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

HOW TO MAKE HEALTH CARE MORE AFFORDABLE

Moderator: ERIC L. SMITHBACK
Panelists: ANDREA KING*
CHARLES F. LARIMER
GREG SCANDLEN†
Recorder: ERIC L. SMITHBACK

Many proposals have been made, all of which address the access to health care. However, providing meaningful health-care benefits at a reasonable cost remains a big issue. What will it take to make health care more affordable?

MR. ERIC L. SMITHBACK: The central theme of this annual meeting was not health care, but due to the presidential elections it became one of the most popular subjects. Health care has become the number two issue in this election, so this session is extremely timely.

Based on what I've heard so far in this meeting, I believe that no two people agree on what should be done about health care. Everyone seems to have an opinion, but the opinions vary substantially. The greatest area of disagreement centers on the optimal level of government involvement.

I've noted five areas where everyone seems to agree: (1) health care is excellent in this country, when you can afford it; (2) too many people are denied access; (3) the financing and cost of health care are the key problems we face; (4) market forces should be a vital part of any solution; and (5) everybody believes there should be more government intervention. The last point may seem somewhat surprising, but everybody I've heard calls for more government intervention, from small-group legislation all the way to a single-payer national system.

This session focuses on the financing of health care. There has been much discussion of the size of the problem. Projections I've seen show that health care will increase by about 4% of GNP in the next 10 years under current trends. That is about $250 billion, or $1,000 per person in today's dollars.

We clearly have a trend problem. Dr. Naisbitt, in his keynote address, mentioned health care several times. He focused on medical trends rather than costs. I think all of us agree with his statement that you can't have an exponential growth rate forever in medicine, as we have had in the past.

On the positive side, although no one solution has surfaced, we do have many ideas. At some point, perhaps soon after the election, we will have to come to grips with which of those ideas we're going to implement. The speakers for this session have

* Ms. King, not a member of the Society, is Domestic Policy Advisor in the Office of Majority Leader of the U.S. House of Representatives 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.

varied backgrounds and are going to put forward some of their ideas for each of us to consider.

Our first speaker is Andrea King. We're very fortunate to have Ms. King with us, because of her extensive involvement with the government's current thinking on health care. Ms. King serves as policy director and domestic policy advisor to House Majority Leader Dick Gephardt. She's also an administrative assistant in Dick Gephardt's personal office. She has been with Congressman Gephardt for eight years, and specializes in the areas of health, education, poverty and social issues. Ms. King has a lot of input on any legislation or policy that comes out of the majority leader's office, so we should listen to her very carefully. Before joining Congressman Gephardt's staff, she taught philosophy at a college in Baltimore, and she has a Ph.D. in philosophy from Georgetown University.

Our second speaker is Greg Scandlen. He's the executive director of the Counsel for Affordable Health Insurance and publishes the *Health Benefits Letter*. Prior to his current position, he spent 12 years in the Blue Cross/Blue Shield system, most recently as director of state research for the national association.

Our third speaker is Charlie Larimer of Gold & Associates, a consulting firm that specializes in HMOs, PPOs, individual practice associations (IPAs) and other managed-care entities. Mr. Larimer works on all facets of HMOs, including claim reserving, rate development, fee schedule development, etc. He started out at CNA, and then he went to Blue Cross, where he worked on health care. Charlie has been involved as an actuary in the health-care field for 18 years.

I'm Eric Smithback. I'm with the Chicago office of Milliman & Robertson. I've been working on health care ever since my first job at CNA in 1975.

MS. ANDREA KING: I want to give you an overview of current thinking in Congress on the issue of health-care reform, give you a little historical background on what was done and not done and why during the 102nd Congress, and attempt a very sketchy set of guesses as to what might happen in the next couple of years in the area of health-care reform. I will attempt to be descriptive and objective in my discussion of what's happened and what the members of Congress and the candidates are thinking and saying about health care. You should understand that I work for the Democratic majority leader in the House, and I wouldn't be surprised if my remarks have a slight slant toward the Democratic view of the world.

We think we've made progress at the federal level in figuring out what to do about health care in this country, but we have quite a way to go. Information, insight and experience are always (believe it or not) welcome in Washington, at least in Congress, and I'd be very interested to hear if you have any helpful suggestions.

Democrats in Congress certainly believe that current trends in the health-care system are unsupportable. We cannot just do nothing. There will be fewer and fewer people who will be able to afford health care in the future if we allow health-care costs to continue to grow at current rates.

HOW TO MAKE HEALTH CARE MORE AFFORDABLE

There are many reasons why health care is a burning issue in Congress. Providers are coming to us with tales of very bad problems they're encountering as a result of uncompensated care, and other irrationalities in the current system. You've all read about, and you probably have some first-hand experience with, people who are reluctant to make job changes because of how that will affect their health insurance. It is a political issue when you have as many people without health insurance as we do in this country. Whether it's 32 million or 37 million, that's a lot of people. Someone or some combination of people and entities are going to have to pay for covering those people.

However, you cannot commit to covering 37 million additional people for services, the cost of which grows at 10-15% a year every year. Not only are the consequences of doing that disastrous in the real world, but also the political consequences are disastrous. You can't even suggest that you're going to get people tangled up in a system growing at that rate without making an effort to get the growth of those costs under control. For that and a number of other reasons, Democrats have spent the last two years working very hard in formal and informal settings in both the House and the Senate, to try to figure out how to get a handle on the problems within the health-care system, both the delivery system and the finance system.

Democrats think of health-care reform in terms of three major goals: universal access, high-quality care, and affordable coverage for everybody. It is the concern and commitment of all members of Congress that we do nothing that would damage the care that is the best in the world. What we learned in the House is that you cannot address goals one and two without addressing issue number three, which is cost. The goal must be universal access to high quality care at affordable prices.

Over a year ago we in the House came to the conclusion that although all three goals are important, and we need to achieve all of them, the linchpin of health-care reform is cost containment. That is what we focused on in the House, and we have worked long and hard on it. At the end of the session we had a vehicle that, had we had a bit more time, we might have introduced and tried to get a vote on, if for no other reason than to let people work the issues through and go on record. But the clock ran out, and we didn't get it introduced.

The package in the House is very similar to the one that Governor Clinton has been talking about throughout his campaign, and which is now just concentrating on health-care cost containment. The package starts with global budgeting, and continues with a combination of regulatory elements that in total are referred to as managed competition.

Before I talk about this package, I want to talk about the mind-set of members of Congress, particularly Democrats, towards the issue of cost containment. In the House there is a widespread interest in a more aggressive regulatory approach.

There is a growing awareness that the phenomenon of health-care cost inflation is itself an enormously complex phenomenon. There is no one cause of health-care cost inflation. We think we have learned from looking at other countries with many different kinds of systems. Many of these countries are doing better than we are in getting their people covered, and even in containing cost increases. Nevertheless, no

country has been really successful in controlling health-care cost increases. It's one of those problems that is just enormously difficult to solve. In Germany, people appear to be in very good shape, and people are satisfied with their coverage and the quality of their care. Their providers have some complaints, but basically they feel as though they're being fairly treated and the system is working. There is a general consensus that things are working. But everybody's scared to death about the growing cost of health care, both in terms of trend and demographics. They're looking ahead 10, 15, 20 years, to an increasingly older population. I'm sure actuaries are acutely aware it's reasonable to expect that current trends will be compounded with all the problems regarding older people in their needs for health-care services.

There's more, though, and here is where Democrats start parting company with Republicans. Republicans, particularly in Congress, will acknowledge in a legislative framework that we have a very big problem that needs to be addressed. Republican members of Congress want to do something, and they want to do something big. However, for years the administration did its best to downplay the magnitude of the problem. For instance, Secretary Sullivan said that solution to the health-care problem is for people not to get sick. To some extent we've had to bear with the administration until it caught up with the rest of the country and realized that we have some very serious problems.

Where Democrats begin to part company with Republicans is on the question that Mr. Smithback raised regarding the role of the market. Democrats are much more inclined to believe that health care does not represent a classical market situation. It certainly does not now, but Democrats believe that it never will, for a number of reasons.

A simple example shows why health care is not a classical market situation. If I walk into an automobile showroom and say I'd like to buy that Cadillac, but I don't really have the money, I'm not going to drive out of there in a Cadillac. If I show up in an emergency room, and say I think my appendix has just ruptured, I need medical attention but I can't pay for it, I'm going to get medical attention. That's good. It shows that we have a fully-articulated commitment to the principle in this country that health care is a right. People are not turned away, or if they are, it's with a great deal of reluctance and shame. That fact makes the health-care market a less than theoretically pure free market.

A second complicating element is the third parties that get between the purchaser and the purchase. That's not just insurance, although insurance is a big part of it.

The providers are just as big a complicating factor in the minds of most Democrats. If a Cadillac salesman tells me I need a Cadillac, I have the ability and the inclination to take that suggestion with a grain of salt. I can evaluate the suggestion and decide for myself whether I need a Cadillac. However, if my doctor tells me I need x-rays or medications, that's a whole different ball game. I have much less ability to evaluate that recommendation, and I also have much less inclination. Medicine is an art and a profession, and we like to look to our health-care professionals as precisely that. If I could figure out what was wrong with me and how to get well, I wouldn't go to a doctor. And that is how most people think.

Most Democratic proposals for health-care reform attempt to increase the role and responsibility of the consumer in various ways. However, as far as the Democrats are concerned, there is a very real limit to the amount of responsibility that you can place on a health-care consumer, a sick person, or a sick person's family, in making classical, economically rational decisions about either health care or health-care coverage. For those reasons, Democrats are less likely to think that by simply removing impediments to free enterprise, an unfettered market in health care will result that will solve the problems.

Another idea I'm hoping will be discussed is the idea of vouchers -- that it's a good idea to just give people money. It's not. Giving people money will tend to increase demand. Democrats believe that, if you increase demand in a system that is as haywire as the one we have now, you're really asking for trouble. The President's proposal combines vouchers and small-group reform. Our analysts tell us (you again have much better information on this than I do, and if we're wrong, I need to have somebody tell me) that the impact of small-group reform will be to increase insurance premiums for a lot of people.

Our analysts also tell us that cost containment can counteract not all, but a huge percentage of those increases as they're felt by the individual. That's what we have to do. If premiums are increasing at 15% or sometimes even 40% a year, and we're implementing something that is going to cause those increases to jump another 25-50%, it's not a productive thing to do. This gets us back to one of the very first points I made: when you give people money and say go out and buy insurance, but the product you buy this year at $3,000 is going to cost 15% more next year, 15% more than that the following year, and well, no, we're not going to increase the money we're giving you by 15% every year, what are you doing for people? What are you doing to them? That is why there really was a standoff between the Democratic Congress and the Bush administration on the best approach to health-care reform.

Democrats in Congress genuinely believe that proposals without cost containment, like the ones represented in the Bush package, are counterproductive. There are many things that Bush has proposed that we also propose, and that we would like to see done, but not without cost containment.

Now that being said, let me just talk about the regulatory approach to cost containment and the managed-competition approach, because those are the two approaches that we've been concentrating on.

There is a strong, although not universal, belief among Democratic members of Congress that the time really has come for the federal government to set some outside limits on the growth of health-care expenditures in this country, and that's what the regulatory approach attempts to do. Bill Clinton has a proposal that is, as I said, similar to the one that we in the House were working on. It entails setting annual increase rates that start at experience and ratchet down to approximately the (nominal) growth in GNP. This approach would not decrease anybody's earnings or profits, rather it would reduce the expected rate of increase in earnings and profits. Exactly how you implement a national budget hasn't been fully determined. I expect that what we're going to get is a combination of a lot of state flexibility with an

all-payer rate-setting system. The all-payer system would function as a kind of fallback or fail-safe for those states or regions that either fail to come up with a plan, or fail to stay within their budgets as they attempt to implement their plans.

The Democratic leaders who believe that this kind of regulatory approach is necessary also believe that government should not be in the business of micromanaging the delivery of health care. Government shouldn't be making decisions about who gets what kind of care and when. However, government should be in the business of providing a context in which providers and patients and their families make their decisions and their choices. It is simply the notion of saying the sky is not the limit. There are choices that are going to have to be made, and we have no evidence that those choices will result in a dilution of quality, and we even have some evidence that making some of those choices might improve quality. I don't think it's safe to assume that the more health-care services you get, the better off you are, and if we can try to establish a mind-set which forces people to delineate between what really is necessary or really is useful, and what isn't necessary or useful, there's a very strong feeling that everybody will be better off.

However, there are many Democrats, as well as Republicans, who disagree with global expenditure caps on two grounds. One of them is that, by human nature, a ceiling becomes a floor. If all you do is set a limit, even if the private sector could be more cost-effective, you are guaranteeing that it will not be.

The other argument that we often get is that the existence of caps at all is inherently anticompetitive, antifree market. Ideologically, that appears to make a great deal of sense. There are more and more Democrats, however, who don't believe this is a dichotomy. They are willing to accept that, if you can, you need to set a ceiling and create incentives to go as far below that ceiling as is possible without damaging care.

There is a growing consensus that both a competitive environment and a regulatory framework are important. In Congress there is also a growing consensus that creating incentives for competition on the one hand, and setting regulatory framework on the other, are not mutually exclusive or contradictory; you don't have to choose between the two. In fact, you can do both. That's what we've been working on, and that's what Governor Clinton proposed.

If Clinton is elected, I would think it's safe to assume that ultimately we're going to see a bill that sets regulatory limits and implements them in as flexible a way as possible, but does have some sort of rate setting as a fallback or fail-safe. The bill would at the same time create health-plan purchasing cooperatives (or whatever it is we're going to call them) where you require the standardization of plans, and you require plans to compete. This is where you get to empowering the consumer, to the extent that that's possible, by making it easier to compare the costs, benefits and trade-offs of plans. Consumers can then make more informed choices based on the cost-effectiveness of various plans. As I say, if Clinton is elected, I would expect that ultimately that's the kind of approach that we're going to get.

If Bush is reelected, we're in an entirely different situation. We will have a very real and serious disagreement between the parties. How that plays out, I'm not really sure. You might be aware that the Bush administration made it very clear that the

President would veto any bill that had any regulatory cost containment in it. In a second term would that thinking change? I doubt it. So the situation will be considerably different if we continue to have a Bush administration, and I can't really predict what would happen.

MR. GREG SCANDLEN: The first point I would like to make is that actions have consequences. George Mitchell once said that the solutions to today's problems always carry with them the seeds of tomorrow's problems. I think it's worthwhile to keep in mind that we're never going to solve problems. We'll work on them, maybe make them better, but today's solutions become tomorrow's problems. It always scares me when someone looks at one big solution as being the object of what we're after. I think mature people realize that actions have consequences, and sometimes unintended ones.

I think it's also important to keep in mind that where we are today is the result of where we've been before. The reason we have the current health-care system is largely because of federal tax policy. Our tax policy tilts towards employer-based coverage and towards first-dollar coverage. If in the 1940s we thought about the likely consequences of our tax policies, we probably could have predicted that. It's not too surprising that we ended up where we are.

Interestingly, I think many of the problems that we're facing, particularly the problems of the uninsured, are the consequence of changing tax policy over the years. We just released a paper that looks at federal tax policy over the years. In the late 1970s, people could deduct anything over 3% of their income in health expenses and insurance payments, and there was a $150 deduction up-front for health insurance premiums. During the course of the 1980s, that was diminished. In 1982, the deduction floor went up to 5% and the $150 deduction was removed. In 1986 it went up to 7.5%. In the late 1970s, I think about 36-38 million people in the country had individual health insurance policies. The latest numbers I saw were from the Employee Benefit Research Institute for 1990, and it was down to 19.7 million people with individual health insurance policies. It's interesting if you try to relate those items. There was fairly generous tax treatment for individuals up through the late 1970s, and there were many individuals who had policies. They took away the tax benefits, and fewer and fewer people have policies. That's not surprising. Like I say, actions have consequences, and where we are today with the 37 million uninsured I think is largely the result of the change in federal tax law.

Another point is that health-care cost rises are not immutable. We can do things to affect them. Again going back to the late 1970s, annual health-care expenditure increases were up around 15-16% for a couple of years. Around 1980, employers started taking more of an interest. Medicare diagnostic related groups (DRGs) came in, and for five years in a row, the rate of increase in health-care costs dropped, and it was a very substantial drop. Every year the rate of increase dropped because people were doing something about health-care costs. I think one of the big things that we're doing now involves switching from inpatient care to outpatient care. If you show these changes in a graph, it forms a perfect X as inpatient care decreases and outpatient care increases. Although a problem we're facing now is that, after six years, the providers have figured out how to game the new policies by increasing their outpatient rates. But I think that gaming is a dance that we'll always have to

face. The people who are paying for the service would like to hold on to their money. The people who are providing the service and getting paid would like to increase their reimbursement, and it's a tug of war. It will never stop, and probably shouldn't.

Another point incidentally related to that is interesting. The Health Care Finance Administration came out with some numbers breaking out the percentage of total health expenditures that are paid for by the government, by individuals out of pocket and by private third-party payers. Ever since the 1960s the proportion of health-care expenses paid by individuals out of their pockets has dropped. In 1965, the proportion paid by the government increased a lot because of Medicare, but aside from that, the government proportion has been fairly flat. But the third-party payment proportion has gone up just as quickly as the individual out-of-pocket expenses have gone down. I think that too has contributed to the rate of health-care inflation that we're seeing. This is another consequence of government actions. To change this situation, I think it's worthwhile changing the actions that led to it.

Another example of changes in the health-care field is the shift from insured plans. In 1974 nobody expected that we would end up with the noninsurance-based health insurance system that we have. No one anticipated the level of self-funding and the fact that most employers are completely exempt from state regulation, premium taxes, and mandated benefits.

The insurance industry itself is really two separate industries now. There's one part that is state regulated, pays premium taxes, is risk bearing, and is mostly focused on smaller employers. The other part of the industry is exempt from state regulation, is primarily doing administrative services for large employers, and is very much focused on managed care and that sort of thing. I don't think when ERISA was passed in 1974 that anyone sat down and said, well, let's see, in 1992, what's the insurance market going to look like as a result of this law that we're about to pass. I encourage Ms. King and other folks on the hill to think through things in that much detail. If we pass a national health-care bill, what's it going to look like 10-12 years from now?

Just a couple of other things I wanted to quickly mention. I simply disagree that in health care people cannot make rational decisions. We make rational decisions in everything else we do. I have a 17-year-old son right now who's a senior in high school, and we're thinking about what college he should go to. This might be the most important decision that we ever make in his life, and we're looking at colleges, we're thinking about it ahead of time, we're getting brochures, and we're taking that decision very seriously. I think throughout our lives we make decisions that are as or are more complicated than the choice of provider or the choice of particular treatment programs that are proposed to us.

Then finally I just want to say something about global budgeting. I understand the frustration that's leading to that idea, but it really scares me. I sincerely hope that we have an opportunity to think this issue through clearly. We passed Medicare catastrophic without thoroughly thinking through it. We passed Section 89 without thinking through it. In both cases it was a humiliating experience for Congress. If something like this passes without being thoroughly examined, it has the potential to be one of the largest mistakes ever made.

A few examples of the issues of what needs to be thought through. If you have global budgeting, what happens if the money runs out and hurricane Andrew comes along? What happens to my ability to contract with you if you're a trained physician and I have the money, and we want to make a deal? Does that have to go into the global budget? The notion's fairly new to me, and I haven't thought through it very well, but it doesn't strike me as an intuitively, obvious thing to do. My intuition says it's a scary thing to do. Look at other efforts of the government to control prices. Certificate of need is a good example. It hasn't worked very well. You can make an argument that it's been mildly effective, but it necessarily has not been the kind of answer that some people are saying global budgeting will be. I feel these are real concerns. Just to underscore once again, what we do and what we're going to do in 1993 and the 103rd Congress is going to affect each and every one of us for the rest of our lives, and I just implore Ms. King and her colleagues with everything I can to give us an opportunity as people that know something about this business to do some hard, serious thinking about all these proposals.

MR. CHARLES F. LARIMER: I will be expressing and representing the views of managed-care organizations on the issue of how to make health care more affordable. I'll be approaching this topic from the standpoint of HMOs and other managed-care organizations.

The projected cost of health care in the U.S. for 1993 exceeds $800 billion. The managed-care viewpoint is that much of the spending is not necessary, in that in many cases the services provided could lead to a lower standard and quality of care. Unnecessary surgeries and other hospital stays can be dangerous to those receiving the care. If you don't need to go in the hospital and you're put in the hospital, it adds an element of danger for the patient. We always need to be concerned with quality. Most of the time quality is questioned when not enough care is provided. Well, sometimes too much care can reduce quality. That's one of the key viewpoints of managed care – most is not necessarily optimum care. Managed care means trying to reach the optimum level of care.

How much could the $800 billion be reduced? Estimates vary widely, and I don't really have a best estimate for you. I read one study that maintained that half of all inpatient stays in the United States could be eliminated. I viewed that as an extreme position, but when you extrapolate hospital days per thousand in California to other parts of the country, it implies that there could be a drastic reduction in the hospital stays. Other studies have estimated that perhaps 25% of surgeries are unnecessary.

I extrapolated current managed-care results to the whole country. I tried not to get too carried away, but it appeared that, if you brought managed care to the whole country, you might produce savings of $80 to $150 billion out of the $800 billion. My first estimates were even larger. I don't want to stick my neck out too far, but there could be substantial savings if managed care is implemented across the board.

I've mentioned that the managed-care viewpoint is that the health care can be done better for cheaper. From that reason, it's very much a market-driven perspective. One of the major faults of a nonmanaged-care system is that the supply and demand equations go way out of whack. The providers of health care are the sellers of health

care, and so there's little or no check on expenditures. Managed care represents an attempt to bring market forces back into health care.

Now I'm going to talk a little bit about some of the tools of a managed-care system. One tool is making providers fully or partially at financial risk for the results. One of the methods that HMOs use to do this is a primary-care capitation. With a primary-care capitation, a primary-care physician is paid on a per-head basis for a limited number of services. Other methods are full physician capitations, or financial incentives and bonuses for doctors to control hospital and referral utilization.

Some of this may be new to some of you. Let me flesh out some of these ideas. In developing primary-care capitations there is no universal definition of primary-care services. When we're developing primary-care capitations for our clients, one of the first things we do is help them define what services are included with primary-care services. Usually these would include office visits by primary-care doctors, inpatient visits, certain lab tests, and certain consultations. Miscellaneous medicine is usually included, and by our definition that would include EKGs, allergy shots and some pulmonary tests. Emergency room visits and well-child and well-baby exams are usually included. Sometimes a primary-care capitation could include certain surgeries, which I sometimes refer to as simple surgeries. Although radiology is not usually included, it sometimes is. Capitated radiology might include chest x-rays and what they call x-rays of the long bones. Usually well women exams are included in a primary-care capitation. The first part of our job when we're working with HMOs is often helping them define what they want to include in a primary-care capitation.

From the physician's financial perspective, capitation means that each dollar or service comes right out of the doctor's pocket. So you're making a very direct transfer of risk to the doctors on a primary-care capitation. Sometimes you might include a stop-loss arrangement. Primary-care capitations present generally manageable risks to physicians as the services covered are high frequency and low severity. You should be careful about capitating a group of doctors for a risk that's not manageable. Sometimes we are asked to develop capitations for certain specialties where there's a low frequency and high severity. We always try to caution them that capitation may not be a good idea in this arrangement.

Most of my work is within managed care. Within that range, primary-care capitation almost seems to be a given, and not a controversial item. During the last year, I've spent more time dealing directly with physicians in PPOs, and I've learned that a primary-care capitation is by no means a given in the physician community. Sometimes I'm warned before I speak to these groups of physicians not to use the "C word," because you can get the physicians too upset. It is true that some of them view primary-care capitations very negatively.

In all these proposals, you have to keep in mind that the world of medicine is not necessarily ready to move over to a completely managed-care system. Certain physicians feel very negatively about some components of managed care.

I'll tell you a little about typical financial arrangements, or financial incentives and bonuses that work with a primary care model. Frequently with primary-care doctors, you might set per-member-per-month targets on hospital and referral use, and if these

primary-care doctors can meet or beat these targets, they may share in a percentage of the savings. They could share 50% of the savings up to a limit. Frequently there are withholds on primary-care capitations to fund these incentives. In other words the HMO may calculate a gross capitation and withhold 20% of that. If the doctors meet these targets, the HMO will return the withhold and then give the doctor a bonus on top of that. For those not meeting those targets, the HMO may use that withhold to pay the bonuses for physicians who meet targets. This is another idea that is not universally accepted by physicians, as you may imagine. Sometimes HMOs will set up arrangements with variable withholds, where a physician who has shown the ability to control utilization might have less of a withhold.

Another tool for managed-care companies is utilization review. This could include pre-admission authorization of nonemergency hospital stays, large-case management, and authorization of specialty referrals. Various studies have shown savings of between $4-11 for every dollar spent on utilization review. Based on these studies, there's a strong feeling that utilization review can produce dollar savings.

Utilization review programs are a major source of irritation to physicians, which is not really surprising. It is high on their list of things they least like about today's health-care system. Some of their complaints arise because the doctors deal with many different managed-care programs, and all these different programs have different procedures and protocols. The physicians sometimes say that, if managed-care companies could just decide on one method to do this, the life of the physician would be a lot easier. All this is evolving, and one of the goals may be to make these things more consistent. On the other hand, as long as there is competition among managed-care programs, and each wants to do things better than the next, there probably will always be differences. We will need to strike a balance if we are to be responsive to the physician community.

I'm now going to go into a little bit different area. One of the questions asked concerns government involvement. I've said that I generally view managed care as a free-enterprise, market-driven system, and I wanted to touch on some of the government issues. Some of my comments represent the managed-care position, and some are my own position and not necessarily the managed-care position.

First, I'm going to give you a list of areas where I think the government should be more involved. One area is malpractice reform which everybody, except perhaps the lawyers, seems to favor. The medical community, the insurance community, and the politicians all seem to favor malpractice reform. Malpractice costs drive up the cost of the system in many ways. One is malpractice premiums. There is also the element of defensive medicine, as doctors try to cover themselves by doing more than is necessary.

Tax reform is needed, particularly for individuals. Many in the insurance community would like to see tax reform of some nature to make individual insurance more affordable.

Improved portability of coverage is needed. This is one of the areas where the government must get involved to develop a level playing field, to set rules that all companies could abide by, in order to increase portability.

Outcomes research, which is included in both the Bush and Clinton proposals, is another thing that could benefit from government involvement.

Another, perhaps more controversial, area is placing more Medicaid individuals in a managed-care setting. The first direction that this population, and any expansion to the uninsured, should be pointed towards should be to a managed-care system. Not all the politicians agree with that, but that's my viewpoint.

Another area that I think should be considered is sin taxes, which would include taxes on cigarettes and alcohol. Personally, I'm in favor of those things. I looked at the Bush and Clinton proposals, and neither included these. It would be easier to tax those items directly than to bring those cost components into insurance rating. In other words, it's easier to tax a package of cigarettes, than to have health insurance rates that vary by smoking versus nonsmoking. It's more direct if you get right at cigarette smoking. That's an opinion of mine that is not necessarily the managed-care opinion.

There are areas where I think the government has overstepped its bounds, and many in the managed-care arena agree. One is mandated coverage. One example of mandated benefits frequently talked about is infertility services. Many of us agree that it's great that medicine has evolved to the point where we can improve infertility services. However, that doesn't necessarily mean it should be forced on the entire community by making the entire community pay for it. We also have concerns about community rating. In a market that allows both experience rating and community rating, there can be all sorts of distortions if you mandate community rating for certain segments.

Another piece included in both the Bush and Clinton proposals is waiving preexisting conditions. That could be very dangerous, and the politicians need to be made aware of that. By waiving preexisting conditions, you're giving incentives for people not to purchase insurance until they really need it, and that in itself, can substantially drive up the cost of insurance for those purchasing insurance.

MR. SMITHBACK: When I originally looked at this panel, it seemed the panelists would have different backgrounds and perspectives. After listening to them, I'm sure that they do. Despite the areas where they disagree, there are many areas of agreement, such as the need for a role for managed care.

I would like to briefly summarize what I heard the panelists say. The current system of health care costs a lot, and the trend in costs is staggeringly high. There are several reasons for that. One, we do not have a classic economic situation where you have a buyer and a seller, and the buyer is exercising his judgment as to what to buy. The system we have is a little bit different. The doctor is the buyer and the seller. The patient benefits from it, and a third party pays for it. The financial incentives that normally exist in a free market are distorted by this third-party-payer arrangement. The lack of knowledge on the part of the patient regarding both the price and the effectiveness of the services also inhibits rational economic behavior. We also have social pressures not only for providing basic health care to everyone, but also to expand the services available to areas such as infertility treatments.

While we seem to agree there are a number of problems that distort the free market in health care, I think the three people up here have a different approach to how to fix that.

I think Ms. King is trying to put together a framework at the federal level to correct some of those distortions in the market. The market could then operate, but only within this framework.

Mr. Scandlen is attempting to put the financial responsibility back on the individual, so that the individual is once again the buyer, and is financially responsible for his or her decisions. He believes that will decrease the number of services ordered.

Mr. Larimer is trying to place more financial responsibility with the provider. Capitations and other managed-care tools are mechanisms that make the provider financially more responsible for the decision to provide care.

I think those three perspectives will all be a part of whatever solution this country works out, but the path we take will determine how big a role each will play.

Earlier we were talking about an interesting question. It seems to me that any solution that the free market puts together will necessarily take a lot of time to have a significant effect. As Mr. Larimer mentioned, he believes that managed care can save $80-150 billion. If we really want to hold the rate of increase in medical care to the rate of increase in GNP, we're probably going to have to cut out $250 billion over the next 10 years. Private-sector solutions, because they are less coordinated, may take longer than a government solution. Many commentators in this area have said that we have a limited period of time before the government will do something drastic. I believe that's true, but I don't know what the period of time is. I'd be interested in hearing what our panelists have to say about how long they think the solutions they're offering will take to work, and whether it's reasonable to expect that society will wait that long.

MR. LARIMER: I feel some government intervention is necessary, and some of the things I laid out as positive government forces could occur quickly, such as malpractice and tax reform. Some of the issues of improved portability could be settled in the next couple years. So I feel there is some need and some room for quick government action. The action could have at least a moderate impact. I agree that some of these free-market forces will take a while, and in certain levels, it may be appropriate to have some government involvement.

MR. SCANDLEN: That's an interesting question. I've never really thought about it before, but I think just having a medical IRA system widely implemented would take quite awhile. We would certainly not mandate it on anybody. We would hope that it would be incremental, and that some employers and individuals would choose that approach, while other people would learn from their experience and be inspired to start moving. I'm not sure I agree that the market responses are slower than government responses. For instance, one of the things that Ms. King said was that, if you gave the people money to buy their own insurance policies and if there were a 15-20% increase, what would they do? My thought is that they would do what they've done with taxes -- they'd yell and scream and holler, and those increases

would not stand because people would not put up with it. I'm reminded that George Bush got elected the first time on a promise of no new taxes, and if he fails to get reelected, it will be because he broke that promise. I'd suggest that the market is a very speedy way of forcing change in the country and much faster than the regulatory process.

MS. KING: I think the point that Mr. Scandlen made is an accurate one. Anything we do is going to take some time. Even if you decided that you needed to come down as hard as you could from the federal government and just slap regulations into place, you cannot squeeze 4% out of the health-care market overnight. You just can't do it, nor would anyone attempt to do it. Even the regulatory approach is going to take a number of years. The difference with the regulatory approach is that you at least know that it's going to happen. It's not just that private sector activities take longer, it's that you're never sure they're going to happen, or whether they're going to happen the way that they've been promised to happen.

The question of how long can we wait to begin to address this problem is one that members of Congress think about a lot. What an elected representative faces is the question of at what point is it absolutely necessary to do something that is going to affect everyone, and there is no question that the kind of reform that's needed is going ultimately to effect the way everybody acts in the health-care arena. Providers, insurers, consumers, and the government are going to have to change their ways to some extent or another. Change is always difficult, even if it's change for the better. This is going to be a wrenching process no matter what we do, and the question is, how long can we wait?

In some ways, that is an entirely pragmatic question. We may wait until there is an explosion among the public over whichever part of the system collapses first. Or until there is a critical mass of employed people who have lost their insurance. Or until a CEO of a major company dies in an emergency room, because the emergency room was closed that day because it had run out of money for that month. We may wait until something drastic forces our hand.

We want to try to act before that happens, because Mr. Scandlen is right in saying that it's important to think through the consequences of policy. We try to do that, but if we are responding to an emergency, we have less ability to do that. That's the whole goal of trying to get this done, to avert the kind of disaster that would guarantee that something gets done quickly. What we keep coming back to is that we tried, or the Carter administration tried, a regulatory approach. It was not adequate for a regulatory approach even back in 1978-79. Dick Gephardt is credited (if you want to use that word) as the person in the House who defeated the Carter hospital cost-containment effort. The reason he did it is that the providers, particularly the hospitals, but also the physicians, saw the writing on the wall if this bill were enacted. The providers came to him and said, "Wait, wait, wait. We understand there's a problem, we'll get it together, we'll figure it out. Let the market work, let competition work." At that point, Dick thought let's give that a try. As he has said frequently in the last year, it's been 12 years and not a whole lot has happened. I think there are an awful lot of policymakers who feel that we don't have another 12 years. We probably don't have another five. How long we have, I don't know, but within the halls of Congress, the health-care problem is beginning to feel like a real crisis.

MR. ROY GOLDMAN: Ms. King, can you explain exactly how global budgeting would work?

MS. KING: In a word, no. The reason I can't is that there are a variety of scenarios, and even within the different scenarios, the details have not been worked out. I can give you an outline of some possible approaches. One notion is that the government sets a number, a percentage of acceptable increase. That number is ultimately pegged to the nominal increase in GNP. It could be pegged to the increase in anything, or not pegged to anything, but what people generally propose is that health-care costs and increases track the increases in GNP.

MR. GOLDMAN: That's easy to understand. But how does that apply to a given hospital, a given physician, and the other providers?

MS. KING: That is precisely the question. How do you take what is a national global figure and translate it into anything, and how do you enforce it? What Clinton is proposing is similar to what they do in Germany. It works in Germany, although they do have a very different situation in Germany. They have a culture and traditions and history that we don't share. Nevertheless, the government sets the increase, and the providers and insurers and consumers get together and hammer out who gets what through a long and very detailed set of negotiations. That's one way to do it.

Another way to do it is to translate the national budget for a given year into state budgets, and tell the governor or his or her design to do whatever that person wants. Some might create a single-payer system, some might want to do what California's trying to do, some might want to copy Hawaii. As long as you stay within your budget, we don't care, just do it. You could also apply Medicare rates to everybody, which is sort of regulatory automatic rate setting. That isn't going to be done quickly if it's done at all, simply because there are so many sectors of the delivery system that we haven't worked out rates for, and it would take a long time to work that out.

Those are the ranges of approaches to this question that have been looked at. I don't think anything is cast in stone, and I think that most politicians are eager to retain as much flexibility as humanly possible, and to keep the decision making at appropriate levels. There really aren't many people in Washington who want to be responsible for deciding who gets chemotherapy and who doesn't.

MR. DOUGLAS S. VAN DAM: My question is, how can we as actuaries have an impact on the debate?

MS. KING: That's easy to answer, and I can do that quickly. There really is an interest in good information, both within the administration, and particularly within Congress. While there are always unintended and unanticipated consequences of policies, every effort is made to understand what reasonable expectations of consequences would be. In order to do that, you need to know what the situation is that you're proposing to change. Therefore -- now this is the first thing I said to you, and it was not opening fluff -- any information is very useful. We need to hear experience, numbers, here's what's been going on, here are the trends, and so on. In the area of small-group reform, the Senate felt it understood enough to actually pass a bill. It doesn't, I'm sorry to say. The Senate doesn't and hardly anyone does, and

we need to get that figured out. So as an organization, as individuals from the places that you work in, in whatever way you can figure out to get your information to your representatives and to the leadership in Congress, your comments would be enormously helpful.

MR. SCANDLEN: Let me just add that there's a hunger for good numbers and for good information. I know the Society has a research arm, and it would be great if the Society as an otherwise disinterested, nonpartisan organization would take a look at some of the public policy proposals and do its own analysis of them when they come down the pike. It would be an enormous contribution. I know that's happening to some extent, but we could use much more of it.

MR. VAN DAM: As a follow-up question, how is the insurance industry viewed on the hill?

MR. SCANDLEN: I think Ms. King may be too much of a lady to tell you.

MS. KING: It certainly is true that there is a widespread perception on the Capitol Hill that there have been many practices adopted by the insurance industry that are not necessarily beneficial to policyholders. There is some skepticism as to whether insurance companies are actually interested in being in the business of health insurance. The risk aversion and the risk-averse behavior of the insurance industry is widely remarked upon.

By the same token, hardly anyone believes that it is the private health insurance industry that has created all of these problems, and that doing something to them is going to solve all these problems.

What's been interesting has been the role that the insurance industry hasn't played in the debate on health-care reform. There hasn't been a very strong presence on the part of the health insurance industry. Now, one of the reasons is clearly that the administration told the industry not to worry about this, it was going to veto anything the industry doesn't like. That doesn't encourage people to go to the hill and work with Congress. Even so, within a very limited range of proposals, or I should say outside a very limited range of proposals, the insurance industry just really wasn't interested in talking to us, and it wasn't even interested in talking to us about pieces of the bill. It was almost a "you and the horse you came in on can all go hang together" mentality. That's one way of approaching it, but when a potentially affected sector behaves like that, it runs a real risk of uninformed decisions being made. I think that's to be avoided.

MR. SCANDLEN: Let me tell you what our experience has been. In the six months that my organization has been in existence, we've been going from office to office on the Hill and meeting with everybody whom we can. The feedback that we're getting is that the people whom we're talking to never hear from the industry, they don't understand the industry, they have no idea of what I just mentioned about risk exempt and state regulated. The few times that an insurance industry lobbyist comes in, they end up protecting their company's or their industry's profits, and that is not acceptable to most staffers. They don't want to hear about that. They want to hear when you are going to pony up to help solve these problems, and they just aren't

getting it. They see the Health Insurance Association of America (HIAA) proposals being self-serving. They certainly see the Blue Cross proposals being self-serving. It's been our experience that they just haven't seen anything very constructive coming out of the industry at all.

MR. CHARLES T. DOE: One of the experiences that we've had in Connecticut is guaranteed issue has been in force now for a year. The assessment that is on the table at this point in time is that approximately 1% of the population is affected. That comes from the dynamics of the Connecticut environment, and the fact that guaranteed issue was in place before, but that's the magnitude of what people are looking at in Connecticut at this point in time.

MS. KING: You're addressing the question of the impact of some of these insurance reforms on premium costs?

MR. DOE: Yes, comprehensive small-group reform and guaranteed issue.

MR. BLAINE M. BARHAM: I noticed that Mr. Larimer had mentioned malpractice reform with respect to premiums and defensive medicine. I'd be interested in your views, Ms. King, as far as the people that you're working with on the Hill with respect to health-care reform.

MS. KING: I would say that majorities in both parties of Congress believe that some kind of malpractice reform is necessary. Democrats certainly don't believe that it's the only thing that needs to be done, or that it's even the biggest thing that needs to be done, but I think it's safe to say that the majority of members of Congress believe that something needs to be done. Now, when you start to talk about what, then we start getting some serious differences. You also run into some very influential Democrats who believe that it is wrong to do just malpractice reform, and that if you're going to do malpractice reform, you need to do liability reform. The short answer to your question is there is very widespread commitment to malpractice reform, but even that is not without its problems and controversies.