RECORD OF SOCIETY OF ACTUARIES
1994 VOL. 20 NO. 3A

PROSPECTS FOR HEALTH REFORM LEGISLATION

Welcome: R. STEPHEN RADCLIFFE
Keynote Speaker: BILL GRADISON*

Mr. Gradison will discuss the latest HIAA activities in the health care debate and industry implications for proposed legislation.

MR. R. STEPHEN RADCLIFFE: I'd like to welcome you to San Antonio and our third spring meeting of 1994. More than 1,000 are attending this meeting, which includes a wide variety of topics for actuaries primarily involved in the health and pension fields. However, we also have some sessions focused on management and investment issues.

We have been asked by the American Academy of Actuaries to allow some time to tell you about its efforts to address health reform. So at this time I'd like to introduce Howard Bolnick. He is a vice president of the Academy and heads the Health Practice Council. He's here to bring us up to date on the Academy's activities.

MR. HOWARD J. BOLNICK: Health care reform is a great opportunity for the profession. It's a great opportunity in some obvious ways and in some not so obvious ways. The obvious way is that we have an opportunity to participate in what is clearly the most important domestic, political debate in decades. But the nonobvious ways are what it does for us as an organization for our profession.

First, it helps us strengthen the profession externally by allowing us to provide unique and meaningful actuarial input to the administration, to Congress, to independent agencies like the Congressional Research Service Office of Technology Assessment, and the Congressional Budget Office (CBO). It has also helped strengthen us internally by helping us improve our internal operating methods by expanding the number of members who have volunteered to work on professional activities. It has helped us develop new links between the Society of Actuaries and the Academy of Actuaries by touching on some relevant needs and interests of many of our members.

The Academy's involvement in the health care reform debate in Congress began when President Clinton announced his Health Security Act in September 1993. We put together a group of leaders from the Academy and the Society of Actuaries represented by Sam Gutterman to develop a work plan. This work plan was formulated in October 1993 and was immediately put into effect.

As a result of this work plan, a number of things have happened. First, the Health Practice Council formed 15 work groups charged with developing issue papers that were to discuss various subjects that were drawn from the Clinton bill. The interface on these issues was with the external audiences on the Hill and elsewhere. From these 15 work groups, to date, 8 issue papers have been published from 5 of the

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work groups. One issue paper was from a previous work group that preceded this particular effort on the Clinton bill. The cost-estimate work group, which has perhaps the most important issue that we had to deal with, has struggled to come up with some interesting ideas and things to say about the President's cost estimates or the Congressional Budget Office's cost estimate. It has added some pivotal thought to the issue of trying to price out not only the President's proposal but any other proposal that comes from the Hill.

This group was staffed by four people, Dale Yamamoto, Alice Rosentblatt, Hal Barney, and Phyllis Doran. They really did a tremendous job on behalf of the profession and worked almost full-time for three months. You might thank them for all the effort they put in.

In addition to the work that's been done, eight issue papers are in our peer-review process and will be issued in the next few weeks. So in total 16 work papers will be coming from these 15 work groups.

Behind the scenes, all the work groups have been in continuous contact with key congressional staff from both the House and the Senate. Many have been up on the Hill discussing the issues behind the papers even while the papers are in progress. Many of the work groups, too, have testified before congressional committees. Many have held press briefings. Some have participated in policy forums around the Hill, such as at the George Washington University National Health Policy Forum.

The second major effort is a joint Society of Actuaries and Academy Communications Task Force that is charged with taking this information and disseminating it to our three audiences: actuaries, Congress, and the public. Actuaries have received a number of things. I hope all of you have been reading practically every issue of *The Actuary*, *Actuarial Update*, *Health Section Newsletter*, and *Contingencies*. All these publications have included information that has been drawn from these work groups' issue papers. I'm going to talk a little bit more about the substantive issues from these issue papers.

Many of the sessions that are on the program are really outgrowths of the work groups and the issue papers that have been in progress during the last six or nine months. The members of Congress have received mailings and have received copies of all the completed issue papers. They will continue to receive copies of the issue papers as they become available. Even the public has been aware of what we've been doing through the press briefings from the work groups. Many of the press briefings have been picked up in the trade publications, but you may have also seen mention in the *New York Times*, *Washington Post*, *Los Angeles Times*, *Chicago Tribune*. Some of our efforts have been noted in those papers.

The Society of Actuaries also is involved with this effort through three task forces and its research committee. They've been working to support some of the efforts of the Academy of Actuaries and to move some of the issues from issue-paper level into some research. Finally the casualty actuaries are working on two issues that also affect health care reform: workers' compensation and medical malpractice.

Well, what has the impact of our work been on the health care reform debate? We've certainly had a high degree of receptivity for our work from congressional staff and the congressional agencies. They've interacted with the work groups. They've asked the work group members to come up to the Hill and talk with them. They have asked for points of clarification and have asked for their opinion on other issues. This has generated and increased the flow of requests from the Hill to the actuarial profession.

This is happening because people on the Hill and health policy people are beginning to recognize the unique contribution that actuaries can make to these types of debates. We have a unique ability to blend theory and practice. The issue papers have really done a good job of unearthing the areas where hazy thinking and inconsistencies lurk behind the theories and the political ambitions that are driving some of these policies.

Well we found these inconsistencies, or we found this hazy thinking, and we've tried to suggest ways to improve on the theory. We've also been able to ferret out a full range of outcomes—some of them positive and some of them negative—that might hit us when some of the theory comes into practice.

The effort that we've just talked about is the one that started in October 1993 and is essentially winding down as these issue papers are delivered. Now we need to look ahead to the future. A group from the Academy leadership and the Society of Actuaries leadership met last month again to plan the next phase of our involvement. Our plans stretch through 1994 well into 1995. The specific things that we are going to be doing include building on the work papers that have already been produced and are going to be produced in the next few weeks and to increase our interaction with people on the Hill.

Second, because of the requests that our work has been generating, we found that we have to focus and expand our federal health committee, which is headed by Alice Rosenblatt, to answer technical questions that are coming from the Hill. So we're reformulating and focusing this group as technical assistance teams to help field all the inquiries we expect to be getting from the Hill.

Third, we're looking to expand the joint Academy and Society of Actuaries communication efforts by making better use of bulletin board systems, by increasing our use of the publications, by beginning to communicate with health policy people outside the Hill, and by reaching the public perhaps through some op-ed series.

We're also planning a number of new work groups in response to areas that we think we have something unique to add but that haven't yet been addressed by the Academy or by other outside audiences who are trying to have a voice on the Hill.

We're also planning an increase in our joint efforts with the Society of Actuaries in a number of areas. Many of the issues that were brought up by the work groups require research. So we're trying to hand off some of the issues from the Academy to Society of Actuaries research groups. We are working closer with the Society of Actuaries on continuing education opportunities, such as this meeting, and perhaps seminars. We're upping the amount of interaction on communications, and we're doing more long-range planning.

In summary, I think we've had successes and we have work yet to do. We've been able to organize and staff what might well be the largest single work effort that the actuarial profession has ever undertaken. We've also been able to greatly improve the cooperation and coordination between the Society of Actuaries and the American Academy of Actuaries. Most important, we've been able to provide unique and well-received actuarial input to the Clinton administration and to Congress.

But we still have more to do. We're going to hear a whole lot more about health care reform from Bill Gradison. This seems to be settling into, in one way or another, not a battle of one year, 1993–94, but as we refer to it, the Hundred Years' War. Regardless of what scenario you look at, either federal legislation will be passed and regulations will need to be dealt with, or the federal Congress will be looking at federal legislation again next year, or the states will be looking at things. But one way or another we're going to have a high level of actuarial involvement for the next few years on the subject, and we have to figure out how we can do this best.

We must continue to work on strengthening the profession both internally and externally—strengthening it internally by more coordination and more work between the Society of Actuaries and the Academy of Actuaries, and externally by being sure that our unique skills are more visible to the external audiences not only on the Hill but to health policy people around the Hill.

In closing, we were able to recruit and sustain a high level of effort from more than 200 actuaries during the last 6–9 months. Without this effort, without this participation, without this interest, none of this work could have been done. I think we all owe a great deal of thanks to the members who did step up and contribute to the process. I assure those of you who would like to join in the process in the coming 6, 9, or 12 months, there will be many more opportunities to do so.

MR. RADCLIFFE: We are delighted to have Bill Gradison, president of the Health Insurance Association of America, deliver the keynote address. Prior to assuming his current post in February 1993, Bill Gradison served in the House of Representatives for 18 years. During part of that tenure he was the ranking minority member of the House Budget Committee and the Health Subcommittee of the House Ways and Means Committee. He was also chair of the House Wednesday Group. That's a by-invitation organization of the House Republicans that was established in 1963.

Mr. Gradison is currently chair of the Economic Round Table of the American Enterprise Institute, a Washington-based think tank. He also served as vice chair of the U.S. Bipartisan Commission on Comprehensive Health Care, known as the Pepper Commission. He is a member of the board of directors of the Life and Health Insurance Medical Research Fund, a member of the Commonwealth Funds Commission of Women's Health, and a member of the National Academy of Social Insurance. He also serves on the board of governors of the National Hospice Organization. Well, our timing couldn't be better, because he will speak to us on the prospects for health reform legislation.

MR. BILL GRADISON: It's such an important turning point in the national debate on health reform. I welcome the opportunity to share with you some of my thoughts about what is going on and what may happen in the near future. I have the good

fortune as a nonactuary to be surrounded by actuaries who are extremely helpful to me in carrying out my present responsibilities.

At the HIAA, my associates include Tony Hammond and Bill Weller. Their services are extremely valuable not only in dealing with issues of national health reform, but also in the continued activities in working with the state insurance departments and the state legislatures. When I came on board in this job just over a year ago, our chair was Ian Rolland, an actuary at Lincoln National. Our current chair is Tom Sutton, an actuary at Pacific Mutual. Our chair next year will be Bill McCallum of Great-West Life, also an actuary.

I also want to acknowledge the major contributions on the subject of health care reform of Howard Bolnick and his associates at the Academy. In my job, it means a lot when somebody such as Howard, with his background, and his knowledge, and his degree of involvement, picks up the phone and calls me, as he does from time to time, to let me know what they're working on and what some of their observations are with regard to the issues that are being debated.

My message is that key actuarial principles, which are barely understood by the public or by policymakers, are at the heart of the debate over health care reform. There is a serious risk that in the efforts to cobble together a plan that will pass—in other words get 218 votes in the House, 51 votes in the Senate, and the signature of the President of United States—there could be unintended consequences that would result in lower coverage and higher premiums, which is clearly not what any of us as health care reformers have in mind.

Now the reason I try to frame what I talk about in that way is to make a point, which I think is lost sight of in most of the national discussion, indeed in most of the press reports.

This national debate has something, but not very much, to do with health. It has something, but not very much, to do with the delivery of health care. It has a lot to do with the question of health insurance. That's why I focus on this; not just because of my job but because that's really what's being talked about in the Congress and around the country today. But let me go back to the beginning and then try to indicate how we got to where we are and set the stage for talking more specifically about some of the actuarial aspects of these issues.

Clearly, the reason that the health insurance issue has moved from the back burner where it was for so many years to the front burner is the growing concern of the middle class. In other words, today what is moving this issue is a concern by people who have health insurance. And 85% of the American people have some form of public or private health insurance today. These are folks who are worried about whether they will keep their insurance if they lose their job, whether they'll be able to continue to afford their health insurance in a world of rapidly inflating medical care costs.

The political aspect of this was brought to the forefront by the victory of Senator Wofford in Pennsylvania. The health care issue was a very important issue. This

was also an important point of difference between former President Bush and President Clinton during the 1992 presidential election.

Having said that, though, I think it is useful to reflect on why it has been so hard to act on these questions. There isn't a whole lot going on today that hasn't been around for a long time in terms of problems with health insurance in the United States. I had the honor to follow the distinguished First Lady in a program in North Carolina a few months ago at the emerging issues conference put on by Governor Hunt. She said that in her view our failure to act on health reform in the past has reflected our inability to overcome the power of the special interests. Those are her exact words.

I don't happen to think that's what happened, but you can form your own judgement. I think there are three reasons why we haven't had action in the past. Each of these is very much alive and is a challenge today. If they have a connection to the special interests, I kind of miss what those are.

The first has been a striking unwillingness of members of Congress to compromise. The last time major health legislation was passed in this country was more than a generation ago, in 1965, when Medicare and Medicaid were put on the books. It's been a long time. There have been many efforts during that period to do something. The main reason they failed, in my view, is not that there are so many different ideas out there, but that people are unwilling to compromise and come together on something that would command a majority.

A scholar at Brandeis who has followed these issues for years says that the trouble in this country in health reform is that everyone's second choice is to do nothing. That's really been true in the Congress. The reason very simply is that people are so strongly of the view that they are right. They would prefer to have nothing happen, figuring that things will get worse, and then the people will realize that their plan is the best plan. That's what's been going on.

There have been extraordinary efforts during the last two or three months between the two political parties to try to reach some kind of accommodation. They have, up until now, been total failures. That may change tomorrow. There's been almost no movement to meaningful compromise over recent months. I assure you that is not a partisan comment. There are at least three Republican versions and at least three Democratic versions of health reform in each House of the Congress.

Closer related to this failure, or unwillingness, really, to compromise, has been a war between those who want comprehensive change and those who want incremental change. Many folks say just fix the parts that are broken. That is not an attractive message to those who want to remake the entire one-seventh of the economy that we refer to as health care.

Indeed, incremental change would make it harder to sell comprehensive change later on. So this is really not just a philosophic debate, it's a question much deeper than that. That's something to watch as things unfold.

Then we come to the number one problem. That's financing, of course. Sometimes I think I overemphasize this. I've made my living in the investment business over the years. I've served 16 years on the Ways and Means Committee, 10 years on the Budget Committee. But I think money *is* at the heart of this debate. I'm skeptical. When people say it's not the money, it's the principle, I think to myself it's the money. I think in the health issue that's especially apparent, because we seem to be shifting from the idea of health insurance being like other forms of insurance where there's some relationship between the premium and the risk toward the idea of health insurance being considered social insurance, by which most of us would mean everybody should be covered. The price or premium should bear no relationship to prior health expenditures, current health status, genetic makeup, or anything like that.

Now, if that is the direction in which we are moving as a country, all bets are off with regard to financing. It is perfectly reasonable in that context to say the government (the taxpayers) ought to finance it. That approach is reflected in the single-payer or "Canadian-type" recommendation. It isn't really a Canadian approach, but that's often how it's described.

Others will say for better or worse we have a system that's built upon large employer contributions. They say not only should we build on that but we should also mandate that every employer pay at least 80% of the cost. Others say the individual should pay. The government would help people with low income to make sure they could afford health insurance. But otherwise health insurance should be just like any other kind of insurance: auto insurance, house insurance, property insurance, or life insurance. That point of view is a respectable one as well and is held by a substantial number of people in the public as well as in the Congress today.

So those three problems continue to be with us. Our association has responded to this challenge in a rather interesting and, I think, in a sense, surprising way. Traditionally, our industry has been state regulated and traditionally we have opposed federal action in the field of health insurance. About two and a half or three years ago, well before I was on the scene, this association began a searching review of what would be the best public policy in this area. It developed its vision for health care reform, a vision that was essentially complete and made public prior to the new administration coming into office. Among other things, it calls for universal coverage, a federally defined-benefit package, a federally defined uniform claims form, a tax cap, and an employer mandate as a means of financing.

In many respects it's similar to the proposals of the President, although you wouldn't know it after listening to some of the things they have to say about us at the White House. But there were three points that we disagreed with once the President's plan was put out there. First, we strongly opposed the mandatory health alliances. Voluntary was okay; mandatory we were against. Second, we were opposed to premium limits. Third, we were and still are opposed to pure community rating. Our message to the public and our advocacy efforts have been built largely around those three points.

We tried to incorporate in our message the things we're for, but people don't usually hear that. There is power to negative advertising. Even when you say "I'm for this

and I'm against that," it's what you're against that usually sticks in the public's mind. That's regrettable but I think it's true.

Why are we for universal coverage? There are many reasons. First, we think it's good social policy. Second, I don't know how to say this without being misunderstood, but it's kind of nice when the government wants to require everybody to buy what you have to sell. That's really what they're trying to do.

One of the great ironies of the White House bashing of the health insurance industry is that they are turning around and saying, "We're not for a Canadian approach. We want you all to buy health insurance from private health insurance companies." So, on the one hand, they're saying that we're no good profiteers and price gougers, and we are responsible for everything but child abuse in America. On the other hand, they're saying, "Well we're going to require you by law to buy policies from these folks." It's an interesting mind-set.

But there's another reason. Without universal coverage we run the risk, as I will elaborate on, of some insurance reforms taking place that could be very damaging to the public and also very damaging to our industry.

Our advocacy efforts so far have focused on the first of those two points. I will not dwell on the health alliances because through our efforts and others they're pretty much off the table right now. Mandatory alliances are not embodied in any of the bills that have a chance of moving forward at the moment. We've also been focusing in our ads on the question of premium limits, which we often phrase as governmentally imposed limits on health care spending. This is an accurate way to say it, but it also tests out better in our focus groups.

Then there are Harry and Louise. Harry and Louise are two actors who have participated in our advocacy efforts. Perhaps a word about how that all happened. A little more than a year ago, I was giving some speeches about health reform, and I was reflecting, I guess because of my 30-odd years in elective office, that I thought that health reform was a unique issue in my experience. It is the only issue that I can think of in my time that directly impacts every American family. I concluded that it would not be resolved by speeches, mine or anyone else's, or by advertising, ours or anyone else's. But it would be resolved over the kitchen tables of America as people sat down and talked about what any of these plans mean to their own family. So we tested all that and found that it worked. Harry and Louise commercials began with Harry and Louise sitting around the kitchen table talking about health reform. They're coming back beginning next week, sharing their thoughts with a waiting world on the question of these spending limits. For the first time they will use the R word, "rationing," to talk about some of the implications of what such governmentally imposed spending limits might mean in this country.

I think the next few weeks, maybe even the next few days, will tell what, if anything, is likely to pass in health reform. You can't tell the players without a program. I'm going to try to describe what some of the players are up to. That might be helpful for all of us in interpreting what happens in the days immediately ahead.

So let me talk about where I think matters now are with regard to each of the major players. First, it is the White House's view that its plan is the best one out there. But it hasn't sold it very well. Therefore, the President and Mrs. Clinton are out from time to time giving speeches and sending surrogates and cabinet officers around to try to sell their plan.

They consistently say that what they really want is universal coverage, that this federal benefit package and everything else is negotiable. I don't question that's their view. The fact of the matter is, the White House has been unwilling so far to negotiate specific compromises with anybody. I mean they will have not even done it with their friends on Capitol Hill on any of these points, neither the two that I mentioned nor anything else.

In fairness, part of this is that the five key Democratic committee chairs, three in the House and two in the Senate, have asked the White House to stay out of this for a while and let them try to move the bills forward. But the clock is running. It's a little awkward, as a strong supporter of the House of Representatives and somebody who just thought the highest privilege was to serve there for 18 years, to make this point. But the Congress kind of acts from recess to recess. This is an election year. If you do the actual count on how many legislative days are left, it must not be more than 40 or 50 by now. So time is really running out. Yes, it is June but minds of members are shifting very quickly to election day in November.

Now what this means is that the White House has yet, I don't say they haven't been thinking about it, to indicate publicly precisely how they will define universal coverage. The President has said he'll take the veto pen out if he doesn't have universal coverage. We can get into this later if you want, but universal coverage has many different meanings. It isn't quite clear what he is talking about there.

Many folks believe that in the end the President will redefine his goal so that there will be a bill he can sign to go down in the history books, so that he can lay a basis for a strong Democratic claim at the polls this fall. Many believe they should be sent back in large numbers in the House and the Senate, because they listen to the public on health care.

So it isn't at all clear to any of us the extent to which the political aspect of this is wanting to have a bill, almost any bill. We don't know how that will play out against the somewhat more ideological view of wanting everybody to be covered and have the plastic card as soon as possible.

In the House of Representatives, three committees are working on it. Only one, my former committee, is really key to this. That's not to disparage the work of the others. It's to recognize, though, that the Ways and Means Committee is the only committee in the House that has jurisdiction over financing.

In a very real sense that's what this argument is all about. The employer-mandate issue isn't just an employer-mandate issue. It's the question of how you are going to pay for it. For the employer mandate, the immediate question is, what's your substitute if you want universal coverage? Something else would have to be in there to come up with the necessary financing.

I believe that the Ways and Means Committee will report out a bill with an employer mandate. The real question is whether it will pass on the floor of the House of Representatives. There's a lot of doubt about that, although one cannot be sure.

The current strategy of the Democratic leadership in the House is to pursue what they've described to me as the 85% solution, which is to pass a bill on the floor of the House with no Republicans. To do that you must get 85% of the Democratic members.

Many are very nervous about the employer mandate. They figure, probably correctly, that the Senate won't have one. They don't want to vote for it in the House and get pilloried by small business right through to election day.

If it's going to get lost and traded away anyway in the Senate, this is called, within the beltway, being BTUd. That's what happened last year. A number of House members, many of them from energy-producing districts, voted for a BTU energy tax. The White House told them "we'll never give it up." Of course, it was lost in the Senate. So there's a credibility problem out there that impacts on the health issue, which goes back to the vote last year on the budget.

As far as the Senate is concerned, the key committee is the Finance Committee. It has financial jurisdiction but it also is more representative of the general membership, unlike the House where there is a strong partisan inclination of the leadership to do things on its own. That is not as true in the Senate and certainly not as true in the Senate Finance Committee.

We saw that when we were working on tax reform in 1985 and 1986. It was tough getting a tax-reform bill out of the House of Representatives. Many Republicans balked even though President Reagan was pushing it. Then it got over to the Senate and the Senate approved its version 20 to nothing.

Now, that's what many of them would like to do. The Finance Committee is composed of 11 Democrats and 9 Republicans. One of the Democrats has already said that he does not think that the health issue is one that should go through just on a partisan vote; that what's done should be done as Medicare and Medicaid and Social Security were done, on a broad bipartisan basis. Those programs don't get jerked around over the years, depending on who happens to be in power.

Right now, as you may have noticed, there is no majority in the Finance Committee for any particular version. But the focus in the Finance Committee is on a trigger. That is to say they almost certainly will not have the votes for an immediate enactment of an employer mandate. But they might have the votes for a provision that if some stated percentage of coverage isn't reached by some specific date, three, four, five years out, then a mandate might trigger in. Now it is down to hard triggers and soft triggers. A hard trigger is one that would automatically take effect if the definition of coverage that's in the statute isn't reached. A soft trigger is one where all you're assured of is that if the number isn't met, a subsequent vote would take place in the Congress. It would be a fast-track vote and unamendable in all likelihood. It could be voted up or down, but there would be no assurance that a mandate

would be approved at some time in the future. I know that's technical but this hard and soft trigger are what's being discussed right now within the Finance Committee.

After the recent meeting with the President, Chairperson Moynihan, and the ranking members, it became clear that they didn't have a majority for anything. Therefore, they're likely to do what many committees do in a case like that: get together and try to see what they can agree on. One of the areas that they likely can agree on is insurance reform, which is our main, number-one concern. I'll come back to that in a bit more detail. But, I think, it is possible, even before this week is out, certainly before next week is out, that we're going to see in sharper focus whether there are insurance reforms coming along that, in our view, would work.

Where is the most important group of all on this issue? The public view has been changing. Support for the President's plan reached its peak immediately following that gangbuster speech he gave to the joint session late last September. Support has been dwindling ever since.

That's not just based on our polls, it's based on polls by others. The most recent one appeared in *U.S.A Today* yesterday or the day before. We find that a plurality of the public are opposed to the President's plan. Of those who are strongly in favor or strongly opposed, the ratio is 2-to-1 of those who are strongly opposed to those who are strongly in favor of the plan. Every survey we've done indicates that somewhere between a third and 40% of the public are undecided.

In that sense it is still up for grabs, which is maybe one reason the White House is still out trying to sell its earlier plan. That number of undecideds doesn't seem to change very much. It may reflect simply the complexity of this issue. People finding it complex may be unsure which way to go. That's certainly understandable.

We see increasingly that the more people know about the President's plan, the less they like it. To know it is not to love it. Therefore, we think the availability of more information about it has something to do with the rising negatives.

This shift to a no vote has been very dramatic among certain groups, particularly the elderly. They were very strongly in favor of it in September and seem to have shifted very strongly in opposition more recently.

Also, the positions on the President's plan are closely related to people's partisan leanings. Republicans, people who voted for Bush, overwhelmingly are against the plan. People who voted for President Clinton are overwhelmingly in favor, although that is slipping a little. Perot voters, who tended to be for it at the outset, are one of the groups that is now shifting very dramatically in opposition.

I go through that, not that it relates to any actuarial or logical approach to this, because the public is what really counts. The members are listening to the folks back home. I'm hearing more and more from members, and the polls bear this out. But the public is in no hurry. They're saying to do it right even if it takes a little bit longer. That may also influence some of the votes that are likely to be cast sometime soon.

Now let me just share with you what I think all this means to me. I coined an expression, which is just for my own amusement, back in 1985 when we were working on the tax-reform bill. "He who controls the computer controls the process." I think that had to do with tax estimates. They could only grind out so many estimates so fast. The people who could get the estimates first had a lot more power as far as moving that issue was concerned.

I think there's some of the same truth with regard to actuarial estimates. The process is very slow, complex, and also very controversial. I found that out in several ways. Back in about 1989, we were working on Medicare catastrophic coverage legislation. Sometimes it's a subject I wish I could forget, but it was the Stark-Gradison bill and I'm the Gradison. Stark and I have applied for listing in the *Guiness Book of World Records* for having written the only social insurance program in the history of this country to be repealed before it took effect.

A lot of this had to do with the cost. The original bill had a flat monthly premium. It was a catastrophic coverage bill and that was about it. There was a lot of pressure to add prescription drug benefits and we did. To pay for that we put in an income-related premium. That's where all the problems came from, which, of course, had to do with financing. But I mentioned the Medicare catastrophic experience because I learned a lot about the difficulty of estimating at that time.

There were two particular estimating problems. We did not have current information on personal health care expenditures. So data that were quite a few years old had to be trended forward. As it turned out later, they were not trended forward correctly. The inflation rate of prescription drugs was not trended accurately. Nor was the proportion, as I recall, of health expenditures going to prescription drugs.

The other thing we ran into, which is understandable, is substantial difference of opinion about the amount of induced demand. Obviously, once a prescription drug benefit becomes available more people are going to use prescription drugs. The question is, how many more and how much would that cost? These are things you grapple with all the time, but it was an education to me.

I learned this in another way. In Medicare, there's been an attempt to ratchet down the cost of the program in a number of ways, but in particular to reduce the payment to providers for certain procedures, certain high-cost, high-volume procedures. Now, of course, what we found immediately is that the lower the payment the higher the volume of the procedures. So that's partly economics and partly human nature. In general, we only accomplished about 50% of the savings. I'm painting with a broad brush here. But the point is correct. We only achieved about 50% of the savings we were seeking to achieve. The increase in the number of procedures took away a good bit of what we had hoped to save through paying less for each procedure.

Now with regard to the President's health care plan, these actuarial estimates have been right at the heart of the debate. There's no better example than the cost of the benefit package. There was, to my knowledge, no peer review, in a meaningful sense, of the cost of the President's package. So all the estimates came out afterward.

The lowest estimate that I'm aware of has been the CBO estimate. It projected that the cost of the benefit package in the President's plan was understated by approximately 15%. There have been a half dozen estimates that were higher than that.

Now that may not sound like much. But that translates in CBO calculations to a shift or shortfall of $130 billion during the first five years. It's a highly leveraged effect. If the benefits cost 15% more, then the subsidy for low-income people and the subsidies for small businesses that have a lot of low-income employees would increase very, very dramatically. That was one of the factors that we had to work with.

Something else that I picked up from my own experience, and this disturbs me a whole lot, is the tendency of people, including the Congressional Budget Office, to come up with point estimates. There are so many variables involved in trying to estimate the cost of health programs. There are so many uncertainties about how the availability of benefits will impact on human behavior. Point estimates are just a big, flat mistake.

It's the same thing we have in the tax field. People argued correctly that a static analysis of the cost of changing the capital gains tax didn't mean anything. That's true, because there's a behavioral effect. But opinions will differ on what that behavioral effect is going to be.

I personally, as a former legislator, prefer to have estimates in ranges that include a percentage probability estimate for each of those ranges. It is better than this estimate where they come up with the last decimal point. It's meaningless. But it gives the impression to many people who don't work with these things all the time, which is most members of the Congress, that these issues are subject to estimates that you can rely upon and that have a high degree of reliability. If you have any doubt about that point, and this is a rhetorical device that I'm going to use, take a look at the estimates of what Medicare would cost today.

They were made in 1965; you'll find they were off by a factor of 9. So these aren't precisely quibbles. Now, having said all that, I should also point out that the granddaddy of them all in terms of actuarial issues, which are part of this debate about the President's plan or any other plan that's really going to work, has to be risk adjusters.

I can only characterize it as a joke. At least I thought it was a joke. In the President's Health Security Act, a 1374-page cure for insomnia, there is the assumption that there will be up and running a workable risk adjuster by April 1, 1995. That's a joke. People have been working for years at this. Many serious-minded people doubt that it can ever be done. It certainly hasn't been accomplished so far. And it is not around the corner.

Here is another example of where the work of your profession has been germane to what's going on. Now, fortunately, there is some real-world experience out there that we can look at. In particular is the question of the impact of reforms on the non-universal environment. That's the experience of the state of New York.

We've been talking about this for a long time, based upon data that we receive from some of our members. But very simply what's happened is New York has guaranteed issue and they also have a flat community-rating approach. What's occurring is younger people are dropping out of the pool because of sticker-price shock. They don't have to buy it. Price has gone up rapidly. The remaining people in the pool tend to be sicker.

So coverage is down, premiums are up, and that was billed as health reform. That's really at the heart of what worries us about what may be happening in the days and weeks ahead. I felt a little lonesome as we were making this point in our rounds on Capitol Hill during the last month or six weeks. I don't feel as lonesome now. A recent editorial in the *New York Times* made precisely the same point. Also, in a publication called *Roll Call*, which is circulated widely on Capitol Hill, the distinguished First Lady made that very point about the New York experience.

We did work with former Chairperson Rostenkowski to try to come up with a way to deal with this during the transition period. Regrettably, his successor, Acting Chairperson Gibbons, who was not a part of the earlier discussion, has other views on the subject. The approach that we had worked out is not being pursued. I think perhaps the more important point is that what the Health Insurance Association of America has to say is that we've been meeting and have developed about a 20-page paper with the Alliance for Managed Competition, which is Prudential, Aetna, Travelers, CIGNA, and Metropolitan, and with the Blues and the Group Health Association of America. All four groups are in virtual complete agreement with regard to which insurance reforms will and will not work during a transition to universal coverage. We hope that will have some impact on the debate that is taking place.

In a nonuniversal environment, to boil it down, here's what we think can work. First is portability. Once you're in the system, you can without any new pre-existing condition limitation keep your coverage if you move to a new job or lose your job and take out an individual policy. Second is renewability. Unless the insurer withdraws from the entire business, the renewability provision, we believe, can work. Third is whole group coverage. To make this work, you must have whole group or something very close to it. You can't just have a small business sign up and then have very sick workers participate and others stay out. We also think that periodic open enrollment would work; not open enrollment just any day of the week or year, but perhaps some kind of a coordinated 30-day period each year when people could come in and enroll.

What we don't think would work in a nonuniversal environment is continuous open enrollment. People could come in and buy their health insurance policy on the way to the hospital to have their bypass operation. I regret saying this, but we do not think it would work in a nonuniversal environment to totally eliminate considerations of pre-existing conditions for those who are not covered by insurance today.

For reasons I've already alluded to, we do not think flat community rating would work at all. In fact, we think it would be counterproductive in an environment without universal coverage.

In conclusion, I think there's going to be a skinny bill. I think that insurance reforms for better or worse are going to be an element that the Congress can agree on. We just hope they do it the right way, that the reforms will work.

I also would report to you that whatever the bill may include on health reform, it's going to keep a lot of you busy doing some very important things. There's bound to be expanded emphasis on outcomes research, and work with regard to risk adjusters. Whole new calculations will have to be made with regard to risk assessment in individual companies as new people come on. The benefit package is changed. Actuaries are going to play a very important role. So even though they may call this the Health Security Act of 1994, or the Clinton Reelection Bill of 1996, I think it could accurately also be called the Actuaries Full-Employment Act of 1994.

MR. JOHN E. O'CONNOR, JR.*: I know you worked with Dan Rostenkowski on getting some agreement. Can you comment on what his recent problems might mean for the progress of this health care reform?

MR. GRADISON: I don't think they're going to substantially change the situation. In fact, in certain respects, the work that he did prior to the indictments is being used as a basis for much of the mark, which Acting Chairperson Gibbons has laid before the Ways and Means Committee. I don't want to do a psychoanalytical or metaphysical piece. But I have to report to you there is a sense in the Ways and Means Committee among the members that it's something special, the Cadillac of Committees as Danny Rostenkowski used to call it. It is the oldest committee in the Congress. It celebrated its 200th anniversary just a few years ago. Under the Constitution it plays a special role in that all revenue-raising measures must originate in the House, which means in the Ways and Means Committee.

What this means to me is that somehow or other, that committee is going to report out a bill. That is its job. Its job is not to get it passed on the floor of the House; that's the job of the leadership. It isn't necessarily even to write a bill that can pass on the floor of the House. It is to keep the process moving to have a revenue component. I don't think the problems that exist in certain other committees exist in Ways and Means. I think at the end of the day, former Chairperson Rostenkowski's problems, while very regrettable for many reasons, will not impede the movement of health reform.

MR. FRANK E. KNORR: There is a presidential election two years from now. If there is no legislation by then that includes universal health care, what do you think the chances are of a Republican president picking up the ball?

MR. GRADISON: Well, two years is a long time for that last part. Health reform is a very important component of the likely national debate at that time. Traditionally, the President's party loses a significant number of seats in both the House and Senate in the first off-year election.

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*Mr. O'Connor, not a member of the sponsoring organizations, is Executive Director of the Society of Actuaries in Schaumburg, IL.

This President, unlike most, lost 10 seats in the House at the very time he got elected. If there were normal, average gains by the minority party, the Republicans in the House and the Senate this year, it is perceived to be very likely that the President would have a very hard time getting many of his agenda elements through in 1995 and 1996, not just health care.

Many people think that if a health care bill passes that he can sign, that will help to minimize losses at the polls this fall for Democrats; maybe even reverse the historical trend. That would lay the basis for his being perceived as effective in 1995 and 1996 in the legislative arena, not just in health care, but in other issues.

So this isn't just another issue that we're all interested in and talking about together. Both parties are trying to size this up. Six months ago, I would have said that Republicans were very leery about the possibility of no bill, that they were afraid it would hurt them at the polls. I don't think that's as true today. My sense is that both parties think that they would have a real shot, if nothing happens, at going to the polls and using the health issue this fall in arguing their case with the American people. Now again they can't both be right. But if they both have that perception, it may diminish the pressure for passage.

I still think something is going to pass, but I don't feel as sure about that as I did a few months ago.

MR. HAROLD L. BARNEY: I was one member of four of that cost-estimates work group that looked at the President's bill. You mentioned earlier the estimates of Medicare being off by a factor of as much as 9. I won't take exception to that, although I think there are some actuaries who may, in particular our friends at the Health Care Financing Administration, who have done both some of the estimate for the President's bill and some of the earlier estimates.

I mentioned that because I think the cost estimates are an extremely important part of what we're doing. But my question deals more with what perhaps George Santayana said some time ago: "Those who do not study history are doomed to relive it." Your point was right in connection with that. My question is, if you look back at history, at the Social Security legislation, Medicare legislation, Medicare catastrophic, perhaps at ERISA in 1974, how would you rate the government's ability to provide security? All of these acts were aimed at providing security to the American public. What have we learned about the ability of the federal government to do that?

MR. GRADISON: Well, maybe the lesson I draw from experience is tangential somewhat to what you're talking about. To me, the great lesson is that once benefit programs are put on the books, they are virtually impossible to change. Somehow or other, the financing has to be developed. In a sense, it's a defined-benefit plan rather than a defined-contribution plan and you're stuck, as businesses are today for that matter in trying to figure out how to finance it. I do not think this entitlement mentality is limited to people's view of government programs. I think the same entitlement mentality exists in business today, where individuals who have a health plan from their employers expect to continue to have it. If it's first dollar, they don't want to change. It is the same attitude.

The problem with this is that in a world of scarce resources, and that's my definition of the case, if large existing programs can't be modified, it becomes almost impossible to figure out how to finance new programs, even those that might meet a higher standard, or that might be more important today than the ones that are on the books. That gets down to honeybee subsidies. That's just not a reflection of health programs or expensive social insurance programs.

There's a recent book on this subject by Jonathan Rouche called *Demo Sclerosis*. He makes this argument, that once programs are put on the books, they just don't change. This makes it impossible to meet new and emerging needs because of the shortage of financing.

I cite Medicare as a perfect example of the point. Medicare is very useful, very popular, it is a state-of-the-art 1965 health insurance package. If we started off today and said we're going to spend the same amount of money for the same people, the elderly and disabled, we would never do it that way. It's 95% fee for service. It has no catastrophic element. It has no outpatient prescription drug benefit. You wouldn't do it that way, that's all. Why is it that way? Because once it's put on the books, vested interest has developed and people don't want the doggone thing changed and there it sits. We found that out with Medicare catastrophic coming along saying, let's modernize it. It doesn't work unless you come up with the money.

MR. DANIEL J. MCCARTHY: You didn't talk about taxes. Yet any bill, even one with mandates, will have cost. Could you talk about your perception as to how the Congress might deal with the low-income subsidies and the small-employer subsidies, that sort of thing?

MR. GRADISON: I think the public has been told for far too long what it wants to hear about health financing; which is, we're spending plenty of money, and if we just spent it right we could have a generous benefit package for everybody. The public has really been fed the line that if you just squeeze out waste, fraud, and abuse you can take care of everything.

Now the President's plan comes along and it says we can do all these good things by just increasing the cigarette tax. Now that isn't really true if you examine the fabric of the bill. There are so-called premiums, which in effect are taxes. But nonetheless, I have thought for a long time that the American people are willing to consume as *much health care as someone else is willing to pay for.*

I think that is the nub of the problem. It's a question of the haves and have-nots. I said 85%, including Medicare and Medicaid, have some kind of health insurance. But whatever the number is for private insured people, by and large, the people who have health insurance are haves in two senses. First, they have health insurance. Second, they have higher-than-average incomes. The only way to take care of the have-nots, the people who don't have health insurance because they can't afford it, is through some kind of collection of taxes or premiums, whatever one wants to call it. I don't think that sold well. The public aversion to taxes is really extreme. I can cite no better example than the recent vote in California.

To the best of my knowledge on the primary day, for the first time in history, every statewide bond issue went down, including bond issues to raise the state matching funds for earthquake relief. Now there's something happening out there, which leads me to believe that when we talk about employer mandates, it's a deeper thing. That's a tax; it's viewed as a tax. You have nothing to do with the selection of the benefit package or the company, nothing to do with the benefit design, just send a check. It is not surprising that some people perceive that to be a tax rather than a contribution.

MR. STEPHEN A. MESKIN: Your ads focus on how people feel health reform will affect them. Aren't you pandering then to just what you've talked about with the things that are happening out there? Why don't your ads also deal with how people feel about what is going on with other people, and what sacrifices they need to make to improve our public policy?

MR. GRADISON: We had a long debate about this. We've tried to balance our advertising with statements on both sides of this. Our experience has been that those positive statements are simply not remembered. We were so shaken up by this that we took a full page on March 13, 1994 in the *Washington Post*. We quoted from our own ads.

We have the language in there that we used in the ads in support of the President doing something about health care reform, warning Congress to pass a bill supporting health care reform for everyone, endorsing universal coverage. We're going to continue to do this. I think we must recognize that that part of the message gets lost because people remember the negative side. I don't say we have any great satisfaction in that. But I hope it is clear that we have three clearly defined items that we want to change.

I was going to say "and only three." These are very important. We will do everything within our power to stop mandatory health alliances whether at the federal or the state level. We will do everything within our power to oppose price and wage controls or governmentally established premium limits. We are strongly opposed to the notion of applying pure community rating, especially having no age adjustment in an environment without universal coverage. That's what the ads are talking about. Now is that pandering? If by pandering you mean we have tried to arouse in the minds of the public strong feelings of opposition to certain parts of the President's plan, absolutely. That's what we're spending a lot of money for, that's what we're trying to do.

On the other hand, I have to say that I don't think these ads would have been effective if those concerns weren't out there already. When we talked about government bureaucracies, which were the health alliances, we knew that not everybody was thrilled with waiting in line at the bureau of motor vehicles. So when we analogized between that and where you buy your health insurance, in that sense it was pandering. But it was building upon feelings that people already had before we ever came along. We were trying to send a message that would resonate with them in the direction we're trying to influence public policy.

No question about it, we are an advocacy group. We've been very up front about what we're for and against. Regrettably, the White House all last year refused to sit down and even talk with us. After the President's plan was submitted and we began our major advocacy program, it wasn't directed at the White House. It was directed at the public and hopefully, through them, at the Congress. We got an unexpected and major assist, however, from the White House, because their criticism of our ads caused the networks to show our ads for free, which they almost had to do to explain what the President and the First Lady were complaining about. We never bought the first cent in that time. We bought a lot of local market. But you really wouldn't know that. They do have a good sense of humor; they did a two-and-a-half minute spoof on Harry and Louise. It's really marvelous. At one point, the President, turning to Mrs. Clinton sitting on his right, said, "And you mean that after hiring all those tens of thousands of bureaucrats and raising all those taxes under the Clinton Plan, we'll still die?" She says "Yes." Then in unison they say, "There's got to be a better way." That's our ad.

There have been many times in history when actors have done parodies of the First Family. This is the first time in history, to my knowledge, the First Family has done a parody on actors.