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THE EVOLVING REGULATORY ENVIRONMENT FOR HEALTH CARE

Moderator: PETER M. THEXTON. Panelists: DR. HAROLD COHEN, RICHARD V. MINCK, DANIEL W. PETTENGILL, NATHANIEL TAFT***

1. How can insurers deal effectively and efficiently with the proliferation of detailed insurance laws, court decisions and regulations? Specific examples:

   a. Mandated coverages - alcoholism and mental health benefits, maternity coverage, etc.

   b. Group conversion requirements

   c. Health Maintenance Organizations

   d. Laws affecting out-of-state group contracts when some employees reside or work in the regulating state

   e. Policy language requirements -- simplified policy language

   f. Forms filings -- loss ratio requirements, premium differentials by sex

   g. Obtaining rate increases on in force policies.

2. What are the regulatory problems with respect to the following?

   a. Benefits designed to reduce incurred hospital costs, i.e. second surgical opinion, preadmission testing, coverage of surgery in ambulatory surgical centers, convalescent nursing home care, home health care

   b. Annually renewable policies -- premiums changed each year

   c. Cost sharing provisions -- use of coinsurance and deductibles

* Dr. Cohen, not a member of the Society, is Executive Director of the Health Services Cost Review Commission of the State of Maryland

** Mr. Taft, not a member of the Society, is Second Vice President, Group, New York Life Insurance Company

3. Can the regulators and insurance companies provide mutual support in responding to legislative activity?

4. What is the current outlook on national health insurance? How can companies plan their current portfolios, group and individual, so as to have the best chance of retaining a reasonably regulated portfolio?

5. What is the outlook for regulation of provider health care services and prices? How will this impact on insured and uninsured plan claim costs?

MR. PETER M. THEXTON: In prepared remarks for a panel discussion on "Managing Health Care" at the Society meeting in Quebec last spring one of the panelists said, "From beginning to end, the current health care shambles is a creation of the government." I disagree with that quite strongly, and I'm sure most of you do, too. Each of us has contributed a share.

The "shambles," if that is the right word, is more caused by a lack of creativity in regulation. Many of us have been so hurt from time to time by the occasional piece of bad regulation that we have become afraid to ask for the creative regulation that sets good rules within which we can act responsibly in serving society.

Some regulations are restrictive, some require us to be expansive to do a better job, some look over our shoulders to see how we are doing. All of this is inevitable in our business.

To describe where we are today, and to give us their ideas on some directions that will lead to a more creative or responsive regulatory environment from all sides, we have four speakers.

MR. NATHANIEL TAFT: Many environments evolve gradually. At one time the regulatory environment for health care fell into this category. During the 1970's, however, this environment has undergone radical change because of staggering increases in health care costs, heightened social awareness, and the growing effectiveness of consumer and special interest groups. This decade has seen a revolution, rather than an evolution, in the regulatory environment for health care.

Coping With Health Care Laws: I will use the term "laws" to mean statutes enacted by legislatures, regulations and rulings of insurance departments and court decisions.

Insurers generally comply with the new laws that take effect each year, but Agenda Question #1 is: How can this be done effectively and effi-

ciently? In other words, how can an insurer avoid problems with the regulators, undue disruptions of its business and excessive increases in its administrative costs? The best answer thus far is by a compliance operation.

Structuring a Compliance Staff: Compliance consists of analyzing a new law, considering every way in which it may affect existing and contemplated company activities, developing a program that sets forth in detail all steps necessary to comply with the law's requirements, and notifying each affected area of exactly what the compliance program requires it to do. A compliance program must be developed by highly skilled personnel. Others may then implement much of the program, such as revising claims, underwriting and other procedures, updating proposals and brochures, sending instructions and policy and certificate forms to policyholders, etc.

Thus far, no one has found the one and only way to build such a staff. Compliance staffs vary from company to company, and, within a company, from group insurance to individual insurance to pensions. Some seek to develop experts in particular subjects, such as mandated coverages, state health insurance plans, etc. Others regionalize with specialists in the new laws of the New England states, South-Central states, etc. A third approach is to develop generalists who can work on any particular type of program as needed.

To illustrate, New York Life's group compliance staff includes people with product development, legal and administrative backgrounds who are learning to be generalists. The internal mix of the skills they bring to their present positions is supplemented by input from people in those group insurance areas that will be affected by a particular compliance program and, when required, from our counsel, electronics people and others. Pricing data, for example, comes from outside the group compliance staff.

Scope of a Group Compliance Operation: Until a few years ago, the various aspects of compliance were ordinarily handled in different areas. It was only in 1975 that my Company consolidated its group compliance functions. We began with two product people, one lawyer and one para-legal, but we quickly learned that a group compliance operation has to be more extensive. In little more than two years, the size of our staff has doubled, and its membership now includes people with administrative and contract backgrounds.

The scope of the compliance problem is broadening, primarily because of the increasing number of new laws affecting group health insurance. From 1975 to 1977, the number of new laws we reviewed rose by one-third, from 416 in 1975 to 471 in 1976 and to an estimate of well over 550 by the end of this year.

Cost figures for a compliance staff can be obtained readily, but they are not truly meaningful. A meaningful figure would be the total cost of all compliance functions, including the cost of the compliance staff, the cost of senior management's involvement in compliance (which may be extensive for such programs as New York's mandatory maternity law, Minnesota's comprehensive health insurance law and ERISA), together with the cost of implementing compliance programs. This total would appear to be many times the cost of a compliance staff itself.

You should realize that total cost figures can readily vary from one insurer to another. They will be lower, for example, for a company that now voluntarily provides liberal coverage in a field where states are mandating coverage, e.g. alcoholism coverage, mental illness coverage, etc. They will be lower too for a company that operates only in a few states. Because of programming and other changes, the degree of a company's computerization will also affect compliance costs, sometimes to reduce them but sometimes to increase them.

Specific Compliance Problems: The basic premises of compliance people are that their companies will comply with all applicable laws, and that they will do so in the most reasonable manner possible. Ideally, ongoing programs will be disrupted only to the extent absolutely necessary, and compliance-induced costs will be kept to a minimum.

The key is to standardize compliance programs wherever feasible. Here are a few examples: If State B enacts a social security freeze law substantially similar to one previously adopted in State A, the earlier program should be extended into State B, even though it may be slightly more liberal than the requirements of the State B law. If a mandatory alcoholism coverage law of State D has some characteristics of a compliance program operating in State C, the State D program ordinarily ought to vary from that of State C only where necessary. However, where non-mandated features would significantly increase the cost of compliance, the ideal of standardization should give way to the practicalities of cost. To illustrate, if you can comply by treating complications of pregnancy the same as sickness, you should not gratuitously treat normal pregnancy the same as sickness. In other words, you fulfill your obligation to society by doing what its regulatory representatives require; and you concurrently fulfill your obligation to your clients by not disrupting their businesses or yours and by not unduly increasing their health care costs.

Advance planning can help. The group health conversion laws adopted a few years ago in Colorado, Illinois, New Hampshire and New York had many similarities, but each had different benefit levels and one or more unique benefits. An insurer which failed to search for a common pattern could comply by having four separate programs, one for each state. Discerning

this pattern, however, an insurer could draft one policy form which included all common features and supplement it with state-specific riders, each to be used only in one state to comply with that state's special requirements. Similarly, there could be a general instruction booklet with state-specific inserts, etc. This open-ended system can thus be extended when new conversion laws take effect, like Pennsylvania's 1977 law.

Advance planning, unfortunately, is not a panacea. In 1974 my Company issued a policy to cover employees in all states. It voluntarily provided liberal benefits for such areas as alcoholism and mental illness care, convalescent nursing home and home health care, and pre admission testing, because we studied trends and anticipated new laws in these areas. We also decided that, regarding insured residents of certain states, this out-of-state policy would voluntarily comply with several local laws. In 1974 we had 70 variations of this policy's coverage, and at present we have more than 200, almost a 200% increase in less than three years, because of new mandatory coverage laws.

Simplified policy language laws have not yet presented major problems to group compliance staffs, but I can foresee some in the future if both these laws and exotic benefit designs increase. If a benefit design is overly complicated and subject to numerous qualifications, exceptions and inner limits, I know of no one who can make it truly understandable, regardless of his or her ability to organize the policy form and to write in the English language.

Also troublesome are extraterritorial laws, i.e. those under which the state of any employee's residence seeks to regulate the employee's coverage under an out-of-state policy. An example is the Minnesota comprehensive health insurance act under which every out-of-state policy (as well as every in-state policy) that insures at least 10 Minnesota employees must make comprehensive coverage available or else the employer cannot deduct its premium contribution on its state income tax return. Another example is the Arkansas regulation requiring special imprints on certificates delivered to resident employees insured under out-of-state employer policies.

A group policy covering employees in many states cannot easily comply with extraterritorial laws. Few want to avoid non-compliance by denying coverage to residents of states with these laws. Even if an insurer has access to employees' home addresses on enrollment, it is expensive to tailor certificates at issue to comply with extraterritorial laws. As employees move from state to state, and they do, up-to-date compliance is even more troublesome.

In some instances, an insurer may comply with an extraterritorial law at time of claim, since claim forms normally show home addresses. This procedure, however, may prevent the insurer from applying a compliance-induced

rate charge only to employees affected by the extraterritorial law.

Some other compliance problems come about when the compliance staff first learns of a new law after its effective date. Others result from relying too heavily on a new law's title, which cannot be substituted for a thorough reading of every word. One sentence in the 10-page Colorado conversion law mandated a completely separate compliance program; it enacted a social security freeze law.

Mutual Regulator-Insurer Support: In one sense, regulators and insurers are not really far apart. A regulator's main responsibility is to protect the general public; an insurer's is to protect that segment of the public that owns its policies. Just as we do, regulators take pride in their work and appreciate its importance to society.

We can make our greatest contribution to mutual support by proposing constructive options for implementing new legislation. Since many new laws may be implemented in any one of several ways, we should encourage the regulators to choose the better methods of implementation.

Those of you who have engaged in this work can readily furnish many examples of its success; I offer two of my own. Compare the October, 1971 draft of New York's Regulation 62 with the current Regulation. As a result of diligent cooperation in a joint Insurance Department-HIAA Task Force, the present Regulation is a much more viable one, protecting the public while taking account of many practical problems of insurers. Similarly, the HIAA's New York Major Medical Conversion Policy Provisions Committee performed a valuable service for both regulators and insurers.

Bear in mind, however, that in some instances regulators and insurers will only be able to agree to disagree.

Outlook for (Mini) National Health Insurance: I would like to say a few warm words about the so-called mini-national health insurance plans, viz. the statewide plans enacted in Connecticut, Hawaii, Minnesota and Rhode Island when their state legislatures despaired at the lack of a national plan.

These state plans vary in philosophy, scope of coverage and many other factors. Let me give you an overview: The Connecticut and Minnesota plans make available comprehensive health care coverage, with benefit levels comparable with those of generous major medical policies. As noted above, the Minnesota plan has a financial incentive to encourage employers to provide comprehensive coverage. Each Hawaii employer with employees in that state must provide them with coverage which, in the opinion of state officials, provides at least rich base plan coverage. Under the Minnesota and Rhode Island catastrophic plans, a resident is reimbursed after he or she has incurred health care costs large enough to constitute a financial catastrophe.

We may see more mini-NHI plans for two reasons: If no federal plan is enacted, other state legislatures may well proceed to adopt their own. If any of the existing state plans proves to be very successful, this will certainly impel other states to move into the mini-NHI field.

One major compliance problem is created by the existing state plans and by those proposed in other legislatures but not yet enacted. They vary so much from one another as to rule out the possibility of a standardized response. If any one state health plan were to be duplicated in many other states, the gains from standardization would outweigh numerous problems that might be created by the terms of the particular law. I believe in this regardless of whether the standard bill provides comprehensive coverage like the Connecticut and Minnesota laws and the COIL and NAIC bills; or base plan benefits like the Hawaii law; or catastrophic coverage like that in Minnesota, Rhode Island or the HIAA's so-called hip pocket bill.

MR. RICHARD V. MINCK: As indicated by Nat Taft, the proliferation of insurance laws, court decisions and regulations affecting insurance companies has led to serious problems for companies in attempting to comply, particularly in the area of group insurance. There are three possible courses of action that may relieve these problems. Only one of the three possibilities may be palatable to insurance companies.

The first possibility lies in the area of the Employee Retirement Income Security Act of 1974 (ERISA). Section 514 of ERISA provides that "...the provisions of this title...shall supercede any and all state laws insofar as they may now or hereafter relate to any employee benefit plan..." The impact this provision has on the jurisdiction of state regulators is still being explored in the court system. Moreover, there have been suggestions by employer groups that Federal preemption be expanded through amendments to ERISA.

The second possible area of Federal intervention has developed because of insolvencies and threatened insolvencies among casualty insurance companies. Senator Brooke of Massachusetts has introduced bills in each of the last two Congresses which would establish a system of Federal charters, Federal guarantees of insurance company insolvency and Federal regulation. A later generation of these bills might very well expand Federal authority to pre-empt the states from regulating the provisions of group insurance providing employee benefits.

A third possibility is that these problems might be solved at the state level if their seriousness is brought into focus at meetings of the National Association of Insurance Commissioners and at the meetings of several state legislative groups. Such groups could help bring about uniformity of regulations at the state level, and possibly, parity between insured employee benefit

plans and uninsured employee benefit plans. Such efforts would have to be supplemented by fairly intensive campaigns at the state level with individual regulators and legislators. This last alternative seems to be consistent with current attitudes among life insurance companies and possibly offers the best opportunity to solve the problems with which companies are currently struggling.

A. Summary of Current Problems: The volume of legislation introduced and laws and regulations adopted by the several states has increased dramatically in recent years. Between 1975 and 1977 the number of bills introduced in the state legislature increased by one-third and the number of bills pertaining to insurance increased by 50%. In all states in 1976 about 425 bills were enacted into laws which affected insurance.

Many of these laws are not uniform from state to state. The formation of various pressure groups has led to the enactment of statutes which require payment to certain types of practitioners or require coverage of segments of the population deprived of health insurance because of social conditions, employment practices or underwriting practices. There has been, in many cases, a patchwork quilt of mandated benefits which results in an unbalanced structure of benefits which may have to be varied from state to state.

In the past there were relatively few instances where legislators or regulators applied non-uniform laws to group contracts issued outside their state. However, there has been an alarming increase in this tendency in recent years.

There is a lack of parity between the treatment by state legislatures of insured benefit plans and uninsured benefit plans. This has provided an additional incentive to large employers to adopt uninsured plans.

B. Federal Pre-emption of ERISA: The statutory language in Section 514 of ERISA does not clearly divide the basic areas of regulatory responsibility for employee benefit plans between the states and the Federal government. At least two possible interpretations have been advanced in court cases.

A "narrow" interpretation is that the pre-emption clause applies to those state laws which duplicate the provisions of ERISA (e.g., reporting, disclosure and fiduciary requirements). Such an interpretation would leave untouched state insurance laws which mandate benefits and would permit such laws to be applied on an extraterritorial basis.

A "broad" interpretation would result in the pre-emption clause applying to all state laws that relate to employee benefit plans. Such an interpretation might apply not only to insurance laws but all other state laws including civil rights laws.

The NAIC and others have attempted to persuade Congress to clarify the issue. However, there seem to be differences of opinion among Congressional staff and within the administration side of the Federal government as to whether a "narrow" or "broad" interpretation is proper in view of the legislative history.

Currently, the issue is being litigated in a number of cases -- at least two of which have been heard by the U.S. Circuit Court of Appeals. In these two cases, the judges came to different conclusions. One took the narrow view and the other took the broad view. The issue seems likely to be brought to the U.S. Supreme Court in one of its next two terms.

One of the two cases involved was Wayne Chemical v. Columbus Agency Service Corporation. The Wayne Chemical Company was a small employer participating in a multiple-employer trust set up by a Columbus agency corporation. The plan was insured until July 1, 1975 when the trustees transferred the funding to an uninsured multiple-employer trust which is now in bankruptcy. The original insured plan provided a conversion option for medical benefits.The uninsured plan contained no such provision. After the plan became uninsured, a dependent of one of the covered employees was seriously injured and is now a quadruplegic.

The District Court granted a preliminary injunction requiring the Columbus Agency Service Corporation to make available a conversion policy and prohibiting them from terminating group benefits on the injured dependent. The court reached this conclusion by reasoning that the preemption section of ERISA was quite broad and applied to the case. The court further reasoned that Congress had "invested the courts with a duty to create law governing aspects of employee benefit plans not specifically regulated by ERISA." This led the court to look at the facts of the case and decide that Federal common law could be derived from a state law if the state law were compatible with national policy. Although there was no Federal statute requiring a conversion privilege, the court concluded that since Indiana and many other states require such provisions, Federal common law could do no less.

The case taking the narrow view of the pre-emption clause is Dawson v. Whaland. The plaintiffs are administrators of employee benefit plans which are established by Taft-Hartley trusts. They claim that a New Hampshire law mandating coverage of mental and nervous conditions in group health insurance policies violates the U.S. Constitution and that, in any event, New Hampshire was pre-empted from applying such a statute to employee benefit plans covered by ERISA by Section 514. The court concluded that the plaintiffs were wrong in both instances.

It is far from clear that review by the Supreme Court of either the Wayne Chemical or Dawson cases will lead to a clearly defined line between the responsibilities of Congress and those of the states in regulating insured (or uninsured) employee benefit plans. It is still less clear that any decision reached by the Court will relieve insurance companies and their customers from the problems created by state laws and regulations and their extraterritorial application. Several groups have approached Congress seeking either clarification of existing law or a change to accomplish their purposes.

The Council on Employee Benefits (CEB), which represents a number of major employers, earlier this year submitted a position paper to Congressman Dent, in his role as chairman of the pension task force of the House Labor Committee. They urge Congress to support and enforce the pre-emption provisions of ERISA. They conclude that such provisions were intended to be interpreted broadly, and that they invalidate "any and all state regulation of employee benefit plans regardless of whether the plan is insured or self-insured."

The CEB paper argues that state laws mandating benefits would destroy the ability of employers to provide uniform coverage to all employees and would significantly increase the costs of administering employee benefit plans. They cite an estimate by the Civil Service Commission that state laws cost the Federal plans at least five percent of premium.

C. The Brooke Bill: Just as the publicized failure of some private pension plans led Congress to design a pension reform bill and eventually to enact ERISA, the financial problems of the casualty insurance business led Senator Brooke to introduce bills in the last two Congresses that would establish a Federal insurance guaranty fund and a Federal chartering alternative for insurance companies.

At the hearings held this year on S.1710, Senator Brooke remarked that underwriting losses and threatened insolvencies in the casualty insurance area evidence the failure of state regulation.

Most of the witnesses at the hearing opposed the enactment of S.1710 and indicated their continued support of state regulation. The bill would, in its current version, leave much of the regulation of insurance companies with the states. However, it would establish a Federal Insurance Commission to which it would give very broad and general authority. It is not difficult to imagine that such a commission would gradually take over more areas of regulation, particularly if employers and unions urged Congress to expand the authority of the Commission to cure what they saw to be defects in state regulation.

Senator Brooke indicated at the conclusion of the hearings that he felt that considerable changes needed to be made in S.1710 and that he was not asking

that the Senate Banking Committee take any action on the bill at this time. However, he also indicated that he continued to feel that such a bill was needed. He said that his staff would continue to work on the bill with the thought that it might be sorely needed at some future date. If such a bill were to be passed by Congress at a time when insurance companies were experiencing widespread insolvencies, it might well include provisions that effectively exclude the states from the regulation of group insurance, or individual insurance, for that matter.

D. Seeking Uniformity Among the States: One of the advantages customarily cited for state regulation is the opportunity it affords to experiment in a single locality with different approaches to regulation. Such experimentation has often led to the development of ideas that proved successful and were later widely adopted. Other ideas were tested and discarded as failures. On the other hand, there have been strong movements among the states to uniformity of regulations in a number of areas, often through the adoption by the NAIC of a model law or regulation.

If insurance companies can make a concerted effort to convince the NAIC, the Conference of Insurance Legislators, the National Conference of State Legislatures and the Council of State Governments of the seriousness of the problems created by the lack of uniformity in state laws in this area, there may be a reasonable expectation of obtaining relief in the state legislatures. If various employer groups and unions were to prove willing to lend support to such an effort, its prospects for success would be much enhanced. Such a process is likely to be slow, but it offers better prospects than either alternative we have considered.

DR. HAROLD COHEN: I am going to discuss various topics regarding the evolving regulatory environment of health care with special emphasis on predicting the outlook for regulation of provider health care services and prices and how that will affect insured and uninsured claim costs.

All in all, cost containment for the present and near future, at least, will continue very much in private sector and state hands, and more and more states will be getting into the act. In fact, Colorado has just formed a commission to set rates, South Dakota is close to forming one, and other states are also considering forming commissions.

I am going to organize my discussion along a formula that expresses claim payout as a function of the percentage of health care charges paid by the carrier, the population, the utilization rate, and the average charge per use.

There's a lot of discussion about states requiring coverage for hospital substitutes such as home care,preadmission testing, and health maintenance organizations. Most of the evidence suggests that, in the short run, these

extensions will increase payout. But, in the long run, I am more optimistic about its holding down the use of hospitals. Deductibles and coinsurance, obviously, also affect the percentage of charges paid and make great sense if reasonably applied. As a possibility, I suggest that insurance companies consider dividing hospital care into the following 3 groups of services: (1) non-elective, not subject to physician induced demand such as accidents, heart attacks, renal failure, etc.; (2) generally elective, including most common surgeries such as tonsilectomies and hysterectomies; (3) personal care, such as most non-accident related plastic surgeries, dermatology, and orthodontia; and I suggest, at least the possibility of an insurance package which had no coinsurance for the first group, that is, for trauma and major kinds of care which are not subject to physician induced demand, the real concern among most regulators. 100% coinsurance might be established for group three and some substantial amounts for group two. This should have a significant effect on the utilization rate.

The size of the population is largely outside of the control of regulators. There is a lot of discussion about regulations regarding abortions but that is not going to have any effect on the number of people that will be insured by non-federal programs.

Utilization rate is the area of greatest possible savings. One of the things that I would like you to understand is that my commission sets hospital rates, for example, for patient days or for relative value units of radiology. A reduction in the rate for a relative value unit from $5.78 to $5.12 might have a cost benefit relationship that pays my salary but it is not where the money is. The real money is in eliminating that test altogether. State rate regulators will get more and more into a system of payment which encourages effective professional standards review organizations (PSRO). Current review systems reward, via cash flow and apparent efficiency, excess length of stay and excess testing. Last year costs in Maryland went up about 10%, of which over 3½% was due to increased amounts of testing per day. Rate regulators, and this includes Medicare and Medicaid, have built-in incentives for hospitals to overtest. For example, we, as everyone else, have cost screens. We measure efficiency on the basis of cost per unit. Because there are a lot of fixed costs, the easiest way for a hospital to reduce the cost per unit is to pump out more units. Not only does this reduce the unit costs, it also improves the cash flow - and the increased revenue provides an added incentive to pump more units. In this respect rate regulators will have to improve.

With regard to costs, retrospective cost base reimbursements to hospitals by Medicaid, Medicare, and Blue Cross have caused costs to escalate wildly. This is one of those areas where the faulty reimbursement systems of the government are largely responsible for what is going on. The President's plan will do little to remedy this, especially if the labor pass-through is included. Senator Kennedy's committee has amended the bill so that if any states ever regulated hospital rates they too would have to have a wage rate pass-through. That is, the wages of non-supervisory hospital employees will not be subject to review. They have to be passed on. Imagine the kind of collective bargaining one would have if one side gets to keep whatever they win at the table, and the other side just automatically charges through to the government and insurers whatever they choose to give away. Since 60 to 65% of hospital costs are for labor, there is no way you can assure that hospital costs are reasonable without being able to assure that hospital wage costs are reasonable.

Let me give you an example in which I think our commission was successful. Last October we sent a memo to the hospital industry of Maryland, indicating that our next inflation adjustment was going to allow an increase in the labor budget by the amount of the increase in the consumer price index, which was 5.3% in Baltimore and 5.7% in Washington. That is, the hospitals were given a revenue constraint. For example, suppose labor costs were 70% of the total. A hospital in Baltimore would be allowed an increase for labor of 3.71% (70% times 5.3%). We do not care how they spent their money. The rates they could charge would go up only 3.71% for labor. The hospitals went into collective bargaining and indeed, got the union to agree to an increase of 3.8% for wages and 1.5% for fringes. As a result, hospital costs in Maryland went up 5 to 6% below the national average last year.

The other element in the system that has to be made to act more cost effectively is the physicians. There is no way to effectively control the cost of hospitals without affecting the way physicians evaluate the necessity and appropriateness of the way they practice care. When Medicare was passed Congress said that this law will not influence the practice of medicine. Well, how in the world could you pump billions of dollars into a system and not influence the primary resource decision makers, the physicians? There is clear evidence that how you pay them is going to influence their decisions. Utilization rates of health maintenance organizations were half the utilization rates of fee for service areas after making the adjustments for various appropriate parameters such as age, sex, and whatever else influences use. So, it is very important to recognize that you have to be willing to regulate some of the things physicians do.

Another major problem is not only the fee for service system, but the 90% of usual, customary, and reasonable (UCR) system on which many companies reimburse physicians. For those of you who do not know, 90% of UCR basically means that a firm will pay everything that 90% of physicians charge and most of what the other 10% of them charge. Most of the studies I have seen, suggest that this is largely responsible for the maldistribution of physicians, both geographically and within specialties. An hour of UCR by a urologist will generate charges far in excess of the charges for an hour of UCR by a pediatrician. Is there any surprise when we have urologists making fortunes while we have trouble finding pediatricians who are not very busy? Is there any surprise when we have trouble getting general practitioners and internists to work in the inner cities and we have plastic surgeons in the suburbs coming out of our ears? This is largely a problem of the reimbursement system. I urge you to try to move your firms away from 90% of UCR and toward fee systems which, per hour of time, generate similar and reasonable incomes for many types of physicians. If your firms can not do that, encourage them to support state and federal regulation which will.

A related topic is capacity or capital project review. Elimination of staffed excess capacity is very cost effective. New York City is talking about eliminating some of its excess capacity. Manhattan has more beds per thousand and more staff people per bed than any place in the world. It may be correct for social reasons to decide that hospitals are an employer of the last resort. I happen to think that is silly. I can think of a lot better places to put people to work. But, if you are going to make the social decision that hospitals are an employer of the last resort, then you have no right to discuss

hospital cost containments, and you certainly do not hire a bureaucrat to control cost in hospitals and not back him up with the politically tough decisions that are required. We have experienced some very significant layoffs in Baltimore but the quality of care has not deteriorated.

I have prepared a table for distribution which describes how Maryland hospitals make their money. One of the things it demonstrates is that the second, third, and fourth largest revenue departments in hospitals are the laboratory, operating room, and radiology departments, respectively. Laboratory is by far the second largest money maker in hospitals. All of these exceed intensive care units, pediatrics, and obstetrics. That is why I emphasize the importance of what goes on in radiology and pathology departments, often run by physicians with monopoly franchises. You can select your surgeon, and, if you do not like what he wants to charge, you can go to another one. However, when you go to a hospital and have an x-ray, you get a bill from them in the future, but you have not met the physician involved, and you certainly have not had a chance to discuss the rate. I think eventually that will be regulated. When I say eventually, I do not mean very soon, because if you read what is going on in the Talmidge Bill there is certainly no determination to regulate radiology or pathology. Radiologists and pathologists convinced them that they should not be separated out - that they should be treated the same as all other physicians even though their relationship with patients is different from that of most all other physicians. So it is going to take quite a while. That is one of the reasons why you might want to support the states getting into the act.

There are two other things that the table will show. One is that hospital malpractice premiums, as opposed to physican malpractice premiums are less than 1% of cost. The importance in the rise of hospital costs has nothing to do with the premiums themselves. They really have to do with how they influence the practice of medicine. The way you pay, and the way you are likely to have to pay in case of a malpractice finding, greatly influences the practice of medicine.

The other item on the table is that capital costs amount to about 4 or 5% of hospital costs. I suggest that the costs of brick and mortar are extremely unimportant. The real impact of these projects is how they will influence the total budget of the institution. In Maryland, we are trying to get regulations which will require hospitals to describe the total budget impact of a new capital project. Review of the capital project can then be made in a much more sensible way.

One final item is the question of equity. Our commission is not only responsible for approving rates, but is also specifically given the job of determining an equitable rate structure. The first thing that the commission did was to drastically reduce the Blue Cross differential. Today, Blue Cross pays much closer to the rates that commercials pay. Since July 1, 1974, when we got regulatory authority, hospital rates in Maryland have gone up by 7% per year. This is about half the national average. At the same time, costs have gone up 11.4% per year. There are two reasons for the difference. One is that Blue Cross, Medicaid, and Medicare are paying a larger share of costs. The other reason is that hospital costs have gone up less than the national average. With regard to equity between various types of payers, the commission decided that patients should pay on the basis of cost of their own care. As a result, we have greatly increased obstetric rates and greatly

Maryland Hospitals

Sources of Funds (Before Subsidization)

Revenue Centers	Percentage of Revenue	Subtotals
Med/Surg	.2781	
Pediatrics	.0388	
Obstetrics	.0315	
ICU	.0395	
CCU	.0090	
Nursery	.0131	
Admissions	.0242	.4342 (a)
Emergency Room	.0416	
Clinic	.0533	.0949 (b)
Operating Room	.0748	
Labor & Delivery	.0149	
Anesthesiology	.0164	
Blood Bank	.0124	
Laboratory	.1070	
Radiology	.0625	
EKG	.0092	
EEG	.0023	
Inhalation therapy	.0124	
Nuclear Medicine	.0104	
Physical Therapy	.0051	
IV Therapy	.0090	
Med. Surg. Supplies	.0225	
Pulmonary Function	.0013	
Cost of Drugs Sold	.0340	.3942 (c)
Other Departments	.0663	
Other Income	.0104	.0767 (d)
Total	1.0000	1.0000

(a) = Funds from Room & Board Costs
(c) = " " inpatient services other than Room & Board
(a)/(a)+(c) = Proportion Room & Board is of inpatient = 52%

Uses of Funds

Categories of Cost Salaries, Wages & Fringe Benefits	Percentage of Cost	
Non-Physician's Salaries & Wages	53.24	
Physician's Expense	6.93	
E.R.I.S.A.	1.15	
Unemployment Taxes	0.18	
Workmen's Compensation	0.18	
Group Health & Disability	0.59	
Other Fringe Benefits & F.I.C.A.	1.15	
Total Salaries, Wages & Fringe Benefits		63.42
Supplies, Contracted Services & Other Expenses		
Printing, Office Supplies, Postage	1.05	
Med/Surg, Pharmaceutical	5.75	
Laundry, Linen & Uniforms	1.09	
X-Ray Films & X-Ray Solutions	0.69	
Blood, Plasmanate & Albumin	0.61	
Contracted Services	3.14	
Professional Fees (Accounting & Legal)	0.57	
Insurance (Excl. Malpractice)	0.28	
Food	2.23	
Malpractice	0.83	
Telephone	0.62	
Utilities & Water	1.91	
Chemicals, Solutions & Uniforms	0.89	
Gases, Glassware & Other Expenses	6.62	
Total Supplies, Contracted Services & Other Expenses		26.28
Capital Facilities Allowance		4.28
Working Capital		2.00
Uncompensated Care		4.02
Total		100.00

reduced pathology and radiology rates. Many hospitals used to run obstetrics and pediatrics like loss leaders. I never quite understood the loss leader concept in a hospital and we have largely eliminated that. Indeed, for every $2 lost in obstetrics some hospitals had to increase their charges in pathology by $3 because some pathologist was getting a third of the gross of that department. That did not make much sense to us either. So we changed those policies and have greatly increased the liability in effect for obstetric patients especially those whose insurance does not cover charges but provides a certain set dollar amount. We have revised the rates for them significantly.

MR. DANIEL W. PETTENGILL: What is the current outlook on national health insurance?

The simple answer is that no national health insurance law will be enacted between now and the next annual meeting of the Society. For the great majority of people, that is a sufficient answer. It permits business as usual for another year, which is about as far ahead as they care to concern themselves.

For you who have elected to attend this session, it is not a sufficient answer because you know that an actuary must provide for contingencies that may occur after one year as well as those that may occur earlier.

The Department of Health, Education, and Welfare is currently putting on a hastily concocted extravaganza to demonstrate that it has gathered the American public's views on national health insurance. Roughly a hundred public hearings have been held across the nation in the past four weeks. Some of them have been completely unstructured with anyone willing to give his or her name, address, and affiliation being permitted to spout off his or her views. Others have included a formal panel of local persons known to represent diverse views.

Thus, an impressive amount of tape recordings will be collected. Whether these recordings will ever be transcribed is unknown, but the timetable is so tight that, even if they are, the volumes of resulting paper will receive, at best, only cursory attention in the final decision-making process.

The Secretary of HEW also has a prestigious Advisory Committee on National Health Insurance Issues. They have toured the nation and have been to Canada to study the Canadian system. Even this committee is only a sounding board. Its Chairman, however, Hale Champion, Under Secretary of HEW, will presumably have a major influence on what national health insurance program HEW Secretary Califano recommends to President Carter by the end of this year. Mr. Champion appears to like the Canadian system and to be unimpressed with insurance companies. This is an important point to keep in mind.

Assuming Mr. Califano does get his recommendation to the President by Christmas, Mr. Carter will then have January of 1978 in which to make up his mind. He will also have input from his own White House staff who are already studying this matter.

Once the President decides on the key features of the national health insurance bill he wants, it will take another month or two for the draftsmen back

at HEW to actually prepare the detailed wording of the bill. So, look for the Carter national health insurance bill to be actually introduced into Congress in April of 1978. Since 1978 is an election year, I am reasonably certain that the four subcommittees, which will be concerned with such a bill, will hold hearings. No final bill will be reported to the Congress for a vote that year because there are so many diverse groups pressuring Congress on this issue and because the issue is so complex.

Then in 1979 we will have a brand-new Congress. The President's bill, along with others, will have to be reintroduced and hearings held all over again. While there is a possibility that Mr. Carter might want national health insurance as a completed issue for purposes of the 1980 presidential election, his opponent will not. So my guess is that, in 1980, national health insurance will once again be an election issue. This brings us to 1981, and there is where my crystal ball really gets cloudy.

However, the contingencies to watch for are these:

1. Is the election a landslide victory, such that many members of the new Congress owe their victory to the President, and is national health insurance so clearly the President's number one priority that he will use his victory credits to get a national health insurance bill passed quickly? (You will recall that this was how Medicare got enacted under Lyndon Johnson in 1965.)

2. Is the cost of health care still rising much more rapidly than other goods and services and hence consuming too many tax dollars that the Congress and the public want spent for other purposes?

If either of these two contingencies occurs, then national health insurance is likely to become a reality.

Most people hearing this version of the current outlook would almost surely conclude that they should proceed on a business-as-usual basis. In order to stimulate us to think further, the Program Committee asked the second question, namely, "How can companies plan their current portfolios, group and individual, so as to have the best chance of retaining a reasonably regulated portfolio?"

The answer to this question depends in part on what type of national health insurance program is eventually enacted. If something like the Kennedy-Corman "Health Security Act" is passed, many companies will get out of the health care insurance business and those who do stay will write modest policies designed to fill one or more of the gaps in the national health insurance program. I think the initial regulation of such supplementary policies would be easily tolerated by the carriers. Eventually, however, such policies would probably be regulated by both the state and federal governments and be eroded by subsequent expansion of the benefits provided under national health insurance.

The Program Committee is expecting, or at least hoping, that some public-private partnership along the general lines of former President Nixon's Comprehensive Health Insurance Plan bill will be passed. In that event, and in light of the comments made by the other panelists, there is no

question but that the typical health care policy of tomorrow will cover even more types of expense than today's so-called comprehensive medical expense policy. Alcoholism, drug abuse, and mental conditions will be covered regardless of where the treatment is rendered. Day care centers will be covered as well as hospitals and doctor's offices. As in the past, the problem will be one of recognizing the quality provider while screening out the ineffective one. With state laws and regulations being what they are, this will not be easy. Nevertheless, the definition of a treatment facility should be as tight as the laws will permit and there should be a requirement that the individual be undergoing a course of treatment that has at least a chance of being effective.

For example, to minimize paying for repeated drying-out of alcoholics and other ineffective types of treatment, my company has added the following definition of effective treatment to its group policies.

> "The term "effective treatment," when applied to the treatment of alcoholism, means a program of therapy prescribed and supervised by a physician, with certification by a physician that a follow-up program has been established which includes therapy by a physician, or group therapy under a physician's direction, at least once per month and includes attendance at least twice a month at meetings of organizations devoted to the therapeutic treatment of alcoholism. Treatment solely for detoxification or primarily for maintenance care is not considered "effective treatment". Detoxification is care aimed primarily at overcoming the aftereffects of a specific episode of drinking. Maintenance care consists of the providing of an environment without access to alcohol."

The policy of tomorrow will include coverage of home health care and confinements in skilled nursing facilities. Here again, thoughtful definitions will be needed.

While most types of health care manpower will utimately have to be covered, I do not see dental care and vision care as being required initially. Also, if the insurance industry works hard enough, it may be possible to have the services of allied health manpower, such as nurse practitioners and physician's assistants, billed as part of the supervising physician's or clinic's charge rather than separately as if each category of manpower were an independent provider.

There will be more rather than less use of deductibles on the group side and continued use of large deductibles under individual policies. Price is the primary reason. In the case of group, employers will not be able to cut back on the portion of the premium that they pay, so they will seek to generate increased employee cost sharing by adding or increasing the deductible amount. This is highly desirable because it rewards those members of the group who take good care of their health and hence have relatively few medical bills.

While, hopefully, it will be possible to have inside limits on highly-elective type care, there will be no maximum benefit for most services. More importantly, any coinsurance used will be limited to some per annum amount such as $1,000 in terms of 1977 dollars.

To discourage unnecessary hospital care, I foresee greater use of specific exclusions such as those added to the Government-Wide Indemnity Benefit Plan for federal employees this year. This plan no longer pays hospital room and board expenses for surgical confinments when the surgery could reasonably have been performed on the so-called "same-day" basis, either at the hospital or at an independent surgical facility like the Surgicenter in Phoenix, Arizona. Hospital room and board benefits are likewise denied for purely diagnostic confinements when the patient's condition would have permitted the tests to be done on an outpatient basis.

Another exclusion that I expect to see appearing shortly will be denial of benefits for services that require but do not have approval by the state Certificate of Need Agency established pursuant to Public Law 93-641.

On the other side of the coin, I foresee that the policies will have to pay the cost of the utilization reviews performed by the Professional Service Review Organizations and the cost of mothballing or converting to some other use the numerous excess hospital beds that exist in this nation. The intent in both cases, of course, will be that the payment of these costs should hold down total costs and hence ease the overall escalation of premium rates.

Although our topic is limited to company portfolios, I hope by implication you will realize the need to participate in the health planning process and in the urging of any legislation needed to bring about the changes in the health care system that, in turn, will cause the above-mentioned changes in the portfolio.

So far, I talked about benefit provisions. There are other important policy provisions which must be considered. Coverage must be made available to those who are willing to pay for it. As actuaries, we must make certain that adequate provision is made both to prevent people from waiting to buy insurance until they get sick and to provide for pooling the coverage on very high-risk individuals and small groups.

We need a pre-existing conditions exclusion which provides benefits, after coverage has been in force six months, for conditions that were either treated or recommended for treatment during the six months immediately preceding the effective date of coverage. Such a clause is fairer to the public than an annual open season, particularly if the actual effective date of coverage is 30 to 60 days after the end of the open season.

With such a pre-existing conditions exclusion and with a mandated pool for the self-supporting uninsurables, insurers could solve the present availability of coverage problem.

Continuation of coverage during layoff and for a reasonable period after termination of employment is a provision that should be included in all group policies. An employer contribution toward the cost of such continued coverage would seem essential if it is to be affordable for most unemployed persons.

While all of the foregoing needs to be, and should be done, the gut issue for the long-term survival of the private health care insurance business is whether insurers can stop being perceived as part of the problem and start

being seen as part of the solution. The solution is not just the availability of comprehensive coverage, but changes in the health care delivery system that will result in:

1. people taking better care of themselves and hence reducing demand on the system;

2. health care, when needed, being better coordinated and more comprehensive, efficient, and effective; and

3. new medical procedures and technology being at least tested for efficiency, effectiveness, and cost before being released for general use.

Such changes cannot be effected overnight, and they are not the prime responsibility of actuaries. Nevertheless, actuaries could help by taking an active interest in both stimulating and measuring these changes.