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EMPLOYEE BENEFIT PLANS FUNDING AND COST

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1. Impact of inflation on non-pension benefit plans

2. Methods used to cope with problems caused by inflation

3. The effect of social insurance on inflation

MR. JACK W. ROBERTS: A great deal has been said and written about inflation in the past several years and it is a little difficult to come up with something new and fresh. For the last couple of years in North America we have been enjoying the worst of all possible worlds. Not only do we have extremely high rates of inflation but we are also blessed with high unemployment and have been living through a prolonged period of recession which only recently has shown signs of bottoming out. Any one of these factors can adversely affect the operation of an insurance company's employee benefit plans operation, but in combination the results can be quite severe indeed. I shall try to concentrate today on the effect that inflation alone has on our business but of necessity there will be some degree of overlapping.

Even without increases in claim costs arising from greater claim frequency, increased utilization, and the development of new expensive procedures, inflation alone would likely result in increased payouts for claims. Hospitals have to pay more money for their supplies and have been subjected to the same kind of salary demands as other businesses. Doctors' fees have been going up. I never recall seeing as high a rate of increase in the cost of medical care as that which occurred in the United States in the latter part of 1974 and the companies which fared best during that crisis were those that anticipated these trends and compensated for them.

In the absence of high unemployment and recessionary effects, it could be said that inflation by itself would have a somewhat salutary effect on Long Term Disability (L.T.D.) experience. We all know that the key to success in the L.T.D. business is to make it very attractive for claimants to return to work. Clearly, disabled individuals who are in receipt of a flat benefit will feel an increasingly severe pinch on their resources in the presence of a continuously increasing cost of living. If L.T.D. benefits were paid in a vacuum, it could be said that inflation might reduce malingering. However, L.T.D. benefits are not paid in a vacuum but are paid in association with social security benefits and it is not easy to conclude that the impact of an increasing Consumer Price Index (CPI) is passed through to a disabled employee in receipt of income replacement benefits supplemented by social security payments. We also must remember that many private pension plans have escalation clauses these days and if they have disability benefits associated with the pension plan these too might well be designed to escalate with increasing cost-of-living factors with the result that the effect of inflationary pressures on a disabled person's income may be somewhat mitigated.

I cannot conclude that inflation has had an unsatisfactory effect on group life insurance claim costs. Historically, periods of high unemployment have exhibited higher than average mortality rates and increased claim rates under the disability waiver provision but it is hard to say that these results would occur in inflationary times that were not accompanied by high unemployment.

In addition to the effect that inflation has on claim costs, we cannot ignore the effect that it has on our expenses of operation. Everything we do these days costs more money than it used to and we simply have to take these increases into account in our pricing. It does not necessarily follow, however, that expense rates, expressed as a percentage of premium, should necessarily go up any faster than the rate at which premium rates are going up to cover the increases in claims costs. Of course this last statement is valid only if it can be said that inflation has not actually added to the amount of work which must be done to administer our business. Maybe we have to process more rate increases in inflationary times. Maybe we have to make more policy changes in order to keep benefit levels more up to date than we used to. Thus, it could be said that inflation not only results in our having to pay more for the normal day-to-day operation of our business, but it also could be said to increase the amount of work that must be done.

Pricing our plans in an inflationary environment calls for some magic. In particular, it is a pretty tough job to make adequate allowances for inflation and still stay competitive with all those other actuaries who are not as far sighted as you are. The rate setter has to make a conscious decision as to how he intends to cope with what appears to be the continuously changing price structure of the medical care business. He can choose to put in what he thinks the effects of inflation over the next year or so are going to be and risk the possibility that it will make him uncompetitive today and very competitive ten months from now; or, he can embark upon a program of continuously changing manual premium rates every month or every quarter, for example. At least the rate setter must be sure that he is watching trends closely and he very well might opt for a pricing philosophy which involves a premium rate guarantee of less than a year. As a matter of fact, I have noticed very few three year rate guarantees for health insurance coverage these days. Very careful attention must be paid to the pricing of major medical benefits superimposed over base plans. Often in these combinations the benefit levels in the base plan are fixed and any increases in the cost of medical care are absorbed by the major medical plan. Thus, in an atmosphere of medical care costs that are increasing by, say, 15% a year, it might well happen that major medical rates might have to be increased by 30%. This is a subtlety that can easily escape one.

I'd now like to talk briefly about how inflation has affected product design. A salary-related group life insurance schedule admirably adjusts for increases in salaries arising from inflation. Thus, it is possible that in inflationary times there will be more pressure to change flat schedules or schedules which depend on class of employee to those which are salary related. In the area of survivor benefits, I would certainly expect to see increasing pressure for the indexing of benefits in line with some index such as the CPI. Naturally, with higher and higher amounts of group life insurance being provided, companies are providing higher non-evidence limits and higher absolute limits. In addition, there seems to be greater

emphasis on pooling arising from these higher amounts at risk. There also may be increased pressure from groups of retired lives to increase flat modest amounts of coverage provided under plans that were designed before inflation really took off. The general belt-tightening atmosphere that pervades these days, plus the rather remarkable increase in disability waiver claims might well lead to considerable pressure for interest on amounts set aside as disability waiver reserves. In the L.T.D. market,we have already gone through a period in which there has been pressure to have benefits indexed,and there is no doubt that the demand for higher and higher benefit maximums is due in part to the effect that inflation has had on salary levels. The demand for a Social Security freeze is nothing new, but its proponents are becoming more numerous now that inflation has become an accepted fact of life. It is worth noting that some states have already taken action to prohibit the integration of benefits under private plans with increases in Social Security benefits. It would be nice to say that increased inflation is a good justification for increases in deductibles under major medical plans, but attempts to increase deductibles in this way have not met with a great deal of sympathy from clients and brokers. I would also like to report that, in order to combat inflation, more companies are using inside limits on room and board amounts, diagnostic procedures, et cetera,but this is an extremely uncompetitive product design feature. I'd like to quote from the February 23rd issue of the Los Angeles Times in which the President of Blue Shield of California stated that "the possibility exists that sometime in the future health insurers will no longer be able to pay physicians and hospitals the usual customary and reasonable fees." Maybe there is some light at the end of the tunnel. It also is encouraging to observe that more and more providers of medical care are suggesting the use of outpatient facilities thus avoiding the more expensive in-hospital route. Consistent with this trend is the growth of group practices and health maintenance organizations. Another aspect of product design that has manifested itself as a result of inflation is the growth in demand for stop loss coverages. Finally, there is not much doubt that inflation has been one of the major contributors to the increase in popularity of very large overall maximums under major medical coverages.

While investment income is not generally a major factor in non-pension employee benefit plans, in many group term insurance operations investment income constitutes the entire profit line. Naturally, if a company specializes in some type of group permanent insurance it may notice that inflation, because it erodes the value of the dollar, could slow down the sale of such products. Such companies may experience substantial increases in loans and surrenders. Other trends arising out of the unemployment situation and recessionary conditions such as a slowdown in mortgage payments could also have a very serious impact on cash flow. Cash flow can also be affected, of course, by poor morbidity. We all realize that the high interest earnings available on new investments do not go unnoticed by our clients, and there is no doubt that we have all experienced severe pressure to increase rates of interest allowed on amounts-left-on-deposit reserve items. Allowing interest on disability waiver reserves arising out of group life insurance coverage seems to be getting a lot of attention these days. While I said earlier that investment income is not generally a major factor in non-pension benefit plans, there is no question at all that, in a business where the margins are thin enough as it is, any decrease in earnings must be considered serious. I might also say that we no longer can count on higher interest earnings as an offset to higher expenses of operation and it is particularly important in inflationary times to avoid falling into this trap. Some day, inflation rates will peak and possibly decline a little. While interest rates may well

follow suit, we must always remember that salary and other expenses of operation are unlikely to do anything but level off. It is something worth remembering.

I seem to have the general impression that companies are no longer falling over each other in order to buy business; nevertheless, I feel that we are still operating in a highly competitive atmosphere. For some brokers and employers, rate increase time is new carrier time, and if a company wants to stay in business it simply has to deliver value for money received. Further, because of the general tightness in the economy, brokers and employers are continually seeking the best deal possible. Don Fackler will be discussing in rather complete detail the imaginative and resourceful devices that have come into being as the result of our industry's attempts to answer these demands of the marketplace.

There is one effect of inflation that is not specifically mentioned in your program. When you get inflation, sometimes you get inflation controls. In the United States in 1971 there was the wage-price freeze. I do not intend to comment on whether or not that action on the part of the federal government was a good thing or a bad thing. I will say, however, that it really did cause an enormous amount of money to be expended in compliance. Last October 14th, the federal government in Canada launched its anti-inflation program. Unfortunately, the Canadian government did not have the foresight to impose a complete freeze on prices and wages as was done in the United States and, as a result, we in Canada have been living in a state of confusion for some time now. I was hoping to be able to announce some kind of specific progress in this program as it relates to the life insurance business in Canada but unfortunately I am unable to do so. In the United States the Cost-of-Living Council eventually decided that the development of special guidelines for fringe benefits was a sound anti-inflationary move; but, so far, the Anti-Inflation Board in Canada has dug in its heels in this respect. The Canadian Life Insurance Association has not given up hope that Canada will see the wisdom of its neighbor's ways; however, progress is slow.

One of the most discouraging aspects about extremely high rates of inflation is that it changes somewhat the role that actuaries have traditionally played in the insurance business. Our fundamental training teaches us to be conservative and long-seeing; yet, in inflationary times we really cannot afford this kind of luxury. In a book called The Reigning Error, author William Rees-Mogg said, "When money is good men plant oaks, when it is bad they can at best plant cabbages." I have concluded that we actuaries who are involved in the employee benefit plan business must change our traditional role. Some of you in the audience will know that the motto of the Canadian Institute of Actuaries is Nobis Cura Futuri. Roughly translated, it means that our concern is for the future. We can still make the future our concern, but these days the future is not next month, next year, or ten years from now. The future is next week.

MR. DON F. FACKLER: In reviewing the methods used to cope with problems caused by inflation, it is necessary to look at these problems as they relate to the employer, the agent, and the insurance company. How has the employer reacted to these pressures? How has the agent responded to them while acting in the best interests of both the employer and the insurance company? What have the insurance companies done in order to alleviate some of the concerns uppermost in the minds of employers?

Fortunately, at least from the insurance company's standpoint, there has been general acceptance by employers of the necessary rate increases. While acceptance is largely in proportion to the size of the case, it is also often in direct proportion to the size of the increase. The larger the case and the more credible the experience, the better the acceptance by the employer of the insurance company's proposed rate adjustment. However, as the size of the case decreases, particularly in the area of 10 to 100 lives which I will label small groups, there is greater reluctance by the employer to accept the rate adjustment. In most instances, the rate adjustment by the insurance company is to place the case on its present manual premium rate. Cases on which the experience of the group is ignored are more likely to be shopped. Agents, and particularly brokers, who placed the case initially with the carrier because of low rates will request quotations from other carriers in order to secure a lower premium. The shopping of these cases almost always will produce a carrier which will provide the same or similar coverage at a reduced premium rate because the manual rate of that carrier has not as yet reached the level of the present carrier. On the larger cases (those cases over 100 lives or perhaps over 100 life years of experience) where the experience is taken into consideration, there is a greater willingness to accept the proper adjustment. This arises mainly from the fact that all parties are more conscious of what is presently happening in the health care delivery system and the insurance company has provided a rational explanation and statistical details to the agent and to the employer. As we approach the largest cases, say, 2,000 lives and over, the question of cash flow is of greater concern to the employer and a detailed discussion of the various cash flow techniques which might appeal to the policyholder is often entered into.

As a direct reaction of employers to the problems of inflation, there is a tendency to utilize the 31-day grace period as opposed to paying the premium on the premium due date. Furthermore, it is difficult for employers to understand adjustments in excess of the Consumer Price Index (C.P.I.) despite extensive publicity of the fact that the CPI for medical care is higher than that of most other components. Frequently, the type of plan and the benefit design are of such a nature that the inflation rate of the specific plan will exceed the medical care index. For example, a comprehensive major medical plan with an all-expense deductible has a higher inflationary factor than a base plan with an inside limit on hospital room and board and a surgical schedule.

The acceptance by most agents of significant rate increases resulting from inflation is generally in direct relation to their knowledge of the group health business. The less knowledgeable group agent who operates in the small case market will have difficulty delivering proper rate adjustments because of the probability of a rate comparison with other carriers. At the medium-size case level, which is usually serviced and handled by a more knowledgeable agent or broker, the sale is simpler since the increase can be statistically justified from the experience, and most competing carriers will require such experience prior to quoting. Hopefully, this will result in the competitors arriving at a proposed premium close to the renewal premium rate. One point which agents have difficulty with is delivering a rate adjustment in conjunction with an experience premium refund. Also, many times on first-year cases a very "favorable" paid loss ratio will, along with the claim reserve, still result in an incurred claim loss ratio which necessitates a significant rate adjustment. Since the cash flow is positive for the year, it is often difficult for the agent to understand the necessity

for a rate adjustment resulting from the setting up of a claim reserve. Furthermore, it is important to remember that the proposed rate is for a future period and that the experience from which the rate was determined is past experience.

With larger groups when the question of cash flow has arisen, insurance companies have met the problem head on. The primary source of the problem is the inability of life insurance companies to receive an interest-paid deduction for interest allowed on claim reserves on their federal income tax returns. Under fully-insured plans, the insurance companies hold substantial amounts of claim reserves. Usually interest is not credited specifically in the refund calculation, and because of the aforementioned problem, if interest is credited the rate will be less than the going rate. This aspect, together with the state premium tax question, is often a discussion item between the insurance company and the employer.

A technique currently used is the delayed premium concept. It modifies the standard 31-day grace period in the contract with an agreement to provide an additional 30-day or 60-day delay of premium. Although not used as often, another approach is the "quarterly-in-arrears" approach, which requires payment of three months premiums at the end of the three month period. It should be noted that the interest loss to the insurance company on these cases is offset somehow, usually by an increase in retention charge. Furthermore, the insurance company determines the credit rating of the employer, usually utilizing its investment personnel.

Cost Plus is an approach which has appeal to some employers; however, if the insurance company holds claim reserves, the principal savings are interest savings resulting from the elimination of an experience refund. This approach provides for a monthly premium which is related directly to the previous month's paid claims. If it is written in conjunction with a method to alleviate the claim interest question, such as the delayed premium concept, the result is an attractive arrangement. For those who would like to note how the situation has changed during the past decade, I refer you to the June 18, 1962 NAIC Montreal Resolution which states "That provision shall be made for payment of premiums prior to the expiration of the grace period, not to exceed 31 days following the normal premium due date as specified in the contract, which premiums shall be adequate to cover the reserves, expected claims, and expense charges of the insurance company for the period to be covered. Such payments shall not be reduced or offset by promises of the policyholder to make reimbursements or other payments to the insurance company after losses have been paid or incurred". To most group actuaries this resolution is passé. Another approach, discussed later, is the minimum premium plan which minimizes the state premium tax.

More and more insurance companies are currently using the retrospective premium approach. Under this agreement, the employer will compensate the insurance company for any deficit incurred during the previous policy year. One difficulty here is that it may require a doubling up of a premium increase in future years in order to take care of the inadequacy from the retro arrangement plus the inflation and utilization increase for the future year. Furthermore, there may be objections to the inclusion of provisions for the recovery of deficits developed prior to the establishment of this type of arrangement within the retrospective agreement.

Another approach we hear more about recently than any other is the Administrative Services Only contract in which the insurance company continues to participate but assumes no risk. The insurance company will continue to provide administrative services, including the payment of claims, on a plan which is fully self-insured. Carrying this concept one step further we have Administrative Claims Only, wherein the insurance company utilizes its claim-paying facilities for a fully self-insured plan but provides no other administrative services.

In order to complete a resumé of available methods, we should mention those situations where captive insurance companies are involved. Here, the risk is passed through another insurance company, or on occasion directly to the captive company. More and more insurance companies are less apt to play such intermediary roles, although it often depends upon the specific circumstances and the legitimacy of the captive insurance company.

At this time I want to say a bit more about minimum premium plans. These plans incorporate partial self-insurance with insurance company payment of claims and retention of the terminal liability. This results in savings to the employer of a significant portion of the state premium tax, generally in the area of 90%. Since the average tax is 2% to 2½%, this results in an approximate 2% premium savings to the employer and, on a large case, this can be a significant amount. However, some states have passed legislation which applies the tax to the entire "premium", both self-insured and insured, thereby preventing any tax savings from being realized by the employer.

At the current time most employers are staying away from minimum premium and administrative only contracts as a result of the financial and fiduciary requirements of the Employee Retirement Income Security Act, the uncertainty of premium tax statutes in many states, problems associated with employees' contributions, union involvement, and, perhaps most importantly, the ability of other methods to solve their cash flow concerns.

As for benefit changes, with few exceptions the employer is not receptive to a benefit reduction. The reason is fairly obvious. While the reduction will not generally be acceptable to his employees, the renewal premium increase will be small in relation to the employer's total fringe benefit package. As a result, the employer is not about to risk incurring the anger of his employees. The comprehensive major medical plan with a front-end deductible is more susceptible, however, than most other plans to a benefit change since an increase in the front-end deductible can be incorporated in lieu of the equivalent rate adjustments.

It is important to note that insurance companies have also reacted in other ways to the need for large rate increases. It is becoming more and more common to offer lower rates at renewal time in exchange for a contractual change which permits a modification of the premium rates on any premium due date. This is opposed to the traditional method of either a guaranteed 12-month period from renewal or the policy anniversary, whichever is earlier. This alternative, however, has some real hazards in that it eliminates one of the primary reasons for insurance company involvement--a guaranteed premium rate for a risk-bearing assumption. Another approach which one company has adopted is to have an automatic quarterly rate adjustment on their non-experience-rated cases.

However, in the final analysis we face the real world and in it we need to assess the various trade-offs that are required on individual cases in order to conserve our group business. We have encouraged plans with reasonable and customary features thereby eliminating the necessity for the employer to revise his benefit plans but also requiring an increased premium contribution on a regular basis. Often the reality of the present environment has forced insurance companies to look at the long-term economies of their business and to forego the immediate increases in anticipation that better days will come, and well they might.

In conclusion, we face a real dilemma. As long as we are faced with the present level of inflation coupled with increased utilization and the practice of defensive medicine by so many physicians, it will be necessary to satisfy our policyholder's needs by developing alternative approaches to the traditional methods of writing and renewing group cases. It falls upon the lot of group actuaries to be in the forefront of the development of these approaches, which indicates a rewarding future for those of us involved in health insurance if we can do the job.

MR. JOHN K. KITTREDGE: In examining the impact of Medicare and Medicaid on inflation, we need to start back in the mid-nineteen-sixties. While a great deal of attention was paid to Medicare when it was enacted, very little attention was paid to Medicaid. Medicaid has turned out to be a sleeper, however, and perhaps has more effect than Medicare on health costs. It is interesting to note the differences between the estimated costs of these programs and the actual costs which emerged. For example, the original 1965 estimate for Medicare Part A costs in 1970 was $3.1 billion. The actual cost turned out to be $4.5 billion. Likewise, the original actuarial estimate for 1975 was $4.3 billion, while the actual costs in 1974 exceeded $8 billion or were about twice the original estimate for 1975. While part of this difference is due to the impact this program had on utilization, a significant portion is also attributable to the inflation that took place in medical care costs. Doctors tested the Medicare and Medicaid programs in the late nineteen-sixties by continually increasing their charges and they found that the charges usually were paid as submitted. As a result, these programs also had a substantial impact on the costs of private insurance plans.

Table I compares the rates of inflation for the medical care portion of the Consumer Price Index (CPI) with the non-medical care portion of the CPI for various periods. It can be seen that even in the pre-Medicare period, medical care costs were increasing faster than non-medical care costs. As an aside, the substantial inflation since price controls were lifted in April 1974 has produced much red ink for the carriers.

Of course, it is important in examining changes in the level of medical care costs to distinguish between that portion resulting from inflation and that portion resulting from the use of more sophisticated methods of treatment. Items such as intensive care units and coronary care units have made significant contributions to the increasing level of medical care costs. Now there is a brand new piece of equipment called the full body scanner which costs about $600,000. There is competition among hospitals to see not only who will have one but also who will have one first. Even as this competition expands there is a widespread feeling that this piece of equipment will be obsolete in three years.

TABLE I

Annualized Changes in the Consumer Price Index for Various Periods

Period	Non-Medical Portion of CPI	Medical Portion of CPI
Pre-Medicare (July '59 to June '65)	2.0%	3.2%
Post-Medicare (July '65 to June '71)	5.7%	7.7%
Price Controls (July '71 to April '74)	5.2%	4.9%
Post-Controls (April '74 to December '74)	9.5%	12.1%
1975 (December '74 to December '75)	7.7%	10.3%

Probably the most important item currently in the legislative arena is the National Health Planning and Resources Development Act (Public Law 93-641). One provision of this law which is of particular interest to us in the insurance business provides for the creation of Health Systems Agencies (HSA's) which will be provided with Federal financial support. This corresponds to the certificate of need planning under Comprehensive Health Planning Agencies.

The law also provides for grants to six states to experiment with rate regulation of hospital and other institutional providers of health services. A number of states have applied for grants. However, it will be some time before we will be able to evaluate what, if any, effect this has on medical care costs.

Another aspect of this law of interest to us is the loan provision which substitutes for Hill-Burton. It is geared to producing additional hospital beds only in underbedded areas.

The major effect of this law on inflation will be gradual through avoiding the addition of unnecessary hospital beds. If these agencies work well, their greatest impact might well come from a furthering of the regionalization of specialized medical services by avoiding duplication of existing facilities and trained personnel providing for pediatric services, open heart surgery, and so forth. Of course, the problem here is that doctors view this as affecting their livelihood--and it does. There will also be a great deal of resistance by hospitals to giving up something which they already have.

The Department of Health, Education and Welfare (HEW) has been quite slow in implementing Public Law 93-641. HSA's have not yet been named and the various regulations which according to the law are to be released by July 1, 1976 are not very far along in proposed form. I would urge all of you here to take the opportunity to get involved in heath planning at the local level. This could be done by contacting your State Health Department or the HIAA. Even though the membership of HSA's may already have been determined, there will be a number of advisory committees on which actuaries and their associates can serve in order to have an impact on state health planning.

The next development at the national level that could impact on medical care costs is the peer and quality review program. Historically, review committees have had little effect on utilization. While they have had some effect on cost levels, these have been confined to the highest cost procedures. The objectives of the Physicans' Services Review Organization (PSRO) legislation is to reduce utilization and improve quality. While the law applies automatically only to Medicare and Medicaid patients, it encourages PSRO's to consider other patients as well. Unless PSRO's extend their review to other than Medicare and Medicaid patients, it is likely that we will see either increased costs for these other patients or we will see no effect on these categories of patients. The results of PSRO programs are not yet in. If these programs are not effective, I would anticipate other action by the federal government to accomplish the same results.

The next question I would like to consider is whether or not Health Maintenance Organizations (HMO's) are a more economical means of providing quality medical care. Generally HMO's have been reasonably successful in reducing hospital utilization although they have demonstrated higher usage of ambulatory care. Usage comparisons of 400 to 500 hospital days per thousand exposed under HMO plans versus 900 to 1000 days per thousand exposed under insured plans are normal. While these figures are not exactly comparable, they are convincing that HMO's are a viable alternative in providing medical care. Most successful HMO's have been structured to provide a financial incentive to physican groups to keep costs down through the provision of medical care in the most economical way that is compatible with adequate quality. For example, Kaiser Health Foundation pays a yearly bonus to its physicans to the extent that its costs for the year turn out to be below budget.

The mandatory dual choice provisions of the HMO law did not start to become effective until HEW released all of the regulations and started to qualify some HMO's. HMO's are difficult to develop and while they will probably expand, anyone thinking of starting a HMO must consider the cost of getting it underway. It is unlikely that HMO's will have a major effect on the cost of medical care for some time to come although it is possible that development of a HMO in a given geographical area could have a significant effect on medical care costs in that area.

Strangely, the 1973 HMO legislation provided a setback to HMO's in that the regulations to implement the mandatory dual choice provision took two years to come out and there are now only nine qualified HMO's. Employers who otherwise might have been interested in HMO's have deferred action waiting to see which HMO's become qualified,which will mean that their plan must be offered.

The final item I would like to consider is the impact of inflation on the probability and form of national health insurance. Inflation has focused attention on the costs of health care and the need to bring total costs under control. It is increasingly recognized that imposing a national health insurance plan on top of the current health care delivery system may not accomplish much. In addition, there is a growing realization that the country has only limited assets and can not accomplish everything.

If I were to predict, I would suspect that Congress might attempt to solve some specific problems such as deficiencies in the Medicaid program, health care for the medically indigent not covered by Medicaid, and the availability of insurance to those who could afford it but are not currently insurable. The balance would be covered under an employment based plan with minimum standards.

The one form of national health insurance that could be enacted as early as 1977 is a catastrophic plan. One objection to this type of coverage is that it might stimulate the development of even more expensive treatment. For example, kidney dialysis costs under Medicare have substantially outrun the original cost estimates. Another serious objection is that such a plan could become a political football with continual pressure to reduce the deductible. Such pressure might ultimately result in a poorly designed national health insurance plan.

In conclusion, I want to point out that there is increasing recognition in Congress of the need to control medical care costs before implementing any national health insurance proposal. Congressmen Rogers and Rostenkowski have emphasized this. Senator Kennedy's Health Subcommittee plans to hold hearings during which they will seek ideas for controlling health care costs. It is likely that legislation aimed at controlling medical care costs will precede the passage of any national health insurance proposal.