyone or withdrawing it from the Rhode Island market. As a result, some companies decided to withdraw from offering individual health care policies in the State of Rhode Island and to discontinue offering certain plans for groups of small employers. In 1975 the Rhode Island law was amended so that companies offering qualified plans need only offer two standardized qualified programs to uninsurable risks. One of these qualified programs consists of a basic benefits plan, and the other includes the addition of supplementary major medical with a $10,000 maximum benefit. Companies which do not offer any qualified plans are not required to offer coverage to uninsurable risks. However, all insurers doing business in the state are required by regulation to participate in the financial experience of the reinsurance pool. Regulations pertaining to the operation of the reinsurance pool are still being developed. The problems occasioned by this legislation are, thus, still in the process of being resolved.

The State of Hawaii chose still another route in the legislation that it enacted in 1974. There, a law was passed which mandated that each employer provide a qualifying plan of coverage for its regular employees and specified certain limits on how much employees could contribute. To be a qualifying plan, the coverage must provide benefits equal to or actuarially equivalent to the plan offered by Blue Cross-Blue Shield in Hawaii. An exception is made in the case of collective bargaining agreements, where the parties are permitted to bargain for different coverage and cost than otherwise required. In Hawaii, too, there has been a great delay in clarifying the implementation of this law. Developing a set of rules for determining actuarial equivalence has proven to be a most difficult area, and, although the HIAA has developed a set of guidelines for this purpose, it is still unclear as to exactly how the Hawaii Department of Labor is evaluating plans for qualification purposes. As a result, insurers are in a difficult position when attempting to advise policyholders with regard to compliance under the law.

The interest of state legislators was sparked by the enactment of these health care bills in 1974 and probably also by the attention that national health insurance was receiving in Washington. To take some kind of action at the state level on this important matter of health care coverage, especially in an environment where the federal administration appears to be temporarily backing away from the problem, has a great deal of political appeal. Perhaps this is what prompted the Conference of Insurance Legislators, more commonly referred to as COIL, to draft model legislation for use at the state level. The COIL bill provides for the availability of comprehensive health insurage coverage for all citizens of a given state. To make possible the underwriting of uninsurable risks, the bill creates a Health Care Insurance Association and requires that all insurers doing business in the state participate and share in the pooling of risks and costs of the association. In addition, the bill provides certain tax incentives to encourage both individuals and groups to purchase comprehensive coverage provided by a qualified health care plan. It does not prevent insurers from continuing to offer contracts providing lesser benefits but does establish certain minimum benefit standards and disclosure requirements for all health insurance policies offered within the state.

An important inclusion in the COIL bill is the establishment of a Health Care Commission to require financial reporting, uniform systems of accounting and prospective rate review for all health care facilities, and the prohibition of discriminatory charges by such facilities. This section of the bill also contains provisions for implementation of certificate of need and peer review mechanisms for health care services and is designed to help assist in

implementing, at the state level, appropriate provisions in compliance with the Federal Health Care Planning Act. Finally, this COIL model bill provides authority for the appropriate state department administering medical assistance and Medicaid to make available comprehensive health insurance coverage for the poor and near-poor within its jurisdiction.

The Conference of Insurance Legislators has been receptive to changes in its model bill that have been offered by the insurance industry as technical improvements. The Health Insurance Association of America generally opposes state health care plans on the grounds that the solution to the medico-economic problems can best be achieved on a national basis because of the need for adequate incentives in financing. It has, nonetheless, in response to the growing interest in state plans, taken the position that, where appropriate circumstances exist in a given state, the HIAA will actively support the State Model Comprehensive Health Care Bill adopted by COIL.

The National Association of Insurance Commissioners (NAIC) has also been active in considering this problem of state health care programs, and on February 28, 1975, its Executive Committee adopted a Model Catastrophic Health Insurance Act. This act mandates the availability of catastrophic medical expense coverage after incurrence of $5,000 of medical expenses in the case of an individual or $7,500 in the case of a family. This deductible is reimposed each calendar year. The amount of deductible is subject to adjustment in future years based on changes in the Consumer Price Index for urban wage earners and clerical workers for the state. Like the COIL bill, provision is made for creation of a facility for insuring or reinsuring uninsurable risks and for authorization of the state Medicaid program to pay premiums for catastrophic health insurance.

This NAIC Catastrophic Health Insurance Act, in its present form, leaves much to be desired, and, as yet, the NAIC has not accepted industry proposals for amendments to this bill, which are very much needed to make it a workable document. This effort is still going forward, and we hope that changes will yet be made by the NAIC. The NAIC is also considering its own version of a Comprehensive Model Health Insurance Act, and the health insurance industry is endeavoring to achieve some uniformity with the bill already produced by COIL. At this time copies of the NAIC proposal for a Comprehensive Act are not available, but it is understood that there are significant differences from the COIL bill.

In 1975 the state of Connecticut passed a state health care program closely modeled after the COIL bill but with a few significant departures. That act will take effect April 1, 1976. One important departure from the COIL legislation is that Blue Cross and Blue Shield type organizations are not required to participate in the Health Reinsurance Association which the act creates to cover uninsurable and substandard risks. This same problem exists in the Rhode Island legislation.

If state law mandates the offering of a minimum qualified plan of coverage to all individuals within a state, then the existence of more than a single facility for covering uninsurable and substandard risks creates a problem that might be described as reverse competition. Obviously, the uninsurable risk has no incentive other than to buy the standardized coverage at the lowest available rate. If there are two sources for such coverage, there would appear to be no reason for a person to choose a facility other than that which offers the lower rate. On the other hand, since it is most unlikely that the rates for such coverage can be set on a reasonable and yet self-sustaining basis, each reinsurance facility will have an incentive to encourage individuals to choose

coverage through its "competitor." This would imply that eventually the two "competing" reinsurance organizations must charge identical rates, even though it is extremely unlikely that the source of business of each will be sufficently similar to generate comparable claim costs. It would be my earnest hope that in the future, where this type of legislation is enacted, a single association can be created to serve all of the uninsurable and substandard risks. There is no reason why a single association cannot reinsure both insurance contracts for insurance companies and service type contracts for organizations such as Blue Cross-Blue Shield, which provide for essentially the same coverage but in language and terms suitable for the organization offering the coverage. Further, all health insurers, including self-insurers, should share equitably in the financial support of such an association.

It is quite clear that there is not yet any semblance of uniformity emerging and that the results of legislation passed to date have been most disruptive of the conduct of the health insurance business. Of the health care bills enacted thus far, Connecticut's is certainly the least objectionable, but there remain important areas for technical improvements in that law.

With respect to what may happen in the future, it seems most likely that there will be increased activity in a considerable number of states. It seems probable that legislation will be encouraged by the NAIC and also by COIL. Health care insurance at the state level is politically attractive to state legislators and especially so with an election year coming up. The fact, too, that plans being offered have little or no cost implications for a state has special appeal at this time. It is hard to predict whether future state legislation will be of a comprehensive nature or provide for only catastrophic coverage. However, it would appear to be a fairly safe prediction that whenever legislation is passed by one state, it will be somewhat different from that passed by any other state.

Of the various features embodied in proposals for state legislation, there are some that have personal appeal to me. First of all, the provisions contained in Section 2 of the COIL bill, which create a Health Care Commission with powers for establishing a prospective rate determination for health care institutions and for approving rates which apply without discrimination to all purchasers, are important and desirable.

Second, if we are to stay in the health insurance business, we must ultimately provide a mechanism which insures the availability of health coverage to all residents, including uninsurable risks. This cannot be done without authorization by state or federal legislation because of existing antitrust law, and so state legislation for this purpose, if soundly conceived, can be most useful.

However, in the area of benefits standards in state legislation, we have a very difficult situation. We can try to influence states that wish to pass this type of legislation to stipulate only a level of benefits that must be made available to uninsurable and substandard risks through the risk-pooling mechanism. Laws which go beyond that and require a minimum level of benefits in all coverage offered could well have negative effects. Such requirements can reduce the extent of coverage now provided by forcing carriers out of business, rather than have the desired effect of increasing the level of coverage, unless we depart from the voluntary concept and move to a mandatory concept such as we have seen in Hawaii. I cannot personally subscribe to Hawaii's mandatory concept at this time for a number of reasons, especially because of the cost implications for our economy.

We have much to learn in this area of state health care coverage, both as to how the state pools for covering the uninsurables will work in practice and how the excess cost which will surely be generated by such pools will be passed along as an increase in the cost of coverage to the more healthy members of the population. Therefore, this matter of providing coverage at the state level should be approached cautiously. The health insurance industry position has been to prefer a bill with comprehensive coverage such as we have seen in Connecticut. This concept has the merit of making a high standard of benefits available to those in our population who are now uncovered. However, the cost of such comprehensive coverage is likely to be beyond the financial means of many who are not eligible for group coverage, who are uninsurable or who have limited financial means. I, therefore, prefer an approach at the state level which offers, on a voluntary basis, the availability of catastrophic coverage. This can be priced at a level that is more affordable by those who need the coverage most and gives us a sounder base from which to learn the intricacies of operating a health insurance risk pool for the uninsurables.

Although uniformity at the state level remains a most desirable objective, and efforts should continue in that direction, at present it appears to be an unattainable goal. This strengthens the argument for catastrophic coverage since such coverage is more readily treated as a supplement to existing plans and is thus less disruptive of health insurance in force.

MR. PETTENGILL: Insurance industry reservations concerning mandatory catastrophe only plans are threefold. First, notwithstanding the publicity given to the relatively few persons having astronomical medical bills, the real need is for universal availability of reasonably comprehensive coverage. The family of limited means that has little or no health insurance should not spend any money on catastrophe only coverage because any large medical expenses would bring economic ruin long before the high threshold of the catastrophe only coverage would be reached.

Second, high-threshold catastrophe only coverage in effect focuses on the esoteric illness. There is a real danger that concentrating mandatory insurance coverage in the area of unusual and expensive forms of medical treatment will cause an over-allocation of medical resources (physicians, technicians, sophisticated equipment, hospital space, and training facilities) to these forms of treatment, at the expense of preventive and primary care which appear to be more cost/benefit effective.

Third, most mandatory catastrophe only programs could not be superimposed on top of the myriad of existing programs without undue expense and confusion. For example, the approach proposed by Senators Long and Ribicoff would not be simple to implement. Their plan divides covered medical expenses into two categories and applies a separate threshold to each. The threshold for hospital expenses is 60 days of confinement per individual and the threshold for physicians' fees and certain other items is $2,000 per year per family. Both thresholds, but especially the latter, would require extensive revision of most existing health care plans.

If the nation should decide to mandate catastrophe only coverage, the least disruptive type of plan would be one which has a threshold that is a substantial amount of actual out-of-pocket expense per individual each calendar year. For example, if there were a $2,000 threshold, then once an individual had demonstrated that he or she was actually out of pocket $2,000 with respect to a specified, but broad range of necessary medical expenses, the plan would pay 100% of all remaining expenses that individual incurred that calendar year.

The next calendar year he or she must once again meet the $2,000 out-of-pocket threshold before the plan would pay benefits. For families, it would be proper to limit the aggregate amount of individual thresholds that must be met in any given year to some amount, such as $3,000.

The advantage of this type of catastrophe threshold is that existing group plans could be amended to comply with the law by the simple addition of a rider guaranteeing that the insured person would never receive less in benefits than is required under the law mandating the catastrophe only plan. This approach could be used for the most modest basic hospital-surgical plan or the most liberal comprehensive plan. If an employer's existing plan provided broad benefits, and there are many such plans in force today, this type of mandated catastrophe only program would involve essentially no additional cost other than the nuisance of ridering his contract. The implication of this approach for an individual would be that, if he or she wants to reduce the chance of being out of pocket the amount of the threshold, he or she had better obtain a good health care benefit plan. Such a plan, if rich enough, could obviate the individual's ever having to meet the catastrophe threshold.

The insurance industry's position with respect to continuation of health benefits for the unemployed is that this should not be tied to eligibility for unemployment compensation benefits. It should be handled within the regular framework of a national health insurance program. Specifically, continuation of coverage under the employer's group plan should remain available for two or three months following involuntary termination of employment. Thereafter, terminated employees, who then have no coverage, should be immediately eligible for whatever plan, be it federal or state, has been established for the poor. Individual insurance should be available for those few unemployed persons who are nevertheless capable of self-support.

Congress spent considerable time this spring trying to develop a program which would have tied continuation of health insurance to receipt of unemployment compensation benefits. Dr. Altman, do you think this concept will be revived?

DR. ALTMAN: Yes, I think it's going to come back if we don't have national health insurance. Whether it will get passed or not, I don't know. It was sidetracked for three reasons. First, the Administration strongly opposed it and the Congress recognized that this was not the kind of bill that they could easily pass over a presidential veto. Second, it was shelved because of a jurisdictional battle between two committees of the House. Third, the anticipated pressure from the unemployed didn't materialize. Either the unemployed found other ways of getting protected or they found a new pill to make them healthier, so the Congress did not feel the pressure of individuals not being able to pay their bills and hospitals not being paid. If national health insurance is not enacted, and the "health pill" wears off so that these people do get sick, and the committees get themselves on some workable track, then the only opposition will be the Administration. We're a forceful lot, but that has not stopped the Congress in the past and they will at least confront us with a bill. So some type of health insurance for the unemployed might be a subject of debate again.

MR. PETTENGILL: Would you comment on whether you think national health insurance should be primary or secondary to bodily injury coverage under no-fault automobile insurance?

DR. ALTMAN: If you think of national health insurance not only as financial protection but also as a way of rationalizing the delivery system, then you may

want to limit the people who are in the paying game to those who deal with the totality of health care spending and not slivers. You can think of automobile health protection as another categorical program. To that extent continuing the primacy of a fault-related or issue-type coverage is really unnecessary. On the other hand, if you're going to have national health insurance with substantial deductibles and coinsurance, yet continue automobile coverage with no deductibles or coinsurance, you will continue to have this problem of two payors anyway. Also, to the extent that automobile insurers will still be involved in rehabilitation and disability payments, which are beyond the scope of national health insurance, there will still be two insurers involved. After all was said and done, the Administration, in its bill, did what any smart bill writer would do - left it up to the states.

MR. PETTENGILL: The health insurance industry's position with respect to no-fault is based on the assumption that national health insurance will not start on a broad scope. It may be relatively broad in terms of coverage for hospitals and physicians, but will not provide total care. To the extent the no-fault bodily injury provision of a state law requires full care for the injuries suffered in an auto accident, then most insurance companies believe no-fault auto should be primary and national health insurance secondary. However, the insurance business really deplores the fact that Michigan, Pennsylvania, and a few other states, perhaps anticipating Dr. Altman's request to solve this problem, have come up with a most difficult solution from an administrative viewpoint. Instead of making no-fault either primary or secondary, they have given each individual the choice. As far as an individual health insurance policy is concerned, this solution may be workable. The insurer can ask each applicant, "Would you like your health insurance to be primary or secondary?" The individual policy would be written accordingly, and if it were secondary, the insurer would cross its fingers that the automobile insurance would be kept in force. For a group policy, this solution is an absolute nightmare because a key element in the theory of group insurance is that the plan shall be one which precludes individual selection by the employees. When some employees are choosing to have their group health insurance be primary and others to have it be secondary, both the health underwriter and the casualty underwriter are climbing the wall.

I believe that we're going to get national health insurance on an incremental basis. Hence we ought to be paying very close attention to what these increments are. No-fault automobile insurance can be regarded as an incremental piece and we ought to be looking at it to see how that affects us. It is just one of the many pieces I think we're going to see over the next several years.

MR. WHALEY: I was rather interested in Alan Thaler's summary of the various state plans and the thrust in them of making benefits available to the uninsurable. Looking back over the history of what has happened in Canada, one of the major problems leading to the socialization of health insurance was the inability of the private sector to provide benefits that were perceived by the public to be adequate and to be available to everybody. Universal availability is the crux of the argument. In Canada, the battle on hospital insurance was over before the industry knew it had begun. When it came to doctors' care insurance, the insurance industry did conceive of a plan whereby a standard package would be made available to everybody, with government subsidies to help the poor pay their premiums. The plan actually was in effect for a couple of years in the Province of Alberta but unfortunately it was a little too late. Had the private industry been there sooner, and had a little longer time to demonstrate that a joint private-public sector partnership can be used, I think we might have had a different picture in Canada.

MR. PETTENGILL: One of the three key thoughts that I hope you take away from this meeting is the urgent need for the insurance industry to make comprehensive coverage available for everyone. For individuals and small groups that we deem to be uninsurable, we must develop a residual market mechanism to provide them coverage. To do this, we must obtain suitable antitrust exemption from either the state or the federal government. You ought to be assisting with this task wherever you happen to be located.

The second is that we actuaries need to be concerned about the socialization of risk factors. Dr. Altman was very careful to point out that the well-known morbidity differences by age, sex and occupation may in the future simply be disallowed. We must be prepared to give Congress and the states the facts so that they will know that these are not myths that we have created, but that these risk factors, these differences in morbidity, are real. We must also let government know the economic consequences of abolishing premium variations based on any given risk factor.

The third is that the biggest single deterrent to national health insurance in the United States today is the fact that no one, in the United States or elsewhere, has been able to develop an acceptable method of balancing the assurance of quality care with effective cost control. We as actuaries need to be involved in assisting the medical profession to develop standards of care, and to determine economical methods of evaluating the care actually rendered against such standards and of measuring the extent to which deviations are appropriate. Then, and only then, will it be possible to define a minimum standard of benefits that the nation both wants and is willing to pay for. A very difficult but necessary part of this latter task will be to determine those procedures, courses of treatment and other aspects of health care that, because of financial constraints, must be excluded from the list of covered expenses for which benefits are provided in the minimum standard. We actuaries can be of assistance in this tremendous task, which is only now getting started in connection with the development of Professional Standards Review Organizations. I urge all of you to be involved.