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HEALTH CARE ALTERNATIVES

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MR. DANIEL W. PETTENGILL: Health is a nebulous, subjective concept with at least three recognized subdivisions, namely, physical, mental and spiritual. Furthermore, the use and cost of health care not only vary by these subdivisions but also are affected by how the delivery of health care is organized and financed, and by each individual's genes, habitat, life-style and occupation.

Thus, when one talks about a health care alternative, one needs to identify what aspect or aspects of health care it is an alternative to, and what its objective is. One objective might be to improve the techniques used by the health professional rendering the care. Another might be to improve the acceptability to the patient of the care received. A third might be to minimize the cost of the care to the party paying the bill. All are desirable objectives and all come under the rubric of improving health care.

No matter what health care alternative you favor, it is a certainty that you will need better data than now exists in order to demonstrate that your alternative will accomplish its objective at a reasonable cost. You may not need a greater mass of data, but you will need data that is more reliable and more pertinent to the problems to be solved.

Data costs money and time to collect and analyze. Thus all health care alternatives which have as their objective a solution to the twin problems of organizing and financing the delivery of health care at a reasonable cost have a common need, namely, to determine what data is essential.

A second common need is the establishment of standards of accuracy and the means of measuring whether a particular set of data meets those standards. No where is this need greater than with respect to the determination and coding of the disease or condition for which the patient is being treated.

Actuaries should at least assist, if not take the lead, in meeting these two needs.

MR. WILLIAM A. HALVORSON: My mission is to provide insight to the question of Health Care Alternatives from the view of the U.S. professional actuary. I will present this view from several dimensions, namely political, economic, marketing, actuarial and finally professional.

Political

The fundamental political question is "Are Americans so concerned about the so-called high cost of the medical care system they possess, (which is being

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paid for primarily by employers and governments), that they will vote for politicians who would change their system from that with which they are familiar to one that they know little about, controlled by politicians and governmental bureaucracies?"

For years politicians in the U.S. have been "mining the hills" of the citizens' insecurities, promising them more, since the richest country in the world could afford to take care of each of its citizens, now and in the future. Politicians are still mining those hills, but they are now finding that economic realities cannot be ignored indefinitely. Proposition 13 has been a not too gentle reminder that limits to the supply to tax money might exist.

Presumably a pluralistic system would build on the strengths of the present methods of both providing and financing health care, and would minimize and correct the faults of the system.

For most of the 1970s, I've been saying that there has been a national policy toward health in the U.S., that manifests itself in the laws enacted. Perhaps it really started in the 1960s, following the passage of the Medicare and Medicaid programs. Time does not permit a full review of this thesis, but the words of the Senate Finance Committee staff study of Medicare and Medicaid in 1970 left little doubt of their views:

> "To simply expand the Medicare and Medicaid programs as now constituted and operated would, we believe, compound costs and confusion. That would not solve the programs of increasing costs - rather it would add to them."
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> "The key to making the present system workable and acceptable is the physician and his medical society. We are persuaded that at this point in time neither the government nor its agents have the capacity for effective audit to assure that a given physician functions responsibly in dealing with the publicly financed programs."
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> "With a view toward spurring increased efficiency and economy in the Medicare and Medicaid programs, the staff is working to perfect an incentive reimbursement system. We believe that effective incentives to improved performance will result if better than average performance is rewarded with a money payment — the better the cost control the larger the payment. This premise parallels (if it is not the same as) that underlying the competitive enterprise system — better performance and efficiency of operation yields higher returns."
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> Report of the Staff to Senate Finance Committee
> "Medicare and Medicaid, Problems, Issue and Alternatives"
> February 9, 1970

Since that date, legislation has encouraged the development of Health Maintenance Organizations to encourage competition between prepaid health care delivery systems, and to give purchasers alternatives by creating a marketplace for prepaid plans.

The other aspect to this national policy has been to introduce local planning and control over the building of duplicate or unnecessary health facilities through the Health Systems Agencies created by the National Health Planning and Development Act, passed in 1975. In other words, where competition fails to have a direct impact over balancing supply and demand, alternative control mechanisms are enacted.

It appears that the country is being given time to develop more competition between health care delivery systems. At the same time, hospitals and physicians are being asked to exercise self-control over costs, while the Health Systems Agencies and the Professional Standards Review Organizations are developing local controls over segments of the health care.

If these national policies work, the result hoped for would be a more efficient health care delivery system than in the past remaining largely voluntary.

What part do actuaries play in this political process? Our fundamental function is to help the health plans we work for succeed in providing either health care directly or reimbursing health care providers so that plan participants receive the degree of security that has been promised by the plan. We assume competition between plans, and we look for ways to improve the viability of our plans while improving the protection offered to participants.

Economic

The fundamental economic question is "How much health care is enough?". Or stated another way, what percentage of gross national product should a country spend on medical care, and what is the optimum balance between the disease prevention, early diagnosis, health restoration and treatment, and life extension on the one hand, and cost on the other. This is a difficult question that only society itself can answer. As you know, we currently are close to 9.3%, and some noted politicians say that 9 is enough. At what sacrifice of overall health, if any, is difficult to say.

The question of health measurement of a community, state or a country might be an area of actuarial research. As a country, we don't have a good measurement of relative health, and neither infant mortality rates nor average age at death is a satisfactory index of health. Perhaps an interdisciplinary team of health professionals, demographers and actuaries could develop a composite measure of health so that politicians and social planners could at least see which direction a country is headed on health.

Our health care systems have encouraged advances in medical technology, and our prepaid health plans have paid for these advances, usually without question. There are evidences now that purchasers of health care plans, the largest of whom is the Federal government, are having second thoughts about paying without question for new and high priced surgical procedures, CAT scanners and life support systems. With new emphasis being given to competition between health care systems, a measurement of health and quality assurances are needed to protect plan participants.

Actuaries should have a major role to play in this area by providing standards of utilization and charge levels for each group of participants, so that purchasers can properly assess the pattern of care being provided.

Marketing

Actuaries will have to be involved in the following marketing functions:

a) The design of benefits, or services to be included in each plan;
b) The development of the classification system for pricing the product;
c) The support mechanisms needed by any risk sharing arrangements between the providers of health care, the plan sponsors, the purchasers of the plan and the reinsurers, if any;
d) The costing of the benefits to determine appropriate prices; and
e) The measurement of experience (compared to standards for the plan participants).

The above represents the entire list of actuarial functions under marketing. Experience with prepaid health care plans has also taught us that marketing, underwriting and actuarial talents must be fully coordinated if pluralistic health care systems are to mutually survive.

Up until recently, competition in prepaid health has been competition between carriers, and not between alternative health care delivery systems. All of the major carriers were paying essentially the same providers and at generally the same level of charges. Even the difference between the Blues and commercial insurers, which originally represented a real difference between the Blue's service benefits (no copayments or deductibles but with charge level concessions by providers) and insurance carriers reimbursement of providers' usual and customary charge levels, has become very blurred as each has responded to the needs of the marketplace and community pressures. Since the major purchasers of health care have been large employer-employee groups, competition has concentrated on the effectiveness of the prepaid plan's services and the cost of those services, as represented by the level of retentions and interest credits on the carriers' use of the purchasers' positive cash flow. A new competitor to both the Blues and commercial insurers is the self-funding of benefits by these employer-employee groups.

Actuaries face a new marketing problem in that the basic employer-employee unit is being divided into subgroups that are grouped by alternative health care delivery systems, and each employee will be given a choice between systems. Under these circumstances, the classification system so familiar to all group health actuaries, that is, the rate quoted to the basic group unit which has been based on the entire group's experience, stands in jeopardy of becoming obsolete. In the future it appears necessary for competing prepayment plans representing alternative health care delivery systems to offer coverage and rating classifications that will attract and hold like sets of health care user cohorts.

These cohort groups may be defined over time by many different characteristics, such as the ones already familiar to marketers and actuaries, namely age, sex and geographic area, but could also be broadened to include occupation or exposure to hazards, or disposition toward alternative styles of health care delivery or protection. These characteristics must be recognized in the areas in which you operate, if the plans are to remain viable. In addition, even group plans may need underwriting rules to prevent adverse selection.

I'm confident that actuaries can help their plans cope with this new style of competition. But we must sharpen our tools. We must study experience to identify workable cohort groupings. We must anticipate that all people are different, and their use of medical facilities reflects attitudes as well as objective needs. Therefore, we need to avoid over-simplifying the classification problem until we can find compatible cohort groupings that work.

We know, for instance, that certain people want the security of having a close relationship with their own physician, and it appears that their pattern of health care utilization (and costs) will be different from those who prefer to use the hospital emergency room as their primary entry point into the health care treatment world. Others will avoid any contact with physicians or hospitals, almost to the point where they may be endangering their life. On top of these variables in attitude, we may observe that certain people just want the cash and will worry about health care prepayment later.

In spite of these potential future complications, actuaries can and must become even more aware of the changing marketing requirements for comprehensive health care, especially as it may affect regular group markets.

Actuarial

A listing of the basic functions that an actuary performs for health plans will be useful for the record:

1. determine the plan's annual health care costs, in sufficient detail to permit analysis and management.

2. compare actual costs with those expected for a plan of a similar size, with similar characteristics of age, sex, income, geographic area, occupations and other measurable factors.

3. project future probable costs for continuing the present plan of benefits, and provide counsel on alternative changes in the plan along with their probable effect on costs and plan viability.

4. provide plan management with a probable range of costs, to give them a feeling for the relative probability of experiencing chance deviations, either upward or downward, so management can apply risk management techniques.

Professional

Actuaries must perform their functions singly, but with the support of a professional organization in terms of guides to professional conduct, principles and practices, and discipline on the one hand, and educational standards, conferences on current developments, research studies on the other. From a public interface point of view, it is desirable to have the public better understand our functions as well as our professional credentials, if we are to be of use on the issues of public debate.

During the last few years, the Society of Actuaries has recognized that health actuaries have unique needs that could be more directly addressed by the Society in terms of education and examinations, meetings and research

activities. Also, it appears that the Academy is currently looking at the problem of providing more professional input and liaison on health matters in Washington, D.C. and throughout the states. Forming a new professional group of health actuaries would further complicate an already confusing overlap of actuarial organizations. A special task force headed by Robin Leckie is studying the possibility of permitting the development of special interest groups within the Society of Actuaries.

A task force of the American Academy of Actuaries is addressing the risk classification problems facing health actuaries in the U.S.

Two other specific areas of concern now, are:

1. The lack of funding standards for health plans under ERISA, and

2. The insistence of community rating under the HMO law, and the lack of actuarial standards for HMOs in general.

How many people will be hurt before we recognize that funding standards for self-funded health plans are needed?

Similarly, how many HMOs will fail financially before we recognize that, to exist, HMOs must be permitted to complete without government subsidy. And when will the HMO Service recognize that there is such a thing as qualified health actuaries who can and should be advising new HMO's.

Perhaps, with a cooperative effort between the Society and the Academy, and the Casualty Actuarial Society, the profession will be able to be of more help to the regulators of health plans and the legislatures who draft legislation affecting the future of alternative health plans. Time is running out.

MR. STANLEY B. JONES : My role is to describe what needs to be improved in health insurance for the good of the U.S. consumer as Washington politicians and policy makers read him. I'm going to mention some problem areas where we badly need "numbers" if health insurance is to respond to the critical challenge it is faced with in the next decade

The people who use health care, and who buy health insurance, in the U.S. want:

- Continuing health insurance coverage throughout their lives;

- Comprehensive benefits; and

- More reasonable health care - and health insurance - costs.

Of course, not everyone is staying awake at night worrying about these wants - especially those who feel they are secure enough in their employment and their present plan or wealthy enough that they'll always have comprehensive insurance that they can afford. But millions of U.S. citizens are not that secure.

With respect to continuing coverage, there are millions of people at any point in time who have no private insurance, and are not eligible for any public program. A large portion of these are between jobs; unemployed; marginally employed in part-time jobs in which they earn just enough to be ineligible for public programs but which provide no group health plan; dependents of workers whose group health plan covers only the employee; or people who earn very little and do not qualify for Medicaid because of our welfare laws.

To put it another way, millions of people without insurance coverage at any one time are no different from millions of workers who are presently insured -- except that they've lost their job, or can't find a job, or have to settle for part-time or marginal work. For every one of these people, there are five to ten working people who fear they can be in the same boat some day. They want their insurance to be continuous; and their unions won't rest until it is; and there will be political ferment until it is.

With respect to comprehensive coverage, the consumer's desire is also clear and nearly unanimous. Rich or poor, union or non-union, big employer or small employer, most people want comprehensive coverage. When they have options to choose from, most pick the high options. Unions bargain to add benefits at every negotiation. And they don't ever want deductibles and coinsurance if they can help it.

Everyday, I pass a Maryland Blue Cross/Blue Shield office in my building, where elderly people line up with envelopes and packages of doctor bills to collect from their supplemental "Medigap" policies what the deductibles and coinsurance under U.S. Medicare does not pay. There is no question that the elderly in America want comprehensive coverage even if they have to pay extra out of limited incomes for it.

Most people share this - and for whatever reason, simply don't want money to be a factor in their getting health care.

What people fear most is that their insurance will not be comprehensive enough to cover catastrophes - and will leave them financially either ruined, or unable to afford the care they or their family need. And they fear there are limits, or exclusions, or some provisions in their insurance that will result in this situation. People want catastrophic coverage first, but they won't be satisfied with that.

Until the coverage is more comprehensive, for everyone, there will be political ferment on this issue.

The thing that concerns the U.S. consumer most today is the cost of health care and health insurance. And in this instance, "consumer" must be broadened to include the unions who trade-off higher insurance premiums against hourly wage increases, the employers who pay most of the premium, and - oddly enough - Federal and state governments who face a $6 billion increase in the cost of Medicare and Medicaid next year.

This audience is familiar with the numbers that reflect the rising costs of health care in the U.S. and the rising percentage of the G.N.P. it represents. Actuaries are even more familiar with how that converts into increases in insurance premiums.

And the most unsettling thing about these rising costs is that no one can point to any plan within the system as it now operates that is going to slow these rising costs. In fact, if there are some empty beds across the country at present, just hang on. The population is getting older every year more doctors are on the way; and who can guess wnat hospital filling technology will come in the next few years. The only thing that seems clear is that actuaries will have an opportunity to calculate how much it will all cost - and insurers, public and private, will pay the bills.

No wonder government, insurers, unions, and businessmen are getting behind all kinds of clumsy external controls like health planning, cost containment and rate setting. The fact is, this is the best we know how to do in the face of the biggest concern U.S. consumers have in health care - namely rising costs.

First let me discuss what seems to me to be micro issues regarding areas where numbers are needed (in that they more nearly fit the classic mode of insurance problems).

Since catastrophic health insurance is being actively considered by the Administration and Congress, and it is part of the comprehensive package that the consumer wants, let me suggest some needed numbers.
We need to know how many people incur out of pocket health care bills for basic acute care services of more than, say, 10% of their income (or more than $2000 per family if the 10% figure is impossible) because:

a. They didn't have any insurance when the health catastrophe occurred;

b. Their insurance contained exclusions or simply didn't cover some or all of the services for whatever reason;

c. They were in a waiting period for some benefits in their insurance; or

d. They exhausted the maximum limits of their coverage.

Catastrophic insurance proposals have usually focused on only the limits - more financial catastrophes may be due to other factors. They need to be identified, the costs of filling them calculated, and ways to fill them designed. Actuaries need to be involved, lest the insurance industry support and be party to a proposal that ends up disappointing a lot of consumers, or costing more than anyone estimated - and sharing a black eye with government in five years.

Second, several of what I call the boundary areas of comprehensive coverage will only be resolved when we have numbers. These include:

- Preventive services,

- Mental health services, and

- Long term care, home health and hospice type services.

In each of these areas, there is enormous disagreement about how to them, what particular services should be in health insurance, and how

much they would cost. Most insurance plans and national health insurance proposals contain arbitrary limits in these areas designed more to limit risks and to let an actuary come up with a number than to cover sensible health care. Actuaries should help design some experiments that over time would give the data needed to make better estimates in these areas.

Third, we need better measures of the effects of deductibles and coinsurance on needed care vs. care generally. And we need to find better ways of giving the consumer some incentive to make efficient use of the health care system.

The macro issue on which we need numbers is the issue of how to constrain costs.

On the question of costs we badly need to know what differences in utilization and costs we can count on from all our current regulatory efforts, be they health planning, cost-containment, recent forms of fee schedules, utilization and professional standards review, new ways of budgeting or paying hospitals and so on. We've gotten so desperate for ways to slow costs that we have gotten way ahead of our data. There needs to be hard-headed actuarial advice given as to what data should be collected to evaluate these efforts. Gordon Trapnell, an actuary who has prepared cost estimates for a number of national health insurance proposals, has said that he cannot give me any cost credit for one regulatory provision or another because we don't really know how much difference it would make. Policy makers are desperate for help in this area.

But there is a more important need in this area of costs. We need to design insuring practices that create incentives for the following:

1) providers to offer services more cost effectively -

   - to use hospitalization less

   - to use lower intensity of services

2) consumers to choose less costly forms of care.

Our current repertoire of regulatory efforts collides with the basic incentives in our system that encourage consumers to use more care and providers to offer more care. Until the cultural revolution comes that Roy Anderson foresees, we will be unable to stop consumers and doctors from pushing our health care costs even higher. We need to change the present incentives to hospitalize more, to provide more services and to invent more advanced and more costly ways to convince ourselves science will make us live forever. Many of these present incentives grow out of basic practices of insurers, under public programs like Medicare and Medicaid as well as those of private insurers.

- Fee for service payment to doctors,

- Methods of payment for hospitals (indemnity plans)

are all part of the incentives problem - and there is far too little work going on among public and private insurers to come up with solutions.

But if insurers aren't working hard on these issues, others are and many of them propose fundamental changes in insuring practices. Interestingly enough, some of these others are private sector, market oriented people who think competition is the way to get the U.S. consumer the lower cost health care and health insurance he wants. What are these efforts?

Alain Enthoven's proposal to increase consumer pressure on insurers to provide new forms of prepaid health care programs is gaining more and more attention in Washington. The heart of that proposal is to force insurers to compete, to make innovative arrangements with providers of care - perhaps as HMOs or perhaps as other yet unheard of arrnagements - that set up incentives for providers to offer less costly care.

The Federal Trade Commission has a related agenda. They recently issued a proposed regulation that essentially forbids physicians from controlling positions on Blue Shield plans in the states. The rule is part of a basic philosophy and a series of proposed actions aimed at forcing insurers to compete with one another to come up with better, less costly, ways to pay physicians and hospitals.

Health Maintenance Organization advocates are still working successfully to spread their movement in the U.S. and are getting more and more interest from corporate purchasers of insurance.

Finally, the labor unions in their recently publicized national health insurance proposal have set up a system that is extremely favorable to HMOs, or any insurer who structures a new plan in ways that reduce costs. The determination in U.S. labor, with regard to pressing insurers into innovative arrangements, is dampened only by their disbelief that insurers will ever respond.

The significance of these new movements shouldn't be overlooked. They come at a time when Washington - and consumers of all types - are desperate for new ideas for constraining costs, especially ideas that require minimal new dollars from the Federal budget and a minimal increase in the size of government. Many of these regulatory ideas are in that category.

So what can an actuary do? At the least, actuaries could sort through what is currently known about the utilization and cost effects of these new insuring/health care provider arrangements and the effects of the various incentive factors involved. Perhaps they can go further and work within the industry to design new insuring arrangements based on this data, arrangements that create new incentives for providers and consumers to offer and to use less costly health care.

MR. JACK W. ROBERTS: Whenever there is a discussion of the health care alternatives available to the American people, there is reference to the "Canadian Experience". Never is there reference to "Utopia in Canada" (unless the speaker is named Kennedy) nor is there reference to the "Canadian Disaster" (unless the speaker happens to be a Canadian doctor or a Canadian Hospital Administrator). It is tough to say whether or not we have utopia or disaster and I would like to dwell only briefly on the Canadian experience, with the following few comments:

- The average length of stay in non-Federal hospitals in Canada is more than one-third longer than it is in the United States.

- The number of days of hospital care per 1,000 population is more than forty percent higher in Canada than it is in the United States.

- Total per capita expenditures for personal health care are increasing faster in Canada than they are in the United States.

The reason we have these results is that Canada has a so-called National Health Insurance Plan. Here are a few more comments:

- The Canadian public likes its National Health Insurance Program; the American public also likes the quality of its health care and is satisfied with its health insurance coverage.

- The quality of medical care in Canada is very high; it is just as high in the United States.

- The American public is very concerned about the rate of increase in the cost of medical care; the Canadian public has no idea of how much medical care really costs.

- In the last year, about 100 doctors a month opted out of the Government Program in Ontario; if this continues, all the fee-for-services doctors in the province will have left the Government Program in ten years. It is also worth reporting that a survey conducted by the Medical Post revealed that more than half of the country's doctors are thinking of moving to another country, presumably the United States.

- The Canadian Hospital Association recently stated in a newspaper article that health care in Canada is falling apart in the hands of the provinces.

We all know that the American Hospital Association and the American Medical Association are opposed to a Kennedy Type National Health Insurance Program for the United States - so are a few others opposed. The hospitals and the doctors became very upset when HIAA supported the Administration's Program for cost containment. Imagine what their reaction would be if it were proposed that, each year, each hospital had to have its budget approved by a Governmental Body and that doctors' fees would be controlled by the State Government. The health minister of the province of Saskatchewan has said that the government is thinking of legislating an end to direct billing, and after allowing an 8.4 percent increase in the fee schedule, said that the doctors would have been granted a larger fee increase if they had been willing to give up the direct billing practice. In Canada, there is a continual, bitter controversy existing at all times between government and the professional providers of health care who think that government has no place in the medical care business. It is not sufficient to say that government is involved only in the financing, not in the delivery; if it is involved in the financing, it is involved, period.

There has been a significant growth in the group practice of medicine in Canada. Many doctors feel that they have been forced into this position because there are not enough hours in the day to carry on a traditional practice and still earn an income that is commensurate with training, education and experience, because of inadequate governmental fee schedules. The

Ontario Medical Association's Fee Schedule is about thirty percent higher than the Governmental Allowances. So the doctors have to process more patients. In a way, a case can be made for the contention that group practice is an efficient way to deliver health care. But if you listen to the other side, you hear about the loss of personalized service and that quality of care goes down when quantity of care goes up. Revolving-door medicine, wherein the doctor suggests that patients should come back for check-ups time and time again, is not unknown in Canada; and I understand that Canada leads the world per capita, in several elective procedures, X-Rays and certain lab tests.

Is there anything we, as actuaries, can do to keep the Federal government out of our business? There are a few things we can do because many of us have some influence on the way the health insurance business is conducted on this continent. We have to clean up the medicare supplement mess. We absolutely must take steps to ensure that the fear of a catastrophic medical bill is eliminated from every American's mind. We can do this by supporting appropriate legislation which will look after those segments of the public which are not looked after by our traditional practices. For the segment of the population which we already cover, we can design plans which do not require co-payments at the very highest levels. Most medical practioners believe that financial deterrents may be effective in reducing utilization, but most also would agree that there comes a time in a treatment program when such deterrents lose their efficacy.

I am not sure we, as actuaries, can have a lot of impact on the public - we never have before - but maybe we can influence politicians. But let us remember that even though you may be able to persuade a politician that a certain idea espoused by a rival is not the best idea in the world, you are not doing him any favors unless you offer him an alternative, something he can support rather than destroy. That is why HIAA's board decided that the health insurance industry should support catastrophic health legislation. We, as actuaries, can add to this support.

Another thing we can do is to promote types of coverage which encourage less expensive types of care and in this way make a contribution toward keeping the lid on cost escalation. We are already doing this by encouraging outpatient care, for example but we need to do more. Let us have a really good look at the Hospice development and the possibilities of providing coverage for home care treatment. Let us recognize that "Quality of Life" is more than a buzz word expression and that we may be able to encourage people to look after themselves by offering lower premium rates on individual policies.

MR. PETTENGILL: Although we have identified the Health Maintenance Organization as an alternative to the traditional fee-for-service delivery system, it is important to realize that there can be and are marked variations with respect to utilization and cost within each system. Both systems are subject to cost escalation.

In either system, controls are needed on both the physician and the patient. The patient, through lifestyle and habits determines when medical care is utilized. The physician determines how much service to render. The task is to optimize utilization so as to provide adequate health care at a reasonable cost.

MR. HALVORSON: The national policy in health has been to promote the HMO as a health care delivery system alternative. The HMO changes the basic incentives for the physician, to provide for the health of the individual, rather than taking care of the sick.

The following limitations in the HMO legislation prevent the HMO from competing with the traditional fee-for-service delivery system:

1. The high level of benefits required;

2. The community rating requirement; and

3. The exclusion of the employer from the board of an HMO for his employees.

The combination of requiring HMOs to provide more comprehensive benefits and to extend coverage to the underprivileged, under-served areas of the community has resulted in HMO costs that are higher than the average employer is able or desires to pay for his health care plan. The employer, who is the one who pays most of our health care costs in the private sector, should be a key element in any proposals for health care alternatives.

We need to provide a position for the employer in any proposal for a health care delivery system. This can best be accomplished at the local level. We cannot succeed in creating a real market place for health care, until we provide a position for the employer.

MR. JONES: The flaws in the HMO legislation are a result of our political process. The original bill did not contain these flaws, and further, contained elements to compensate for these problems. In congressional committee, clever compromises were made that created an almost undoable act.

The local unions are grappling with the problem of premium increases. These increases come at a time when they would like to negotiate hourly wage increases. The new union national health care proposal reflects a willingness on the part of both the employer and the local unions to try some new alternatives and work with the insurer. If, in addition to the HMO, the insurer were to approach the employer and union with an arrangement that had previously not been heard of, that provided traditional lab and inpatient facilities and contracts with good doctors at a lower premium, the union proposal would provide an incentive for the employer to buy into that kind of arrangement with insurers. The local level is the appropriate place to use imagination and demonstrate that such alternatives can work, not in Washington.

MR. PETTENGILL: Political compromises are an inherent part of our political process in Washington and generally result in transforming good plans into unworkable systems. The practice of asking government for a solution should be carefully considered in light of this fact.

I would urge actuaries to try innovations at the local level with cooperative policyholders of sufficient size to provide an appropriate spread of risk.

One function that actuaries can perform is the gathering of statistics on hospitals in a given area that indicate the differences in practice. An as yet unpublished study of 12 hospitals in Connecticut indicates substantial differences in such areas as average length of stay, whether diagnostic X-rays are performed, the number and type of lab tests done routinely upon hospital admittance, etc. Much of the difference is attributable to the individual physician. If an insurance commissioner would allow it, actuaries working with employers could use such information to direct employees to doctors and hospitals that are practicing reasonable restraints and good medicine. This would seem to represent the biggest incentive to encouraging the remaining doctors and hospitals to adopt these restraints. If certain doctors are getting all the patients that they can handle and making a good income and the hospitals are prospering, the others will follow suit.

MR. HALVORSON: Blue Cross Associations have instituted a recent program for eliminating the payment of diagnostic X-ray and lab tests that are routinely given upon hospital admission, unless the attending physician specifically requires them. Will the insurance companies do something similar? Can they make if effective? Can they get the insurance commissioner to go along with it?

MR. ROBERTS: It soulds like a good idea. The existing contract wording would permit this in a number of situations. This should also encourage restraints on tests performed on a routine basis.

MR. PETTENGILL: The actuaries must help the doctors develop standards by providing meaningful statistics. These statistics are needed to determine when unnecessary procedures are probably being performed. In that study of 12 Connecticut hospitals, there was roughly a 300% difference in the incidence rates of tonsellectomies in those hospitals in relation to the per thousand population presumably served. Similar large variations existed in the rate at which certain X-rays and laboratory tests were performed. Conversely, the doctors must help the actuaries understand the fact that proper performance cannot always be measured by a statistic because people are all different and there are occasional cases that fall beyond the standard, and yet are perfectly valid because of the patient's special characteristics.

MR. HALVORSON: One way of controlling costs is not uncommon in the HMOs that I worked with. For the first time, physicians in communities are seeing what the practice of every other physician in that community is, as to how they are practicing medicine. They are learning from each other, one of the most positive things that has come out of the HMO movement. There is a substantial amount of peer review now with respect to economics of health care as well as just the practice of medical care. These two have to be considered together, we can't just look at the practice of medicine. The more that we can set up mechanisms at the local level so that physicians can get this interchange between themselves (where the general practice physician can see clearly the practice of a surgical specialist and the internist can see how they're operating and what they charge), the more effective we will be in our cost control effort. It's really quite an education for the physician and it has an element of cost control in it just because the physicians want to be accepted by their own peer group. It is a very subtle way of getting at it perhaps, but it's fair and it should be encouraged.

MR. JONES: Some of the experience of the open panel HMOs, IPA type organizations, bears out that line of thinking. If physicians are in a situation where they know their peers are going to look at their work, not from outside in a regulatory way, as a part of a government agency or for that matter as part of an insurance review group, but as part of a group of colleagues who also share some business relationships. Their utilization rates go down and their practices tend to standardize, and the extreme ends of the bell shape curve fall off. I suspect, it is a combination of human nature and putting the incentives in the right place. My own instincts are that the country could save a lot more by that kind of self motivative choice on the part of physicians, than by policing them from the outside, whether the outside is an insurance review activity or a government review activity.

MR. PETTENGILL: Actuaries have to design reimbursement systems which reward the physician who practices good medicine economically, and penalize those who do not. One of the reasons that the Kaiser Permente Foundation is so successful with its group practice prepayment plan is the fact that they built a margin into the budgets for both hospital expenses and physician expenses. These margins become bonuses to the physicians at the end of the year if they are not spent. This approach has the potential danger that the doctors may skimp on the quality of care rendered. So some quality review mechanism is still necessary.

Nevertheless delivery systems will not work well if they fail to give the doctor reasonable compensation for a job well done. This is basically the problem with the Canadian National Health Plan, with Medicare and with Medicaid. There is no real way that these government programs are compensating doctors for a job well done. Because of the increase in cost, governments have basically cut what they will pay the doctor, with the result that in Canada, doctors are withdrawing and in the U.S., the number of physicians who will accept an assignment under Medicare is so depressingly low that it is a disgrace.

MR. HALVORSON: The problem of catastrophe coverage is that everybody worries about huge out-of-pocket expenses which the plans will not cover. What has generally been done, under both comprehensive plans and major medical plans, is to specify that there will be a maximum dollar out-of-pocket limit with respect to the covered expenses that the individual will have to pay by reason of the deductible and co-payment. Our basic problem, of course, is that we can sell a million dollar maximum or an unlimited maximum for a very small additional premium, but when we offer a $1,000 annual limit on out-of-pocket expenses, we are talking about a fairly substantial increase in cost. The typical congressman does not understand the difference between my being out of pocket $1,000 with respect to covered expenses and my incurring $10,000 of covered expense. There is a major difference, depending on the construction of the benefit program, as to whether you would be eligible for reimbursement if you are reimbursed for catastrophe benefits after you have incurred $10,000 of covered medical expenses, vis-a-vis being reimbursed by not having to pay any more money out of your own pocket after reaching the $1,000 annual out-of-pocket limit.

MR. ROBERTS: Another alternative is an out-of-pocket limit that is a percentage of earnings; $1,000 is not practical for everyone. I think some limit based on earnings would be a little more sensible. Maybe that $1,000 turns to zero for people who have limited earnings.

MR. PETTENGILL: This is terribly important at the moment, because of the catastrophe legislation which is being given serious consideration by the U.S. Congress. The out-of-pocket concept is much to be preferred over the expense incurred concept. I agree with Jack. Even though it means more work for the insurance company to operate the plan, we ought to relate the out-of-pocket limit to the employee's wages from his employer. That is something the employer knows about, so that the carrier would not have to go to the government to find out what the employee's income was. Basing the out-of-pocket limit on what the employer is paying the employee makes a percent limit practical because it eliminates the confidentiality of income problem. Admittedly, this would be rough justice because wages are seldom precisely the same as total income. Under the U.S. Income Tax Act, even total taxable income is not perfect justice because tax exempt income could produce disparities between two people otherwise the same. What worries actuaries is that the U.S. will adopt, for example, the original Long-Ribicoff bill, which defines a catastrophe as $2,000 of incurred Part B expenses per family in any year.

If that kind of bill is passed, there will be tremendous pressure on succeeding Congresses to lower this $2,000 (expense incurred) threshold.

MR. HALVORSON: One fundamental thing actuaries have learned over the years is that you cannot change the benefit structure without changing the basic underlying utilization statistics. With respect to the catastrophic, I want to pose a couple more problems that have not been alluded to.

We know that urban centers have a lot more medical technology available to them and catastrophic insurance for those urban centers is catastrophically priced. Whereas a catastrophe coverage for the more rural areas and small towns can be very reasonably priced. If you establish a policy of national health insurance which says that we are going to standardize coverage, unlimited in effect to coverage, are we going to see the rural areas and small towns then come up to the level being observed in the larger cities, encouraged as they would be by the additional source of funds which very small employers in small towns cannot afford now? Are we going to see them raised to the full level of cost for catastrophic coverage? I am concerned with the whole catastrophic thrust that we are taking but I do not have a substitute for it.

The second problem is that, in my discussions with people who are concerned with the health of the community, the question always comes down to what is the employer's responsibility and when does the community take charge of the particular illness, thinking about a chronic disease or a newborn child who turns out to be retarded and, therefore, needs continual institutional care for the next 20 years at which time death is probable. Does the employer have the responsibility to pay for that? Employer's do not think they do now. The new Kennedy Bill, would seem to give the employer the entire cost of the program. Are the employers now elected to take on this entire burden? Has society made its decision on this? I think it is a grey area that we should have more public debate about.

MR. PETTENGILL: Mr. Halvorson's grey area is grey with respect to the amount of dollars involved as well as who should pay those dollars. If we were just talking about providing physician's care, what used to be called medical care, for the long term patient, we in this room might be half-way comfortable with coming up with a premium. But health care in the public's

mind includes all mental health plus all custodial care, whether for the senile octogenarian or the mentally retarded child, and involves unknown, but presumably horrendous costs, costs that are not now covered by today's catastrophe plans.

You can argue that this is an income maintenance problem, as against a medical care problem and I would not quarrel with that. Nevertheless, the fact remains that the public wants something done about it. We have got to educate the politicians and the public about this doublely grey area. What is the public sector's responsibility, to be paid for by the tax payer, on the basis of an equitable tax? What is the private sector's responsibility to be paid for by insurance premiums? Obviously, from what you have heard, we want to solve as much of this problem in the private sector as we possible can. On the other hand, there are limits to what the private sector can do and coverage beyond these limits is going to have to be handled by the public sector with the politicians deciding there are only so many billion dollars available and, when they are spent, no more such care is available. Nobody is going to like it, but there is going to be that kind of situation.

Are there any final comments on health care alternatives from the point of view of a national health program in the United States?

MR. ROBERTS: The theory of the HMO is really very very simple. It has an incentive for reducing care. Unfortunately, the government did all it could to prevent the success of HMOs because of the way the legislation was worded. I think the HMO idea is great, I support getting legislation passed that will see that movement grow and nurtured. Finally, we have to eliminate the fear of a big hospital bill from the American public's mind somehow.

MR. HALVORSON: Health care alternatives is the way that we should go and I think that is the way the country has been going for the last 9-10 years. We have not done a good enough job making these alternatives workable and viable. In that regard, actuaries can play a big role. We do know something about marketing good health care plans, we know how to price them and we know how to adjust those prices as we go along. We know how to build incentives through experience rating techniques and we know how to handle risks in case of unforseen swings in costs. I believe that actuaries can do more to encourage the development of alternative health care programs within the private sector.

MR. JONES: From our national policy perspective it seems to me that it is time to relax into what is apt to be a ten-year period where government is not likely to make major changes that cost a lot of money, and will be under pressures to cut costs, the same as health insurers and providers. I am convinced that for the next few years, Medicare and Medicaid problems are going to look more and more like insurance problems. This may just be a time for some pooling of creativity, interest and capacity. There are very different capacities in those public programs and in private programs in terms of the data that is there and the kind of experiments that can be done. I suspect insurance is going to go through a very rough time, not

government versus the private sector, but all insurance, public or private. I do think this notion of alternatives in the broadest sense is the name of the game. People who are very hard headed about numbers have got to get into the creative game of saying what exactly does make a difference and what kind of design of an organization effects costs and utilization, then help set them up.