RECORD OF SOCIETY OF ACTUARIES
1993 VOL. 19 NO. 4A

FEDERAL HEALTH CARE REFORM

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Recorder: HOWARD J. BOLNICK

- What role have actuaries and actuarial organizations played in the development of President Clinton's health care reform proposal?
- How will the federal debate evolve following release of President Clinton's proposal?
- What role will actuaries and actuarial organizations play in the debate?
- Discussion of cost estimates for President Clinton's health care reform proposal
- Discussion of actuarial issues contained in the President's proposal

MR. HOWARD J. BOLNICK: Alissa Fox is the executive director of congressional relations for the Blue Cross/Blue Shield Association in Washington. Erling Hansen is the general counsel with the Group Health Association of America. Linda Jenckes is from the Health Insurance Association of America (HIAA). Ms. Jenckes is senior vice president, chief lobbyist and the chief spokesperson for the HIAA. Before that, she was involved as VP of federal affairs for the HIAA. Both Ms. Jenckes and Ms. Fox have worked at the Department of Health and Human Services (HHS).

MS. ALISSA T. FOX: As most of you know, the Blue Cross/Blue Shield Association is the coordinating organization for the 69 independent Blue Cross and Blue Shield plans across the country. Most people think of Blue Cross/Blue Shield as fee-for-service, indemnity-type coverage; as you all probably know, that's really not true. About one-third of our enrollment is in managed-care networks, HMOs, preferred provider organizations (PPOs), and point-of-service products. We have the largest HMO network in the country, with enrollment that is exceeded only by Kaiser, and we're growing in that direction by leaps and bounds.

For several years, the Blue Cross and Blue Shield system has been advocating comprehensive major reform in health care, and our plan had three major pieces, all three of which are embodied in President Clinton's plan. First, insurance reform starts at home. We propose strict federal standards to be enacted at the federal level, which would stop cherry-picking. If insurers want to be in business, they have to open their doors, take all comers, give community rating in the small end of the

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market, and provide a lot of consumer protection. Insurance reform is step one of cost containment. Insurers can no longer compete by picking the best risks; they have to compete by managing costs.

Second is cost containment. We're very pleased that President Clinton's plan relies on managed-care networks as the way to control costs. Our experience and our customers' experiences have shown us that the best and most effective way of getting unnecessary procedures out of the system is through the right incentives. Managed-care networks, as opposed to fee schedules, do that. We have a lot of experience with fee schedules. Fee schedules simply tell providers that the more they do, the more they make. Those are the wrong incentives, and we're pleased that President Clinton is talking about managed-care networks as the right incentives.

Third, it is critical that if there is going to be reform, every American must have coverage in a basic benefit package. The employer mandate is a good way of balancing the responsibilities to make sure that everybody pays a fair share.

We have two major concerns with President Clinton's plan. First, the health alliances are totally unnecessary. We think all the President's objectives can be accomplished without adding this new bureaucracy. Second, we're opposed to premium caps. President Clinton's alliance theory is basically the big bang theory. Reform doesn't start until every state sets up new bureaucracies to oversee and monitor the new system.

Essentially, there will be no insurance reform, except some very limited stop-gap provisions, no cost containment, and no universal coverage until these new bureaucracies are established across the country.

By January 1, 1997, states are supposed to have these alliances up and running, and they're going to have a lot of responsibility. We don't think that many people in Washington have thought through all the new kinds of responsibilities these alliances will have. They're going to have to collect billions of dollars in premiums. If you compare what these alliances are going to be responsible for with what state governments (the governor of every state and their legislatures) do, the alliance budget in many states will outweigh and exceed the state government budgets. Alliances are going to collect premiums, risk-adjust the premiums, and then pay health plans. They're going to have to administer all the subsidies for small employers and low-income individuals, and they're going to be responsible for negotiating premiums. Essentially what we're talking about is having a shadow IRS tax-collection system and a shadow eligibility system, and we don't think that makes sense.

President Clinton's plan is to tell all employers to drop their existing insurance arrangements and sign up with the new health alliance. All individuals will choose from competing plans. Normally, actuaries figure out their next-year premiums based upon incremental types of proposals. Starting January 1, 1997, no longer will employers be picking, but individuals will be choosing their own coverage. Then people who are in self-funded arrangements must be brought into insured arrangements, and they will be charged extra because insurers will need some reserve requirements. We'll have new benefit packages, and we're going to open the doors; there will be no medical underwriting or community rating. There's going to be risk adjustment, and you're all

going to have to set your premiums before knowing who is going to select you. That's going to be a very difficult task. If you're wrong, in terms of guessing who is going to pick you, and your premium is too low or too high, next year you will be locked into a premium cap. We're very concerned that this could be a very unstable happening, everything happening all at once.

We think there is a better way of proceeding on health care reform. Let's look at what these health alliances are supposed to do. First, health alliances came about because people thought that small employers and individuals needed to pool their purchasing power. But, if you look at President Clinton's plan, the pooling doesn't happen at the alliance level. It happens at the carrier level. We don't think you need an alliance to achieve those results. When you tell insurers to community-rate, this is where the pooling mechanism occurs.

Another key objective of these health alliances is to reduce administrative costs. But, when you look at all the new additional requirements that these alliances are going to be responsible for, and you realize that employers are still going to have responsibility and health plans are still going to have responsibility, what you have is a whole new administrative layer. We don't think the alliances will achieve the goal of lower administrative costs.

What we're proposing is not to depend on these health alliances before you start getting to universal coverage and cost containment. We think you can get there right away and not have to wait for these new entities to be developed all along the states. You could have insurance reform, cost containment through managed-care networks, and price consciousness behavior all by simplifying the benefit packages, doing insurance reform, and providing the tax cap. If you have all these pieces together, you get the cost containment and the competitive forces that you need to contain costs. Through an employer mandate, we think you get universal coverage.

MR. ERLING HANSEN: I was reviewing position papers and articles and other things that were written about health care reform, looking for that catalyst that would bring all my thoughts about the President's health care reform into focus. I don't have time to share with you every concern that my association has with the President's plan. Let me just say parenthetically that the Group Health Association of America (GHAA) is the leading national trade association of health maintenance organizations. We have 347 member companies. We're providing health care to about 32 million Americans, 75% of the 42 million Americans who get their health care through HMOs.

There are numerous instances where our member companies and all of you have said that you couldn't believe some of the things in the President's plan. There was an article in *The New York Times* today about many problems facing HMOs, including the federal regulation of premiums and 50 different sets of state rules. How do we accommodate 37 million additional people in the health care system? Will the payment be adequate? Will the subsidies be sufficient for the cost of Medicaid recipients, the homeless, drug addicts, people with chronic diseases? All these things are concerns of the HMO industry as well as the commercial carriers.

Let me focus on one example of what's wrong with the President's numbers and therefore, the credibility of his plan. The plan projects holding health care premium increases to the consumer price index (CPI) plus population growth after 1998. Regional alliance inflation factors during a phase-in period are as follows: CPI plus 1.5% in 1996, CPI plus 1% in 1997, CPI plus 0.5% in 1998, and CPI thereafter. My math says that we get 7.4% next year; it decreases to 3.5% in 1999.

The most current GHAA data show that medium profit margins in the HMO industry are 3.4%. Assuming that this is correct, is it realistic to limit premium increases as the President's plan suggests, without allowing for capital needs, to accommodate the anticipated increase in enrollment and the cost of at least ten additional programs whose expense the health plans must absorb? My good friend, George Strom, put together a list of current costs that will be added to health plans. These costs include 2.5% of premium to underwrite alliance operating costs; 2% of premium for an insolvency guaranty fund; and an additional 2% may be reserved by health plans participating in corporate alliances. Health plans have to reimburse designated specialty providers and centers of excellence in an unspecified amount. There are instances in which there is nonpayment of premium to an alliance, and the health plans participating in alliances have to make up the shortfall; once again, an unspecified amount. Health plans have to reimburse essential community providers at 100% of cost, based on Medicare payment principles.

During the transition to the national program, the Secretary of HHS may organize a national risk pool funded by premiums and assessments against all insurers, another unspecified expense. As part of the quality-management program, a per-capita levy on insurance premiums will be made, an amount established by the National Health Board, another unspecified expense. States may require some plans to cover the entire alliance area or suballiance area, when at present they have a smaller service area, and there will be an expense of expanding to the statewide or to a larger service area. Alliance data requirements will include 100% in counterreporting, an electronic submission of claims, causing all health plans and HMOs to incur substantial costs of revising their data systems, which for most HMOs are not based on individual encounters. Finally, funds for residency training are to be pooled from all insurers through a surcharge on health plan premiums.

Where is the allowance for all of this in the 3.4% that we're making in CPI? This plan appears to be penalizing already efficient HMOs, whose administrative costs are generally under 8% and whose margins are used to subsidize premiums and to improve services to members through capital improvements. U.S. Health Care, probably the lowest cost health plan in New York, recently requested a 6.5% rate increase. You may have read recently that its request was denied. Not only was it denied, it was told it had to decrease its premium on the order of 3-4%. This is New York State's reward to an efficient carrier. Do you think that this is going to get better when New York State sets up a series of state-controlled alliances or, as it may under the President's plan, its own single-payer program?

The challenge facing the actuarial profession is to challenge the President's numbers and the President's assumptions and get some reality on the table. When the American people have the real numbers, the real costs of health care reform in front

of them, when they see a fairly shocking number, then the President can answer as he should, because I think we all do want reform.

MS. LINDA JENCKES: I worked at Blue Cross/Blue Shield for ten years. I moved to the HIAA in 1978. We represent 250 private insurance companies. Collectively we cover approximately 80 million people. Together with the Blues, with all of Mr. Hansen's HMOs, and with the self-insured market, we have brought coverage to 180 million Americans, and we've done that on a voluntary basis. The issue is not what to do about the 87% who have coverage, because when you add to our 180 million figure those enrolled under Medicare, Medicaid, the VA, and the military, 87% of the public has coverage. The issue is how to bring it to the 13% who don't have it and at the most affordable price. We must do this within public expectations and also within the financial capability of employers and individuals in this country.

One of the things that we have suggested the Clinton administration needs to do is avoid the mistakes of the Medicare catastrophic law. The public did not buy the Medicare catastrophic law. One statistic is that approximately 40% of Medicare beneficiaries who were supposed to benefit from the passage of the Medicare catastrophic law were in fact getting those very same benefits for free or paid for, generally to the tune of 80%, as part of their preretirement packages. Their employers have said that when they retire, they would carve out Medicare but continue to give you the same benefits that they had when they were employed. Those 40% were exactly the Medicare beneficiaries who were taxed to help pay for the Medicare catastrophic law, for something again that they were basically getting for free.

We have said to Mr. Magaziner, and to not quite all 500 members of the task force who were working on the subject, that the very same thing could happen with health care reform. Don't do the issue a disservice; bring the public on board. We also reminded them of the complexities of Section 89. Again, it was well intended, but we found, and I'm sure Mr. Hansen and Ms. Fox did too, that employers started dropping health coverage because it was so cumbersome to comply with the law. They said that it wasn't even worth it to offer the product. So, again, seller beware is the message that we're giving to the White House.

Right after the election of Senator Lawford in Pennsylvania, we felt it was vitally important to see how high on the radar screen the whole health care reform issue was going. The reason we singled out Senator Lawford is because he's the one we personally feel was responsible with highlighting the issue. He came out with his campaign quote that if every criminal is entitled to an attorney, all Americans should be entitled to health care. He didn't say single payer, he didn't say nationalized health insurance system. In fact, he had no proposal.

We hired a Democratic firm and a Republican firm to survey the public and what they've told us is as follows: The three issues for the American public are the economy, jobs, and health care. Eighty-six percent of the American public wants reform, but they want a private-sector option. There is still a tremendous distrust of the federal government's capability of managing almost any program. The other thing that the public told us is that everyone hates Congress, but they love their congressional member. They hate the medical community, but they like their doctor. They hate their insurance companies, but they like their agent.

This is our poll and the reason that I'm going to be very careful here is because I do think the media is giving us a tremendous service collectively as an industry and as a nation in the way it is now beginning to report the details of the proposal. Our statistics of nine months ago indicated that 83% of the public was happy with the care that they get, 75% were satisfied with the quality, and 69% were satisfied with their insurance. CNN and *USA Today* released a poll in the early summer and the numbers have gone up. Ninety percent of the public is satisfied with the system, 77% with their insurance, and they added another question, 58% were actually satisfied with the cost. They didn't feel the system was that costly. Again, these are not our polls. As the details have moved forward again, the media have been very careful to try and make it simple.

The one question we ask is, how much are you willing to pay for extended coverage for the 13% who don't have it? Over 90% of the American public is not willing to spend more than $200 per person per year. Conservative estimates indicate that a basic set of benefits could be $1,500 per person per year. I think that's where the issue will focus. How are you going to pay for it? Then there is the choice issue.

On the whole subject of alliances, we decided we'd better find out what the public thinks. Ninety-three percent of the American public favors a system where they can choose their own doctors and hospitals and not have the federal government or even a state government tell them or preselect for them where they have to go. We also asked them, what if the federal government or the health alliance or the purchasing cooperative preselected your insurer? Eighty-one percent still preferred to pick their own insurer. Seventy-five percent of the American public supports an individual mandate. That surprised me, because every other poll that I've seen indicated that they felt that their employers should be required to offer the coverage, but the numbers go down there. Sixty-six percent also oppose any form of a global budget, because they believe it's going to mean a cutback in services or standing in line.

After studying the issue for years, and Mr. Bolnick was on some of our key committees with this issue, we've developed a two-pronged approach to health care reform. As I move forward, I'll talk about where President Clinton's plan fits into this and where his plan doesn't fit into it. The reason I say *two-pronged* is because I believe that after 24 years in the industry, health care reform is already under way. One of the key features of President Clinton's proposal that we support is what Ms. Fox talked about, and that is insurance reform. It was difficult. There were people plotting our deaths when we suggested that we have to change some of the industry practices as they relate to small businesses. We did craft a piece of legislation about three-and-a-half years ago, so that all small businesses in the United States could get coverage, keep it and take it with them, guaranteed issue, guaranteed renewability. We even said we would do it within premium pricing limits. We also said that we were going to eventually eliminate preexisting conditions and we are for universal coverage, but you have to have a phase-in until you get there, and that's why these insurance reforms for small businesses are key in the equation of health care reform. Twenty-nine states have passed these reforms in their entirety to date. Forty have actually passed some form of premium pricing limits. Health care reform is under way. We don't have to wait for Washington.

As Ms. Fox indicated, the whole purpose of these alliances was centered around purchasing cooperatives, with the humble belief that this would help small employers pool their risks. I'm here to tell you that all employer groups of 5,000 or less are considered big-group cases, not small businesses. In this new structure, any group of 5,000 or less must get insurance through the alliance, which will preselect your insurer. Again, it is the employees of these groups who get to select from the preappointed list who they're going to have their insurance coverage with. The employer's role will be picking up 80% of the tab.

Let me address this in terms of health care reform right now. Our companies are already consolidating. We have companies that are renting services from one another. New York Life charges all of its small groups in Los Angeles the same rate. It has already pooled its small businesses. It is under way; it is happening. You do not need a new government structure to deliver on consolidation or pooling on behalf of any size group.

We feel that consolidation is taking place, and states are beginning to market-test it. Unfortunately, we only have proof positive from one, California. Commissioner John Garamendi's plan in California was supposed to be the perfect model of President Clinton's proposal. The legislature and the citizens of California said they didn't want this to be exclusive; they wanted people to have the opportunity to purchase coverage outside of the alliance. The law went into effect in July 1993. They did in fact select 18 carriers, most of which were HMOs or PPOs. I believe there is only one fee-for-service option, but there might be two. Of the groups that have enrolled to date, 25% were previously uninsured. This is voluntary; this is not mandatory on the part of employers. Of the business that has been sold, 72% has been sold by agents and brokers, the very people the Clinton administration wants to eliminate. Every time I talk to an agent group, I say they can now go to work for the government alliance, because now they're going to have to hire people who are going to have to preselect and figure out which insurers are best. But the point is, it's working in California on a voluntary basis.

We're going to continue to watch the other states as well, Florida, Maryland, Minnesota, and Texas, that will begin implementing it this coming year. I caution all of you to look at California very closely, and that's our point that we deliver to the Clinton administration on a regular basis. Let's see if it works.

This is what we support in President Clinton's proposal. We take issue only with three points. We are for portability, the eventual elimination of preexisting conditions. We are for subsidies for small business. You can't get to universal coverage unless there is a requirement. We feel it should be on the individual as well as the employer. The employer is still the conduit or the heartbeat, having provided coverage to so many Americans today. It ought to continue, but we will only support it if in fact there are subsidies for either the workers or the employers.

Of the people who work in firms that are currently uninsured, 90% make less than $20,000. These people must be subsidized. If you're a family of four and you're making $20,000 or less, no matter how dear health care is to your heart, you can't afford it. Some of the small businesses must be subsidized as well. Many of them are financially marginal small groups. They simply can't afford it. Of the firms that

are not providing insurance, there is a 40% turnover rate of employees in any given year. So in many cases, the incentives, even if they have the dollars, are not there because they don't have a stable workforce.

We're all for the administrative reforms. We believe we have to start in the house of insurance, and that's by cutting our administrative expenses. I first met Ross Perot in 1969. He developed the computer program for processing Medicare, and he had a vision at that time that we would go to total automation. The state of the art was not there until 1993. Mr. Hansen's HMOs have computers, the Blues have computers, Mr. Bolnick has a computer, and hospitals have computers, but none of these computers could talk to each other. They were not computer language compatible. Now we are concentrating on a work group for electronic data interchange. The Blues, the American Medical Association (AMA), and the American Hospital Association are on it. We've developed a uniform claim form, we've gotten through the common procedure codes, and we hope to begin pilot-testing it soon. Our industry computers say that the entire system can be online in maybe two to three years, with preliminary cost estimates of $8-10 billion. This is in the President's proposal, and we applaud him for it.

The concept of alliances has been well covered. We feel it should be pilot-tested. We don't believe that people want their choices eliminated. That is uppermost on people's minds. If they want fee for service, if they want to select their own doctors, they should be able to. We are all for managed competition, but an HMO or network may not be for everybody. We suggest that everybody sit down, determine what their own personal or family needs are, and make the decision based on that and not have the federal government doing it.

I think price controls were covered. We don't like premium caps either. In addition to all of the problems with premium caps, one that was not mentioned, which should strike fear in everybody, is solvency of our companies because of the unpredictability. Second, the Clinton administration is betting the house on managed competition and more networks. It costs money to establish a network. Our companies, the Blues, and everybody else has invested millions of dollars. If there are these arbitrary limits on premiums, something has got to give, beyond just technology. It's got to be a cutback in services, and it's going to be fewer investments in the areas of network.

Last is the subject of community rating. We are for modified community rating. We do believe you have to look at the age, the sex, the location, and the occupation of the group, and not exclude anyone from coverage. We're for guaranteed issue, but put a fair price on it. We're sitting in the perfect city that gives us the best illustration of how not to do community rating. The State of New York passed it, and it went into effect. According to an insurance department bulletin, not ours, if you are a single male in New York, 30 years old, your premium will go up 130%. We don't think that's fair. We think there's a better way to do it.

In conclusion, let me just give an observation about Washington. This is not a partisan issue. It's not Democrat versus Republican. It's not big business versus small business. It's not doctor versus patients, and it isn't insurance industry against anybody. I hope that next year at this time we will have some elements of health care reform officially passed. We cannot achieve health care reform without the

federal government. If we want universal coverage, the federal government or some entity named by the federal government must establish the essential set of benefits; otherwise, there will be 50 varieties out there, and we'll never have portability of coverage. There is a legitimate role for the federal government.

MR. BOLNICK: The three panelists are each in contact very closely with the administration. They can bring messages to the Hill. I would encourage anyone who has something to say to say it. As much as I'd like these people to answer questions that you may have, I'd like you to tell us what you've seen that may not have been seen by the people in Washington. You can add to the comments that are coming from the industry and, in a responsible and constructive way, shape what's going on in Washington. I'm involved with the American Academy of Actuaries, and I've been getting phone calls from our colleagues saying, what are you doing, when are actuaries going to speak up, what are we going to say? I can assure you that the Academy, in conjunction with the Society of Actuaries, is doing a lot and is planning a lot. Here's an opportunity for you to add to what's being said to the people who are going to vote on this health care reform bill.

FROM THE FLOOR: Mrs. Clinton spends a lot of her time talking about universal coverage. I do believe that the administration is fully aware that the most critical issue in health care is the rate of increase in costs. It's not universal coverage, that's easy to solve: make it mandatory. It's not the level of costs, because we can afford it now. But it's the rate of increase in costs, and I'd like to hear what your organizations would propose to limit the rate of increase in costs. Mr. Bolnick, in response to your request, it's my belief that one of the critical elements to controlling the rate of increase in costs is the old claims measurement and provider guidelines.

MS. JENCKES: There's no silver magic bullet. It's a combination of things that we as an industry have to do. We have to work in partnership with other elements of the industry. Let me start with medical appropriateness guidelines and outcomes research. The Rand study said that perhaps 20-25% of medical procedures that are done in this country may be unnecessary and, in fact, may be harmful. Finally, the AMA is taking the lead on this. This is something that we've suggested, and I know Ms. Fox will want to comment on this as well, but we can't play doctor. We might hire legions of doctors to help us look at some of the claims, but we are not the full arbitrators of that. So the AMA is working with its medical specialties to look at some of these new technologies as well as existing technologies. They may not be for everyone, and that's the beauty of managed care or more network-type arrangements.

Insurance was started to guard against a financial catastrophe if you had a serious illness. Our benefits were not tailored to provide for primary services. Networks are moving the benefit structure in that direction so you have a system, or will have a system, that's oriented to wellness in the future, and not sickness, which will start to stabilize prices in the long run. There are also some financial incentives to get more physicians to practice primary medicine. Many of our managed-care arrangements insist that you, as an individual or on behalf of your family, select a primary-care practitioner as your primary physician. That individual will determine if you go to a specialist.

These are just a few steps that will help to stabilize prices, but I give one other cautionary note. Until we can do something about the overall government cost shift, meaning Medicare and Medicaid not paying their full rate, and the cost shift was $22 or $23 billion, that gets arbitrarily passed on to every single person. Until we get the government to pay its share, we will never have complete stabilization of prices.

MS. FOX: We haven't had price competition in health care plans, especially in the small end of the market where the competition has been selection. If you standardize the benefit packages and make price competition nearly work, you say two things. First, you say if you equalize the tax treatment, you tell insurers they're going to have to compete based upon that price. Second, you tell consumers to be more price conscious and make them more sensitive to the price differences. We think that if you have meaningful report-card-type information, you will have real price competition. We think that will control costs, and I will say that we are seeing evidence of this price competition starting to work in the big businesses. An article today in *The Wall Street Journal* talked about medical inflation being down, and I know that some of the big businesses are getting rate increases of 3-4% this year. Some are even finding decreases. We think there's evidence of this competition working already. We just need to make it work better.

MR. HANSEN: Many of the things that would drive down health care expenses have nothing to do with health plans, or health insurance, or our system. A lot of this expense comes from the violence in our society, the fact that people don't wear seat belts, they don't wear helmets when they are on motorcycles, and they don't eat proper diets. A lot of expense that is probably unquantifiable could be eliminated to societal adjustments rather than making nips and tucks in the health care system. But a renewed focus on health care outcome through report cards, managed care, the use of networks, and making providers more efficient will be a step in the right direction.

MS. JENCKES: I have one more comment to make. I strongly recommend that everybody get *The Wall Street Journal* today. There are several excellent articles, but one is the health care inflation fantasy, and the whole point of this piece is that we're forgetting the aging of the population and we're also forgetting that so many new technologies are right on the brink of being discovered. We have to be aware that we have huge numbers of older people who are going to be healthier in the long run, and they're going to cost more.

MR. BOLNICK: I second your compliment of the news media. I'd also like to nominate Senator Monahan for honorary membership in the Society for his fantasy-land comment.

FROM THE FLOOR: There are many things to talk about with these proposals. One of the things that strikes me: we've talked about estimated costs for single and for family, which I assume is 1993-level costs. It hasn't been clearly stated, but the plan isn't supposed to go into effect until 1997 or 1998. The benefit levels look like a $200 deductible; that's maybe out of date as of now. Many companies have much higher deductibles. I'm not sure, by the time we get to 1997 or 1998, whatever time this plan goes into effect, what the premium levels would be nationwide. Would they keep the benefit levels the same as they are now, the cost-sharing elements?

But the plan also includes many elements that are not insurance elements, they're prepayment-type elements, like well care. In addition, as I understand it, the people who cannot afford to pay premiums will be subsidized to the extent that it will cover their deductibles and coinsurance. So some of the poor people who don't have coverage now are not only going to have a benefit plan they hardly pay for, but also not even going to pay a $10 doctor fee or a $200 annual deductible. That might have an effect on utilization, which I don't think anybody has thought about.

I've also heard Hillary Clinton tell the AMA that it was unthinkable that a doctor would have to call up some clerk to find out whether he or she could perform a diagnostic test. So there are mixed signals where you can really have managed care, a gatekeeper, point-of-service plans, and all the rest. Maybe some people in calculating the rates are thinking, "yes, you can have it," but other people at the alliance level may not allow those plans to fully manage the care for people and restrict costs. Even if that number was right nationwide, there's got to be someone in LA or Miami whose costs are 50% or 70% more. The cost figures are almost incomprehensible. You cannot figure out how you're going to calculate payrolls, how you're going to calculate average pay based on how to count people, and how often people have to fully identify themselves as a family so that there's employer share on people who have multiple employment, self-employment, full-time employment. It's absolutely not clear how anybody can do any budgeting. When you ask the people about these questions, they say that that level of detail hasn't yet been decided.

MR. HANSEN: I want to go back to something Mr. Bolnick said, and I know everybody up here agrees. When we do get the final legislative package, you're the experts. You have to help all of your respective industries and let your congressional representatives know what you agree with, what you don't, and what's administratively difficult. We're trying to second-guess the estimates, but we don't have the total benefit of all their assumptions. We simply have to wait for the legislation. But this is where the Society can help, and not just as an association. I think all of you can help individually by letting your congressional representatives and your senators know your concerns.

MR. THOMAS F. WILDSMITH: One message that several individuals have offered in this debate, which I don't think has come through very clearly, is that we are in the process of rapidly changing the way health care is delivered, and we have been for five or eight years. We are moving as rapidly as possible into managed care, into new and more innovative network plans, point-of-service plans. There are gatekeepers, everything we can think of, and there's essentially one thing driving that and that's competition, specifically, price competition. There's an assumption that seems to be made very vocally, very openly by most of the academic and governmental entities involved in this health care reform, and that is that we don't have price competition and we need it. Frankly, that baffles me, because as an individual employee with benefits provided by my employer, I'm not that interested in price, but my employer certainly is, and anyone who provides employee benefits is well aware of that. Very small employers with 20 employees or 50 employees routinely use an agent or a broker who solicits 8 or 10 quotations. Then a head-to-head comparison of the benefits and the price is laid out. It is as pure a form of price competition as I'm aware of. I'd like to know why people believe that this is not a price-competitive market. What can be done to educate the people who need to learn that?

MS. FOX: We don't believe that it's not a price-competitive environment, especially in the smaller end of the market. Actuaries have said that 4% of the population results in 50% of the costs. We know that many carriers are trying to exclude these individuals to bring their costs down, so there isn't real price competition. What you have is competition based upon risk selection. We think we have to end that as one element of trying to get real price competition.

MR. WILDSMITH: That's interesting. I believe that in the baby group market there may be some truth in that when you individually underwrite each employee. But routinely, by the time there are 20 employees, we don't do that anymore; and that's very easy to solve by some very simple insurance reforms that the HIAA supports and are rapidly being passed in most states in this country. Once you get above that case size, you very quickly get into a very price-competitive market. That being the case, I don't understand why people believe that American health care is fundamentally not price competitive. The only area that I'm aware of that's not price competitive is with the providers, where they're not required to post or file what they charge. You go into a doctor's office without knowing what the charge is going to be.

MR. BOLNICK: I'm assuming most everybody here has had a chance to wade through 239 pages of that book and has formed their own opinions about workability of this proposal. I would like a show of hands as to how many people think that the Clinton proposal, as played out in these 239 pages and guessing what the law and the regulation would look like, think that this thing is workable. How many people who have looked at this thing think it is unworkable as proposed? How many just don't want to hazard a guess? I would report back that it's heavy and it isn't workable. That's an interesting piece of information from a bunch of people who have to run it.

MR. WILDSMITH: I do not understand why there seems to be such consensus among policymakers that insurance companies don't compete on price, because that's what I'm paid to do, to help my employer compete on price.

MR. HANSEN: We've done a good job on many things, but we've done a lousy job of informing the public as well as policymakers about the basics of insurance. Nobody understands his or her insurance policy until it's time to use it. Because of that, you have these other problems about their not understanding how competitive we are. Unless you are the employee benefit specialist in most of these firms, you really are removed from that equation, and that includes most public policymakers.

MR. BOLNICK: Your question is a very good one. One thing that we take for granted, because we all know it, is how the world works in the insurance area. The biggest problem that we have is that people don't understand what insurance is and how it works. I think your question goes to the heart of the matter. Do those people really understand what's going on? The answer is no. That doesn't let us off the hook, and that's the sad message that comes with it. We have to find ways to get that message across. I've heard some things that I know aren't particularly true in the small-group area. I've heard them time and time again, and I've given up trying to be on a crusade to straighten them out. I'm more concerned about what the outcome is going to be.

MR. HANSEN: You're talking about price competition and loss ratios. I had a difficult time before the Senate Finance Committee trying to explain a loss ratio to Senator Richfield. People absolutely think it's what the return on the dollar is. So you have to help us, too, with some of this. We can do the job with Insurance 101 in terms of the public, and that's making them sure our policies are easier to understand. But the second part is something that you have to work on with us.

MR. BOLNICK: One trap you may fall into is just the idea of thinking you can go and explain it to your congressional representative. It's a rude awakening. You can't explain it.

FROM THE FLOOR: The insurance industry is largely a victim of its own success. Inventing the major medical concept some 35 years ago and other comprehensive coverage, billions of dollars have been poured into the system, thereby encouraging private businesses to develop technological improvements. Most of these improvements were made despite the fact that we say 20% of procedures are unnecessary, there's fraud, there's abuse, and there's too much claim administration. Nevertheless, the technological imperative is what's really driving up the cost of health care from 2% of GNP to 14% of GNP. I'm not sure it's all bad. Magnetic resonance imaging (MRIs) examinations, computerized axial tomography (CAT) scans, open heart surgery, hip replacements, new drugs – they are all very good. But they exist only because there is a market to the businesses that want to invest their money to develop those products. Perhaps what's happening is there's too much technological advancement. There's too much of it because there's no supply and demand control at the consumer level. One thing I haven't heard mentioned here, and maybe it's really against the interest of the HIAA, GHAA, and the Blue Cross/Blue Shield Association, is that by having a medical IRA of thousands of dollars and a deductible plan of thousands of dollars, the great bulk of primary-care-coverage money would rest with the individual consumer. The money would rest with the consumer instead of being passed through the insurance companies, through networks, and through gatekeepers.

MS. JENCKES: I have one comment on medical IRAs. We don't support them, we don't oppose them. It's not going to solve everything in health care, particularly cost. We're saying that it is an option that has to be looked at, but it does not get at the inherent cost problems in the system.

MS. FOX: Our perspective on medical IRAs is that we think you need to reorganize the delivery system, and medical IRAs don't provide those incentives. We don't think of cost control.

MR. HANSEN: Driving down the per-unit cost of processing claims isn't the name of the game anymore. I'm just seconding what Ms. Fox said. We're talking about trying to actually not manage risk, but manage care and drive down a per-unit cost of medical care, get at the providers, make the doctors and hospitals deliver more care for the dollar, and make the providers much more responsive. It's a reform of the providers' side.

FROM THE FLOOR: Regardless of all attempts to control the cost of care, isn't it a truth that the technological imparity will continue to require that more money be spent

on health care as opposed to many other things that people buy? As people age, people are going to die. They're going to get sick and the technological imparity will continue to operate to require that more money be spent on health care. So, unless we're going to have premium caps causing rationing, there's no way to control the cost of health care compared with the other things that we buy.

MR. HANSEN: You said the "R" [rationing] word, but you're one of the few who has said it. The administration and most policymakers try to stay away from it, because that is the issue that technology confronts us with. As long as we're not willing to talk about how much care we should get as individuals, as a society, then we never will get a handle on technology costs or probably on any costs.

MS. ALICE ROSENBLATT: I want to say to Ms. Jenckes that yes, I think it is possible to do a risk adjustment. Many actuaries are willing to work on that and help the administration figure out how to do that.

MR. BOLNICK: Ms. Rosenblatt is the chair of the Academy committee that has been working on health risk adjustment and has done a tremendous job.

MS. ROSENBLATT: We have a long way to go. In the President's proposal, there's some language on page 89 that is very similar to the Academy's papers. I also want to reiterate some of the things that Ms. Fox said. I think is very important that we get competition, not based on risk selection, but competition based on true administrative and medical management efficiency. That's one of the points that we make in the paper. Someone mentioned that he didn't understand why people were questioning price competition and that maybe in the small group market there was an issue concerning an impact on risk selection. I think it's much more widespread. It's not just the small group. If you look at large-employer groups, many employers are being given choices. There are optional plans out there in which people are given choices among many HMOs, a PPO, and an indemnity plan, and without a risk adjustment mechanism, there's tremendous adverse selection occurring among those choices. Very often the contribution the employee pays is set as a percentage of the premium. If the premium reflects adverse selection, we do not have the consumer making the choice that takes out the effect of risk selection, and it's very important that we as actuaries understand that.

MR. MICHAEL J. COWELL: Mr. Bolnick, congratulations to you for putting together a group of panelists like this at the last minute. I have one question for your panelists and one specifically for you. My question to the panelists is, I believe what you're telling me, that 90% of the insured public is happy with their health care plan, and we all agree that in general the overall quality of care, as evidenced by the number of people who come to the United States to get it, is the best in the world. There should be a plan in the works that, instead of throwing the baby out with the bath water, says that 37 million people are not taken care of, multiply that number by $1,500 or $3,000, and you get the number of $50-100 billion that is needed. We can roll off the successful part, address the unsuccessful part, and give incentives rather than try to bring in a massive, federal program to level everything down to the lowest common denominator. To the extent that the private sector brings the system under control within the next three to five years, we'll need federal regulation only if

the job isn't done. Address the 37 million in a separate system that doesn't muff up the basic good features of insurance. That's my general question to the panel.

My specific question to Mr. Bolnick is, what do we as a profession do to convince the rest of the world that our numbers aren't supporting the proposal? How do we prevent the good work that you and Ms. Rosenblatt and others have done from being misused by the administration? I think, based on all the quotes I've been reading, and they're going to be covering more in *The Actuary* next month [November 1993], that the profession's professional advice is being misused.

MS. JENCKES: There are several pending bills. Senator Bentsen's bill, when he chaired the Senate Finance Committee, is very much on the mark. It's insurance reform, it has some cost-containment incentives, and it actually has a couple expansions for the Medicare program. It is not too dissimilar to the bill that many Senate republicans just introduced, but we as an industry did not take any formal position on it because, again, we don't want to make this a partisan issue. That's why I concluded my remarks by saying we should take the 50% or 60% that we know is workable, the insurance reform, the antifraud, the administrative costs or automation aspects of it, again encouraging the medical profession to move forward with medical appropriateness guidelines, and then experiment with these health alliances. If the administration would just take that alone, we will have gone light-years ahead of where we have been. But then, too, keep in mind that when it comes to insurance reform, 29 states have passed it, and the rest are not dawdling, because many of them are scared to death over the dictate that could come from Washington. So, if we can at least get those states forward with insurance reform, we will have done a lot.

MR. BOLNICK: The American Academy of Actuaries in conjunction with the Society of Actuaries has a list, which you should be receiving, of work groups that are working on various aspects of the reform, trying to give good professional input to the President's task force. One work group, which comprises senior members of the Health Practice Council, the senior people from the Society of Actuaries, and some former Academy presidents who are involved with health care, will look at the numbers that are coming out of Washington. We have sent invitations to Guy King from the Office of the Actuary, who produced the numbers for the administration. We sent an invitation to people of the Ostuw Group, the actuarial reviewers who were widely reported in *The Wall Street Journal* and *The New York Times*. We're going to find out what they did and what they didn't do. We also sent an invitation to Ken Thorp, who is the only person in the administration who knows where those numbers came from. If we can sit down with him and he agrees, we'll see if he'll deliver. But we intend to express an opinion to our membership and to the press about what those numbers are and what we think about them. We have taken on the responsibility. I've been getting phone calls about the need to do that. There is uniform agreement that we need to respond. The good news is that there's uniform appreciation on the part of the people who are involved. They have been extremely open with us and are willing to have the profession take a look at the numbers and say something about them. I assure you that will be done. The time frame is probably the end of November 1993. I think something will be out by then.

We have a list of about 14 work groups covering various areas that will be sent to the Health Section Council, looking for people to volunteer. When you see the list of topics, if there's anything you feel you have particular expertise in, if you would let me or the Society office know, we will try and plug you into the process. We need help; there's a lot of work. We have an enormous task ahead of us, because the proposal is loaded with actuarial issues.

FROM THE FLOOR: I sit here with a strong sense of foreboding that we all agree on this, and it's just the people in the Beltway who don't have it right. The problem is that when I sit back in Chicago and I talk to the people on the street, they really like the health care proposal. They heard the speech, and they say if the other guy has to pay an extra dollar a day on his cigarettes, it's fine with them, they are going to get all this coverage. The real issue is that in America, with the downsizing, and everybody's downsizing, there's no security left in health insurance through employers. People are concerned about that, and the Clintons have picked up on this. They ran with it and whether this is a good proposal financially doesn't make a difference; this is political reality. The real concern here is if this does not become a political issue, if somebody doesn't mention the "R" word and say this is what this really means, your taxes are going to go up like you won't believe. It will make Social Security look like a joke. There's going to be rationing of care, and the people who are age 60 and think this is the greatest thing to ever come down the pipe are going to find out that they're not going to get any service. If those issues don't come up, and they are only going to come up as a political question, then by the time we figure out that we've made a mistake, it will be too late to do anything about it. We've seen it happen in government-financed health care before, whether it's Social Security or whether it's Medicare, it's a disaster based on the original proposal. Why shouldn't it happen here?

MS. JENCKES: It is. I saw this just yesterday in the *Washington Post*. These stories are now starting to go outside the beltway, talking about the fact that Medicare tripled in a very short period of time. You mention the "R" word. Let me mention the "T" word. The critical issue is going to be how the Congressional Budget Office scores the new premium employers have to pay. They may determine that it is revenue, therefore a tax, and when that big "T" word gets out there, you watch what's going to happen with this proposal, because even though that "T" is on employers, it is also going to be on employees, and that's where I think it's going to fall apart. The Clinton administration maintains that these premiums are going to be state alliances and they are not federal revenues. It's going to be a critical issue.