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TOWARD A *WORKING* HEALTH CARE SYSTEM

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Speaker: IAN M. ROLLAND

Mr. Rolland will discuss the nation's care system and the changes the industry must face to ensure its long-term financial strength.

MR. WALTER S. RUGLAND: Around the time we were planning this session, the Health Insurance Association of America (HIAA) announced the adoption of a policy statement by its board of directors. The board unanimously favored requiring certain basic health benefits for all Americans and establishing uniform rates that public and private insurers would pay for doctor and hospital services. It also called for a ceiling on tax breaks for employer-provided health insurance.

I invited Ian Rolland, as chairman of the board of the HIAA, to speak to us about the nation's health care system and the changes the insurance industry must face to ensure its long-term financial strength. Ian is a Past President of the Society. He has had a distinguished career as a leader in the actuarial profession and in the life and health insurance business. He serves on several civic boards and has been active in numerous professional and business associations. He received a masters degree in actuarial science from the University of Michigan. He also received honorary doctorate degrees from Manchester College in 1985 and Purdue University in 1987. Ian is currently the chairman of the board and chief executive officer of the Lincoln National Corporation. And all of this from someone who never left Fort Wayne, Indiana!

MR. IAN M. ROLLAND: We're in the midst of one of the great national debates of our time. How we pay for and deliver health care will affect every single American. The outcome of this great debate will be pivotal to our nation's economy. It has the capacity to raise or lower the expectations of our citizens for a full and productive life. And the outcome will carry a message about the private sector's future role in providing financial security to the people of our country. All parties involved in the debate – providers, third-party payers, politicians, employers, and the public – recognize the need for change, and this is a significant development. All parties say they are willing to seriously seek ways to make health care available to 37 million uninsured Americans and to control health care costs. I'd say the fact that there are 37 million Americans uninsured today really should bother all of us and clearly is an issue that must be addressed. This is not going to be an easy process, of course. What the nation is looking for is comprehensive, systematic change. What the country is trying to move toward is a working health care system.

This was the objective of the HIAA when it began developing its vision statement about a year ago. The HIAA sought to fashion a comprehensive plan, a plan that produced sustainable health care cost savings, a plan in which the competitive, pluralistic, flexible financing and delivery system could flourish, and a plan that offered universal cradle-to-grave portable coverage to address the problems of the uninsured. Neither piecemeal change nor the previously developed HIAA small-group insurance reform proposal alone could cover all Americans at an affordable cost. The HIAA had ample evidence for the need for comprehensive reform. For example, there's been a doubling of health care spending as a percentage of GNP over the past 25 years.

Three quarters of the uninsured are in the workplace or are in a family where one member is employed. There are believable predictions that, if unchecked, health care spending will amount to 20% of GNP by the turn of the century.

There is an urgency to address the issue. The timetable for change was clearly set by the voters in the 1992 election. Health care reform was a major issue in many successful congressional campaigns. President Clinton deserves a good deal of credit for outlining a proposal during his campaign and providing a focus for this complex issue. After all, health care reform has defied resolution during the previous six administrations. Some of the approaches have been global, like President Johnson's launching of Medicare. Some have been decentralized programs, aimed at regulating provider behavior, like the health systems agencies of the 1970s. In the past decade, federal policymakers have exerted more influence through peer-review group guidelines and the Medicare prospective payment system; neither behavior nor budgetary controls have slowed health care inflation. What is different now is the unrestrained consumption of expensive technologies, the growth in the uninsured population, and the level of public awareness. The American people not only want change, they say they are willing to make sacrifices to achieve it.

For example, a nationwide *Wall Street Journal* and NBC poll in March 1993 found that 66% were willing to pay higher taxes so that everyone could get health insurance, 52% were willing to accept limits on the right to change their own doctors, and 46% were willing to even accept higher insurance deductibles and copayments. Now this support for reform does not mean that the American people understand all the issues or even all the terminology; and it doesn't mean the public won't oppose some forms of a new proposal. A recent HIAA survey showed a high level of confusion about the terms used in the national debate and about the components of reform. The respondents were suspicious and worried about government control, and they also said they didn't like the sound of purchasing pools or community rating.

These positions are natural and ought to be expected. After all, this is a society where individuals enjoy the finest medical care in the world and participate little in its cost. We are accustomed to immediate and unquestioned access to medical care. And remember, our older citizens have seen a lifetime of medical miracles that have extended life expectancy. We have to recognize that people born before the advent of penicillin, and people born in a time when tuberculosis and influenza were dread diseases will not easily adopt reduced expectations for medical care today. And others who grew up during an age of technology may question any limits on its use. Still Americans remain convinced that the system is not working properly. A poll in June 1992 showed that although 70% of those surveyed here were satisfied with the quality of their own care, only 36% were satisfied with the quality of the nation's system of health care.

This then is the environment into which the HIAA brought its plan. It received a good deal of public attention for its call for universal cradle-to-grave coverage. Its essence requires compromise on the part of every player in the health care industry. For example, insurers have to cover all citizens, eliminating all preexisting-condition exclusions. Government, in general, must change its behavior. It cannot be allowed to continue paying providers less than the true cost of treatment for Medicare and Medicaid patients. The federal government must be an enabler of change. It has to

establish the rules of the marketplace and develop tax policies for employers providing benefits and employees receiving benefits. It must set in motion the process of defining an essential package of health care benefits, and it must cover all of the poor. Employers must offer and participate in the cost of an essential package of health care benefits. Ours is, in part, a workplace-based financing system, and it's been effective in covering the vast majority of working Americans and their dependents. Providers must change the way they practice medicine by becoming more cost effective through the use of managed care. Hospitals and physicians have a huge responsibility: they have to develop ways to deliver quality care while keeping costs down. And the public must accept greater financial responsibility for its own health care while also exercising better habits for good health. The public has to be an intelligent purchaser of health care.

There is a need for change on the part of all the players in the broadest terms. Finding a consensus on the concept of these changes may be much easier than working out the details. As one observer recently noted, it may be relatively easy to find the general strategies we can live with; the devil will be in the details. I want to get into some of these devilish details. And one of the most important is defining the essential package of benefits that will be covered.

As the HIAA envisions it, the essential package of benefits would include primary, preventative, and catastrophic coverage. This package would be formulated by a government-authorized independent body of providers, payers, employers, and consumers. The design of this package is paramount. It must be flexible enough to encourage cost-conscious behavior, but it must have inherent limits to prevent continuous expansion of health care needs. At some point, consumers must realize that our ever-growing need for health care eventually will outstrip society's resources to pay for it. Recently, there's been considerable talk about including mental health benefits in the essential package on the same basis as benefits for physical illness. A caution is required. Some level of mental-illness coverage is important, but the benefits must be designed carefully to prevent abuse and to ensure they cover only those in the need of care; otherwise the costs will be prohibitive. There hasn't been a great deal of research on total mental-health expenses and outcomes. The American Psychological Association, however, reported recently that $55 billion of the $74 billion the nation spends on mental health goes to in-patient treatment. And some studies of adolescent medical illness say that up to 50% could be treated as effectively in much less expensive outpatient settings. Perhaps the care could be delivered more appropriately in other settings. These are the kinds of questions that ought to be examined before mental health care is added to the basic benefit package.

Another idea advanced to the Clinton team is to include the medical component from workers' compensation in the basic benefits package. Now this is a laudable bill and could probably save some money, but there is a lack of uniformity of workers' compensation laws among the states. California, for instance, covers stress-related illness if it can be proved that 10% of a worker's disability is attributable to the job. There are many such distinctive definitions of occupational health among the various states. It's unclear how these differences can be incorporated in a national plan.

Another troublesome area in the debate will be the many proposals for cost containment. You've heard of one of these proposals, which would place caps on health

insurance premiums. The argument is that capping premiums is the easiest way to control many of the health care products and services. This proposal presumes price controls. So, instead of having to devise price regulations for thousands of products and services, capping premiums would ostensibly provide a blanket under which providers and patients would have to negotiate. That's the theory, but not so. Premium caps won't do anything to affect rising provider charges, increasing sophistication of services, or continuing medical progress. They will do nothing to address the underlying causes of the cost of health care. They can, however, jeopardize the financial health of insurers and drive some carriers from the business. In addition, premium caps would not cover the large segment of third-party payors; that is, self-insured employers. Depending on how self-funding is defined, an estimated 40-60% of all group coverage involves some measure of self-funding.

Now let me add one last point about premium caps. It would be detrimental to the future development of managed-care plans. Managed-care networks require a significant up-front investment for provider contracts, utilization staff, and data systems. Caps on health insurance premiums would deny insurers a reasonable return on investment. This would mean less investment capability for building newer managed-care networks.

Now managed care has its proponents and its critics; it's been an evolving concept. It began with utilization review, and moved to a discounted fee-for-service approach and various forms of HMOs. Managed care needs substantive data on protocols and outcomes to move into the next stage and organize care in efficient, user-friendly ways. Managed care is the one option that encourages cost effectiveness and quality care, and it has the potential to be the primary vehicle for achieving system-wide cost savings. It has even greater promise if it is allowed to develop to its next generation.

Now with government's enormous buying power and its ability to influence provider cost, there is great potential in the concept of requiring Medicaid and Medicare beneficiaries to participate in managed-care systems. Today government programs cover 42% of the nation's health care cost, but only 6% of the Medicare beneficiaries are HMO or PPO members. Insured arbitrary controls on health care premiums are not the answer; using expanded managed-care plans could very well be.

Now beyond cost containment lies the problem of expectations. I think President Ford earlier addressed the issue of expectations. That is the case, regardless of whatever reform plan is proposed. Some people are looking for immediate, dramatic impact from health care reform. Now, in reality, change will happen more gradually. But given the prominence of the public debate over health care reform, the expectation for significant change is still there.

Community rating is an example of this expectation, in part because people don't understand it. Today, in its simplest form, community rating means every insurance company must charge the same rate to all its small-business customers, regardless of economic area, age, gender, or health profile of their employees. The myth here is that community rating will make coverage more affordable and reduce the number of uninsured persons. The reality is, if you don't require everybody to participate in the insurance system at all times, community rating will decrease the number of insureds

as coverage becomes less affordable for most currently insured employers and employees. All of you actuaries know this fact.

This fact was supported during the "Conversations on Health Care" program in which I participated last month in Washington. A small business owner recounted his experiences in dealing with the newly enacted New York State law mandating a community rating system. Rather than an environment where its coverage was more affordable, he faced a significant increase in his premium under the new system. This illustrates one of the pitfalls in the current debate. There is insufficient public understanding of the terminology. Community rating sounds good, and it can be, but only if everybody has to play.

Purchasing pools is another proposal that sounds attractive, but it, too, has its dark side. Purchasing pools can be set up in a variety of ways to benefit small employers. But some reform advocates are pressing for health insurance purchasing cooperatives (HIPCs), which would have exclusive jurisdiction in a defined geographic area. All employers with fewer than a specified number of workers, as many as 1,000, would be required to arrange health benefits only through an HIPC. Mandatory HIPCs are not the answer. We at the HIAA believe in a pluralistic and competitive marketplace. One alternative is voluntary HIPCs, and there should be a level playing field. If HIPCs are a better approach, they will naturally gain market share. The market, not the government, should determine the most efficient way to insure all Americans.

Guaranteed availability of coverage and portability of coverage for small businesses and their employees can be achieved and are being achieved in many states today through voluntary market reforms. These reforms assure fair pooling of risk by limiting premium variation and establishing a reinsurance pool to spread the cost of high-risk cases over the entire small-employer market. Why go to an untested mandatory system when there are already answers in place? Now one element constant throughout the health care reform to date is the need for information. What works? What doesn't? It's essential to our HIAA proposal.

Recently a news magazine used a quote from USC medical professor William Schwartz to summarize its view. Professor Schwartz said the medical care crisis of today is a crisis of medical success. That's true in one sense, but maybe not in another. We're learning what technologies work, but we're not sure which are cost effective. To reform the health care system properly, we need better tools, tools to develop standards for the use of medical technology. We need to eliminate duplication of high-cost technologies in our communities. We need standards of medical practice based on the assessment of treatment outcome. In short, we need to know how health care dollars can be spent more effectively.

This then is an overview of the HIAA plan. Its guiding principles call for (1) universal coverage, with all employers and individuals paying for an essential package of benefits that provides primary, preventative, and catastrophic care; (2) cradle-to-grave coverage, with insurers and other private payors guaranteeing the issue and the renewability of coverage for all; (3) government subsidies for those employers and individuals who cannot afford to purchase the essential package of benefits; (4) a change in government policy so that it pays for the full cost of health care for Medicare and Medicaid recipients; (5) cost containment through the use of managed

care as the primary vehicle for system-wide savings; (6) reform of our pluralistic delivery and financing systems so that all players, public and private, compete under the same rules; (7) tax preferences that are limited to the essential package of care so the public is motivated to find the best value in health care; (8) a government that sets the rules, legislates malpractice reforms, and sanctions self-regulatory bodies that define the essential package of benefits and evaluate technologies.

Some industry observers have maintained that the HIAA plan goes too far; others say not far enough. One thing is clear: it does not lack for boldness or breadth. There is greater industry consensus on a reform proposal. The HIAA has discussed its proposal with the representatives of the Clinton health care task force numerous times, and we have found reasonable, thoughtful people who are willing to listen to our ideas. Clearly the administration has a monumental task ahead of it.

The debate and ultimate enactment of reform will likely extend into next year. President Ford earlier said that because health care is so complex, a universal coverage will cost so much money. How much is health care reform likely to cost? Estimates range from $30-90 billion a year. The task force reportedly told the President that it would cost $280 billion over five years, but this all depends on what is in the essential package and whether universal coverage is phased in over a period of time. Now to finance this reform, a large, broad-based tax could be necessary. There are some savings that can be realized out of the current system; some waste dollars can be squeezed out. A so-called sin tax on alcoholic beverages and tobacco products can raise some money. A taxation of benefits beyond the essential benefit package would also produce revenues. But it is still going to come down to the taxpayer, who, as I said earlier, is willing to pay more if the reforms are understandable and equitable, and if sacrifices are universally shared.

In closing, let me emphasize there is a mammoth educational program in front of us. The insurance industry has to build support for what it knows is right for the American system. We know everyone must have access to at least the basic level of health care. We know all sectors – private, public, individuals – must compromise and take on a new role. We know that quick fixes, while politically expedient, must be avoided in favor of lasting, economically responsible change. And we know the federal government must be the facilitator, the agent of change that creates the environment in which reform can succeed. The key for us as an industry is to be a respected participant in the national debate. Only by being an active player in the discussion can the health insurance industry help shape policy that includes meaningful and sustained health care cost savings, finance reform and universal coverage. Only by being an active player in the discussion can the health insurance industry help forge a consensus that leads to a competitive and pluralistic system to solve our problems. We must avoid an inefficient monolithic system at any price. And only by being an active partner in the discussion can we use our actuarial skills to help identify the cost and the financing applications of the various reform proposals that are being presented.

I said at the outset that the outcome of this national debate will carry a message about the private sector's future role in providing financial security to the people of our country. Now that's not an exaggeration. Health care is an important element in guaranteeing the financial security of the people of our country. We find ourselves in

a situation where costs are out of control. Millions of Americans are without coverage, and millions more are fearful that they might lose their jobs and, therefore, their insurance coverage, as well. This is a recipe for dramatic and possibly disastrous change.

There is also a message here for other forms of financial security beyond health insurance. Whether those products provide retirement security or automobile liability coverage, if these forms of security are important to people, and they can't get access to them or they can't afford them, the pressure will build for a dramatic change. We have to examine how our industry is operating in these areas, or a private-sector involvement may really be in peril. As to health care, I think we're in for a marathon run on this issue. It's going to take a long time for the reforms to be developed, put in place, tested, and refined. I don't think we can really envision what the American health system will look like in the year 2000, although I'm confident the HIAA plan is the closest plan to it so far.

Neil Armstrong once said that science predicts too much for the next year but, so far, too little for the next ten years. The former astronaut's observation is probably right in this context, too. There are many challenging days ahead as we move toward a system of health and wellness and away from a system of sickness and costly repair.

FROM THE FLOOR: If Clinton's regime is threatening to curb lobbyists, do you see that as a threat to the effectiveness of the HIAA, or do you see a way that we can work around it? Or do you see the HIAA as perhaps contributing more to the technical aspects than to the political expediency?

MR. ROLLAND: Well, I'm not sure that the Clinton administration is looking to curb lobbyists. I really don't believe that in a Democratic society, they're going to be able to curb the expression of legitimate opinion on important public issues. So I can't imagine an environment in which the industry, individual companies, and the HIAA won't have an opportunity to express their views to the administration and to the members of Congress as this thing is debated. Even though that hasn't been the case so far, ultimately the experts in delivery of health care are going to have to have their say. It will be regrettable if the Congress, in dealing with this, doesn't listen to the industry, which has much expertise. So I see our role as going well beyond just providing expertise, which I think we can do. I think that's clearly a role that the actuarial profession can do in providing technical expertise to whoever is dealing with this issue, and I'm gratified to see the American Academy of Actuaries already involved in that process. But I think we have to go beyond that and advocate as well for what we think is right and what we think ought to be in the system.

I am very fearful that the administration will come down on the side of a monolithic, regulated system. I think it probably will come down on the side of exclusive HIPCs, things of that sort, or maybe even price controls on insurance premiums. And I think in that environment, we've just got to advocate very strongly our position that these kinds of things won't work.

FROM THE FLOOR: I appreciate your confidence that we will be heard.

MR. ROLLAND: As I said in my talk, the health care task force has listened to us. Bill Gradison is the new president of the HIAA, and I'd say we're very fortunate to have him on our side. He was the ranking Republican on the health subcommittee of the House Ways and Means Committee. He understands the issues, he knows the important players in this field, and he has been in touch with the task force. And whether we'll influence and get what we want in their final recommendations, I don't know, but at least they've been listening to us so far.

FROM THE FLOOR: If one of the roles of insurance is to encourage risk-free behavior, how do you think that fits in with HIAA proposals.

MR. ROLLAND: If I understand your question, I assume you're talking about promoting the idea of healthy lifestyles among the public. That is in the HIAA proposal. Our belief is that one of the responsibilities of the general public, and it applies to every one of us, is to engage in healthier lifestyles. And it's certainly my view that one of the greatest devices for cost containment is to not get sick in the first place. And so, if we can quit smoking, and if we can quit doing things in excess and try and get some exercise, and all of us ought to be doing this, we'll play a role in making this happen. As I say, not only do we have to purchase health care more sensibly and responsibly when we need it, but we also must pay attention to our health so we don't have to show up at doctors' offices and hospitals very often.

FROM THE FLOOR: You indicated our opposition to caps on premiums. Would you support caps on retention, that portion of the premium used for expenses, profit, and contingencies?

MR. ROLLAND: The view at the HIAA right now is that that would be inappropriate as well, and that the comparative marketplace deals with those things. I think those of you who are actuaries in the health insurance business know that the driving force behind costs is not excessive insurance company profits. And so I really think, and I believe the HIAA supports this, that the competitive marketplace will sort out those companies and drive profits to reasonable levels. But we have to get decent returns on our money in this business, or people simply aren't going to put it there. We have other options for capital. And, if you can't earn it in health insurance, you can get it somewhere else, hopefully. So I think we would not favor that.

FROM THE FLOOR: I am somewhat puzzled by the cost estimates. We are trying to control overall health care costs and I wonder what the source is for the $30-90 billion a year in health care reform costs. Are providers, doctors and hospitals supposed to get 10% more money per year or are there going to be 10% more doctors and hospitals? It takes time to become a doctor or to build a hospital.

MR. ROLLAND: The issue is less cost. As I say, the range of potential cost is pretty wide. The number I've seen banging around most from the press recently is closer to $90 billion than it is to $30 billion. But one of the issues is that you have 37 million people right now who do not have health insurance coverage. About two thirds of those work for small employers or have somebody in their family who does, and about one third ought to be covered by government plans. So getting those 37 million people covered is going to have a cost to it. Another cost that will apply to government relates to the cost-shift issue. If you move government into an

environment where it is paying the full costs to Medicare and Medicaid beneficiaries, it is going to have to face up to its full share of the cost, and that's going to be an additional burden on taxpayers. Uncompensated care would be picked up under this system. So I really believe there are substantial costs. I don't know what the number is, and HIAA doesn't have a position yet on exactly what the number is, but my judgment is, particularly when government starts estimating, if it says something is $30-90 billion, you can count on it being closer to $90 bilion, or even more than that.

Some claim that we can get rid of all those costs by simply wringing waste out of the system. I don't believe that's the case. I think some waste can be eliminated with a paperless claim system and a reduction of administrative costs in the insurance industry. I think we're looking at a broad-based tax to raise substantial monies to pay for this system and to get people covered.

FROM THE FLOOR: Who gets the $90 billion?

MR. ROLLAND: The $90 billion, I think, goes into the system. Most of it will end up in the hands of providers that deliver care to those people who were not previously covered.

FROM THE FLOOR: One of the objectives you identified was universal cradle-to-grave portable coverage, and yet the HIAA proposal really supports the idea of continuing the employment-based delivery. Isn't that sort of inconsistent, because maybe other than Lincoln National, many employers don't provide cradle-to-grave employment?

MR. ROLLAND: This is how the HIAA plans to deal with that, and we wrestled a long time over this one. The first HIAA proposal to come out contained a mandate directed at individuals. The idea was that every single American citizen would be required to have this essential package of benefits. It would be an individual mandate after Congress passed the law to require every individual to get this coverage. Now the assumption was that those who could not afford to provide coverage on their own would get subsidies from government. And the assumption was that government would step up and provide full coverage for the very poor.

The more we talked to people in the administration and others about the individual mandate, the more we decided it wasn't totally workable, and what we had to do also was move to an employer mandate. The HIAA position is that individuals are required to obtain this coverage, and all employers will be required to offer this package to their employees and pay a portion of the cost. So for anybody who works, his or her employer will be required to offer the package and pick up part of the cost. Self-employed people will be required, of course, to do it with their own resources. Individuals will have the same responsibility, and government will have to put in place a system to subsidize costs for those who can't afford it. That gets everybody covered.

FROM THE FLOOR: It seems to me that the administration's health care proposal seeks to find a vehicle to get more competition in health care, particularly for small groups and individuals who don't really have an ability to impose buying power or a

way to get insurers and providers to be more responsive. HIPCs are ways, I guess, to provide a vehicle for small employers to get the leverage that large employers have today. Is there a part of the HIAA proposal that seeks to meet that perceived need or what I perceive to be a need?

MR. ROLLAND: The HIAA proposal recognizes the fact that pooling mechanisms may make sense. The HIPC is not inconsistent with the HIAA proposal; in fact, we view it as part of a pluralistic system, but what we object to is making the HIPC mandatory; forcing all employers, say under a thousand lives, into the HIPC. We would envision that the HIPCs could develop, and build networks. If they're effective, they can compete with other forms of delivery and they'll be successful; if they can't, they won't be. So we envision a pluralistic, competitive system under which various forms of pooling mechanisms and delivery systems can spring up. So to the extent that, if a small employer wants to combine with other small employers in a purchasing group of some sort, that's totally consistent with our view, but we don't believe that ought to be the only way that an employer has to buy health insurance.