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DEBATE: WHO SHOULD PAY TO CARE FOR THE UNINSURED?

Moderator: GORDON R. TRAPNELL
Panelists: JOHN M. BERTKO
JOHN F. FRITZ
Recorder: GORDON R. TRAPNELL

- Providers (as they do now – or through taxes)
- The uninsured – at least what they can
- Employers of uninsured workers – and the workers themselves
- Insured employers and employees – through premium taxes (or insurer assessments), payroll taxes or community rating
- Premium taxes or assessments on other health insurance
- General revenue taxes of states or the Federal Government

The debaters will represent advocates of private, voluntary, and cooperative private-state solutions and state or government intervention (e.g., employer mandates) to finance health care for the uninsured.

MR. GORDON R. TRAPNELL: The number of uninsured in the U.S. is estimated by various studies to be between 30 and 40 million. All of these numbers are very soft, because they're compiled from surveys that record answers to multiple questions that may be used as the basis of tabulations. For example, they may ask not only whether respondents are currently insured or uninsured, but whether they are covered by work-related insurance and then whether they work part time or full time, how many hours they worked last week, and how many weeks they worked last year. Medicaid may be counted as insurance or as uninsured. Most surveys fail to find more than a fraction of those documented to be eligible for welfare or Medicaid, and adjustments to include them can be made in a variety of ways. In addition, they change some of the questions from year to year and the results are apparently affected by the way questions are asked.

Consequently, it's very difficult to determine how many uninsured there really are. But this does not deter newspaper reporters from grabbing hold of a number reported by some analyst and treating it as Absolute Truth – at least until the next article in *The New England Journal of Medicine* reports a different number. Then that number becomes the Truth. But in reality, no one really knows how many uninsured there are and there could be 10 or 15 million more or less than the 30 or 40 million range that's widely advertised. The number may have grown in recent years but no one really knows because, again, we have no reliable data source to measure the growth. But what has grown relentlessly, at least over the last couple of years, are the apparent pressures to find a solution, especially, a federal solution.

We will discuss whether there really is a major problem and what it is. Our debaters represent the perspectives (1) that the private sector can do it all, perhaps with a little help from states, but certainly it does not need any interference from the Federal Government and (2) that a major public intervention is needed to assure coverage of the presently uninsured.

Our private solution advocate is John Fritz, FSA. John recently left the consulting field and is now the Vice President and chief actuary of Family Health Plan Inc (FHP) and FHP Life Insurance Company. This is a fast growing, mix modeled HMO licensed in California, Arizona, New Mexico, Utah, and some of the territories with 600,000 members.

For our counterpoint we have John Bertko, who is a senior actuary in the Cooper and Lybrands San Francisco office. He was previously a group actuary with the Metropolitan Life Insurance Co. His current consulting practice includes large employers, especially SFAS 106 consulting, insurers and HMOs, providers, that is hospitals and physician groups, state governments. He also has a lot of experience in studies intended to lead to state initiatives to provide coverage for the uninsured and for improving Medicaid programs. For example, he has worked with the prepaid Medicaid program in Ohio to reform the state employee health care purchasing in Washington State, the Oregon initiatives for prepaid plans for welfare recipients, and prioritized health care initiatives to Hawaii State Health Initiative Plan, California's uninsured program, and a recent study for restructuring the Veteran Administration (VA).

I will organize the debate in the fashion of the political debates and act as the sole press representative. I'll start by directing my first question to John Fritz. We've been inundated with newspaper articles on the inadequacies of health insurance protection. How can we assure appropriate coverage for persons who are uninsurable and do not now have access to coverage?

MR. JOHN F. FRITZ: Well, it seems to me that that problem is being addressed right now to a large extent with the state risk pools. Twenty-five of the states have already adopted a risk pool concept of one form or another. The oldest is in Minnesota. I think that none of them are the final solution to the uninsurable problem and I think there's going to be an evolution of solutions, but I think this kind of a solution is the way to go in terms of the uninsurables, especially if they are not employed. At the same time, we have some proposed solutions in which employers are involved. For example, Health Insurance Association of America (HIAA) has proposed using a reinsurance pool where the employees or groups that are uninsurable would then be reinsured through this private reinsurance pool and take care of the employed. The kinds of coverages offered through the risk pools are fairly basic coverages rather than totally comprehensive (although there may be some exceptions). I think one needs to be realistic about the cost aspect of covering the uninsurables and what is affordable in the first place both from the standpoint of the individual and the subsidy required form the government. Many of these risk pools involve contributions on the part of the insureds themselves, those who are able to afford to make some contributions, and then there's some subsidy from government or some other form of broad funding.

The private reinsurance vehicle that I mentioned is really part of the overall small group reform that the insurance industry has been looking into and is a proponent of, so I'll be talking more about that later on even though we're talking about the uninsurables separately from the uninsured. As for private reinsurance, the kind of coverage that would be provided is determined by the coverage that was really the base coverage of the ceding company that had the employer group in the first place.

So, basically, I think we're on the right track in terms of solving the problem of insurable uninsured. Maybe that's too optimistic at this point, but at least in finding solutions to the uninsurable situation the private sector can help. I think this is an area where I have to admit that there is need for some government assistance, such as the risk pools and where employment is involved the use of the private reinsurance pools.

MR. TRAPNELL: John, are you comfortable that these solutions will provide adequate access to care for persons who are currently uninsured as the uninsurable?

MR. JOHN M. BERTKO: I think, Gordon, that John's got to be kidding here. Let's step back and just take a small look at the pools that are in place. Luckily the *Health Section News* just came out, this past issue, with a brief summary of the pools that have been operating for a few years and I'll go to just one part of them first. And that's that they don't come close to covering the uninsurable population. Our own estimate was about 5% of the total uninsured are uninsurable and that pretty much matches what we heard a couple people say in the group reform session. About 1% of a state's total population look like their uninsured. If you look, for example, at the Minnesota pool, a rough estimate is a cost per uninsurable of around $5,000. You get about 7,500 people or so in Minnesota who are covered today, maybe 10,000 if you stretch it. I'm guessing that Minnesota has got about seven or eight million people, so you don't come close to the 70,000 or so that probably have the problem. So, John, all I can say is you're a heartless insurance actuary.

MR. FRITZ: You went back to the Minnesota example. I think the real number in Minnesota is 25,000 and I said this was an evolving solution that we're working on and it's not going to be solved overnight. And we certainly don't want to have Big Brother step in and try to impose a solution on us that will be permanent. Whenever Big Brother steps in, it's going to be a solution that will be imposed on us, maybe starting off small, but it will keep getting bigger and bigger so that we will have absolutely nothing to say about it.

MR. BERTKO: Okay, I can understand that. Your comment about evolving says – I think your 25,000 is the number that are enrolled currently. Okay, let's even say that that's a reasonable number and has to evolve to the 75,000. The insurance industry has got quite a few tricks up its sleeve. In addition to what's going on in the country, you have AIDS throwing more people into the uninsurable ranks.

MR. FRITZ: Are you blaming AIDS on the insurance industry?

MR. BERTKO: Oh, no, no. I won't go that far. Some of the people I listen to might, but cancer is out there throwing a lot of people into the uninsurables. The next thing that seems to be around the corner is some kind of genetic testing. The current direction of the insurance industry underwriting, though, is to make more people uninsurable. So by the time you get to 75,000 we may have a 100,000 or 150,000 more uninsured. We're going to be playing a game of catch up for ever and somehow, again, it doesn't seem equitable to these uninsureds that they be the bottom of the barrel.

MR. FRITZ: I really disagree, because the HIAA's approach, for example, assumes that underwriting will not be used to exclude uninsurables, but rather to determine which of the individuals or which of the groups are to be put or placed into the reinsurance pool. So that's not one of avoidance or avoiding the problem of the uninsurables. I think the approach that HIAA is taking is that we have a responsibility.

MR. BERTKO: Okay, which year is the HIAA going to do that?

MR. FRITZ: These things take time.

MR. BERTKO: I've been hearing that for a long time.

MR. TRAPNELL: Let me move on. Let me move on to the next question. One thing that I hear in common between the two of you is that a solution to the uninsurable is going to require somebody else to help pay for it. Neither of you is suggesting that uninsurables can pay for their own care. I want to note that that's in marked contrast with most of the politicians I've worked with in my life who believe in the most wonderful actuarial concept of all, the self-supporting pool for uninsured persons.

MR. BERTKO: Even I don't believe that.

MR. TRAPNELL: Since none of us here believe in self-supporting pools -- I once did give an answer to the question. I was asked how much the premium would be for a self-supporting voluntary pool for the uninsurable. My response was $50,000 a year. "What do you mean a premium of $50,000 a year?" And I said, "Well, it would be $100,000, except half of them will die before they can use the services." So let me start this time with John Bertko and ask who you think should pay for the inevitable subsidies that are needed for any kind of protection that is provided for uninsurables? And, again, I'm talking about persons who cannot get insurance because they're uninsurable.

MR. BERTKO: Well, I'm a Democrat and Catholic by both religion and preference, so I'd say everybody ought to help pay for it. In some ways, John and I really are not that far apart. I would describe what is needed to be a public and private partnership. The public has got to take a pretty substantive role in this thing. Let's start with the people who need to think about what they're going to pay and how they might pay for it. Let's also start with people who have been beat up considerably, the providers. There is just no way the providers are going to get paid what they ask for in billed charges. They have to come through with discounts, and probably substantial discounts. This is not as impossible as it may sound, because providers in some cases are paying for or getting reimbursed through Medicaid for some of these same people already at very, very low rates, offering to serve them at cost. Our experience in Oregon is that the providers are much more flexible than you might expect and that hospitals are talking about giving 25-30, maybe even 40% discounts. The physicians, who many of you might accuse of trying to protect the German fleets in their garages, are even willing to come down to cost, and we have some evidence that cost for them is, depending on specialty, somewhere between maybe 55 to maybe 60% of charges. Prescription drugs maybe is another category. You know Medicaid

and the VA and everybody are having their own problems with them. I'm not sure there's going to be as much discount available, although you can lean on the pharmacies, at least for very reasonable dispensing fee.

Next, the uninsurables are going to have to pay for some of it also and they could pay for it in two ways. Most of the uninsurable programs today require payment of 125-150% of some average premium. But the insurance industry ignores the fact that many of those uninsurables can't afford to pay anything. Three thousand dollars a year, roughly which is the cost of some of these programs, out of your gross income of maybe $10,000 or $12,000, just doesn't cut it. It's not possible. So there may be some sliding income scales that need to be used. The other way the uninsurables will have to pay for it is through a reduced benefit package, limits on lifetime or annual coverage, appropriate care like organs looking into. In the California program we put a $50,000 lid on it. It's implicit prioritization or rationing.

Next, the insurance company is going to have to pay for it one way or another. It's my understanding that the vast majority of the 25 programs that are in effect have excess amounts above the premiums paid from assessments on insurance companies. That approach has a lot of flaws though. I think as identified this morning, for the most part, it doesn't touch the self-insured employers who are avoiding paying any share. Sometimes the Blues and HMOs are charged the assessments, sometimes they're not and there's a massive problem here of getting around ERISA. So I'll be interested in John's response here that the current mechanism works well enough.

Next are the general funds of states and I'll say this with careful touch here. California has the biggest deficit ever, around $13 or $14 billion. I think it's bigger than the budgets of about half the states. There ain't no more money out there and Medicaid itself is going to be cut back in the way that it currently serves California residents. Certainly, newspaper articles seem to say that the rest of the states are pretty much in the same ball park. I would hold out a different source of revenue here, sin taxes, such as liquor and alcohol. Politically they can be proper. In California we're funding a good piece of the uninsurable program by some of these sin taxes. We're getting $30 million bucks and while again it's literally a drop in the bucket compared to the cost maybe 200,000 or so uninsurables, it's a start. There is also competition to spend the sin taxes. I think the overall tax is somewhere in the range of $600 million and a bunch of it is going to education and a bunch of it is going to studies. The academics also have their hooks on it.

Lastly, the federal government, with its budget problems, obviously isn't going to create any new revenue sources for this. However, Medicaid is still a matchable program and it's legislated in law. The Oregon program, which prioritizes health care needs, must get a Medicaid waiver. At that point if they succeed in getting the waiver through Congress and through the Health Care Finance Administration (HCFA), they'll have matching funds. Now that's taking money from one federal government pocket and putting it into another, but it's a source of money that's already legislated. So I think there is a combination of things that's out there to pay for a good piece of the uninsurables.

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MR. TRAPNELL: I hadn't realized that one of the reasons that Medicaid costs were climbing so rapidly in the last couple of years is that they are hiring better consultants.

MR. BERTKO: You bet.

MR. FRITZ: I guess you didn't leave me a whole lot to disagree with.

MR. TRAPNELL: What do you mean? He wants to increase everybody's taxes.

MR. FRITZ: Well, as you know, this is one of the areas where I think that the government should be playing a role and I think you hit the nail on the head when you talked about the potential problem with assessment with the state risk pools. I had a conversation out in the hall about the Minnesota program and the assessment situation there is resulting in a shrinking base against which they can assess the pool losses. In other words, more and more of the employers are going self-insured, or to the HMOs, which then gets outside of the base which is used for the assessment.

MR. BERTKO: It sounds like your conceding that one to me. I get one point over here, right?

MR. FRITZ: Well, just because I agree doesn't mean that there's a winner or a loser here.

MR. TRAPNELL: Yes, it does. It means the taxpayers lose.

MR. FRITZ: One thought I had is, of course, if we keep taxing sin all the time, we're likely to have a world without sin and then where would our funds come from to pay for the uninsurables?

MR. BERTKO: I won't try to touch that one, John.

MR. TRAPNELL: Let me move on to the next topic. The persons who are uninsured, you might say, are either financially uninsured or uninsured by choice. Persons who could obtain insurance if they were willing to pay for it but either can't or have other higher priorities, which may range from shelter and putting food on the table to paying for servicing a Porsche. But let me first ask John Fritz to explain why persons who choose to be uninsured because they have higher priorities should be forced into some system and if they should be forced to take care of themselves. What measures are reasonable?

MR. FRITZ: Let me answer that by making a statement that might be a little drastic, but maybe we don't really have an uninsured problem in this country at all. Maybe it's only a politicized problem. When we talk about care, I think you have to admit that the kind of health care that we have in the U.S. is the best in the whole world. We have the best technology. We take care of our population better than anyone else. Even those people who can't afford coverage have access to care. One way is through Medicaid. Others who just can't afford to pay can still get admitted to hospitals and get treatment at least until their conditions are stabilized, and the hospitals suffer the consequences through uncompensated care. You know the politicians have been looking for the horror stories to point to that crystalize the

problem to gain support to nationalize health care. Yet they have not succeeded in all these years in finding the real horror story. I think what we've got here is a politicized problem involving paying for all these people who are "uninsured" in a different way than we're covering them right now. The hospitals don't want all this uncompensated care anymore. Too much is maybe falling on Medicaid and the government wants to shift more costs to the private industry. So I'm not so sure that the problem is as bad as the newspapers and some of the politicians would lead us to believe. Now having said all that I have to also be a realist and say, well, okay, it's politicized so now what do we do about it, because my argument isn't going to hold any water in Washington. So we have to be realistic enough to try to come up with solutions and I think that's exactly what the industry is doing. And before I get into the solutions, let me back up and talk about some of the statistics that are being bandied about.

Gordon opened up the session and said that we've got 30-40 million people and he admitted those are soft numbers, that maybe these are 10-15 million more or less. You know no one can really say exactly where those numbers are. The best numbers that I saw so far seem to put the numbers somewhere in the low 30s.

Another statement was made in the last session that illustrates how this whole issue is being politicized. A statement was made that 56% of employers don't provide health care for their employees. Leave it at that and it sounds horrible. Then you break it down and you find out that 99% of all employers who have more than 100 employees provide coverage for their employees. Ninety-six percent of all employers who have more than 25 employees provide coverage for their employees. The under 10 market is where the shortfall comes from. Only 33% of them provide coverage for their employees. When you just count employers without weighting it by the numbers of employees, of course, you've got this horrible number that says 56%. That's what the reporters write about and that's what the politicians point to. When, in fact, 87% of the people in this country are covered either through private or public insurance. Okay, so that's trying to put the problem of the uninsured's situation in a little better perspective.

Now let me kind of address the uninsured problem from what the industry is proposing and try to solve that problem by first dealing with the employer population through the small group reform that's being hotly debated and discussed in the industry and in other places. Some of the numbers here again are that roughly two thirds of the uninsured are full-time workers and another 14% either are part-time workers or have family members who are employed. So here we're talking about 80% of the uninsured who are somehow tied into employment and then two thirds of this 80% are employees of business establishments with fewer than 25 employees and, bingo, there's where you've got the small group reform and why the industry is really focusing on this issue. Two-thirds of this 80% is well over half of the "uninsured" population that can be addressed through small group reform.

In the last session we talked about the definition of what the industry is trying to do. Referring to our approach as addressing "access" is perhaps overstating what we really can do as an industry. I think we can make the coverage available, but we can't force access on the employer community. So the best that the industry can do is to make it available and to do this we have the small group reform. And it's not

just the insurance industry. The Blue Cross/Blue Shield Plans, the HMOs -- everyone is interested in working on trying to come up with solutions for this. And I believe that, in general, we're on the right track in terms of coming up with these solutions. The issue is very, very complex. We're not going to hit the nail on the head the very first time we come out with the program. You know it's going to be one step at a time and as long as we're moving in the right direction we will get there. With all of the different entities involved, and all of the different considerations that have to be dealt with -- we need to carefully walk a tight rope and come up with just the right way of approaching this or it's likely to cause major adverse consequences, or even bankruptcies, for insurance companies. It won't solve the problem at all if we approach it in the wrong way and then the federal government ultimately does step in. But I think what we're doing is showing progress and we need to keep moving in that direction.

Unfortunately, the problem that we have in small group came about because of competitive forces and I'm not going to get into all of the reasons and why we're where we are, but I think we all agree or I think most of us agree that some of the pricing and underwriting practices that we have in place now were caused because of competitive forces and there are some undesirable side effects. Things like unaffordable rates for some employers. A lot of confusion and instability in the marketplace. Carriers are dropping out of the market and so forth. What we're trying to now come to is a way to get ourselves out of the box that the industry is in and while I don't want to admit that we need the help of government, I think we do need some assistance, including help with small group reform. Some of this has to be legislated because we have to level the playing field for all players in the marketplace and that's the only way it's going to work. I think things like guaranteed availability are very important and HIAA's approach is that we want to guarantee availability of coverage to the employers with employee counts between three and 25, that coverage would be available for the entire group so that the employer, the insurance company, the HMO, or the Blue Cross/Blue Shield plan would not be able to exclude individuals from a group. I thing renewability of coverage is another crucial aspect, to formulate a solution that will not only work, but will also give the right signals to Washington that we're on the right track. Another is continuity of individual coverage. Once someone is in the system and has satisfied preexisting conditions, that person should have access to coverage without resatisfying the preexisting conditions even if his or her employer changes coverage to another employer. If the employer goes out of business and the employee has to go to another employer, he should not have to resatisfy the preexisting conditions. We need premium pricing limits and those of you who attended the last session heard a lot of the cautions of how to do that. I don't think anybody has the magic solution on how tightly do you bring this down to or how closely do you bring it down to a community rating model, which has some pitfalls. One drawback is that you give an advantage to a new carrier because they won't be saddled with the whole gamut of risk.

We've seen various proposals. NAIC has drafted one as a model bill. HIAA has one that's a little bit different but in the same direction, all trying to limit the abuses of the rating system, I say that in a kind way because I know how we got to those "abuses" and it's not possible to pull out of doing the kinds of things that are happening in the small group marketplace without risking the financial stability of the company. We also need to allow small groups to buy coverage that isn't

unnecessarily loaded down with a whole lot of state-mandated benefits. I know that's only a one-time solution. I mean once you've got your 6% or 20% discount off of the price, the rate for getting rid of this excess baggage, depending on whatever state we're taking about, you're still going to be stuck with trend. And one of the underlying themes of everything that I'm saying is that we have to have good managed care. Every one of you probably has different ideas of what managed care is, but note that I just joined an HMO.

MR. TRAPNELL: John Bertko, would you agree that this combination of private sector initiatives and limited public regulation can assure access to care for the presently uninsured that meets public expectations?

MR. BERTKO: Gordon, you already know the answer to that one. We have to admit John's heart is in the right place. He wants to fix things. He wants to make things better. Let me address the basic issue though. We've got that 13%, the 30 million people that are uninsured. I think all the things that John has proposed will have some effect, but what is the effect? They'll slow down the growth of the uninsured. They don't really address the problems of how to take care of the 30 million that are already out there. He made a statement at the beginning of his speech and I know it's for debate purposes, but let me pull at it a little bit. I think the basic argument was made that this is a political problem and not a real problem, that there is coverage out there for everybody and that there aren't any big uninsured groups out there.

Let's just walk down some of those kinds of coverage and whether that's a real statement or not. First off, high costs are the main problem for small business. Rating problems and the practices of insurance companies exacerbate these but high cost is the real problem and small employers not only are not taking coverage, but they're dropping coverage and they just can't swallow a 30% increase, a 50% increase, let alone a 100% increase that some of them are seeing.

Next, there are practices that the private insurance market is doing to people. They're canceling lots of groups. Now "lots" is relative. John's comments here said that the insurance industry is willing to work towards eliminating some of those. Once again, if he eliminates some of them there's going to be a whole bunch of constituencies out there that say, gee, you've taken away our market, we don't like that. I think it's going to be a long time before he gets enough agreement on that. Okay, let's suppose that the people drop out of the private insurance market and land in what this administration calls the "safety net" which in California we call "Medical" (California's Medicaid program). I'll ask John. How would you like your family to be covered by Medical and that's only partly rhetorical. There just aren't enough providers. Medical pays too little.

Suppose we put you on Medical. I think he mentioned the other night that he just had a new kid, right? Let's suppose that you're on Medical and you tried to find an obstetrician. Good luck. When Maxicare canceled its Medicaid HMO contract in Alameda County they threw 4,000 women on to a system which I think has four obstetricians in the southern part of the county who weren't even thinking about accepting Medical patients. That safety net just doesn't work very well. Okay, suppose that you dropped through Medicaid. You're making some money. You don't qualify for those categorical eligibility requirements and you just have to go into

the hospital to take charity care. Hospitals do have a federal requirement to provide the charity care to take care of you for a while and then send you off to the county hospital. It's just a fact that we heard from Governor Lamm that the people who don't have health insurance get some large percentage less care than people who do have insurance coverage. I think he may have used a number around 40-50% less care. We all agree that some of the care providers that fully insured is unnecessary, but it's like looking at Kareem Abdul Jabar and Danny DeVito. I know there's a difference there no matter what. I always pick Kareem for my pickup team. The county hospitals are in dismal shape at least in California. Again, I live in Alameda County. Highland Hospital in the north part of the county is literally a disaster area. They're trying very hard to handle an enormous amount of all kinds of problems, including being a trauma center. Because of the state's problems, they're cutting costs. You get in there and I think the *Oakland Tribune* said there's a six- to eight-week wait for just a regular doctor visit. If you call that part of the care or the safety net that we don't have an uninsured problem I would disagree with it. That's uninsurance.

I'll also go off now and just say a couple of comments here that this is a political problem. Again, if what the insurance industry addressed is the growth of the problem and not the problem itself, I think you agree that the door here has to be open for some government help. My favorite health economist, Alain Enthoven at Stanford, has a good phrase for it. There's a "collective action problem." It works a bit like nuclear disarmament. The insurance industry doesn't have anybody that can go first and I think you need some help this time. I mean the famous phrase: "I'm from the government, and I'm here to help you." I think the insurance industry has to have the health and I don't think it's just a little crack in the door. I think it's got to be some sort of partnership where each side says, gee, we've got to work on this and get a new system out here as opposed to tinkering and adding a new shed on to the back of the current system.

MR. TRAPNELL: It's really difficult to get a true advocate of public solutions in this forum from the membership of this society.

MR. FRITZ: I agree with John that the issue is cost. I think there's a limit to what the insurance industry will be able to do. I think what is being proposed will have an impact on cost. There are several studies that have said, yes, if you can get me about a 20% reduction in rate, this was a survey of small employers, 16-20% of the employers said they would buy coverage for their employees. And by eliminating all of the mandated benefits, costs can be reduced in many states by 16-20%. And if we manage the care better with the kind of tools that we are starting to get, we can hold costs down so that the trends of the future won't be the same as the trends of the past.

The insurance industry can not be the solution to every single problem, so, I think we still need Medicaid. I think Medicaid needs to expand its horizons by raising the income limit for eligibility to 100% of the federal poverty level. This will increase the numbers of people eligible for Medicaid by nine to 10 million, which takes care of one third of the uninsured population. And if you do what I was saying in terms of the private side and provide small group rate reform, you make coverage available to

roughly another 15 million people, so we've just solved 26 million of the 31 million problem of the existing and held the brakes on costs for the future.

MR. BERTKO: My response to that, John, is that having been trained as an actuary and passed part seven with cynicism, it looks like wishful thinking to me, but let's start just with a comment. I think we heard the insurance department representative from North Carolina say that mandated benefits in his state cost only 5%. That number sounds okay to me. You made a somewhat higher number there that sounds pretty tough.

MR. FRITZ: He also said 16-21% in Maryland and Virginia.

MR. BERTKO: Yeah, still perhaps on the high side. The other is you can be cynical about trends in managed care, too, and I would bet that in California there would be some good takers in the state government if you'd be willing to sign on the line for guaranteeing rate increases for your product to them in the next three or four years.

MR. FRITZ: One thing that I haven't heard from you, John, though is what is the solution.

MR. BERTKO: Fair comment. Is that my cue going? Yes. Okay. Now it's John's turn to hit me over the head with a club, but let me make a pass at it. First of all, we discussed the insurable uninsured first for a reason and I think we had some consensus here, at least my end of it was that when we talked about the problem of the uninsured we would have eliminated the uninsurable piece of it, that 5 or 10%, whatever the number is by funding it in a slightly different way. So I'm not going to talk about the residual uninsurable uninsured problem.

For purposes of debate, I will propose a relatively effective version of an employer mandate. Who knows. This may come out in Senator Mitchell's program. Each employer must offer minimum level of coverage or pay some sort of payroll tax. Is there a model for this? Does it work? Well, Hawaii's had this version for about the last 18 or 19 years. They have had mandatory employer-provided insurance for all employees for many years. When ERISA was passed they got an exemption for that. Dependents of employees don't have to be covered. The poor are not covered. However, it was fairly effective. The uninsured population in Hawaii by most estimates is around 5%, not 13 or 15 or 17% levels. For a variety of reasons Hawaii is a reasonably prosperous state. It's getting a lot of Japanese investment money. It's got a lot of tourism and there's a number of people who would say that Hawaii is a special case. Maybe so. We heard some talk again at one of the other sessions that states can function as laboratories. I would propose to you that here's one, Hawaii, that's a laboratory that's working, so let's just look at that.

How big would the payroll tax have to be? I honestly don't know. I mean that's a fair question to come at me. One of John's proposals here is that we have stripped down coverage which has been offered in a number of states. Our proposal that we got through in Hawaii will offer coverage to the remaining 5% through a voluntary program. It would have relatively low levels of cost. If you're at the low end of the income scale the cost was only $7.50 a month and while politicians may make some comments about this, the current California Governor made some comment about

welfare recipients buying six-packs instead of necessities of life. I think that a reasonable level of coverage for a very affordable price would be acceptable to a lot of people. There would have to be some changes though.

In Hawaii in our experiment again with this program that is alive and working, they historically have had two major carriers, the Blues and Kaiser. Those two are delivering the care and so what you've got is a public financing partner and a private delivery partner where, in fact, there is in this case a little bit of risk. Our California model is somewhat similar for I think six of the seven carriers there's no risk involved. It's just an ASO or pass through kind of arrangement. This suggests that to fix the problem there may not be business as usual. Why do we have 1,600 or so health carriers in the U.S. today? Is that a reasonable number?

MR. FRITZ: I think a few less than that.

MR. BERTKO: A few less, okay. Let's say it's 1,000. It's again Kareem Abdul and Danny DeVito here. It's more than five. Who else is going to pay for this thing? I mean John's question here is how is this thing going to work? The poor or the uninsured are going to have to pay for it again. Sliding scales are the vehicle that's most popular. There's a couple of other states that have modest uninsured programs that are using sliding premium scales. Second, benefits will have to be restricted and I think the degree of restriction to what we like to term appropriate care, however that evolves, it's going to be significantly different than even the stripped down mandated packages. Again, in Hawaii there's a very, very limited inpatient package. I think it's only about five days of inpatient care which is the average hospital stay. What happens if you say longer? Well, the hospital gets paid for the first five days and then it's got its burden of charity care to pick up, but on the whole the state program will pay for most inpatient stays.

Second, you provide a reasonable level of professional preventive care. You want to keep people out of the hospital. You want to keep them out of the emergency department. You pay for that kind of thing. On the far end, experimental treatments are excluded. And there are a lot of gray areas there.

Providers need to offer discounts again. I mean this is part of their job. If you're going to pay them reasonable reimbursement for commercial work and you can pay costs at least on the government side, I think they've got to take that. They have to know it. Otherwise, they know they're going to be working for the government sometime in the future.

I think flat out for the poor end of this, the people right around 100% of poverty level, the state's going to have to cough up some money. In Hawaii, the State coughed up about 10 million bucks out of general funds. In California for the insurable program which, again, is a little bit different, that number was about $30 million. Lastly, the federal government isn't going to have any money for the uninsured. I'm just very discouraged on that part. The budget deficit really precludes those kinds of things.

Insurers, and here again we'll come back to that, probably are going to have to reduce what I'll call nonbenefits and administration, retention, marketing,

commissions. I'll be bold enough at least in the debate forum to say that there is room for the commissions paid to general agents and brokers today for these kinds of products. If you don't have, well, we agree more than five insurance companies or 1,000, you need to have that same kind of delivery mechanism, particularly for this case. Do we go from a voluntary system to some sort of what I'll call a utility model that has much less of an administration perspective? From this cost perspective, you may not be able to have all those carriers and you may need to choose from four or five or ten. I'm not going to say that government comes in and runs it, but I think the public, private partnership says government is the major buyer and they get to decide. If they're going to cough up the money it's their football. They get to call out what at least some of the rules are. The flipside of that is that in these states that I've worked in, the people in the government side aren't saying the same thing that the Kennedy and Waxman are saying. They know they've got to cooperate with you. In California there was a very big effort to say let's not attach the stigma of Medicaid to the people in the uninsurable programs. Somebody who enrolls in it is accepted, gets a card from one of the Blues or one of the other major insurers or from one of the HMOs. These people walk into a hospital and they've got a card there that looks like anybody elses. They don't have to put themselves out and say I don't have any money, sorry, do what you can for me. I think those kind of programs with a fair amount of government involvement, more than just a foot in the door, are a way to at least address the problem and have everybody cough up some of the money to pay for it.

MR. FRITZ: A clarification. Did I hear you say that you're really for eliminating a free marketplace, that you want to have an anti-competitive model where you don't have competing forces out there when you keep pointing to the Hawaii model?

MR. BERTKO: Not reduced competition. The state is a major purchasing agent. It says who are the best people out there? Keep a number of players. Hawaii's unique. It only has two or three major players. Let's go to California. We've got seven people as real competitors here. The individuals enrolling get to make the choice. There's competition but at a different level. I think you admitted in your part of it that there just isn't a way for the health insurance market without government help right now to contain its own competitive forces.

MR. FRITZ: You also pointed out the administrative savings and this is one of the areas that tends to be a real political football pointing to the administrative inefficiency of the present system and all the savings that will be inherent in trying to solve the problem using some kind of a government approach. And when the reality of the situation really is that if you look at total administrative costs for the industry and express that as a percent of the total health care dollar for the country, that's been hovering right around 4% and so we're tinkering with trying to come up with a solution that's going to deal with 4% and not deal with the heart of the problem which is the other 96%. So I think what we need is a private solution where the marketplace is free to compete when those competitive forces cause the kind of a problem that we now have in small group reform. Yes, I agree, we do need some government help to help us get out of the box, but I think our economic system in this country has proven to be far superior to any other economic system in the world and, in fact, even the Russians are admitting that our system is better now. They're

moving toward our system and for us to then try to back off of that system on the health care side just seems a little bit ironic that we throw in the towel there.

MR. TRAPNELL: Okay. All right, go ahead.

MR. BERTKO: I think it was Mark Twain who said there are lies, there are damn lies, and then there's statistics. The problem we're addressing here is the uninsured and I'll make the leap of faith that most of those uninsured are working for small groups. To say that there's a 4% administrative cost on the margin for small groups fits into one of those three categories of Mark Twain and I think it's the first or second. The general administrative costs which pick up all the nonbenefit costs are in the neighborhood of at least the high 20s and probably in the low 30s a lot of the time. Those are the costs I'm advocating get removed. You know the average in the commercial marketplace is probably closer to 10 or 13% when you combine it for everything. We also haven't addressed some of the other parts of the inefficiencies on the provider's side for everything they've got to do. That's really a separate issue, but I think the administrative costs are quite a bit greater than 4% for the marginal piece that we're looking at.

MR. TRAPNELL: I was going to intervene in kind of a point of order and say that based on the studies that I've seen that if you divide private health insurance administrative expenses in private health insurance benefits, including all the self-insureds, self-administered HMOs and everything else, you get around 10%, not 4%. I've never seen a number that low. I don't know how you came up with it.

MR. BERTKO: Oh, I didn't say – I said 4% of the total health care dollar which counts the public dollar as well.

MR. FRITZ: I agree.

MR. TRAPNELL: Oh, you averaged in the 2 or 3% for Medicare.

MR. BERTKO: The other thing about statistics is that I think the government solutions if you stretch it beyond what even John is saying and impose a national solution on it and all of the administrative savings that will entail and talk about, gee, it only costs "X" percent for Medicare is very misleading because not all costs are in that. Not all the administrative or indirect costs involved with administering the Medicare program are in that number. And so you can't point to that either and so it's –

MR. FRITZ: I won't argue that one with you, John. I'm just saying that the piece we're looking at for savings is that piece on the margin which is pretty big and it's a multiple of 4, 5% rather than even being close to the 10%.

MR. TRAPNELL: Actually the Medicare number is a good number, which includes allowances for indirect costs. But let me move on to the last formal question that I was going to pose. Since both of my debaters want to spend a lot of money on the uninsured, I want to ask them where it should come from and since John Bertko, as usual, wants to spend more, I'll ask him where it should be found.

MR. BERTKO: Well, Gordon, I think that in answering John's question I probably coughed up most of the change I have lying around here, so I'll run through it quickly and probably duck while John throws a few bricks in my direction. First off, small employers are going to have to cough up their share. To some extent they're freeloaders right now. They're dumping people into the market. Major corporations are paying for it. Medicare perhaps is a break even proposition. Medicaid in most states is not an even break even, so the federal government and the state governments aren't even paying their fair share.

MR. TRAPNELL: I will note that you have a curious notion of break even if you apply it to Medicaid.

MR. BERTKO: No, no, that's --

MR. TRAPNELL: It's a question of who pays for it, the federal government or the state government of the locality.

MR. BERTKO: Okay, I was thinking of in terms of actually providing the costs. Medicare's reimbursements to providers are generally at or around or maybe slightly above break even. Medicaid pays providers in most states below break even rates.

So small employers are going to have to pay for it one way or another, either by buying the coverage or through some payroll tax. I have had the opportunity, in one case, to listen to an association of fast food franchises and recognize their very legitimate point that they can't provide comprehensive care in the same way from a standard policy. They just can't afford it. Their profit margins aren't there. At the same time, this is a group in which all were members of the Chamber of Commerce. A couple of them were willing to concede. I guess I'm almost ready to pay that payroll tax if it keeps everybody else off my back. I think there is an emerging consensus there that some version of coughing up private funds is workable.

MR. TRAPNELL: Can I interrupt you to ask for an explanation of payroll tax in that context and I think you had in mind the pay or play concept.

MR. BERTKO: Yes, the pay or play concept means that an employer can provide a certain minimum health insurance benefit level or pay an agreed upon percentage of wages. Let's say it's 4 or 5% just for discussion purposes, paid into some financing organization. In my system it would be run probably by a state that would help do the purchasing. And then the small employers would offer (say) a variety of five cards that the employees get to choose from. It's obvious here, I think to me at least, that the poor, the uninsurable, are going to have to pay for it indirectly by having reduced benefits. There just isn't room to pay for everything. Governor Lamm made that point the other day. There isn't enough money out there, so they're paying for it. The providers here are going to have to have massive discounts and the discounts that I have in mind for this proposed system are at cost however that's defined and that's a tricky discussion. But cost is substantially less than charges and generally less than even what HMOs are contracting for. And then, lastly, the states are going to have to kick in some money. I don't know where it's going to come from. Certainly, not in this environment. I give up on that one. Lastly, insurers and the whole insurance industry are going to have to kick in

something. I don't mean to be bashing agents or marketing systems, but given the importance of the priority perhaps that's the one that's delivering care or part of the system that is most amenable to some changes. After all, I wouldn't want to put actuaries out of business.

MR. TRAPNELL: Are you going to defend the agency system costs, John?

MR. FRITZ: In terms of your pay or play for those entities that pay the tax as opposed to buying it from a private carrier, where would they get that coverage?

MR. BERTKO: As an example, the coverage comes from an organization, a private carrier. They've passed say the Return Premium (RP) process. The state has said, yeah, you've got the right delivery organization. You've got the right average charges. You're delivering it under managed care, again, however you define it either as a PPO or as an HMO and you're qualified. We're willing to entertain it. Maybe put it on a level playing field where benefit packages are standardized and you're out there. In some cases it may be one where, for example, if you're competing against Kaiser, your benefit package is a little bit different or your delivery system is a little bit more expensive or less expensive and there's an additional premium to be paid for choosing your card or for choosing Kaiser's card. But the payroll tax would allow some what we'll call now free coverage to employees and their dependents.

MR. FRITZ: Before I had a conversation out in the hall, before this session, I was going to talk about employer mandating as being un-American and the issue of some employers not being able to afford the coverage and what that's going to do to their business and, therefore, provide unemployed people because they can't stay in business. Until someone pointed out to me that the private solution that I'm proposing actually works better with some of that mandating going on and the reason for that is if there is no employer mandate there will be leakage from the system. Things like there are multiple employer trusts out there that don't fall under the umbrella of anything available through what the industry is doing. They're able to do it on a basis that selects the best risks and so adversely selects against the industry. You start having a pool of very good risks in that side and get all of the bad risks into the insurance side. Then over time it just becomes an unworkable kind of thing and all you're covering basically is maybe the uninsurables or a high percentage of the covered population will be the uninsurables. So I think because of that I have to admit that a certain amount of mandating is probably a good thing even for the private sector model that's being proposed. As long as the provider of the care or the intermediary that is providing that coverage is the private sector as opposed to some government body, since when has the government done anything right?

MR. BERTKO: That's right. I think an intelligent response by the insurance industry would be that the government is making me do this and they then recognize because they are twisting my arm behind me I've got to do it this way and you cut down that leakage. You cut down on adverse selection. Our new elected Insurance Commissioner in California, even though he doesn't have quite enough to keep him busy with those bankruptcies, announced health insurance reform yesterday and it made the pages of *USA Today*, so it's got to be popular stuff. I think that the insurance industry just has to come to a recognition that this government partnership is in the cards and that you need to know how to play it right to keep alive.

MR. TRAPNELL: Let me ask if there's a member of the press in the audience that would like to ask questions to the debaters? Good heavens, none at all.

MR. ARTHUR O. DUMMER: I'd like to ask a question but I'm not a member of the press. It strikes me after hearing some of the comments in the session earlier on under 25 group regulatory activities and in this session that I haven't heard anyone say anything about the tax on sickness. I've heard sin taxes. And that some of the problems we're talking about in terms of leakage from the insurance industry into multiple employer welfare associations (MEWAs), etc., and some of the problems associated with reallocating the costs of covering uninsurables from smaller groups to larger groups would go away if we were taxing at the provider level instead of at the financier level. Since I haven't heard anybody say anything about that, I know that it may on the surface seem like a politically difficult thing. I'm wondering if everyone is giving up on it and no one is seriously talking about it. The second thing that strikes me is that if you do, in fact, as you recommend take care of the uninsurables by giving them access and you still have the problem, as you've pointed out, of people who choose to have a different set of priorities. Is there any talk about providing income tax deductibility for individuals who buy individual policies where their employer has chosen not to provide group insurance? I'd like comments from the panel on those two issues.

MR. BERTKO: I'll take the first one, taxes on providers. I would agree with part of that question or comment which is it's politically very difficult and I think that in my framework here I'm doing it implicitly in saying that the taxes come through the discounts, that is the amounts being reimbursed are less. I've made an assumption that it would be important to pay only costs rather than any version of charges or discounted charges and that all the providers involved are going to have to cough up the money at least through that mechanism. This retains, if you can believe it from my perspective or not, some free market abilities. That is, not all providers would have to pay the tax. They'd have the ability to contract or not contract. Now I think that statement is problematic for a lot of hospitals and for many physician providers. They would have to contract because there would be so many competitors out there willing to pick up the pieces that were left. The other income tax one, John, you're the free market guy. I'll let you try that one.

MR. FRITZ: I think that's a valid point. I think to offer an incentive to those individuals that are not able to get coverage through their employment because the employer chooses not to. Of course, that problem goes away if you mandate employers. So if you don't mandate employers to provide coverage then I guess it is an issue and I would agree that would be a possibility that is worth pursuing.

MR. DUMMER: Mr. Bertko, I don't think your response was entirely responsive.

MR. BERTKO: You noticed that.

MR. DUMMER: While it does raise some revenue from the providers, it doesn't achieve the objective of redistributing the burden more equitably among larger groups and smaller groups, among ERISA trusts and insured trusts which I think would be one of the benefits of a tax on the health care itself or a sickness tax as I loosely refer to it. Do you have any comment on that?

MR. BERTKO: I think that provider taxes as you're advocating would be very, very difficult. At least in our state, provider lobbies are quite powerful politically and while this may be appealing and perhaps we've come through the initiative process in California, God knows what we get as initiatives. I don't see it coming out of the legislature itself.

MR. DUMMER: Well, while we all know providers don't pay taxes and insurance companies don't pay taxes, the people who use them do. I do recognize some substantial validity in what you say, although I think perhaps the political climate has heated up enough now that this sort of thing maybe ought to be put on the agenda.

MR. FRITZ: I want to add to that that there is one state that does charge a hospital tax and uses it for spreading the cost of uncompensated care. And you can view a hospital tax as basically an insurance tax that gets around ERISA and taxes the uninsured despite the barriers that have been created by the federal government to state taxation in self-insured programs. There's another category –

FROM THE FLOOR: Which state is that?

MR. FRITZ: Florida. It's a small tax, but that was the thinking behind it; they couldn't tax the self-insured arrangements, but they could tax the hospital and since every insurance arrangement has to provide hospital care, it's a tax that inevitably hits the entire population unevenly because it hits those who need hospital care more than those who don't. Another interesting tax scheme that may become very popular unless Congress shut the door on it is started with donate programs in which the hospitals wanting higher payments for Medicaid were willing – the particular hospitals with large populations of Medicaid patients were willing to donate money to the state which the state then used to increase Medicaid payment, so they got the money back. But they also got the federal matching which in some states goes up to 80% of the program. Now this is an ingenious shenanigan, but as in any cartel arrangement there's disputes over how much you want to donate. So a more thorough and consistent method is to actually tax the hospitals and use the funds to increase the Medicaid payment and the state's the winner at, of course, the expense of the federal government. And some of these programs have now been expanded to increase the payments to physicians and couple it with a self-supporting from the state's point of view, tax on physician revenues. And, of course, that's a little more controversial because it hits all physicians and not just those that have concentrations of Medicaid patients, so only a few states so far have adopted that approach. But, of course, none of these things are real solutions. You know they are using them, but you might say they're breaking the ice of using a tax mechanism as a funding mechanism.

FROM THE FLOOR: I have one question for each of the panelists. For Mr. Fritz, when you talk about 10 employers or fewer than 10, 33% of them offering, does that include the self-employed and, if so, if we throw them out how many employers of three to nine are really offering anything? And for Mr. Bertko, while you only pay the HCFA people 2% what's your broad figure for Medicare?

MR. FRITZ: Medicare estimates the fraud rates to be very low, but Medicaid's fraud rates are estimated to be relatively high.

MR. BERTKO: Okay, I was trying to figure that out here. I don't have my calculator. The percentage of self-employed that are uninsured is 11%, so if that's 11% of the uninsured it's 30 million, so that's roughly three million and if – I didn't think I was going to have to do actuarial things here.

MR. FRITZ: Close enough. It just has to be close enough for government work.

MR. BERTKO: And 33% of the one to nine is the number – I don't have a number here that says how many employees are in the one to nine category, so I have a missing piece. I can't give you the answer.

FROM THE FLOOR: Mr. Bertko, I can see the relative merits of many aspects of what you suggest in terms of an approach, particularly, the more limited competitive model, where each state may select those carriers, HMOs, and so forth that managed care programs that demonstrate the greatest degree of cost effectiveness, not just in terms of managing the medical component, but also the administrative component. I'm just wondering how you suggest from the various range of constituencies that we all talked about this session and, also, in the small group session, how politically that type of program might be pulled off?

MR. BERTKO: Okay, let's approach it again in the state that I know the political process, the best if that's not an oxymoron. In California the groups are out there and they are moving towards a common consensus at least in some cases. Because we have an initiative process I've kind of likened that to a couple of the groups, health access being one, holding a loaded 45 to the head of the legislature and say fix it or else. Each of the groups has had different versions of it. I think last year we had four or five bills going through the legislature. I think because each group is going to give in some, there is a chance that the emerging bill, with the support of provider groups and the insurance companies may actually evolve into something that's workable like this. People in the administration in our state would support some kind of an approach like that. As a Republican administration they strongly support keeping the private people as active as possible. So you probably have three of the four or five groups that are willing to make those compromises. In fact, in discussions with a couple of the health access people, I believe they'd be willing to settle for something which covered many but not all of their objectives, because they got burned and the initiative lobbyists got burned in the last election, where only one of the 10 or 12 key initiatives passed. So it's conceivable that it goes into that political sausage maker and evolves with high industry support to something which looks like this partnership. So is that a fair answer on the question?

MR. TRAPNELL: We can take one more question.

MR. HOBSON D. CARROLL: In this I think we have the greatest form of government and all that sort of thing and especially in comparison with the crumbling in the east, but I wonder if the recent sessions haven't helped point to the fact that we're not a perfect system and in some things maybe we're not actually very good, including taking care of chronic indemnic societal problems. We're just not able from the top to say this is the way it's going to be. It seems to me that very few people would argue with the statement that says we spend every bit as much as we need to now to incorporate appropriate care for the uninsured. If you take the fact that providers

earn too much money, that hospitals are overcapitalized, that we use too much technology, that we overutilize tests whether it's for malpractice fears or whatever, that we have study after study saying that this many or these surgeries are totally unnecessary, some of them are actually dangerous, these drugs we don't need, etc., we could probably squeeze 25-33% out of what we currently spend on health care which I submit would be more than enough to cover all the people who are currently uninsured. I also realize that's an idealistic position.

MR. TRAPNELL: Of course, there are those who would cite all the same facts and say that they were proof that we had the best health system in the world. And on that note I think I'll close this forum.