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NATIONAL HEALTH-CARE REFORM AND THE SUPPLEMENTAL MARKET

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- The impact of health-care reform on supplemental health insurance plans such as Medicare Supplement, Hospital, Cancer, etc. The session will also explore new opportunities for supplementary markets and products.

MR. H. NEIL LUND: When we put this program together last January, we expected to see a detailed health-care plan by the end of April 1993. We have just received an outline of President Clinton's plan, so this program will not follow the outline in the preprogram books. We will first take a brief overview of the Clinton plan. Then we will look at the experience under the Civilian Health and Medical Program for the Uniformed Services (CHAMPUS), look at the experience under the Federal Employees Health Benefits Program (FEHBP), look briefly at Medicare supplement, and look at other supplements as part of the program. We're looking at these for several reasons. One is that there may be some applicable lessons. Also, it gives us some possible models for looking at supplements. Unfortunately, we will not look at new markets and products, because the proposed plan has not been around long enough to really figure out what new markets or products may exist.

We can characterize President Clinton's plan as an employer-based, universal, guaranteed coverage system built around purchasing groups, with standardized benefits, community rates, and an emphasis on community care. One of the key things that President and Mrs. Clinton seem to be really striving for is universal coverage. It seems to be a key element. I rather doubt that we'll see much compromise in the area of universal coverage, although we may see a fair amount of compromise in other areas.

A key component is the National Health Board. The Board has seven members appointed by the President. Members serve four-year terms, and the terms are staggered. But the Board members serve at the will of the President, so when there is a new administration, the President has the capability of firing the entire Board and starting over. The chairman of the Board serves a term that is coterminous with the President, so whenever there's a change in the administration, there will be a change in the leadership of the Board. Authority of the Board includes oversight of the states, which is very important. If the states do not act to promulgate regulations put forth by the Health Board, the Board can request Health and Human Services to step in and act instead of a state. The Board also reviews and updates the guaranteed-benefits package, has budget enforcement and allocates the budgets among states, establishes and manages the national quality-management system, and has authority over the pricing of new drugs if they're considered "breakthrough drugs." In operation, this Board is composed of a series of committees. It has the authority to contract with the Health Care Finance Administration (HCFA) and anyone else that it sees fit to do so. It should be noted that to make this Board operate properly, ERISA will be modified.

The current plan includes three standard plans. There is a low-cost-sharing plan, which is essentially intended to be an HMO-type model; a high-cost-sharing plan, which is essentially a fee-for-service model; and a combination plan, which is somewhere in between – basically a point-of-service model. Mental- and substance-abuse provisions contain internal limits that significantly limit coverage. Overall, there are no caps on other benefits.

Stepping down a level to the state, in President Clinton's plan the states will have a significant role in the operation. The responsibilities assigned to the states are the establishment of an alliance or multiple alliances within a state, the regulation of health plans, and the operations of guaranteed funds. The states may provide benefits in addition to what's in the standard plan. They can upgrade the standard plans, but they cannot mandate less than the standard plans. Because they can add benefits, the bad news is that it looks like state-mandated benefits are not over. I expect that state mandates are something that will come creeping back in.

As mentioned, one of the keys is the establishment of alliances. They're established on a geographic basis, and they're established by the states. The state has the option of developing more than one alliance per state, and in my office we often like to use Illinois as an example. Chicago and the Chicago suburbs are much different than the rest of Illinois. Many other states are in that same situation, in which there is one or several large cities and then a significant rural population. It is most likely that we will see multiple alliances in those states. The alliances cover employees of small firms, small being less than 5,000 people (which I thought was a fairly large firm). Small firms and government employees -- federal, state, and local – are all swept into this plan, as are the self-employed, part-time employees, retirees not covered by Medicare, and individuals who are not employed.

The first role of the regional alliance is to enroll all eligible people. If they fall into one of the categories, the regional alliance needs to enroll them. The alliance also manages access to the health plan. People covered by an alliance cannot be contacted directly by any health plan for marketing purposes. These people can only enroll in a health plan through the alliance. The alliance contracts with the various health plans, controls all marketing, and publishes information about the plans. The regional alliances will also establish some risk-adjustment mechanisms. The risk-adjustment mechanisms are very interesting, because premiums are community rated. There is recognition that there exists a variety of risk characteristics in any population. When you start to subdivide, the premiums will be redundant for some plans and underfund other plans. The intent of the risk-adjustment mechanisms is to reallocate funds that come into the alliance and disseminate them in a disproportionate fashion in some manner through the health plans. Details of the risk-adjustment mechanism are not currently available. The regional alliance also collects premiums and disburses the funds to the health plan.

Earlier discussions of the health plan mentioned a limitation of 2% of premiums allocated to the regional alliances for their services. Remember that these entities are doing all the marketing, a large portion of the administration of these plans, and the risk adjustment function, and they're expected to do it for 2% of premium. It sounds like a tall order to me. The thought behind the alliances is to bring massive purchasing power to the individuals and small employers and bring it to bear on the health

plans. It should also be noted that the alliances are quasi government organizations run by a Board. The board members cannot be health-care providers, be associated with the health plans in any way, or be insurers. This consumer board will solely represent employers and consumers.

The health plans provide medical services or fund medical services. They can be fee-for-service operations, PPOs, HMOs, or whatever. This is where alliances of insurers, hospitals, and other providers will take place. You don't have to be an insurance-company-organized health plan. There does not have to be an insurance-company-involved in this health plan. We hope there will be. The health plans must accept all enrollees and must community rate. It is encouraging that they've recognized that a health plan may need to purchase reinsurance.

There is of an alternate route called corporate alliances for large plans. These include employers of 5,000 or more employees, collective bargaining plans of more than 5,000, and rural electric and telephone cooperatives with more than 5,000 members. Health plans that can be offered here are certified, self-funded plans. In other words, the corporate plan can set up its own plan or it can contract with state-certified plans. No matter what it's doing, it must provide at least one fee-for-service plan. It can provide more, it can provide HMOs and PPOs, but it must provide at least one fee-for-service plan. Payments are made directly to the health plan and do not go through an alliance. It should be noted that corporations that continue with their own plans will face a surcharge on the premiums or health-care costs that help fund coverage for the unemployed among others. It should also be noted that unlike pay-or-play approaches, an employer down the road may elect to drop the self-funding and opt to go through a regional alliance, but with some penalty.

Schematically, individuals, government, and small businesses must go through an alliance. From the alliance, the individuals, (not the employer and not the government unit), choose the health plan in which they're going to have their health care provided. The employer will pay 80% of the average cost of all these available alliances. The individual will make up the difference. It may be more than 20% or it may be less than 20%, based on the plan that is chosen. Also, somewhere in this approach the health portion of auto insurance will be integrated as will workers' compensation. So the intent is that the health plans will provide comprehensive health care in all situations for all individuals, and it will be individually chosen.

I've gone through a lot of material and I'll be honest, I haven't figured out how the total budgeting process works yet. It doesn't hang together for me, so that's basically all that I'm going to say about the budgeting process. One of the key factors, though, is that the budget will be limited to the CPI plus 1.5 points in 1996, the CPI plus 1 point in 1997, the CPI plus a half point in 1998, and it will be limited to the increase in the CPI thereafter. The intent is to scrunch the cost increases down to the standard market basket.

The plan also affects a few other areas. Health care provided for Medicaid recipients will be purchased through the alliances. Existing long-term-care patients will continue in their current programs. Also, I found it very interesting that in the proposal the Secretary of Health and Human Services has the authority to integrate Medicare into the alliance, which means that the government can put forth the option of eliminating

Medicare as we know it. Also, even if the existing Medicare program remains, an individual, upon reaching age 65, may elect to stay in the alliance and purchase care after age 65 with payments made from Medicare. The program also adds an outpatient drug benefit and has a variety of cost-savings mechanisms, including a reduction in the market basket index that's used for the Part B trend, among other things. There are many other impacts. If you're a Medicare supplement carrier, the most immediate impact will be on your trend, which will probably be knocked down a little bit. I think what we have here is another subtle approach at cost shifting that has not been advertised or disclosed.

Finally, we get to supplemental plans. As far as supplementing standardized benefits, the National Health Board is directed to establish two standard supplement plans. These plans for supplementing health care can only be offered by qualified health plans. If you're not a qualified health plan, you can't offer supplemental coverage to anyone in this scenario. The supplemental plans affect only high-cost-share options, are mandated to meet a 90% loss ratio, can only be offered during the annual enrollment period, and both supplemental plans must be offered. If you're going to offer a plan, you have to offer both. The plans must be community rated and duplication of coverage is prohibited. Fortunately, there are some exemptions. Long-term care, dread disease, hospital indemnity, nursing home indemnity, Medicare supplement, and accident-only products are exempted. They will continue to exist. There's also a provision that individuals not covered by the health plan, which by and large will be visitors to this country, may purchase private health-care insurance to the extent that it's available, and that's a quote right from the plan. I'm not sure that there's an expectation that much will be available.

Overall, this has been a brief overview of the health-care package. At this point, Royal is going to look at what's happening with CHAMPUS.

MR. ROYAL A. JOHNSON: One of the reasons for discussing the CHAMPUS is so that we can find out what ticks when the government gets its hands on a benefit program. The government does run two major national health-care programs now. The CHAMPUS is for active-duty and retired military people and their dependents. It also runs the Veterans Administration health-care program. I'll touch on those a little later.

The CHAMPUS started about 25 years ago. Basically, it covers dependents of active-duty-service members, retirees and their dependents, former spouses, and dependents of reservists ordered to active duty. So it's a military plan. How does it work? You must register in the defense enrollment eligibility reporting system, and then you become eligible. To get care within the CHAMPUS system, and, in particular, outside the military health-care system, you need a nonavailability statement. It's required if you live within certain zip codes near military bases, and it's required for certain services and procedures regardless of where you live. You are allowed to go outside the military health-care system for your care. Certain procedures that require a special, nonavailability statement include cataract surgery, a D&C, and a breast mass or tumor removal. There's sort of an eclectic list of services that you must get prior approval for. Providers in the entire military health-care system, which is extensive, and all civilian hospitals that will accept Medicare patients must participate in the CHAMPUS system and accept the CHAMPUS diagnostic-related group (DRG)

reimbursement level for that care. The CHAMPUS has its own list of physicians and other providers. Chiropractors are not included. There are other providers who are not eligible for CHAMPUS reimbursement. The list is not all that extensive, but it is different than what you find in most civilian plans. The CHAMPUS reimbursement level is very close to what I would consider to be industry reasonable and customary (R&C). Participating providers, physicians, and others accept the CHAMPUS allowances for their services. It should be noted that the CHAMPUS is second payor to everyone, with the exception of CHAMPUS supplements. So it is always second payor, and that's one of the unique features.

Health care at service hospitals and military facilities is free but is on a space-available basis. The civilian health-care copayment for active-duty dependents is $9.30 a day for inpatient and 20% for outpatient services. There is a deductible for outpatient services: $150 per individual, $300 per family for E-5 and above; $50-100 for E-4 and below. An out-of-pocket cap for the dependents of active-duty military is $1,000. It's a strong plan. For retirees and their dependents, the benefits for inpatient are 25% of billed charges, or $265 per day, whichever is less, not to exceed the DRG allowance. We sometimes see claims in which CHAMPUS pays zero when 25% of the billed charges exceed the CHAMPUS DRG amount, so the individual essentially winds up paying the entire allowable charge. Outpatient services are 25% copayment; the deductible is $150-300, with an out-of-pocket limit of $7,500. That's substantially different from the active-duty dependents. In addition to those costs, the individuals under this system are subject to excess charges if they do not use participating providers. Now the excess charges are the excess over the billed charges, and that can be substantial if they're not careful. People in the system are very much aware of that, and they're very careful about who they choose to provide their services. They very seldom get trapped with substantial excess charges, although there could be significant liabilities there.

Supplemental coverage generally pays the cost share up to the cap. It's based on a contract that follows the CHAMPUS very closely. If the CHAMPUS pays, you pay. There may be additional restrictions. You usually find them on mental and nervous, but not on much other than that. The CHAMPUS deductible may or may not be covered, but it is usually not. The excess-charges coverage is a popular one, and it is provided by about a third of the supplemental plans that are in the marketplace. Again, the typical plan design will offer options. There could be an inpatient-only plan. An outpatient plan might have deductibles ranging from $0 to $500 and an excess-charges benefit that would range from 100% with no deductibles to something on the order of 100% of R&C with a $1,000 deductible. So there's a wide range of coverage there.

There are about 6 million CHAMPUS eligibles. They include about 2.9 million active-duty dependents, 1.2 million retirees, and about 1.9 million retired dependents. The total insured marketplace is about half a billion dollars; that's a pure guess. Another guess is that there are about 700,000 lives insured of which about 400,000 are active and 300,000 are retired and retiree dependents. There are 35-40 organizations that actively market CHAMPUS supplemental coverage. About 30-35 of those are military associations. The remainder are companies that sell CHAMPUS supplemental products directly to the military and usually through the mail.

What's happened? There have been four factors that have impacted the CHAMPUS plan and the CHAMPUS supplemental plan in recent years. The first is base closings. Base closings have resulted in the loss of military health-care facilities, driving CHAMPUS eligibles to the civilian health-care system for their care. The second is the drawdown in force. Fewer military providers in their own military health-care system are there to serve the eligible. In other words, even before they've closed the base, they tend to first cut back on the health-care services. So, where there was a facility that might have been accessible to CHAMPUS eligible, all of a sudden it no longer has the capacity. The third is the health-care-cost increase, which has been a major impact on the CHAMPUS system. The fourth has been, of course, the budget reductions on top of the base closings.

The result? The CHAMPUS eligibles have stayed at about 6 million during the last five years. The claims filed in that period have gone from 10.5 million to somewhere in the neighborhood of 22 million claims. (We are not through with fiscal 1992 yet.) That's happened in the last five years. That's part of what's happening there. Also access, as I said, for those who are eligible has become more and more limited. Priorities in the military health-care system are (1) active duty (that always will be the first priority), (2) active-duty dependents, and (3) retirees and dependents. Five years ago, active-duty dependents could get almost all of their health care through a military health-care facility. Now the odds are probably the other way around. Ten percent may be able to do that on a regular and consistent basis, so it's become very difficult. For retirees, access to the military health-care system almost doesn't exist. Again, costs continue to rise and available funds are decreasing.

How has the CHAMPUS system tried to respond to change? Through a variety of programs come from a variety of sources. These are initiated from the Department of Defense, and they've been installed in various places as it attempts to gain control of the cost of the CHAMPUS program. The CHAMPUS Prime is a program that currently is available in California, Hawaii, and New Orleans. The CHAMPUS Plus is an almost identical program available in Austin, Fort Worth, and Alexandria, Louisiana. These are PPOs. The CHAMPUS Extra simply makes those PPOs in those areas available to the CHAMPUS eligibles, and they get a reduction in their copayment. That's the only benefit they get. Under the Prime and Plus programs, you must enroll, and you cannot go outside the system. The Extra system simply makes it available to those who want to use it. Of interest is the uniform services family health plan, which is a managed-care program based on public service hospitals that have now agreed to accept CHAMPUS eligible. The military pays the premium, there are very low, almost nonexistent, copayments, and the plan operates in a few locations through individual hospitals. There's one in Baltimore, one in New York, and one in Massachusetts. I think there are three in Texas. They're individual community programs. Now they do seem to be popular; certainly the one in Baltimore is popular. It's a hospital that Johns Hopkins took over a few years ago and it's very attractive.

Each of the services has set up its own program, so there is a series of PPOs with different names. Navcare for the Navy is a series of outpatient clinics that have been around for some time. "Prime" is a similar type of program run by the Army and the Air Force, respectively. All of these have been PPOs. The Prime programs are three to four years old. They just renewed the contract for the Prime provider in California and Hawaii. There was active, aggressive, and controversial bidding. Aetna won the

award but is being challenged. The new Prime plan, which is in Texas and in other areas, has significantly higher copayments. Outpatient service copayments have gone from $5 to as high as $20 for a retiree. For inpatient services, the copayments have gone from $75 under the old Prime to $125. They're talking about expanding the Prime program into Washington and Oregon. At this point in time, the Congressional Budget Office and the General Accounting Office have said it can't be done because the cost numbers are not acceptable. It cannot be demonstrated that money is actually being saved. So I don't know where that's going or whether it will happen. It's interesting that these offices are getting involved in that. There is a real controversy there. There are several studies and there's no evidence at this point that those plans have been successful in reducing costs to the military.

What's happening next? The next program the Department of Defense has on its agenda is a regional health-care plan. It wants to set up 12 regions; a lead agent (not an alliance) would run each. It may sound like an alliance and it may look like one, but it's not. It'll be one of many military medical treatment facilities within that region, and the commander of that facility will be the lead agent. He'll be responsible for developing and approving the civilian treatment network. It'll be based on civilian health-care networks, probably Prime-type networks. When I say Prime, I'm referring to their prior programs. Those networks are going to be run by either civilian contractors or they will be managed by the military. The lead commander decides which procedures must be provided and may require that certain procedures be provided only at certain facilities. For example, to have open-heart surgery, you may be required to go to Walter Reed Hospital in Washington, D.C. if you live in that region. By the way, within this system, the priorities in terms of treatment priority stay the same: active duty, active-duty dependents, and then retirees. That program is supposed to be introduced next year. If it does happen, standard CHAMPUS will be available, barring any national health-care program that might be in place that would replace it.

The next is President Clinton's plan in the military. In this program, there will be a system called "Tri Care," which will be a military-based system. It will include only military facilities or approved networks that are not dissimilar to the regional plan. There will be little or no choice and modest, if any, annual premiums for the eligibles. But there will be no deductibles and modest copayments. That is primarily addressed to the active duty and active-duty dependents. In addition to that, the way the President's health-care plan is set up is that there would be an opportunity for networks or fee-for-service plans through the standard health-care-reform package. So that's all that's happening here. The military will have one more option for those eligibles than they might have under the President's health plan.

Regarding the future of the CHAMPUS supplements, what has happened? The Prime plans have increased their copayments to the point where people are asking for supplements to the Prime plan. So there's a supplement now for the standard CHAMPUS, and a supplement for the Prime program. My observation is that the new PPOs are probably going to have substantial copayments. What's substantial in the terms of the supplement world? My guess is that they're going to run 15-25%; the inpatient copayments are going to run $150-250 a day. But I don't think the military can afford to provide a program. I think CHAMPUS is a good program, and costs must be kept within the bounds of what they're going to be required to do.

President Clinton was strangely silent about the military in his speech. It is, however, covered in his book. In any event, whatever happens, on the military side there are six major House and Senate committees. There's a Senate and House Committee, an Armed Services Committee, an Appropriations Committee, and a Veterans Affairs Committee. All have a say in the legislation that impacts the military health-care system, and all in the past have had their say one way or another. There are 14 subcommittees, all of which are involved in the military health-care system. The military has more clout, considering the size of that community, than any other group of which I'm aware. Veterans claimed 83 million eligible dependents.

There was an interesting article this week in the *Army Times*. Speaking before a joint hearing of the Senate and House Veterans Affairs Committee on September 21, newly elected American legion national commander Bruce Tyson urged the lawmakers to pay attention to the examples and lessons learned by the VA as they consider how to revamp the nation's health-care system. He went on to say that any reform of national health care must include veterans in the decision-making process. Don't underestimate the clout on that side of the street. The military community received a commitment for free care for dependents and retirees. That's what they expect. Paying premiums is not part of that. Real commitment to veterans care is a national issue.

There is a real controversy within the military community and Congress between the Congress Test Base Office (TBO), the general accounting office (GAO), the General Services Administration (GSA) and the military community on PPO plans. There is no consensus as to any real health-care-expense savings as a result of the managed care programs that have been tried. *U.S.A. Today* and the GAO have said that little evidence exists of cost savings from network-based managed care.

We see that there is resistance among the military community to HMO and PPO managed-care options. When the Prime plan went into California, we saw few people join. Right now the enrollment from California is higher proportionately than it is in other states. At least in California, one of the ways that PPOs have attempted to obtain cost reductions is by very careful management of the mental and nervous benefits. You cannot go anywhere in California under the Prime plan and get more than five outpatient psychiatric visits approved. So your option then becomes either to get out of the plan or to go into a mental and nervous hospital facility.

If President Clinton's plan is passed as is, perhaps there's a hospital indemnity and long-term-care program available. If the military regional plan goes in, I think there will be plenty of room for supplemental products. The dynamics are going to change. There may be some new benefit structures out there and some new supplements to provide, but as I say, I don't think it's going to eliminate that product.

MR. LUND: I'm going to look very briefly at the FEHBP. The FEHBP covers approximately ten million active and retired federal employees. It is primary to Medicare in the retiree market. The FEHBP is composed of 19 fee-for-service plans and approximately 300 HMOs. The individual has choice, but no individual has the choice of 300 HMOs. Depending on location and the agency an individual works for, he or she may choose from a couple of plans up to maybe a dozen. The FEHBP has often been held up as a partial model for managed competition, but the FEHBP has some

problems. Federal employees, and I don't think they're atypical, tend to choose the most expensive plans that fits their needs. There are significant levels of benefit antiselection. Each year under the FEHBP program, there's an open-enrollment period when you can alter your election. What we find, not unexpectedly, is that young people tend to gravitate toward low-premium, catastrophic plans. As couples approach the childbearing years, they gravitate toward plans with extensive benefits for children: prenatal care, well child, and so on. At older ages, people tend to move away from those plans into plans that provide services for seniors. There is a lesson here for us as we move toward managed competition. Consumers will pick plans that are advantageous to them. The risk adjustors will have to have a well-oiled mechanism to keep this system running, because people will choose what's appropriate for them. Within the set of products that are appropriate for them, they will choose the most expensive.

The FEHBP has also had problems with the withdrawal of carriers. Many people do not want to change carriers. They do not want to change plans at all, once they're in a plan that seems right for them. There is significant resentment if a carrier withdraws from the plan.

Supplements in this market have been very popular. But marketing the supplements is expensive, because you need to market to everybody every year during the open-enrollment period. You need to re-enroll each person. You have to think of this as a one-year, nonrenewable sort of product in which everyone has to sign up again. This means you can only amortize your marketing expenses over one year. Second, the antiselection among the supplements follows the antiselection among the base plans. When people migrate from one plan to another, there is an increase in benefits paid in those plans, and there is an increase in what the supplement is going to pay. So with migration, every year you see increased claim costs or antiselection in the initial period. It is also very important in the supplemental market to keep up with the benefit changes under each plan. You make a mistake and miss an improvement in say mental or nervous conditions, and the supplement can get clobbered. Finally, the various base plans, of course, adjudicate their claims in different fashions. If you're operating in this market and you're supplementing a variety of plans, your claims-adjudication system is going to have to be flexible enough to take into account all sorts of differences in the base-plan claims practices.

The FEHBP is a very interesting market because of the way that it has worked. It has been a constant candidate for reform. The promise of FEHBP reform has been held out before Congress, but it has really never happened. Necessary structural changes to the FEHBP approach have not happened because for everyone within the government, it's affecting themselves. It's very difficult for Congress to make changes in a program that affects all their direct employees. So there is de facto lobbying that goes on with any change. Federal employees do have clout. As Royal pointed out, military and retired military people have clout. That clout is probably going to be far in excess of the influence that we as a profession have or potentially will have.

MR. JOHNSON: Neil had asked me to talk about Medicare. It's in the President's proposal. The basic shift is going to be that everyone who is eligible for Medicare will have an option to stay in the alliance plan that they are enrolled in at the time they

turn 65. What that does to the Medicare supplement market is going to be anybody's guess. I'd like to point out that with Daniel Moynihan and others as the self-anointed protectors of the current Medicare system, there probably is not going to be a major change in the Medicare structure, at least in the near term. I don't know how far that's going to run. I do think that the element of choice, in other words, the option of remaining in the alliance plan, is going to throw a wrinkle into the pricing structure. I'd like to point out that it's been a little more than a year since the Medigap legislation took place. August 1, 1992 was the date that it was all supposed to be in place. My observation in reviewing what happened as a result of that is that every person who was insured under a Medigap plan realized a premium increase of somewhere between 20% and 30%. Now they may have gotten better benefits, but the fact is, their costs went up substantially on the whole; there was no reduction in Medigap cost. So I think we might want to keep that in mind as legislation moves forward on these plans as well.

MR. LUND: Finally, we want to take just a brief look at the exempted plans: dread disease, hospital indemnity, nursing home indemnity, accident-only-type plans. These are very popular in the marketplace. As an industry, we probably cover 15 million people with these plans. Plans are characterized by small average premiums, ranging from maybe $50 to $200 per year. These plans are usually purchased, according to most studies, to protect income. In other words, they're used to replace income lost during spells of illness or hospitalization, or to cover ancillary expenses that go along with a spell of illness or hospitalization. Ancillary expenses may be hiring someone for child care or transporting the family to another area. My father-in-law lives in northern Minnesota. He was recently quite ill and had to seek care in the twin cities area, which is about 100 miles from where he lives. His wife, of course, went along with him and needed a place to stay. This is not covered under most health plans.

Even though the supplemental plans are exempt from this regulation, there are some short-term and long-term issues. First is loss-ratio standards. This is a critical issue that the NAIC is looking at today. Pay attention to it because it impacts you. We are clearly going to face the question, if health-care-reform proposals are expected to operate at a 90% loss ratio, how can we have supplemental plans operating at 40-50% loss ratios? There are some compelling counterarguments to this question. Another issue is, if the loss-ratio standards are increased, what are the appropriate marketing methods? Or, if health agents lose the ability to sell individual and group major medical plans, are they going to rush into supplements and hope to make up lost income from commissions? The market can probably not stand that sort of influx and will probably not support that level of new marketing opportunities.

Finally, there are well-established competitors currently in the supplemental markets. If you're not there, it may be very difficult for you to make inroads into this marketing arena. Carriers have been there for a number of years, are successful, understand what goes on, and understand what works and what doesn't. So even though these plans are listed as exempt, you should not take them as a safe harbor, a place where you can steer your company and hope to find a new niche. The people who are there will defend their marketing niches very aggressively.

FROM THE FLOOR: One of the panelists at the Health Section meeting said that he thought the regional alliances were not necessary, that the current system, including

brokers and agents, could take care of most of what they wanted to do and eliminate that whole level of bureaucracy. I would like to know what your opinion on that is. My second question is, when it comes to these regional alliances, is there a cap on the number of health plans that they would license to do business? If they have 15 plans, can they say, "We've got our 15, sorry, No. 16, you can't do business?" And then I have a third question. As far as people on Medicare who have reached age 65 and have a choice, is it something like what goes on in Florida with Humana where it takes over that person's liability and then gets paid per head by the federal government to manage care under Medicare or independent of Medicare?

MR. LUND: I think one of the critical issues under President Clinton's proposal is the 35 million uninsured people. Any approach is going to have to address the uninsured population, and it's going to have to address it in an efficient manner. The current scheme, perhaps for a variety of reasons, has not addressed the issue of the uninsured. Therefore, I don't know if you can categorically say that the current system is operating and we don't need alliances. Some proposals in Congress do not make alliances exclusive. They still rely on purchasing cooperatives of some sort, but they do not have to be geographically exclusive. You can have competing alliances. But I don't see the current approach addressing the uninsured question, and that is a critical issue on President Clinton's agenda.

Any cap on the number of providers is in the hands of the states. A state has the option of setting up a single-payor plan in which case there's only one insurer. A state has the authority to establish a cap on the number of plans, and it has the authority to say they're unlimited. There's no real answer to your question, but it will vary by state. In some states, the limit will probably be imposed by market forces. There won't be a lot of players in some geographic regions. Others should allow for many different plans, and some almost have to allow for many different plans. Large metropolitan areas, such as Chicago, Philadelphia, or New York, will almost have to permit a large number of plans, simply allow access to care for everyone.

MR. JOHNSON: Let me just make a comment. If the President's plan goes through as is, the best job for the next couple of decades may be a ward healer in an alliance. Somebody's going to make the decision as to which plans are permitted and brought into the alliance. I can guarantee that in Baltimore, Johns Hopkins is a lock; I don't care what its costs are, that's going to be a political decision. It will be run by a bureaucracy.

Finally, the Medicare approach would be similar to the Humana approach.

FROM THE FLOOR: My question has to do with the exempted plans. If President Clinton's plan goes through, and we have national health care, what is the rationale for having coverages such as dread disease? Would the national plan already provide for this, or are we to expect that we're just going to have some basic coverage that may not be enough for the more catastrophic illnesses?

MR. LUND: I think you've got to look at a couple of things. First, these plans historically haven't been purchased to provide direct medical reimbursement. They are meant to supplement medical care in other avenues by replacing income or by providing for ancillary expenses. Those sorts of situations will continue to exist even

under the plan. President Clinton's plan doesn't provide for spousal travel if you have to travel 100 miles or more for treatment. It does not provide for child care or adult care while you are hospitalized. There are ancillary expenses involved in the delivery of health care that all of us face. The intent of these supplement programs is to cover that. You've asked us a question that all consumer advocate organizations will ask: why do these plans continue to exist? Is there a need for them anymore? It's an area of individual choice. The other thing that I turn to is, historically through the FEHBP, CHAMPUS, and other government-run programs, the government really has a history of allowing deductibles and copayments to grow and expand. They reach the level where people actively seek a supplement. When Medicare was introduced in 1966, the expectation was that there was no need for any form of supplemental health insurance for seniors. Copayments and deductibles were quite small. We see a huge market; there is $5.5 billion of premium in Medicare supplement plans alone. I am not convinced that the basic supplemental package as proposed under the President's operation will survive, and I'm not convinced that there won't be an active supplemental market for agents and direct-response-type operations, such as there exists for Medicare, or the FEHBP, or the CHAMPUS. Remember, the government is not going to really have anywhere to transfer costs anymore. Cost shifting, hopefully, is muted under any reform program. The one way that the government is going to control its outlays is through changes in deductibles and copayments. As they grow, that creates desire in the marketplace for supplements.

MR. JOHNSON: I have an observation on that issue. There are the caps in President Clinton's plan, and the price fixing by the alliances on the physicians' fees and on the providers' fees are going to result in either a rationing of care or a cutting back of benefits, which may be in the form of increased copayments or deductibles. That's inevitable, it can't not happen. So there is going to be real pressure somewhere along the line to provide those through supplemental products. Even though they restrict the supplemental products, that isn't going to last long under that kind of pressure. There's another option, too. At least one company in this country is selling a supplement to Canadian citizens that says that if they do not gain access to their system within some period of time, 45 days or whatever it is, it will pay for them to come there to have their procedures performed. Maybe we can offer to fly people to Mexico for health care.

MR. PAUL A. CAMPBELL: Several months ago, when a professor went on sabbatical, I volunteered to teach the social insurance course next semester. Talk about watching a moving target. Do you know when and in what scenario the alternatives are going to come forward, and is some kind of a reconciliation going to occur? Does any kind of a time frame exist before some of the substantive issues in President Clinton's plan or in the opposing plans might be approved?

MR. LUND: The best observation that I've been aware of is that Congress has to act before the elections next fall. On the other hand, the President's program is not yet drafted into legislative form, it has not been introduced by anyone, and the debate in Congress has not started yet. Interestingly, the time schedule included in all the documents released by the administration calls for passage of the program in December 1993, which I don't think anyone expects. I think that once it's introduced, we will start to see hearings in Congress during the first quarter of 1994. It will move to a vote sometime in the summer on some form of compromise plan. On all other pieces of legislation and also as a governor, Bill Clinton has been a person of compromise. I expect that you will see that posture continued from the administration.