RECORD OF SOCIETY OF ACTUARIES
1992 VOL. 18 NO. 4A

PROPOSALS FOR HEALTH-CARE REFORM

Leader: GREGORY N. HERRLE
Speakers: LIZ CONWAY*
GREG SCANDLEN†

Two proposals for health-care reform will be presented, one from the Blue Cross/Blue Shield Association and one from the Council for Affordable Health Care. These dramatically different proposals will be compared and open for critique.

MR. GREGORY N. HERRLE: Many Health Section activities are going on, and I'd like to mention three or four that we'll be focusing on in the upcoming year.

The first is in the area of research. I'm not sure that we've devoted enough of our efforts, resources and time to some of the research that we need to conduct to meet the needs of the Section members. One research project that we're currently in the middle of is a large-claim incident study on medical claims. I'm happy to report that about 30 companies have expressed interest in supplying claims data for this particular study. In the past, some of the problems with research studies have been coming up with the idea, finding people to run with it in a volunteer organization, finding companies willing to provide data so that the research could be done, and then completing it within a reasonable period of time, especially in the medical area, to make it current enough to use.

We're looking at this particular study as one that would maybe set a prototype or an example of future successful endeavors. Like I said, 30 companies have expressed interest in supplying data for the large-claim study. Nine organizations have responded with formal proposals in response to a request for a proposal that was sent out to conduct some of the research and analyze some of the data. So, again, there is a lot of interest. We're moving along. If your company had planned on supplying data, we hope to be getting the final specs out to you shortly. I'd like to thank John Bertko, who's on the Health Section Council, who spent a lot of time running with this particular research project. He put in a lot of time and effort to move it along. I'd also like to thank those companies that will be contributing data.

The second area that we plan to focus on this year is to continue efforts to work more closely with the Academy's Health Practice Council. There are many areas of common interest with regard to public policy, and I think there's a need for both the Health Section and the Academy Practice Council to work together on public-interface-type issues. There are some common areas of interest that would benefit both memberships, and we'll be looking at areas to pursue there.

Third, we'd like to continue our efforts on continuing education in the areas of offering meetings, seminars, symposiums, communications, whatever. I'd like to

* Ms. Conway, not a member of the Society, is a Senior Policy Analyst at Blue Cross/Blue Shield Association in Washington, District of Columbia.

† Mr. Scandlen, not a member of the Society, is Executive Director of the Council for Affordable Health Insurance in Alexandria, Virginia.

thank Bill Thompson, who's the Health Section representative on the SOA Program Committee. Bill spent a lot of time and effort planning this particular meeting and a number of meetings over the last year or two, and he is planning for the upcoming year. A lot of time and effort goes into that and Bill has worked hard. He's added a lot of new, creative ideas to try to make these meetings more beneficial and enjoyable for all of us. Some of the continuing education activities that will be going on in 1993 include the spring meeting in San Diego. It will be a health specialty meeting. Also, some seminars are in the works on health-care reform and also on *SFAS 106*. You'll be hearing more about them, and there should be some other ones coming up throughout the year.

The fourth area is an area that we'll need to focus on and respond to: changes within the SOA. Some of you may have heard that there have been some reorganization changes, restructuring of the SOA. The Health Section Council will be looking for ways to facilitate those reorganizations. Sam Gutterman is the new Vice President of Health for the SOA and would like to tell us what he knows about the reorganization.

MR. SAM GUTTERMAN: The objective of the reorganization/restructure is to try to make the SOA more responsive to the needs of the practicing actuary. I hope that, as a result, the SOA will be able to listen better and respond more efficiently. It is not meant to substitute or get in the way of the Health Section Council, because I think it's functioning very well and I hope it will function even better. I do hope that the SOA will be more focused and be more responsive. Some actuaries think that the SOA is relatively slow to respond to the specific needs of the practicing actuary. The hope is that, in fact, this new structure will allow it to be more responsive and listen better.

I look forward to working with the Health Section and the health actuary. If you have any ideas about ways that the governance structure of the SOA could improve and could help you more, we want to listen.

MR. HERRLE: We look forward to working with you and, again, making it a more responsive organization. The mission of the Health Section is to encourage and facilitate the professional development of its members through meetings, symposiums, research, papers, and the like. As members of the Health Section Council, we really look to you for ideas and response in terms of what we're doing to make sure that we are meeting your needs. Feel free to contact me or any other member of the Health Section Council with your ideas or questions, or if you want to volunteer. I'd like to move onto the program, which will be on health-care reform. We're all aware of the attention and controversy surrounding our health-care system. It's in the papers every day. Everybody has an opinion on the way to best solve the health-care problem, or maybe even debate whether there is a problem. It's an election year and we've heard the candidates' rather broad and ever-changing or evolving, depending on who you're voting for, opinions and ideas on health-care reform and how the system should work.

As actuaries in the health insurance field, we have a deeper understanding and appreciation (more so than the general public) for the problems involved in solving some of the health-care issues. It's probably safe to say that we don't all agree on

what the best solution is or what the best alternative is for going forward. Our speakers will illustrate that, I think. Liz Conway will present the position of the Blue Cross/Blue Shield Association, and Greg Scandlen will present the position of the Council for Affordable Health Insurance. They're two different proposals within the broad insurance industry. I don't know if they're on the opposite ends of the spectrum, but they might be reasonably close to the opposite ends of the spectrum. But they're both proposals coming out within our industry, and I think many people on the outside of the industry are looking for perhaps a common industry response or solution to this issue.

So they're each going to outline their proposal: what it is, why it's the best proposal and what it accomplishes. I've also invited them to critique the other person's proposal and/or critique or comment on the proposals offered by the Bush, Clinton and Perot plans.

Greg is the founder and Executive Director of the Council for Affordable Health Insurance. The Council was created in March 1992 in response to a need to promote a vigorous and competitive market for quality health-care products and service. The Council strongly supports empowering medical patients to make informed choices for their own health-care needs through the development of medical savings accounts and equal tax treatment for individually paid health-care expenses. Mr. Scandlen is also the publisher of *The Health Benefits Letter*, a publication he began two years ago after leaving the Blue Cross/Blue Shield Association. He was with the Blues for 12 years, most recently as its Director of State Research.

Liz is a Senior Policy Analyst in the Washington, DC office of the Blue Cross/Blue Shield Association. She is responsible for employee benefits, managed care and medical technology. Liz has been with the association for three years. Prior to that, she was a Research Associate at George Washington University's Center for Social Policy Studies where she co-authored the book *Families in Flux – New Approaches to Meeting Work Force Challenges for Child, Elder & Health Care in the 1990s*.

MR. GREG SCANDLEN: I should tell you that Liz and I used to work in the same office. It's kind of funny how in this business you switch from employer to employer and from job to job. I see many familiar faces here and not all are still working where they were when I used to know them. It's interesting how frequently the deck gets shuffled, but I think we're all serious about what we're doing and very concerned about the direction of the future here. In fact, generally, I think it's important to keep in mind that the health-care system is something that affects each of us in a very intimate way. We are all going to get sick, and we will all eventually die, and it's the health-care system that holds our hand during that process. Before that happens, it's perhaps the most intimate sector of the economy in that it actually probes us and prods us and cares for us at our most vulnerable moments. I think it's very important to keep that in mind.

In fact, generally, throughout my career in this business, my primary concern has been to keep policy patient centered, and I think the only reason that there is a health-care system is for the good of the patient. It's not to give me a job. It's not to give you a job, and it's not even to employ physicians for that matter. It's to take care of

patients. I think whatever happens, they have to keep the patient foremost in mind, and that's exactly what the Council for Affordable Health Insurance is trying to do.

Let me just tell you a little bit about who we are. We're definitely the new kids on the block. We've been around for six months now. Currently, I believe our membership is up to 22 companies. We had 14 companies six months ago. It's mostly small- to medium-sized insurers. To this audience, the names are probably fairly familiar, but to many audiences, people have not heard of the members. In fact, I think all of our members get the majority of their premium income from their health lines. They are not multi-line companies. They may do some life also, but it's mostly health. They live or die on what happens in the health-care system, so obviously they're vitally concerned.

The Health Benefits Letter is a publication that I started when I left the Blues about two years ago. I continue to publish *The Health Benefits Letter*, but Jean Casey has taken over the day-to-day operations of it while I am at the Council for Affordable Health Insurance. Jean came to *The Health Benefits Letter* from her position as managing editor of *The Actuarial Update*, with which you're familiar, and it's a real privilege to be working with her. She's very well-grounded in this industry.

Generally, looking at the proposals for health-care reform that are out there, we see three broad categories. First there is pay or play, or employer mandate, and this is the approach that's being supported by Bill Clinton, by Senator Mitchell, by most of the more liberal Democrats in Congress. Second is single payer. Although the Canadian system is a second approach, this is supported by David Himmelstein of Physicians for National Health Insurance and some of the more radical members of Congress. Marty Russo was their chief sponsor of the primary bill in Congress that was pushing for this.

Finally, there are a number of incremental approaches. Certainly the Health Insurance Association of America (HIAA) proposal, I think, should be categorized as an incremental approach. The proposals that the President has been supporting are largely incremental. When we look at these three approaches, we believe that none of them, although they've been thoroughly discussed in the media and in public forums, have succeeded in capturing the imagination of the public. The surveys that are done by Bob London from Harvard and others generally show that one-third of the population supports one, one-third supports another, and another third supports the final. Generally, that's the kind of results that you would get if you simply tossed a coin.

We believe that all three of these are fundamentally flawed because they don't address the real problems in the health-care system. We are supporting something that I think is truly revolutionary in health care, although it would be considered not very revolutionary at all in any other sector of our society. We're supporting return-to-market principles in health care. In the future we believe there will be enthusiastic support once people hear a little bit more about it.

I can tell you personally that it took me about six months from the time that I first was introduced to the idea to come into a position of actually enthusiastically supporting it. It took me about six months to think through the implications, think of how it would personally affect me and the people I know, and think how it would

play out in the great marketplace of ideas. I'm absolutely convinced that this is the way our society should go; in large measure, because it's the one thing that has a chance of addressing the biggest problem that we're facing, which is cost.

Let me talk a little bit about medical savings accounts. The general concept is that employers could take approximately two-thirds of what they currently spend on health insurance premiums, invest that money into a medical IRA for their employees, and take the remaining one-third and purchase a catastrophic insurance policy for those employees. The big question about this is whether the numbers work. Let me tell you. Our board of directors, unlike a lot of other associations, are hands-on insurance people. They're senior executives, but they all have actuarial and marketing backgrounds, and they know this business well. You'd be familiar with many of them, I'm sure, from previous SOA meetings.

The most important question is, do the numbers work? We've looked at it, and we're continuing to look at it to make sure that we're not misleading anybody on the veracity of the numbers. I'm not an actuary myself, but the folks who are able to crunch these numbers tell me that they are credible. Obviously, there are enormous price differences from place to place in the country and enormous utilization differences, so it's not going to hold true for every place. The numbers that have been used most often are that the average employer may spend $4,500 per person currently on premiums. You would take $3,000 of that and invest it in a $3,000-deductible medical IRA. Unfortunately, once you get into it, certainly in Congress and the political arena generally, numbers like that get locked into place. People think they're sacrosanct. They're not intended to be sacrosanct; they're intended to be illustrative.

Just the other day, someone mentioned to me the cost difference between Austin and Houston. If I remember right, it was about a 50% difference. Health-care costs in Houston were 50% higher than Austin. There is no single number that works here and that's the whole idea. You cannot sit in Washington and survey the country and say you have the answer. The market will develop its own answers as it goes along. During the discussion period, let's not talk too much about $4,500, $3,000 and $1,500. Let's talk conceptually. You can talk about a specific circumstance. If you want to talk about Cincinnati, we can talk about Cincinnati. Let's not waste our time just getting locked into those particular numbers.

It is my contention that this approach will have enormous beneficial effects on the health-care system. I believe it will restore the patient/physician relationship for the first time in a long time. I think first-dollar coverage and the way that we've been going over the past 40 years has basically taken the patient out of the equation. The patient ends up being a passive slab of meat on the steel gurney – that's the image that I have – while the physician and the insurance executive are standing in their respective outfits and negotiating over what to do to this slab of meat. I think it's a sick health-care system, and I think it needs to be fixed.

I'd like to see the patient rise up from that stainless steel gurney and reassert his or her own authority and ability to make some decisions. That's the second point. It will empower patients to begin to take a more active role in their own health-care decisions and in their own health-care treatment. It will create a demand for

information. One of the criticisms that this proposal gets around the country is how the patient is going to know what's right. Patients are not informed that health care is complicated, or that they are unable to make decisions or even have opinions about the appropriate course of treatment for themselves.

Part of the reason that is the case is because there's no demand for information right now. We are suggesting that this proposal will create that demand. All of a sudden, patients will have a reason to want to know the most efficacious procedure that's available to them. It will certainly reduce administrative costs. It simply does not make sense to have insurance companies processing small claims anymore. What does it cost to process a $50 claim? I would suggest to you that the vast bulk of the problems in excessive administrative costs are coming from processing those small claims. We must get the insurance companies out of that business. Individual customers, individual consumers and patients would be paying directly from their own medical IRA for the cost of small claims.

Once something starts kicking in to $3,000, $2,500, then I would suggest it's appropriate for the insurer to come in and apply some managed-care techniques, process those claims, and audit them. But how many $100 claims get audited these days? They simply don't and the insurance companies are blind to the validity of the $100 claim. They don't apply those kinds of techniques to those small claims.

The proposal will also put the insurance companies back in the business of insurance. Most audiences need to be reminded -- I assume that you do not -- that insurance is intended to be protection against unforeseen events. That's always been a problem in health insurance. That's why for decades the Blues insisted it was not an insurance company. It was a prepaid medical hospital service organization. First-dollar coverage is simply not insurance. It is not unforeseen. It is within the control of the insured. We're suggesting that having the insurance company provide a catastrophic policy that goes on top of the medical savings accounts makes the insurance company perform, once again, as an insurance company.

I spent a good deal of my career dealing with mandated benefits -- acupuncturists and the whole long list. In fact, an issue of *The Health Benefits Letter* lists the 1,081 mandated benefits that currently exist around the country. It's been interesting being in business for myself. All of a sudden I think in very economic terms, and I tend not to give things away.

The medical IRA approach will end all those hassles over mandated benefits. If I have a savings account with $3,000 in it, and I have lower back pain and I decide to go to the chiropractor, and I'm happy with that treatment and I'm spending my own money, who cares? It's not your business, I would suggest, as long as I am satisfied. Conversely, if I would go to an acupuncturist and I'm equally happy, that's my business. That's not your business. If I'm not happy, then I'm going to take it up with that provider. I'm not going to ask you to intervene for me with that provider. I would suggest that this is part of the way that small claims ought to work.

Finally, I think it will greatly help employers because it will make their health-care contributions more predictable from year to year. There's a concept, I'm sure you're familiar with in the pension arena, of the difference between a defined benefit and a

defined contribution. I don't think very many employers provide defined-benefit plans anymore, where you're guaranteed a certain level of income after you retire. Basically, they take a defined-contribution approach. They say, "I'm putting $4,000 a year into this. I hope it's good enough for you. It will take you as far as $4,000 will take you, but I have a budget to deal with. I have shareholders to deal with, and I can't afford to invest any more than $4,000."

Health care has been entirely the opposite. No matter what it costs next year, if your employees need 121 days hospitalization each, you're going to pay for it. You cannot budget for that. We are suggesting that this approach will allow employers for the first time in decades to say, "I know what I'm going to spend on health care. In 1993, I'll spend $4,500; 1994, $4,700; 1995, $4,900. It's predictable, and I will invest what we don't spend on the catastrophic premiums in your medical savings accounts. You have a responsibility to fill in any gaps that are there."

Now, I don't think this concept by itself is enough. In fact, it has to be combined with many things. Tax equity for individually paid premiums and health-care expenses is absolutely critical. We're going to be pushing for that on both the state and federal level. We do believe there should be subsidies for low-income people, people who cannot afford all this stuff out of their own pocket, probably in the form of tax credits. We do believe there should be risk pools for the chronically ill around the country. Twenty-seven states have them now. I think they're working fairly well. They're criticized often for losing money. They're supposed to lose money. They're created to lose money. That's all right. That is not a criticism. We're supporting trying to get risk pools adopted in every state, with possibly some kind of national mechanism for reciprocity and going across state boundaries, that sort of thing.

We've all talked about malpractice reform. Everybody knows about that. Regarding patient education, generally, we push outcomes research, the whole laundry list of patient education activities that have to happen. Finally, there is small-group reform. My group has been probably most controversial for our position on small-group reform. Let me make it clear to you what we support and what we don't support. We do support rating restrictions. We support continuation of coverage. We support once you're covered, you will not have to undergo a new underwriting cycle. We support portability. We support guaranteed renewability. We support continuation of coverage between jobs.

We do not support two things. We do not support community rating. We do not support guaranteed issue. We believe both of those are in violation of basic insurance principles which, to any other audience, generates a yawn. I hope that this audience will appreciate something about basic insurance principles. It is not inappropriate that insurance be priced according to risk. It's not inappropriate that burning houses not be provided with fire insurance. The example that I always give is myself and my 22-year old son, Josh, who's just out of the Army. He's a physical specimen. He goes to the "Y" every day. He does some part-time work at UPS for $8 an hour.

On the other hand, I'm 45 years old. I've been smoking cigarettes since I was 15, and I apologize for that, but it's true. I don't do a lot of exercise. I don't have time to do it. I'm really stressed out in this business, but I happen to be making more money than I ever have in my life. Is it appropriate for Josh to be expected to pay

the same premium as I am? Is it appropriate for me to be guaranteed a policy, no matter what happens to me, on the same level that Josh is? Isn't it appropriate that to get Josh inspired enough to purchase an insurance policy we have to rate it according to his risk, and we have to say, if you wait until you're sick you're not going to get in?

I believe that the American people are intelligent enough to evaluate that situation and act appropriately. Actually, let me put it this way. I believe they will not purchase it, they will not throw their money away if they know that after they take ill they can get in.

Let me just talk a minute on the politics of medical savings accounts. There were eight bills in the 102nd Congress, which has now adjourned, all taking different approaches to medical savings accounts. Phenomenal. We call our proposal the Stealth Proposal. There are a total of 178 cosponsors -- liberals and conservatives, Democrats and Republicans -- on the various medical savings account bills in the 102nd Congress. We believe this is a winning proposal, and we believe we can get this enacted into law in 1993, and that's what we're pushing for. We're going to take those 178 cosponsors, or those who are returning, and try to combine them with the newly incoming freshmen congressional representatives, of which there will be something in the neighborhood of 150, and that's a majority of Congress. We believe that we can get this passed, if only as an option for anything else that's passed.

Can I say just a word about managed competition? Managed competition is all the rage of the Jackson Hole group. You've heard a lot about it. Let me just make a few quick points. I'm not sure if this is what Liz is going to be supporting, but we're not. Let me say, first of all, that the concept of managed competition is an oxymoron. Competition is not to be managed by the government. The proposals that I have seen, particularly Jackson Hole, would set up a state-sanctioned oligopoly of a very limited number of players. We think that's not the way to go in the United States of America.

We tried an oligopoly with the automakers. There used to be three, and they all made junk, and then the Japanese came in and started making quality. That's what competition is supposed to be. As long as you have an oligopoly, it's not going to happen. I think it will continue to burden hard-pressed employers by requiring them to pay more than they can afford for coverage, and it still keeps people removed from the economic consequences of their own decisions. In no other part of this country's economy are people removed from the economic consequences of their decision, and it makes no sense whatsoever for that to be the case in health care.

Finally, it will not control costs, and we all know it will not control costs. To remedy that, people are now suggesting global budgets, price setting and a whole array of additional regulations, because they know it won't control costs. We're going to add a whole new crop of regulations on top of it and it just may be regulations that are put out by these three, four or five insurance companies. Insurance company bureaucracy is not much better than government bureaucracy. Having the insurance company tell the patient where to go, when to go, why to go, and so on down the line is not the answer. I think patients can make those decisions for themselves.

There are other problems with global budgeting. Who are the three, four or five people who are smart enough to sit around a table in Washington and say, "In 1993, this country is going to need x billions of dollars in health care, and that's it and we're not going to spend any more than that." Who are those people who can figure that out? I'm not smart enough to do that. I'd suggest there is no one that's smart enough to do it. What happens when the money runs out?

Overall, I think this kind of global budgeting, this kind of Washington-based telling the entire country what to do and when to do it, is a result of policy analysts sitting around in rooms in Washington, feeling that only they are smart enough to get a handle on it if they only had the power to do it. Personally, I think that's a really scary scenario. An alternative would be 250 million people, each of them empowered to make their own decisions, each making decisions every day of the week on everything that they do, including health care. I would suggest to you that 250 million people are powerful enough and smart enough to make decisions that result in the kind of health-care system the entire nation needs and wants.

MS. LIZ CONWAY: I'm going to give you a quick overview of the Blue Cross & Blue Shield Association Health-Care Reform Proposal. I'm not going to spend a lot of time on details. We can get to some of those in the discussion, if you'd like. To start out, though, I think I want to put my remarks in a little bit of context. When Greg sent out the invitation letter, he included a list of questions that he thought we might want to address, and the first on the list was, is there really a health-care crisis? This gets at whether we need to do anything at all. So I thought of that both in policy and in personal terms.

I think it's probably a little bit too strong to call what we have now a crisis. I would certainly say that the vast majority of Americans already have private health-care coverage. The vast majority of those people have health-care coverage provided at work or through the workplace of a spouse or a parent. I think most people would agree that we have the best medical technology, the best doctors, etc., that money can buy. I think, however, that we do have a significant health-care problem that may, in fact, be getting worse. We're spending what I think most people would agree is too much money -- something like $800 billion a year, and it's rising rapidly.

Access to health care, and certainly to health insurance coverage, is very uneven in this country. I was talking to my sister on the phone this week, and I think that it helped me put it in perspective. I have three sisters, and when I look at all of our circumstances, they illustrate the range of where things are. I have good insurance coverage at very little cost to me. Blue Cross/Blue Shield takes good care of us. I am enrolled in an HMO, and I get all my health care taken care of. HMOs focus heavily on preventive care – especially for children and pregnant woman -- and a lot of that preventive care is free or low-cost. I had a baby last year. I paid $5 for my baby to be born. I don't contribute to my health-care premiums. I have one sister who's in a similar situation, as her husband's employed with a pharmaceutical company.

A second sister is, along with her husband, self-employed. They have nongroup health insurance coverage. They pay $300 a month out of their pocket after taxes for it and they have a $1,000 deductible. It's good coverage, but she's paying much

more than I am out of a lot less income than I have. My youngest sister was temporarily uninsured. She had gone back to school and came down with a chronic illness. In the future, she's going to have a real hard time getting coverage at all. If she can get it, it's going to be very expensive. These widely divergent situations are common in the U.S. today – and they point to some serious problems with the health-care system.

Such disparities are what prompted the Blue Cross/Blue Shield Association to get involved in this health-care reform discussion. Last October, our National Board of Directors adopted a series of principles that would underlie our approach to health-care reform and we, on the staff, have spent the last year or so filling in the blanks of that with a broader proposal, which we unveiled this year. It's still a work in progress. Various pieces of it are still being fleshed out, but I can tell you about where we are right now with it.

We call our proposal "Community Partnerships for a Healthy America." Our proposal is built around three important values that are the basis of what we're talking about -- community, accountability and partnership. The community reflects our belief that solutions to the health-care crisis are going to have to be found at the local level. I think we agree with Greg that a big federal bureaucracy is not the answer to our health-care problems – that the local community is where providers and individuals know best what they want and what they need. We want to base our health-care reform on the community.

The second fundamental principle is accountability. Americans want figures of authority to accept responsibility for what they do. We believe that government officials ought to be accountable for maintaining standards in the system and that health-care providers need to accept accountability for the quality and cost of the care that they provide. We also believe that insurers need to be accountable for efficient administration of the health-care system and that employers need to be accountable for the welfare of their workers. Finally, we feel that Americans need to be accountable for the health consequences of their own lifestyles.

Third, the concept of partnership is key to our proposal. We feel that everybody is in this together, that we can't just throw our hands up and say that it's the government's fault, or the government is responsible for the whole thing. We can't just say, "Reform the system, but leave me out of it." Everybody is going to have to participate in making the health-care system better. That includes doctors, hospitals, individuals, regulators, and insurance companies. For many in the insurance industry, taking accountability is going to mark a major change in how we operate. I also believe, and the association believes, that we can't tell everyone else that they have to change and then continue to do what we've been doing all along.

The Blue Cross/Blue Shield Association plan begins with two new concepts in health-care finance and health-care delivery. We're calling them Accountable Health Plans and Community-Care Partnerships. I'll lay out briefly how they work. First is Accountable Health Plans. Our proposal would cause the health industry itself to undergo major reform to make private health insurance coverage more available and more affordable. We believe that insurance practices that put profitability above

affordability and availability just can't be tolerated in the system anymore. People are getting sick of it, and it's not improving our nation's health.

Under our plan, insurers would have to be licensed as accountable health plans and they would be held to federal standards that would be enforced at the state level. Any insurer that didn't abide by the Accountable Health Plan Rules wouldn't be allowed in the marketplace. There would be three sets of standards that you'd have to meet to be an Accountable Health Plan -- a set of standards for insurance reform, a set of standards for managed care, and a set of standards for administrative simplification.

As many of you know, we've been actively involved over the years in the small-group insurance reform debate, and we've supported guaranteed availability of health insurance in the small-group market, restrictions on rating practices and similar measures. Those measures are included in our reform proposal, but we feel that insurance reform has to go quite beyond that. There's a lot of other trouble in the health insurance market that goes beyond the small-group area.

Accountable Health Plans would have to assure several things. It would assure, first, that all Americans would be covered under a set of benefits that includes primary and preventive care. Second, all groups or individuals would have access to private coverage for health care. This is definitely a proposal based on the private sector. Coverage would continue even if an individual lost or changed his or her job, or if he or she joined another group policy. Preexisting condition waivers and exclusions would not be allowed. Paperwork for enrollees and health-care providers would be minimized through electronic billing and data improvement.

We feel that Accountable Health Plans are the key to making these things happen. In today's insurance market, too often the easiest way to increase profits is to avoid insuring people who might get sick. It's much more difficult to achieve the same result by selecting the best care givers, giving them good incentives and good information, and organizing them efficiently. We believe that risk management, rather than risk avoidance, needs to be the foundation of our private health insurance system, and that's what these reforms are designed to move us toward.

After the insurance marketplace is cleaned up, we need to control health-care costs. To do that, our proposal includes strong cost-management incentives that are designed to change the way that health care is provided and the way in which it is consumed. Under our plan, Accountable Health Plans would be required, over time, to move more and more of their enrollees into what we're calling community care partnerships. These are state-of-the-art managed care arrangements -- partnerships of hospitals, physicians and other providers that would compete for business based on cost, quality and patient satisfaction.

We believe that much higher levels of cooperation and communication among everybody involved in patient care are necessary if we're going to achieve better effectiveness and better efficiency. Employers would have tax incentives to enroll employees in community care partnerships that assure high quality, provide only essential care and monitor enrollees' health outcomes. The marketplace is already moving toward

managed care networks, but it would move much quicker if we put in stronger incentives.

In addition to reforming insurance practices and controlling costs, we also need to guarantee private insurance coverage for basic benefits for all Americans under age 65. We would reach this goal by striking a middle ground based on our current system of employment-based coverage. Under our plan, all working Americans would have access to private insurance through their employers, regardless of the size of the company. We would require employers to make insurance coverage available to their employees and, conversely, we would also require individuals to accept the coverage that's offered to them. We can't solve access and cost problems if, as Greg mentioned before, you can wait until you get sick and go out and buy insurance. That just doesn't work.

Our program recognizes that many small employers have marginal profits, and they can't afford to contribute the full cost of insurance coverage for their workers. So what we would do is ask small employers to pay part of the premium cost directly, or pay a small tax to cover partial premiums. In addition, the working poor, as well as people who are not employed, would get government subsidies for coverage.

Finally, we think that the federal government should regulate, but not operate, the nation's health-care system. Government needs to assure that everyone not covered under Medicare or Medicaid is covered by private health insurance, preferably through the workplace. We believe that an improved Medicaid program needs to remain in place as a safety net for people who fall through the cracks, as inevitably people will. What we've tried to do with our reform initiative is preserve the best pieces of our current health-care system, but make the system more responsive to individuals, to employers and to providers.

Our proposal does this by maintaining private coverage and maintaining consumer choice, but at the same time it phases down the cost and access problems that are currently threatening the continuation of that private health-care system. Small-group insurance reform is not enough – it's necessary, but it's not going to solve our problems. At the same time, we don't think that government needs to take over the health insurance business. That makes our proposal different from many that are floating around out there. Greg ran through the litany of the incremental approach, which is what President Bush seems to be dealing with, as well as the single-payer approach and the play-or-pay approach.

I would say that if you're going to put our proposal into a box, it's probably closest to the managed competition model, although we do not support expenditure targets, global budgets and those other price controls. We believe that what you need to do is restore competition to the private market and then let it work.

MR. DAVID J. BAHN: I think you said that you had a baby last year and that there was a $5 cost for your baby.

MS. CONWAY: Yes.

MR. BAHN: If I could just pick up on that and use that as an illustration, recognizing that it's not completely true. A Barbie doll would probably cost about $25. Could you get five babies for a Barbie doll? Seriously, step back and think in terms of the kinds of cost the individual patient is expected to bear within today's health-care market. I work for a Blue Cross company also. Benefits are great, but at the same time, in terms of my understanding of what medical-care costs are and the real expense that the patients are expected to bear in today's system, I think that the insurance industry, and perhaps the Blue Cross system, has done a disservice by permitting $5 babies when a Barbie doll is $25.

My second comment picks up on something on which you and Greg remarked. I think, Liz, you said you have a younger sister who was a student and who came down with a chronic illness. You asked what she should do about insurance right now to get that paid for. Greg, I believe you may have mentioned that you have a young son who is out of college, and you asked what he should do about insurance, and it's irrelevant as far as his own value scheme right now. Is that a reasonably accurate statement – that he doesn't really think that much about health insurance?

MR. SCANDLEN: Well, I make him think a lot about it.

MR. BAHN: I have two daughters roughly the same age, and I try to help them think about it also. Seriously, for that age segment, I think as a society we may have created a very strong sense of entitlement on their part, that they are entitled to burning-house insurance, without having to assume any sort of responsibility from their own cost standpoint. It's their responsibility to provide for insurance in the same way that they're expected, once they get to be 25, believe it or not, to bring home money to buy food. I don't think they all realize that yet.

MS. CONWAY: If I could address the first point that you made, I made a flip remark there, but actually I was trying to point to the different circumstances that people are in. There are people like myself, who have good jobs and good health-care coverage. My employer can buy this Cadillac coverage for me, and there are all kinds of tax benefits for my employer and for me. None of my employer's contributions to premium costs are taxable income to me. There are no payroll taxes paid on that. It's not taxable for income purposes.

Individuals who are out on their own, however, who are self-employed, pay through the nose right now, and I think that's the problem. I think you raise a good point, which is that for many of us, we don't have to recognize the cost of our care. But there are other people who are recognizing the cost of their own care and also, because of cost-shifting within the system, they're often recognizing the cost of other people's care as well. I think we need to address that through health-care reform. I don't think that you can solve the problems that are out there unless you look at that, unless you look at the disparity in access and in payment. Right now, many of us who could recognize a greater portion of our health-care costs pay nothing – or next to nothing. And those with the least ability to pay are facing the biggest bills. This is no way to run a health system.

MR. BAHN: I agree with you. I think we're probably coming back to the same thing. A working health-care reform may involve some pain and suffering on our part, those

of us with employers who pay most of the cost and leave us with just "a $5 baby." We are going to have to share in that and incur some pain ourselves to really understand and make a reform proposal work.

MS. CONWAY: I do have to defend myself. Since I do work in health care, one of the issues I usually work on is medical technology. I spent much of my time in the hospital telling doctors that they couldn't use various high-technology things on me. I kept saying, "That's costing too much, and it's not helping me. You can't do that."

MR. BAHN: Did it work? Did they listen to you? Or did they say, that's okay, now we're going to do what we want?

MS. CONWAY: No, I was adamant about it, and my husband was in my corner fighting for me too. I kept threatening to get up and leave.

MR. BAHN: In continuing this discussion, this may be another aspect of the problem. Those of us who work in health care know what the costs are. How do we get the average citizen to be able to challenge and question his or her doctor in an authoritative manner that says, "Dr. Smith, that test you are doing may have some merit, but it costs $2,000. Is there not a $25 test that we should be doing first that would give a very good indication of the cause, etc., and lead to a treatment?" How do we get that kind of education and empowerment into the hands of the average patient?

MS. CONWAY: There are some interesting things going on. I think you have to work on both the doctors and the patients. On the one hand, we as insurers may want to do only so much dealing with doctors who are going to use a $2,000 test instead of a $25 test that works just as well. There's much of that well within our own Blue Cross and Blue Shield system, in terms of elective networks of cost-efficient providers and that sort of thing. In terms of patient education, there are some very interesting things going on. John Wenburg, who I think is at Dartmouth, started out working with prostate surgery and working with patient education and the doctor. There are interactive videos that describe several courses of treatment and show patients that they have real choices, depending on what they want to do and how they want to deal with their health. There are some very interesting programs to educate people so that they know that the $8,000 operation is not the key to their continued existence, if there are some other alternatives.

MR. SCANDLEN: Clearly, first-dollar coverage isn't the same. If you applied that to any sector of the economy, you would get the same kind of thing that we're getting in health care. In fact, the reason Washington restaurants are so expensive is probably because everyone here is on an expense account, and they don't have to look at the prices. If you provide a payment system like that, you're going to get a result like we have. Your point about technology is very well taken, I think. Liz is trained in this field, and she's also a very moral person, and she cares about these things. I would suggest that most people in her situation would say, "Hey, whatever it costs, Doc, give me the best. It's all paid for. I have coverage." We have to change that.

I didn't spend much time on the tax equity issue, but that is also critically important. One of the problems that some folks, like Liz's sister, are facing right now is that they

pay for their own coverage. A waitress in a diner is not considered self-employed and has to pay out-of-pocket for her own coverage. We should at least make those premium payments deductible for those people. Studies show that in order to buy a $4,000 insurance policy, if you're paying for it yourself, you have to earn $8,200 in income. That is a very minimum of change we need to make right away.

MR. ARTHUR L. BALDWIN III: I'd like to go back to the issue of informed decisions. I think it's rather unrealistic to expect most patients to be able to negotiate properly with physicians, because they lack the knowledge, they lack the power and, to some extent, when you're in a situation dealing with a physician, the anxiety of having whatever your medical ailment is, prevents you from thinking about it rationally. A year and a half ago, I went to the fitness center one day and rowed at lunch time on the rowing machine. At five o'clock, I was in the emergency room and the next morning they were taking out my appendix. Cost containment was not one of the things I was thinking about at that time. Many people are not going to be able to make an informed decision.

MR. SCANDLEN: I don't disagree with that at all. Many circumstances are emergencies. You're in pain, you want service, and you want it fast, and you want it done well. I do carry in my mind, though, a more typical situation, where the physician and the patient meet, and the physician lays out the options and says, "Well, Aunt Millie, these are the various courses of treatment that are available to us. This is what the cost is going to be." Ultimately, it has to be Aunt Millie who makes that decision. It cannot be me as an insurance executive making that decision for her. She has to be invested in it. It's okay if she decides that she'd be more comfortable with the more expensive course. Again, that's her decision, particularly if it's her money.

MS. CONWAY: I would agree with that. I think that when you look at the kinds of health care that we get, you can break it down into three categories. The first includes things like an appendectomy, where it happens fast, and you don't have a lot of time to make decisions. There are other things where, as Greg said, you do. You have a choice. Do I get the operation for lower back surgery, or do I take pain killers? But then I think we also have to look at things like preventive care.

We feel it's very important, when you talk about taking financial responsibility for your own medical decisions, that you deal with some realities in the world as far as preventive care goes. There are certain things like prenatal care and well-baby care that many people aren't necessarily going to get if they need to pay a lot for it out of pocket. Our health-care proposal stresses preventive and primary care. It's something that saves costs in the long run if you get it done, not to mention that you need it for your health. I think you make different decisions at different points in your health care.

MR. JOHN A. HARTNEDY: A comment, I think, primarily to Liz. You made a comment in the early part of your presentation about the role of the individual, but then your whole solution, I thought, dropped the individual out of the picture. It was all managed care, and the individual really wasn't basic. Basic benefits would be determined ahead of time, I assume, apparently by the government. So the individual

is basically out of the picture. Cost control would be done through managed care, namely by the providers. Did I understand that correctly?

MS. CONWAY: No. There are a few places where the individual comes into play here. I would say first we would, on the access side, require employers to make insurance available to all their workers. Our proposal also includes a requirement that individuals have health insurance. So just because I'm young and healthy and my employer offers coverage and I have to pay 20% of the premium, I can't just say, "No, I don't want it. I'll wait until I get sick." Instead, young individuals would have to carry insurance now so that when they do get sick, it's there for them. That's part one.

Part two is the basic benefits that we were talking about. That's another piece of the proposal that's still under development, but what we're looking at is a set of basic benefits that would be defined for actuarial equivalence purposes. So the design of the benefit package could, in fact, vary considerably. Changes that we would make in tax incentives would affect both the individual and the employer. First of all, for me as an individual, I would have the right to get a health benefits package that's richer than the basic package. But if I did that, anything above and beyond the basic package would be taxable to me as income. I'd have to buy it like I buy anything else in the market, like a new dress. Second, on the managed-care side, employers would have to purchase coverage delivered through managed-care arrangements in order for that premium to be deductible for the employer.

MR. HARTNEDY: I see. I'm sorry, I wasn't clear. I listened to Greg's comments about the medical savings account, and the individuals decide who they go to, what they will spend it on, and what kind of basic care they want. That's what I meant by individual decision. If I understood you right, many of those kinds of decisions will be taken away from the individual. The individual will have to be covered -- I understand that -- but managed care, government, somebody else will decide what basic care he or she gets and basically the care given through managed care. So the individual's responsibility is out of it, which means the only thing that will hold cost down is the managed-care person saying, "No, I'm sorry, you can't have this care."

MS. CONWAY: I think it's a question of how you interpret it, and I don't interpret it that way. I think there's a fundamental difference here in terms of how Greg is presenting health insurance and how I'm presenting health insurance. What Greg is saying is pay out of pocket up to this catastrophic limit and then insurance will kick in, which is a lot like my car insurance. I would say that -- and this may be coming from our background of a hospital and medical service corporation rather than traditional insurance -- we believe that everybody ought to have access to a basic package of benefits. What they get above and beyond that, with cost sharing and that sort of thing, they then pay for, and they make their own financial decisions.

MR. HARTNEDY: I understand.

MR. SCANDLEN: Liz keeps saying everyone ought to have access to a basic package of benefits. In fact, with the proposal is a requirement that every single person must buy and pay for the package that Blue Cross or some government panel

decides it must buy and pay for. It's not access. It's an absolute irrevocable mandate on each and every person in the country.

MR. HARTNEDY: I have another comment related to the gentleman before me who made a comment about the emergency. I've heard, but honestly I can't verify, that emergency care is approximately 15% of the care that our insurance company pays for. I wish I could document that better and I hope somebody here might be able to. My point is that if the individuals are involved in the decision-making process, they will have met the doctors and they will have dealt with hospitals. I have five children and there has never been an emergency where I didn't know ahead of time who my doctor was and what hospital I was going to go to. The reason being, with five children, all boys who played football, I knew the emergency room people on a first-name basis and I knew the doctors, numerous doctors, extremely well. So when an emergency did come up, I knew who the doctor would be.

Now, part of my point here is that as deductibles have gone up and co-payments have gone up, I assume there's a connection here. I saw a recent article in *Forbes* that indicated that patients are getting much more involved in what these things cost. Nurse hot lines is a thing that comes to mind. It seems to me the easiest way to educate the customer is by making them responsible through medical-care savings accounts. I would think that we might get a *Consumer's Report* on doctors, hospitals, costs, and outcomes, because patients would demand it. It happens with cars. I know that's different, but I think there's enough similarity. If I'm paying out of my own pocket, if I buy a car, I'll get a *Consumer's Report,* and I look it up.

I would think there's a better chance of doing that, if I'm paying out of my own pocket. I'll do the same thing for doctors and for hospitals and find out what these things cost and how they're coming out. I would think the easiest way to begin to get our customers educated is by giving them the financial incentive. Again, I tend to question Liz on what she has proposed there, because a financial incentive is not with the individual, and we spent years trying to educate people. It's been very difficult. I think, to say that there has been marginal success is a gross overstatement. But I'd like to see more financial involvement of the individual. Both of you could comment on that. It's more of an observation.

I'd like to make one more observation. We speak very positively about preventive care and we should, and I think it will tremendously improve the quality of life. If we get people financially involved, I think we'll see an increase in preventive care. Immediately implementing preventive care across the board would immediately raise costs. I think in the interim it would lower costs. As actuaries, I think we need to be careful when saying just, period, that it will lower costs. I'm not sure, and there are no studies. In the long run, it may raise costs; the reason being, those who stop smoking now and who don't die of lung cancer when they're 50 are going to live until 80. Where does most of the expensive health care take place? It's in the later ages.

Now, again, I'll say that's an assumption on my part, and I could be wrong. If we do an excellent job on prevention, we'll save employers money. We may not save the health-care system money. We will certainly improve the quality of life. We need to strongly support prevention, but I would just suggest a little caution on saying that

overall it will reduce health-care costs. I'm not sure. So I'd appreciate comments from both of you on those last two things.

MR. SCANDLEN: Just a quick comment on prevention, John. As with everything else, I think you can't just take it at face value. One of the most frequently quoted studies that I'm aware of in prevention is the notion that every dollar of prenatal care saves $3 in health-care cost down the line. I have a friend, who was a policy analyst with the National Conference of State Legislators (NCSL) in Denver, and she took the time to look up that study. It turns out that was a study that identified women with high-risk pregnancies and they were given prenatal care. For high-risk pregnancies it worked, but it simply cannot be extrapolated to the entire country. There's an awful lot of statistics like that out there, and it's really worth looking at the sources and making sure that it really says what it's purported to say.

MS. CONWAY: Greg's right, a lot of the research isn't particularly good. I had a professor in school who was a demographer, and he had done a lot of work on heart disease and advances we've made in curtailing heart disease. He ended up saying that when we eradicate heart disease, everyone is going to die of cancer. I think it's key to bear in mind that preventive care is something that there's a lot of interest in. I think if you look at HMOs now, they tend to focus heavily on preventive care. I don't think they would if it didn't save them money. I'm not sure that there are many big, formal studies that prove it, but I think preventive care tends to improve people's health and it seems to be something that Americans want to invest in.

MR. THOMAS F. WILDSMITH: First of all, I'm tempted to come forward and request baptism. The position paper from the Council for Affordable Health Insurance strikes me as the proposal that I feel best about. None of the individual proposals, at first glance, seem all that exciting. But the more I think about them and taken as a whole, it seems to me that they would have a tremendous impact. Greg referred to the individual health IRAs as the Stealth Proposal. It seems to me that the price disclosures are the true Stealth Proposal in this package. That seems to me to be the greatest failing in the marketplace for health care. People don't have a clue what something costs until after they buy it.

In fact, I would like to see it go beyond that and, as the previous speaker at least ended at, go to outcomes disclosure. I believe that if every hospital in the community that I live in had to, on some basis, perhaps by diagnostic related groups (DRGs), disclose their outcomes and their costs once a year, there would be series of newspaper articles on health care and which hospital you should go to for which illness, that would come out like clockwork every year.

Now, it's true that it's very difficult to negotiate with a doctor on a face-to-face basis when you're sitting there, and he's ready to take radiographs. But I believe we all negotiate in the passive manner. That's easy to see when you think about how many times you or someone you know has gone to a different physician this time than they did the time before. The sad part is we do that now without any good reason. We do it based on his or her personality or the way he or she strikes us that day, a touchy/feely thing, instead of what the cost is, and is he or she recommending the things that will be good for me.

I have one basic problem with a number of the proposals, and it may be that I'm just not looking at them right. I'd like to address this to Liz and get her read on it. The biggest problem I have with the Blue Cross/Blue Shield proposal is that we're taking one specific approach in providing health care. I'm a believer in managed care. I believe that well-thought-out, well-executed programs can save claim dollars. On the other hand, there have been some spectacular managed care failures. These community coalitions may be the best thing since sliced bread, but it occurs to me we're going to be locking into them. My concern is that if this approach does not work or is not optimal, we've put ourselves into a system that will not let the market make a gradual transition to another approach, or that will allow different market segments to experiment with the different approaches. That's one thing that appeals to me about the Council's position paper. It doesn't force us as a nation to lock into one, two or five specific approaches that we won't get out of until we change and restructure the system.

MS. CONWAY: I think that you made a good observation, and that's something that we've been grappling with. As I mentioned before, this is a work in progress and we're still deciding how various pieces of it work. One of the things that we've been grappling with, and we're still trying to come up with an answer to, is how to make sure that when you move the system toward managed care, you're not moving it toward something that's fixed, something that can't change over time. We are trying to make sure that we don't do that. Managed care is changing a lot now, and the type of managed care that we're advocating is not the look-over-the-doctor's-shoulder-every-five-minutes, utilization review kind of managed care.

We're looking at arrangements where an insurer contracts with good providers, does provider profiling to find out how they practice, picks the good doctors, and then lets them do their thing. That's where the managed care market is moving now, but in five years it may want to move somewhere else.

I do want to make just one statement about what you said about hospitals publishing their outcomes. I think that's a good idea. It's something that we might want to strive for. The problem with outcomes research right now is that it's very limited. It's the same problem that Greg was raising earlier -- that the data just aren't there. We do a lot of work in house on this, and we're going to be doing more, but it's a goal.

MR. SCANDLEN: Tim, you mentioned the outcomes. Walter McClure has written a lot on outcomes. If you haven't read him, I was going to suggest looking over some of his articles.

MR. HARRY L. SUTTON, JR.: Just a comment about quality of care and prices. One of George Bush's proposals is to publish a blue book that would give you the batting average of physicians and the prices of hospitals and physician services, so that you could do a better job of picking where you want to go. A former insurance commissioner in Pennsylvania used to publish prices, but I don't think it ever did anything for Pennsylvania.

I'd like to address Greg's proposal. I have a problem, because I'm firmly in agreement that the patient or the family has to be involved in purchasing and know how much

money is being spent. You may remember that before the IRS killed Section 125 by use it or lose it, we had the ability to do that, in effect, because we could tax-shelter money and the employee could just leave the money in there and actually earn interest on it and then use it to buy health care to fill deductibles or whatever. This is the simple problem I have with the $4,500. One of the problems with the $4,500 is coordination of benefits (COB). If the employer gives you $3,000 and your spouse is covered someplace else and you get full coverage there, all you do is get a tax-sheltered block of money. COB is a big problem in a lot of medical services.

Forgetting that, the main problem I have is this. Let's suppose the employer is spending $4,500 per employee. Now, that's usually a family; but if it includes families and singles averaged together, that's an even worse problem. The fact is that in data I've seen, approximately 5% of families have zero medical expenses in a year. Of individuals covered by Medicare, 15-20% never have a Medicare expense. They might spend up to the Part-B deductible, but they have no other expense. Of individuals in general, through HMOs and so on, 25-30% of the members of an HMO have no medical expense in a year.

Now, if you're actually spending the $4,500 or whatever it is, and you're giving everybody $3,000 and then writing $3,000-deductible coverage, many people are going to wind up with a lot of money that they didn't spend, and yet the total claims are supposed to be reimbursed. *Washington Post*'s and John Rooney's articles picked up about exactly the same process that you've mentioned. The Rand Study would show that if you're paying with money out of your own pocket, you'll buy less medical care, and so the costs might go down. How is that reflected to the employer? That's a sideways question. I can't believe that if you're going to pay the same claims, forgetting the change in utilization, that a lot of people are going to get a lot of money. How can the cost possibly go down or even remain frozen? It just doesn't compute to me because so many people don't spend any money in a year.

The final thing is, you said that if you take the $3,000 out, the employer will have a more stable cost for the excess over the $3,000. As far as I know, the bigger the deductible, the more fluctuations and inability to predict expense you'd have for the excess over the $3,000. In other words, a high-deductible coverage has much more likely fluctuation in cost from year to year than the basic $4,500, because of the fluctuations underneath being absorbed by the base cost.

MR. SCANDLEN: Those are both good points. On your final point, the thought is that the employer's total contribution would be whatever, $4,500. He would remove from that whatever it cost to pay for the catastrophic policy, and then invest the remainder in the medical savings account.

MR. SUTTON: The amount of money contributed to the expense account or to the employee's account could be reduced every year as the cost of the supplemental catastrophic coverage went up.

MR. SCANDLEN: It could be. That would be the employer's decision. Yes, it's very likely that there will not be enough left over to fully fund a deductible, but most employees are paying some form of deductible already. They're also paying co-payments. So if it's a $250-300 existing deductible plus 20% up to a certain level,

the expectation is that employees would continue to invest that, only investing that now would be tax-free, which would make that investment more powerful. You'd also be saving the administrative costs on those out-of-pocket expenses. If a typical loss ratio in this market is 75%, then that's a 25% additional savings.

MR. SUTTON: No, paying the claims is only 3-4%. The rest is corporate overhead.

MR. SCANDLEN: Then you're not paying premium taxes on the medical savings account. You're not paying the premium taxes, and you're not paying the profits on the cost of claims, so you'd be saving virtually everything that's not claims expense. There would be some administrative expense, but what you're asking ultimately is, do the numbers work? There are policies available on the market right now. I can think of four companies that are offering individual policies with $2,500 deductibles in the neighborhood of $1,500 in premiums. I think those are generally per-person deductibles rather than family deductibles, they're individual rather than group, and you guys would be in a much better position than I am to make those adjustments to see if it works. But generally we seem to be in the ballpark on what a catastrophic policy costs.

MR. P. ANTHONY HAMMOND: I'm a health policy actuary, so I tend to come at this more from the policy perspective. The real issue here seems to me to really be two things. One is health-care costs and affordability, and the other issue is what an appropriate national health-care policy should be, not necessarily what the approach should be. I think that comes after you decide what the policy should be. Both of these proposals, while maybe not missing the point, hide the health-care policy decision that is being made here in terms of what we're saying the role of the federal government, or the state government, or any government is. There are implicit assumptions in both of your proposals as to what the appropriate role of government is.

Once you decide what the role of government is, you can start getting at what the appropriate way is to control costs, given that role for government. Obviously, the Blue Cross/Blue Shield proposal has some implicit assumptions that don't seem consistent to me with a free-market, capitalistic, individualistic society. The metropolitan statistical areas (MSAs) are more consistent with that. I'd like to hear you both explicitly say what assumptions are really going into your plans, in terms of what the role of the government is.

MR. SCANDLEN: Great question, Tony. MacNeil-Lehrer on PBS recently had five-minute speech segments for both Clinton and Bush, and it was really interesting. They were both talking about allowing people to take control of their own lives again. I expected that from Bush and it surprised me from Clinton, although Clinton is talking about choice of public schools and that sort of thing. Our philosophical stance, as far as that goes, is very much along those lines. We believe that government should, first of all, take care of people who can't take care of themselves -- the aged, the poor, the disabled. Then it should facilitate the workings of the marketplace beyond that, and particularly facilitate consumer choice and the ability of people to make decisions that affect their own lives. There's obviously a need for regulatory framework or structure, but we would keep that to a bare minimum, and aside from that, keep government out of it.

MS. CONWAY: I see the basic difference between Greg's approach and ours as the level of what the government would do, although I think that our approach is clearly one where the government doesn't operate the health insurance system. We don't want to move to play or pay, or single pay. We look at the world in terms of health reform, and the federal government is going to have to set some basic standards for how insurers can operate. They are intended to be basic. They are not intended to be extensive requirements. Then the state government would have the role of enforcing them. We do not believe that the federal government should take the role of enforcing standards on insurance companies.

MR. WARREN A. SHUGARS: One of the things I learned immediately when I started to price medical benefits insurance was that it's very difficult to extrapolate from my own thinking and the way I think about the world. If I was going to price a benefit plan, I'd ask, what if this co-payments was changed from $5 to $10, what would that do to me? I knew if I looked at it that way I'd always be wrong. I'm hearing a lot about making the individuals accountable and making them make the right decision at the time that they're getting the service. We as a group, I think, are obviously intelligent. We know a lot about health care. We know a lot about financing. We look at things very analytically and in a very crystal clear sort of way. We work our way through the implications of things. I don't think we should extrapolate that to everyone.

The U.S. population has a very, almost insatiable, appetite for medical care. I personally believe that doesn't mean you should take those people out of the decision-making process. I think what it means is that you give them tools and mechanisms to make the right decisions. There are many different proposals out there to do that and to give people opportunities and ways to make the right decision. Some proposals say to not let them make the decision at the time that the child is bleeding, or when they're having the appendicitis or, in fact, after they've just been diagnosed with cancer.

Liz has talked about some proposals, and while I don't agree with the whole ball of wax there, I do like the idea that individuals make decisions up front about what suppliers to buy from, whether that's through an HMO or through some other kind of managed care form. At that point they've made the decision, "Yes, I'm going to abdicate some of that decision at the point of where I'm buying that service. I'm going to hire someone who's an expert in that to help me make that decision." At that point they can think rationally, and they can work through that. I think we have to remember that we don't want to take the individual out of it, but there are different times when you can let them make that decision.

MR. SCANDLEN: Yes, quite frankly, your attitude is exactly the problem. I was on a panel with Karen Ignani, the health policy person at the AFL-CIO, and she said, "We can't do this. It's like throwing people into a sea of sharks." Sea of sharks? This is the health-care system we're talking about. We're talking about dealing with nurses and doctors and people who are trained to care for people. Now, I don't call that a sea of sharks. I disagree with you entirely that people are incapable of making their own decisions. When it comes to Aunt Millie's services, I'd rather have Aunt Millie make that decision than you. I don't think you're competent to make that decision for Aunt Millie. I think Aetna is way off base on this.

MS. CONWAY: Not surprisingly, I tend to agree with the questioner there. Basically, I think that Greg's approach to individual decision-making is theoretically appealing, but when it comes right down to what the American people want, I don't think that's it. We see people willing to go on strike because their employer plans to raise their deductible. I just don't think that people are ready at this point to accept $3,000 out of pocket. We've taken an approach that tries to meld policy needs and health-care cost needs with what the American public wants and needs. I think that's essential to getting a proposal that works.

MR. GEORGE CALAT: I think this last few minutes of discussion really crystallizes in my mind that really the crisis we face is that we each have different philosophies and different criteria on which we're going to judge whatever proposal is put on the table at any given point in time. I guess the concern that I have is that when I hear Greg's proposal and Liz's proposal, I think they probably have excellent aspects to them. But just the fact that it's Greg's proposal and that he's coming from a particular philosophy and with particular criteria and Liz or Blue Cross/Blue Shield is coming from a particular philosophy and particular criteria, I think that's going to automatically turn off people who have different philosophies.

I guess it's really more of an observation that I have, but I think there needs to be more discussion about what the philosophies and the criteria to evaluate a program are going to be on either a federal level, if it's going to be a thorough program, or a state level, if it's going to be a state-level program. Until those philosophies and criteria are set down and agreed to, not necessarily agreed to by everybody unanimously, but agreed to as to what it's going to be at whatever level, then I think it's really difficult to come to terms as to what program we can implement at the federal, state or any level.

The various experts – and there are actuarial experts and policy experts – need to start to state their positions more publicly as a group. Then, once those positions are developed from each of those perspectives, there's the potential for a merging of those positions and maybe some national consensus or state consensus, if it's a state program, as to what the philosophies and criteria will be as sort of the framework on which a proposal is eventually agreed to.

It seems to me that what would be very helpful in this is that with our actuarial expertise, we might some way evolve a position, either through the Society or through the Health Section, of what the criteria might be to evaluate a program. I've heard a number of different criteria assessed here about whether you allow Aunt Millie to make the decision, or whether you allow Aetna to make the decision, or whether you allow a government organization to make the decision, as to what the most efficacious care would be. That in and of itself is a critical question that has divided at least a few of the speakers here. Those discussions need to happen before we can get to a point of consensus on anything at any level. If it doesn't start with the various experts, then by default it gets decided in Congress and that, to me, is a serious situation.