RECORD OF SOCIETY OF ACTUARIES
1987 VOL. 13 NO. 4B

HEALTH INSURANCE FOR THE UNINSURED AND UNDERINSURED

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- o State risk pools
- o Federal catastrophic coverage
- o Mandated minimum health benefit coverage

MR. HOWARD J. BOLNICK: This issue of the uninsured and underinsured really is a challenge to a lot of people. It is a challenge to society from the perspective of how you can have all these people with no insurance coverage in such a rich society. It is a challenge to employers because people say the employment-based insurance model that we've put together over the last few decades doesn't work all the time and that we've got to force it to work better.

This leads to legislative proposals for employers to be more forthcoming with benefits. I think for our purposes it's important to focus on how challenging this is to us as an industry.

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I'd like to refer to an article from the fall 1986 *Inquiry* entitled "Ethics in the New Insurance Market." This article was written by Lynn Ethridge, who was in the Carter administration and has since become a consultant and done a lot of work in health care. He talks about high expense populations and says that a major concern with health insurance competition is for the welfare of persons with consistently high medical costs whose expenses are now subsidized by healthier individuals as part of various group insurance plans. As a competitive market offers healthy persons less expensive coverage, higher cost persons could be isolated from mainstream insurance protection and join the ranks of the uninsured. Our society has two basic ways of dealing with situations in which self-serving economic behavior produces socially undesirable results. The first approach, preferable in a pluralistic society, is for individuals to recognize the need for socially responsible and ethical decisions and to govern their own actions accordingly. The second approach is for government to intervene to regulate the private market to change its financial incentives so that good business becomes good social policy or to establish new government programs that partly replace the private market. I think that covers the essence of the challenges we have before us today. I'd like to introduce Dr. Stephen Long, who is deputy assistant director of the Congressional Budget Office (CBO), responsible for health and income security. Steve has his Ph.D. from the University of Wisconsin and, prior to joining the CBO, worked on national health insurance as a Brookings Policy Fellow during the Carter administration. He also has spent time at the Maxwell School of Syracuse University in public administration.

DR. STEPHEN H. LONG: Let me start with what we call the CBO Caveat. The Congressional Budget Office is a non-partisan organization that makes no recommendations. So while I'm here to describe the background of the problem and also one policy option and its implications, I'm neither advocating nor opposing the policy.

I'd like to cover three things. First, I'd like to talk about the size of this problem of the uninsured and what's been happening lately in the numbers and the implications for access to health care. Second, one proposed policy response is mandating employer coverage for all workers; I'd like to talk about a generic plan for doing that on which we did some analysis recently. Finally I'd

like to talk about some of the potential affects of that kind of plan on firms, workers and the federal budget.

We are talking about a large number of people; about 37 million people this year are uninsured according to census data. That 37 million represents 17.5%, or about 1 in 6 of the non-elderly population in the country. These numbers have been growing throughout the decade. Between 1980 and 1987 the non-elderly population grew by 6% but the uninsured over the same period grew by 25%. The cause of the growing uninsured is simply that there's a lower rate of insurance out there. Private insurance coverage has not been growing as fast as the population. Over that period, it's only grown by about 1.5%. Public insurance grew at a faster rate, 18%, but by covering a smaller share of the population, its growth wasn't enough to offset the slow rate of growth of private insurance. Now that's superficial; the underlying causes are much harder to sort out. I think there are probably many factors underneath this trend, and at this point we're not ready to say what they are or how much each accounts for in the growth.

We do know this problem of uninsurance has some implications for access to health care. If we control for health status and other personal characteristics and compare the use of services by the uninsured to two other groups, people insured with private insurance, and people who are enrolled in HMOs, we find the uninsured use only about half as many hospital services as privately insured people, and they use about 2/3 as many hospital services as HMO enrollees. This information is from Health Interview Survey data. On the physician side the uninsured use about 2/3 as much care as the the privately insured and about half as much as HMO enrollees. The effect of this lower level of care on health status is not clear, but I think it's important to recognize that the uninsured do not get zero care, they simply get less care. The ultimate question to be resolved is just how much worse their health status might be as a result of this lower care.

There are a variety of different policy approaches which have been talked about to remedy this problem. The one that seems to be getting the most publicity this year is a proposal that Senator Kennedy has made to mandate employer coverage throughout the economy. I'd like to talk about a plan we cooked up at

CBO that is similar but not identical to the Kennedy plan. I'd also like to talk about some estimates we've made on that generic option.

Let me describe what this generic plan would do and then I'll go on to some of its effects. All employers would be required to provide health insurance coverage that meets minimum standards or the actuarial equivalent of those minimum benefits to all full-time employees, their spouses and dependents, unless the spouses or dependents are insured under some other employment-based plan. Basically all work force independents would be covered. A full-time employee would be defined as working 18 hours or more a week. Employers would be required to pay at least 80% of the cost, and employees would be required to accept the plan and pay up to 20% of the cost. The self-employed and household, farm, and seasonal workers would be covered by the mandate. This generic option could be thought of as providing the broadest possible coverage imaginable. The real options would be scaled back some.

This required plan would cover inpatient and outpatient hospital, inpatient and outpatient physician and diagnostic tests. The required plan also would have cost-sharing limits. Small employers under this plan would be offered a choice of community-rated plans for their geographic areas. Employees and their spouses and dependents who are covered by Medicare, Medicaid, Champus or some other insurance plan would be required to accept the employment-based plan.

What are the implications of such a plan? We can break down the implications into short-run implications and long-run implications. Let's start with the immediate effects on people and firms with the recognition that, in the long run, there might be behavioral responses that would change the outcomes. This kind of plan would require about $28 billion in new employment-based coverage, with about half coming from firms that employ fewer than 25 workers and about 20% from firms that employ 1,000 or more workers. This is not entirely a small business problem, and the impact mirrors the distribution of uninsured workers. The effects by industry would be greater in agriculture, construction, retail trades and most industries where insurance rates are currently low.

It would cover about 43 million people, with about 24 million being people who otherwise would have been uninsured and 19 million being people who otherwise would have been insured by some means other than employment-based coverage. We have about 2/3 of the 37 million uninsured tied to the work force or in a family of someone who's tied to the work force.

That's the short run; in the long run what might happen to the economy or the federal budget under this scenario? In the long run, at least at CBO, we imagine employers and employees might go through some negotiations about compensation. We think the majority of these costs, initially borne by firms, would be shifted to workers in the form of lower wages or lower benefits to the extent that the workers had any (many of the workers that would be affected have very few fringe benefits). Mostly the plan would be a transfer into lower wages in the long run.

We also might imagine the economy would adapt by changing the composition of the work force. Mandating health insurance, of course, mandates a large fixed cost on every employee. Workers who either have lower wages or fewer hours receive a higher percentage increase in their compensation as a result of this mandate. For example, a single person who works 40 hours a week at the minimum wage would receive about a 10% increase in compensation since wages at the minimum cannot be adjusted. For an 18-hour work week or for family coverage, the increase at the minimum wage level might be as large as 25%. People working at the lower range of mandated hours or at lower wages might find it difficult to secure employment. We are working on some estimates of how many people this might affect.

In regard to the federal budget, we estimate there would be very little net effect. This is because of two offsetting kinds of reactions. On the one hand a mandate that required coverage regardless of other insurance would make mandated insurance primary to Medicare for the working aged and their spouses who now have Medicare coverage resulting in a Medicare savings. Additionally, since about 8% of the Aid to Families with Dependent Children (AFDC) population works, the mandate would require private insurance coverage with Medicaid savings to the extent states are successful in becoming secondary.

Since employer contributions to fringe benefits are not taxable as income, the change in compensation packages to more fringe benefits and lower wages would represent a federal income and payroll tax loss. We're talking (approximately) $6 billion of outlay reductions and about $5.5 billion of revenue losses resulting in an offsetting effect on the federal budget.

MR. H. MICHAEL SCHIFFER: I addressed the Society of Actuaries meeting about nine years ago on the subject of catastrophic health insurance. In a sense nothing changes except the names of the players.

Most of you work for insurers. How many of you are into the small employer group insurance market? Let me suggest to you that I think your life is going to change over the next four or five years. I don't think we expect any immediate action on this front, but there are some changing facts and circumstances I think will impact the business.

Let me propose five premises. First, I think we are seeing a growing political concern over the problem of the uninsured. Second, access to health care is in fact a real problem. Third, the health insurance industry is a part of the problem. Fourth, we are perceived to be a larger part of the problem than we really are. And fifth, I'm not sure that we, not as individual companies but as an industry, are ready to be part of the solution as yet.

Let me now expand on each of these. Why is this a growing political concern? Clearly because the problem itself is growing. Back in 1978 or 1979 we were estimating somewhere in the neighborhood of about 18 million uninsureds. By the early 1980s that had grown to 22 million. Today Steve is proposing that there are 37 million uninsureds, and those figures are very well documented. More importantly, we know a lot more about those 37 million people than we did about the 18 million ten years ago. We know something about their income, family status, employment status, where they live, etc. That makes them a very good political target. The likelihood of something happening in the political arena is much greater today than it was ten years ago, and there is activity.

Steve mentioned the Kennedy bill. An important piece of legislation, it's the benchmark against which other pieces are going to be measured. But there is activity in the Congress of the United States that goes far beyond

Mr. Kennedy's committee. We are working with some of those groups trying to convince them of the wisdom of our ways.

There's also a lot of activity at the state level. Karen Smith will cover Massachusetts in some detail, but Massachusetts is not the only state where the problem of the uninsured is under consideration for some kind of legislative solution. Within the last month in our conservative industry controlled State of Connecticut, we had the chairman of the public health committee of the Connecticut general assembly saying Connecticut needed something like the Massachusetts proposal of requiring all employers to provide coverage. There is have action under consideration in Oregon, and there always is something happening in California.

In addition to addressing the problem of the uninsured, there's activity at the state level with respect to the uninsurable. The uninsurable risk pool phenomenon is spreading rapidly. After it began with Minnesota and Connecticut there was kind of a lull in activity for a number of years, but within the last five years, additional states have enacted these risk pools. We now have a total of 15 states, almost a third of the U.S., which have some kind of insurer of last resort, which is administered at least, if not financed, through private sector activities.

The form of this risk pool legislation is all pretty much the same. There's a pattern to it. Individuals become eligible if they are turned down by insurers for coverage. The plan of benefits is usually fairly comprehensive. The rates are established at usually 150% of what a standard rate would be, so there's no competition with individual insurance, and there is usually some kind of public subsidy to finance the inevitable excess losses. So far the pools have only covered about 25,000 people, not quite the expansive source of coverage one would think. The subsidies in those states with mature programs are running at about $500 per individual, hence these programs are not a real expensive proposition. In Illinois and Connecticut the subsidies are provided by an assessment on insurers with an offset against premium taxes. In effect it's general revenue funding of the excess losses. The danger for the industry is it's very easy to take away the premium tax offset if the state gets into any kind of fiscal difficulty.

The point I want to make is that there's an awful lot of political activity. The problem of uninsurables is perceived as real and growing. I think it's going to ultimately affect our lives quite a bit.

Steve touched on the question of access to health care, is it a legitimate concern? He mentioned a few statistics that are corroborated by some things I've seen in a Robert Wood Johnson Foundation study. Let me quote a couple numbers to you. He did some comparative statistics for 1982 and 1987. During that period, there was a 65% increase in the number of people reporting no regular source of health care. Currently, some 18% of the population say they have no regular source. There also was a 70% increase in the number of people who had no ambulatory visits to a physician in the prior twelve months. Currently, 33% of the population say they have had no such visits. To a large extent, as Steve indicated, it is a function of the financial resources of the people. Sixteen percent of the population say they have difficulty obtaining any kind of primary medical care, with half of those indicating there are economic barriers.

The problem of access to primary health care does seem to be a real one. If somebody has an accident, a heart attack on the street or whatever, he or she is certainly not going to be left to die. The acute trauma situation is by no means a problem. These folks are going to get care, one way or another, but there is a real problem with respect to access to primary care. This is a problem which needs to be solved.

My third premise was that health insurers are part of the problem. Because insurers underwrite, they create uninsurables or cause some people to pay higher rates for coverage. To some extent this creates a situation where people can't afford to buy coverage. We have this stigma attached to our industry that says we exclude people by underwriting -- a terrible thing. Our adversaries and political opponents never look at the flip side of that coin. The fact of the matter is risk selection makes insurance more affordable for most people. We had a fairly dramatic demonstration of that recently in some work we did with the Health Insurance Association of America.

We were trying to price out the relative costs of plans for small employers and large employers primarily to get at the expense differences. We found that the

larger employers had the lower costs, but costs peaked at about the 15 life level with smaller cases actually paying less in premiums. Looking at this, we realized it was the effect of underwriting and good risk selection driving down the cost for the smaller employer. Sure some people were not getting coverage, but those that were paid less.

The political focus, however, is always on the have-nots and never on the haves, and to the extent that it's on the have-nots we start to find ourselves in some difficulty. In the political sense, you stop talking about the right of access to health care. It turns into a debate over the legitimacy of risk selection.

This leads me to the fourth premise, that the insurance industry is perceived to be a bigger part of the problem than it really is. When the political debate turns to the legitimacy of risk selection, we are always going to look like bad guys because it looks like we are excluding people from coverage. It doesn't matter that 2/3 of these people are poor and couldn't afford a lot of coverage in any event. It doesn't seem to matter that 2/3 of them are employed, with many of them working for employers who could well afford to help them buy coverage. It doesn't seem to matter that 1/3 of them have the resources they need to buy coverage for themselves but simply decide to spend their monies in other ways. All those things don't seem to matter a whole lot. The accusation is we exclude people and we have this obligation to cover people. The fact of the matter is risk selection by definition is not compatible with universal coverage. There are some things, however, which can be done to insure with universal coverage.

The difference between now and ten years ago is that national health insurance (NHI) is no longer a real threat. Now, we have a series of new threats. One is State Health Insurance. We also have Elimination of Responsible Risk Selection. You see this particularly in the AIDS controversy. Finally we have the Threat of Additional Regulation. We no longer have NHI, but now we have a whole series of new acronyms ready to jump up and bite us. It's a little more complicated situation than some time ago.

We start to paint a fairly gloomy picture I guess. I think it was Senator Biden who said it's always darkest just before it goes totally black. However, there are some solutions we have been working on. I'm not sure the industry,

however, is convinced. This is the fifth premise, we really want to be part of that solution for a couple reasons. First, look at the uninsured out there. By no means are they the cream of the crop. If they were, we'd have already figured out some way to insure them. Second, there is some desire to preserve the status quo. Finally, I think the real reason is that the industry hasn't come to the point of being willing to accept the price that we would have to pay to be part of the solution. The idea of employer mandates or strong incentives to create the extension of employment-based coverage is desirable but with it most assuredly comes some regulation. We're concerned about what the regulation might look like and what it might do to us. It's more than just the preservation of the status quo.

There is certainly the strong desire on the part of all of us to continue our competition on the basis of risk selection. We think we're smarter than the Travelers or the Celtic Life or anybody else in our underwriting practices and risk selection. We want to maintain that level of competition, but to the extent that we exclude people, we may have to be willing to support an extension, growth, or proliferation of these uninsurable risk pools. This is because with a mandate comes a requirement that everybody be able to get coverage someplace. If we want to compete, on the basis of risk selection, we have to support an insurable last resort, and we're not sure we like that yet. We're also not sure about what it ought to look like, but we're working on it.

Another area is this whole idea of providing a level playing field by getting rid of some of the implicit cross subsidies existing in the health care system. Most of those subsidies are for people who don't have coverage or who can't afford coverage, i.e., low income people. We say we need to improve the Medicaid program so the poor have access to care and to the ability to pay, but with that improvement probably comes some increase in taxes. To the extent that we are looking at the government to provide us with an additional market of 25, 30, 35 or 37 million people, we have to be willing to accept the fact that there is going to be a price attached. It's these trade-offs that are still under consideration and, I think, slowing down the industry's resolve to be a part of the solution at this point.

Clearly the issue is not whether we want to be a part of the solution but when are we going to be a part of the solution. It's a timing issue in my judgment.

I think we're at the crossroads, we have the opportunity to either continue to play the reluctant bridegroom or to be a part of the focus or a part of the group that is actually making the proposals. I would hope we would at some point move to that later category.

MS. KAREN SMITH: I'd like to talk about how we got to where we are in Massachusetts, to briefly highlight on the governor's bills, since there is a lot of misinformation and disinformation out there, and to describe the political pressures and the political process from the point of view of key constituencies involved in developing this legislation.

First, I'd like to say Massachusetts is not much different than other states in terms of the number of uninsured and in the process we have gone through. We've had studies, commissions, and political debates and in that sense we are like all the other states that are involved in this process.

How did we get to where we are with all this political debate going on between our two houses and the governor? Despite many of the criticisms, this was not a piece of legislation that the governor sprang on the public within a one week time period. The debate on this issue actually began close to five years ago. Our approach to dealing with the uninsured has really come out of several pieces of legislation that were piecemeal hospital payment systems. Five years ago we got a waiver from Medicare's Diagnostic-Related Group (DRG) system and came up with an all payor system for Massachusetts known as Chapter 372. In late 1985 we amended that to commercial insurers, Blue Cross, and Medicaid. At that time, December 1985, the private sector coalition that had been putting together hospital payment legislation realized it had pushed the hospital system about as far as it could go. We were beginning to get cost control, but it was still far higher than anyone was satisfied with, particularly the business community, which was really the catalyst in this private sector coalition. We put together a study commission and found if we're going to get a hold on our hospital payment system and medical costs in general, then we needed to start by trying to control premium increases, we can't just deal with the hospital payment systems. We had to take a look at what the insurance industry is doing relative to the people who aren't going to fit into a more competitive environment. We also had to take a look at what we're paying through the hospital payment system for these people.

In December 1985 we instituted what was called a hospital bad debt and free care pool. Basically, when people arrived at a hospital either with no insurance or with insurance that had high copayments or deductibles which were unaffordable, those bills get paid. There was a surcharge on every hospital bill paid by anyone who had insurance. The surcharge started out close to 10% and amounted to about $280 million. In two years it has risen to $315-320 million. It's the fastest growing part of our hospital payment system.

The size of that growth and the concern that we're actually paying for expensive hospital services in emergency rooms and outpatient departments rather than for managed care or some other kind of plan controls or administration became increasingly intolerable to the people who were paying the bill. This is probably the single largest cost factor that contributed to the members of this study commission grappling with the question of what we do with the uninsured: a recognition that there's no free lunch, that we're paying for these people anyway, and that we're not going to accept a situation where there are two systems of care with some people not getting care and being turned away at hospital doors.

This study commission met for two years without any success. For the first time this private-sector process failed to come to a conclusion. The hospital payment system was to expire on September 30, 1985, so the governor submitted his own legislation intended to take on the same range of issues as this study commission. These issues include the hospital payment system, the uninsured, some changes in the insurance market, some additional changes in state regulation dealing with our determination of need programs and some quality of care regulations.

We have a very influential chairwomen of Senate Ways and Means who has been very much committed to this issue. About six months ago she came out with her own legislation to deal with a program for the uninsured. It does not deal with the hospital payment system or any other parts of our health care system. It was for a comprehensive health insurance plan that included the basic benefits that state-licensed HMOs are required to provide. It also called for a payroll tax on all business.

A little before this there had been a referendum in Massachusetts. We had two questions on our ballot, both of which passed overwhelmingly: a tax cap and a call for universal health insurance in Massachusetts. Given that as a starting point, we ended up with the governor's legislation which went to the House Ways and Means Committee. The House Ways and Means left many of the pieces of the bill the same; however, there were some changes that are probably of particular interest to actuaries. One is that the House Ways and Means hoped to alleviate some of the pressure from the hospital industry. The hospital industry felt the governor's proposed hospital payment system was too lean and it would cause severe financial harm to hospitals. Therefore, the House Ways and Means added approximately $100 million to the proposed hospital account which brought the total new dollars going into hospitals to about $350 million.

In addition, the House Ways and Means changed one key insurance provision, the provision on what to do about pre-existing conditions. Like Senator Kennedy's bill, the governor's proposal called for an elimination of pre-existing condition exclusions in private insurance policies. The House Ways and Means took this provision out.

Now, a little bit about all the components that were in this legislation. One component included some changes to the Insurance Industry. In Massachusetts Blue Cross and Blue Shield has a lot of financial advantages. We estimate approximately $200 million in financial advantages for which we get maybe $80 million in benefits as a result of that company's current underwriting losses for two products, a Medicare supplement product called Medex and the company's non-group or individual policies. Those two products are BC/BS's only regulated products for which it has had some fairly substantial losses in the past several years.

As the business community delved into the hospital payment issue, it became much more sophisticated and much more aware of the inequities in the system. If Blue Cross was going to get financial advantages, the business community wanted to make sure it was getting back social benefits that were of somewhat equal value. The theory that it all comes out in the wash was clearly no longer true when people looked at the differences and the advantages versus the social gains. In addition, because of the hospital differential that Blue Cross enjoys, businesses were feeling they couldn't afford to leave Blue Cross and go to

commercial insurers. There is a 7.5% differential, so even if Blue Cross is the worst administrator in the world, it's still going to have a better price.

In the hospital payment system the question of fair share came up. Because of the bad debt and free care pool, employers who purchased insurance for their employees were basically subsidizing the employees of employers who didn't purchase or offer insurance as a fringe benefit. That became an increasingly intolerable situation for the business community, and it's not just a big business/small business battle. A large percentage of the small businesses in Massachusetts do in fact offer insurance. However, small businesses were less clear than big businesses on how the insurance industry was able to serve them. We were getting an increasing number of complaints coming in from small businesses because of a 100% premium increase in one year. We also were getting more complaints from small businesses which felt that they couldn't find an insurer; that for them, more than for big businesses, shopping around in a competitive marketplace was not something that was ever going to be a fact of life. They often could find only one carrier, which was usually Blue Cross/Blue Shield, to offer them coverage. It was a take it or leave it offer with a fairly high price. This was of increasing concern to the small businesses. All this is what lead up to the governor's legislation.

One of the main points in the governor's legislation was the financing, administration, and a clear description of the benefit package for the uninsured. In terms of the financing, the governor's preference was to go with an employer mandate to seek an ERISA exemption. There was no and there still is very little interest in Massachusetts in replacing a private insurance market. The intent was to come up with an employer mandate, and since Senator Kennedy's bill was in federal debate already, that was used as a starting point. Some changes were made because we were really talking about universal coverage with a system for all of the people who are not part of the labor force.

Failing an ERISA mandate, which many people see as a very unlikely option, the governor knew there had to be a contingency plan. The contingency plan in this case uses an employer surcharge. The employer surcharge would go into effect if there is no ERISA exemption by January 1, 1989. The surcharge would be 12% on the first $14,000 of income with employers unable to receive credit against the surcharge for any incurred expenses related to health care for their

employees. Employers offering the minimum benefit package would be exempt from the full 12% surcharge.

Under either the ERISA exemption or the 12% surcharge there would be a continuation of the hospital bad debt and free care pool we now have, except that instead of using those dollars to pay the services at hospitals, the money would be directed to a new state agency that would administer the program. The new state agency would use the money to actually purchase insurance and would replace our Medicaid department that purchases health care for Medicaid recipients and our group insurance commission which arranges health coverage for state employees. The governor's bill would focus the state's buying power in this one agency.

One consistent complaint we've heard over the years is the state speaks with too many voices. People get tired of being shuffled from agency to agency. There are different messages and different policies. We need more uniformity in state government. The governor's bill would create "The New Mass Health Partnership" as part of the Department of Medical Services. The House Ways and Means bill changed this slightly. The significant difference between the governor's bill and the House Ways and Means bill is the governor proposed the rate setting commission be part of that new agency, while the House Ways and Means left the rate setting commission as a free-standing agency.

When people saw the governor's proposal, the rate setting commission found it had more friends than it had ever thought possible. The commission's allies came out of every corner to defend it and protest that we absolutely had to keep it as an independent agency, that it was unthinkable that it should be part of this new state agency. Their concern was conflict of interest; you cannot have the agency that is purchasing health care and health insurance be the same agency setting the rates.

The administration that this agency was charged with would be primarily that of a broker, with the intent not to replace private insurance options and the hope to contract with existing health plans, primarily managed care plans. However, since we don't have HMOs in every corner of the state yet, there may have to be alternative arrangements made. In the event it's not possible to contract

with existing health plans, authority was put in the legislation for this agency to directly contract with providers, hospitals and physicians.

A little bit about the benefits. As I said we started with the premise that the Kennedy bill may end up enacted at some point. We started from there and made some modifications specific to Massachusetts. The benefit package is the same, inpatient and outpatient hospital care, inpatient and outpatient physician care, well baby and prenatal care, and diagnostic and screening care, we also added the state mandated benefits. The major mandated benefit people are concerned about in Massachusetts is the mental health benefit, which is $500 a year or 20 visits.

A little bit about some of the politics of the different constituencies involved in this. The private sector coalition that had been negotiating in past years on the hospital payment system included Blue Cross, the commercial insurers, physicians, hospitals, the HMO association, state government, the business community and organized labor. A consumer representative has been added to this coalition. It's fair to say the business community has been very concerned with the governor's bill and the House Ways and Means bills, from two very different perspectives. The larger business community is concerned about the cost and the benefit package. The small business community, already facing fairly high costs when purchasing insurance, comes at it from a different philosophical point of view. Small businesses are opposed to any mandate; it's a get government off our backs response.

The consumers in this state are very supportive of universal health care. Many of them feel that this bill does not go far enough. They would in fact be much more interested in a system like Canada's where there's a provincial system of universal health care but one financing source and a minimum benefit package. These consumers are less interested in preserving the private insurance options than are other constituencies.

One very interesting thing that happened in this political debate is the age-old alliance between hospitals and physicians has been split. The amount of money on the table for the uninsured is large and its use is so hotly debated that physicians rightly see they stand to gain enormously in a system of universal health insurance. Right now hospitals get paid for providing free care, but

physicians do not. This is a real sore spot for a lot of physicians. They see universal health insurance as one way to get a fair share of the payment for treating people.

Even within the hospital industry we're beginning to see a split in the hospital association's control over its members. The environment is getting more competitive. We have more than one set of hospitals to deal with. There are teaching hospitals, community hospitals that have been very successful, and community hospitals that aren't that successful. We have 109 acute care hospitals and approximately 5,000 excess beds in this state. That's a lot of excess capacity to be supported on a daily basis. Clearly there are going to be some losers.

The starting point for the discussions from the study commission was the need for a more competitive environment. That's really going to be the key to keeping costs down and consumers happy. However, as it has unfolded, the debate is really not about competition. There are some people who want deregulation, but they don't really want competition. They clearly want to continue some protections, either guaranteed income for hospitals, physicians or guaranteed health insurance for consumers. It's really not about a free market system. When you really push all the parties who have been at the table, a free market system is not what they think is the best situation for them. What we really have to grapple with in Massachusetts, particularly with the Senate and the House continuing to be active on this, is to find that balance between the kinds of regulation to be used to reach the objective, which is health care for everyone, whether it's health insurance or other ways of providing care.

MR. BOLNICK: I want to give some numbers on some of the issues that were discussed here, particularly with respect to what the income levels of the uninsured people are and who these uninsured are with respect to wellness status and insurance.

These numbers are pulled out of a compilation of a number of studies that were done by the American Hospital Association. Two of the characteristics by which they tried to describe the uninsured were whether they're poor or non-poor and whether they're well or sick. Their data were based on a 1983 group of 32.7 million uninsured, which is very much in line with the numbers Steve gave. Now out of the 32.7 million uninsured, 18 million of them were described as

non-poor, well, and uninsured, where non-poor means more than 100% of the poverty line; 8.8 million were poor, well and uninsured, where poor means at or below the poverty line. This is a large group of people which Medicaid has not picked up.

Next we get to the categories that we as an industry really get tagged on: the non-poor, sick and uninsured at about 3.1 million people, and the poor, sick, and uninsured at about 2.8 million people. There were about 5.9 million out of the 32.7 million who are supposedly sick, where sick means that they classify themselves as in fair or poor health. The data also show that out of the 32.7 million uninsured, 11.6 million, or roughly 1/3, were under the federal poverty level; another 9.6 million, or roughly 1/3, were between 100-200% of the poverty level; and the other 11.5 million, or roughly 1/3, were above 200% of the poverty level. This gives a picture of the uninsured as being relatively poorly compensated, below the poverty line, and thus unreachable by insurance. There are also a lot of them between 100-200% of the poverty level and thus difficult to be reached by insurance, because it's difficult for those people to cover the out-of-pocket expenses and any contributions. It seems as though most of the sick people who are uninsured would fall into categories that likely wouldn't be reached with insurance. While the insurance industry is looked at as excluding these people from the insurance market, it is probably much more an issue of the state and federal government not being able to pick them up under existing programs. Mike says that the insurance industry is part of the problem, but state and federal government also is clearly part of the problem and I'm not so sure it's willing to admit to its responsibilities either.

MR. MARK S. SELIBER: Under the Kennedy proposal, approximately 60% of the people who are presently uninsured would be covered either as members of the work force or dependents of members of the work force; who are the others?

DR. LONG: Well, there are lots of different folks. The uninsured are a very mixed bundle of people. Some of them are kids who have left insurance units. You also find a lot of young adults are not working. They would fall into the groups of those you can't reach with the Kennedy plan. Those young adults who are often single also don't qualify for Medicaid or any other similar kind of program. There are people in the 55- to 64-year-old range who have retired and are no longer tied to the labor force and have difficulty finding insurance

because of some health problem or whatever. There also are people just above the Medicaid eligibility standards that expanded Medicaid would pick up. Medicaid expansion is an obvious option for getting some share of this other 13 million people.

One group that would get picked up by the mandate is a very interesting group. Currently, there are about 2 million children who are the dependents of people who are in the work force and who have become uninsured. These children would be covered by the mandate, but people who are employed seem to drop dependent children. This may be as a result of changing terms being offered by employers for how much they'll subsidize family coverage.

MR. BOLNICK: In 1983 there were about 35 million people below the federal poverty level, of which Medicaid covered about 21 million. Obviously those people don't have much of a connection to the work force. I think that's probably a big chunk of that missing piece, but clearly the working uninsured are the largest piece of the total.

MS. NANCY F. NELSON: My question relates to the need for coverage of some basic preventive services with no copayments or deductibles in a national program. In particular I'm thinking of well baby care and preventive prenatal care. There have been studies done that have estimated that for every dollar put into prenatal care, between $3 and $20 of savings will result from reduced need for neonatal intensive care services and other related problems of a low birth weight or premature infant. Do set up a program to do that? How are you going to encourage your underinsured population to appropriately use the services and actually get to the doctors earlier?

MR. SCHIFFER: Clearly you have a lot of sympathy in your position and I think there is some well demonstrated evidence that both prenatal and well baby care does result in some lower expenditures. I think there are three issues involved. One is just tradition. Typically insurance programs have covered things other than prevention and wellness, and we've been slow to adjust our coverages to recognize the value of such programs. Second, there's an issue of whether it's appropriate to cover, through an insured program, those expenses which are entirely predictable. The third issue is just one of cost. You have to make some decision on whether to spend your dollars on the lower cost small

expenditure items or on the more catastrophic events. One debated issue in the industry is whether to propose a plan of catastrophic health insurance benefits and make the insurance industry the insurer of last resort or to propose a plan that offers very, very basic benefits but doesn't cover any kind of catastrophic events. We're having trouble coming up with a precise proposal because we have strong proponents of both positions.

MS. SMITH: There's a program in Massachusetts called Healthy Start working on that issue. Since it's only been in operation for a couple of years, there isn't any definitive evidence one way or the other at this point. The legislature felt very strongly that we had to start dealing with the problems of infant mortality in Massachusetts which was beginning to rise. Legislators put a program in place so that if a woman's income was under 185% of the poverty level, she would be eligible to have her prenatal care and delivery paid for through the Department of Public Health. In the first year we had far more women coming in for this service than had been anticipated. The budget went from $4 million in the first year to the current $16 million. The intent clearly is to get women to come in during the earliest stages of pregnancy. However, during the first year, we had a lot of women coming in at their eighth month or a week before delivery. This was because it was a new program and there hadn't been time to come in earlier. The outreach work is beginning to deal with the issue of how soon women start coming in for care.

DR. LONG: There have been in recent years expansions in Medicaid coverage for these things. It is a state option rather than a federal mandate for coverage. Now the game is one of watching to see how many states will cover mothers and children up to the poverty level. The expansions came in response to pressure from the southern governors conference, which was concerned about this problem and recognized the cost effectiveness of the studies.

MR. SCHIFFER: When we talk about federal poverty level, we mean about $11,000 for a family of four. When Karen talks about 185% of the poverty level being eligible for this program, you're talking about people up to about $19,000 of family income.

MR. RALPH E. EDWARDS: I would like to hear some comments on the area of catastrophic coverage.

MR. SCHIFFER: The emphasis right now in the political sense is on catastrophic coverage because of the work done by Health and Human Services a year ago. President Reagan in fact started this debate over catastrophic health insurance two years ago when, in the state of the union message, he talked about catastrophic health insurance as being something he'd like to see available for all of the American people. It played out initially in the Medicare catastrophic debate and now has moved over to the employment sector. As I mentioned before, there is a debate in the industry on whether the employment sector is where we ought to keep it. If we're going to have any kind of mandated coverage, the industry's interest is that the mandate be as thin as possible. We want to have room to continue to compete on the basis of a plan design that supplements whatever is mandated. In summary, the emphasis on catastrophic coverage is one being emphasized through the political process rather than something of our own doing.

DR. LONG: The nature of the mandated plans is almost always for some kind of out-of-pocket maximum to which the insured would be subject. It's either $2,500 or $3,000.

MR. BOLNICK: As I understand it, the proposals do not solve the problem of the really catastrophic, extremely long illnesses. I think it is possible under any of the proposals for an individual employee to become sick, disabled, to lose his employment status, to not have continuing coverage in the private sector, and to not qualify for Medicare.

MS. SMITH: To the extent that people are already paying for these medical expenses, the new state agency, in effect, becomes the insurer of last resort in Massachusetts. Individuals exceeding any benefits, either through private health insurance plans or whatever, could become eligible to continue to get services paid for through this new state agency. However, the bill's discussion of catastrophic care is not dealt with in as much detail as primary acute care.

MR. BOLNICK: We talked about underwriting in the small business market and about small business market being roughly half of the uninsured. Michael pointed out that by underwriting we exclude certain people, people who are very seriously ill, from getting coverage in the private sector. Who is responsible for those costs and charges that can't be made to the individual themselves?

MR. SCHIFFER: If you start from the premise that health care is in fact a right, it follows that the person who is unable to get health care because he has insufficient financial resources or lack of insurance is no longer a strictly private sector problem; it is a social problem. If it is in fact a social problem, then the additional cost that such an individual might incur for getting insurance is a broad responsibility. This is why we argue that the subsidy for uninsurable risk pools, above and beyond what premiums will cover, ought to be financed through some kind of general revenues. Society ought to be paying for those excess costs.

MS. SMITH: The issue with small business was the single most difficult issue in the entire debate. It's probably also the area that will be most subject to change in the coming weeks as we debate this bill. The answer we've come up with so far, while it's certainly not pure or as clean as people in the industry or in government would like, has been to try and provide some relief for small business. We recognize there are some people who are uninsurable and if those people end up in a small business risk pool, it would cause rates to go wild. There are two special populations dealt with in the legislation. One is disabled people who wish to leave Medicaid and return to work. Arrangements should be made for them to continue their Medicaid coverage, so they don't become part of an employers risk pool. An employer could pay part of it, and Medicaid could act as a wrap-around. Those people need far more in terms of services than the standard acute care plans provide since they have chronic medical needs. The other population is families with severely disabled children. There should be money set aside especially for these children. There are instances where these families stay in jobs because they can't afford to change jobs. They are really at great risk of losing important insurance coverage.

MR. BOLNICK: You've got the answer for a few select sub-groups, but you don't have an answer for who's responsible for the overall problem.

MS. SMITH: The business community says these people who are not standard risks should be the government's responsibility. Pay for it out of general revenues. The government then says, how do expect us to pay for this? What existing programs don't you want? What new taxes do you want? And that's where I think the breakdown in the solution comes.

MR. JAMES M. GLICKMAN: I'd like to get a reaction to what I think will become an issue if any of these mandatory coverages are provided. A lot of the health care costs are currently being passed through by physicians and hospitals to the people who are insured in the form of some type of higher rates. It strikes me that the system is not elastic enough. When we start providing for direct payment of what is already in the pricing of the delivery system, aren't we going to provide a windfall to the health care delivery system?

DR. LONG: One of my clients has been trying to get me to write a memo that would have CBO say how much small business would save and how much the business community in general would save, as a result of covering all these uninsured, whose costs presumably now pass through as bad debts into higher premiums. I keep refusing to write the memo because I say the hospital system is such a complicated system. I can't tell you whether there's another queue of bad debt people who will flow in and take the places of these people who will now be paid for, or whether bad debt has recently been subsidized by the windfall that Medicare payments have offered hospitals. Those are very hard things to know. How all of that comes out, I can't answer. My client is sure that the business community will have cost savings, if that's an argument in favor of the plan. I'm more skeptical, as your question implies.

MR. ROBERT J. MYERS: Among the uninsured, how many are there who don't want insurance because they don't believe in the traditional forms of medical services because of religious principles or conscience? Are these people going to be forced to pay premiums for something they won't use?

MS. SMITH: I have had daily conversations with the Christian Scientists for the past several weeks, and surprisingly, they have been very supportive of the governor's bill. The one change they requested, to make the bill more acceptable to them, was to include services in their facilities. Their belief has been, if this is going to be universal, the kinds of services the members of their church are most likely to use should be part of the benefit package.

DR. LONG: I wouldn't be able to estimate how much it would save to exclude them. The set of plans on the Hill right now has not gone into that level of detail. I doubt exceptions would be made. The spirit on the Hill is to look toward as universal a set of eligibility rules as one can reasonably get.