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NATIONAL HEALTH INSURANCE— CANADIAN EXPERIENCE/UNITED STATES POTENTIAL

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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. PETER A. ROBINSON: We will now begin Concurrent Session O on National Health Insurance. My name is Peter Robinson, I will be your moderator for this session. I'm pleased to have three very capable panelists with me today who have extensive experience with health insurance. Mr. Doug Lee will give the first presentation on the Canadian experience with medical care. Doug has 25 years of experience with pensions and group insurance in Canada. Mr. Gordon Trapnell will review recent U.S. developments and current proposals. Gordon has been in the insurance business for about 25 years. Gordon has worked very closely with the government on proposals for national health insurance and he has supplied the official cost estimates for the last three administrations. Mr. Ed Wojcik will comment on the ramifications for the insurance industry of recent developments. Ed originally worked for 12 years in the group insurance industry and has spent the last 11 years with Blue Cross and Blue Shield Associations in Chicago.

MR. H. DOUGLAS LEE: This morning, I will try to give you a very brief outline of the history of national health insurance in Canada, identification and discussion of some of the problems which are emerging, and a commentary on what we might expect to see in the future.

I do not intend to provide a detailed history of national health care in Canada, since it has been done very ably at concurrent sessions at our annual meetings in 1975 and 1979. I intend to provide the background or development of our Medicare system only insofar as it is relevant to our understanding of the current program and ensuing problems.

In Canada, we do not have a national health care program if by "national" you mean a universal, consistent program from province to province, but rather a health care program in each province which varies from province to province. There is a universality of coverage in that an individual travelling from one province to another is covered for out-of-province hospital and medical costs as provided in accordance with the provisions of his own provincial plan. In Canada, health care falls under provincial jurisdiction. Having said that it is a provincial responsibility, it is

rather ironic that Canada was launched into a health care program care program by our Federal government.

During the Second World War our Federal government greatly expanded its ability to tax, and as a result of this taxing authority it assumed significant power over not only national issues but also provincial issues. The Federal government decided in the mid-forties that they should promote the establishment of a national health care program by means of grants to provinces. In 1948, the Federal government embarked upon a major hospital construction grant program which had contributed to the cost of over eighty percent of all hospital beds in Canada when this program ended twenty-two years later. In 1957, the Federal government also offered a cost-sharing approach under which the provinces could establish a hospital insurance program and the Federal government would contribute approximately one-half of the cost. By 1961 all the provinces had accepted this cost-sharing program which covered the cost of hospital care at standard ward level. The private carriers were excluded from this field, except for insuring the additional cost of private or semi-private coverage.

With the hospital care program running smoothly the next phase of the program was to examine medical care. It's somewhat ironic but in 1960 the Canadian Medical Association requested the Federal government study the adequacy of medical personnel and facilities, and other problems associated with the delivery of health services. Our Federal government eagerly accepted this challenge and appointed the Royal Commission on Health Services in 1961 (known as the Hall Commission) to carry out a complete assessment of the provision of health services in Canada. One of our provinces, Saskatchewan, proceeded in 1962, prior to the report of the Hall Commission, to initiate a government-sponsored medical care insurance which featured pre-payment, universal coverage, and public administration. The Canadian health insurance industry during the early sixties was not sitting by idly, but rather was actively working to provide alternatives to the federal government, in the form of a submission to the Royal Commission, as well as working with the various provinces. In 1963, the province of Alberta had implemented a plan, in co-operation with the insurance industry, which provided for medical care in the province of Alberta. The insurance companies were also working in 1965 toward using the Alberta model in Ontario but the public reaction was so strong in Ontario against the use of private carriers in lieu of public insurance and over the insurance industry's proposed scale of premium rates that the Ontario government rejected the insurance industry proposal and implemented a compromise which had certain larger companies providing administrative services only. This rejection of the insurance industry was strongly supported by the Royal Commission which published its report in July 1964, and recommended the extension of the existing system of Federal cost-sharing and rejection of the continuation of existing, voluntary health insurance programs. With that encouragement the Federal government passed in December, 1966, the medicare act under which the Federal government agreed to pay half the cost of all eligible medicare programs commencing July 1, 1968.

In order to be eligible for the grants, the provincial plan had to provide the following:

1. Cover all types of physician services which are medically required,

2. Available to all residents on equal terms and conditions,

3. Provide out-of-province coverage, and

4. On a non-profit basis managed by a public agency.

The Federal government made our provinces an offer they couldn't refuse, with the result that:

- Alberta abandoned its joint government/private insurer plan;

- Ontario decided to switch from the private carriers providing the administrative services only to a public administration;

- By 1971, all provinces had accepted the federal government's program of state-operated health care; and

- Our medical profession regretted asking for a study on the adequacy of our health care delivery system.

At this point in time, 1971, we had essentially a national system of health care insurance administered by the provinces and shared equally between the province and the Federal government as to cost. It soon became apparent to our Federal government that they were in the position of paying half the cost but had no control as to the level of services provided or the cost of services. Some of the less expensive services which were not covered by medicare were abandoned in favour of more costly services that were covered under the program. With inflation in the mid-seventies, rapidly increasing utilization of services, pressure from the doctors to increase their fees, our Federal government decided there was too much heat in the kitchen and wanted to renegotiate the cost-sharing arrangement. The provinces were really not in a position to abandon medicare so their negotiating position was not strong. The negotiations resulted in the Federal government transferring certain additional income taxing arrangements, plus some cash, to the provinces with no restriction as to how the provinces should use the money. In summary, the Federal government had successfully persuaded the provinces to embark on a program that they probably would not have undertaken without the heavy financial endücement of the Federal government and after locking the provinces into a very expensive program, our federal government decided that they didn't want to play the game anymore.

It does not take a great deal of imagination to understand that with this background we have some major problems with our provincially-run health care programs. Although there are some problems common to all provinces, others are more regional.

Clearly one of the problems is with respect to cost. The provinces are facing mounting critism as to the cost of health services programs. Since there is no limitation on utilization of services, the only alternative

the provincial government has in containing the spending on health care is to limit the amount of care that is provided. This has been done by dramatically cutting new construction costs of hospitals, strict control on hospital budgets, reducing funds for new technology and research, restraining the various provincial medical association fee schedules, and by limiting the availability, or number, of doctors through restrictive immigration practices, as well as cutting back on the construction of new medical schools. In Ontario, these costs control measures were such that they were able to relatively stablize our health care costs.

At this point, it might be of some interest to compare national health care costs as a percentage of the Gross National Product in Canada and the United States.

	HEALTH CARE COST AS A % OF GNP	
YEAR	For Canada	For U.S.
1960	5.6%	5.3%
1965	6.1	6.2
1970	7.1	7.6
1975	7.1	8.4
1976	7.1	8.6

So over 16 years Canada had moved up about 1.5% of its GNP whereas the U.S. had moved up about 3.3.

We see, therefore, that although Canadians are complaining about health care costs in Canada, the situation in the United States is also cause for concern.

In Canada, there has been strong dissatisfaction on the part of the medical profession with government interference and the inequities that have followed, with the result that in Ontario, slightly less than twenty percent of the doctors have elected to opt out of the system.

In some small towns, no doctors remain in the medicare program; in some specialties in some hospitals, no doctors remain in the Ontario Medicare program. The doctors who are opting out of the program are usually charging the Ontario Medical Association Fee Schedule, which is about thirty percent higher than what is provided by the Ontario Medicare program. Some doctors, charge low-income patients the medicare rate, but charge the regular fee to those patients who have the ability to pay.

A moment might be taken to explain what is involved when an Ontario doctor opts out of the Ontario Medicare program. Under this arrangement, if the doctor does not accept the medicare schedule, then he bills the entire fee to the patient and at the same time fills out a form in order that the Ontario government will pay the patient the medicare scheduled amount.

The province of Quebec, on the other hand, has a much stronger arrangement, whereby if a doctor decides to opt out of the Quebec Medicare

system, he must recover the entire medical fee from the patient and there is no payment to the patient or the doctor from the Quebec government for any service provided by a doctor who has elected to opt out of the plan. The result is that compared to approximately twenty percent of Ontario's fourteen thousand doctors who have elected to opt out of the system, in Quebec only about sixty doctors out of approximately thirteen thousand have elected to operate outside the provincial plan. It has been suggested that the situation in the province of Quebec is different than Ontario in that a number of French speaking doctors would be reluctant to leave the province and the Quebec government is thereby able to exert strong control over the medical profession. In Ontario, it is argued such control is not possible in that the doctors have the real option of moving to the United States or to other provinces where the two-level system is operational. However, the number of Ontario doctors who have moved to the United States over the last three years, the highest in our history, is only two to three hundred per year, out of fourteen thousand. One must question the argument. There is, however, a problem.

If you were conducting a poll of Canadian citizens on the acceptability and success of our health care program, it would show very wide acceptance of the program - essentially the people judge it to be successful. There are, however, contrary views. In 1979, a Fraser Institute Report, entitled "The Health Care Business", advocated that the medicare system should be limited to a minimum level of adequate care and argued that anything more should be covered by private health insurance. This report cites what it calls signs of the Canadian system's decline, such as paying doctors in the province of Quebec a salary, the reduction of Ontario hospital beds as a result of decisions by civil servants, and consideration of rationing health services. Professor Ake Blomqvist, a University of Western Ontario economist, who wrote the report, suggests that under his system "The rich would receive better health care than the poor," but he sees nothing wrong with that, "the rich will get better health care just as they get better housing, education and transportation. If you are an egalitarian, you should make sure that more income is transferred to low-income groups." The professor goes on to say that he does not see how his proposals will be implemented in the next ten years. There is a lot of truth in that.

Where we are going in the future is easier to ask than to answer. Our Federal government has decided to re-examine the situation and in September 1979, our Minister of Health at the federal level stated that he wanted to try and define more precisely what the basic national standards for medicare should be. And, at that time, he announced that Mr. Justice Hall, the same man who conducted the Royal Commission on Health Services fifteen years earlier, would be conducting this new study to determine if our medicare system is fulfilling its goals. Justice Hall was asked to complete this report in six months, and as of today's date, the report has not been made available to the public. If past is prologue, then clearly Justice Hall's new study may have as much impact on the national health care program in Canada as his first study did in 1964.

At the moment, the major area not covered by medicare in most of the provinces is in the field of dental care. Many of the provinces provide routine dental care for children under the age of twelve or fifteen. Clearly, this is an area that will be examined by future federal and provincial governments, but at the same moment, the high cost of medicare will discourage expansion of the program into the dental area for working

adults.

The prevalence of prescription drug coverage varies significantly from province to province. Some provinces, such as Manitoba, cover eighty percent of specified drugs in excess of $75 per year per person. Other provinces provide specified drugs for residents over sixty-five or in low-income situations, and so on. It is expected that prescription drug care will expand as funds become available.

How applicable is the Canadian experience to the U.S. potential? I think the circumstances, level of coverage, timing, style of governments, socialist tendencies, are quite different with the result that although certain problems may be similar and our experience may be helpful, the route to a national health plan in the United States will likely be different with the insurance industry playing a greater role.

MR. GORDON R. TRAPNELL: The last few years have been a very active period for national health insurance in the U.S., at least as far as the development of proposals. Let us retrace some of the most important events over the last three years.

In the summer following the election of President Carter, serious planning began at HEW for the content of an Administration-sponsored national health insurance bill. A variety of different approaches to a national plan were reviewed. These varied widely by:

- The scope of coverage, from plans that target new benefits to persons most in need to comprehensive coverage of the entire population.

- The comprehensiveness of the benefits, from hospital and physician services to broad coverage of all needed health care, including many services not traditionally insured.

- The extent of cost/sharing, from large deductibles that confine benefits to catastrophic illnesses to full payment for all services.

- The degree of volunteerism, from tax incentives to government fiat.

- The degree of reliance on the private sector.

- The approach to controlling overall expenditures, from proposals to increase competition among medical providers, to national budgeting schemes that would in effect make nearly all decisions concerning the quantity, quality and cost of services through a centralized bureaucracy.

- The type of administrative system introduced.

- The level of government responsible for administration or regulation.

- The sources of funds to finance the proposals.

- The overall cost of the proposal.

As the planning progressed, the choices narrowed to:

- A comprehensive plan, at least as the ultimate goal. All persons in the country would be eligible for a standard plan of benefits with all institutions and practitioners paid the same rates. There were two versions of this plan, one mandating the purchase of private health insurance by employees and non-aged, non-poor unemployed and one establishing an all-encompassing social insurance program.

- A plan designed to target most new benefits to specific population groups believed to be most in need: low income persons not now eligible for Medicaid, the working poor, and the aged and disabled.

- A private sector oriented "competition" approach, designed to provide incentives for consumers to reduce the cost of health services they purchase.

An intense struggle developed within the Administration among:

- Those motivated most by concern for guaranteeing all persons equal access to quality health care;

- Those concerned primarily with national, and federal, expenditures for health care and the implications of those expenditures for national economic efficiency and competitiveness; and

- Those motivated by the belief that both efficiency and equity would be served best by introducing free competition to regulate use and costs of health care.

This altercation was ultimately resolved symbolically at least, in favor of a comprehensive national approach. The ultimate plan, however, was to be "phased in" over an indefinite future period, with the early phases targeting benefits on those most in need. The internal debate shifted to the content and cost of the first phase. The same protagonists resumed the debate, shifting their positions to be within the confines of the more limited range of options feasible with the resources to be made available initially. Yielding to limits on the cost of the proposal set by the President, benefits were scaled back, the number of low income persons given free coverage reduced, the burden on employers lessened, and many other reductions in scope accepted.

At this juncture, an event of national political significance brought the national health insurance debate to the attention of the general public. After a series of public gestures toward compromise, Senator Kennedy proclaimed the Administration's plan to be inadequate in the protection provided, and despite the inadequacy of the benefits, inherently inflationary through failure to regulate and control medical costs. He unveiled a new proposal, a scaled-down version of the Health Security Bill, the comprehensive, centralized social insurance approach he had advocated for years. Important compromises were included for both insurers and medical providers. Further concessions were made in the scope of medical services

to reduce the cost of the proposal to a more realistic range. In fact, the benefit package and many other important features were nearly identical to the Administration plan. But the compulsory, centralized federal social insurance framework was retained. The new bill accumulated political significance as it became increasingly likely that Senator Kennedy would challenge the President for the nomination, as the champion of the liberal wing of the Democratic party.

The media love a good political debate, even if moot by all realistic standards. Although there appeared to be virtually no consensus concerning how the important issues should be resolved, the debate between Senator Kennedy and the Administration concerning national health insurance plans made good copy, and the issue was given a major boost through the publicity generated.

During the spring and summer of 1979, the Administration and Senator Kennedy fleshed out their approaches and drafted their bills. Perhaps influenced by the Kennedy challenge, the Administration adopted a plan that included the principal features of a national plan. All persons were eligible for at least catastrophic benefits for a uniform set of medical services. The providers of services to low income persons would be paid at the same rates as for other patients, ending the "second class" nature of these services. Medicare and Medicaid would be merged into the new national social insurance program, "Healthcare". All pregnant women and infants would be eligible for full services without cost-sharing, including preventive care services and screening for vision and dental problems. The estimated cost was at the maximum level that it was believed the President would accept.

As the debate in the media and among affected groups quickened, Senator Long announced that the Senate Finance Committee would go into executive sessions to draft a national health insurance plan.

Although attention was paid to Senator Kennedy's bill and to Dr. Entoven's "competition" approach, the real focus turned out to be on an approach very similar to the Administration bill, but with the Committee substituting for each component something they liked better. It turned out that what they liked best was the idea of providing the following:

- Catastrophic care for employed persons and their families,
- Increased benefits for the aged (some prescriptions if possible),
- Benefits for the working poor,
- Insurance pools for the unemployed - free of all federal intervention or subsidies,
- As little intervention into the affairs of insurers or health care providers as possible,
- As little compulsion of employers and employees as possible, and
- A preference for augmenting the existing Medicare and Medicaid programs rather than establishing a new social insurance program, and

- As little cost as possible, especially in 1981.

It also turned out that those sections of the bill affecting insurers and employers were very similar to the recommendations of the Health Insurance Association of America.

The hearings were resumed from time to time: e.g., mid-July 1979, October 1979, March 1980, and April 1980, and with promises of more to come. Chairman Long danced adroitly through the easy issues on which the committee members could agree. For example, agreement was reached concerning the benefits employers ought to offer their employees. The committee avoided altogether most of the tough issues, such as how much help the bill should provide to low income unemployed persons not now eligible for Medicaid, how to control costs, whether there should be any new regulations and controls, and whether anything should be mandatory.

It is very difficult to assess what Senator Long expected to achieve, and the object of the executive sessions if nothing could be agreed upon. He apparently hoped to obtain enough agreement among the Committee to at least draft a new bill, which might be voted out of the Committee and perhaps even pass the Congress if conditions were just right. A panic stricken Congress about to face an election campaign in a highly nervous state over the dissatisfaction of voters with inflation, the price of gasoline, the apparent American impotence in world affairs, and a Congress that couldn't seem to do anything about it might vote for something labeled "catastrophic health insurance" as a gesture of action. Hospital cost controls had passed the Senate under similar conditions (although many voting for it admitted they would have withheld their vote if they weren't sure the House would kill it). Passage might be feasible if the bill was not too controversial or strongly opposed by the provider and insurance lobbies.

But countless difficulties and hard choices would have to be resolved if a Committee bill was to be even drafted. There is, however, no evident possibility of a consensus concerning most of these issues. Further, a hint of favorable prospects for legislation would bring out dozens of determined and influential lobbies, each with many Congressional champions. But the Committee carefully avoided the controversial issues. For example, there are virtually no discussion of:

- How to control hospital costs, when nearly all catastrophic bills are paid 100% by Federally mandated insurance.

- Whether Medicare reasonable fees should represent full compensation to practitioners.

- Whether the employer plans should be mandatory or voluntary.

- The extent to which the country should be committed to major increases in spending for health.

In spite of this lack of attention to the hard issues, however, much of the outline of a Senate Finance Committee proposal has emerged. Some features are reasonably clear. Others, especially anything controversial, are highly speculative. Informed speculation can provide examples of the range of possibilities, however, for a proposal that would incorporate the

principal decisions made to date.

A new and interesting debate has begun in the Senate Finance Committee, although in a very low register.

Senator Long contends that without a bill or an existing program, the needs of health are never compared to, say, an equivalent expediture to build a dam, to fund an aircraft carrier, or to provide food stamps for college students and other persons not traditionaly regarded as underpriviledged (or disadvantaged, or diswhatever else is the current euphemism for those who are left behind in the U.S. economy). Only by getting a program in operation can the priority of these needs be realistically compared to the priorities of other needs and public attention focused on the nature of the choice.

Most of the rest of the committee including all the Republicans and the senior Democrats, argue that to even consider a program costing billions when the budget is unbalanced is irresponsible. The committee may be forced to cut existing programs and beneficiaries, which as a practical matter is far more difficult than failing to enact a new, controversial program. It is argued that the country will not take the Senator's concern for economy seriously if national health insurance is adopted.

Another refrain that has been frequently heard is: if we just tax alcohol and tobacco by enough to offset the Federal cost of the harm done by these products, enough revenue would be generated to start national health insurance.

Although interesting, and entertaining (Senator Long should sell tickets to his hearings and devote the proceeds to funding national health insurance) one does not get the feeling of momentum, or even of groping toward any particular resolution of the outstanding issues. A major change in the political environment would appear to be necessary to provide the impetus for actual passage of legislation. And even with widespread public support, a major change in the membership of Congress may be required, such as occurred in 1964 as a result of the Goldwater candidacy, which led directly to the passage of Medicare.

It is extremely difficult to see how a serious legislative proposal could emerge from all this. Perhaps Senator Long could obtain enough additional sufferance from his Committee to permit the drafting of a Committee bill, which then would become the next serious contender among national health insurance proposals. But when it is clear that nearly all Senators on the Committee would vote against <u>any</u> real proposal imaginable (there appears to be no consensus on a score of important issues), it is not clear what purpose would be achieved. Who remembers the Ways-Means draft bill of 1974, which reached a similar point amidst much more promising circumstances? Any progress awaits changes in public opinions that are translated into a mandate to resolve the many controversial items outstanding.

But it is worth noting that there <u>are</u> many significant matters on which the Committee members appear to be agreed. For example, there appears to be a consensus in the Committee for:

- The framework of employer plans for employees and their families, Medicare for the aged and disabled, Medicaid for the poor, and insurance pools for everyone else.

- The content of the benefit package: as defined in Medicare.

- Employer responsibility to furnish catastrophic health insurance to full-time employees.

- Maintaining the roles of state and local governments in running the Medicaid programs, but increasing the federal requirements to achieve Federal objectives.

- The establishment of state-wide pools for the "three N's" - non-aged, non-employed, non-poor - run by consortia of private insurers operating under state regulation.

- Tax subsidies to employers to lessen any tendency of health insurance requirements to reduce incentives to hire employees, especially young people.

- Subsidies or extra benefits for the working poor.

- Major underwriting and administrative roles for private insurers.

- As few new Federal controls and regulations as possible, consistent with meeting the objectives of the legislation.

- Reliance on the regulatory and administrative framework of Medicare, which represents the political status quo on the principal issues of vital importance to providers.

- A preference for voluntary participation, perhaps encouraged by tax incentives, over mandatory requirements.

There appears to be a consensus for the view of national health insurance as an evolutionary step within the framework of present Federal social insurance programs for health, rather than a revolutionary new program. I would project this tendency to become more evident if legislation is considered which it is believed has a real chance to pass.

So, where are we going? In all probability, nowhere in the near future. Perhaps national health insurance, in the form of a massive new Federal program, is an issue whose time is past. But attempts to predict political events is several orders of magnitude more difficult than the prediction of economic events. So it behooves us to continue our research to discover as many of the answers to the important technical questions as possible. We may still need this knowledge at some future date.

MR. EDWARD J. WOJCIK: National Health Insurance (NHI) has been a long standing subject of debate in Washington. More recently this debate has been focused on certain key goals or objectives for which there appears to be a consensus. These goals are that any form of NHI should:

1. Ensure universal access to quality medical care regardless of ability to pay;

2. Eliminate the risk of financial hardship which can be brought about by an occurrence of a catastrophic illness;

3. Control the rise in health care costs (this goal is presently given most serious consideration).

Despite the wide variety of proposals in existence today, each proposal attempts to achieve the above goals by variations in focus and methodology. These variations can be more precisely categorized in terms of three model approaches. These models are comprehensive, catastrophic and consumer choice, intertwined in some cases.

The Comprehensive Model provides broad basic coverage, catastrophic coverage and preventative health care. The objective of proponents for this type model is to maximize accessibility to all health care services while requiring a minimum amount of cost sharing. However, the goal to control the rise of health care costs may not be met because the very liberal benefits coupled with broad scope of covered services might exacerbate the problem of increased health care utilization and cost, which would have to be financed through increased employer and federal expenditures.

Increased health care costs would develop because of the expansion in scope and level of covered services for Medicare, Medicaid, individual and small group programs. Also without any patient financial interest, there will be a tendency to utilize more expensive services and perhaps more services in number. Finally, there is some difficulty in controlling costs while attempting to provide access and quality care. For example, is quality of care or access compromised by covering only those services which are judged to be necessary, or by postponing care for electives, or by reimbursing providers an amount less than what such providers would charge without controls while holding the insured harmless from being billed for excess amounts?

The Catastrophic Model offers an individual or family comprehensive benefits once the individual or family has surpassed a specified level of medical expenses in a year. Individuals and families could choose to pay expenses below this level from personal funds or could insure part or all of such liabilities through employment-based or individual insurance. The objective of this program is to protect individuals against financial hardship.

This model would also tend to increase health care costs because of an increased federal budget to improve Medicare benefits and by providing a subsidy for the low income population to improve access to and quality of care. In addition the federal budget would increase due to subsidies for small employers whose costs would increase above a certain percentage over current costs. The current proposals would also contribute to general price inflation through increased benefit costs for some employers, i.e. the small employers not providing major medical. This model further enhances possible increased health care costs because there is no incentive (financial interest) on the part of the individual to control costs once the (Catastrophic Medical) expense limitation triggers comprehensive coverage. This increase in costs will probably be manifested by increased utilization of services for terminal care, chronic care, mental health care and home health care with a greater emphasis on more expensive technology resources.

The Consumer Choice Model makes available to individual employees various levels and scopes of coverage (comprehensive, catastrophic, and HMO with preventive care). To obtain tax incentives, an employer would be

required to offer to his employees a minimum number of plans with different levels of coverage. The objective of this type model is to develop a more competitive lower cost health care system in which the consumer plays a larger role in the decision making process. This is assumed to be achieved by modifying health related tax incentives to both employer and employee and by increasing consumer cost sharing of health care expenses.

This model attempts to make the consumer aware of and sensitive to rising health care costs by modifying the tax structure and creating incentives for employers to offer and employees to choose coverage with cost sharing provisions. However, this model does not address the poor and unemployed sufficiently and therefore does not assure access to quality care for all. Implementation of this model prototype would have a mixed effect on cost inflation. The incentive for employees to choose less extensive coverage could lead to decreased utilization, a possible disincentive for an individual to choose the appropriate coverage. On the other side of the ledger, there could be a poor cross section by age of employees choosing extensive coverage giving rise to increased costs. Additional strain on supply of resources in some chronic and preventative areas would tend to contribute to an increase in health care costs through utilization and price effects. So what might the impact be on the health insurance industry with the implementation of a national health insurance program based on one of the aforementioned model types?

At least one proposal of the comprehensive type model would have a government run health care program competing with the private sector for coverage of all population segments. By subsidizing premium with general revenue, the government could make private coverage non-competitive. Government controls in establishing policy and standards, setting of budgets and negotiation of premium while having authority to certify insurers and financing through subsidy will act as a disincentive to provide the desired range of services by the insurer or risk becoming non-competitive on price. A Federal government voluntary reinsurance program to HMO's and self insuring employers will encourage competition which will tend to reduce volume of coverage by the traditional insurance carrier.

In addition to the above Federal government competition, insurers will have to demonstrate cost efficiency to attract accounts since each competitor receives income per contract on the same negotiated community rate. However, regulations must be carefully balanced to protect insurers from adverse selection. Insurers will have to be given the prerogative to underwrite risks more selectively in allowing enrollment under their community pool.

Poor risk groups or individuals should be provided an alternate residual pool for access to care. Use of this type relief will assist the insurer so that he doesn't attract a disproportionate amount of bad risk groups. Without a representative cross section of risk while providing cost effective services, each insurer can expect a certain amount of selection based on the quality of services provided. This concept along with the other mentioned government influences will tend to eventually lead to complete government underwriting with insurers acting only as fiscal agents as presently is done in Medicare (this might be the biggest bonanza for third party administrators).

Under the Catastrophic Models, the market would be expanded with room for product differentiation in terms of scope on basic and levels on both basic and catastrophic. Marketing strategies will have to demonstrate competitiveness in service and price for benefits that would become standardized with competitors. Government regulation (primarily in quality control of health care benefit packages) would increase by setting standards for insurers which offer qualified employment-based catastrophic insurance.

To assure access to all individuals, qualified insurers, self-insured groups and HMO's would be required to participate in residual (high risk) pools as a source for firms and individuals to elect as an option. Insurers will have to develop effective systems and operations capability in order to keep appropriate records for catastrophic by individual.

Federal regulation will be at a minimum under the Consumer Choice Model, since the key to this model is a realignment of competitive forces in the private sector with a moderate alteration in the public sector. However, if the government limits severely the extent to which insurers can compete by experience rating and risk selection, an insurer will lose his competitive edge and thereby perhaps want out of the health insurance business or will ride with it in an uncreative way. These limits on risk selection will further have to be loosened especially due to required "open seasons" in which insurers must enroll anyone who approaches them. These models contemplate significant tax law revisions for both employer and employee. The requirement that employers offer three coverage options from different carriers will encourage carrier specialization and inhibit development of coverage alternatives with possible resultant decrease in coverage volume. This type model attempts to stimulate demand for HMO's and other alternate coverage programs. This stimulates greater rate competition among carriers providing an incentive for cost controls. However, an opposite effect will be reduced for each insurer and the bargaining power of the employer reduced; both will tend to increase operating and benefit costs. Market strategies will have to focus on selling both employer and employee. Carriers will need to develop strong systems and operations capability to handle and identify contract provisions by individual rather than by group, with possible variations in cost sharing based on employee income and the eligibility screening to differentiate between programs within an account and supplements by employee.

All in all there will be a heavier burden on marketing, systems and operations resources of the carrier and more complications in account rating. Selection by individuals of different carriers and programs each year (anti- selection problem) will tend to discourage carriers from providing a wide range of variables in scope and level of coverage.

Whichever model is finally legislated, there will be some additional inflationary effect as a direct result of such legislation. Also free enterprise or competition will be stifled to the extent and degree of federal government regulation.

While it is recognized that there are inequities in our health care system, it is not clear that legislation can alone address these inequities adequately. No arrangement of a national health insurance program focusing on access to care, quality of care and control of cost of

care can attain all these goals simultaneously nor does it guarantee health. *The health care system, financial access to it and control of its* cost are important aspects of health to Americans but are limited in *influencing the health status of the population. If NHI is to have a* material effect on health, it must be developed as a part of a bigger *overall health promotion strategy. This strategy should include health* education, and and effects on health of various lifestyles, eating habits and even working habits.

MR. ROBINSON: I would like the panel to comment on the following statement: "It is too late to have a national health insurance scheme in the United States on a comprehensive universal basis. It would never be adopted due to the high costs involved and the anticipated future costs increases due to inflation, utilization and our aging population".

MR. LEE: I don't think its ever too late to introduce a national health care system because of cost. As long as a reasonable percentage of the population (be it 5, 10 or 15%) is not covered and the cost of coverage is very high, there will be a motivating factor to promote national health care.

MR. TRAPNELL: With the Federal budget procedures effectively forcing the Congress to come to grips with the cost of new programs, it's very difficult to see how a massive comprehensive program could be passed now in the United States. On the otherhand, things can change with startling rapidity. If you project all of the events that appear to be running their course in the United States economy, (the reduction in average living standards being the most prominent) and the demographic changes in the country, perhaps we should project cataclysmic changes in the political environment of the kind that could lead to a total readdressing of this issue. Of course there's always the prospect of a plan with a false cost estimate that is used as an excuse as opposed to the real basis of planning. In fact, most large social programs have been passed in the United States accompanied by artificially low cost estimates and that appears to have been the case to a limited extent in Canada as well. There is no Federal requirement for an honest cost estimate.

MR. WOJCIK: Its never too late for a national health insurance program. Impressions that were left in the last couple of years about increasing health care costs will force the Federal government to do something about a national health insurance program. I think it's going to be a piecemeal type of thing when it does occur. What they'll do is get into some kind of catastropic type of program which is not going to be very costly. They might also take care of the uninsureds. They will probably try to take care of them by either improving Medicare or Medicaid and maybe standardizing Medicaid. As far as a comprehensive program is concerned, in the short term, (and by the short term I'm really talking about maybe the next 20 years) it is almost an impossibility in my own mind that that would ever happen. The costs are too prohibitive and that in the long run it would not reach all three goals that I've mentioned, i.e. quality of care and access to it as well as cutting down costs. I don't think these three goals are ever going to be attained.

MR. KENNETH T. RANSBY: Doug, I was interested in your statistics showing the growth in health care as a percentage of GNP for the two countries. I guess just taking those statistics right off the top has led to the

conclusion that there's something in the delivery of health care services in the United States that caused that jump in the costs. What reasons do you see for that difference?

MR. LEE: I agree, there is something in those statistics that might suggest to U.S. legislators that possibly there is a way of cutting down costs. If you go back to 1960 when both countries did not have a national health insurance system the U.S. actually had a lower GNP ratio for health care costs. Since the early '70s in spite of high inflation, health care costs represented as a percentage of GNP in Canada have stayed about level, whereas in the United States they have gone from about 7.6 to 8.6%. If one wanted to present arguments of controlling costs and also maintaining a reasonably good health care delivery system you might in fact turn to Canada and say that proves a point. I don't think it actually does.

MR. TRAPNELL: I would be very leary of straight comparisons like that because of the innumerable differences in the definition of what constitutes a health service, between Canada and the United States.

For example, something like about 40% of what they count as health spending in the United States is nursing care of one form or another. It's basically residential care; the cost of taking care of people in lieu of normal living expenses is included as a health service. I don't know if that's a practice in Canada or not. But this has been the largest growth area in health care spending in the United States. Also, you should look into the denominator as well as the numerator of the ratios. Economic development has been far more rapid in Canada which is still a rapidly growing country both economically and population-wise compared to the United States which is a much more mature economy. I haven't looked at any comparisons of growth rates and GNP between the countries, and wonder if that would be borne out in GNP statistics.

MR. LEE: I shouldn't think so. I think the U.S. GNP has increased as rapidly as the Canadian GNP.

MR. KIRAN DESAI: I agree with Gord, I read somewhere that GNP differences account for the fact that the ratio has stayed stable in Canada and not the U.S. There is no real merit for health expenditure to be 8.6 or 9.6 or any such number, it is what is necessary. In countries like the U.K. where the ratio hasn't gone up the reason is partly that research and development of new hospitals (which are part of the ratio in the U.S.,) has considerably deteriorated in England. That effect won't be felt for a long time, so it may be erroneous to compare ratios from country to country without seeing the long range effect those ratios have.

MR. WOJCIK: In comparing these ratios you really have to start thinking historically as to what forces in the environment were working on these particular ratios. For instance, we came up with Medicare in late 1966 which really increased utilization and cost of the aged. I think that's one thing that would bring that ratio up considerably. Secondly, we were going through a stage in the late 1960s of unionization of people in the service category in hospitals. Where prior to that the cost of health care was very low, unionization increased wages and attributed to an increase in cost. I'm not sure if the same things were happening in Canada at the same time.