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NATIONAL HEALTH INSURANCE: CANADIAN EXPERIENCE/ UNITED STATES POTENTIAL

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*Panelists: WILLIAM A. ALLISON, DAVID A. STOUFFER, DAVID ROBBINS**

1. Canadian View

    a. Where have we been? What is next?
    b. How did the Canadian programs develop?
    c. What problems are emerging?
    d. What future developments are expected?

2. U.S. view

    a. Where are we going?
    b. What are the recent developments?
    c. Various current proposals - pros and cons
    d. What is the insurance industry's response to these proposals?

MR. LLOYD G. ROLLERSON: Our subject is national health insurance and we intend to cover it from both the point of view of Canadian experience and the current situation in the United States. Each of our three panelists, Bill Allison, David Stouffer and David Robbins brings a different viewpoint to the subject. Our first panelist is Bill Allison. Bill was born in Glasgow, Scotland and after completing his schooling, went to work for the Scottish Amicable Life Assurance Society, where he began to write the examinations of the Faculty of Actuaries. In 1957, he joined Confederation Life in Toronto, where he is now Group Vice-President, Canada. In addition to being a Fellow of the Faculty of Actuaries he is an Associate of the Society. He is currently vice-chairman of The Canadian Life Insurance Association committee on private pension plans and serves as chairman of The Canadian Life Insurance Association sub-committee which pioneered reciprocal portability agreements for employees moving between Canadian life insurance companies. Bill Allison is going to tell us why he thinks governments get involved with health insurance programs and review the history of the development of the Canadian program.

MR. WILLIAM A. ALLISON: I will begin my remarks by spending a few minutes considering some of the reasons why governments get involved with health insurance programs. As governments become more democratic or more representative of the people, they inevitably become more involved with the groups of people in the population who give their consciences a twinge, however slight that might be in some cases.

Prime examples of these groups of people are the old, the poor and the sick. When only the landowners had the vote and even before that, when the system was more feudal than democratic, looking after these people was left to their families or to the charity of the church.

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Giving the vote to workers led to the first steps in social reform. High on that list of reforms was the belief that looking after the old, the poor and the sick was a government responsibility rather than one which could be left to the mercy and charity of the church, or any other group for that matter. As a result the developing public conscience in these areas led to increasing demands from the voting public for programs such as national health insurance which would look after these situations.

Why do people think that social programs such as national health insurance are a government responsibility? A major reason is that government is perceived as the only body capable of ensuring that all citizens will have equal access to health care regardless of their financial resources.

Having government develop and introduce a universal or national health insurance program is therefore seen to reduce or eliminate the financial barriers to obtaining necessary health care. Many people do not realize that it does not, in any way, however, guarantee that an adequate health service system will exist.

Now adequacy, like beauty, lies in the eye of the beholder. Something that is satisfactory to one person will be seen as totally inadequate to another. But whatever it means to the public at large, there is a strong feeling among many of them, that any perceived inadequacies in existing health care delivery systems can best be solved, and perhaps can only be solved, through government involvement with health insurance programs.

Today's politician is anxious to gain the support of the voters. No matter his political colour, he will support his constituents' demands if that will help get him elected. Today, therefore, all politicians in democratic societies such as we have in Canada and the United States, are in favour of looking after the old, the poor and the sick. Government bureaucracies are clearly not opposed to developing programs which will expand their spheres of interest and influence. They are, therefore, active supporters of governments getting into such things as health insurance programs. The justification is easier when the motives are clearly beyond criticism, such as a national health insurance program, which will provide equality of access to care for all, and can be expected to improve the adequacy of the services being provided.

There are, however, factors which tend to slow down the involvement of government in health insurance programs. The costs of a health insurance program and the government's ability to raise the necessary funds to pay for these costs is always a major factor. Then, there is the inability of any two politicians to agree on what form a government health insurance program should take and this tends to delay the implementation of any program. And, of course, another important factor is the prodigious effort on the part of private industry to persuade government that health insurance needs are being met and that a government program is unnecessary.

A couple of examples will illustrate how these factors sometimes reduce and even disappear altogether:

The 1943 Beveridge Report, which was the prelude to the British National Health Service, was presented during the Second World War when a coalition or all-party government ruled. All political parties were therefore com-

mitted to a National Health Service. The party elected to power after the war would have the privilege of introducing it. The political debate then reverted to details rather than the issue of whether or not to have a national health insurance program. Cost was discussed, but was not considered a factor, and private industry did not provide the breadth of coverage to justify an opposing view or support of it.

In Canada, in the mid 1960's, the federal government introduced legislation which gave federal money to any province with a medical care program which fulfilled certain conditions. Any province without such a program would get no such federal assistance.

No provincial government could afford to have its citizens without a medical care program since, in that event, they would be subsidizing, through federal taxes, those provinces which did. There was, therefore almost indecent haste to introduce a program - the cost factor had been reduced and the provincial politicans just could not afford to debate the subject if they wanted to keep their constituents' votes. Private industry fought back but could not prevail against the "gift" of federal money.

The next part of my remarks, reviews, in general, the history of the development of the Canadian program. The growth and development of national health insurance in Canada spans a period of 30 years which began just after the end of the Second World War.

It will be easier to understand what happened if two facts are remembered. Each of these was critical, both to the way in which national health insurance developed in Canada and also to the form it took when it was developed. These two facts are, first, that the constitutional responsibility for health care in Canada rests with the provinces. Second, that the major capacity to raise money in Canada through taxes or other means rests with the federal government.

As a result, although there were some forms of health insurance programs in existence in some provinces prior to the introduction of the major national health insurance program, the real impetus for setting up these programs only came when the federal government offered grants or a share of the cost to the provinces.

In 1945, the federal government did make such a proposal of financial aid to the provinces with provisions relating to hospital and medical care. Agreement could not then be reached but it was clear that the federal government regarded health care as a major priority.

There were two major steps which led to the present national health insurance program in Canada. In 1958, the federal government, by means of the Hospital Insurance Act, offered to pay 50% of the costs to those provinces who would provide hospital and diagnostic services to all residents on uniform terms and conditions laid down by the federal government. If a province wanted the federal money they had to set up a hospital insurance plan on the terms set by the federal government. Thus, while each province could have developed its own health insurance program and we could have a completely different one for each, the federal government, by attaching conditions to its cost-sharing, influenced quite heavily the form these provincial programs took.

The federal government's conditions for cost-sharing embodied three basic principles. The first was comprehensiveness. This meant that all required services had to be covered without any dollar limits or significant exclusions. The second was universality. This meant that at least 95% of the population had to be covered on uniform terms and conditions. The third was portability. This meant that benefits had to continue to be available when an insured person was temporarily out of the province, changing jobs, retiring, and so on. Within a year of the federal government's offer of financial assistance, all provinces except Quebec had set up hospital insurance plans that qualified. Quebec set up its plan at the beginning of 1961.

The second major step took place in 1968 when the federal government's Medical Care Act took effect. This legislation did for physician services what the earlier Hospital Insurance Act had done for hospital care. The federal government offered to pay 50% of the cost to those provinces providing medical services to all their residents on uniform terms and conditions, again, laid down by the federal overnment. British Columbia and Saskatchewan qualified on July 1, 1968 and the last province, Quebec, finally introduced their plan on January 1, 1971.

Both the Hospital Insurance Act and the Medical Care Act had an impact on the pattern of health services which later evolved. Both emphasize high cost services,and the provision of hospital and physician services on a so called free basis brought about an inevitable increase in the demand for them.

In addition to hospital and medical care coverage, several provinces have introduced other programs without federal government aid. For example, several provinces now provide dental services for school age children. Others provide residents over age 65 with dental services and assistance in the purchase of prescription drugs.

A major concern about the national health insurance program in Canada has been rising costs. By using its power to raise money and distribute it to participating provinces, the federal government had managed to introduce an almost uniform national health insurance program in Canada. But once in place, the federal government had no control over the cost since they were committed to pay 50% of whatever the provinces spent on covered services. As a result, the federal government decided to turn over full responsibilities for the costs of these programs to the provinces. Beginning 1977, the federal government transferred to the provinces some income taxing capacity and,in return, the original 50% cost-sharing arrangements were abandoned.

Future expansion of the present national health insurance programs in Canada seem unlikely in view of the concerns about the cost of the existing programs. There has been talk of more extensive dental coverage but that is all it will likely be unless and until the federal government decides that it is a high priority item and offers financial assistance to the provinces. In view of their past experience and under present economic conditions, there seems very little likelihood of federal interest in any kind of denticare program for the foreseeable future.

Finally, some comments on how the present arrangements are working. Although now removed from its cost-sharing responsibilities for the national

health insurance programs, the federal government still feels some responsibility in this area.

During the brief tenure of the Conservative federal government in 1979, they called on Mr. Justice Emmett Hall, Chairman of the Royal Commission that had laid down the groundwork for the medical care programs in Canada during the mid 1960's, to find out just how the national health insurance programs in Canada are working out.

His studies are not yet finished but this much seems clear. Canadians, in general, are satisfied with their health service. Whatever else he concludes, Mr. Justice Hall will not be calling for the dismantling of Canada's national health insurance programs.

His report will undoubtedly highlight the areas of major concern to Canadians. Some of these concerns are predictable and would be concerns under any system. Here are some examples:

Provincial governments are not spending enough to meet rising health care costs. In other words, the adequacy of the health insurance system is being questioned.

Doctors are complaining that their fees are not rising as quickly as their expenses. As a result, many are now over-billing their patients by as much as 30% or more of the approved schedule of fees.

Most provinces prohibit private insurance from covering the excess charges of doctors but do allow insurance of hospital care beyond the standard ward level. Any significant spreading of the practice of doctors over-billing their patients strikes at one of the cornerstones on which Canada's national health insurance programs were built - that is the removal of financial barriers to universal access to health care.

There are concerns that an increasing number of doctors are opting out of the system and that some doctors are leaving Canada. This raises fears that perhaps all the people will not have equal access to health care and that the number of doctors will soon be inadequate to meet the needs.

I am sure that you will recognize, in at least a couple of these complaints, the very reasons which were advanced for getting government into national health insurance programs in the first place. The more things change, the more they stay the same. But these are areas of continuing concern. In other words, it is questionable if a perfect solution can ever be found.

The introduction to a booklet put out by the Ontario Government begins - "Because the Ontario Health Insurance Plan works so smoothly in the province, many residents have almost forgotten what a doctor's bill or a hospital bill looks like." Although possibly an exaggeration of the true situation, it is perhaps the point to be remembered when listening to criticism of Canada's national health insurance program.

Canadians do have a comprehensive national hospital and medical insurance program in place -- it does work and generally speaking, Canadians are reasonably satisfied with it.

MR. ROLLERSON: Our second panelist is David Stouffer, Dave graduated from the University of Toronto in mathematics in 1964 and is an Associate of the Society. After spending some time in the Individual Actuarial Department of the Excelsior Life Insurance Company in Toronto, he was hired by the Province of Ontario. Until 1979, he served as Senior Actuary, Actuarial Services for the Province and is presently Senior Budget Advisor, Taxation and Fiscal Policy in the Ontario Ministry of Treasury and Economics. He serves as a representative for the Province of Ontario on the committee examining the financing of the Canada Pension Plan and is responsible for provincial policy on matters connected with public and private pensions and social security systems. Dave's remarks will reflect the view point of a government actuary concerned about budget as well as the problems of keeping both the providers of services and users of services in the health care plan satisfied.

MR. DAVID A. STOUFFER: I have been asked to speak to you today on current problems of a National Health Insurance Plan from the point of view of a government actuary concerned about the budget as well as the problem of keeping both the providers of service and users satisfied. Although my remarks will be limited to a discussion of Ontario's plan, I believe they will be general enough to apply to a national system. I should point out that in Canada, each of the Provinces runs its own health insurance scheme and that there are differences between the plans, particularly in the area of financing. Although I will be discussing only the problems with the system, it is important to remember that from the point of view of the user, the Ontario Health Insurance Plan (O.H.I.P.) has been a remarkable success.

My comments examine the problems of a National Plan under three broad areas prefaced by a brief summary of the O.H.I.P. system:

1. Financing.

2. Problems on the demand for services side.

3. Problems on the supply side.

I would point out that, although I am an actuary by background, my approach to the subject is not a traditional actuarial one which is concerned with matters of insurance principles and equity in a broad sense. Rather my comments reflect my orientation toward problems of government finance and the framework of political realities within which I must work. Finally, these remarks are my own and should not be construed as setting out policy positions of the Ontario government.

Now for a brief summary of the O.H.I.P. system. Various services of course are covered, but under medical services basically all physician services in office, home and hospital are covered. In addition, with certain limitations, the service of optometrist, chiropractors, osteopaths and podiatrists are covered. The cost of ambulance services above $20 is covered. Then we have a drug program under which prescription drugs for persons over the age of 65 who receive the Old Age Security are free. Now that covers more than 99% of the elderly in the province. Under hospital services, O.H.I.P. provides standard ward coverage, and necessary nursing services and drugs during the period of hospitalization. In addition, ser-

vices in hospitals related to occupational therapy, physiotherapy and speech therapy are covered. Extended health care is provided for persons requiring continuous nursing services and regular medical supervision. In these cases the patient pays only a portion of the regular ward rate. Outside of the system there is an arrangement whereby if the patient can't afford it, or if the doctor recommends it, the patient can be relieved of the coinsurance. There is also a home care program covering health care services at home on a visiting basis where prescribed by a doctor. As Mr. Allison mentioned earlier, one of the requirements for the plan was that it be portable. Consequently the coverage in Ontario is extended, with certain limitations, to persons requiring services outside of the province both in Canada and in the rest of the world.

As far as financing is concerned, the program is financed through premiums and general tax revenues, as well as transfers from the federal government. Currently premiums are $20 per month and $40 per month, for single persons and families respectively. There is also a premiums assistance program for the low income person.

Now this brings me to the discussion of the problem areas. The first one of them is financing. In order to give you some idea of the magnitude of the cost of insured health services and how they have developed, consider the following facts.

In 1972-73, insured service costs amounted to $1.606 billion. This cost was financed by $520 million (32%) in premiums, $746 million from federal cost sharing (47%) and transfers from general taxation of $340 million (21%).

By 1978-79, the cost of the program had increased to $3.340 billion with premiums of $975 million (29%), and federal transfers and general revenues accounting for $2,365 million or 71% of the balance. I should point out that new federal cost sharing arrangements were introduced in 1977-78. Under this new system, funds were transferred to the provincial governments through an increased percentage of the personal income tax allocated to the Province, as well as an increased share of corporation tax. Under the system of federal transfers in effect prior to 1977-78, the Provinces received roughly 50% of their health care costs from the federal government. This system was relatively open-ended and did not provide enough incentive for the Privinces to limit the costs of their health care programs. The new system, under which an increased proportion of the personal income tax and corporation tax is transferred to the Provinces to cover costs of both the health care system and education, has created a substantially greater incentive for the Provinces to control health care costs.

You will note from the previous figures given that the premiums charged account for a declining proportion of the health care cost.

Just to provide another perspective on the cost of the program in relation to the premium income, in 1972-73, the per capita premium income was $66 and the per capita insured health expenditure was $205. By 1978-79, the per capita premium income had increased by 74% to $115 and the per capita expenditure by 93% to $395.

Of particular interest is the rapid growth in the per capita cost of health insurance, 93% in 6 years from 1972-73 to 1978-79. The C.P.I. increased in that same period by approximately 67%. Clearly, costs of health care increased dramatically faster than the C.P.I. However, as a proportion of Gross Provincial Product, the costs have moderated slightly.

In order to assess the reasons for the increase in health costs, I looked at the changes in costs for Hospital costs and Medical services separately. Unfortunately, the analysis had to be confined to the years 1970-71 to 1975-76. On a per capita basis, the cost increased from $105 in 1970-71 to $198 in 1975-76, an increase at virtually twice the rate of inflation. In that period, the volume of hospital services had not increased substantially. Consequently, the entire cost pressure has arisen from rising unit costs. The primary cause of the increase can be traced to the wage and salary bill. The number of paid hours increased only 4% by the period 1970-71 to 1975-76, but the average increase in pay per hour rose 96%.

In the case of the Medical Services, the cost trends are somewhat different. The per capita cost for medical care rose from $58 in 1970-71 to $90 in 1975-76, an increase of 55%. However, total expenditures rose by 70% from $436 million to $742 million in the same period. Unlike the hospital sector, where unit costs pushed up the total expenditure, in the medical sector it is the volume of service which drove up spending. The volume of claims increased 60% over the period.

To analyze this further, we found that the number of practitioners had increased over the period by 28% and the claims per practitioner by 26%. Utilization of medical services as well as the population of doctors appears to be the prime problem area here. In 1975, Ontario had 1 doctor per 565 population, the U.S.A. 1 per 620. The World Health Organization suggests that a rate of 1 physician per 650 population is more than adequate.

One is tempted to speculate that the presence of a national insurance plan may have the effect of creating an oversupply of physicians. This is in spite of the fact that doctors are vehemently opposed to "socialized medicine."

The figures above would suggest that, in creating the national insurance program, we have created a monster. The problem then becomes, how do you control the monster? Especially such a popular one.

Perhaps the easiest sector to control is the hospital services sector. As was found earlier, the problem of the increasing cost in this sector was not utilization, but unit costs. Individuals have a greater reluctance to enter a hospital then they have to pay a visit to their friendly doctor. In Ontario, the Ministry of Health, which supervises the budgets of hospitals, embarked on a long-term program to reduce the spiraling cost of hospital services. These actions included the elimination of surplus hospital beds, controlling the volume of lab tests, restricting capital financing and placing hospitals under tight constraints in budget financing. The actions are now being felt and have been highly effective at least from a financing point of view. However, I would point out that the closing down of hospitals met with opposition so strong in some areas that those plans had to be abandoned.

Controlling the costs on the medical services side has not been as easy. First, the individual when he visits the doctor does not seem to understand that an expenditure has been made on his behalf. Because the service appears free, he is inclined to see a doctor for relatively minor ailments - a practice that doctors tend not to discourage.

Second, the supply of doctors is increasing. The increasing availability of physicians per patient may increase patient utilization. This problem is exacerbated by the fact that the price mechanisms which enter the usual supply and demand equation have been eliminated. These factors are probably the most direct and indirect contributors to increasing utilization. The supply of Ontario graduates is currently sufficient to maintain the population of physicians. However, there is a substantial immigration of doctors and it is impractical to limit immigration entirely.

Attempts have been made to limit the growth in physicians' fees. For example, as a first attempt, the Ontario Medical Association, whose fee schedule was used until 1978 to establish the amount of reimbursement, was asked to limit its fee schedule increase in 1976 to 8.1%. Later in 1978, the Province abandoned the O.M.A. schedule and developed a reimbursement schedule of its own, independent of the O.M.A. Physicians who accept the level of O.H.I.P. and do not bill their patients are called opted-in doctors. The others (opted-outs) bill their patients directly and the patient receives a cheque from O.H.I.P. based on the O.H.I.P. fee schedule.

Initially, the move was successful as far as limiting costs under the plan. However, an increasing number of doctors decided to opt out until currently about 17% of physicians in Ontario are in this category. The result has been that, as the difference between the fees of opted-out and opted-in doctors increased, the opted-out doctors could earn a higher level of income even on a reduced patient load. If the trend to opting-out should escalate, the O.H.I.P. system will either be forced to adopt higher fee schedules to lure physicians back into the plan, or become progressively ineffective in its attempt to provide comprehensive medical service coverage. The patients who have been using a physician who has decided to opt out are faced with out of pocket costs of perhaps 25% of the fee charged. Further, these persons do not have access to private insurance coverage. One can say, Tough luck, see an opted-in physician." The selection of a doctor, however, is a highly personal matter.

There are other cost control mechanisms that might be considered to limit utilization.

For example, patient participation or utilization fees could be instituted (e.g. patient pays $2.00 cash for an office visit). Other jurisdictions have experimented with the approach and found that it is not a satisfactory curb to consumer demand. The problem is that to be effective, the utilization fee must be fairly high. However, if they are too high, they may deter the patient from seeking necessary help and be prohibitive for the poorer patient.

A second approach is to attempt to control physicians' generated utilization with regard to particular items. This is not feasible due to the multiplicity of items in the schedule and the variety of ways physicians can circumvent the government mandated actions.

With so many services covered, it would be difficult to see how there could be problems from the user point of view. However, there are.

Prior to the introduction of the Ontario Medical Services Plan, many persons were covered under private medical insurance plans. These plans in many cases provided a higher level of coverage than the 90% offered by the Ontario plan. With the introduction of the national plan, private insurance to cover the difference between the bill rendered and the portion paid by O.H.I.P. was made illegal. Currently, since many doctors have opted-out of the O.H.I.P. system, and since the fee paid by O.H.I.P. is now substantially below the Ontario Medical Association fee, persons who see an opted-out physician can be faced with substantial medical bills for which no insurance coverage exists.

Several solutions are possible. First, the levels of fees paid doctors could be increased so that fewer physicians would opt out. This could be costly and would likely attract even more doctors to Ontario.

A second approach could be to allow private insurance to cover the difference between the fee paid by Ontario and the fee charged by the doctor. This would undoubtedly result in even more doctors opting-out of the system and consequently prove a hardship for persons without the second level of coverage.

I have already discussed the high cost of the program and the difficulties with controlling those costs in the first section. Perhaps one of the more difficult non-financial problems is the doctors' aversion to socialized medicine. Each practitioner wants to be the master in his own house, and somehow the presence of a large national system creates an uneasiness among practitioners. I think that Ontario has coped reasonably well with this problem even though opted-out physicians form 17% of the population. It should be noted however, that many in this group do not charge above the O.H.I.P. fee schedule.

A second problem centres around the covered services. There is pressure from some sources for a drug program.

Finally, although the system is coping well at the present time, there are pressures created outside of the system which may have an impact on the program's ability to cope in the future. Of primary concern is the spectre of Canada's aging population. As the population ages, there is an increasing demand for medical services and hospital care. Undoubtedly, this effect will place a tremendous strain on the system in terms of capital requirements for increased facilities in future years.

MR. ROLLERSON: Our final panelist is David Robbins. Dave is not an actuary but many of you who have had contact with the Health Insurance Association of America in recent years will have met him. He has been a member of the HIAA staff since its organization in 1955. He joined the association as a statistician and is now Vice-President and Controller. In that capacity he is responsible for the association's actuarial research and financial activities. Prior to joining HIAA Mr. Robbins served with the Department of Health Education and Welfare in Washington D.C. and with the New York State Health Department in Albany, New York. Dave is going to report to us on the proposals and prospects for national health insurance in the United States.

MR. DAVID ROBBINS: National health insurance has been debated in the United States for more than four decades. Prior to the enactment of our Social Security program in the late 1930's, President Roosevelt was advised to include payment for medical expenses as part of the program. He rejected this advice although private health insurance was then practically non-existent.

In the late 1940's, during the Truman Administration, the issue re-emerged. Although strong efforts were made by the Administration at that time to enact such a program, it was defeated despite the fact that only about two-fifths of the population were privately insured for health care expenses.

In the late 1950's, there was a new debate. This time, national health insurance proponents advocated that coverage be extended to only Social Security beneficiaries at ages 65 and over. There ensued 10 years of discussions which culminated with the enactment of the Medicare and Medicaid programs in 1965. In that year, some 80% of our population had private health insurance but only 50% of the aged were insured.

Spurred in large measure by the enactment of the Medicare and Medicaid programs, a major escalation in health care costs and expenditures in the late 1960's and 1970's occurred which sparked a new debate on the advisability and feasibility of a national health insurance program. Two significant developments during these last 15 years are worthy of note. First, unlike the earlier debates, all parties of interest have been generally in agreement that there is a need for some kind of a national health insurance program in the United States. Still at issue is the nature of the program to be enacted. The major remaining point of debate focuses on how the program should be administered and financed. One group insists that both the financing and administration of national health insurance should be in the hands of the federal government. Most others feel that both the financing as well as the administration should be jointly undertaken by the government and the private sector. The debate in recent years has taken place during a period when authorities such as the Congressional Budget Office estimate that all but five to eight percent of the United States population is covered for health care costs under either private or governmental programs.

The second development worthy of note during the last decade and a half is that, in many ways, this country through various laws that have been enacted already has a national health program. Along with the Medicare program for the aged and disabled, the Medicaid program for the poor and government programs for service personnel, their dependents, American Indians, etc., we have legislation which calls for appropriate planning of health care facilities and health manpower, for the encouragement of alternative health care delivery systems such as HMOs, and for the review of the appropriateness of care rendered to Medicare and Medicaid patients.

Now there are three major national health insurance proposals under consideration by the United States Congress: The National Health Plan Act (S. 1812 and H.R. 5400) introduced by Senator Ribicoff and Representative Rangel on behalf of the Carter Administration; the Health Care for All Americans Act (S. 1720 and H.R. 5191) introduced by Senator Kennedy and Representative Waxman; and a catastrophic health insurance proposal cur-

rently being considered by the Finance Committee of the United States Senate. I will describe the essential features of each of these proposals and how each, if enacted, might impact on the health insurance business. I will then describe the essential features of a national health proposal which is supported by the private health insurance business and, finally, provide an educated guess as to the prospects for enactment of any proposal in the immediate future.

The National Health Plan Act is the Carter Administration bill. It would require employers to provide all full-time employees and their dependents with health benefits coverage meeting uniform federal standards. It would also establish a separate governmental mechanism called "HealthCare" which would provide coverage for the aged, blind, disabled, and low income population (replacing Medicare and much of Medicaid) and also provide an option for individuals and employers who are "unable to obtain private coverage at reasonable rates" to buy government insurance at subsidized rates. A federal fund would be established to make reinsurance available to HMOs and self-insured plans and to provide funds for a federal insolvency program.

We believe that the implementation of "HealthCare" would place the federal government in direct competition with the private insurance industry for group and individual coverages meeting federal minimum standards. The government's program would enjoy a partial federal general revenue subsidy with premium payments designed to cover only the claim costs for the coverage. Further, the claim costs for pregnancy and infant care coverage would be paid for entirely out of federal general revenues. It is quite clear, therefore, that "HealthCare" would ultimately absorb the vast majority of the present individual health insurance market.

The proposal requires employers to provide their employees with a plan of health benefits meeting federal minimum standards. Employers of any size would also be allowed to buy such benefits from "HealthCare". As with the individual coverage, the economic incentive for employers to enroll in "HealthCare" is very strong.

The "HealthCare" reimbursement methodology further skews the system toward a wholly governmental program. All health care providers, as a condition for federal certification, would have to agree not to charge "HealthCare" enrollees more than "HealthCare" pays. Private qualified health plans must pay at least what "HealthCare" pays, but providers are free to charge them more than this amount.

There are many other undesirable features of the Administration's proposal including a significant increase in federal regulatory authority, the creation of an unnecessary federal reinsurance fund which would encourage self-insured plans, and a serious infringement upon state regulation of health care and health insurance.

Senator Kennedy's bill would provide universal coverage for comprehensive health benefits either through individual purchase, an employment based plan or status as a government beneficiary or recipient. A National Health Board would administer the program. The Board would establish a national health budget, a national community rated premium and a national premium rate. At the state level, State Health Boards would negotiate

prospective state budgets with institutional providers and fee schedules and other payment mechanisms with physicians and other health professionals. To participate in the national health insurance program, a private insurer, Blue Cross plan, HMO, or employer self-insured plan would be required to belong to a consortium or organization of its type. The program would be financed through income related premiums, Medicare payroll taxes and premiums, state payment for the poor, and federal general revenues. Increases in the national health budget established by the National Health Board would be limited to the rate of increase in the gross national product.

Everyone in the country would have the option of choosing either a service plan, a private insurance company, a group practice arrangement, or a self-insured plan. The aged and the disabled would continue to be covered under Medicare. The premiums for employed groups would be related to income and employers would be required to pay at least 65% of the wage related premium for his employees with payments made to the applicable consortium. The consortium would pay insurers "capitation amounts" adjusted for area, age, sex, disability status and "other relevant factors" of those insured. These adjustments would be made to eliminate any financial incentive for risk selection or experience rating "or otherwise to prevent attainment of the objectives of this Act." There would be negotiated fee schedules for individual practitioners and payments to institutional providers would be based on prospective budgets negotiated by State Health Boards and such providers.

This proposal is essentially a scheme to finance federally mandated health benefits through off-budget taxes (referred to as "premiums" related to wages and non-wage income). The "meaningful role" for insurers is the role of a highly visible, but virtually powerless intermediary between potentially uncontrollable health care costs and an almost omnipotent federal bureaucracy. Insurers would have minimal discretion regarding the conduct of their business and would become little more than instruments for the implementation of federal policy. The ability to conduct business would be revocable under highly subjective criteria. The bill imposes complete federal control of the health care system, a cumbersome national health budgeting process, government negotiated budgets for institutional providers of care and fee schedules for non-institutional providers.

Virtually every detail of the program would be subject to regulations to be promulgated by the National Health Board. The bureaucratic infrastructure would be immense. Under the National Health Board would be at least ten sub-agencies. There would be 57 State Health Boards, each with at least three sub-agencies. There would be five consortia. State Insurance departments would continue although their relationship to the State Halth Boards is unspecified.

The bill's concept of competition is unusual. It assumes an ability to compete on price, although every possible government pressure is brought to bear to depress the level of premiums at the outset. The ability to compete in benefit design beyond the broad range of basic benefits and within the total health budget would be very limited. Risk selection and experience rating is expressly prohibited. Claim procedures, marketing and customer service would be standardized by the consortia.

By eliminating patient cost-sharing, the bill would remove reasonable constraints on consumer demand and stimulate utilization thereby driving up costs. Moreover, by eliminating experience rating and competition among carriers, it would remove the incentive which now motivates employers and insurers to develop better cost control measures.

During the past year, the Senate Finance Committee, chaired by Senator Russell Long, has tentatively approved elements of an employer-based catastrophic health insurance program for employees and their dependents. The Committee has also agreed to changes in the Medicare program that would provide the aged with catastrophic coverage as well.

Some of the elements of the proposal that have been tentatively adopted by the Committee include the following:

1. All employers with at least one full-time employee would be encouraged to provide and contribute financially toward the cost of a catastrophic health insurance plan. The plan would use a single, fixed amount of $3,500 as the catastrophic maximum personal liability threshhold. Individuals and families could choose to pay the out-of-pocket threshhold amount from personal funds or could insure against part or all of the $3,500 liability.

2. Covered services would include, at a minimum, at least those types of services presently covered under the Medicare program.

3. Persons employed for at least one year would continue to be covered for up to 90 days after leaving employment. Dependent coverage would continue for up to one year following death, divorce or legal separation.

4. The catastrophic deductible would be indexed for inflation, that is, adjusted from time to time to reflect increases in prices and utilization of covered health services.

5. Workers whose family incomes were less than $14,000 annually would be entitled to catastrophic coverage after their non-covered expenses exceeded 25% of such income.

6. Employers would be required to pay at least 75% of the premium cost.

7. There would be subsidies in the form of a tax credit for employers whose payroll costs increased by more than 2% because of establishing catastrophic health insurance plans.

8. All qualified insurers and self-insured employers would be required to participate in pools as a residual source of catastrophic health insurance for individuals and small firms who elect that source of protection. Premiums for coverage provided through such residual pools could not exceed 150% of the average premium charged small employers' groups.

9. The Medicare program would pay 100% of the costs of all covered services after a beneficiary incurred out-of-pocket expenses for copayments and deductibles of $1,000 annually. Medicare would also cover

the costs of certain maintenance outpatient prescription drugs for the treatment of chronic conditions of beneficiaries who reach the $1,000 catastrophic expense limit.

The private health insurance business has been providing technical assistance with respect to this proposal at the request of the Senate Finance Committee and its staff. Until such time as this bill is finally written and reported out of the Committee, our business cannot take a position with respect to it. It is encouraging, however, to note that the program, unlike the other two which I have described, is essentially a private sector proposal which would utilize, to the fullest, the private health insurance business.

With respect to the prospects for enactment of national health insurance let me say, at the outset, that 1980 is an election year in the United States and during such a year strange things can happen. Despite this caveat, however, I do not personally feel that any major legislation with respect to national health insurance will be enacted either this year or in the immediate future. To begin with, we have observed no compelling interest in the enactment of any kind of a broad comprehensive health insurance program. Poll after poll indicates that the demand for such a program is well down on the list of issues which concern the public. If there is any strong sentiment and concern on the part of people, it is with respect to the possibility of bankruptcy due to catastrophic episodes of ill health. It is conceivable that the Congress might wish to respond to such concerns and, if so, something along the lines of the program currently being considered by the Senate Finance Committee might move forward.

A second major deterrent to the enactment of any kind of a comprehensive program in the near future is the present double digit inflation being experienced by the United States. The public's concern with the effect of such inflation has, in recent months, caused the federal government to take strong efforts towards balancing the budget and reducing federal expenditures. Thus, there is little likelihood that the Congress would consider any new massive federal program, particularly one where the private sector has already solved most of the problem "off the federal budget".

During the 1950's and 1960's, the insurance business opposed the enactment of Medicare and other forms of national health insurance. It felt that such programs would be a foot in the door toward the eventual demise of our business. The fact that the overwhelming majority of the population below age 65 has chosen to purchase private health insurance clearly demonstrates that private health insurance has found public acceptability.

In 1969, however, after an exhaustive review of this country's health care system, our industry re-examined its long-standing policy in opposition to any form of national health insurance. We concluded that our business, by itself, could not solve the need for financial coverage against health care costs for all Americans. We realized that such financial security could only be obtained by a combined effort on the part of both the government and the private sector. Accordingly, for some 10 years thereafter, we supported a proposal for national health insurance introduced in the Senate by the then Senator McIntyre of New Hampshire and Congressman Burleson of Texas as the "National Health Care Act".

For the past year, in conjunction with our periodic review of policy, we have advocated a fresh approach. We call this approach "Building Blocks". Our current proposal identifies where the American people now are and where we eventually want to be in terms of universal health insurance coverage. We seek to move from where we are now to where we hope to be by building upon the present system and filling in the gaps in that system, one block at a time. It is built upon the following principles:

1. Every American should ultimately have broad comprehensive health insurance coverage of a major medical type with high maximum benefits and some reasonable annual limit on out-of-pocket payments for coinsurance and deductibles. The comprehensive coverage should be gradually phased in based on the availability of adequate financing. The first phase representing a major step forward could be the provision of catastrophic health insurance benefits.

2. The proposal should build on the present system of private and governmental health insurance coverage which currently provides protection to over 90% of the U.S. population.

3. Government financing should provide benefits for the poor and the elderly and private insurance premiums should provide insurance for everyone else.

4. No family should have to spend more than a reasonable amount of its income in excess of the poverty limit for private health insurance premiums. Thus, there should be some government subsidization of the premiums for those families considered to be "near poor".

5. There should be a minimum standard of benefits for persons covered by private plans.

6. All plans should include deductibles and coinsurance, although these devices should be flexible based on ability to pay.

To meet the needs of those who are unprotected or underprotected, we make the following recommendations:

a) Reform the Medicaid program by broadening benefits and extending eligibility to all of the poor.

b) Provide government subsidization of health insurance premiums to cover the long-term unemployed and the working poor, i.e., the near poor.

c) Continue private health insurance to cover the temporarily unemployed. For example, require employers to continue coverage for ex-employees for three months or until the employee finds a new job, if sooner.

d) Broaden dependents' definitions to assure continuation of coverage for widowed and divorced.

e) Establish residual market mechanisms (insurer pools) that would guarantee the availability of adequate health insurance to all.

f) Stimulate the improvement of private sector benefits through a series of tax incentives and subsidies.

To summarize and conclude, there are three major national health insurance proposals now before the Congress. Two of these, those proposed by the Carter Administration and Senator Kennedy, would, if enacted, be highly detrimental to the country and to the private health insurance business. The third proposal, Senator Long's, calling for a private sector catastrophic health insurance program, has many elements worthy of support. In my opinion, there is little likelihood for the enactment of any program for the immediate foreseeable future, although anything can happen during an election year.

The private health insurance business has a positive program. We support the enactment of a national health program which seeks to fill in the gaps with respect to the uninsureds and underinsureds in our country. Under our proposal, the private sector would administer and finance programs for most of the population. The government's role would and should be confined to taking care of those people who are financially unable to take care of themselves.

MR. RICHARD R. GREER: I would like to ask Mr. Robbins if Senator Long's proposal contains any provision with respect to cost containment and cost control. If not, are there other proposals in Congress that would address the question of cutting down the cost of health care or trying to control it that would complement Senator Long's proposal?

MR. ROBBINS: The Senate Finance Committee has not yet addressed the question of costs or what kind of cost containment items they might include in the Bill. However, they have discussed a few ideas in open session. One of them that they are quite intrigued with is the concept of offering the employees a choice between a high option plan and a low option plan and allow the employee to keep the difference between the cost of those two options. They think that this might conceivably lead to reduction in health care expenditures because they believe that the existence of extensive coverage where people are not required to pay the money out of pocket makes them unaware of the actual costs. If they had this low option plan and were faced with paying bills out of their own pockets this may reduce costs.

MR. ROBERT MURPHY: Has the national health insurance program in Canada caused increased costs over and above inflation? Also do you have a comparison between Canada and U.S. with respect to health care costs as a percentage of Gross National Product?

MR. ALLISON: One of the purposes of national health insurance is to give access to health care to everybody in the population. Therefore when a program goes in you would expect costs to increase faster because theoretically all of the population now has access whereas before only those who could afford it had access to health care.

MR. STOUFFER: I have some figures for Canada as a percentage of gross national product, Ontario as a percentage of gross provincial product, and comparable figures for the U.S. This is only for the year 1973. In Canada health expenditures were 6.8% of Gross National Product. The com-

parable number in the U.S. was 7.7%. However for 1980-81 we are looking at something under 7% for our total health care costs, as a percentage of Gross Provincial Product. Therefore it does not appear that the expenditure is getting out of hand. As far as growth in the system goes, up until 1977 when there was the open ended federal cost sharing arrangement, we found that there was a disincentive for the provinces to hold the line. With the different tax allocations that came in in 1977-78 health expenditures have not grown particularly rapidly; certainly not as fast as they were going before and not more rapidly than the gross provincial product. So there seems to be the ability of government to control the cost to an extent.

MR. MICHAEL HAFEMAN: I was wondering what impact the national health insurance system in Canada has had on the medical malpractice situation.

MR. STOUFFER: We have had a few medical malpractice situations, but not as severe as the U.S., primarily because the legal profession does not charge a percentage of the settlement.

Incidentally that is one of the great deterrents for Canadian doctors who wish to come to the U.S. We find the average doctor's insurance costs for malpractice suits in the U.S. is not too far from 2/3 of our average doctor's salary.