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HEALTH REFORM DISCUSSION

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Recorder: NANCY F. NELSON

The current federal proposals for health care reform will be analyzed in detail, including the effect of such changes on "traditional" health insurance programs. The roles that actuaries can play in setting policies and programs as well as the role of actuaries in compliance with new rules will be addressed. [This portion was not recorded due to technical difficulties.]

MS. NANCY F. NELSON: Walter Zelman is the senior health care advisor to the administration, he's with the Department of Health and Human Services. He has a degree from the University of Michigan and a Ph.D in political science from UCLA. He spent 12 years as a consumer advocate working for the organization Common Cause in California. Prior to joining the administration, he was with the California Insurance Department as a special deputy to the commissioner. In that role, he was instrumental in developing the health reform proposal for California that was presented in spring 1992. It featured a mix of regulatory and competitive marketing approaches, which is the very model that the Clinton administration is now considering.

He was invited to Washington in February 1993. His work in Washington has been instrumental in the structure of the various components of the health reform proposal, including the structure of the alliances, the structure of the National Health Board, state and federal relationships, and questions of insurance reform.

MR. WALTER ZELMAN: We're nearly at the end of an incredibly exciting year in health care reform, and approaching the beginning of an even more exciting year.

Those of us who have been working on this project for a long time are already drained, but we're going to have to recharge over the next few months. Now someone else is looking at what we've done rather than us trying to create something. We knew it was going to be difficult, and that it was going to be a long haul. I remember Ira Magaziner, the Senior Health Care Advisor, called me a few days after the inauguration. He said, "Well, I know we've talked about this, but now it's really happening, and I'd like you to come to Washington to help out." I said, "Well that's great. When do you want me there?" He said, "Well, there's a meeting with the first lady tomorrow at noon. I expect you'll be there." I got there the next day at noon, of course. He asked how many people I needed and gave me an assignment. I asked for five or six people to chair different subcommittees. He asked if I could get them. And I said, "By when?" He said, "Tomorrow." I got on the phone and called

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five or six people, one of whom was Gary Glaxton, who was supposed to be here. Within about half an hour I had the five people who I thought were best for the various different roles. Not all of them came the next day, but most of them came within a couple of days. This story gives you a sense of how hopeful so many people are that this year or next year may be one of the years we actually get something done.

There have been dozens, if not hundreds, if not thousands, of potential health care reformers waiting in the wings for this moment. Even Harry Truman probably didn't have a lot of hope in 1945 when he proposed health care for all. This is the single best opportunity we've had to get there, and I think everybody is enthusiastic and very optimistic. We have a proposal that I think will weather a lot of changes; I think it is very comprehensive and very thoughtful.

I'd like to explain why we really have a chance this year. It goes back to my history as a political scientist. It takes three things to generate real reform in the United States. I know all of you are actuaries, but you probably all took political science I, back in college. If you learned anything you learned that we have a system of checks and balances, of separation of powers, or, some have put it more aptly, of institutions sharing powers. It was set up that way. It was set up for our system to move incrementally. Culturally, politically, and sociologically. America doesn't make big changes fast, we make them slowly over time. We adjust rather than make leaps. This is one of those areas in which we may have to make a leap by making big changes in a relatively short period of time. This kind of thing happens only when three conditions are present.

First, you have to have real sense of crisis. It must be a crisis that's not just a crisis for one segment of the population, but a crisis for the whole or very large portion of the population. In this sense I think we have a crisis of security and health care. However good our insurance may be, we, or at least someone in our family, is at risk of losing that insurance in the near future. We have a great concern about this issue that's been growing each year.

The second thing you need to resolve the crisis is consensus. America is not a country in which big change gets made by us beating them, or by them beating us. It generally is the country that moves when the vim and the vigor come together around something. You don't get big change unless it grows in the middle in America, or unless you have a large consensus around the nature of the problem and around how to resolve it. I think we're going to need consensus. We're going to need a bipartisan approach; we're going to need people coming together. I'm not sure the President's proposal offers a middle ground consensus solution to the health care crisis. It is not what all the regulators have wanted; it's not what the Pete Stark's or the Henry Waxman's, or many of the liberal Democrats have advocated over the past ten years. What those people have wanted is a universal access that mandates that everybody pay, and almost by definition, a recognition or belief that government has to run the system. You need a heavy dose of regulation to go along with universal access. For the liberals, those two things have gone hand in hand.

Conservatives, on the other hand, always advocate making it more voluntary, using a marketplace solution. In using marketplace solutions, they usually back away from anything that would make everybody pay. Without making everybody pay, we can't get to universal access. So they generally propose market-based voluntary solutions that didn't have a mandate of any kind and didn't get universal access. The Clinton plan is proposing a cross between the two. It's saying we have to get to the means that Democrats and liberals have been advocating, namely what he calls health security for all . . . a card for every American that guarantees them health care. On the other hand, we don't want to get there by the means that many liberal democrats have traditionally advocated, namely, government regulation of the health care market. Rather, we want to get there by restructuring the markets so that there's a real competitive environment, and so that free enterprise drives the system. We want people to get their care in the private marketplace, not from government regulated mechanisms.

In a sense I'd like to think of it as political -- public guarantees and private delivery. It's going to take the public's commitment to guarantee everybody health care. Private insurance won't get us there. Once we have that public guarantee, the delivery of health care can remain in private hands. I think that is a workable compromise – a workable consensus to get us from here to there.

If you want to look at it from a rhetorical perspective, you could call it, choosing the means generally associated with more conservative forces, competition. To achieve the ends, more often associated with liberal forces, call it health care for all. So it takes a consensus to make big change in America.

The third thing it takes is leadership. It must be leadership from the top. Hamilton wrote over 200 years ago in the Federalist papers that energy comes from the executive branch. When you have a system of government as fragmented as ours, the only way you get big change is from unity, enormous energy and coordination from the top. It's the only place where you have the capacity to overcome the fragmentation of American government. We think we need a comprehensive, sizable change. A new direction. What it takes to get that new direction is crisis, consensus and leadership.

If you look at today's political environment, it's possible. We certainly have the crisis, we may have the consensus, and we certainly have the desire for the leadership. How effective it proves to be remains to be seen. Certainly there is a willingness on the part of the leadership, two of them in fact, to take an enormous step forward, and to really push hard on this issue. We're very optimistic that we can get somewhere in the very near future.

Gary Glaxton, who is truly our insurance expert, is the one who really should be talking to you, because he understands some of the concerns you have a lot better than I do. My role has been putting together the grander design, in terms of the structure, the health alliances, and the relationships between the federal government and the states. Gary was brought in to work on the insurance reform issues. It's unfortunate he couldn't be here, because he is such a good technician. Gary is stuck in Washington, and I'm left with not as much to do until this thing really gets out.

Let me start by talking about what I'll call three crises. Depending upon the group, I could define these crises in different ways. Another group may see different crises. I think this group should acknowledge that we have three major problems driving this reform need.

The first is the crisis of security -- the crisis of 37 million people without health insurance, and many more losing their health insurance every month. It is estimated that over the next two years, 25% of us will have no health insurance at one point or another. Tens of millions more will be underinsured, either because their deductibles are too big, or because their caps are too small. We have a real crisis in terms of people being able to take care of themselves and their families. I think that, more so than anything else, is driving this crisis. As all of you probably know, it is not a crisis of poor people.

I fear that if it were a crisis of poor people, we wouldn't be where we are. We're where we are because it's a crisis of the middle class. As my ex-boss always used to say, "We're all but one job or one illness away from having no health insurance." You can have the best job and the best health insurance in the world, and the next year, or the next month you, or someone in your family, might not have it. As the costs grow, which I will discuss in a moment, more and more employers find they have to give less and less.

So we have a crisis of security. People just don't feel they're covered. When they have good insurance they usually assume that insurance will work for them, or at least they're comfortable that their health care will work for them. I don't know that they're that comfortable that all aspects of their insurance will actually work, because they're not so confident about getting bills paid, and they might have to go after somebody else for money. Sometimes the charge is not usual and customary. They're not happy with that piece of it. But they are, I think, relatively content with the health care they get when they have insurance. People are worried that they may not have insurance. The more people read about the way the system is functioning, the more rightfully concerned they are.

The second problem we have is one of cost. Large employers keep telling us, we're doing fine, that we are holding our cost trends down to 3-5%. I keep wondering where these 8%, 10%, 12%, or 15% a year numbers are coming from. Are some of these big employers holding it down? Well, they're coming more in the mid-sized and smaller group markets, where costs are going up much faster than people can afford. Costs are going up two to three times the rate of inflation.

I know that's all modified insurance. A lot of that is pure health care, and a lot of that is new technology. Some of that is attributable to aging and other things. The truth of the matter is, we are spending greater and greater proportions of our personal income, our family income, our business profits, and our society money on health care. It's getting to the point where it's beginning to push other things out; we must get the genie back in the bottle one way or another.

Health care is fast becoming unaffordable for more and more individuals, more and more families, more and more businesses (especially small or mid-sized businesses), and for the government. We're putting more and more pressure on the government

to cap Medicare and Medicaid costs. And those of us that see the need for those programs are more and more reluctant to cap Medicare and Medicaid costs unless we can do something about the private market, and unless the gap between what we pay doctors and hospitals for those programs, and what the private sector is paying for these programs gets so great we begin to get severe access problems in Medicare and Medicaid. I think we already have the access problems in Medicaid.

We must get the cost under control. We're now at something like 14% of gross domestic product (GDP). I think Canada is at about 10%, and Germany and Japan are at about 9%. We're going up. They tell us by the end of this decade it will be close to 20%, if things proceed at the current rate. As a nation we simply cannot afford to do that.

The third crisis we have is what actuaries are more familiar with: the insurance marketplace itself. The underwriting and preexisting conditions have gotten awfully aggressive. There are exclusions, there are waiting periods, and there are problems with people when they change jobs. If you ask Americans in a poll, how many of you (or a member of a family) are reluctant to change a job, or over the last year were afraid to change a job for fear of losing health insurance, the numbers come back 25-30%. Huge numbers of people are reluctant to move from one job or another for fear of losing health insurance, for fear of getting a preexisting condition clause slapped on them.

I had one of the less serious forms of skin cancer. When I left my employer of many years, and went out as an independent contractor for awhile, my COBRA ran out. There I was with a pre-existing condition for skin cancer. I had to cover $500-700 a year, or two times more than that for the ongoing treatment of my possibly "life threatening if you don't do something about it" skin cancer. I also assumed a very hefty deductible trying to buy individual insurance. All of us have these personal problems. I'm sure everyone, even those who have good jobs with big companies has had some problem along these lines, or a friend, or son, or daughter, or mother has.

The insurance market has really broken down from competition over risk, and I think it's very understandable. Unless we do something about it, there will be competition over risk selection. Something like 10% of the people drive 75% of the cost. An insurance company or health maintenance organization (HMO) would be crazy not to take that into consideration when anticipating whether or not people will come into their plan. Over the long term, that is not the kind of competition that's going to help us improve the quality of our health care delivery system. It's going to protect them on the financial side, which has to be done in some way, but it doesn't solve our health insurance crisis. In fact, it aggravates our health insurance crisis.

The combination of insecurities of a broken insurance market, or increasingly troublesome insurance market, and costs going up too fast, for whatever the reasons has us in a true crisis. The economist would put this in a larger, more ideological framework and say that the problem is that the supply side is out of control, and the demand side is not up to the supply side. That is what most economists fear when these kinds of things begin to happen. Normally those who have the demand would hold

the reins on those with the supply; and you would get equilibrium. Things would change eventually.

That doesn't seem to be happening in health care. As all of you know, quite the opposite seems to happen in health care. You have heard the stories of the cities that have more hospitals, and more empty beds, and more specialists. Under any economic theory, prices ought to go down in those areas, as they compete for business. Somehow prices in those areas go up as the demand increases. Somehow the supply has got control of the demand in health care in a unique way, and the market, as currently functioning, cannot solve its problem.

What is the nature of this supply and demand crisis? For the most part, we have relatively unsophisticated purchasers, with the exception of very large employers who are beginning to get smarter. Most of the small employers are experts about clothing or food, or being a lawyer or something else. They're not experts about buying health insurance and are forced to become experts in something that's very complicated that they can't understand well. Most of the purchasers are not very powerful in a market; many of the purchasers having the greatest trouble have 5 or 10 or 15 or 20 lives to insure.

Consumers are not very cost conscious. When we buy health insurance we're not very conscious of the price, unlike when we buy cars and televisions. After all, the employer is paying for most of the insurance, and the insurance company is paying most of the bill. We don't have a lot of incentive one way or the other to try to spend less. Most of the ways our employers pay for it sways us the wrong way. When the employer pays 80% of any plan, what does that make the individual do? The individual thinks, "Good, for every dollar I spend, my employer is going to spend four, so I might as well spend more." That's the bargain. There's no incentive for the individual to buy a lower cost plan, when the employer is going to put in four dollars for every one the individual spends.

This is more or less the way the federal government employee system works. Which in many ways works well. Basically, the federal government will pay 75% of just about any plan you choose. If you don't choose a high cost plan, you're throwing away a deal. Many employers will pay 100% of any plan. There may be an HMO, and there may be a preferred provider organization (PPO), and there may be a fee-for-service plan. The HMO may actually cost less than what the employer is putting in. So why buy it? Why not buy the PPO? Why not buy the fee-for-service plan? It's getting paid anyway. It's only a few bucks to the consumer. Consumers are not very cost conscious.

The purchaser is also kind of locked in as the employer. An employer of 500 or 600 people offers a couple of HMOs to his or her employees and finds out a couple of years later that one of the HMOs isn't doing so well. It doesn't seem to provide the greatest care and the price is going up, but 200 or 300 employees really want to stay there. The employer isn't able to say to that insurer, "Sorry, you're not doing well enough; I'm moving my people out." You can't do that. Two or three hundred of your employees want to stay there, and they're going to stay there if you continue to offer that plan. So you can't walk out very easily and drive economy and value by walking.

We don't have any capacity to judge value, especially as individuals or small employers. You can get *Consumer Reports* when you want to buy a Ford or a Chevy. There's nothing to refer to when you want to buy Kaiser or Cigna or Aetna, or Health Med, or whatever it is. It is very hard to compare these different things. Even if they were offering the same thing, it's very hard to do.

The incentives are all in the direction of do more and we'll pay more. We pay lots of fee-for-service medicine, and again, in a noncost-conscious environment, there are many reasons for doctors and hospitals to do more and get paid for more (until the insurance company balks, but that's not an argument we hear, that's an argument between the doctor and the hospital and the insurance company).

Suppliers are well organized in this universe if we look at it from a political point of view. The suppliers, whether they be the insurers, the HMOs, the doctors, or even the nurses, are very powerful politically and very well organized. The purchasers are not. I'll tell you a story which brought this home to me in such a dramatic way. Certainly the small businesses have no real organization from which they purchase health insurance. They have organizations that lobby for them about small business issues, but health care is not usually the first of those small business issues. I remember having a discussion a few years ago when some of the ERISA plans came into my office. I was sitting in a room with the health care representatives of some of the nation's biggest corporations. They wondered what would happen if you had this new system, and the state legislature in California enacted a bill that said chiropractors had a right to be included in the benefits package. I said, "Well you'll work against that, if you don't think that's a good idea." They laughed in my face. They know when it comes to health care, the chiropractors are stronger than the corporations, because the chiropractors are organized around health care. Chiropractors contribute a lot of money to health care. It's all they care about.

Major corporations are much more concerned about other things. Health care is a little tail on their dog. You would think all these giant American businesses would have some lobby clout when it comes to health care. They feel that they don't match the provider community. The sellers. In health care, we have the ultimate perversity of supply and demand in which the supplier actually controls the demand. You go to the doctor, you go to the hospital, they in fact tell you what you need, and you're usually not about to argue. So supply and demand hasn't worked, and therefore, we need to do something about it. I'll offer two solutions.

Many people argue that basically the government has to take over; regulation is a way of controlling the suppliers, regulation is a way of getting this equation back into line, and basically government must micromanage the system and control prices. Medicare, single payer systems, and the Canadian health care system are examples of this type of approach.

The Clinton plan has clearly rejected that. Clinton, from the very beginning, didn't want that. He didn't think the government should or could micromanage one-seventh of the economy. More importantly, he also doesn't believe in the long run that the regulation of each price and service is the best way to improve efficiency and value in the health care delivery system. If you look at Medicare or the Canadian model, they too are having as much trouble controlling cost increases and expenditures as anyone

else. The problem is, we still have a system in which doctors, hospitals, nurses, and other professionals are not forced to cooperate, to integrate, to communicate, and to build more efficient organizations.

We're still paying all of them individually. If we went to a system like Canada's, with doctors and hospitals being paid individually for each service, we'd be paying the bad ones as much as the good ones. We would still be encouraging doctors and hospitals to make more money by doing more, and we would be doing very little to force them to come together and to do it better. Take ten intelligent people, put them together and say, "You're no longer working as individuals; see how the ten of you can accomplish this task together." If you do it right, you can probably do a better job than you were doing as ten individuals."

If you think of a secretarial pool of ten secretaries, and you had ten projects, you could go to any one of them and say, here's a project to do. They'll take it, and they'll do it. You could go to the ten of them and say, here are ten projects. I know you all have the expertise to do them. I'm going to give you the same amount of money I would pay each one of you individually to do one of these. See if there is some way that by working together, you can be a little bit more efficient, and you can keep the difference. I'll bet they'd find a way. That's what organization is all about. We don't have a lot of organization in health care.

The Clinton plan, by looking either at Medicare or by looking at the Canadian model, didn't want to go down a road of government management in which we either tell everybody how to do it or just pay everybody individually for doing it. We wanted to find a way to incent private health care community to come together in more efficient ways that produce better value and better economy and health care.

We do that by strengthening the purchaser, by trying to make the demand side equal to the supply side, by leveling the playing field a little bit, and by changing some of the current rules of the game. We then leave it to the private market to improve value and economy and ultimately lower the cost. The essence of the Clinton plan is reform of the insurance marketplace. The reform is aimed at empowering the purchaser, strengthening the demand side by increasing the cost consciousness of the consumer, and by improving the information available to the consumer, both on satisfaction and quality. It would give the consumer greater choice, which includes the capacity to walk, to weave, to go somewhere else as we have with most purchases we make. It gives the consumer greater capacity to move between different plans. Most importantly make the providers either health plans, organizations of doctors, hospitals, insurers, in whatever way they want to form, compete on what we want them to compete on: price, quality and service. Now they compete on how to avoid share of that 10% and how to get a better risk pool?

Unfortunately there's often more money to be made by getting the right risk pool than there is by delivering care efficiently to the risk pool you have. Those are some of the goals. Economically the goal is to enable the demand side to better reward those suppliers that are improving, producing better value, a better economy and better health care. While this is a very market-driven approach, it does require some restructuring of the insurance system. It requires changing the rules by which

insurance is marketed and sold and delivered, providing a level playing field. Competition can really take place on the basis of value and quality and service and price.

The keys to this change are the insurance reform principles and the health alliances. The mechanism of the health alliance allows the purchasing cooperative to offer everybody choice, a level playing field and to change the rules of the game. What are the rules of this alliance? How do we anticipate that this alliance will be able to accomplish these worthy goals?

Currently the alliance is not the way some of us would have liked it to be. The alliance we currently have must take all certified health care plans. Any plan that's certified to deliver the guarantee benefit to the population has to be allowed to compete. We think that while we have defined three types of service plans, an HMO-type plan, a fee-for-service type plan, and a point-of-service, or PPO type plan, we expect that over time all kinds of new things will bloom. Some plans will come from the top down, organized by Aetna and Travelers and others. We expect many plans and many communities will come from the bottom up by organizing around local hospitals, local providers, local nurses, and local health care professionals, and getting together to figure out how to best serve the community.

All plans are allowed to bid, and all offer one price for each family category we have. The plan has to list on the consumer brochure the price to enroll in the plan for each family status. All plans offer the same benefit. There are arguments for competition and choice, suggesting that different types of benefit packages should be offered, and most of us would agree that there may be some value in competition and choice. The majority of insurance policies offer similar benefits; except for those that are catastrophic, with huge deductibles, or are bare bones with limited coverage. We threw out the two exceptions because we don't think they're very viable.

Most policies don't vary that much and are similar in terms of their benefits. What we really get is enormous jingling of bells and whistles, much of which is geared to attract certain groups, and maybe deter other groups. We think there's a lot more benefit on the competition side, and on the efficiency, and economy. We should be saying here's the guaranteed benefits everybody has to offer. Now compete on that and on your price. We'll let you sell supplemental benefits, but they are outside the price we want for this package. We want to know what you're going to charge for this package. This is what the consumer can use to really compare.

And, they're going to say that all carriers and all competitors in this new system must take all enrollees. Capacity allowing, you have to take anyone who wishes to enroll in your plan. That also gets away from the ability of the plan to select the risk. The public gets more information than it has. The public will get a brochure which gives it not only the price of the different plans, a little bit of information perhaps on whether or not they impose restrictions, and what doctors you can see. The public will also be asked to respond to a survey we'll take of each set of carrier members, or enrollees in which questions are asked about the consumer will price satisfaction for his plan.

The survey will tell the number of individuals that are satisfied or that liked the plan, and it provides the number that don't like the plan. It will show the complaints we've

gotten about this plan, and the number of justified complaints we received about this plan as opposed to what we received from every other plan in the last two or three years. It will show how this plan has done on certain quality checks, immunization rates, well baby care, prenatal care, and on a few other things we'll be able to measure. It gives information on how many left the plan last year and why they left that plan. We will interview everybody who leaves and tell what they said. This is the kind of information we will be able to give consumers in a relatively clean format.

Then why won't people enroll in the individual plan? Because people will enroll through their alliance. They may actually do it through their employer, but they're not going to be recruited by the plan directly. They will not go to the plan to enroll. They will enroll by telling their employer which of the plans listed in the brochure they want to enroll in. Some rules will be placed on the marketing of plans by insured. If they do direct marketing by mail, we're going to want to see to what areas they're marketing. Or are they just targeting certain areas? Are they just marketing to the local health club, but not to other local businesses or places of activity in the local area? We want to be a little careful about that, although we don't want to be too invasive.

An individual will be able to change plans every year. People can move from plan to plan and will not be locked in.

The employer will pay 80% of the average premium with the individual having to pay the difference between what the employer paid and the price of the plan they chose. So the individual will see the difference between what the employer is paying, and what they want to pay. If they want to choose a low-cost HMO, or a low-cost plan, the probability is they will pay nothing or next to nothing because there will probably be a plan 10% or 15% below the average, and that won't cost them very much. If they want to pay for the average plan in that alliance, they'll have to pay 20% of the premium. If they want to buy a more expensive plan, they'll have to pay more than 20% of the premium.

Here is the key thing from your point of view, and here's where we'll need lots of help from you. Plans will then be paid on a risk-adjusted basis. Plans will be paid on the basis of the enrollees that are in their plan. Are they higher cost or lower cost? Older, younger, male, female, or do they have certain kinds of defined-medical conditions or not? If we can get that piece right then we will really have plans delivering health care and not so many selling insurance.

A lot of the single payor people keep saying to us, why are you letting these insurers stay in the game? They butchered the industry. They butchered our lives? Why are you letting the insurance company play the game? And my answer is, that's an old question, because insurance companies that want to compete are going to compete in roles that are very different from the ones they know. It doesn't really matter whether they want to call themselves an insurance company or not. They're not going to be making a lot of money taking risk. As the First Lady keeps saying, insurance companies are going to become delivery systems. And if they prove themselves better than HMOs and other organizations at organizing health care delivery systems, more power to them. They can thrive.

If they want to make more money by selecting risks and getting the right pool, that's another story. That kind of money making we're used to is not going to be as readily available, because taking something right off the top in addition to delivering health care is going to make you clearly more expensive to those you are competing against. Insurance companies are welcome in the game, but the game is different and the rules are very, very different.

Let me touch on a couple of issues that I know may be particularly interesting or important to you. Why a budget? Why a limit on private health care spending? Why are we proposing that? To begin with, we think it's a back stop. We think there are enough cost containment features in the plan that the so- called budget, or limit on the rate of growth on the alliance premium will not kick in in most places most of the time, but will in some places some of the time.

Why do we feel it's necessary to do that? Let me give you two reasons. Aside from the global economy picture, which says overall, we as a society just can't afford this, we have to do something unusual to get this under control. First, I suggest that if we're going to go to all businesses, and to all individuals in America and say, "we're going to impose on you a requirement to pay for health insurance," then we're going to have to be able to assure the American public and the American employer that we're not going to make this burden too great. If we go to them and say, we're going to require you to pay for health insurance, and it might continue to go up 10% or 15% a year, not only is that politically impossible, it's almost unethical. If we're putting that responsibility on them, then we have responsibility to make sure that the burden is manageable.

The second reason involves the relationship between the public and the private program. We have got to control the rate of growth in the public program, and we cannot do it in a vacuum. We cannot just keep clamping lower and lower charges on Medicare and Medicaid. Lowering the charge on Medicaid doesn't get us all that much. You lower the charge on Medicare, the doctors do more, which presumably means more people are getting unnecessary and more inappropriate care. But even leaving that aside for the moment, we've got to find a way to control the rate of growth in the public program. We cannot put a cap on the public program without touching the private program. Because the gap between what we pay public programs versus whatever we pay private programs will be too great. The only way we can control the growth in the public program is to have some impact on controlling the rate of the growth in the private program.

We're confident that we can do that using the cost containment mechanisms and the competition mechanisms we've put in. It won't depend on this artificial construct of a limit on how much premiums can go up at any one year, but if necessary, we're prepared to use that. We must, one way or another, get a handle on the growth of premiums in the private sector.

Can we hold private spending down without an imposition of an arbitrary limit? Are the cost-containment features in the Clinton proposal enough to enable the system to correct itself? To get more value, more economy, more efficiency? Let me make three points in connection with why I think we can truly slow the rate of growth in the private sector from where it is now to where we want it to be.

Look at all the things we're doing in the new system. We're going to pool small businesses, so that small businesses no longer have overhead of 20% or 30%, or in some cases 40%. We're going to pool small businesses into a larger purchasing cooperative. This would give those individuals choice and would dramatically reduce the overhead of selling insurance to small businesses and all the underwriting that goes along with that.

We're going to do great things for the hospital and doctor community in terms of the reduction of bureaucracy and paperwork. Right now, all kinds of hospitals and all kinds of doctors are paid by literally hundreds of different insurance companies on different forms; it is a paper chase.

This is a regulatory and bureaucratic nightmare that I think we don't need. If we have a system like we're encouraging, with more doctors and more hospitals affiliated together, most of them will be paid from fewer plans with whom they will have contracts. They know what they're getting paid for what procedure, under what circumstances. They can bill once every two weeks or once every month for the work they did for them. Or they can be on contract on a yearly capitate basis. Or they can be on salary. But you'll know what they're getting. They're not going to have to hire more and more people to chase down more and more different payers paying different bills on different pieces of paper.

We're going to change. We're going to leave fee-for-service out there for those who want it, but we're going to encourage more capitated payments. We're going to do a lot to try to get at the question of inappropriate care. I don't necessarily mean inappropriate care resulting in staggering cost, or end of life issues. I mean all the tests and procedures that doctors and hospitals now affiliated with plans are going to think a little bit harder about doing, and be a little bit more cautious about doing. They're not necessarily going to get paid by some outside payer for everything they do. They're going to get paid more for taking care of a population.

The more tests or procedures they do that are unnecessary, the more money they will lose. We're switching those incentives, though obviously, we'll have to keep the floor solid. We're dramatically going to change the incentives in the way most providers get paid. We're going to add some cost-effective preventive care. There are certain areas in which we know we should be doing more preventive care. Hospitals praise the wonderful things they do with newborn premature infants, but then we find out that some mothers never saw a doctor in the nine months before they gave birth.

We're going to improve the cost consciousness of the average consumer. Every consumer is going to have decide between buying a lower-cost plan or a higher-cost plan. The higher-cost plan would require more money out of the consumers pocket. Exercising the right to choose makes the consumer more cost conscious. We're going to greatly enhance the competition – the kind of competition that leads to greater economy or value in health care. It could be competition over price, service, and quality and not over risk selection. We're going to do everything we can to make health care delivery systems compete on the basis of how well they deliver health care, not on how well they figure out who is in their pool or how well they can get people in or out of their pool.

We're going to promote greater efficiency and greater organization in the medical community. It's very much like a cottage industry. All kinds of doctors and hospitals are largely practicing on their own. These primary care doctors and specialty care doctors have very little relationship with each other. Think about the difference between a primary care doctor who says, "You need to see a specialist" and one who says "You need to see a specialist. You're going to go see Bill, who's in the same plan." By referring a patient to a specialist in the same plan, both time and costs are saved.

We're going to have better quality, better data, better practice parameters, more practice protocols, and better outcome research in the system. Over time, as we collect data and as doctors and hospitals deliver care, we will begin to find out more about what works and what doesn't. Doctors and hospitals will be able to deliver care according to those protocols and guidelines and outcome research.

After four years we'll still be spending a lot more money on health care than we are now. The Clinton administration is not proposing to suddenly add more benefits, add more security, and spend less money. For four years we'll be spending more money than we are now, so we're not expecting any miracles. Only in the fifth year do the lines cross. In the year 2000, when this first wave of reform is over, health care in America will still be at 17.3% of GDP. No other nation will be higher than 10% or 11%, and they are all covering their people and seem to be doing well on the quality side. Why can't we get there? Why can't we as Americans improve to that level of efficiency?

Finally, I'll close with a note on the question of risk adjustment. Much of what we have to do will depend on our ability to adjust for risk and to pay health care plans fairly and appropriately based on the risk of the population they have. Now we're going to do a lot to get away from bias selection in some of the things I already talked to you about. We're going to have universal coverage. It's not going to be there for a matter of enrolling some and not enrolling others. We're going to have a standardized benefits package. You can't appeal to some by giving a little bit more preventive care, and therefore, get in the families that are more conscious of preventive care and more conscious of good health, and therefore, less likely to be costly.

We're going to have larger pools of individuals to begin with, and probably fewer ultimate competitors. These competitors will all have larger pools and be more capable of spreading risk over a larger pool. It's easier to spread your risk when you have 100,000 enrollees rather than when you have 3,000, 4,000 or 5,000 in a given area. We're going to have insurance reform measures of guarantee issue, and guarantee renewal, and community rating, which will level the playing field.

If we're going to get insurers or health maintenance organizations to play this game, we're going to have to guarantee them that we're going to pay them fairly. We're going to need a lot of help from actuaries to figure out how to do that. In the beginning, we'll probably have to use both a risk-adjustment mechanism and the reinsurance mechanism. Over time we won't have to use as much reinsurance, but we're going to have to work with these things. If we cannot figure out how to do this fairly, we're not going to get plans willing to play the right game. I can't tell you

how many insurers come to me, especially the larger ones, and say they are willing to play this game differently, but you've got to make everybody play the game differently.

MR. STEPHEN A. MESKIN: I applaud you, your work, and the work of the Clinton Commission to bring forth an interesting plan and to set the dialogue. I was particularly interested in a statement from your plan which says that the system should avoid the creation of a tier system providing care, based on differences of need, not individual or group characteristics. In my view, and actuaries like to look into the future, the system will encourage development of two types of plans. One will be a low-cost, high-volume plan that hires minimally qualified staff. It would restrict the access to secondary care. The second type of plan will be a high-cost, boutique plan, or fee-for-service plan. As a result, the plans the people choose will become another status symbol along with cars and sneakers.

MR. ZELMAN: Right now you can buy a Mercedes, and you can also buy a Hyundai. You can buy the cheapest Chevy in the world, or you can buy a Jaguar. But there are a lot of options in between. If you look at the car market, there is everything you can imagine beginning from about $7,000 on up. I've never gotten to the upper price range. It's not that clear to me that what you're suggesting will prove to be the case. I think there are a huge number of Americans like me who probably would not buy the lowest-cost, most restrictive health care plan available. I also am quite comfortable with an HMO or PPO that says I'll get a better deal if I go to one of its doctors in the system rather than go to anybody I want.

I think the market will produce a lot of variations, including variations in price and variation in access. Hopefully, there won't be too much variation in quality. I'd be lying if I said there will be no variation. But, in order to compete, you must meet the quality standard. If you're really giving low-cost, nonaccess care, at some point, if the system works right, We'll say, "No, that's not adequate care; you're charging very little, but your care is not adequate enough."

MR. MESKIN: Well, it sounds like your answer contradicts the statement of principle about not having multiple tier plans because the people are going to choose based on cost, and we don't want people driving around in their "Yugo" health care plan.

MR. ZELMAN: Rather than cars, I think a better analogy would be service. When you get on an airplane, the primary thing you're concerned about is safety and getting there on time, whether you go coach, first class, or business class. The amenities may change. You get better food in first class, but it's not critical. You get better food and more leg room in business class, but it's not critical. The basic service that's being provided is getting you from here to there safely and that it's provided with quality. There will be gradations of luxury and amenities, but I think gradations in quality may not be that great. In fact, there's a lot of evidence to suggest that those people who have the greatest choice are not necessarily getting the best quality. As I suggested earlier, the system giving the greatest amount of choice about doctors or hospitals is not a well-coordinated system, because often it does not lead to the best quality.

MR. HOWARD J. BOLNICK: I'm also very involved with the American Academy of Actuaries. First, I want to compliment you and the entire Clinton administration on a marvelous job of assimilating a tremendous amount of data and putting together a plan with some good thought behind it. I think everybody in America agrees with the goals. It's very hard to disagree with some of the things you talked about.

I'd like to report on a meeting we had with about 200 actuaries. One of the questions that I asked the group was whether they thought what was delivered in the 239-page report was workable or not. I will be the first to admit this was not a scientific survey at all, but the room was full of people who have to deliver what you'd like to do. You had one supporter. One single supporter in the room said what you propose is workable. Virtually everybody in the room said it was not workable. There was a smattering of people who said that they just really didn't know. I think that's something that requires some thought on the administration's part.

MR. ZELMAN: Not workable. May I say in what respect?

MR. BOLNICK: Well, that's the second part of what I was going to say. I don't know what all these people meant. The American Academy of Actuaries is going to look at various aspects of the plan in a nonpartisan view, and try to report back to Congress, to you, to Mr. Magaziner, the First Lady, and the President on what mechanisms we have some trouble with. I hope you'll be receptive to some of it.

MR. ZELMAN: I think we will be and I think that will be extraordinarily helpful. We realize the risk adjustment piece is very critical. We are willing and open to input on this too. There's no question the system will work better if we can really develop good risk adjusters, be it prospective or retrospective. I know Gary has met with a lot of you already, and I'm sure we're going to continue to talk with you about it. I appreciate that.

FROM THE FLOOR: I would like to applaud you for mentioning many of the defects in the system, such as preexisting conditions, unwarranted risk selection, and the lack of choice employees of large companies have in their plans. I would also submit that in trying to slay the dragon of preexisting conditions, unwarranted risk selection and the lack of choice, that that's a dragon that's practically dead right now. New York state has small group reform; preexisting conditions have been severely limited. As long as a person had any kind of decent prior coverage, no preexisting conditions are imposed. Risk selection is prohibited in New York state; I believe it's prohibited in Vermont; I think there are a whole host of other states that I can't enumerate right now. But I believe risk selection is a dying phenomenon in the health insurance market. We have to compete with HMOs, with group practice HMOs, with a lot of point-of-service HMOs. The competitor that you're talking about certainly exists for us.

I would like to ask one overall question. You're talking about Harry Truman's health care plan back in 1945 that never passed. I'm going to repeat what a lot of people have said. The United States of America still has the best health care system in the world. We see people from foreign countries flocking here to get health care. We don't see Americans flocking to foreign countries to get health care. I can't enumerate all technological improvements made since 1945: magnetic resonance imaging

(MRIs), cat scan, the fetal monitor, amniocentesis, shock wave, open heart surgery, organ transplants, and tremendous improvements in drugs.

If the Clinton plan had been effective in 1945, with all its caps, would we have all those things? What if a child with a sore throat, instead of going to a doctor, could open his mouth in front of the television set, and a half-hour later have a prescription pop out on the home computer? That would be a technological improvement, but it requires people to put up money and invest. People have a chance of making some money. If we had these caps in 1945, would all the enormous improvements and medical technology that have occurred in the last 50 years have occurred? If we have these caps in the future will the bright future that exists out there actually come into being?

MR. ZELMAN: Let me respond by saying that I believe that many of the states are beginning to move in the right direction in terms of insurance reform, preexisting conditions, and guaranteed renewal, guarantee issue, etc.

Almost all of those proposals failed to do two things. They don't really do much about the cost. In fact, if anything they attempt to drive up the cost for a lot of people already in the market. Second, because they don't do anything about the cost, they don't do anything about the access problem. They are very good for those people who tend to be quite sick, and are not getting insurance even though they are employed because they're sick. Those are the people who benefit the most from those kinds of state reforms. And that is a positive for sure. But I don't think anybody expects the reform we enacted in California, which is similar to the reform you have in New York, to dramatically lower the price of health insurance. The indications are a lot of insurance costs are going to go up, because we're bringing in the sickest people without doing anything about changing the system into which we bring them.

It's not clear that we've got to control the costs or get the access up. Therefore, we think we need to take positive steps and put them on a national framework with a few other things, as part of a more comprehensive reform package. As for the technology and the budget question, and people coming here from other countries, most of these people are rich people who want to take advantage of our unique high-tech services. The people who would be going to other countries are people who don't have good preventive care; people who don't have insurance; people who don't have health care. They can't go to Germany, or Japan, or Canada just to get those kinds of day-to-day services. That's where we're falling down. We're great on the high-tech side, but we're weak on the prevention. We're weak on the day-to-day care, and we're weak on covering all our people.

I'd like to think we can have both. I'd like to think that we can put some restraint on the growth of insurance premiums, and still have innovation and experimentation and the progress we've made. We're not ignorant of the fact that this is a tremendous export industry and a great money maker for the United States in many respects. We've got to find a way to get technology working to control costs. We simply can't let every drug company or every manufacturer do anything they want. We can't say, "Come up with anything that helps anyone, and we'll put it on the market and pay for it." There must be some capacity to limit that.

FROM THE FLOOR: I partially agree with you about the high cost of coverage. I would submit that preexisting conditions cannot really be entirely eliminated at least not until we have these universal coverages.

I would submit that universal coverage can be accomplished without the entire apparatus of the Clinton reforms. The rich people come here to seek out the best. We should all have the best. That's why they come here. You're confirming that the American system is the best in the world.

MR. ZELMAN: The American system is the best in the world at some things, especially the high-cost, high-tech kinds of things. I don't think anybody can argue with that. The question is, do we have to give a little bit on that, in order to get so much else on the other 95%? I'm not even sure we do, but I think we have to be willing to entertain that notion.

FROM THE FLOOR: The high cost that a lot of us are concerned about is the cost of malpractice awards. I'm not suggesting that restrictions ought to be billed down which prevent doctors from doing what they have to do, but many doctors feel they're compelled to provide every test, to do every conceivable check, to determine the patient's condition. In part it's for fear of malpractice. Many doctors pay premiums of $50,000 a year or $100,000 a year or higher to cover the risk of malpractice awards. I think if there's anything that needs some kind of cap it's on the size of malpractice awards, and the legal expenses that go with them. I'm just wondering if any attention at this point has been given to the area of malpractice.

MR. ZELMAN: A lot of attention has been given to it. There's a lot of debate as to how much those costs really are. The congressional budget office, which a lot of us regard as an authority on many issues, tends to down play that. It points out that malpractice premiums may be 1% or 2% of the total cost of delivering health care. It's not all that clear. Doctors and hospitals will frequently tell you that 20% or 30% of what they do is defensive medicine. That's treated with a lot of skepticism by a lot of reputable sources.

There's no question that there's a true malpractice crisis in some specialties. Obstetrics is one, neurology is another. These are areas where costs are extraordinarily high, and there is a problem. We have a few proposals to cope with this. There is a serious proposal in the Clinton plan to begin to address the malpractice crisis. They include improved alternative dispute resolution mechanisms. They include some evidence that the plaintiff has to present, from a qualified physician, that there's reason to believe that there may have been some malpractice. We also hope, over time, that as we begin to collect more data on practice parameters, and outcomes, and protocols, that we will be able to say to increasing numbers of physicians, "If you practice within these general guidelines, if you did the normal things that are expected when presented with a set of circumstances, and if there wasn't something extraordinary about this case that should have made you do something different, then maybe you can have something of a safe harbor from a malpractice lawsuit."

As we get better information, and we have better parameters, we can maybe begin to give physicians more protection. We did say that there's a limit on what the attorney can take, which is 33%. The question is, should there be a limit on pain

and suffering? I know they have it in California. That's what a lot of the physicians want. That's what others may want. I have some reservations about that, whether we believe it's right or not. That would take the ship of health care reform and point it straight at the rocks of tort reform.

The biggest, hottest, ugliest special interest fight in every state in the United States is doctors verses lawyers. Lets accomplish health care reform without having to take on the doctor and lawyers battle in every single state in the most horrible of fashions. We'll never get this thing through if we try to solve all the problems. I suggest that that's one that can be dealt with separately.

FROM THE FLOOR: I'd like to make one comment and then bring up a couple of points with regard to how alliances would be managed. Most of the people I deal with are in the self-funded market, and the employers pay the claims directly based on their summary plan descriptions. The insurance companies that do the administration are third-party administrators and may not be insurance companies at all. They have no interest at all in whether people have preexisting conditions or not. It's simply a function of what the employers allow. None of the employers seem to have preexisting conditions or exclusions that last until a particular point in time. It's not an insurance company issue.

That was not true obviously in individual insurance, in very small groups where the insurance company has taken full risk. With regard to alliances, do I understand that each alliance will set a service maximum through negotiation for doctors. Will that be alliance-wide, or will it be different geographically?

MR. ZELMAN: The rate that has to be negotiated by the alliance I believe is an alliance-wide rate. It may be that the alliance is very large. It might negotiate several regional rates. In other words, California, if it wanted, might decide to have one alliance for the state, but might want to have service areas in which the rating structures were different.

FROM THE FLOOR: With regard to the financial experience, will each alliance have to be self supporting? For example, what if an alliance in southern Florida had set rates, and they didn't work out well, and they were going to hit a budget cap? Would that alliance only draw the money that it receives through the people who pay into that alliance? Or would it be subsidized? If it has to be self supporting, it could be where these budget caps are. They go back to all their accountable health plans, and say, you're going to have to restrict charges to do more utilization control. And even the alliance setting the doctor fee and the fee-for-service might have to reduce these. It could work out very well if the accountable health plan would put in utilization controls such as limiting referrals to allergists to three visits rather than three months. You could go through a whole series of protocols, which would really make those plans significantly different than those administered in other alliances in the U.S.

MR. ZELMAN: I expected actuaries would ask difficult questions, I didn't think they'd be so long. How do I address all that? We tried to structure the alliances in terms of the geography of who is in an alliance. One key decision we made is all employers with 5,000 or less employees, or the Medicaid, or the unemployed population, all go into what we call the regional alliance. You have to be an employer of 5,000 or

more, in order to have your so-called corporate alliance, to do your self-insured separate thing.

For the regional alliances, what we've tried to do is make sure that they are, that a state cannot draw an alliance size, in such a way that it discriminates in any way against a particular vulnerable population. We want alliances to be heterogeneous communities – large enough to be heterogeneous, large enough to be able to financially spread the burden. If you take New York for example, you couldn't have an alliance of the Bronx alone because the higher cost of health care in the Bronx, the higher incidence of violence, the higher incidence of all the problems that drive up health care in the Bronx, would make the alliance cost in the Bronx prohibitive.

Now it's true the employers and employees would still be capped, so the taxpayers and the government in effect would be subsidizing those. The alliance would still get the money it needs, but it would still force the maximum out of every employer and every individual in the Bronx. It would probably force more government subsidy because in surrounding areas, the employers and the employees are not hitting their caps and would be paying less. What we would say about the Bronx is, the Bronx has to be mixed in with a larger, more heterogeneous community. In that sense, no alliance is on it's own, because it's too small to be on its own. We expect alliances to be fairly large coalitions of heterogeneous groups, some of whom may have very low incomes, but many are middle income and upper income individuals.