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MEDICAL BENEFITS FOR THE UNINSURED AND UNDERINSURED

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Recorder: CHARLES S. FUHRER

- o Who are these people?
- o Core benefits plan design
- o Funding uncompensated care
- o State pools for high risk and near poor
- o Is government health care inevitable?

MR. DENNIS CARLSON: My name is Dennis Carlson, and I work with Rural Security Life. My involvement in this area has been working with the uninsurable plan in Wisconsin called HIRSP for many years as well as some recent initiatives by the state legislature to examine the whole problem of assisting people, in the state of Wisconsin, to obtain and be able to afford health insurance. Next to me is Gordon Trapnell. He is President the of Actuarial Research Corporation. His firm was retained by the Senate Subcommittee on Labor and Human Resources and the House Committee on Energy and Environment to provide cost estimates of the mandatory health insurance programs that would be established pending legislation. These estimates were incorporated into the overall congressional budget office estimates of the aggregate cost and economic impact of the bills.

Raymond Marra, from the Travelers, will talk on the Connecticut Insurance Program. Catherine Dunham is the Director of the Governor's Office of Human Resources in Massachusetts. Catherine has the task of implementing the new plan in Massachussetts for health insurance.

MS. CATHERINE M. DUNHAM: It is actually: "an act to make health security available to all citizens."

MR. CARLSON: Our recorder is Charles Fuhrer. Hopefully, we will have a few minutes for questions and answers after our presentations. At that time we will ask you to go to the microphone and identify yourself and your affiliation so that we can get that recorded properly on the record.

I have handed out a few pages that summarize the items that I will be covering this afternoon. It will be an attempt to identify the characteristics of this population which we call underinsured or uninsured. In Wisconsin in 1984, the

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legislature passed legislation to study the problems of those in the population who do not have health insurance and to develop recommendations to alleviate those problems. The acronym was the HIRSP Initiative.

A council was formed by the legislation to study the problems and make recommendations. Those of us who are in the private sector, the private health insurance companies in Wisconsin, formed a coalition and people from our companies participated to assist the council in its deliberations by giving them our insights on this subject. One activity that we decided to do was to sponsor a survey by the Peter D. Hart Research Associates, Inc., to identify the characteristics of this population. This afternoon I would like to review the results of that survey. It was conducted between June 27 and July 3, 1986. It was a telephone survey of 8,693 households in order to locate 600 households that met the criteria for participation in the survey. That is, at least one adult age 18 or over who was not currently covered by a health insurance plan. Incidentally, this would not include those covered by Medical Assistance, Medicare, or Medicaid. This happened to work out to be an incidence rate for the uninsured households of 6.9% and I will profile the results of the 600 participants according to: demographic characteristics, insurance history characteristics, employment situation, and finally, household profile.

First, I will cover the demographics. The state was divided into four geographic areas for the purpose of analysis. Southeastern counties surrounding Milwaukee, in essence a urban-suburban portion of the state, had 35% of the uninsureds that we found. Northeastern Counties, which would include a less urban concentration than Southeastern, had 26% of the uninsureds. Northwestern counties, primarily a more rural area, 21%. And finally Southern Counties, outside of Southeast, 18%. By age grouping: 18 to 24 comprised 31%; 25 to 34 30%; 35 to 49 20%; 50 to 64 16%; and for some reason, there were a few people over 65 that did not have Medicare or any other type of insurance. What strikes you here is that there is a significant percentage in the young age group, particularly 18 to 24.

In terms of total family income, the proportion of uninsured respondents that had total family income of less than $5,000 was 17%; $5,000 to $10,000 20%; $10,000 to $15,000 16%; $15,000 to $25,000 18%; and $25,000 or more 8%; and then finally 21% did not choose to or were not sure of their income level. Again, not a heavy concentration in the very low income areas, as perhaps you might expect. A heavy concentration in the low incomes, who would not be able to afford health insurance, would result if it were a pure affordability problem.

In terms of insurance history, the length of time without insurance: less than six months, 14%; six months to one year, 12%; 1 to 2 years, 14%; 3 to 4, 15%; more than four years, 25%; never had health insurance, 18%; and not sure, 2%. Again, a fairly large percentage of people who had never had health insurance or hadn't had it for over four years. On the other hand, a fairly sizable percentage that had it within the recent past. Text of the question that was asked is right underneath the data for your information.

In terms of length of coverage, during the period that they last had health insurance: Less than one year, 6%; 1 to 2 years, 18%; 3 to 4 years, 11%; more than four years, 42%; never had, 18%; not sure, 5%. So, a significant number of people had health insurance for a sizable length of time, when they had it. Then there was a question asked, "What are the major reasons that you are not covered by health insurance?" And we allowed multiple responses to this

question. Of the 82% (or the complement of 18% that never had it), 53% said they couldn't afford it. Incidentally, this was their response, we did not try to lead them with any kind of wording. Some said they were presently unemployed and there may have been some that gave both reasons. In other words, they were unemployed and, therefore, couldn't afford it, so we recorded that as a response for the same person. For those that responded that the employer does not offer health insurance or a health plan, I think the result is significant, only 7%; will have insurance with an upcoming job, 3%; presently healthy, don't need health insurance, 2%; they don't believe in it, 2%; turned down for occupational reasons, 2%; for medical reasons, 1%; all other, 4%; and not sure, 1%. Again, a mixture of reasons in the minds of these people.

Our conclusion, as you may have concluded yourself, is that there is a significant number of young people in this group. A significant number were covered perhaps under their parents health insurance prior to the current time. Probably they are now in a position where they don't feel they can afford it, they are not employed yet, but perhaps they will be soon. There is probably another sizable group that is between jobs.

Let's look at the next element, the employment situation. The current employment status of these people is: full-time employment, 32%; part-time, 23%; a full-time homemaker, 12%; retired 6%; student, 3%; and unemployed, 24%. Unemployed here may mean between jobs or involved in longer term unemployment. Of the 32% that are full-time employees, 29% were self-employed, 44% worked for an employer with less than ten employees, 25% have been laid off within the last two years; 31% have been unemployed within the past two years. Of the 23% who said they were part-time, half of those are seeking full-time employment and presumably would have access to insurance shortly, once they achieve full-time employment, assuming they don't have any access to it today. Some 52% have been unemployed within the last two years. Finally, of the unemployed we asked the length of time of their unemployment: 37% have been unemployed less than six months; an additional 20% have been unemployed six months to a year, so that over half are recently unemployed, that is one year or less. Then, of course, the percentages go down except for the long term unemployed of four years or more, 17%. Also, of those that are unemployed, 31% were last employed just over a year or less. Again, 27% were last employed over four years ago. A total of 54% had health insurance with the last employer and 8% are qualified to continue health insurance from the last employer while unemployed. Then finally we asked for a profile of their household situation, (marital status): single, 43%; married (and some volunteered that they were separated), 39%; divorced, 12%; and widowed, 6%.

Other characteristics of the household composition and insurance coverage of other household members were as follow: 33% of these people live alone; 36% have a spouse living in the household and 77% of those spouses have no health insurance; 18% had at least one parent living in the household and the majority of these parents, 74%, do have health insurance. Perhaps it's Medicare or perhaps non-Medicare type insurance.

In addition, 35% have at least one natural or adopted child in the household. The majority of these children, 69%, are not covered by health insurance. There is high correlation there between parental coverage and the children's coverage.

There are a lot of cuts of the population in these pages and it is very hard sometimes to see direct correlation. Certainly the uninsured population would appear to be quite diverse in its characteristics. I would like to make one comment regarding the 6.9% of the population found to be uninsured or projected to be uninsured at the time we made this survey. One question that is asked repeatedly has to do with the percentage of people in the state who do not have health insurance. If you project 6.9% to the entire population of Wisconsin, you would obtain a number of 330,000 uninsured. That assumes that people covered by Medicare, Medicaid, or Medical Assistance are considered to be insured. Several reports that have been published by agencies of our state have used a number of 550,000. This represents about 10 to 11% of our population. I don't know if they do this because it is to their political advantage to show a larger number, but we have some real problems with this number because it was developed by a survey done after ours was done. We have identified three serious problems with their survey in terms of statistical sampling technique. We are comfortable with the results we have because Peter Hart is very careful in its surveying techniques to make sure that it maximizes randomness and, therefore, reliability. The state survey, however, had three serious problems: (1) they arbitrarily divided the state into four sections and then identified equal number of uninsured people from each of those four sections, and then added the results from all four to say that this is the profile of the entire state. The fact that four sections were identified on a nonrandom basis raises a serious question as to whether this information can be used as an extrapolation or indicator of the statewide situation. They used an extremely long survey, in terms of time, averaging 45 minutes on the telephone. The questions regarding the characteristics of the uninsured population came right at the end. We feel that after this length of time, the reliability of the responses maybe somewhat questionable. Finally, they had a total response rate of approximately 80% and I think it is generally accepted that if you don't have at least 85 to 90%, your reliability is in question.

At this stage I would like to stop and turn the microphone over to Raymond Marra who will talk about the Connecticut program as an example of an existing system in place.

MR. RAYMOND J. MARRA: My intention is to keep my comments somewhat focused this afternoon. I will speak with a little bit of detail, get into some of the mechanics of how the program actually works, and a little bit of its history. Approximately, one dozen states now have programs similar to Connecticut. Connecticut was one of the first to come on board in the mid-1970s.

The specific topics I would like to touch on this afternoon are the purpose of the program, the legislation which created and guides the Association, the plan of benefits that the Association offers to the public, the organizational structure of the Association, its financial conditions, some current issues and a little bit of a future outlook. Throughout my talk rather than keep repeating Health Reinsurance Association of Connecticut. I'll refer to the HRA, the Association, as we commonly do within the organization. My association with the Association goes back a few years. Currently, I am Chairman of the Actuarial Committee. Some of the specifics of the committee and its role, I will address in a little more detail, later.

To touch on the history and the purpose of the Association, currently coverage is provided to approximately 2,000 individuals and that entails about $3 million of premium annually and in the last calendar year over $5 million worth of claims.

As recently as 1983, the program insured over 4,000 lives. As you can see, it has shrunk quite a bit in the last few years.

The Association was formed in 1975 by the Connecticut Health Care Act. The goal of the legislation is to make available, to eligible residents of Connecticut, a comprehensive health care plan to meet the medical costs of nonoccupational injuries and diseases. In part, this was in response to the threat of national health insurance that ruled at that time. The result, in essence, was to create a risk pool of individuals who are excluded from buying health insurance in the private market place. The insurance is available for all who apply. The Association began operations in late 1976.

One notable difference between Connecticut's program and many of the other states is that there is no requirement in Connecticut to show that you have been declined for health coverage before you can join the pool. Several of the other states require that an individual be declined coverage by two carriers before the risk pool will allow them to come in. The way the Connecticut program was set-up there is no such requirement. In past years, we used to say that this was maybe one of the reasons why the experience of our pool was running somewhat better than some of the other pools. The pattern in the last couple of years does not continue to bear out that pattern.

There is a nominal one time fee of $50 paid to agents who refer people to the pool. I would say it is not a very attractive sum to give someone to go out and market it.

The law goes into quite a bit of detail speaking of minimum benefit levels and allowable premium rate levels. Both of those I will get into a little more detail later on. The other thing I would note on the law is that many of the actions that the Association tries to undertake wind up being constrained by the enabling legislation that created the Association. For example, the law mandates the benefits. In essence the law dictates the minimum benefit levels. To change any benefit parameter that would fall below this minimum level, is something that can't be done. For instance, in the last couple of years there has been a lot of attention focusing on putting in some kind of cost containment control. While there are some programs in effect, like large claim review and some case management, putting in a newer intensive inpatient preadmission utilization review program without having any kind of benefit parameters in place, to facilitate such a program, makes such an addition less attractive. In addition, the law imposed limitations on the premium rates that can be charged.

Let me speak a little bit about the organization of the Association. As mandated by the enabling legislation, there's a board of directors, consisting of seven members, all representing insurance companies. In addition, there's an actuarial committee with five members, all of whom must be members of the American Academy. The role of the actuarial committee is to assess the appropriateness of the premium rates and make recommendations to the board. There's a balance that the committee strives for because the rates year after year have become increasingly inadequate, given the constraints in the law regarding allowable rate levels.

The Travelers Insurance Company is the administrative carrier. As such, the Travelers handles all of the administration, billing, and claim settlement. As I mentioned earlier, premiums run in the neighborhood of $3 million a year. In the last calendar year claims were running in the $5 million range. Clearly, in

the last few years the Association has had quite sizable losses. The process which brings the Association back whole, is to assess the prior heavy losses to the approximately 250 structured companies that do business in Connecticut. Each company's share of the assessments is based on its level of Connecticut paid claims on insured business. This process is carried out each spring after the close of the prior year's books.

Let me speak to the plan of benefits that is offered. As I mentioned earlier, the enabling legislation spoke to minimum benefit levels. The original three plan offerings were all-inclusive comprehensive medical expense plans. There was a choice of annual deductibles of $200, $500, and $750. The plans included a $1,000 out of pocket maximum. Pregnancy benefits, for normal deliveries, were limited to $250. All plans have $1 million lifetime maximum. As you can see, those are fairly generous plans to put out on the street. Other than the normal pregnancy limit, there are no other inside limits in the plan. On January 1, 1985, in an effort to hold down the needed rate increase, benefit reductions were put into place. Essentially the dollar amounts of the deductibles and out of pockets were doubled. These are now the plans offered today. Thus, there's a $400, $1,000 and $1,500 annual deductible with a $2,000 out of pocket. Normal pregnancy benefits are still limited to $250. The pool actually offers three programs: (1) a program that's available to individuals; (2) a program for those converting from group coverage; and (3) a program of group coverage available to groups of four or more. The only difference between the individual and the group conversion program is that the six months preexisting condition limitation is waived for those converting from group coverage. There's no difference in the premium rates charged between the programs. Roughly two thirds of the business is individual policies and the balance group conversion policies. There's little or no group cases covered in the Association. In the last five years, the largest number of group cases on the books, at any time, was three or four.

Let me speak about the premium rates. The enabling legislation mandated that rates must fall between 125% and 150% of the average group rate charged to a 10 life group case. The intent of this was at both ends of it. With the lower end, to set the rates such that the Association is not stealing business from the private carriers. On the upper end of the band, the intent was to put some limit to how high the rates could go so that there's still a level of affordability. You'll find that the 10 or 12 other state associations have similar types of premiums bands. Some of them use the 125% to 150%. Some, I think, go up to 175% or 200% at the upper end.

The average rate is determined annually, and this is done by surveying nine of the largest carriers in the state. Typically this is done during the summer, asking the carriers to price these plans as of January 1 of the following calendar year. During the fall the results are complied and actual pool experience is analyzed. New rates for the following year are then proposed and filed with the state insurance department. Premium rates have been at the 150% maximum level for about five years.

Because claim costs have been trending for the Association at a faster rate than for similar group health products, the overall level of the rates has become more inadequate each year. One demonstration of this is to note the history of the amount of the annual assessment. Accumulated assessments from inception in 1976 to 1982 were less than $1 million. That's accumulated for six years. In 1983 alone, they were a $.5 million. In 1984 and 1985, they were in the $1.25 to

$1.5 million range; 1986 took a little dip, only $1 million; 1987 took quite a jump to $3.8 million. At this point, 1988 is going to look more like 1987 than any other prior year.

Obviously the one thing coming out of this is that paying quite a bit more in claims than you're collecting in premiums each year, and not getting a balance of the assessments until almost half way into the next calendar year, the Association tends to have a cash flow problem. This is addressed through credit at a local bank. We draw on it as needed until the later part of the calendar year the assessments start coming back in from the carriers that were hired. Then the Association runs positive for a couple of months and starts again.

Now I will speak on mental and nervous coverage. As mentioned earlier, the law speaks to minimum benefit levels. The law doesn't talk about inpatient mental and nervous coverage. As such the Association is bound to offer unlimited inpatient mental and nervous coverage. This has proved to be a very costly benefit that's used extensively by a core group of users. Any attempt to try to limit the Association's liability here, again, goes back to the enabling legislation and the need to pass a new state law to allow a change here. This is one of many issues that have been brought up and it's always a difficult process to get on the legislative agenda in the state.

Two notable items that are absent from the assessment base are HMOs and self insurers. Neither of these are subject to the annual assessment process. There appears to be no good way to go after the self insurers. Many of the associations have made an attempt to go out and collect from the self insurers but they were not successful at that. There's no legal obligation on the part of HMO's to foot their share of cost of this program. Because of these two omissions, several insurers have raised the contention that they are in effect paying more than their fair share for the cost of this program.

Another item of note: a kind of a quirk almost to the Connecticut plan, is the relationship with Blue Cross/Blue Shield. In 1984 Blue Cross/Blue Shield of Connecticut, incorporated as a mutual insurance company. One result of this action was to subject themselves to the HRA and its annual assessments. Based on negotiations at that time, a deal was made that their obligation with regard to the Association would phase in over a number of years. This was in part because up until that time, they had been, in essence, running their own program for uninsurables. Over the last four years, their liability has been slowly phasing in. Next year they are going to reach 100% of participation in the program. As such, bearing their full share, their assessment will be approximately 70% of the losses of the Association, since that's their market share in the state.

Premium Tax Offsets -- The Connecticut program currently allows no offset against a company's premium tax liabilities for the amount of the assessment. Some of the other state programs do allow such an offset, either fully or partially. Given the size of the assessments in the last couple of years, there's been more and more interest on the part of companies to see if they can get some relief in this area. The Association along with some of the larger companies have tried, although unsuccessfully, to push something through here. Obviously, a tax offset merely results in shifting some of the cost of the program to the state of Connecticut. At this time it doesn't seem like we will get any legislative relief in that area.

Affordability -- We've filed with insurance department for a 27% rate increase effective 1/1/89. That rate increase merely brings rates up to the 150% level. That is what has been seen in the small group market place in the last year. If that increase goes through, premiums rates will have more than doubled since 1985. Again since the HRA has been at the 150% cap throughout that time period, that's a similar increase to that seen in the small group market place in Connecticut.

Clearly though, with rate increases of that magnitude, and a base 50% over what the group market place is charging have caused the premiums to become less and less affordable each year. There doesn't appear to be much in the way of relief.

Summary -- The state of Connecticut's population is slightly over three million. Currently less than 2,000 individuals are covered by the Association. From the perspective of social good, such a low penetration rate would indicate less than a complete success. The large rate increases in the past few years have made this program become less and less affordable each year. It's probably not a coincidence that the number of insurer's is now approximately half of what it was in 1983. The cost of this program was assessments of 3.8 million for 1987. These were funded directly by the insurance industry. However, indirectly it's those employers who provide insured health coverage for their employees who are the ultimate payers. Clearly a more equitable approach would be an employer tax, perhaps based on payroll. Thus the cost would be spread over an entire employment base. Dennis mentioned 6.9% of the population in Wisconsin having no health insurance coverage. I heard this morning that 37 million Americans are without health insurance. The issue really has two components. One is the question of availability. Clearly the Connecticut program and states with similar programs address this issue. The coverage is there for the asking and the paying for it. Second, the affordability of the coverage. Clearly in designing this program 12 or 13 years ago, there was an attempt to cap the ultimate cost to the consumers, with the use of the 150% band. For a number of years that level worked very well and the Association grew, in terms of the number covered from 1976 through 1983. At that point, the Association membership started falling off, in terms of number of insureds. The large rate increases drove the rates beyond a reasonable affordability level.

As society addresses this issue, it seems the question is who's really going to pay the freight?

MS. DUNHAM: It is a pleasure to be here. We are proud in Massachusetts to be the home of the first universal coverage legislation in the country. Let me give you a brief introduction into how that happened as a precursor to what in fact we were doing, and what we are in fact not doing in Massachusetts, or have not resolved yet.

The Massachusetts bill which guarantees universal availability of affordable health coverage for each of its citizens, was signed into law in April of this year. It was the result of an intense legislative debate, that took unusually, only six months to accomplish. Fueled by concerns from constituencies to the bill, that their hospital financing mechanism would be abandoned with the commitment to universal access, the bill was the third in a series of bills attempting to cap hospital costs and guarantee access provisions to the citizens of Commonwealth (Ed: Massachusetts). Massachusetts has distinguished itself, somewhat unhappily, as being one of the most expensive health care states in the country.

For that reason we were able and forced to take leadership early in the 1980s, to try and get on top of what were out of control health care costs, which were then obviously reflected in the premium rates. The proportion of their growth was of increasing alarm to the business community and consumers in Massachusetts.

The first and second cost containment legislation had provisions to protect access to care, not guarantee of coverage but access to care. In our second rendition, we developed an uncompensated care pool, that would make a more equitable distribution of responsibility for the provision of care among hospitals. It was not extended to primary care providers or insurers. It was simply a matter of taking those hospitals who were obviously using cost shifting techniques to stay alive while providing free care. Many hospitals were providing a disproportionate share of uncompensated care. So the pool finance arrangement was a surcharge that was tacked on to everyone's hospital bill, thereby aborting some of the Connecticut problems where we automatically assessed this charge to HMOs, self insured plans and regular indemnity plans across the board. The assessment was then pooled in an accounting sense by Blue Cross Blue Shield who was managing the pool, and four times a year redistributed. So the hospitals that did more free care got some money from the pool. Those that did less free care than average paid into the pool, and an increasing pool was shifted around to cover both free care and bad debt. The characteristic difference between the two was the definition of eligibility based on income. Up to 200% of the poverty level was regarded as free care. Not met bills of those above 200% of the poverty level were considered bad debt.

The pool mechanism worked for awhile, and it took pressure off of some particularly stressed hospitals. It did unfortunately nothing to arrest the growth of the cost of uncompensated care. As a matter of fact, it did almost exactly the opposite. We watched the free care bad debt pool go from $29 million in the early 1980s to $325 million this past year, yet more cause for alarm by those who were paying the bills: the employer community, the consumer community and the health insurance industry that had to market the premiums that paid the bills. Everyone was alarmed, and no one could agree on the solution. We had a sunset provision on the cost containment bills as a characteristic of all cost containment bills. There could never be absolute legislative consensus. So instead of agreeing to put some mechanism into place in perpetuity, you compromise and then sunset the provision after two years. So as a result of the second cost containment bill that brought us the uncompensated care pool, we had a commission formed from all of the invested parties participating from the business community, insurance community, provider community, and the consumers.

The commission worked for 18 months to solve the puzzle of the distribution of responsibility for both assuring access and keeping cost down. They brought basically some recommendations to the governor in June of last year. They were unfortunately not conclusive. We had found the situation where everyone had compromised to a certain degree, yet no one was completely happy with the result. The governor and the legislative leadership decided, especially as the stakes had become very very high in terms of the cost to the parties that were contributing to this, that we had to finally stop the backward tumbling down the stairs of cost containment and try to grapple with reforming the health financing system as a whole, and try to rationalize that system, first for consumers, then for employers, and all other players to the drama that we've been describing today. It was a very large order and we were not guaranteed success, in the sense that we were tackling something by establishing certain principles. The

principles that we were pursuing and that were articulated in the legislation that we were suggesting are: first to redefine the responsibility of the employer community. The legislation first encourages, and then requires employers to contribute to the purchase of health coverage for each of their employees. That is obviously a change from the current practice, even though the majority of employers in Massachusetts currently cover, the minority are contributing to the added cost for those employers who already cover. We had to also state and try to reflect in the legislation a commitment on principle to a private system of insurance. We also stated an intention and a preference for deregulating a lot of the cost containment features and allowing the market to operate in what we saw as a large and less than efficient delivery system in the state of Massachusetts. We had many more beds than we needed and were paying daily for the privilege of heating empty space in underutilized hospitals. So another principle that we were pursuing was when to allow competitive pressures to encourage those institutions to convert themselves to other more useful purposes in their communities or at least diversify themselves so they could have a source of income that was not the health care premium dollar. We also submitted the last principle, that we were pursuing, was to rationalize the insurance industry in Massachusetts.

These were not humble goals; you could accuse us of grandiosity. But since we were trying to reform an entire system, we knew that there were many parts of the system that were broken. The insurance system in Massachusetts was one of the broken parts. We had a very inequitable situation in both the tax and the regulatory treatment of the various insurers. As new products and designs entered the market, it did nothing to rationalize the situation. If anything, it contributed to an increasingly confusing array of providers of insurance, and their treatment by the government was very inequitable.

We took this monumental 136 page reform package to the legislature, just a year ago, in September. It achieved perfect consensus, almost immediately. Unfortunately, it was negative. We managed to offend almost everyone in the process of proposing our legislation. The providers thought there wasn't enough money allowed for their survival. The employers thought there was much too much money allowed for the providers. The insurers could not agree on the pace to which the playing field would be leveled. The consumers were probably the happiest of the lot, because we had established the principle that every citizen in the commonwealth must have access to affordable health coverage. At that point we were saying within two years. Because of particularly the employer mandate, an enormous amount of work to do, in terms of clarifying and obviously negotiating a successful conclusion to our legislative proposals, we saw our package go down to a humiliating defeat.

Undaunted, we continued to give legislative leadership, to both streamline the package and to represent a modified package that would be more palatable to all concerned. We took out the insurance reform aspects and put it into a special commission. When in doubt, form a special commission, which I have the pleasure of chairing as we speak. We are trying to work through the issues of equitable distribution of tax and regulatory treatment as well as the shape and structure of the insurance industry's response to the uninsured and uninsurable. We took out a number of provisions that were going to speak to the improvement of our ability to maintain quality oversight and put those off to another day. We kept access provisions and we kept the hospital finance provisions. The remarkable difference in the legislation, as it was represented, is that it further established the principle that the state had a role in the financing of the affordability of

uncompensated care. Up until that point, the state had in effect escaped any role other than its natural role in Medicaid for the poor. It contributed nothing. The market took care of the uncompensated care pool responsibilities by sharing the cost among itself, in this case among those who purchased hospital days. So it was broader based than in Connecticut, but still not as broad based as it might be.

We had to and did, not too reluctantly, somewhat reluctantly, agree to join in a three way partnership with consumers, employers and the state, in effect reinsuring the uncompensated care pool. The uncompensated care pool was capped and statutorily designed to go down over the course of the next four years, with the state insuring that if access demands pressured the pool, that the state will insure it to 110% of its $325 million and anything above that would be split between the hospitals and the state in terms of responsibility. Our intention obviously was to proceed in the direction that took the money that was being spent on acute, in many cases emergency care, and convert it into coverage for individuals so that they could prevent the acuity of the illness and keep people healthy earlier and reduce the draw on the uncompensated care pool. Likewise, we have mechanisms in the bill to encourage and help small businesses to get coverage for their employees. Prior to the mandate date which is 1992, the state will try to assist in creating pooling mechanisms to assure that small businesses who have been actively discriminated against in terms of price were given some edge and some relief so they could join the market and cover their employees before they were so required.

The last mechanism that we had to design, in terms of both the coverage of individuals who are employed and those who are not, was in the role of insurers of last resort. We needed obviously a small department of medical security that would manage the brokerage and purchase of mainstream health insurance products, on behalf of the uninsured. That has been our intent and the legislation actually dictates that the state cannot compete as an insurer other than with those groups that the insurance industry quite frankly doesn't want anyway. So we are being given the legislative statutory ability to become the insurer for groups of five or less, as well as to offer nongroup coverage for disabled individuals who would not be insurable in other markets and anyone else that came to us whose employer did not cover them. We expect and hope that the employer community will want to cover their own employees. The mechanism to finance this was designed with two purposes in mind: One obviously, was to pay for the coverage for all employed individuals, so that the state would have a secondary role in paying it. Second, to avoid federal dictates that discourage states from intruding in the employment relationship, we had to design a system that got around ERISA. We were and still are hopeful that there will be a national health plan that rationalizes this relationship. But in anticipation of that, the only action left to the state is to use its ability to tax differentially businesses. So we assessed a 12% premium tax on wages up $14,000, for those employers who chose not to offer health insurance and wished for the department of medical security to do so on behalf of their employees. That figure comes to $1,680 which was derived from both Kennedy bill actuarial studies as well as studies that we had our own internal staff work up, which attempted to model the equivalent of a federally qualified HMO and adding state mandated benefits, Massachusetts state mandated benefits. This is then multiplied by a factor to estimate what family coverage would be. We are trying to encourage family coverage, because of the nature of the dependents, as we heard before, the uninsured dependents of employed individuals. As we did these studies, we tried to be as rigorous as we could, consulting with technical individuals who

knew this better than we did. Thus we arrived at the $1,680 figure as the state's share of a plan to which we would ask individual contributions. Last year the legislature, in their wisdom and by necessity, transposed that number to be the one to be used in 1992. So in 1992, $1,680 may well be the best deal since sliced bread and we are very worried about our ability to offer coverage for that amount, as well as the untoward effects on the market.

We will see, I think, a great interest in our pool because of its cost. Introducing that, we have complicated our lives significantly, but that was the nature of what we were trying to do. We pass legislation not to make our lives simpler, but to establish a very important principle. I'll restate the principle and then tell you where we are now, and what we are working on doing. The principle is that in this day and age, this country joined only by South Africa is not extending health security to its citizens. We think that is lousy company. We have been about the business, in this state, of trying to make sure that the responsibility for coverage and the rationalization of health care system financing does not fall on the individual consumers, who through no choice or fault of their own, finds themselves either unemployed, uninsured, or uninsurable. We feel that we would like to reestablish the principle of broadening a pool and eliminating as much as we can the nervousness of the participants in the insurance industry around adverse selection. We have looked at risk pooling and decided that that encouraged the wrong behavior.

Our interest was in mainstreaming and broadening the responsibility for both coverage of the uninsured and the financing of that coverage. But what we have not done is taken the final step which would broaden it all the way to being supported completely with tax dollars. We've wanted to maintain the system that kept an active involvement from the private sector, both the employer community and the insurance community. Our principles have been stated, and our four year course has been charted now by this legislation. We are pleased with establishing the principle, and it's a very important principle to have accomplished legislatively. As I mentioned, it's not an easy fight, but we didn't say it was going to be easy, it was just important.

What is unresolved, I'll start with the insurance industry, is the problem of inequities among carriers at this point. The commercial carriers of Massachusetts clearly carry a very heavy load in terms of the responsibility, in both the premium tax and in terms of competing in a market that has been dominated, as in many other states, by Blue Cross/Blue Shield. Blue Cross/ Blue Shield does not feel as the favored son, however, because we have enormous regulatory control over Blue Cross and hold them to very high standards in their non-group coverage and rate regulate them. So they are not feeling particularly favored in our commonwealth.

The third group, which are HMOs and now a proliferation of other short acronyms, are coming into the insurance market in a very different way and with different rules. We both want to make sure regulatorily that that is wise and that consumer protection is strong and also to figure further and anticipate how they can contribute equitably to the final solution. The commission that I chair is now addressing the issues of how in fact to design our new department of medical security so that we can accomplish those goals. We do not want to tip the market so that all of the bad risks come to the department of medical security. We also do not want to go into competition, because of our affordability standards, with the rest of the industry. So we are in very intense discussions, which are not yet concluded, with the industry and business,

over how in fact to design what will be a very delicate middle ground that continues the vitality of the health insurance industry in Massachusetts.

This, quite frankly, underscores some further systemic troubles that we have in terms of the insurer domination. We have a majority of large employers self insuring. The insurance is no longer insurance as we once new it. We would like to see the risk pool grow and have it mainstreamed. This original legislation suggested eliminating the preexisting condition clause, which sent many of our colleagues in the insurance industry for their Pepto Bismo. We found that there was not a consensus on how to set rules so that the average selection location would not change. We expect that many of the questions related to the equitable distribution of responsibility among insurers hinges on the basic question of financing, what share and what responsibility would the state government take for subsidizing premiums. That is the significant question.

This legislation has required us to practice if you will, on some group coverages that we are required to offer to people who are formerly underinsured or uninsurable. We have coverage for disabled individuals that want to leave welfare or social security to go to work, and before could not afford to leave their coverage. We have designed coverage for these individuals and are now establishing a sliding fee scale and design plan that will give us our first experience with both levels and types of subsidy as well as our ability to manage the care for these plans. Our hope in terms of both defining the parameters of the subsidy and the outside exposure to risk of all parties in this venture is that we have to go back to the cost containment principles. However somewhat differently we are investing most of our interest in managed care systems. We at this point see indemnity coverage as something that is suffering as much as the rest of the insurance industry, and would like to invest in management and prevention as much as possible to keep costs under control, and at the same time guaranteeing comprehensive coverage for people, so we are not simply creating another problem for ourselves. There are two other partners to the financing and affordability puzzle.

One of them is individuals. We have not in our law required individuals to join a plan. So we have an unresolved issue about individuals who choose to remain uninsured, such as the young people that we have identified. Many college students as well as young adults who think they are invulnerable and would never get sick, and if they get sick they would deal with it later. They are really not devotees of insurance. We want to make them devotees of insurance, because they would obviously contribute to the health of a risk pool. They are good risks and we would like to get them into our pool. We have not legislatively or strategically figured out exactly how to do that. It is an unresolved issue, however, that we're going to have to deal with before we complete the four years of transition.

Without mandates, the affordability issue will again define the pool, and we will end up with a growing uncompensated care pool and a shrinking enrollment in our new coverages. The last role and one that nobody talks about anymore sadly, is the federal role. Our preference obviously, being a state that has taken the bull by the horns, is to tell the federal government to send money. That's the first message always, we tend to send lots of tax money up and very little of it comes down again. That however, is not sufficient, but maybe necessary, but not sufficient to the solution that Massachusetts and other states are seeking. We need change to the basic ERISA statute, so that we can get into a more logical relationship with employers in Massachusetts. Our plan to tax

differentially is ingenious, but it is convoluted. It's going to lead to unnecessary complications in the implementation of this law. Complications that we will take on but that we would just as soon avoid. The other issues that need to be dealt with are the competitive advantage or disadvantage that we set our employer community at. We think, because our economy is so hot now, that there's no immediate danger of employers leaving the state, especially, since the coverages in mobile companies is very high. The coverage in retail firms and construction firms is lower and we know that they have to stay here to stay in business. So we think that the solution would be more rationally pursued at a national level to guarantee that there is no unnecessary migration of both uninsured individuals or employers.

Which calls the next question, and it's an intriguing one that we looked at, but it's way off on the horizon in terms of the federal role. That is the more we become a global economy, the more employers who have to compete globally and compete in other countries where there is a much larger federal role in subsidizing the cost of health coverage are going to start to raise issues about the equitableness of that arrangement. I fully expect within the near future that there will begin to be some interesting discussions about the federal role in subsidizing or at least encouraging states to join in partnership, as Massachusetts has, with its employer community to guarantee coverage.

My hope as we venture into the next four years, is that we will begin to grapple with issues so that other states can benefit from our experience. We have benefited by looking at other states experience with risk pools and with a variety of problems with provider financing. Massachusetts hopes to be able to offer guidance to those states as they venture into the uncharted territories they we are currently grappling with.

MR. GORDON R. TRAPNELL: I am going to talk about the Kennedy-Waxman bills which provide true prototypes for what national mandated employer plans would look like. These bills have nominally been introduced, have had hearings, and in one case has actually been reported by a senate committee. There are really two bills. Senator Kennedy and Representative Waxman introduced identical bills which I will refer to as the original bill to which all of the work I did was related. However, after hearings, the senate committee on Labor and Human Resources actually reported a new version of the bill which I will refer to as the senate committee bill. It has some very significant differences, from the original proposal, for actuaries and insurance companies. Both bills had the same general outline and content. There would be mandated minimum coverage that employers would have to offer to employees, and employees who could not demonstrate that they had other coverage would have to accept. The minimum scope of benefits would include hospital inpatient and outpatient services, professional services of physicians, diagnostic test, X-rays, laboratory procedures and a specific limited package of prenatal and well baby care. In contrast to the typical coverage that you see in employer health insurance plans, especially anything that's covered by state mandated benefits, there is a long list of exclusions that are not covered in this scope of services, including prescription drugs, mental health, mental hospital, alcohol treatment facilities, drug abuse treatment facilities, oral surgeons, dentists, optometrists, pediatrists, chiropractors, physical, speech, and occupational therapists, and audiologists. There's no home health care, nursing care, there wasn't even medical equipment and supplies. The minimum cost sharing that the employer could offer in the plan would be a $250 deductible for single individuals, $500 per family, 20% coinsurance,

and a $3,000 stop loss per family. That would apply to everything except prenatal and well baby care.

A feature of particular interest to the insurance business and the health insurance actuaries, was the proposed restructuring of small employer group plans. All employers, under both bills, with fewer than 25 employees who are not insured with adequate coverage that is meeting the standard on the inception date of the bill, would be forced to join a federally run and sponsored pool of insurers. In the original bill the Kennedy-Waxman bills, there would be a request for proposal (RFP) type process of proposals and deciding which insurers had won. They would select in each of the six census regions, five insurance companies or consortia that would be able to offer the sponsored coverage to the small employers in that area. In each case, each of these insurers or consortium of insurers would have to offer both indemnity and managed care options. The process would be a very revolutionary change, especially for this market, and would resemble a lot more closely the federal employee health benefit system. It would be the same as the federal employee health benefit system, if you had an additional process in the open enrollment periods that they hold each year, in which they select which insurers can offer them and only select a few. One of the things that I believe is that the successful offerings under this kind of system would not generally be the companies that write this market today. They would be companies that would mount a serious bid to be one of the five insurance companies in their region who would have a company wide task force combining elements that mostly came from the large group division, trying to figure how they would structure their offer.

In analyzing the bill, we concluded that the most likely plans that would be offered, at least in initial years, would be a Blue Cross affiliated HMO entry, an insurance company sponsored IPA model network entry, an entry based around the physician, medical society oriented IPAs around the country, a network of consortia that was based on the staff and clinic based model HMOs with an insurance company to offer the indemnity plan coverage and background, and the fifth entry would be either a duplication of this latter or perhaps a PPO entry as they were trying to get a diversification of entries as well as intense competition of the insurers in shaping these entries. The competition would be unlike anything that we have seen in health insurance. It would be more like the old days when you bid on choice large group cases, would get 50 to 100 bids, and the only way you ever won one was to make a mistake.

Once the consortia had been chosen, there would be an open enrollment process, in which the employer would choose the insurer. These are all employers that have one thing in common, that they were not willing to pay for health insurance. All of the entries include managed care options including some limited panels. Our conclusion is that the winning insurers, as far as enrollment goes, would be the least adequate panel of providers that managed to slip through the qualification procedures before they decided to take the low bidder. You have to really think through the characteristics of this system before you make judgements about what it's going to cost. It's very different from anything that exists in the health insurance market today. There's another important feature of the bill of interest to actuaries, and that is, that after considerable deliberation on the subject, the offerers decided to incorporate an actuarial equivalence feature in the bill. We were unable to envision any economically efficient way of judging actuarial equivalence with the incredible variety of plans that there are in existence, including all of these negotiated plans which had the primary objective of avoiding to disclose that they had to add a benefit here or there.

So let's do it on a dollar basis, so in the original bill our interpretation of the procedure to be set up would be that the secretary of health and human services or someone in treasury, probably in consultation with health experts at health and human services, would determine amounts of money which probably would vary by age, sex, area, perhaps occupation and other characteristics. Which if you multiply those out in a matrix times employees and single families or maybe by number of family members HMO style would produce an amount of money that you could then compare with the average expenditure by the employer for his plan. However, you are going to determine that, it would provide a safe harbor for whether they had met the minimum standard. That's the way we interrupt the bill and once we have done that, then our cost estimates would be easy because we weren't estimating the cost of any insurance. We're estimating the impact of the end results of the governmental process to determine the amount, and that's much easier to do. We knew that would go to the nationally recognized data sources. Accordingly to the ones that were the most familiar and most agreed to by the academic kinds of standards that the federal government uses in a thing like this, which were the most authoritative and most believable.

By the way, our firm was a part of the cost estimating process. The committee had requested estimates from the congressional budget office. The congressional budget office said that they would estimate the employment effects and aggregate costs but that they wanted actuarial assistance as far as the rates to use to multiply by the eligible employees to get the aggregate amounts. That's why we were retained. Another thing that we are very conscious of was the use of our cost estimates, which was to plug into this CBO model. Our primary concern was the validity of the cost estimate that resulted which was for an aggregate amount. We knew that they were using population surveys of employed, unemployed, insured and uninsured employed and insured and uninsured unemployed people to multiply times the amounts of money we gave them to get aggregate amounts of money. We reversed the process, and we started with the aggregate spending in the country for hospital and physicians services as compiled by the government sources. We carved out of that certain services which will not be paid for by an insurance plan: mental hospitals, sanitariums, long term institutions, alcohol treatment facilities, VA hospitals, federal hospitals, etc. We then did a similar process with physicians although we wound up not doing anything because we knew some extra things, i.e., laboratory services, were not included in the physician services. But it was mostly starting with these aggregate figures that estimates the total spending in the country, sort of health GNP and then carving down, first the scope of services delineated, then attributing that over the population to the people so that we could add up that portion of it that was for the groups we wanted to look at. Then look at certain averages and certain distributions of expenditure to determine what the deductible coinsurance things like that would do. For this purpose we took the NMCES file which is the National Medical Care Expenditure survey. This is pretty old now, 1977, but there's nothing better available, if you want to use public, well recognized national surveys that have been thoroughly gone over and accepted in the academic community. We projected the NMCES file to 1988, both by making it meet current demographic projections including employment figures and also to match these aggregate national totals for spending. So we now had a file which had a comparable number of people to the sources being used by the CPO when they multiple by, basically take an aggregate amount of money divided by people to get means, adjusting those means for the effect of deductible, coinsurance etc., reimbursement system and then those adjusted means will be multiplied back by the population to get aggregate figures. This is the context that the numbers we were using fit into. To do the deductible and coinsurance part, we

used our ARC rating model which was ultimately derived from national distributional data such as NMCES, but it has also been compared extensively to private insurance spending data to make sure the distributions look reasonable. We also have a number of algorithms that incorporate the findings of the RAND health insurance experiment in order to adjust the level of utilization for the amount that's being paid for by insurance. From this we derived these average per capitas, adjusted them for effect of the plan of insurance and then added 15% for administrative expense which works out to be 13% of premium. Since the total administrative expenses of the federal employee system is only 8% of premium, we thought a figure somewhat higher than that, 50% higher, would be adequate for the system that we were contemplating, since in many ways its structure would be similar. This contrasts rather starkly with administrative expenses in the range of 25% to 30% or more that you find in this particular segment of the business today, which is characterized by two completely different systems. There's the Blue Cross/Blue Shield pools which are really run like pools and have relatively low sales and administrative expense and pretty high persistency. They tend to collect all of the bad risks in the community, especially in areas where Blue Cross is told to take all groups and not where the premiums are controlled. The rest of the business is characterized mostly by the trusts that companies set up. The life of the trust is three to five years because in the early stage of the trust, the cost is very low. There is the impact of underwriting, preexisting exclusion clauses, and as a trust ages, you have the impact of the groups that can now continue to qualify for a new trust and thereby pass the underwriting screens. Nobody has preexisting conditions. They will take a new rate by leaving the group. So that the anti-selection wearing off of the selection and losing the preexisting exclusion, the rates are jumping up by 30 to 40% a year and they are visibly giving everybody huge rate increases that reflect a combination of trend and anti-selection. There's a constant churning. Commission rates apparently, I don't know exactly what they are, but they appear to be in the range of 10 to 15% the first year, 10% renewal, with all the additional agency expenses and bonuses and so forth, which probably increases the cost over the commissions another 50%. The persistency is very low, so there's a huge administrative expense for a product that's really run very similar to individual insurance. When we are trying to compare the kinds of numbers that we've come up with individual actual insurance that people have, you have to allow for huge differences in the cost of administration, and differences in the scope of benefit packages, differences in reimbursement and others.

We produced these estimates about two years ago, when first starting this. Unfortunately we are right at the end of one of the flattest periods of health care costs that we've ever seen, and we, of course, missed the huge increase that's occurred in the last year. Our objective was to come up with the best estimate we could of what these actual fail-safe numbers would be. We were not deliberately trying to come up with numbers either higher or lower than what they would be. It did not include any contingency margins, it did not follow the traditional actuarial reaction to risk, trying to figure out not the best assumption with the best estimate to have of something, but the safe estimate of it. Which is maybe somewhere between two to four times the best estimate of it. There's also a very different perspective. The perspective of actuaries is that their traditional role is that they are supposed to give a premium that under no circumstances proves to be too low. When you are working in a public environment, the perspective of the politicians is that if you give them an estimate that is too high, you have denied benefits to constituents and their job is to maximize the benefits constituents get. Consequently there's no justification of any margins or to be safe.

Another aspect of it is that because we started with these national expenditure totals, we had the money that's actually being received by the hospitals and physicians. Thinking about it later in trying to figure why our rates turned out to be much lower than anybody offers insurance and trying to rationalize the differences, we also have in effect incorporated all the discounts that anybody obtains from hospitals including those of Blue Cross Blue Shield which are probably most significant, but also the HMOs. Insurance companies tend to pay charges, whereas we are looking at the average rates actually received by the hospitals. We also are looking at the actual income of physicians and not their charge level. So part of the question is what do physicians do, what is their behavioral reaction to greatly expanding insurance and greatly reducing their bad debts? I must admit my considered opinion is they pocket them. We did not make an allowance for that. The other things which could be very powerful is this program eliminates a lot of the shift bias that you get now. Provided, at least as far as this market goes, the federal government would be sensitive to premium rates charged in these pools and would authorize insurers to at least get a fair deal and certainly not force them to pay charges. In fact, the winning bids would usually be people who negotiated good rates with a select panel of hospitals.

There's an unknown degree of bias selection in persons who are now in employment groups with insurance opposed to those who are not, the contrast in the insured and uninsured employed population. Included in the insured are all of the big heavily unionized firms with very generous plans and they also tend to be in areas of the country that have the very highest cost, like Massachusetts. If you look at the characteristics of where the uninsured are, you find that they tend to be much more rural, although they are increasingly in urban areas with small firms. I would speculate that at least in the early years of any program of this kind, that the average expenditure by persons who are now employed but uninsured is likely to be significantly less than those who are currently employed and insured.

There is also the possibility that these national data sources miss some spending. They've been thoroughly gone over to the point where I now think one of the reasons we are expending such a high proportion of GNP on health, is that we do a better job of counting the health spending than we do on counting the rest of the spending compared to other countries. It is still possible that some of the data sources used in making these estimates still have some soft spots, especially for physicians. Generally speaking, the method of ours is based on IRS receipts. Since the IRS has an excuse to hide behind its confidentiality, it can never examine the statistical procedures and adjustments used in compiling these figures. My general experience with government statistical systems would lead me to suspect that they have tricks like if they can't decide whether it's an optometrist or a physician, they will classify it as other. Other gets to be a very large group. They don't allocate that over all the things that it could have come from. There are many other sorts of statistical aberrations like that which you find in government data systems, that you would with the IRS data, but you have no chance to examine it. But it is possible some of these national data sources do give us lower estimates. I'm still trying to figure out why there's a large discrepancy between the experience. Companies have taken their actual experience, taken an administrative expense out and then carved out the types of services that are not covered in this bill and still come up with numbers that are closer to 2,000 per family. They come up with numbers anywhere between 10 to 25% above the numbers that we came up with. That's a

cause for concern for us; we knew there would be a discrepancy but we didn't expect it to be more than 10 to 15%.

The committee bill that was actually reported by the senate, had two very important changes of interest to actuaries. One of them was that they dropped the five insurer maximum and opened up to any insurance company that wanted to meet certain qualifications to offer a plan, so that they could have multiple number of entries. This has a number of interesting effects. One interesting effect is that with five entries, there is an incredible competitive pressure to be one of those five, sometimes the nature of competition is really one slot that fits you and you have to beat everybody out to get that one slot. That's replaced by multiple insurance companies so there's no longer the same pressure to get the minimum cost entry that you could. This would open up the possibility that you could build in allowances for salesman sales commission if they can. If it's an open enrollment with the employer choosing, with the preexisting exclusion clauses prohibited, it's a lot harder to play any of the selection games that occur in that market today. But they still might be played to the extent that the administrative cost and premium cost go up. On the other hand you have changed the nature of the qualification process for the limited panels. Because now I mean if you are going to select five out of an infinite number, you can be pretty sure they are not going to select any panels that don't have a pretty representative representation of medical specialities and hospital facilities available. However if you let everybody participate who can get by a set of standards including all of the appeal processes to the courts that they can take.) You don't have the opportunity for many more games to be played as far as that kind of panel that is being offered as we noted earlier when you are trying to appeal to employers who simply want to minimize their expenditure. The least qualified panel that you can get through this process wins.

With rate books and tables using an apparatus very similar to one that's going to be used to judge discrimination, which has the virtue that any plan gives you one answer, it may not be the right answer but gives you an answer. This has completely changed the nature of the bill because now employers don't have to meet some dollar expenditure, they actually have to have benefits that are equivalent and be ready to prove it. That would very much change the minimum level of expenditure that they would need to make. When we got involved in this we thought this was as academic and far an out idea that we had heard of in a long time. But we knew the people on both the committee staff side and CBO who were asking us to do it, and we said all right. We never thought this could go anywhere. We still try to do a decent job of it, but we thought it was a totally academic exercise. Of course the world has changed rather abruptly in the last couple of years in this respect.

The other observation is that there are certain vacuums that I see emerging that are responsible for this. The system we now have of financing health care in this country is a national system. We already have national health insurance but we don't call it by that name. We have a very funny system of state and federal requirements and programs that rely on tax incentives for employers to provide health insurance to employees, certain other subsidies for other people to purchase insurance, the Medicaid system, and of course the expansions on the idea of the Medicaid system (most states have additional programs). In addition to that you have various federal programs that offer other little bits and pieces of coverage, such as the VA system. But underlying the system of financing is the way bad debts are financed, which you went through in quite some detail. It's a very curious system that the way we pay for the care for the uninsured is

they present themselves at hospitals, who are forced to take them and provide coverage. Since they have no other way of getting the money back, they charge the people who do pay. Since the hospital bills are so high, people with assets and income can not afford them without recourse to insurance. So insurance pays the general charge level which pays the bad debts. This system works all right provided that everyone gets their share of the bad debts. But increasingly, there is competition in the individual negotiations between HMOs and preferred provider plans with hospitals, and pressure is being generated by government programs that now typically account for 50% of hospitals' income telling them what they are going to get and it's below market rate. The hospitals are under immense pressure not to subsidize anybody, but yet they still have to. So they are busy trying to shift this population someplace else if they want to survive financially. Increasingly for the employers, every time we get another 15 to 25% increase in health care cost, it's an even bigger item on employer expenditure side, of course with the accounting changes that are going to put the liability for the retirement benefits on balance sheets, many balance sheets of many American corporation are going to be transformed from being very solvent to being either insolvent or near it. The pressure that is being generated by that is the vacuum that is this unstable way of paying for the bad debts. In particular, they look around and they see the employers that are not contributing anything for these bad debts and in fact actually increasing them, and they are looking for a way to get revenue from those deadbeats. I think this has not been a factor in the past, even in the huge cost increases in the late 1970s and early 1980s. Employers still reacted to this type of problem saying yes there's some deadbeats out there but we're much more afraid of the government getting involved with things. A lot of employers are changing in their perspective, saying this has gotten bigger than us, and we can't do anything about it. The government has got to intervene. I see this vacuum with paying these bad debts and the fact that the employers with the health insurance plans especially the ones with the negotiated plans where they have a union that's dictating that they can't change the plan and the ones with the huge liability for paying benefits for early retirement. That is a vacuum that is going to lead to a lot more pressure for doing something different than what we do now. Especially if we go into a very severe recession that is marked by continuing escalating costs of health insurance plans, which will almost certainly continue to escalate because of what the government is doing. The government is shifting its cost to the private sector and doing so in an increasing amount.

The Massachusetts problem was that they decided that the hospitals would get, how much money, $50 million. What is the percentage increase that the hospital budgets are going to be allowed in the next two years?

MS. DUNHAM: The increase will be about 9%.

MR. TRAPNELL: I have seen more like 50%.

MS. DUNHAM: There were many interesting rumors. The total aggregate amount was $330 million on a base of $5 billion.

MR. TRAPNELL: I remember looking over a financing sheet that explained how this works, and seeing this huge new amount of money that was going to the hospitals to compensate them for the federal government taking away their revenues on the other side.

MS. DUNHAM: The Medicare shortfall was $50 million.

MR. TRAPNELL: They've decided that the hospitals get the $50 million but they really haven't decided who is going to pay it. This kind of pressure let loose can lead to very different players and very different interest groups lined up on each side of legislation in the future.

MR. HARRY L. SUTTON, JR.: Catherine, you mentioned this huge pull for the small employers who don't have coverage and will buy in, if they don't purchase coverage. If that pool of the $1,680 or whatever goes into it, is way insufficient to cover the cost, where does the rest of the money come from?

MS. DUNHAM: There is an implicit understanding that the state will stand to close the gap between the $1,680 plus the individual contributions, which we also estimate to be roughly 20 percent, and whatever the ultimate cost would be. So the state is liable for the difference once the guarantee of coverage goes into effect in 1992.

MR. SUTTON: If $1,680 is supposedly the current cost, is that plus 20% for employee contribution?

MS. DUNHAM: Yes.

MR. SUTTON: How does the $1,680 square with Blue Cross rates that are $4,800 per family? Is the benefit plan that the state is pushing a low cost, low option benefit plan to keep the cost down to $1,680 plus?

MS. DUNHAM: As I said, we are going to encourage choices between managed care models. So we are not at the moment intending to set up an indemnity product. We anticipate, there is a mechanism in the bill to adjust the premium after the first year of operation. There's a formal mechanism to review the danger that we will hit the same problems as in Connecticut, that quite a number of people will enroll at the $1,680 level and the rates will go up substantially in the second year and you would lose participation. So we are doing everything we can to figure out how to put together a very efficient benefit package and a case management system that will insure that we make the best use of all those monies. At the same time, we fully expect the state is going to be on the hook for backing up and paying for the difference.

MR. SUTTON: I think from what I know of HMO premiums, that they are at least in the range of $3,000 a year. Apparently you don't consider those managed care systems to compete with the $1,680?

MS. DUNHAM: No, actually the cost has enormous variability, depending on what part of the state as well as the groups that the people are involved with. There are two major sources of competition or corroboration that we have. One is the existing rate for the group that we're targeting, which is a young good group that is very attractive. They are young and healthy, by and large. So we think we could get a good rate if we in effect put this group out to bid, which we will. Secondly, we will not let go of the Blue Cross/Blue Shield non group coverage, which is subsidized by their differential advantages in negotiating with hospitals. We have to keep the whole market from shifting into the department of medical security. We have to watch the equilibrium between those projects. We intend to. Again we do not know at this point what competitive pressures we will put by offering a program that has to meet certain minimum

standards in terms of the benefit package and also meet a test of affordability. That's precisely what we are working on now.

MR. SUTTON: Gordon, in looking at your coming up with costs that seem to be too low or at least very efficient, did you consider the fact that the uninsured population, that's mostly what's being shot at, even though it might be somewhat younger than average, is having what we are seeing in rural areas with HMOs, rather than Medicare contracts, in low cost areas that the unmet needs increase the level of utilization sharply? Would you assume that the utilization would be the same as the national averages or that it might go up if you provide coverages for people?

MR. TRAPNELL: They seem to be the same as it presently is with insured groups. But I think the bias, my judgement is, would go the other way. The selection inherent in who buys insurance, who's willing to pay for it, is much stronger than unmet needs and this plan would have a $250/$500 deductible per year which would discourage a great deal of use.

MR. SUTTON: Comment on Minnesota and our catastrophic health plan. There were 11,500 people that lost $12 million in that last year and $15 million this year. Originally carriers paid, but they had an offset against premium taxes so that essentially it came out of the general state revenues. In 1987 the legislature changed it. They taxed HMOs, insurers, and Blue Cross. So HMOs pay half the subsidy, Blue Cross about 30%, and commercial insurers pay the rest. As far as the rest of the employers who are self insured, there are proposals in there to change the financing to a payroll tax, similar to your plan. Employers are afraid that it will expand into a Massachusetts plan and probably will fight it to the death, if they could do that.

One other interesting thing is permitting HMOs to move uninsurable people into the state pool. HMOs have to enroll everyone if they enroll the group. Carriers or HMOs would be permitted to exclude a high cost case and move it into the state catastrophic pool, which would increase the size of that pool. Likewise it's not clear from the statement that once an employee got over $100,000 expenses they could take another employee plan and put them in the state pool. Hopefully, the employers will have a lower cost premium that way, somehow, and the rest to come out of general revenue.