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HEALTH SECTION -- NATIONAL ISSUES

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Recorder: DAVID V. AXENE

- o Current developments
- o Medicare
- o Uninsured risk pools
- o National health proposals
- o Relations with regulators
- o Relations with health care providers
- o The panel will present practical experiences in dealing with these issues and will identify ways that health actuaries could become more active in the policy-making process.

MR. DAVID V. AXENE: Before we get started on the session, I wanted to bring you up to date about the Health Section Council. First of all, we have four new members on the Health Section Council. Joe Moran, Paul Fleishacker and Irwin Stricker are the three people who have been brought on to the Health Section Council for a three-year term. Henry Essert is filling the remaining term of John Young, who had to go off the council. Dave Trindle, W. Duane Kidwell, and Ron Wolf, are the three people going off the council this year. The people who are left, including the three who have come on, are Bill Bugg, Guy King, Alice Rosenblatt, Dave Llewellyn, and myself. John Bertko is not on the Council, but he is responsible for the newsletter. Our board advocate has been Phyllis Doran.

This is going to be a panel discussion on national issues. What we're trying to do is to make sure that you're informed on some of the critical national issues that are going on, but more importantly, as the incoming chairperson for the council, my objective is to get each one of you and perhaps other actuaries more involved publicly in what's going on. Now some of you who don't work in a consulting environment are probably saying, "Well how can I do that?" At the end of this session, you'll have a better idea of how you can do that. There are many issues going on, and what I'd like to do is to start off the program just by making a few introductory remarks. First of all, how would you characterize your NIQ (i.e., your National Issues Quotient)? How much do you know about what's really going on? Do you know what's going on in Washington right now? Do you know what legislative bills or actions are being considered right now? Who do they rely on? Obviously, we always wonder who does the Hill really rely on? How do we as actuaries fit into this? Do you complain about the state insurance departments or are you helping them set their policy? Do you blame the doctors and the hospitals for all the health care problems or are you helping them understand how they can do things better? I hope that our profession will take a more active stance as we look at these public issues. I hope this will be one of many forums that we will have to discuss them.

We have four speakers who are very knowledgeable on this topic. Three of them happen to be consultants and one works for the government.

Our first speaker will be Guy King. Guy is on the Health Section Council and he is the chief actuary for the Health Care Finance Administration (HCFA). He has a unique perspective from inside the government and what it's like to actually be an actuary inside the government and reporting through the political process. Gordon Trapnell is a consultant in the Washington, D.C. area, and he has been involved in the public policy process perhaps as much as anybody in our profession.

PANEL DISCUSSION

Bill Bluhm used to work for the New York Insurance Department. He has seen it from the inside and he's going to be talking about state regulatory issues, and how we, as actuaries, might be involved in that process. Our last speaker will be Dennis Hulet who is a consultant in the managed care area and does quite a bit of work with both hospital and physician providers in educating them about their process.

MR. ROLAND E. KING: I think I can answer one of the questions that you asked. Who does the Hill listen to? I think the answer to that is, whoever tells them what they want to hear. The theme of this meeting, as Dave said, is to get involved, and there's probably no better example of the need for more actuarial involvement with things that are going on in the federal government, on Capitol Hill, than the recent catastrophic legislation, and more in particular, with the cost estimates that were associated with the prescription drug program. To give you a little background on the controversy, I should first tell you that Congressional Budget Office (CBO) employees know actuaries. They employ economists and statisticians who function as budget analysts. But the only way Congress gets any actuarial input is through the actuaries who are employed by the administration. If they're going to get any other actuarial input, they have to get it directly from the actuaries working outside the government.

I know of one actuary, Russ Mueller, who works for the Congress; he works on pension issues, but to my knowledge, there are no actuaries working for the Congress on health issues. The nine years of a Republican administration and constant tension over cost estimates on social insurance issues has really reduced the influence that the administration's actuaries have with the Congress.

I can remember a time when we worked closely with the staff up on the Hill. In many cases they were people who had moved over from the administration to the Hill, and so they knew what actuaries had to offer and they relied on us. With the kind of turnover that the Congressional staff has now, there just isn't that long-standing relationship and background. This further reduces the impact that actuaries who work for the administration can have. This creates a great need, both for more forceful and more persistent input from actuaries in the private sector.

My experience with Congress has been that, when you tell them what they don't want to know, they have to be told several times before they'll listen. There's probably no better example of this than the debate over the prescription drug estimates that was part of catastrophic. When the prescription drug program was first proposed in the Ways and Means Committee, the very first markup sessions, CBO had their estimates and we had our estimates. Congressmen were thrown for a loop, because our estimates were more than eight times what CBO's estimates were for the cost of that program. Now, reasonable professionals can differ, but differences of this magnitude are rather unprecedented, even in the frequent clashes that we have with the budget analysts at CBO. There were some Congressmen who were somewhat upset, but as you all know, Congress pushed ahead with the legislation anyway, and there were frequent opportunities for both sides to revise their estimates, as the legislation changed somewhat, as it went through the legislative process. By the time that the bill had passed, CBO had raised their estimates by 400% and our estimates were still the same as they had been on that first day of markup. So at the time the legislation passed, we were no longer 800% higher than CBO, we were just 100% higher.

By that time we were being pilloried by members of Congress for the size of our cost estimates. They were pretty well convinced that our cost estimates were "politically motivated." There was a requirement in the law, because of all the controversy over the cost estimates for the administration in April of this year, to submit data that were going to come from a National Medicare Expenditures Survey (NMES). These data would be on prescription drug expenditures for the elderly. When the data were obtained, Congress decided that they would have asked the actuaries in HCFA to reestimate the cost of drug expenditures and then our cost estimates and all the associated documentation would be submitted as a report. The report on the NMES would just be an appendix to that report. So that's the way the report went up to the Hill. And the immediate reaction from the senators who were most closely involved in this issue, was to say, "Look at this, the administration has submitted another politically motivated report, even though the actuaries are sticking by their estimates. When you look at the NMES data and the Appendix, that shows that CBO was much closer to the mark than the administration."

Fortunately for us, even though the CBO employees may not be actuaries, they're not technical dummies either. The legislation gave them 60 days to revise their cost estimates after they received this report. They finished those cost estimates the day before Senator Bentsen was going

to have a hearing on the large surplus that he thought existed in the catastrophic program and how to get rid of that surplus by reducing the income-related premium for beneficiaries. The day before that hearing, CBO gave him their revised cost estimates, based on our report. Their report said that they were revising their cost estimates upward by about 200% and that the surplus in the catastrophic funds had now not only evaporated, but they had turned into a deficit. Their cost estimates are now slightly higher than ours.

Quite frankly, I felt a lot more comfortable when ours were eight times what theirs were than I do now. As most of you know, for reasons relating primarily to resistance of the elderly to the income-related premium, the House repealed completely the entire catastrophic program and the Senate repealed a substantial portion of it. The conventional wisdom is that when the House and Senate go to conference, some portion of the catastrophic legislation will remain intact and the income-related premium will undoubtedly be gone completely. What will remain in benefits will probably be the Part A restructuring, getting rid of the spell of illness division, and a few of the minor and ancillary benefits like the mammography tests and some of the very minor drugs, which are referred to as the "Mitchell" drugs. This is the first time in history that a major change in a social insurance program has been repealed at any time, let alone so quickly after it passed. It's the kind of experience that underscores the need for more actuarial involvement in legislative issues relating to health care. There are opportunities for participation by health actuaries coming up. Two examples are the various bills (probably Senator Kennedy's the most well known) relating to uninsured issues; and another issue that may be coming up, if Congress hasn't been scared away, is the issue of dealing with long-term care.

I have some suggestions about ways that you can participate more fully in the process. First of all, you can offer to testify on cost estimates. If you have expertise in a particular area, get in touch with your congressman on the Ways and Means Committee or the senator on the Senate Finance Committee and offer to testify when they hold hearings on these issues. During the course of the catastrophic legislation, the Academy did send a letter to Congress, saying that they thought the CBO estimates were, for the prescription drug program, vastly understated, but it didn't appear to have much impact. I think when people appear in person, it has a great deal more impact. You can, of course, write your senators and congressmen and explain your particular expertise, the area in which you specialize, and then you can tell them why you think policy changes should be made or why you think cost estimates should be changed, etc. So write to your own congressmen and senators or write to key congressmen and senators on the Ways and Means Committee or the Senate Finance Committee.

Another important suggestion is get involved before an issue actually comes up. That way they'll know who you are and they'll know the kind of expertise that you have before a specific issue comes up and you're not just coming out of left field. I know that Howard Bolnick and Ed Wojcik have gotten involved through the Health Policy Forum. I know that Harry Sutton has gotten involved through his relationship with Senator Durenberger, so there are ways that you can get involved before the issue actually arises.

MR. GORDON R. TRAPNELL: I was going to address myself mostly to the mandates for employer health insurance coverage, of which the leading example is the Kennedy Bill, but a number of states are now involved in major studies, which would presumably lead to proposals similar to that in Massachusetts, that would require employer mandates. It is similar to Hawaii, since Hawaii has had mandated employer coverage of employees for at least 20 years. I want to point out reasons why these proposals actually may pass some time in the next decade. If you follow the scenario of major economic recession, followed by the election of a Democratic president representing the wing of the party that has been predominant in the last 20 years, we might have employer mandated insurance for the same reasons we got Medicare. I see three major vacuums that are leading to a lot of the pressure for these programs. The first and most important is the bad debt of hospitals, coupled with a shrinking role of Blue Cross/Blue Shield plans in a lot of the largest states in providing tools for marginal insured insurance groups. In many of the states, the structure of the health insurance coverage has in effect been that Blue Cross, with very large discounts from hospitals, has used the surplus revenue to do a variety of public-oriented things, such as offer individual health insurance with minimum screening and frequently no screening. To operate small employer pools at a loss and, of course, to operate Medicare Supplement policy coverage at a loss has provided a structure to the markets where those employers, especially small employers that had people in their groups who could not qualify for insurance,

could find coverage at a reasonable rate. By reasonable I mean not several times the average rate in the market, but perhaps 25% or so above what might be available elsewhere.

The pressure that's been generated on Blue Cross/Blue Shield plans by competition from PPOs and HMOs and other groups that have hospital discounts and in many cases, the narrowing of the discounts, has led to a gradual reduction of these subsidies and the pressures on the Blue Cross/Blue Shield plans to engage in underwriting practices similar to other health insurers. This in turn has begun to dry up the available coverage of marginally insured people, which has led to great increases in uncompensated care to hospitals. These bad debts, particularly when they are distributed unevenly over hospitals, tend to hit the public hospitals in metropolitan areas the hardest, throws their deficits on to the general tax roll, and leads to a lot of the instability of the situation. The bad debts for hospitals drove the Massachusetts proposal. The state of Massachusetts was having to come up with huge amounts of additional revenues to fund these deficits or they had to close hospitals. They chose funding the deficits with artificial monies, and the insurance program in many ways was an attempt to collect some of the money that was required to pay those bad debts from the freeloaders, the employers who weren't offering the coverage. Thereby, without bearing any of the cost, patients still had access to hospital care through the various provisions.

A second major vacuum leading to the pressures for these programs is the short-sightedness of management of most of our large industrial corporations over the last ten or twenty years in making promises that they couldn't keep and failing to make any genuine financial provision for those promises. In particular they were tied to health insurance. In many ways, I fault our own profession, especially the pension actuaries, who looked at these things and said, "Well, we don't know what the cost increase will be, so we'll assume it's the same as wages." They always came up with relatively minor cost estimates for retiree medical programs, and they completely missed this major liability that was being accrued under their noses. The situation that's developed where you have a combination of very comprehensive coverage, an older work force, and the retiree medical coverage, is putting such a financial burden on these major corporations. As long as they're all in the same boat together, there was a chance that this might have been worked off by higher prices from their industry, similar to what happens from the monopoly of the labor unions over most of the products in this industry. The competition with foreign plants, especially Japanese, who have young work forces, no retiree obligations, and offer only HMOs or other more competitive forms of care, is putting older industrial corporations under an unsupportable, competitive disadvantage. It comes from their lack of foresight. On the other hand it's a national problem, between Toyota and Honda and the big three. I've seen figures in the newspapers that illustrate that they are certainly very much aware of the problem. It's the competition of the foreign plants that may finally drive the major manufacturing organizations of this country to support a national health insurance program, anything to get that competitive disadvantage off their backs and create what they feel is a level playing field.

I have no solutions to offer for this problem. One of the things that has occurred to me is that if there were state residual pools, one of the solutions open to the employers would be to throw these groups into those pools and thereby reduce somewhat their competitive disadvantage. Of course, they would spread the cost, and assuming that the self-insured were included in that, that would be a way of getting the new foreign plants to help pay for the higher cost of those labor forces.

The third vacuum, and one of the most serious, is in this small employer market, under 25 employees, especially under 10. The facts of life in this market are that it's almost impossible for an insurer to offer a stable product. The main difficulty is that employers can cancel any time they wish, or switch carriers anytime they wish, and will do so for relatively minor price advantages.

The entrepreneurs in this area have no understanding of health insurance. They think you merely pay a premium and all the rest of the misconceptions that the general public has about insurance. But this leads to an underwriting cycle in this sector that is characterized by an insurance company constantly starting a new multiple employer trust. In the first year they offer it, they have the advantages of underwritten groups and preexisting clauses. Consequently they can set relatively low rates, despite marketing costs and installation costs. However, the second-year costs will be dramatically above the first, because preexisting conditions wear off and effective underwriting wears off in health insurance just like it does in life insurance. So sometime by the second or third year, the insurance companies raise their rates, and of course, the inevitable result

of inflation means that the insurer is going to need a hefty rate increase. Rate increases lead some of the entrepreneurs who can still get their groups underwritten to immediately go find another insurer, because cost containment entrepreneurs are finding a new insurer. So the insurance company has to build in a much larger increase than the cost increase. They can get 50-100% increases very easily. It's coming sometime in the second to third year. From then on, in that thrust, it's all downhill. The only entrepreneurs who are going to stay in there are the ones that have somebody in that group who is no longer insurable and is willing to pay that price in order to keep the insurance for that one person. The possibilities of this, and ultimately what it really amounts to, is experience rating to groups of under 25. It's the overall effect of it in the longer run. Unless something is changed in the regulatory environment, unless the rules change, this leads to small employers either failing to insure people, or the ones who can afford it, will simply really be self-insuring; there's not much insurance really happening here. It's operated by allowing people to anti-select against them and maintaining a community rate. This kind of phenomenon did not lead to public unhappiness, but as Blue Cross/Blue Shield has been weakened by the disappearance of its subsidies, it has not been able to provide the same level of pool coverage for the small employer groups as it has in the past. I see this becoming an increasingly acute problem, where small employers are going to be running to Congress and saying we've got to have another solution.

Where in effect you could not start a new multiple employer trust, you had to offer a plan and you had to offer it to everybody. If you're going to raise the rates of anybody, you had to raise the rates for the entire class and you couldn't avoid the effect of that by continually proliferating your different groups of coverage. People immediately raised a dozen relevant objections to that, as to why it wouldn't work, but my point is, that if you work along those lines, you may be able to tackle those objections one by one and find solutions for them. It would take a lot of thought as to exactly how to do it and a willingness to tackle these problems. Another helpful change would be to simply prohibit preexisting solution additions. If groups are underwritten, there's no real reason to have them. The way the underwriting practice in this field would be adequate, I believe, would be if no one else was allowed to use pre-existing exclusion clauses. Another helpful approach which may have some potential for limiting the impacts of this cycle, would be to put limits on rate increases and on how high an ultimate rate for any group could be.

If you force insurers to have established tiers and have a limit on the ratio of their top tier rate to the low rate, these things will have many practical objections to them. I'm not convinced that a systematic attack on these problems by people who really know the ins and outs of the business couldn't lead to solutions. Of course, there is a structure like the Kennedy Bill itself, which would provide that insurers would have to offer coverage; they either play in this game or don't play in this game. If you play in this game you offer a fairly uniform coverage to all comers. One of the changes that would need to be made in the Kennedy Bill would be to offer rates not regionally, but by age and sex and industrial class and any other actuarial category, especially health service area, by which rates can be measured and found to vary substantially from one group of persons to another. The Kennedy people insisted on regional pools because they didn't want to face the political criticism that somebody in the high-cost area would say, "We won't be paying $2000, we'll be paying $4000." They were much more sensitive to the high-cost areas than they were to the low-cost areas.

What can actuaries do in general about their lack of influence in most public bodies, in seeking solutions to practical problems about which they are far more knowledgeable than any of the other groups that are involved? Some actuaries are consultants. They are salesmen, successful salesmen, or they wouldn't last very long as consultants. Others work for organizations, with the possible exception of Blue Cross/Blue Shield plans, whose major purpose is to sell something to somebody. I worked for an insurance company for eight years and came to the conclusion that insurance companies existed to pay commissions to agents. If in the process they manage to generate some administrative money from which our salaries, as officers of the company, could be paid, it's a nice living. But they were primarily sales organizations, and if you hope to succeed in insurance you better know how to sell. That's what the insurance business needed. Yet we find ourselves being constantly oversold by professions for which sales is thought to be irrelevant and where the objective is not selling anything to anybody. How do we harness these tremendous capacities that we have as salesmen, to sell something that we happen to need to sell to somebody, to preserve our own influence and our own roles in the business community? Let me give a case in point. In laughing over the antics of the kind that Guy was telling you about, I thought of a new economic phenomenon that I wanted to figure out a way to publicize, which I call the "CBO

Effect." Now that Guy has explained what CBO does and its influence, the way the "CBO Effect" works, in general, is if Congress, especially now that we have this monolithic legislation once a year, in which every piece of legislation affecting every aspect of American life comes up for change each year, in the middle of the night, you have literally hundreds of proposals to change the Medicare program. I always thought that *The Wall Street Journal* monitors the market by having one person each day who is responsible for monitoring all the reasons why the market would go up and another one who is compiling a list of reasons why it went down. And depending on what it did, they would take a few from one and a few from the other. Well, the "CBO Effect" is very much like that, because on the one hand, you've got all the pressures coming in from constituents, mostly providers, but also from patients or consumer groups who want expansions of their coverage that's available to them. This one is the largest pile. There is another pile that is generated by a different type of specialist, the budget specialist, the policy advisor. These are the people who are responsible for coming up with ways to cut the cost of the program. Now they come up with scores of them. I'm only aware of scores. Then they go to CBO and get a cost estimate for five years when they tackle the budget of all of these changes. That is the price tag that the Congress uses.

Of course, you add one more principle that the cost estimate assigned by CBO is random with respect to what the real cost is, or maybe it's not random, but it has a very large variance. Most congressmen can tell that this proposal to cut the program is not getting any opposition from the providers or patients, and it's going to save $100 million. Put that one in.

The fact is, it's not really going to save any money, because nobody is screaming. This never occurs to them. That one is going to greatly improve home health care, all the people in the home health agencies are real eager to get this. The American Association of Retired Persons (AARP) says it's wonderful and CBO says it won't cost anything. They believe in an infinite number of free lunches.

So you see the way the CBO principle works is, of course, they take all the ones in which the cost estimates are wrong on both sides. And that's why they come up with a "balanced budget" that continually expands the cost of the Medicare program. And I call this the "CBO Effect."

If we had an academic tradition, or if we had people who wrote papers continually, like the Health Services Research Institute, we'd be documenting all this. And you know, the "CBO Effect" would be famous. Newspaper reporters would be writing columns on it. We don't get our story across. The incentives of our profession are to serve our clients quietly and not to write papers except the ones we share among ourselves. Any meeting of this size of Health Services Research is going to have people from the press. They have a table for them and whatever is presented, major discussions, you see it in the next day's newspaper. It's science.

For a group of very successful salesmen, we do a lousy job of selling ourselves, because we never had to. This last summer I went to a meeting of Associations for Health Service Research, where they discussed their papers in that field. They meet from 8:00 in the morning until 12:00 at night. They even have evening sessions. They have two or three sessions after 3:00. Their productivity is about triple ours at one of these meetings. The ballroom filled up and there must have been 500-600 people there. All the money comes from the federal government, or a few foundations like the Ford Foundation, Robert Wood Johnson Foundation, which act like they were government. It should be no surprise, they're always advocating public solutions because public solutions give them influence and more money.

MR. WILLIAM F. BLUHM: I'm going to talk about state regulation, which is one of my favorite topics. The relationships that I think of as being the historical ones are the annual statement, which is annoying at a certain time of year, policy forms which are also annoying, and rate regulation which is frustrating. The problems that have occurred over the years stem from three main sources. The first is lack of communication in one direction or the other. Second is lack of education on one side or the other and the third is attitude. I'll talk about that at the end of the talk. But what I really want to talk about is what the opportunities are for new relationships. Because if some solutions are going to be found, it has to be through the efforts of groups like this. The way to do that is to get into the midst of the new things that are emerging, where there are opportunities to help provide input to the regulators who are struggling to solve some difficult problems. There are actually six that I've identified.

The first is with respect to CCRCs, Continuing Care Retirement Communities. There are emerging regulations and laws with respect to reserves and financial statements of CCRCs. Continuing Care Retirement Community or Life Care Community involves promises of long-term care to residents of a community, contractual promises that result in increasing health care costs over time, which you would think are now natural topics for actuaries to get involved with.

There is some disagreement from the accounting profession; in my view, they feel there doesn't need to be very much in the way of actuarial input into that. The projections that we have done demonstrate an amazingly steep curve on those health care costs. They involve prefunding and it would seem that if that's not prefunded, there's going to be trouble. Anyway, it's a primary where you can have some input to regulators who are stuck in a tough position without having the research there at hand and standard practice that they can rely on, as to how to approach it. One good example is the state of Maine; it has adopted regulation (or is it a law) on setting reserving standards. New York has either exposed for comment or promulgated a CCRC regulation on reserving. But it's still in its infancy and it's a good opportunity to help provide some valuable input.

Secondary is long-term care which I'm not going to talk much on because everybody else is. But it is a good chance again to provide some input from an actuarial point of view. It's politically sensitive so it's also a good opportunity to learn how hands are washed.

The third is HMO development. There have been some federal changes that allow a loosening up of the rating process for HMOs. Experience rating is now allowed. It offers a lot of opportunity for consultants to help the HMO industry learn about it, but also from a regulatory point of view, the state regulation and federal regulation are starting to approach each other in this area. And any time you can step in and help the communication back and forth it is very useful. There are other areas; I know the state of Florida has a requirement for an actuarial opinion on the soundness of HMOs. They also have one, I believe, on soundness of self-insured public plans, like school systems. Requiring somebody to put their professional opinion on the line that things are being adequately funded is enlightened. Somebody should explain to the other regulators around the country the value of having an opinion like that.

The fourth area is what one describes as the mandates area, the social insurance area, where the ignorance of many of the politicians, whether intentional or unintentional, is just staggering. I get a firsthand view of it in Minnesota.

The fifth area is the area of covering the uninsureds. There was some legislation in Minnesota that came very close to passing last year, called Health Span, which set up a program to cover all the uninsured in the state and it was designed by the staffers who worked for a state legislator. They had decided that the insurance industry had never really figured out how to design a program that would be low cost, as they would do everything that needed to be done. They designed it for the state. It included no deductibles, first dollar coverage, and they were going to make sure that all that preventative care was going to hold down costs. It almost passed. They've now set up a commission to study it instead. The commission is stacked. I view it as an opportunity to teach people some things and help increase the awareness and create some interplay. Also, it puts (surprisingly sometimes), the insurance department and the insurance industry on the same side of things.

The big one is the NAIC exposure draft. I thought at first I would ask for hands to show who was on that committee, but maybe you don't want people to know. It's generating a lot of comment. I describe it quickly as an Academy committee that has to do with liaison with the NAIC. But the committee has developed a draft that was passed along to the NAIC actuarial task force or actuarial committee, on rate regulation, who set up or proposed new model guidelines. The goal, believe it or not, was to try and find a way that would be politically acceptable and regulatorily acceptable to make the environment safe for insurers to reenter the individual health insurance market. And the way it was felt to do that was to provide a mechanism for automatic rate increases, if you will, or "file and use" rate increases. It was felt that the one thing that was forcing companies out of the market and keeping them out was the inability to trust regulators to act responsibly and rationally and timely at the time of rate increases. So, we built "file and use" into this regulation. But in return for that, we felt that it was important to make sure that the regulators felt comfortable, that insurers couldn't come in and do what they pleased with the rates and make all sorts of money and never have to pay the piper for it. So it was felt that there had

to be a mechanism in place that would also automatically pull in the reins if such a company was abusing that "file and use" rate. Because, whether you like it or not, there's a public policy that says you can't charge rates that are too high. However, you want to express that, it's still being expressed in terms of loss ratios; rates too high means too low of a loss ratio. So the thing that was built in was a guarantee that would automatically trigger if an insurance company was having too low a loss ratio. It would generate a liability that no matter what happened, that insurer did not get that money. It wasn't going to be allowed to flow into surplus. If the loss ratios were too low, it would generate a liability to force money to be put aside, that would either be used for that block of policyholders or for some other block that the insurer or the commissioner would approve, or something else like an uninsured pool for the state.

I want to make one point that this is not the benefit ratio reserve. This is the regulatory liability. There are two big differences. The first is the purpose for which it's meant. The benefit ratio reserve had been proposed as a solvency reserve. I was a vocal opponent to that. I felt it didn't do what it was supposed to do. It did the opposite. The regulatory liability has similar characteristics but it's not being used for solvency purposes. It's being used for the purpose I just described, guaranteeing performance by the insurance company, and presumably it would be totally independent of any solvency reserves that would be there. The other difference is in how it works. If an insurer has a 55% lifetime loss ratio that is anticipated, and in the first year has actual loss ratios of 25%, but actually expected first-year loss ratios of 30%, the benefit ratio reserve used to require that you would have to hold the difference between 25 and 50. The regulatory liability requires you to hold the difference between 25 and 30. So you would hold the difference between the actual results and what you originally expected in your projections, not the difference between actual and a level flat loss ratio, a big financial difference. When all is said and done and we've gotten through with this academic exercise, the committee agreed there is probably very little chance that any of this is actually going to take place without some substantial efforts being put forth by the industry, by our profession or by somebody to convince regulators how important it is. There's an opportunity to do something, to potentially save the individual health industry. But it takes effort, and it's going to take a lot of communication and a lot of convincing.

I happen to believe that if you can find some states that will do it and will reassure insurers that they will stick by this and not withdraw this right for "file and use" rates, I would be willing to try and convince my clients that it would be a good environment to do business in. If that starts happening with a few states, there will be other states watching it and we'll see that take place. It also provides more potential for solving some of the other problems that exist like uninsured situations.

The only other thing I wanted to comment on was about the causes of some of the frustrations that people feel with regulators and give you some benefit of the experience I've had. First is in communications. I have found it amazing how many insurance company actuaries will only deal with regulators by mail. I like to use an example of saying, what do you do with the guy in the office next to you, if he does something that bothers you? Do you write a memo to him and send it through company mail and make sure that you never speak to each other? Obviously that direction causes some problems. The same thing is true with regulators and I mean the same thing on both sides. The insurers and regulators both do the same thing. Communication is really the most critical element of the whole thing.

Second is education. When I started in the New York Insurance Department, I was a smart student with a year's experience. I was put at a desk, given a regulation and told this is the regulation governing health insurance. Here's your stack of files, go to it. I didn't know what I was doing. I learned along the way. I've seen it happen again and again with new examiners or actuaries in insurance departments. It's helpful for the industry to understand that it's not that person's fault that they haven't gone through some rigorous training session or had years of experience. They were hired to do that job. It's helpful to help educate them. But you can only do that if you're communicating.

I'll throw out a far-fetched scheme for you that I have thought about and maybe you could consider it. The problem is that most insurance departments can't afford to hire high-powered actuaries to do rate reviews. When people go through the evolution of regulators and come to the stage of where they know what they're doing, they often get hired away and go to work for the industry where they can earn more money. What would be the effect if there were a central place

where rate filings could be approved, according to the NAIC standards, on behalf of any state who wanted to use that? You could have somebody who is acting on behalf of or is a proxy for state reviewers, who subscribe to that standard NAIC rules, whatever that might be. The insurance departments could avoid having to hire people to do those reviews. They could rely on it and the industry could be assured of having something that was standardized and rational. And they could probably, if the resources of these insurance departments were pooled, afford to hire people who had some experience and knowledge. I just throw that out to you.

The other thing is somewhat controversial, but I've come around to the point of view that one has to fight for what is right. Too many times, insurers are willing to back off of seemingly irrational positions by state insurance departments, because they don't want to make them angry. I have found that the only way to get the politically motivated, irrational decisions revised or looked at from an objective point of view is to up the ante far enough that the politicians no longer find it necessarily in their best interests to make the decision the way they want it to be. That's not true when you're dealing with people who know what they're doing and they're making a professional judgment. It is true when you have insurance departments where the commissioner is elected and says, "You can't have that increase because it's too big and I don't care if you're losing money and that's the way it is." When push comes to shove, the politician will almost inevitably try to rely on some professional judgment that would back up that opinion, and it's very often hard to find. It also makes politicians take a look at the basis for making those judgments, which may not have been looked at.

MR. DENNIS J. HULET: A couple of weeks ago I was speaking in front of a group, probably half this size, made up of hospital CFOs and CEOs. I spent four hours talking to them about what benefit there was in having an actuary help them in the problems they were dealing with through their contract care and their public payer relationships. It's a need that the providers of health care have and I don't believe is being met.

Our skills are such that we can assist them with those problems a great deal. I remember an actuarial meeting I went to when I was an actuarial student, and there was a discussion about the actuary of the future. They were talking about who their publics were and at that time the concentration was on insurance carriers, the government and employers. From what I've seen of how we have integrated the relationships between the insurance carriers, the products and the providers, there is definitely a clear need for actuarial involvement with the providers directly.

My first involvement with providers was when I worked for an insurance company in the early 1980s, and we were restructuring some of the contract language. We had some provider consultants who were working with us, so that we reflected the latest technology and terminology into those contracts. We were dealing with PPOs in the southern California marketplace; I was also involved in trying to help providers know what they needed to know in relation to the insurance products and then helping the insurance company understand what needed to be done to properly price those products, given the relationships they were establishing with providers.

Since that time in my consulting role, I have worked a great deal with managed care plans and as part of that, I have helped their providers understand what the contractual relationships meant to their operation. On my flight to New York, coming from Seattle, I had an opportunity to pick up a copy of the *Readers Digest*. I like to flip through and read all the humorous stories scattered throughout the pages. There was one that I thought was appropriate for two reasons. It talked about a doorman at one of the high class Manhattan apartment complexes, and evidently this doorman was very gregarious. He was friendly to all the people and very good natured and he established a relationship with many of the tenants, so that he was even invited to some of their parties. In one particular instance, the host overheard a conversation, and all the people around the doorman were talking about the professions they were involved in. Of course the host was a little worried about what the participants would think when the guy says, "I'm the doorman from downstairs." Well, the host was not embarrassed at all by his reply, but rather a little bit amused. When asked what his profession was, he indicated that he was an access control consultant.

That's maybe more meaningful to consultants than to insurance company actuaries. But it tells us a little bit about what our potential can be as actuaries, rather than what we have always done. I think there are a lot of individuals out there who get into the consulting game and pass themselves off as health care consultants. I read blurbs in the various trade presses that introduce a particular consulting firm. I try to look at the background of those individuals and ask myself,

What have they done in their prior career that equips them to better handle health care problems than I am equipped to handle them? What is their background that gives them any advantage? I generally find that from a micro-perspective, they probably had a particular expertise in a particular small area of health care, where they can add some real insight to a consulting relationship. From the experience that I've had with insurance products, with the multivariable analysis that we need to do as actuaries and the various ways we handle contingencies, I believe actuaries are much better able to deal with the myriad of problems that the health care providers have to face. You heard some of the discussion about what's going on in public policy, whether it be state or federal policy, and we find from that there are many of things that are going on that will impact the way providers provide health care services.

If you look at hospitals and the way they have historically done business, they've had to balance revenue and expenses and have done so by continually raising their charges to keep ahead of what they project their expenses to be. Once Diagnosis-Related Groups (DRGs) went into effect, and because of all these contractual relationships they have established with managed care entities and insurance companies, they're finding their ability to raise revenue by increasing their charge base very limited. In many situations, that has put financial burdens on hospitals that they've been unable to recover from.

In southern California, there's a lot of press about the problems of emergency rooms. Hospitals that have emergency rooms are finding that they get so many of the Medicaid patients that they don't get adequate reimbursement from the state, they can no longer keep those facilities open. If one hospital closes their emergency room, that means the people have to go across the street and it exacerbates the problem of the people across the street. If you run the scenario out to the limit, pretty soon you've got a situation where there are no emergency rooms open, just because the state isn't paying what would seem to be a fair share of the bill. There are many contractual relationships; DRGs, I mentioned. There are many things going on in Congress right now that will affect the way physicians are reimbursed.

In early June, there were a couple of bills that came out of committee relationships that will change the way physicians are reimbursed. There was one bill that would implement the Resource Based Relative Value Schedules. It would put expenditure targets into place. They are talking about things that would change the quality program by trying to force people into certain delivery patterns, that would be more efficient and more effective, supposedly. I think these are all issues that actuaries can help deal with, not only from the creation of public policy, but help providers themselves to deal with these issues. Because if they aren't successful in dealing with them, all of the normal insurance vehicles will be in trouble. There are certainly a number of ways we can be involved.

Those who are with insurance carriers need to be involved in understanding what the proposals are in the public sector, so that they know how that might impact the way providers do business and therefore how they ought to be restructuring their insurance products. If you are somebody who is in a consulting environment, I'd encourage you to try and get involved directly with providers. Assist them -- help them understand how all these multivariable policies will affect the way they do business. How can they restructure the way they do business so they can take advantage of those and be financially successful in the future? Because of the need that they have, I believe that they will find actuarial expertise somewhere.

If actuaries don't provide it, CPAs or some other financial entity will provide that to them. I believe that actuaries have the background that would best meet those needs, and so we should be involved and that's certainly an emphasis with the consulting practice that I'm trying to create. But, it's not only something that actuaries should be involved in, but I think it's also something that you would all find very interesting, because it is a little bit different than what you read in the books about actuarial science. It uses the same principles and is just applying them to a new area of expertise.

MR. AXENE: Does anybody have any questions they'd like to address to the panel?

FROM THE FLOOR: The reason for the CBD effect I think is because there are hundreds of proposals every year in the Medicare program. Some that conceivably save money and some that conceivably cost money. The point that Gordon was making is that with so many proposals being considered, there's bound to be some random error that creeps into the estimates. Congress, by

keeping its ear to the ground politically, knows which of these big savings proposals doesn't generate any resistance and of course, those are likely to be the ones where a mistake was made and the savings were overstated. Alternatively, if there's a cost proposal that has extremely large support among the beneficiaries and providers, and yet somebody has made a mistake on the cost estimate and said that it doesn't cost very much money, then the combination of political attractiveness and an attractive cost estimate makes Congress want to enact that particular proposal.

MR. TRAPNELL: The only thing I would add is the theoretical basis of the CBO effect that I was interested in portraying was not only the random error, which of course occurs rather routinely in actuarial projections as well, but what I call the naivete effect. That is, the academics think the way to make a cost estimate is to look up the literature, looking at a lot of almost totally irrelevant type of quantitative analysis and jump to a conclusion that simply doesn't follow from the evidence. This generates a relatively large random error. On the basic question, which I agree with, I think it's more a question of complexity, in that Congressmen are able to understand a lot better the implications of changes in the Social Security program than they are in the disability or health insurance program. Now why there aren't comparable degree of changes in the disability program based on that hypothesis, I don't know.

MR. AXENE: I think that what you described is what the AAA is all about. Jim Murphy is really a leader in the Academy in this particular area. The Academy's role in this is really in the public interface. There are a lot of similarities to what we've been talking about to a client experience that I'm going through right now. There is a major health care underwriter where senior management has said, "We don't understand what our actuaries are saying. We don't respect their opinions. We don't know what's going on. Can you help us find out what's wrong with our organization?" There are some very talented actuaries who are working there, but for some reason they cannot get the message across to senior management of what's going on. What we have here is that Uncle Sam and other people in our publics are generating a lot of information, but perhaps they don't believe we have the answers either. I think whoever focused on the word communication has the key. We have to do some publicity, but more importantly, we've got to do some communication.

I had a call last June from Guy, wanting to know if I could come testify at the Senate Finance Committee Hearing. I had never done that before and I said, "I'll be happy to do that." A week later he called and said, "They don't want you. They wanted an economist." I had my feelings hurt for a few minutes, but really what it comes down to is we have not gained the respect as an industry with the people who are making the public policy decisions. There is a group named NAHMOR, National Association of HMO Regulators. I had a chance to meet them in September at a meeting in Minneapolis, and they didn't understand how actuaries make rates. All they wanted to do was to understand the process a little bit better. Any two- or three-exam actuarial student could have made the presentation I made. They just essentially wanted to know how to make rates. Why? Because they were regulating rates and they didn't understand what HMOs were doing. General Motors is taking a very definitive stand toward managed care right now. Other automakers have supported national health care because they believe managed care doesn't work. Apparently General Motors is saying something slightly different. They believe it does work. They're trying to find out how they can make it work at GM.

The state of Oregon, through their uninsured program, has decided to prioritize the need for health care services for the entire population. They're trying to find a way of funding guaranteed health care benefits for everyone. Significant actuarial involvement is needed.

There are major corporations right now trying to buy trend reinsurance. They don't like the idea that costs are going up out of sight and they want to buy reinsurance that will protect them from future health care increases. These are just a few examples of how we, as an industry, can become involved in what's going on.

I hope we, as a panel, have stimulated some of your own thinking, but perhaps this will motivate you to take some more action in your publics, however limited or broad they might be.

MR. BLUHM: What occurred to me when you were talking about the Academy is what it really needs is champions, people who want to go out and do it and make the effort to do it, whether it's within the Academy or not. It takes somebody who is motivated in order to get it done.

MR. AXENE: My number one priority as Health Section Chairperson for the coming year is to find some of those champions within our discipline, get them to Jim Murphy, get them to the Academy, get them out. If any of you have an interest in doing that, as your altruistic goal as an actuary in the coming year, let the Health Section know, because we will pass that information on to the Academy. I know they would love to talk to some of you.