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HEALTH CARE – ITS PAST AND ITS FUTURE

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MR. DONALD R. SONDERGELD: We are pleased and honored to have with us Congressman Dan Rostenkowski, member of Congress, representing the 8th District of Illinois. Congressman Rostenkowski was elected as the youngest member of the 86th Congress on November 4, 1958, and has been reelected to each succeeding Congress. He is currently the chairman of the House Ways & Means Committee and has been on the committee since 1981. He is also the chairman of the Joint Committee on Taxation, a member of the Democratic Steering & Policy Committee, and a member of the Subcommittee on Trade. He is with us to discuss health care and to comment on some of the health care proposals that are currently on the table, including the Administration's plan for overhauling the health care system.

THE HONORABLE DAN ROSTENKOWSKI: I've been in Congress since 1958. I was the youngest member of Congress in the House, and Jack Kennedy, a young fellow from Massachusetts, was the youngest member of the Senate. And it was then, too, that we were talking about health, and the conditions under which we were going to try to deliver a health system.

But let me just as an aside give you an experience. In 1960 when Jack Kennedy and I were running around the country, we were talking about what choices an audience like this has. We talked then about the young person who had to make a decision as to whether or not he was going to support his child's education or whether he was going to have to pay for the health care that's needed to service his grandmother or his grandfather or his parents. And we decided then that decision should not be placed on him, that government should make that decision with respect to senior citizens. And so in 1960, one of the largest planks in the platform of our Democratic party, and the Republican party as well, was what are we going to do about health.

Now mind you, after 1960, that legislation wasn't moving at all. In 1963, you know what happened to Jack Kennedy. In 1964, Lyndon Johnson, then the president running for election, ran and won all over the country and interpreted that win as a mandate to do something about health care. I don't know how many of you are familiar with Lyndon Johnson. He was without question the best arm twister in the world. You'd get a telephone call and he'd say, "You know, Lyndon's done

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something for you. Now it's your turn to do something for Lyndon." And he was good at it. He had been a member of the House. He had been a member of the Senate. He had been Vice President of the United States. And he was President. So he knew all the excuses and he knew all the angles. Now the reason I start off with this off-the-cuff observation is that with a mandate as large as his was, with a professional like Lyndon Johnson, it was then that he twisted the arm of Wilbur Mills and those of us on the Ways & Means Committee, and moved legislation with respect to Medicare and Medicaid.

Now compare that to the situation that we find ourselves in today. I was discussing with several of you what is the mandate that the American people is giving us? You're disgusted, disappointed, frustrated with us. But what is your priority? What do you want from us? If I mention several items -- drugs, crime in the street, the infrastructure, education -- I'd get the vertical head shake. I can narrow it down to, "Well, let's do something about health." "Oh sure." But what is the priority? And that's one of the reasons why I want you to understand what the problem is that we're going to be facing.

I don't know how many of you were in Washington in September 1990 when I spoke to the Academy. Those of you who were recall that my topic was the federal budget deficit. The deficit was the hot news of the day. The government was paralyzed. Draconian spending cuts loomed on the horizon unless the President and the Congress reached an agreement. But the President and his party were digging trenches on one side and the Democrats were digging trenches on the other.

Let me quote some of the remarks I made the last time that I spoke to you. I said that if there was no budget agreement, we can expect the economy to get worse before it gets better. And I said that the deficit is the kind of fiscal creature that thrives on hard times. It will only get bigger and the bigger it gets, the harder it is to bring under control. I also said that we confronted many long-range problems -- real problems. The problems that affect the lives of millions of Americans and their children. But the needs giving rise to these problems were being neglected because government was bogged down in a battle over taxes, especially capital gains. Much of what I said that September day could be said today. But said with even more conviction and urgency. The deficit remains -- in fact, it's bigger this year than ever before. And the neglected problems are still with us – bigger and more difficult to solve than ever.

One of these problems is health care. A problem that we've been wrestling with for over a decade, but still haven't pinned down. It's a problem that everyone agrees must be solved and resolved soon. Tens of millions of Americans are without any health insurance coverage and the number is growing daily. Tens of millions more are seeing their coverage threatened and their benefits shrinking. Insurance companies are hedging their bets by seeking out healthy individuals and denying coverage to those who need it most. These trends all justify taking a hard look at the way health care is delivered in this country. But there's another side to the health care crisis, one that you are very familiar with and that is every bit as important as insuring that Americans get care they need. I'm talking about the challenge of bringing health care costs under control.

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The statistics on health care costs send a clear and unequivocal message: Unless we put a harness on health care expenses, the nation's health care bill will soon approach 20% of GNP a year. That my friends is simply too much. It's too much under any circumstances. But it's especially too much when American industry is in a dog fight with foreign competitors and when the battle for international markets and capital is getting keener by the day. I've been watching the health care issue percolate for several years now. I saw that our incremental efforts to reform the system were meeting with marginal success, but not really providing the general solution we so desperately need. And above all, I saw how the White House was dragging its feet on the issue.

Last year I got fed up. I decided it was time to get the White House involved in the debate. So I offered a plan. The Health Insurance Coverage and Cost Containment Act of 1991. As you know, the Bush administration now has a health care reform proposal of its own. I'd like to think that this has been the result of my prodding. But to be perfectly honest with you, I think Harris Wofford had as much to do with moving the White House as anyone else. This is an Administration that has constantly turned to the polls, and there's no poll better than an election. When Harris Wofford beat Dick Thornberg, you could hear reveille being played down at 1600 Pennsylvania Avenue. Suddenly, everyone in the Administration was saluting health care as a number one national priority.

I have, I hope, a reputation of being a realist. That means I'm someone who practices the art of the possible. I look for solutions that will command a majority of votes and the support of the American people. Many of my colleagues in Congress thought we should have voted on health care in 1991. But it was clear to me that this issue was so complicated and so politically charged that any vote would have been far too premature. There's no better way to move an issue off the front burner than to vote on it and lose. But it was also clear to me that millions of Americans were suffering because of the defects in our health care system. For many of these people, there's no reason to postpone relief until we reach a compromise on the big reform measure. It was with that thought in mind that I introduced my small group insurance reform bill HR3626.

Let me make a few remarks about some of the health care proposals that are currently on the table. I'll start with the Administration's plan for overhauling the system. From my vantage point, the White House proposal falls far short of hitting the three targets that any reform package must strike to be a success. It doesn't provide adequate coverage. It doesn't hold down costs. And it doesn't pay for itself. To help people meet the everrising costs of health insurance coverage, the Administration offers a tax credit and a tax deduction. The credit is for low-income Americans. The deductions for middle-income Americans. Neither the amount provided by the credit nor the amount of the deduction will help most people buy the coverage that they need. At best, the credit and deduction are the equivalent of half a loaf. But contrary to the old adage in health care, half a loaf is not better than no loaf at all. Half of a widely unaffordable amount is still an unaffordable amount.

To help small businesses and employees of small business gain access to adequate coverage, the White House is proposing small group insurance reform. But this plan doesn't begin to pay for the cost of small group reform. In fact, the cost

containment measures that pay for the package as a whole are woefully inadequate. For example, there is a provision to promote managed care. We've seen managed care at work for nearly a decade now. Or to put it a better way, we've seen managed care barely work for better than part of a decade. The evidence on managed care's impact on shaving costs is clear. There is an up-front reduction in health care expenses, but then the cost cutting stops and medical bills begin to rise at the same accelerated pace as with other insurance premium plans.

The Administration is counting on medical malpractice reform to dramatically control health care costs. But very few people seriously believe that fear of medical liability suits is the chief villain in this health care drama. At best, malpractice plays a minor role. These cost cutting proposals simply won't work. They are all designed to convey one simple message to the American people. We can reform health care, and it won't cost anyone a dime. To be fair, the Administration does not have a monopoly on this bogus message. Politicians of all stripes and colors are more comfortable delivering convenient messages, and this message is, if nothing else, convenient.

I recognize this. It's the main reason why I believe that acting on major health care legislation in 1991 would have been folly. No one was willing to vote for pain. But some degree of pain is inescapable if we are ever going to seriously tackle the health care issue. There's going to be pain involved in expanding health care insurance coverage. Someone has to pay for it. And there's going to be pain in controlling the costs. Someone is going to get less than they're getting now. There's a silver lining inside this cloud of pain, however. It's called real cost containment. If we can convince the American people that the prospect of exploding health care costs and lost health insurance coverage will disappear, then we can build a political consensus needed to truly reform the health care system. This is an inescapable trade-off. Unless we recognize the need to make this trade-off and unless we are willing to take the necessary steps this trade-off demands, we will not resolve the health care crisis.

As I said, I'm a realist. For my perspective, there's no point in trying to make the American people believe in painless solutions. They have got to understand that a proposal like the Administration's or one that claims vast paperwork savings is nothing more than an exercise in self-delusion. My health care proposal faces up to the cost containment realities. That's not to say I'm not willing to entertain other proposals. I certainly am. Just save the smoke and mirrors and wishful thinking. I've seen enough of it, and more important, so have the American people. We have to be prepared to make some tough choices.

That's half of my message. The other half of my message is that the present election, far from being the substantive debate over issues like health care that I had hoped for, is in serious danger of degenerating into yet another content-free campaign. The White House is to blame for some of this. It's obviously in the interests of the Administration which has no domestic policy and no idea of how to fix the economy to steer the debate away from substantive issues. But some Democrats are to blame as well. Many of my colleagues, many of us on the campaign trail, are shouting, "mea culpa" and promising institutional reform. Some have taken up anti-incumbent rhetoric and mimic the voices of outrage and protest. These gambits represent American politics at its worst. They are phony. They only address the symptoms of public disenchantment; not the root causes of discontent.

The American people are upset because they correctly understand the people's business is being left unattended. But directing public debate toward issues like, "Who smoked what, when and where?" "Who bounced checks at the House bank?" "Who gets cheap hair cuts?" will only postpone the debate we so desperately need in order to remedy the problems that are becoming more and more acute.

That's where the people like you can come into the picture. You're smart. You understand the issues. Let the politicians know that you're not going to fall for their shell games. Hold their feet to the fire and demand that they talk about the problems that this country faces. And above all, demand that they provide honest and substantive solutions. I am so tired as a member of Congress of visions of what we ought to be doing. I'd like in this campaign to narrow in on health care legislation so that we could look at what the candidates stand for. I've been in Washington for 33½ years. A social program as large as this cannot be fostered; it will never be accepted unless the President of the United States takes the front end of the reins and leads. That's the way we're going to solve this problem. I can come up with grandiose propositions and they won't go anywhere if it's ignored in the Rose Garden. And so you people have to demand that the candidates, be they Democrat or Republican or even Ross Perot, address these issues specifically and come up with the solutions that are necessary in writing, so that we have the mandate that we finally got in 1965 with Lyndon Johnson as President. Health care is an enormous problem for us in the United States. And we should try to solve that problem. I want you to understand that is not exclusively the only problem that we have. But priorities are going to be important. And so I beg of you, give the Congress of the United States some direction. Tell it what you want done. And I guarantee that you'll see a reflection from your members in doing what has to be done. We've got to put some steel in the stomachs of these legislators to, if necessary, take the tough vote and then have the capability to go back to their district and explain to their people why it had to be done. And I'm not big on first-person singular. I've been voting the tough line for the last 20 years. I am criticized by more factions of people, by protecting my membership. And I think that that's my responsibility. Until such time as your members are going to have the steel in their gut to do the right thing, and then come back and convince you, the constituents, we'll keep on wavering.

MR. SONDERGELD: Actuaries are supposed to be seekers of truth, and I'm sure we may not all agree with Congressman Rostenkowski's views on every subject. It's important that we understand them, and we provide him and Congress the input that I think actuaries are uniquely capable of providing.

Following the keynote speaker's presentation, we have put a panel together comprised of actuaries and a professor who will comment on the presentation and other aspects of the health care reform issue. There will be time for questions and answers following the panel's formal remarks. I will now introduce the panel. First the moderator, Bob Dobson, will comment and will also introduce. I will introduce all three panelists. Bob Dobson is consultant with Milliman & Robertson. He is a Vice President of the American Academy of Actuaries, and Chairman of the Academy's Health Practice Council that recently conducted a survey of the Society of Actuaries Health Section members on health care reform. Bob is also a spokesperson for the profession's Forecast 2000 public relations activity on health care issues.

Richard Hill is Vice President and Actuary at the Prudential. Dick is responsible for Prudential's small group and individual health lines of business. He is also a CLU, Certified Financial Counselor (CFC) and Chartered Property and Casualty Underwriter (CPCU). He is on the Small Group Reform Technical Advisory group of the Health Insurance Association of America (HIAA) and serves on the board of a hospital health care management corporation.

Our third panelist, Paul J. Feldstein, Ph.D., is a professor and Family Health Plan (FHP) Foundation Distinguished Chair in health care management at the Graduate School of Management at the University of California in Irvine. He has written four books and over sixty articles on health care. He is also one of the coauthors of *A Plan for Responsible National Health Insurance*, the health affairs paper behind some of the Administration's health care reform proposals. Please join me in welcoming this distinguished panel.

MR. ROBERT H. DOBSON: My first job is just to mention what format we're going to follow. First we're going to each make a brief commentary on what we heard Congressman Rostenkowski say and what we think in general about the issue. Then after that, we're going to have some back and forth among the panelists, but also welcome questions and comments from the audience. We're going to start with Dick Hill, then follow with Paul Feldstein, and then finally I'll make some comments.

MR. RICHARD W. HILL: It's interesting following Dan Rostenkowski. I certainly admire him for his emphasis on cost. We should not expand the financing of health care without doing something about the cost. And as he said, some degree of pain is inescapable if we seriously tackle this tough health care issue. He is also a realist, and he knows that we need the support of the people. And the people are his customers. I think sometimes as actuaries, we don't listen to our customers. It is a political reality that we need to convince people that we can contain costs and improve access. His message also implies that the solution should be a simple solution. He feels quite strongly that the incremental reform efforts that many of us have been involved in so far are meeting only with limited success. And that many people are offering what he calls "bogus" solutions.

While I like his emphasis on cost and cost containment, and I certainly agree that small group reform is not moving too rapidly, I take issue with his view that managed care barely works. Congressman Rostenkowski did not discuss any of his specific plans or his latest bill, House Bill 3626. He mentioned it. It has to do with small group reform. He didn't give any details. To set the stage for your questions and the rest of our discussion, I'd like to give just a brief summary of his small group reform bill. One, it provides for guaranteed issue and also has limits on the preexisting conditions/exclusions. It also has rather tight rating bands. And most important, it provides for strong federal regulation in benefits meaning standard minimum benefits roughly equivalent to Medicare benefits plus preventive care, mammographies, well baby care, prenatal, etc. additions. These are very liberal benefits. Also, there would be spending controls. To reduce the increase in cost, there would be global spending limits such that over the course of four years, the cost of health care could not increase by more than the increase in the GNP. And there would be price controls. Price controls would be done by fee schedules like the resource based relative value

schedule (RBRVS) approach and also the diagnostic related group (DRG) approach in the hospitals. And those approaches would be the way that costs would be contained.

This is where we have major differences. The question is whether we will have regulation or whether we're going to have competition, and what works better, for example, HMOs or the government. We view the managed care as an intelligent purchase of health care. And when it is done properly, we feel that it works. I also have serious concerns with using universal Medicare-type fee schedules as a strategy for containing health care costs. Even when the fee levels are tied to these global expenditure levels, this still amounts to controlling health care by fee scheduling of prices. Our view is this strategy has been tried many times before and has been a failure. Even in a universal-type coverage where there would be no shifting of costs, there still would be no way to prevent increased utilization of services and increasing the volume of services.

In my view, an effective approach to containing costs would be to restructure the health care delivery and financing system into organized delivery systems that are accountable for the cost and the quality of care, and that compete with one another on the basis of both quality and price. In the experience of companies such as Xerox, Allied-Signal, Southwestern Bell, and Southern California Edison, we have some very positive track records in terms of both cost and employee satisfaction. Making these kinds of systems available to more of the buying public will require some revamping of the coverage system. We strongly support the reform efforts in the small group market as proposed by the HIAA and other groups to improve availability and stabilize prices, by narrowing the premium rates. But, we also think that the idea of health insurance purchasing cooperatives (HIPCs) as being developed by Paul Elwood's Jackson Hole group and which we will see in some congressional proposals soon to be introduced, has considerable merit for making these choices available to more individuals in small group.

In short, we need to be more experimental. And I certainly think that going down the track of managed competition is the right way to go. I look forward to discussing this more with you later.

DR. PAUL J. FELDSTEIN: Let me first compliment Dan Rostenkowski because he spoke of some of the real concerns that we have in this country, which are the millions uninsured, those with insurance afraid of losing insurance, and the rapidly rising health care costs. And then he also spoke about the political realities today. For example, there's an increasing deficit. No one wants to spend money or raise taxes. If you want to increase expenditure, somebody's got to feel some pain. And we have to make trade-offs and some tough choices. And my only question is, does his plan really enable us to make tough choices or is it really another out for the Congress?

Let me talk about two parts of his plan that were introduced in the summer 1991 and whether Congressman Rostenkowski really made some tough choices or not. The first part is an employer mandate; the idea of a pay or play type program. Under a pay or play program, what happens is that you either have to pay say 9% of your payroll into a pool, or you have to provide your employees with health insurance

benefits. As you know, the real effect of that is that it's the small firms, those employers with 25 or less employees, that have most of the uninsured. And the question really is who is for and against this? Why is this such a politically popular idea? I think that's important to understand. The ones who are for pay or play are basically first the states, because it would take the people who would normally be on Medicaid off the Medicaid rolls and make them pay for their own health insurance or have this small employer pay for them. They're basically low-income workers. So it's a way of shifting the cost from the state Medicaid program onto the employees and the small employers.

The second group for pay or play is really the large employers because they're basically unaffected, except as the chairman of American Airlines said, the reason he's for pay or play is that it will raise the cost of low-cost competitors. It will make Continental pay more labor costs, and therefore give American Airlines a competitive advantage. So again, it's a self-interest perspective of who's for and who's against it.

The third group who's for pay or play are health care providers, hospitals and physicians because it's a way of getting the low-income worker off Medicaid, increasing the demand for hospital and medical services, and getting better compensation instead of getting Medicaid reimbursement. So that's the national health insurance plan for hospitals and physicians.

And the last group, the most important group in any health care reform package today, is the middle class. The middle class is so important because you cannot form a political majority without those in the middle. So when Dan Rostenkowski has to hear your opinion, he wants to hear what the middle class really believes. And so far today, the middle class has not reached any consensus on what it wants because it has basically been insulated from rising health insurance costs. The middle class has had employer-paid premiums and that's before tax dollars, and it has not had to pay much out of pocket yet. So up to date, the middle class has been sort of insulated from rising health care cost. The middle class is probably for a pay or play program because it sees the program as a way of helping the uninsured and the poor without the middle class having to pay increased taxes to do so.

The only group really opposed to pay or play is small business. And small business is opposed to it because it will increase the cost of labor. It will decrease demand for labor and result in unemployment. Small business will try to shift those costs onto employees, even though they are imposed on the employer. And the part small business can't shift to the employee, it will pay for with an increase in consumer prices. Both of those are aggressive taxes, meaning it's a higher proportionate tax on low-income people than on high-income people. But the effect of pay or play will be to make the low-income employees bear more of their own health care cost and it will increase the Medicaid pool because a lot of employers will find it's much cheaper to pay than to play. Because if you're going to have to pay 9% of payroll for employees making $10,000 or $15,000 a year, you cannot buy an adequate health insurance policy of the kind that will be mandated unless you just pay that money and let the state pick it up. And so we'll have an increase in Medicaid pool and that will be the effect of the pay or play.

Now I'd like to talk about the other part of Congressman Rostenkowski's plan, which is the cost control. So the first part is the employee mandate. The second important part is the cost control. There are two ways to achieve cost control. One is you want to get value for your money. You want to increase efficiency. The other way is you just want an arbitrary expenditure limit that will give you less but it will cost you less. It has nothing to do with efficiency. And that's what Congressman Rostenkowski is proposing. He's proposing arbitrary expenditure limits on hospitals and physicians. Now again, you have to find who's for and against those proposals. Again, those for are basically the states because it would limit how fast Medicaid expenditures are going up, which is the fastest rising state expenditure. So since the states have to balance the budget each year, they wouldn't have to raise taxes or cut out a politically popular program. Again, larger employers are very much for the proposal because of the FASB. The idea that you have to fund and list on your balance sheet unfunded retiree medical liability is an enormous cost to employers. If you limit how fast that can go up, that will result in an enormous savings to employers. So large employers are very much for expenditure limits.

Again, the middle class would be very much for cost control because what the middle class wants in national health insurance is its choice and it doesn't want to pay much for the choice. And if you can promise the middle class expenditure limits, it would appear to the middle class that it is getting what it is getting now without paying more for it. The real problem with expenditure limits is that there are legitimate reasons why expenditure is going up when you consider increased technology and an aging population. You have to pay higher wages to nurses and to other technicians in hospitals. And if you put expenditure limits on, you're going to have to forego some of that. But you won't notice it very quickly. It won't be obvious what you're giving up in terms of access and technology, but so far it will be something that you can promise the middle class without inflicting much pain.

So the question of whether politicians really want you to make tough choices, they're not willing to make tough choices I don't think because they want to make it appear that you can get something without really paying much for it and that the taxes that will be imposed won't be obvious. The taxes will be imposed on those who are politically less powerful, like the lower-income employees, and the politicians won't really raise taxes on those who vote.

MR. DOBSON: I want to make three brief points before we get into the back and forth among the panelists and get into the questions and answers. I'll spell my points out now and then say a couple of words about each one. First is I think that instead of continuing to say "no" to different proposals that we hear about, we need to start saying "yes." We need to say "yes and" or "yes but" maybe, but we need to stop saying "no." Second, I want to make some comments about the insurance industry's role in this, though I hope everybody recognizes that we're here as a professional group and not representing the insurance industry. And then finally I want to talk about some things I'm worried about and get back to the leadership issues that have been mentioned a couple of times.

First of all, just say yes. The survey that was taken of the Health Section membership showed that only 2% of the actuaries responding favored the status quo. I think we are at a point where almost everyone agrees that things need to change in one

way or another. In fact, in a response that was surprising to me, 83% of the actuaries said that, yes indeed, they recognized there was a health care crisis. I was quite surprised at that because I thought actuaries would look at that question and say, "Define crisis. What does crisis mean?" And I thought they wouldn't answer. But 83% in fact did say that there was a crisis. And I think what we need to recognize is that we all want the best possible solution and that we as actuaries do have a lot to add to the debate. But to make that message more effective, I think we need to be saying "yes" rather than "no" in our comments.

Second on the insurance industry, I think we recognize that any solution is going to be complex, many faceted, and everybody has to give something. We've heard that said a couple of times already. I guess Dick Hill is proving my comments about the insurance industry wrong as we speak because he already admitted that the insurance industry has to give some. In a follow-up session from here, Open Forum 5, Jack Maurer is going to talk about an insurance industry proposal. But in spite of these positive aspects, I still think the insurance industry is a little behind in recognizing that things are going to change and that we're best off to be on the leading edge of those changes.

Finally, here are my worries. In 1986 at the April spring meeting of the Society in San Diego, I started off a talk on the underwriting cycle by saying I'm worried. And in fact, 1987, 1988, and 1989 were three of the worst years in health insurance industry history. People didn't realize it, but I was also worried at that time because that was the meeting when I found out that Tillinghast was going to be acquired by TPF&C. But that's a different subject. Anyway, I've now found a different way to deal with my worries. Last fall I was in Albuquerque, New Mexico, and picked up these worry dolls. And the idea is that if you have a worry that's going to keep you awake at night, you get out one of these dolls and tell that doll that worry. And then it's the doll's job to stay up all night worrying about it and you can sleep. I've actually taken advantage of these dolls quite a bit -- so much that they all have names now. This is national health insurance. This is small group reform. This is community rating. This one is the health insurance industry. I have trouble because that one keeps putting its head in the sand. And then finally I have two that must have a tapeworm or something because they just can't get enough to eat. These are Medicare and Medicaid. Anyway, that's how I deal with my worries.

But I think the legislative process has got me worried, too. I spent enough time around Washington and recently went to Tallahassee, Florida to see how things worked at the state level. We think there are problems in Washington -- you ought to see the states. Because of this, I've become pretty convinced that democracy is really not going to work. But I think in line with what Congressman Rostenkowski said, I have to agree with the need for leadership. If you look at what got Medicare through, it was a strong leader. Whether or not you like what Oregon has come up with, that came from one person's vision and one person pushing it through the senate president there. I don't know if we're going to see this kind of leadership from the democrats or the republicans. I think that Paul's paper that he will discuss in Open Forum 5 is a good start. But the Bush proposal has been labeled "the timid step" in the direction of the proposals outlined in that paper. So I'm hoping that we can get some strong leadership from somewhere and that we as a profession can contribute to making that leadership more effective.

MR. HILL: I was just going to say that I feel that the insurance industry is getting a little bit frustrating because we don't seem to have anything happening. And I guess particularly frustrating is that every start is going off in different directions. I was kind of excited recently to see that in California people are talking about having a Health Insurance Communications Program (HICP) type experiment in northern California. And that type of move I think is extremely progressive. It's something we should support and we should learn from and not expect that every solution every time is going to be the right answer. Let's work our way through and evolve to a correct solution.

MR. DOBSON: Dick, can you see companies coming to the table together and sharing ideas? And particularly in regard to Prudential, say with the Blues or HMOs or the small companies, do you see the different factions coming together on a proposal?

MR. HILL: I think what we're going to see probably is more of an emphasis on regionalization. I think that the providing of health care in a managed environment is an extremely local issue. I think the days of having big national companies being able to have the same product all over the country and being equally successful are probably going to be behind us very soon. And it'll be competition at the regional level where there may be the Blues and some other types of providers, the Kaisers and some insurance companies. There may be some local companies. There's going to be I think very aggressive competition, but different competition.

MR. DOBSON: Paul, you're somewhat of an outsider to the industry and the actuarial world. Do you have any comments on that?

DR. FELDSTEIN: I would just say that the whole nature of politics is to shift cost and that, unless the insurance industry does something, it will be seen as a way that you can shift cost through it. So if the industry doesn't do something soon, I have a feeling that what will happen is Congress will look for a least cost way of achieving something. And the way Congress will do that is to try to shift cost more to the insurance industry.

MR. THOMAS M. INCHALIK: One comment that Congressman Rostenkowski raised was that the Administration proposal placed too great an emphasis on malpractice reform as a means of cost containment. It's been my experience that providers at least think that is a very important step. And I'd like to hear the comments of the panelists on the prospects for controlling cost that way.

MR. HILL: I guess I'm not really an expert on this. My gut feeling on that would be if you had a more managed environment where you had groups of doctors operating in cohorts, then I think you would have much less of a malpractice problem. And I think the objective is to have fewer tests and to keep the cost down. I think that would probably be the most successful way. The independent practitioners probably drive up the cost of testing more than the group-type practice.

DR. FELDSTEIN: I agree with that, but I don't think malpractice reform is the real answer to the problem. Malpractice premiums haven't been increasing for several years, and yet we saw a very rapid rise in medical expenditures. So I don't think

that's the main cause behind high costs. I think there's a legitimate reason to have malpractice insurance because there's a lot of malpractice out there. But I think the way it will be cured is really by what Dick said. You have more physicians in groups being evaluated more by employers on capitation and on outcome and by physicians doing more evaluation of their colleagues. This will lower costs better rather than just having some simple solution.

MR. JOHN H. KERPER: I wanted to get your comments on what I see are probably four of the main problems with the system. The first one I see is that when you have your health care linked to employment, it creates a plethora of problems. I've seen it from the inside because I've got a basically uninsurable daughter. It makes situations tough when your care is linked to employment. Second, along those lines is it takes the actual consumer of the health care out of the loop at really looking at what the cost of the health care is that he's purchasing. In that the health care is covered, you have a certain amount of deductible or copay that you have to meet. You go get it from wherever you feel like you want to get it, without looking at the cost. A third problem on those same lines is that the health care providers have made it virtually impossible to figure out what their costs really are in that they give you these incredibly detailed listings of their charges for every single injection or pill or whatever they give you. And it's almost impossible to look at the cost of one provider versus another provider and say which one's the more efficient provider. They charge you for their mistakes, too. The fourth problem I see is that the health care providers don't make as much use of the information that's being gathered on all the people that they're treating as possible. Some kind of centralized information system is needed that can take all of these data in and analyze them and make the best use of them for the entire populous. Forget individual rights. Everybody would get the use of the information and get better and cheaper health care in return. I'm wondering what your thoughts are on those.

MR. DOBSON: I'm not sure we can remember each of the four parts. But you did mention the employer base which is something that I've spent a lot of time thinking about. I believe that we need an overall mandate to get everybody covered in the country, not necessarily under a play or pay, but I believe it should be individually oriented rather than employer based.

DR. FELDSTEIN: I think the four points are excellent points. I think the idea of linking health insurance to employment is a problem because you lack the portability if you have preexisting conditions. And therefore I believe, and we put together this health insurance proposal that you really mandate the individual, not the employer, and individuals can take the insurance with them when they leave jobs. They can take jobs without insurance. So I think that's a very important point. I think also the idea of the consumer bearing some cost is good. Right now consumers don't have to bear the cost of their choices. And I agree with you that they might as well choose the most expensive, the high quality care. And this was one of the things that was written into Medicare, that great plan that was passed in 1965. It built in inefficiencies that hospitals were paid their cost and patients paid a deductible. That was it and they didn't have to make choices between high or low cost hospitals or anything like that.

The other point about the providers having specific fees and lists, I think that's why in California on the managed care, you're seeing global fees. You're seeing capitation base systems. And you don't want to get 10 different fees from everybody that was involved in the surgical procedure. I think that's the way to go. If you go for expenditure limits, you're not changing anything. You're just putting a limit on how fast fees can go up and you're not changing the system. And the last thing you mentioned about the information, I think only in a system where employers are going to ask providers and insurers for information on the cost to take care of their employee group and what the outcomes are, you're going to force people to use information systems and technology to really find out what's going on. And I think that's the only way to do it. And I think the only way you can do that is in a managed care framework. And in an expenditure limit system like in the Canadian system, there's no incentive to really find out what's going on because you get your fees and that's it.

MR. HILL: If we're supposed to disagree, it's going to be a little bit tough. At the bottom end of the market for the small employers, the more I look at it the more I think that the employer based coverage is probably not going to last forever for smaller groups, be it under 10 lives or under 25 lives or whatever. That's why I like this idea of these purchasing corporations where employees within groups would have the options of having different providers within the purchasing corporation. It certainly is a big shock to all of us if we head in that direction. But it increases portability. It's a very natural bridge with the social programs for the near poor or the marginally employed, and of course, the people who cannot get health insurance because of their health status. So I think that's in a very important direction for us to head.

Wrapping together some of your questions is the idea of outcomes research and improving the efficiency of managed care. Again, that's something that we have to do. And the final area really is the bundled billing or the unbundling of the billing. And again, if you have a capitation approach, you'll get away from those problems. And that's certainly hitting us very heavily right now, particularly right now with the RBRVS cost shifting. And some areas, particularly poorer areas where there's a lot of older people and Medicaid type people, the cost shifting there is getting quite rough.

MR. ROBERT L. WHITNEY: I have a simple one-part comment. My understanding is that Hawaii has a pay or play plan. And while theoretically I would agree with Dr. Feldstein that such plans do appear to be regressive on paper, I've talked to people who live in Hawaii and they don't seem to feel that way. And I wondered if the professor or any other member of the panel could tell us more what they think about the Hawaii plan.

DR. FELDSTEIN: I haven't seen any real evaluation of the Hawaii plan. And so I'm really not that familiar with how well it's performed and who's been affected. So I can't comment. But I hope there would be some evaluation in the next year or so, so we could find out. The only studies I've seen on mandated pay or play are the estimate of the number of jobs that would be lost if you instituted a pay or play plan. From what I understand, Hawaii has a very high employment rate, and so that's one reason it's not getting the decreased demand for labor. But I don't know the other aspects of how it's worked.

MR. DOBSON: There are other differences between Hawaii and the rest of the country, of course. And one of them is the fact that it's an island. So you don't have people moving in and out quite as much. But I agree with you; I think it's something that we need to find out a lot more about before we make comments on what will or won't work.

MR. JOHN A. HARTNEDY: I'd like to comment to Bob. If we're going to be saying "yes" I would suggest more that we have to come up with reasonable proposals and say "no" to the things that we think will not work and offer proposals. And I would suggest that it seems to me that that's where we as a profession have been lacking. The other thing I've heard mentioned is medical IRAs. And I would like the panel's comments on that, particularly the professor's, because it seems to be going along with some of the things that he has said. Any other cost controls, including managed care, are going to put some sort of limits that are not controlled by the consumer. If we go to a medical IRA and sell high deductible insurance, we're putting a lot of the cost of medical care back in the hands of the consumer, which the professor had mentioned was a problem. We're isolating the consumer from the cost. Medical IRAs have been proposed by a number of the national think tanks -- I think they would be a way to begin to get cost under control that might work in this country.

The second point I'd like the panel to talk about is general tax equity, giving everyone the same deduction. I know the Congressman made the comment that Bush's proposal doesn't go far enough. But some sort of tax equity including tax credits and maybe a deductible tap on the higher paid, would find a way to pay for this, but it would certainly attack affordability in some way.

MR. DOBSON: Let me start by making a comment about what you said about consensus among the profession and then I'll let the other two panelists respond. I'm sure Paul could talk for days about the things you've raised and maybe I might suggest you come to Open Forum 5 where he will talk more about it. In terms of what the profession has been trying to do to reach a consensus, we had a health practice council of the American Academy of Actuaries meeting back in January. And I had written down a page of things that I thought were absolute truisms that certainly everybody would agree with. And got it thoroughly torn up and chewed up and spit back at me. So I'm not sure we're too close because I can't get everybody to agree with me and see the right way to go on these things.

DR. FELDSTEIN: The idea of the medical IRA is appealing. There are a couple of problems. One is that it takes time to build up the size of that IRA to where you could really start using it for your medical expenditures and your long-term care. So you're talking about really having an effect maybe years from now rather than anything immediate. The other thing is that to have a medical IRA deduction, you have to have some minimum income level. Otherwise you're really not going to put anything away for the IRA because you just can't afford to. So again you still need something to help those who are low income. And that becomes important; how do you do that? The point you made about having consumers face the cost of their choices, that's true. The question isn't medical care. Consumers are not very well-informed. It's easier for them to make choices on choosing between different insurance plans and different managed care companies than choosing between

different physicians or which hospital to go for a transplant. So I really think that the market would be much more improved if the employer continued to help be a screening agent for the employee on talking about what kind of health insurance plans to offer. And give the employer a cost conscious choice to make on which health plan to make. So I think medical IRAs are feasible in the future, but I think that's not really an immediate type thing today.

MR. DOBSON: Dick, some of those comments sounded like a mandate for managed care, too. Anything you wanted to add to that?

MR. HILL: I have trouble disagreeing with Paul at all. But like any other savings vehicle, the people who have the money will save it, and the people who don't have the money won't be able to save it. So I don't know if that's really going to solve our problems. With regard to the changing in the tax laws, I think we all agree on that. And particularly it has appeal as far as bridging, again, the poor and the near poor. I think doing that through the tax system -- either with tax credits or whatever -- would be the way to go.

MR. JOSEPH W. MORAN: Put on your various Academy hats in dealing with this one, Mr. Dobson, because the Academy is the established vehicle for the profession to communicate with the public on matters of public concern. What I'd like to address is the question as to whether you think the profession and the Academy have adequately created a structure in which to respond to some of the big picture issues on this health care and health funding reform question. And whether there is a mechanism in place that enables actuaries to make effective use of their knowledge and their perspectives. I'm thinking particularly of the extent to which the role of responding to legislative proposals seems to have been defaulted by the profession more to the trade associations of insurers and HMOs and Blue Cross organizations, rather than having the Academy out on the front line in responding to proposals such as, for example, purchasing groups. I'm not aware of any Academy body that is addressing the question of some of the actuarial or economic implications of purchasing groups as a potential substitute for the established competitive marketplace. Other areas would be the big picture problem of what economic value is added by having the employer acting as the customer surrogate in fighting the economic warfare between buyers of health care and the providers of health care, where the buyers seem to lose most often? Could you address that subject?

MR. DOBSON: Yes, I certainly would. I think that's a very fair question and I think that I would certainly recognize that we could do a lot better job than we've been doing. I think probably there are more things going on at the front line than a lot of people are aware of, though you mentioned this specific instance and I'm not sure if anything is. That's a good suggestion to put on our list. I think that some of the people within the health practice council and health committee of the Academy have recognized that we're not being as efficient as we can be. And with volunteers' time, maybe there's a need for more staff or redirecting some of the staff, or dedicating some staff. We don't have all the solutions yet, but I think we have recognized that there are a lot of opportunities out there for the profession to have an impact, and this is the time when we want to take good advantage of it. And all I can tell you is we're looking at it and working on it and we recognize some improvements could be made.

MR. MORAN: I had a suggestion I wanted to throw out. We're talking about having something to be able to say "yes" to. I'm not sure many would say yes to this, but this is something I would think would be a good way to go. I think we should mandate some type of a minimum benefit plan. Throw out all the state mandated benefits. It could be a minimum benefit plan along the lines of say the Oregon Medicaid where the state provides only the benefits that have the most economic benefit back as a result, such as well care and prenatal care and the like. And then allow insurers to provide this plan where it's a capitation basis. They're reimbursed on that. And then those insurers have the ability to offer additional coverages to the people that they've covered under this minimum plan. That way you'd have people covered under a single insurance plan for their medical benefits, but they have the option to get additional coverage if they want. Employers could provide that additional coverage to them if they want. But that would take care of just about all of the points that I have covered in my previous suggestion. I'm wondering what your thoughts might be on that. One other thing on top of that. We should move health insurance from a, let's say, when the bills are incurred basis to the illness incurred basis. This would be much like it is done in casualty insurance. If you develop cancer in 1992 and you were covered in 1992, you're going to be covered by the same insurer in 1994 if you're still around. They can't cut your coverage off on you.

MR. DOBSON: That's an interesting thought and one that I haven't heard proposed. It would certainly take some major changes. Do any of the panelists have any comments on either of those points?

MR. HILL: On the second, eliminating preexisting conditions and once someone is in the system they continue to be in the system, it doesn't make too much difference because if people stay continuously employed the health care is going to be covered. And I guess the other problem is it might be a little bit difficult to determine when an illness actually was first incurred. But the idea of continuity of coverage which is a common thread I think solves that problem.

DR. FELDSTEIN: Just one reaction on the idea of being very explicit about what would be covered and what wouldn't be covered. It's been my experience that Congress and legislators don't want to be explicit in denying people care. What they do instead is they try to be implicit by not providing the funding and then leaving it up to the provider to make that allocation. I think what you see happening is that, if you said that in a minimum plan, the poor could not get access to a transplant, well, obviously that will get in the paper when somebody's picture comes up that they can't have access to a transplant. They're going to ask the legislators. No legislator would vote for death. So they'll all sort of say, "Sure, we should have transplants," or force some insurer to pay for it. So I think in the past the whole idea has been that you give the county hospital or you give Medicaid a limited amount of money, and you don't want to know what the poor gets and doesn't get. We're different than in Canada and other places, where we ration according to different criteria such as age. So I think legislators would find it very hard to be explicit and deny certain kinds of care to people who need it. I think there's a potential political problem with that approach.

MR. DOBSON: It would be interesting to see how that works in Oregon. I've already heard some comments that it wasn't well understood by the public, and they didn't exactly know what they were buying into.

MR. J. STANLEY HILL: I have two quick questions. The first one concerns the new Minnesota health rate bill, the most comprehensive piece of health insurance ever approached in Minnesota which has probably a 95% or better chance of becoming law because it is supported by both parties and the governor. It is supposed to deal primarily with access and to fund the cost of improved access by a provider tax. The provider tax begins at a 2% level to which probably all health actuaries would like to say no. But those of us who have both actuarial instincts and hospital trustee instincts believe that a more realistic tax level, if that's the source of funding, is 8%. And that's kind of frightening.

The other question is a little more positive and that is the collaborative model. I'm leading a group in St. Paul which is going to try to get all of the adult hospitals in the greater St. Paul area to cooperate on a collaborative model. We think this will not only improve access for the entire community, but will in effect help to control cost because it is sufficiently socially oriented that we believe we can bring in major foundation funding to help subsidize the cost of health care. I'd like to hear the panelists' comments on both subjects.

DR. FELDSTEIN: I'm not familiar with the Minnesota health rate bill, so I'll just make a few comments on the provider tax to fund care for the poor. Basically what that would do would be increase the cost of health care. When you add the tax, it would increase the cost of health insurance, and probably for those who don't have health insurance or have it and don't have very high incomes, it may increase the cost too much so that they may decide to drop it and go on Medicaid. I think that's a potential problem that we have to look out for. Whether the provider tax is adequate would depend upon the size of the benefits, the number of people covered and how much money you would raise from the tax. The only thing I would say is that again, it's a way of trying to make it appear not very obvious that you want to tax those who could afford it to help provide care to the poor. And that's the way the funding really should be done. The provider tax appears that we're shifting the cost to somebody else. We'll lower consumers prices, but increase their taxes. But somehow that has to affect care for everybody. It's a regressive tax because it will increase the cost of care the same amount to everybody which will be a higher percent of income for those with low incomes. And I fear that if it gets higher, those low income people may drop their health insurance coverage. A provider tax is a way of getting broad based fundings for any insurance reforms. It's one of the few ways that you can have some sort of tax on the noninsured groups like self-insured ASO cases or whatever. If you go through the provider, you can collect funds that way.

MR. GREGORY W. PARKER: I think everyone agrees that portability is a very important component of the access issue. Given the large amount of self-insurance that goes on in the country today, including some of these organized care programs that Dick had described earlier, what are your thoughts on how portability can be achieved if we continue to have a large segment of our medical care being self-funded by employers in this country?

MR. DOBSON: The portability there would be a bit more difficult with the large employers, I guess, because I really haven't thought through that one too much. The portability that I've been concentrating on is mainly at the bottom end of the market, for example, those smaller employers where both the small employer himself may go out of business or the employees tend to be often seasonal or part time and move from employer to employer. And there I felt that if an insured purchases through one of these, through a managed care organization within his local environment and he moves from employer to employer, he would have coverage. I guess all I can say is that if this comes to pass that many of the large employers would also be buying from the same managed care operations and they too would be able to move. But I guess I really haven't thought that through all the way.

DR. FELDSTEIN: I will just briefly say that this gets back to the point made earlier by an individual talking about the health insurance link to the workplace. The portability is an important issue, and as long as it's linked to the workplace it will be a problem. The only way to really solve that is to again, I think mandate. You know, link to the individual rather than the workplace. And that would increase portability.

MR. RONALD E. BACHMAN: I would like the panel to comment on two areas in particular. In general, first is trust and the second is economics. In the area of trust, it seems it's awfully difficult. Representative Rostenkowski mentioned we ought to get talking about the issues and not talking about who smoked what when and what other problems there might be with the leadership in both Congress and the Administration. But it seemed awfully difficult to turn over a problem to people whom we don't seem to have as much trust in. People who maybe have their ideal of a medical system as the Veterans Administration (VA) system or people who have brought us S&L scandals and all sorts of other problems. So how do you turn over these types of problems to those people, and which of the issues and proposals have the least amount of government involvement and the most amount of private industry involvement? It's tough to just say yes to those folks. So Bob, you might be able to comment on that.

The second area of economics maybe Dr. Feldstein could comment on because while many people may have other problems with the 1980s, it seems like one of the real miracles was the creation of 20 million jobs. And those jobs weren't created at General Motors or IBM. They were created in small businesses. So it was the period of the entrepreneur it would seem to me. My great concern is when big business and big government get together they are going to close out that one area that seems to be fighting the group reform, the medical reform. That's small businesses. And it's not much constituency for people who don't ever get a job because that business was never created. How do we prevent that from happening?

MR. DOBSON: Let me comment on your first point. I agree with you that maximum private sector involvement would be nice, and that's why I made a few comments kind of chiding the insurance industry, hoping that if enough of that's heard, maybe some people will get together and come up with a proposal as a unified insurance industry. Because I think that would be great, but I just don't see it happening. I don't see enough people looking beyond their individual companies' self-interest. And that's what I worry about in that regard. But I also made some cynical comments about the elective process, and I am worried about the trust issue you raised. I don't

know how we'll get around that one without some major reforms in Congress and maybe longer terms for Congressional representative and a maximum limit on how many times they can be reelected. But that's a whole different topic that we can spend time on, too, and we're running out of time. So I'll turn it back to the panelists.

DR. FELDSTEIN: I'll comment briefly on both. The late Sen. Everett Dirkson used to say that the first rule of politics is to get elected. The second rule is to get reelected. And when you talk about trust, what Congress wants is political support. And whoever can provide political support is politically powerful. And so Congress responds to those who are politically powerful. And that's why the middle class gets more than the lower income people. That's why big industries who can provide political support get import tariffs and quotas and things like that. And small businesses don't. So I think to turn it over to Congress, what you're saying is you're going to turn it over to those who have a big interest in the outcome, which may not represent the best for the country. So I would be very reluctant to turn it over to Congress.

The second thing about the economics, I agree with you, is that I share concern about small businesses. The large employers have their agenda. Lee Iacocca wants to reduce his FASB requirement. He wants a Canadian-type system for the country. But I think when he says Canadian type, he means expenditure limits for everybody, but buyout for himself. So again, I'm concerned about the employer mandate and the role of big business because I think it will hurt the growth in the economy which has been the small businesses and the innovation. So I share those concerns.

MR. HILL: Again, I agree completely with these two guys.

MR. DOBSON: We didn't bill this one as a debate.

MR. HILL: Right. But I think with regard to the economic side, I think there has to be cost spreading right now. The small employer, very often the young entrepreneur or any entrepreneur cannot get coverage. Very often it's too expensive. We have to keep it more affordable. And there has to be a broad spreading of costs so it can be more affordable. I think most of the suggestions that we have will make it more affordable, even if it becomes mandatory on an individual or a group basis.

MR. TED L. DUNN: In this country, we're spending 12% of our GNP on health care. Every other industrialized country around the world spends between 6 and 9%. Even so, one out of seven individuals in this country is either uninsured or significantly underinsured. Years ago we thought we had a problem with health care in this country. So we passed the Hill Burton Act to build new hospitals, and we also set up new medical schools to get more doctors. And those initiatives were certainly successful. The problem is we can't seem to get any doctors to move to the outback of Wyoming because their Mercedes Benzes cannot get service there. It seems to me that the people who are getting this 12% are going to have to give up some of it or there will be no solution. If we have to inflict some pain on somebody, I think we have a target group to work with. I don't know whether you want to touch that with a ten foot pole or not, but it's really not a question.

MR. HILL: I would say this is something that we really haven't talked about specifically, but I think we all agree that the system is inefficient. It's wasteful. And it's full of abuses. And part of the core problem is to attack the provider side and to rachet down that cost. I think we all agree on that.

MR. DUNN: The question is how you do it. There are a number of different ways, of course. Paul, did you have anything you wanted to say on that?

DR. FELDSTEIN: No, I agree with my colleague here.

MR. ROY GOLDMAN: I wanted to ask a question in a moment about how do we split out what I see are really two problems. One problem that has been mentioned many times is the increasing cost of health care in general and the large percentage that it is of our GNP. The second problem is the one of the "uninsured." Actually most everybody in this room is probably uninsured because we work for large employers that have ASO plans. And I know Dr. Feldstein, you probably use as an example American Airlines, worried about low-cost companies like Continental. But American Airlines is not insured, neither is Continental Airlines. And in fact, both of them have managed care and both of them have it with Prudential. And perhaps American Airlines is concerned because Continental started its plan in 1991 and American Airlines in 1992.

But the point I wanted to get to is, can we solve what are really two problems. One is the increasing cost of health care in general. And the second is those individuals who are not covered at all, and they mainly work for small groups. Given the sort of the power of large employers, do you think it is for wellness in any of these proposals. And I think that certainly it's something that in a current insured environment, that some of us are pushing for quite a bit. I've been struck by the fact over the last couple of months in the newspapers how many articles there have been on major corporations that are recognizing wellness more and more. And some are changing their contribution levels to reflect such things as smoking or nonsmoking status. I don't see why most of those ideas couldn't be integrated into any system with regard to the price of care and trying to encourage people toward wellness. As far as the 40% or whatever it is of the expenses being in the last six months of life, I don't think you'll ever, as an actuary, get away from that. The only thing we're doing is we're shifting those last six months of life to older and older ages.